check

Independent learning program for GPs

Unit 585
August 2021

Adolescent health

RACGP

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Adolescent health

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The five domains of general practice

- Communication skills and the patient–doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP

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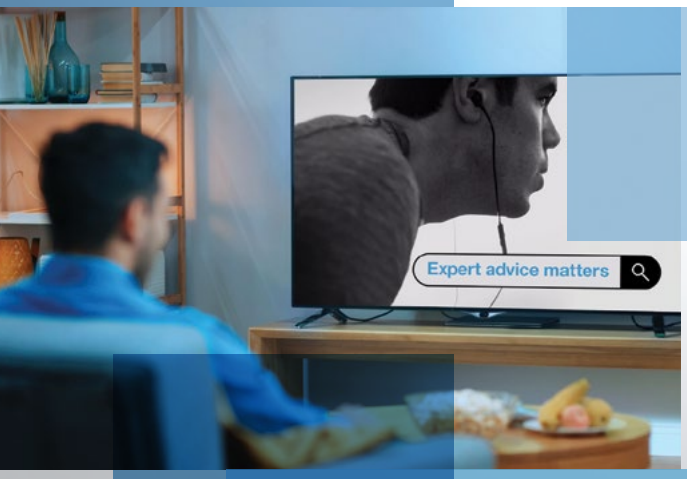
Royal Australian College *of* General Practitioners

To protect patients during the pandemic, we reminded them GPs are the real experts

It all comes back to care

During the COVID-19 pandemic, misinformation spread as quickly as the virus. Lockdowns discouraged some patients from seeking essential care for chronic diseases and emerging illnesses and getting vital routine check-ups.

The RACGP's Expert Advice Matters campaign reminded the public that GPs are the real experts. We knew if we got patients back into your practices, you'd take care of the rest.



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About this activity

Approximately 80% of adolescents visit a general practitioner (GP) at least annually,[1] presenting GPs with an ideal opportunity to assess young people for conditions that may affect this age group.

Australian data show that, in a 12-month period, 31.6% of adolescents exhibit disordered eating behaviours,[2] and the prevalence of eating disorders is on the rise.[3]

Depression affects 13–17% of adolescent males and 14–30% of adolescent females in any given year. A smaller percentage (1.6–9.0% of males and 2.7–8.9% of females) experience major depression.[4]

Data from the second Australian Child and Adolescent Survey of Mental Health and Wellbeing indicate that approximately 10% of adolescents have ever deliberately self-harmed, and 75% of these individuals had harmed themselves within the past 12 months.[5]

Family violence is a major health issue, and early life exposure to domestic violence can affect development and increase the risk of behavioural and learning difficulties and mental health issues.[6] In 2016–17, approximately 34,000 children experienced domestic violence–related homelessness.[6]

This edition of *check* considers the investigation and management of health concerns affecting adolescent patients in general practice.

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Learning outcomes

At the end of this activity, participants will be able to:

- identify signs that may suggest a patient has an eating disorder
- describe the approach to management of an adolescent who is experiencing family violence
- discuss the factors that increase the risk of self-harm in adolescence
- outline the guideline recommendations for the commencement of antidepressant medications for adolescents.

Authors

Case 1

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Case 2

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Case 3

Claudio Villella MBBS, MMed Res is a General Practitioner (GP) with many years of experience working with young people in a variety of settings including youth justice, secure welfare, youth drug and alcohol and headspace. He is the headspace National GP Advisor, where he supports GPs working in headspace centres across the country who are supporting and managing young people aged 12–25 years. Some of these GPs have been consulted and made meaningful contributions to this case study without wishing to be acknowledged.

Case 4

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Vern-Li Tan MBBS, DCH, FRACGP is a General Practitioner who has worked in Melbourne for the past 18 years. She embraces all facets of general practice, but it brings her much joy to develop the potential in each child. She has completed a Diploma of Child Health and trained at the Royal Children's Hospital in Melbourne. Dr Tan served on the medical team for the XXI Commonwealth Games. She currently works in private practice in Templestowe, Victoria.

Abbreviations

AOD	alcohol and other drug
DASS21	Depression Anxiety Stress Scales-21
GP	general practitioner
IDDM	insulin-dependent diabetes mellitus
K10	Kessler Psychological Distress Scale
MDD	major depressive disorder
MHTP	Mental Health Treatment Plan
PHQ 9-A	Primary Health Questionnaire
RCADS	Revised Childhood Anxiety and Depression Scale
SSFC	Single Session Family Consultation
STI	sexually transmissible infection

CASE

1 Do-san is having trouble at school

Do-san, aged 16 years, presents to you with his mother, Na-eun. Na-eun starts the consultation by explaining that Do-san has been having trouble completing his homework for school, is eating less than usual and spends a lot of time alone in his room. Do-san has his arms crossed, looks down at his shoes and appears withdrawn. Do-san tells you he feels sad most of the time; he is stressed about his final exams for school and has been having trouble sleeping for the past few months.

Question 1

What further mental health history would you seek from Do-san?

Further information

Do-san has felt low for the past three months. He has had trouble going to sleep at 10.00 pm and a few times a week will wake at approximately 3.00 am and struggle to get back to sleep. He feels tired most days and has reduced appetite. Do-san previously enjoyed school, but his teachers have reported that his grades are declining, and he is having trouble concentrating on his work. He has been otherwise physically well, takes no medications and has no allergies. He has normal observations, a body mass index of 22 kg/m^2 and no clinical signs of anaemia or hypothyroidism. His Kessler Psychological Distress Scale (K10) score is 24, which indicates a high level of psychological distress.

Question 2

What else would you include in your initial assessment of Do-san?

Further information

Do-san agrees to see you without his mother present, so Na-eun leaves to sit in the waiting room. You discuss patient confidentiality with Do-san. You advise Do-san that anything he tells you is private, and you will not tell his mother or anyone else anything he says, unless you are concerned that Do-san or someone else is in serious danger. You and Do-san complete a HEEADSSS (Home, Education/Employment, Eating/Exercise, Activities, Drugs and alcohol, Sexuality, Suicide and depression, Safety) assessment together.

Do-san is the eldest of three children and lives with his mother, father and two younger siblings.

Do-san is in his final year of high school and feels a lot of pressure with exams. He has two good friends, Angelo and Jacob, and he plays lacrosse at his school once per week. Do-san often skips breakfast on school days but eats regular meals and snacks otherwise.

Do-san has tried alcohol and cigarettes a few times at parties this year but does not drink or smoke regularly, and he has never tried illicit drugs. Do-san is attracted to females, has had one girlfriend previously, and he has never had sexual intercourse.

Do-san says he cut himself twice last year when he was very upset but has not done this since. He thought about suicide a few weeks ago when he was feeling very upset, but he reports no plans to hurt himself today, telling you that, 'I just want things to get better'. Do-san shares that his father and mother fight a lot. He says it's been like this 'for years', and he thinks it's because his father has a very stressful job.

Question 3

What would be your initial treatment approach for Do-san?

Further information

Do-san returns two weeks later to review his mood and progress. He feels his mood is about the same, although he has been waking up less at night and feeling a bit less tired. He has been speaking with his school counsellor twice per week, he has registered for the online mental health course you prescribed, and he has an appointment with a counsellor next week. You ask Do-san how things are at home, and he tells you his father came home drunk last night and hit his

mother several times. On further gentle questioning, Do-san tells you that his father has hit his mother on a number of occasions, and once he pushed Na-eun backwards over a coffee table. His father yells at Do-san a lot, but Do-san tells you that no verbal, physical or sexual abuse has occurred toward himself or his younger siblings. Do-san asks you not to mention any of this to his mother.

Question 4

How would you approach Do-san's home situation?

Further information

You check you have the correct mobile contact for Do-san and arrange a telehealth follow-up within the next three days to check on his safety and wellbeing at home. In your telephone appointment, Do-san sounds agitated and answers your questions in quick, short sentences. He says he is stressed about exams at school and tells you everything is fine at home before changing the subject. You arrange to have a face-to-face appointment the following week.

The next week you receive a call from Do-san's high school counsellor. Do-san has arrived at school with left-sided facial bruising and a split lower lip. Do-san told the counsellor that his father became angry after Do-san stepped between him and his mother while they were fighting, and he hit Do-san. The school has taken Do-san to the local emergency department to assess his injuries.

You speak to the school counsellor again that evening at 5.00 pm about the outcomes of the hospital visit. Do-san has a mild head injury with a normal computed tomography scan of the brain, some facial bruising and no other physical injuries. Do-san has spoken with the emergency department social worker but has declined to stay in hospital overnight or to press charges against his father. Do-san is discharged to his home later that evening. The social worker and the school have made a mandatory report to child protection services. You arrange with the school counsellor for Do-san to have an urgent appointment with you the next day after school.

Question 5

What would you do to support Do-san's safety?

Further information

You call Do-san the next day to check on his safety and to see how things are going at home. Do-san shares that his father has told the school that Do-san has made this all up and forced him to move out of the house. Do-san slept on his school friend Angelo's couch last night, and he reports that he feels safe there. Angelo's parents have offered for Do-san to stay in their home for the next week. Do-san cannot think of any other friends or family with whom he could stay after this time.

Question 6

How can you support Do-san to find safe housing?

CASE 1 Answers

Answer 1

Assessing symptoms of depression and other mental health conditions is an essential component of history-taking. Symptoms of depression in young people to ask about include:

- lowered sense of self-worth
- changes in sleep patterns including insomnia, hypersomnia or broken sleep
- changes in appetite or weight
- anhedonia (a reduced capacity to experience pleasure)

- poor concentration and memory
- reduced motivation
- an inability to control emotions such as pessimism, anger, guilt, irritability and anxiety.[1]

It is important to consider differentials for Do-san's mental health presentation and assess for symptoms of anxiety, mania, hallucinations and delusions, and take a detailed family mental health history. A thorough mental health history could include a case formulation using the five P's model:

- the presenting problem (initial signs and symptoms, eg low mood)
- predisposing factors (pre-existing vulnerabilities, eg a history of adverse childhood events including a gentle assessment for childhood trauma)
- precipitating factors (recent life stressors, eg bullying in school)
- perpetuating factors (barriers to recovery, eg an unsupportive home environment)
- protective factors (personal strengths, eg supportive relationships).

Mental health conditions are common in young people. More than one in six young people aged 4–17 years have experienced a mental disorder in the past 12 months.[2] This includes depression, attention deficit hyperactivity disorder, anxiety disorders and conduct disorders. Over 75% of mental health conditions occur before the age of 25 years,[3] and suicide is the leading cause of death in young people.[4]

It is important in every mental health presentation to assess safety and the risk of self-harm, suicide or harm to others. A thorough assessment of safety for an adolescent will also include asking about exposure to family violence, school and community violence, online safety and other high-risk activities such as riding with an intoxicated driver. In young people, a full HEEADSSS assessment is a core component of a safe mental health assessment.

For a mental health assessment with depressive symptoms, other physical conditions, such as anaemia or thyroid disease, should be considered in the history and physical examination. Do-san's symptoms could be assessed further using a validated depression scale. There are several options for depression in adolescents: the K10 or the Depression Anxiety Stress Scale may be suitable for older adolescents; alternatively, the Kutcher Adolescent Depression Scale can be used for young people aged 11–17 years.[5]

Answer 2

A psychosocial assessment is an important tool for identifying risk and protective factors in young people, which can help target interventions. In addition, it can facilitate engagement and improve clinician capacity to minimise morbidity and promote health.[6] The HEEADSSS framework is a flexible schema for enquiring about the context of young people's lives.[7] It emerged from the recognition that most morbidity and mortality in adolescence and young adulthood arises from health risk behaviours.[8] These in turn are a result of biological, emotional, cognitive, social and cultural influences in a young person's life.

A thorough HEEADSSS history may require two or more consultations. The domains being explored can be asked in any order, although beginning with less sensitive topics is helpful for building rapport.

It is good practice to see all mature minors on their own as patients, unless the young person declines this offer.[9] General practitioners (GPs) can set the norms and expectations in a consultation with a young person. Some parents/carers (hereafter referred to as 'carers') may be keen to wait outside to allow their child to have a private consultation with their doctor, while other carers may be more hesitant. Similarly, many young people may wish for the carer to leave so they can speak privately with their GPs, or others may want their carer to stay for support. There are many ways to approach this situation. One is to set the expectations of the consultation at the outset with a statement such as:

'I routinely see all young people on their own without a carer present. This offers a young person a private space to discuss their health and helps them to feel more comfortable with what happens at a visit to the GP. Do-san, does that sound okay to you? If you feel uncomfortable with this, it is okay for Mum to stay.'

With an appropriate pause and attention to the young person's verbal and non-verbal cues, you can support them in maintaining their privacy and setting a boundary with their caregiver.

Answer 3

The first step in management would be to provide psychoeducation about depression and the lifestyle factors that can improve or worsen symptoms (eg sleep hygiene, physical activity and nutrition). Next steps could include identifying what supports are available in the young person's life, facilitating linkage with either a school counsellor and/or arranging referral for psychological therapy.[10]
For mild-to-moderate depression, or while waiting for the first appointment, online resources can be a helpful adjunct for managing mental health conditions. The Australian Government website HeadtoHealth (https://headtohealth.gov.au) has a range of online courses and apps suitable for young people, including the TeenSTRONG course from ThisWayUp. Safety netting for the risk of self-harm or suicide in young people is essential. A young person's GP can encourage them to seek help early if they are in crisis and provide them with numbers for the Kids Help Line (1800 551 800) for individuals aged 5–25 years and Lifeline (13 11 14). For people with mild-to-moderate depression, it is preferable to trial non-pharmacological approaches in the first instance, although severe or refractory depression may warrant consideration of specialist opinion and commencing a low-dose selective serotonin reuptake inhibitor such as fluoxetine while balancing the risk of medication side effects such as an increase in agitation and suicidal thoughts.[11]

Answer 4

It is important to acknowledge the courage with which Do-san has disclosed information about home. Offering a label for what Do-san describes can be validating and provides a clear framework for further assessment and management. It also establishes a potential link between Do-san's presentation (depression and self-harm) and the situation at home, and allows safety to become a key focus.[12] It raises the possibility of mandatory reporting, which can also be discussed with Do-san with a statement such as:

'Do-san, I want to acknowledge that it is very brave to talk about what sounds like a really hard situation at home. What you describe about fighting between Mum and Dad sounds like domestic violence. [Some other terms are family violence and intimate partner violence.] What I mean by that is a pattern of behaviour between partners that is abusive – it can be physical, verbal, emotional or sexual abuse. Domestic violence can also be when one partner controls what money the other partner has or tries to control their social life. Domestic violence is never okay and can harm not only the partner being abused but others in the family. It's likely that there is a link between the situation at home and the way you have been feeling. How do you feel with me saying all of this? How are you feeling at the moment?'

Await a response, listen and respond accordingly. Do-san might express fear, shame or relief, or he might not say much at all. Continue with a statement such as:

'Do-san, something I'm really concerned about right now is safety – yours and others in the family. It seems like this has been going on for some time. Often without anyone getting help – including your Dad – things can get worse. Importantly, children can feel unsafe for themselves or the person being abused and it can have a negative impact on their health and mental health. It can sometimes be a situation where we do need to involve other services so that everybody can get support and is safe. It is very hard to get through the day at school or look after your mental health if you're not safe at home. As well as looking at how we can manage your depression, I'd like to talk about this in more detail with you too. I'll also be able to explain what can and can't be kept confidential, but I want to reassure you that it is all about keeping everyone in the family safe. I want to check if you feel safe right now, and whether you will be safe between now and when I see you again next week.'

At this juncture, it is important to work on engaging Do-san in an ongoing relationship with you. It can be a delicate balance between wanting Do-san to feel he can open up further and reminding him about the limits to confidentiality.

Answer 5

Do-san is living in an unsafe situation, and he needs to be offered empathetic support and practical options to ensure his safety. It is important to ask Do-san to share how he is feeling and ask him about his levels of distress and if his suicidal symptoms have increased. Discuss prioritising Do-san's safety and assisting him in planning to contact the police and to exit the home if violence escalates. Provide him with the 1800 RESPECT number for domestic violence counselling and the telephone number for crisis accommodation, and remind him that he can also call the police (000). To ensure Do-san has these numbers easily at hand in a crisis, you could help Do-san to enter these numbers into his mobile phone or diary during the consultation. It is important to let Do-san know you will also be making a mandatory report to child protection about his recent injuries and discuss what this means for Do-san and his family. Do-san's family is in crisis: his mother Na-eun requires support, as do Do-san's younger siblings, and his father requires an intervention to change his behaviour and assume responsibility for his actions. It is important to reassure Do-san that he is not responsible for protecting his other family members, and that there are community supports available to keep him and his family safe. You could offer to contact Do-san's mother, Na-eun, and arrange linkage with her own GP for support. As Do-san's GP, you can support him through this difficult period by being an empathetic listener, by monitoring his mental health and safety, and by being a consistent figure of support, perhaps booking in weekly appointments in advance to encourage regular check-ins with Do-san.

Answer 6

Youth homelessness is different from family homelessness and from adult homelessness. Most young people experiencing homelessness are in 'secondary homelessness' – which means transient, temporary, frequent movement between places of accommodation such as couch surfing, short-term youth refuges or short-term stays with other family members.[13] Young people are overrepresented in homelessness data, and youth homelessness is associated with health and psychosocial problems, including mental health problems, food insecurity, poorer physical health and difficulty accessing healthcare.[14,15]

Safe and stable accommodation is a priority for Do-san. His ability to manage schoolwork and his health will be compromised unless his basic needs are met, such as shelter, clothing and food. Each state and territory in Australia has a homelessness hotline, and there are various non-government organisations that may also be able to provide advice or immediate assistance, depending on location and availability of accommodation. The Homelessness Australia website (www.homelessnessaustralia.org.au) lists the various state and territory hotlines and websites that can be a good first port of call.

As well as helping Do-san find accommodation, keeping Do-san engaged in school will have longer-term health and other benefits. It could be very useful for you to talk with Do-san about letting the appropriate person or people at his school know about his situation. You can also offer to speak to the school for him, or with him.

You can anticipate with him that bolstering mental health support would be helpful.

Conclusion

Do-san continues to see you weekly while he finds stable housing. His mood improves over the next few months with support from his psychologist, but he still has up and down days. He is able to complete his final year examinations at school, and he applies to start a Bachelor of Psychology at university next year.

As it can be challenging for any health professional to support a young person dealing with domestic violence and trauma, it is suggested that all GPs seek support to protect their own wellbeing, and to reduce the risk of burnout and/or vicarious trauma. These options can include one-on-one supervision, peer group supervision such as Balint groups, semi-structured debriefing with a colleague while maintaining the anonymity of the patient, contacting support services for doctors such as the DRS4DRS helpline, or The Royal Australian College of General Practitioners' GP Support program (refer to Resources for doctors).

Resources for doctors

- Head to Health, https://headtohealth.gov.au
- headspace, https://headspace.org.au
- ThisWayUp, https://thiswayupclinic.org
- Kids Help Line, https://kidshelpline.com.au
- Lifeline, www.lifeline.org.au
- 1800 RESPECT, www.1800respect.org.au
- Homelessness Australia, www.homelessnessaustralia.org.au
- Raising Children – information for parents on supporting teens to see their GP, https://raisingchildren.net.au/pre-teens/mental-health-physical-health/health-care/teens-seeing-the-gp
- DRS4DRS, www.drs4drs.com.au
- RACGP – GP support program, www.racgp.org.au/running-a-practice/practice-management/gp-wellbeing/the-gp-support-program
- Balint Society of Australia and New Zealand – Support groups in Australia, www.balintaustralianewzealand.org
- Blue Knot Foundation: National Centre of Excellence for Complex Trauma, www.blueknot.org.au

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CASE

2 Siobhan needs to see you urgently

You arrive at work to find a message from the practice manager. It states, 'Siobhan called early this morning; she needs to see you urgently'. You check your schedule and find there are no gaps. Siobhan is one of your regular patients. She is 18 years of age and her father, another one of your patients, died last year as a result of bowel cancer. Siobhan lives with her mother, Trish, and two younger siblings.

Question 1

How would you respond to the practice manager?

Further information

You quickly call Siobhan before your first patient arrives. You inform her that this is a telehealth appointment, billed to Medicare, and gain her consent.

She tells you she is not coping. Her anxiety is at an all-time high. She is constantly arguing with her mother and feeling stressed about being at home so she tries to stay at her friends' houses. She finds sleeping difficult. She has started to smoke marijuana to relax, and this is 'the only thing that has helped'. Siobhan wonders if you can prescribe her something to help with the anxiety feelings.

Question 2

What would you like to ask Siobhan?

Question 3

How would you assess Siobhan's risk on a telehealth call?

Further information

Siobhan has been seeing you recently for problems related to her mood. She has felt that she is increasingly erratic at home, often yelling at her siblings and mother. She feels her mother does not 'get' her. Trish has also met a new partner, and Siobhan feels it is too soon. A few weeks ago, you arranged some blood tests and, apart from iron deficiency, these were all within reference ranges. Siobhan's sleep is only helped by marijuana. She smokes two joints per night. She watches Netflix in bed and talks to friends using Snapchat. She buys marijuana from a man with whom she has a casual relationship. Siobhan works at a local burger shop and recently completed year 12; she has decided to take this year off after a tumultuous final year of school.

Siobhan takes the oral contraceptive pill. She has no allergies. She has no other major past medical history.

You ask Siobhan whether she feels at risk of suicide. She denies this but goes on to tell you she has started hurting herself. She initially did this with blunt objects as she did not want to draw blood. But as the stress increased, so did the self-harm, and she started using a knife. She hides the knife under her pillow so her mother does not find out. She cuts both her forearms each night. She tells you it helps 'numb the pain and stress' she has been experiencing, and she does not want to stop.

Question 4

How will you follow up Siobhan?

Further information

You feel it is appropriate to see Siobhan today given what she has told you on the telephone. She feels safe until then and will be driven in by her mother.

You ask the practice manager to hand Siobhan a Depression Anxiety Stress Scales-21 (DASS21) questionnaire to complete when she arrives. Siobhan's DASS21 indicates scores of extremely severe depression and anxiety and severe stress. She appears tired and pale. She is dressed in tracksuit pants and a hoodie. You call her in from the waiting room. Her mother follows.

You ask Siobhan how she is feeling. Siobhan says, 'A bit over it, to be honest … I feel like I just need you to prescribe something to stop me worrying'. You discuss matters further with Siobhan's mother, Trish. Trish says Siobhan has been argumentative and difficult to deal with. Siobhan spends nights away from home, often driving home 'high on drugs'. Trish does not know how to help Siobhan anymore. Trish says, 'Siobhan's anger can be extreme', and tells you that Siobhan yells at her when she's not getting her way. This has occurred since Siobhan's father died, although it has become worse more recently.

Trish works during the day and cannot take time off to watch Siobhan all the time. You thank Trish for the information and ask her to wait outside the room while you meet with Siobhan.

You ask Siobhan about her self-harming. She shows you her forearms, which have multiple cuts.

Question 5

What are the main reasons for young people self-harming?

Question 6

How would you talk to Siobhan about her self-harming?

Further information

You ask more questions about Siobhan's mood. She tells you she is having 'good and bad days' – the good days being when she gets to see her friends. On the bad days, she spends a lot of time crying for no reason and then thinks about cutting herself. She is wondering if she might be depressed. She reports two or three panic attacks over the past month when she could not breathe and felt she needed to smoke a joint. She is often tired but put this down to being low in iron.

She describes feeling guilty for letting her mother down. She says, 'Mum is probably sad about Dad too, but she doesn't realise it affects all of us differently; I guess this is what it has done to me'.

Siobhan says while she feels suicidal, she does not actually want to die. 'Some days I just want the world to suck me up. I wouldn't actually do anything though. I feel pretty safe'.

You collect a dressing pack from the nurses' station, being aware that Siobhan's mother does not know about Siobhan's self-harming. You clean the wounds and put some simple dressings on them. They do not appear infected. You discuss possibly speaking to Trish about Siobhan's self-harming, but for now Siobhan is adamant she does not want her mother to find out.

Question 7

What is your diagnosis?

Further information

On the basis of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, criteria you diagnose Siobhan with a mixture of major depression and generalised anxiety disorder, presumed related to a complicated grief precipitated by the death of her father and aggravated by excessive drug use and lack of sleep.

Question 8

What is your treatment for Siobhan?

Question 9

How can you assess Siobhan's risk of self-harming in the future?

Question 10

How could you best involve Trish in the process of supporting Siobhan?

CASE 2 Answers

Answer 1

This appears to be an urgent situation, and you would need to find out more about what is happening. You could initially ask the practice nurse to telephone Siobhan to check on her safety and wellbeing and liaise with you about a management plan. It certainly sounds like Siobhan may warrant a telephone call, and you could use Medicare Benefits Schedule telehealth item numbers to do this, if available. If it is impossible for you to talk to Siobhan, you could consider asking a colleague to help.

Answer 2

It is important to check on Siobhan's safety once again. Is she feeling safe? What are her protective factors (family, friends, other supports)? Some further history would be useful, for example, what is causing the distress? Is there a trigger to her anxiety? What is it about home that is causing her to not feel comfortable? What is she arguing about with her mother?

The next step is to review other mood symptoms including whether she feels hopeless or depressed and/or suicidal. Does she have any psychotic symptoms such as hallucinations or paranoia (considering a drug-induced or first-presentation psychosis)?

In terms of the marijuana, asking about the quantity of marijuana and her willingness to cut back or cease use is recommended.

Using the HEEADSSS screen, consider:[1]

H Home

E Education and employment

E Eating and exercise

A Activities and peer relationships, social media

D Drug use, including prescribed medications, cigarettes, vaping, alcohol, and other drugs

S Sexuality and gender

S Suicide, self-harm

S Safety and spirituality

Answer 3

If there is a concern about risk from your initial conversation with Siobhan, it is important to assess the severity of that risk by asking if she has made any suicidal plans or has access to means. Exploration of protective factors should also be considered, such as 'What stops you from harming yourself?' and 'Who else can you talk to for support?'

Answer 4

Siobhan's risk is now elevated due to self-harming behaviours. You should attempt to see her within 24 hours. Trust and continuity of care are very important in managing a patient at

risk. If you are unavailable in a timely manner, Siobhan may need to see a colleague. If this is the case, it may be beneficial to brief the other doctor so Siobhan does not need to retell all her story. Alternatively, make space in your schedule by asking a colleague to see other patients for you, to help you create the space needed. If this occurred on a weekend and no one was available, you could speak with your local emergency mental health service. If there is ongoing difficulty getting help for Siobhan, you may need to ask her to attend the nearest emergency department for an assessment of her wounds and her mental state. Between now and the follow-up consultation with Siobhan, it is important to mention relevant contacts and telephone numbers including Lifeline (13 11 14), the local mental health services hotline, and details of her nearest emergency department.[2]

Answer 5

'Adolescent self-harm is the result of complex interactions between biological, interpersonal, social and psychiatric factors'.[3] Self-harm typically begins in adolescence and is characterised by an adolescent state of mind. Adolescence is a transition from childhood to adulthood. This transition is now longer than before, with some girls experiencing their first periods as young as nine years of age. Adolescents spend more time at home and more time online. Self-harming can be normalised by social media outlets and teens thinking it is a 'cool' thing to do. Research has demonstrated strong links between online forums and self-harming in teenagers.[4]

Self-harming is often thought of as a 'cry for help'. If we delve deeper than this, it is actually a sign of deep distress. It is a way of trying to control uncontrolled feelings and find relief for them. For some people it provides a method of healing. For others it is to try and feel something rather than emptiness and loneliness. Some people do it as a form of revenge, to get back at others who might have hurt them.[5]

People who self-harm are at increased risk of attempting suicide.[6]

In Siobhan's case, the trauma associated with losing her father has likely disrupted her care at home and led to feelings of detachment. She is grieving, and paediatric patients often grieve differently to adults. This grief process can be quite physical as well as emotional. Teenagers have not yet fully developed their frontal lobe; therefore, coping strategies can be poor and may include risk-taking behaviour and self-harming.[3]

Siobhan is also unlikely to realise that there is a link between her marijuana use and anger outbursts at home.

Answer 6

Patients may require pre-warning that you are going to ask more difficult questions.

At this point it is important to specify that the consultation is confidential except in the situation where you deem the patient to be at very high risk of hurting themselves or ending their life.

Examples of how you might raise this include:

- 'It is good that you have told me what is going on; now we can work together to try and help.'
- 'I'm relieved you have come in today to show me what's going on.'

Often patients feel ashamed of their self-harming and may try to hide it by wearing longer sleeves. It might not be immediately obvious and therefore needs to be asked about. Having an open and honest conversation can be challenging but is important.[5] If you suspect a patient is self-harming but they have not yet discussed it with you, some questions to ask may include:

- 'Often people self-harm when they are feeling strong emotions or very distressed about a situation, is this the case for you?'
- 'When people feel strong emotions, they sometimes hurt themselves through cutting their arms or causing pain, to distract their thinking and manage this. Is this the case for you?'

Answer 7

Self-harm is a symptom of multiple mental disorders, not a disorder on its own.

Evidence suggests that the majority of people who present to hospital following an act of self-harm will meet diagnostic criteria for one or more psychiatric diagnoses at the time of assessment.[7]

The National Institute for Health and Care Excellence guidelines indicate that self-harm is self-poisoning or injury, irrespective of the apparent purpose of the act.[8]

Mental health conditions place individuals at higher risk of self-harm or suicide. Depression, adjustment disorder, personality disorders and eating disorders have all been linked with an increased risk of self-harm. It is also important to consider substance abuse.[9] [AUTHOR: This paragraph has been reworded as it was previously produced verbatim, please confirm that it is correct]

Answer 8

Treatment for Siobhan may include biological, psychological and social interventions.

Biological

- Immediately manage any wounds.
- Consider referral to the local non-acute mental health service.
- Exclude organic causes with blood tests such as thyroid stimulating hormone, full blood examination, iron, vitamin B12 and folate. Commence iron replacement if needed.
- Evaluate sleep in more detail and try to support Siobhan with sleep hygiene advice and information. Poor sleep is a very important risk factor for poor mental health.

- Assess any family history or genetic link to mental illness.
- Consider antidepressant medication such as a selective serotonin reuptake inhibitor or serotonin–norepinephrine reuptake inhibitor. Given the level of risk established, you may write a script for a small number of tablets to be dispensed at a time, such as 10 with a letter to the pharmacist.
- Screen for sexually transmissible infections (STIs) given Siobhan's casual partner (urine, chlamydia and blood tests if warranted), as per the STI asymptomatic screening tool (www.stipu.nsw.gov.au).
- Discuss compliance with any contraception and suggest the possibility of long-acting reversible contraception.[10]

Psychological

- Arrange cognitive behavioural therapy with a general practitioner or a psychologist and through the Medicare Benefits Schedule Better Access initiative (Mental Health Treatment Plan [MHTP]).
- Help young people to cope with self-harm thoughts (refer to Resources for a self-harm management plan) – some ideas include keeping a gratitude journal, listening to music, going for a walk, watching a favourite movie or TV show, drawing or reading. Some young people will hold on to ice blocks or flick a rubber band on their wrist to still create a physical sensation but without injury.
- Encourage practising mindfulness with one of the various apps (Smiling Mind, headspace, Calm, Insight Timer).
- Advise to remove any items around the house that might be of risk (medication, knives, razor blades).

Social

- Evaluate who is in the immediate support network, including friends or a partner, by asking, 'Who is one person you can text when you're in trouble?'[11]
- Address Siobhan's relationship at home with Trish.
- Provide drug and alcohol counselling and support information, such as local contact numbers of services.

The goal for care of Siobhan is to manage her mental health in the least restrictive manner. It is good to do what you can to 'de-escalate' the situation by remaining calm and empathetic, especially when she is already feeling overwhelmed. It is important to ensure Siobhan's safety through providing a series of contact telephone numbers and reviewing her support at home. Provide her with the local contact telephone number of the emergency mental health team should her feelings escalate to being high risk. Her follow-up with you may require a few appointments spaced close together (ie weekly). A good therapeutic relationship is essential.

It is likely Siobhan will require a MHTP to access funding for psychology visits. This could be completed in the follow-up visit. She could be referred to headspace or the local private psychology clinic.

Answer 9

There are no widely accepted tools for assessing a patient's subsequent risk of self-harm. Standard risk assessment tools should be completed but have not been shown to reduce overall risk of repetition.[3]

There can be subtle signs a teenager is continuing to self-harm, and these should be considered in the mental state examination, including dramatic changes in mood, changes in sleeping and eating patterns, social withdrawal or a sudden drop in academic performance.

Answer 10

Trish is Siobhan's main support person. It is important to try to engage Trish independently and offer her the chance to see yourself or a colleague on her own for an appointment. There may be a need for family counselling to try to improve the dynamic at home. Siobhan should be encouraged to talk to her mother and let her know about the self-harming. It can often be helpful when others are involved in the treatment. If Trish becomes involved, you could discuss some of the signs of self-harming, such as Siobhan wearing long sleeves or inappropriate clothing for the weather, unexplained injuries such as cigarette burns or hidden dangerous objects such as razor blades.[7]

Conclusion

Through a series of questions and prompting, you ascertain that Siobhan is safe to follow up with you in two days' time. She feels better having reported her situation to you and would like to keep seeing you. She asks you not to tell her mother about the cutting, and you agree. You call Trish back into the office. You offer them both internet-based resources on anxiety and grief. You suggest to Siobhan that she has a MHTP for psychology and considers antidepressant medication. Siobhan is unsure about this idea but will review what you have given her and come back to discuss it at the next appointment.

Resources for doctors

- GP Psychiatry Support Line, www.gpsupport.org.au

Resources for patients

- headspace – Toolkit for self-harming behaviour, https://headspace.org.au/blog/a-toolkit-for-when-you-or-someone-you-know-feels-like-self-harming
- Beyond Blue – Online safety plan, www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning/create-beyondnow-safety-plan
- Department of Health – Head to Health, https://headtohealth.gov.au
- Healthdirect – Mental health services infographic, www.healthdirect.gov.au/mental-health-services-infographic
- Black Dog Institute – Anxiety tips, www.blackdoginstitute.org.au/resources-support/anxiety

- Smiling Mind – Mindfulness app, www.smilingmind.com.au

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CASE

3 Louis isn't coping

Louis, aged 16 years, presents to see you for the first time. As per your standard practice, you ask for Louis's pronouns and note they are 'he/him'. Louis is completing year 11 and lives at home with his parents. He tells you he has been feeling depressed and is not coping. He has not seen his family general practitioner (GP) for more than nine months and is presenting to you alone on the recommendation of a friend as Louis would like to find his own GP.

Question 1

How would you approach the initial consultation?

Further information

You assess Louis using the headspace assessment tool. Your findings can be summarised as follows.

Louis is living at home with his father (a self-employed business owner) and mother (health worker). He has no siblings. Louis's irritability, poor motivation and disengagement is affecting his school, employment and relationship with his parents, and he is increasingly fighting with them. His mother has a history of depression treated with antidepressant medication.

Louis has previously been doing well at high school. He is also working part time in hospitality. He is finding it increasingly hard to focus on school or work and has been declining shifts at work. He is also consistently failing to hand work in on time, and his marks have dropped significantly over the past two months. These issues were preceded by some bullying on social media that has now ceased, and he has mostly withdrawn from social media.

Louis plays various sports, although he has lost enjoyment in these activities and is less motivated to train and participate.

Louis has tried alcohol recently in the context of a party with no regular or problematic use. Louis identifies as heterosexual, has no current partners and has not been sexually active.

Louis does get anxious in social settings at times; this has increased over recent weeks with no avoidance of social situations or school. He has a history of anxiety at transition to high school, which settled without formal treatment.

Louis reports irritability and lowered mood over the past 8–10 weeks. This has included loss of interest and enjoyment in his usual activities. He rates his mood as deteriorating to approximately 2–3/10 over this time, which has persisted at this level for at least six weeks. His sleep is irregular with a mixed presentation of initial insomnia or early waking, and his appetite is reduced without significant weight loss. Louis has lowered motivation and tiredness on most days, affecting his ability to complete his studies. He has no thoughts of suicide or self-harm, although he does increasingly have feelings of low self-worth.

There are no indications of delusions, perceptual disturbances or history of recent elevated mood. You do not note any conduct difficulties or risk taking, or any eating-related issues. There are also no indications of abuse or domestic violence.

Question 2

What are the key findings from a formulation approach in this case?

Question 3

What other screening and assessment tools might be helpful?

Further information

Louis's Kessler Psychological Distress Scale (K10) result is 30, which indicates a high level of distress.

The Revised Childhood Anxiety and Depression Scale (RCADS) results (depression: 21, anxiety: 7) support a diagnosis of depression rather than anxiety.

The Primary Health Questionnaire (Adolescent version; PHQ 9-A) result is 19 and is consistent with moderately severe major depressive disorder (MDD).

Louis asks about being prescribed antidepressant medication, like a friend of his was.

Question 4

What are the key guideline recommendations for the use of medication for treating depression in young people?

Question 5

Would you involve Louis's family at this time?

Further information

You ask Louis about his views on involving his family in the decision-making process about his treatment. He clearly states he is not interested in involving his family at this time and he is old enough to make decisions alone. You assess Louis as being a mature minor. Based on the discussion regarding the treatment guidelines, Louis agrees to your recommendation that he trial psychological treatment in the first instance.

Question 6

Notwithstanding that Louis presents as a mature minor, given his reluctance to involve family in the treatment decision process, what steps can be taken from here in assisting Louis to consider more deeply the involvement of his family?

Further information

After exploration of Louis's concerns about involving family, he agrees to a Single Session Family Consultation (SSFC).

Question 7

How can you prepare Louis and his family for an SSFC?

Further information

During the SSFC, antidepressant medication is discussed. Louis and his parents are receptive to future consideration of medication in the context of ongoing psychological treatment if Louis is not responding. In the first instance, Louis and his parents agree to review the situation after they undertake new strategies identified in the meeting to assist with managing the conflict in the home.

Question 8

If you consider prescribing antidepressant medication for Louis, what is important to include in the consent process and how frequently is monitoring required?

Question 9

Who else can assist with advice?

Question 10

Who else can assist with monitoring mental state and effects of medication?

CASE 3 Answers

Answer 1

It is important to conduct a comprehensive and holistic assessment. The headspace assessment tool includes 10 domains with strong utility in general practice.[1] It is based on an assessment interview commonly used in primary care for assessing psychosocial issues in young people (HEEADSSS tool – assessing the domains of Home, Education and Employment, Activities, Drugs, Sexuality, Suicide/depression and Safety).

The additional time spent completing comprehensive assessments will assist with positive engagement and developing trust. Unexpected and helpful information is often revealed that may otherwise be missed. Practicalities of appointment lengths for GPs will often require holistic assessments to occur over two or more sessions. The focus on the initial session may well be largely on developing rapport, ensuring Louis feels heard and understood, as well as assessing safety and organising follow-up.

GPs should focus on a positive, warm and non-judgemental regard, expressing curiosity and interest in the young person's story. It is also key to carefully explain confidentiality and its limits and to ensure some time is spent alone with young people when they present with family or carers.[2]

Answer 2

A formulation approach provides broader context for understanding the young person's presentation.[3] The key domains are presenting problem, predisposing factors, precipitating factors, perpetuating factors and protective factors.

From a formulation perspective

Presenting problem(s)

Louis has lowered mood, irritability, with impacts on energy levels, sleep, appetite, concentration and studies. There is also some mild social anxiety.

Predisposing factors

There is a history of maternal depression with previous treatment with antidepressants. There is also a history of anxiety during Louis's transition to high school, which settled without formal treatment.

Precipitating factors

The lowered mood was preceded by Louis having some issues with bullying from peers on social media. As a result, he is engaging less with social media.

Perpetuating factors

There is deterioration in Louis's relationship with his parents including increased verbal fighting with them.

Protective factors

Louis has supportive friendships and a usually positive relationship with his parents and continued engagement with study, work and sports.

Answer 3

The K10 is a distress scale validated for use in children and adolescents including in Australia.[4]

The RCADS has also been validated for screening for depression and anxiety in children aged 13–18 years, including in an Australian cohort.[5]

The PHQ 9-A is a nine-item tool with high validity.[6]

With respect to screening tools, it is important to explain what they are for and seek permission to use them so that young people are not disengaged by their use. While screening tools can be useful to monitor severity and response to treatment, it is important to focus on the comprehensive clinical assessment to inform diagnosis. Overall, the clinical assessment here supports a diagnosis of moderately severe MDD.

Answer 4

The Royal Australian and New Zealand College of Psychiatrists treatment guidelines for mood disorders[7] recommend:

- psychological interventions (cognitive behavioural therapy or interpersonal therapy) as first-line treatment of MDD in children and adolescents, irrespective of illness severity
- when psychological treatment has not been effective for those with moderately severe MDD, trialling short-term use of fluoxetine, with consideration that this be combined with either the same or another psychological therapy.

Answer 5

A recent evidence summary highlights the importance of 'encouraging the young person to involve family and friends to support them in decision-making and during their assessment and treatment'.[8]

Family can have a crucial part to play to assist with monitoring and supporting safety and management plans, including when antidepressant medications are prescribed. Therefore, the inclusion of family in the decision-making process and treatment planning can have considerable benefits for young people as well as for the family.[9]

Confidentiality for young people[10] and the mature minor assessment[11] are well documented and are crucial concepts for all clinicians working with young people.

Answer 6

It is important to engage Louis to explore the reasons that underpin his reluctance to involve family.[9] The reasons may include being concerned about what information will be shared with family, concern that involvement will increase worry for the family or aggravate family conflict, and concerns about loss of confidentiality or control about what information is shared. Understanding these potential barriers to family involvement can provide opportunities to address them. This should also include an exploration of any abuse or domestic violence as well as any other risks to the young person that may result from disclosure to the family.

It is also important to engage Louis about his family's understanding of what is going on for him, how they might better help Louis as well as the advantages and disadvantages of the family being more involved in his care.

Where medication is being considered, discussing the young person's safety regarding potential side effects of medication treatment is a useful reframe. Exploring practical issues such as hiding medication from family as well as what would happen if a family member were to find the medication can assist reality testing.

Importantly, young people's attitudes to family involvement may develop and change over time, so it is important to check in regularly, including when there is a significant change in presentation or treatment being considered.

A Single Session Family Consultation approach

SSFC is a consultative, needs-driven and strengths-based process for identifying and addressing the needs of a young person and their family, which can address barriers to formal family therapy and can be delivered by a range of clinicians including GPs.[12] While the focus is on brief intervention, additional sessions can be added as required. Developed by the Bouverie Centre, SSFC is supported by multiple studies, including those with young people in Australia.[13]

While SSFC is a formal model requiring further training, for most effective practice some of the principles of SSFC can inform thinking and planning for any family involvement in a young person's care. For time-poor GPs, the model can provide a useful guide and scaffold to consider. Formal training in SSFC is available online (see Resources for doctors) and is highly recommended for GPs who work extensively with young people.

Answer 7

A summary of steps to prepare Louis and his family follows and is based on the Bouverie Centre SSFC Manual.[12] Louis's preferences should strongly inform how an SSFC session is convened and conducted.

Using family-friendly language to describe SSFC (eg a family meeting or get-together), discuss the following with Louis:

- why a longer consultation is recommended and how this will be helpful
- who may be invited to participate and how this will occur
- how the family understands his condition
- what the family are doing that is helpful or unhelpful
- what would indicate a good outcome.

It is also important to directly address any concerns or risks that may arise; negotiate with him what he would like discussed, as well as goals and set boundaries on topics; and encourage him to be an active participant in the session.

Preparing the family should include:

- inviting the family via telephone to participate in the session
- explaining the purpose, duration and venue for SSFC
- agreeing on what will be covered and if anything is 'off limits' (for the young person or family) to set realistic expectations
- clarifying their aims for the session
- exploring any reluctance and normalising it
- addressing any concerns where possible.

The steps in conducting the SSFC[12] include:

- conducting introductions and orientation of the session
- identifying, clarifying and prioritising of needs and concerns of participants
- working on prioritised issues and concerns
- summarising progress and next steps.

Answer 8

Given the potentially serious side effects of antidepressant medication include an increased risk of suicidal thinking or behaviours, informed consent needs to include these risks as well as safety planning in the event of these arising. It is also important to warn young people of increased side effects if medication is taken inconsistently or is ceased abruptly. Monitoring should be weekly for the first month and can be scaled back thereafter.[8] Young people should be advised of the importance of discussing cessation of medication together with their prescribing GP in order to best consider timing, the need for slow dose reduction and monitoring for side effects, as well as impacts on mental health. It is also important to have a relapse prevention plan in place.

Answer 9

Seeking advice from colleagues, the multidisciplinary team or secondary or primary consultation with a psychiatrist are important to consider prior to prescribing antidepressants to people aged <18 years of age. This will partly depend on experience and expertise in working with young people, including experience in engaging with colleagues and specialists in past cases. If consideration is given to prescribing antidepressants to a person aged <18 years of age without the inclusion of family, it is crucial to clearly document mature minor assessment, discussions with colleagues, attempts and responses from the young person to involve family, and the rationale for prescribing including consistency with guidelines. If you feel unsure, discussion with your medical indemnifier is also recommended.[10]

Answer 10

With consent, it is important to engage family in assisting with monitoring mental state, adherence to medication and any side effects. It is therefore useful for family to be involved in the development and monitoring of the Mental Health Treatment Plan (MHTP) where possible. Where the young person is reluctant to engage parents, there may be other adults in the family who consent to take on this role.

Review and monitoring can be undertaken by a range of health professionals where this is within the scope of their practice; this may include mental health practitioners and other supports such as school nurses or counsellors. Ideally this should occur where a young person has consented to sharing of the MHTP.

Final comments

In considering this case, some key principles have not been extensively discussed. It is important to be familiar with confidentiality[10] and assessing mature minor status,[11] including in the context of prescribing to young people.[14]

Some best-practice principles are challenging to implement, with barriers including timely access to psychological treatment and psychiatric assessments. GPs are key deliverers of psychological services themselves, and improved access to telehealth for GPs, allied mental health and psychiatric services has enormous benefits for young people as well as GPs working to support them.

Resources for doctors

- headspace – Accredited online training for GPs working with young people, https://headspace.org.au/health-professionals/gps-and-general-practice-at-headspace
- headspace – The headspace clinical toolkit (depression): A collection of resources to assist GPs working with young people with depression, https://headspace.org.au/clinical-toolkit/depression
- headspace – Family inclusive practice, https://headspace.org.au/assets/clinical-toolkit/headspace-handbook-Family-and-friends-inclusive-practice.pdf
- Orygen – Family inclusive practice in mental health services for young people, www.orygen.org.au/Policy/Policy-Areas/Government-policy-service-delivery-and-workforce/Service-delivery/We-re-in-this-together/Orygen_We-re-all-in-this-together_2019.aspx
- The Bouverie Centre – Training in SSFC, https://events.bouverie.org.au/ssfc

Resources for young people and their families

- headspace – Understanding and dealing with depression, https://headspace.org.au/young-people/understanding-and-dealing-with-depression-for-young-people

- headspace – Understanding depression for family and friends, https://headspace.org.au/friends-and-family/what-is-depression-in-children/
- headspace – Antidepressants: An FAQ guide for young people, their family and friends, https://headspace.org.au/assets/download-cards/HSP10725-antidepressants-faqs-FA01.pdf
- headspace – Shared decision making (SDM) for mental health – What is the evidence?, https://headspace.org.au/assets/download-cards/sdm-evidence-summary.pdf

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CASE

4 Jade needs an insulin script

Jade, aged 17 years, attends your surgery as she is looking for a new general practitioner. She has just moved interstate and needs her insulin scripts. She tells you she is looking for a fresh start after an unhappy early family life (her parents divorced when she was nine years of age) and is staying with a friend for the moment until she finds her feet. Jade is doing some casual bar work and seems a bit chaotic but is chatty and engaging.

Question 1

What examination would you undertake at this stage?

Further information

After asking permission to proceed, you conduct a thorough HEEADSSS examination, explaining the reasons for asking about sensitive subjects.

Jade is currently staying with different friends or her older brother since she arrived six months ago. She left school halfway through year 10, having attended three schools due to moving frequently when her parents separated and her mother having to find work. She missed a lot of school due to illness, especially when she was first diagnosed with diabetes. At school she particularly loved art.

She wakes up late, never eats breakfast and only eats two meals each day, mainly takeaways. Jade is vegetarian. You ask Jade about her relationship with food – she frowns and says it is 'so hard'. Jade used to go to the gym but does not currently do any exercise. In terms of activities/hobbies, she likes to draw and read, and likes shopping. She tells you she has few friends.

You ask about alcohol and other drug (AOD) use, and Jade says she drinks alcohol often to go to sleep; she has previously experimented with cocaine, marijuana and ice but not recently, and sometimes friends give her ecstasy tablets when they go out.

You ask about her mood and Jade says she often feels low but has never been suicidal.

Jade has been sexually active but has no regular partner. She identifies as heterosexual.

You ask if she has any spiritual beliefs you should be aware of, and she says she used to go to church when she was young and misses it.

You access additional medical history for Jade, which shows she was diagnosed with insulin-dependent diabetes mellitus (IDDM) at eight years of age and has had episodes of diabetic ketoacidosis requiring hospitalisation. She has no allergies but reports amenorrhoea.

Previous medications include fluoxetine and quetiapine, which, according to Jade, did not help.

Question 2

Is there any further screening you would perform at this stage?

Further information

You provide insulin scripts and arrange another appointment for examination and follow up after Jade has had some blood tests, including full blood examination, erythrocyte sedimentation rate, C-reactive protein, electrolytes and liver function tests, iron studies, vitamin B12/folate, thyroid stimulating hormone, blood sugar level, glycated haemoglobin and a comprehensive metabolic panel. You give her the telephone number of a local youth centre to visit to obtain support with looking for accommodation.

Question 3

What are your plans for Jade's next visit to further assess her risk for an eating disorder?

Question 4

Are there any particular considerations for patients with concurrent diagnoses of IDDM and an eating disorder?

Question 5

What are some common comorbidities in patients with eating disorders, particularly bulimia nervosa?

Further information

At Jade's next visit, you undertake further history-taking. Jade moved interstate as she had a big fight with her mother and needed some space. She admits inconsistent insulin use and tells you has missed several diabetes clinic appointments. She mainly eats takeaways and purges after 'every meal'. She has visited the youth centre you suggested and has connected with a case worker who is helping her apply for priority housing.

Question 6

What would you look for on physical examination?

Further information

Examination findings

- Physical examination reveals swollen cheeks – parotid/submandibular hypertrophy
- Knuckle callouses – Russell's sign
- Bruises of different ages
- Normal body mass index

Investigations

- Blood tests – hypokalaemia, elevated blood sugar level, elevated glycated haemoglobin
- Electrocardiography – normal

Diagnosis

- IDDM
- Bulimia nervosa (moderate severity)

Question 7

What are the characteristics of bulimia nervosa?

Question 8

What are the treatments for bulimia nervosa and binge eating disorder?

Question 9

How would you prioritise your next management steps for Jade?

Question 10

Who else could be helpful in Jade's care?

CASE 4 Answers

Answer 1

A HEEADSSS examination as per the Adolescent Health Resource Kit would be recommended to assess Jade at this point.[1] It is helpful to consider a third-person approach to sensitive questions and look for protective as well as risk factors. The following definitions have been reproduced with permission from *Adolescent health: Enhancing the skills of general practitioners in caring for young people from culturally diverse backgrounds*.[1]

H – Home (consider living arrangements, transience, relationships with carers/significant others, supervision, childhood experiences, family cultural background/s)

E – Education and Employment (consider school/work retention and relationships, bullying, belonging, study/career progress and goals, change in grades/performance)

E – Eating and Exercise (consider nutrition, eating patterns including recent changes, vegetarianism, weight gain/loss, physical activity, fitness, energy, preoccupation with weight or body image, attempts to lose or control weight or bulk up including restricting, purging, supplements)

A – Activities, hobbies and peer relationships (consider free time; hobbies including screen time and use of technology; culture; belonging to peer group; peer activities and venues; involvement in organised sport; religion; lifestyle factors; risk-taking, including managing chronic illness and adjustments in adolescence; injury avoidance; sun protection)

D – Drug use (consider alcohol, cigarettes, caffeine, prescription/illicit drugs and type, quantity, frequency, administration, interactions, access, increases/decreases, treatments, education, motivational interviewing)

S – Sexual activity and sexuality (consider knowledge, sexual activity, age of onset, safe sex practices, same sex attraction +/– activity, sexual identity, sexually transmissible infection screening, unwanted sex +/– sexual abuse, pregnancy/children)

S – Suicide, depression, anxiety and mental health (consider normal versus clinical, mood, anxiety symptoms versus stress, change in sleep patterns, self-harm, suicidal thoughts/ideation/intent/method/past attempts/treatment, depression score and mental state examination)

S – Safety and spirituality (consider sunscreen protection, bullying, abuse, traumatic experiences, risky behaviour, belief, religion; what helps them relax/escape; what gives them a sense of meaning)

Answer 2

Jade's answers regarding her relationship with food suggest that she may have an eating disorder. Eating disorders affect 4–5% of the population and present commonly in adolescence and particularly in females. There is an argument that all adolescents should be screened. In addition, people with diabetes are more than twice as likely as the background population to have an eating disorder. Eliciting a history of trauma in a homeless young woman could indicate that trauma is a risk factor for the development of an eating disorder.[2]

Another test that can be performed is the six-item InsideOut Institute screener (Table 1),[3] which was recently developed and validated for online use in order to address the limitations of existing tools. It was designed to be accessible to people online and to be used for self-referral purposes. It uses language that is less confrontational than some existing screening tools. It is also useful in prodromal and less typical presentations, and was designed to 'start a conversation', which is particularly helpful in the GP context.

Answer 3

Sensitive history-taking could focus on characteristics of eating behaviours, including regularity, amount, restrictions or fasting, variety and behaviours such as subjective or objective binges. Patients should be asked about weight control behaviours such as purging, excessive exercise or laxative/diuretic use, and about cognitions such as weight or shape overevaluation and body image and eating preoccupations.[4] It is important to ask about comorbidities (ie anxiety and

Table 1. Six-item InsideOut Institute screener[3]

Item	1	2	3	4	5
1. How is your relationship with food?	Worry and stress-free	A bit problematic	Moderately problematic	Very problematic	Full of worry and stress
2. Does your weight, body or shape make you feel bad about yourself?	Never	A little bit	Sometimes	Quite a bit	All the time
3. Do you feel like food, weight or your body shape dominates your life?	Never	A little bit	Sometimes	Quite a bit	All the time
4. Do you feel anxious or distressed when you are not in control of your food?	Never	A little bit	Sometimes	Quite a bit	All the time
5. Do you ever feel like you will not be able to stop eating or have lost control around food?	Never	A little bit	Sometimes	Quite a bit	All the time
6. When you think you have eaten too much, do you do anything to make up for it?	Never	A little bit	Sometimes	Quite a bit	All the time

Reproduced with permission from Bryant E, Miskovic-Wheatley J, Touyz S, et al, Transitioning to digital first line intervention – Validation of a brief online screener for early identification of a suspected eating disorder: Study protocol, J Eat Disord 2020;8(60), doi: 10.1186/s40337-020-00339-8.

depression, impulse control and substance use disorders) as well as neurodevelopment and gender/sexuality concerns.

The Eating Disorder Examination Questionnaire is available on the InsideOut Institute website (https://insideoutinstitute.org.au/resource-library/eating-disorder-examination-questionnaire-ede-q) with easy scoring.[5] It can be a useful adjunct to history-taking as well as a prerequisite for the GP Eating Disorders Plan if appropriate.

Answer 4

'Diabulimia' is a colloquial term to refer to the overlap of diabetes with an eating disorder. It can be particularly risky due to insulin omission as a purging behaviour and consequences of hyperglycaemia including electrolyte imbalance and poor wound healing, and requires careful multidisciplinary care.[6,7]

Answer 5

Estimation of the presence of comorbidities varies between 20% and 95%.[2] Most commonly they include: mood disorders, especially anxiety and obsessive compulsive disorder, AOD use disorders and personality disorder.[2]

Answer 6

It is important that physical examination proceeds with sensitivity and with frequent checking in regarding feelings of safety. Height and weight should be checked as a baseline but with options for how this is done to be given to Jade – some patients prefer not to be told their weight as it may trigger difficult emotions, and a 'blind weight' may be preferable.

Blood pressure and pulse measurements can be done sitting and standing to elicit postural instability. The opportunity should be taken to check for peripheral stigmata of eating disorders as well as observing facies; ear, nose and throat; teeth as well as heart/chest and abdominal findings.

Answer 7

Bulimia nervosa refers to recurrent episodes of binge eating with feelings of lack of control and followed by inappropriate compensatory behaviours; detailed criteria are available from the *Diagnostic and statistical manual of mental disorders*, fifth edition (https://bodymatters.com.au/wp-content/uploads/2015/01/DSM_V_Diagnostic_Critera_for_Eating_Disorders.pdf).[8]

Bulimia nervosa can also be classified according to severity, which takes into account the average weekly number of 'inappropriate compensatory behaviours'. The categories include mild (1–3 episodes), moderate (4–7 episodes), severe (8–13 episodes) and extreme (≥14 episodes) bulimia nervosa.[8]

Answer 8

The following information regarding treatments for bulimia nervosa and binge eating disorder has been reproduced with permission from *Treatment summary for eating disorders*.[9]

Research suggests that a range of psychological therapies such as cognitive behavioural therapy (CBT), dialectical behaviour therapy and interpersonal therapy are effective. Ongoing medical monitoring by a general practitioner (GP) and nutrition support with a dietitian is also important.

For adults, CBT has been shown to be the most effective treatment for bulimia nervosa.

Guided self-help has also been shown to be effective for bulimia nervosa and binge eating disorders. In guided self-help, individuals work with a trained clinician to implement a CBT-based self-help program.

For children and adolescents, both family-based treatment and CBT have research to support their use with people with bulimia nervosa.

Treatment may be provided individually, in groups or through guided self-help programs.

Some people benefit from more intensive community-based day programs, which involve treatment for a number of hours per day, one or more days each week.

Hospital-based treatment may be required if symptoms are very severe or if there are any medical complications that need immediate treatment. Hospitalisation is also a possibility if there is a risk of self-harm or suicide.

Answer 9

As you have assessed Jade as being an at-risk young person, it is important to ensure her safety both mentally and physically. If she requires a safety plan with respect to suicidality, you could consider a written safety plan or an app such as Beyond Now or ReMinder.

Physically, she may need potassium supplementation if she is unable to commit to stopping purging, and she will benefit from regular blood tests and diabetes monitoring.

Psychoeducation is very important and will be an ongoing process. She may be unaware of the longer-term risks of hyperglycaemia if her transition from paediatric to adult diabetes services is disrupted as a result of family dysfunction.

Counselling about complications of purging should include discussion of arrhythmias, dental erosions and longer-term risks including osteoporosis, cardiac problems, gut dysmotility, and endocrinological and haematological system problems.

Approaching this consultation with trauma-informed care is essential. This involves focusing on what has happened to a person rather than what is 'wrong' with them.[10] It is recommended to employ the core principles of safety, trustworthiness, choice, collaboration and empowerment in any conversations about trauma.[10] Ideally Jade will be actively involved in her own goal setting. A shared decision-making approach is helpful. As her GP, it may be challenging to engage her at this time, and she may not be ready to work on anything until she is safely housed or until she feels able to trust you.

Answer 10

Eating disorders are complex biopsychosocial illnesses requiring multidisciplinary care. Ideally you can involve a psychologist, dietitian and psychiatrist. An endocrinologist and diabetes educator will be needed as well as a case manager for help with housing.

Jade will already qualify for a GP Management Plan and a Team Care Arrangement as well as a Mental Health Treatment Plan. If she does not respond to 'usual treatment' within six months, she will qualify for a GP Eating Disorders Plan. The GP Eating Disorders Plan allows the patient to access a total of 40 rebatable psychology sessions and 20 dietitian sessions. A review is required after every 10 services, with review by a psychiatrist or paediatrician after the first 20 services (or any time before the twenty-first service). It assumes and values multidisciplinary care and communication, and assumes a level of knowledge of clinicians and use of evidence-based treatments.

Ideally it would be helpful to involve a family member or friend as a support for Jade, but this can be challenging, and it is important to respect Jade's wishes.

Summary

Jade's presentation is of bulimia nervosa with complex comorbidity. Evidence-based recommendations for treatment would include CBT, dietitian support and psychiatry review for trial of medication. At her level of illness severity, she would benefit from inpatient treatment.

Unfortunately, young people like Jade often fall through the cracks in the system, and a long-term relationship with a GP is vital in providing the safety of relational whole-person care and longitudinal care coordination.

The GP's role in managing patients with eating disorders includes not only detection and diagnosis but encompasses a cradle-to-grave approach ranging from prevention, health promotion, diagnosis, referral, collaborative care, medical monitoring and relapse prevention.

Resources for doctors

- InsideOut Institute for Eating Disorders, https://insideoutinstitute.org.au
- Butterfly – Support for eating disorder and body image issues, https://butterfly.org.au
- Blue Knot Foundation, www.blueknot.org.au
- Birmingham CL, Treasure J. Medical management of eating disorders. 3rd edn. Cambridge, UK: Cambridge University Press, 2019.
- Gaudiani J. Sick enough: A guide to the medical complications of eating disorders. New York, NY: Routledge, 2018.

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ACTIVITY ID **275484**

Adolescent health

This unit of *check* is approved for six CPD Activity points in the RACGP CPD Program. The expected time to complete this activity is three hours and consists of:

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Case 1 – David

David is a mature year 12 student, aged 17 years, who presents regularly to your practice and is living at home with his parents and younger siblings. He presents with moderately severe major depressive disorder of two months' duration, which has not responded to six sessions of psychological treatment. You carefully review his presentation and are unable to identify any additional underlying factors, so you remain satisfied with the diagnosis. David is reluctant to involve his family in the treatment decision-making process about medication.

Question 1

Which one of the following options may **best** assist David in deciding to engage his family in treatment decisions when he is very reluctant to do so?

A. Explaining the importance of having family involved in the decision-making process

B. Exploring with David the reasons that he is reluctant to involve family and how engaging family may benefit David and his family

C. Explaining that his family will need to assist with the administration of any treatment or treatment plan

D. There is no need to engage David's family as he is a mature minor who does not want his family involved

Question 2

In relation to the following treatment options that consider commencing medication for David, which one is **best** supported by current guidelines?

A. Commencing fluoxetine and ceasing psychological treatment

B. Commencing venlafaxine and continuing with psychological treatment

C. Commencing fluoxetine and continuing with psychological treatment

D. Commencing sertraline and continuing with psychological treatment

Case 2 – Heidi

Heidi, aged 15 years, is a regular patient at your practice. She has previously lived with her mother and siblings, but today she tells you she has been staying at her best friend's house for the past two weeks. She says it is closer to school and she gets to sleep in longer. You are concerned about Heidi's living situation.

Question 3

Which one of the following options best describes how you would determine whether Heidi is at risk of homelessness?

A. Heidi is not at risk of homelessness, as she is living with a friend and is getting more sleep.

B. Explore Heidi's living situation to assess the situation with her family, a history of frequent moving and whether she has long-term safe and stable accommodation.

C. Ask Heidi whether living with her friend is causing stress and mental health problems.

D. Ask Heidi if she has accessed youth refuges for young people experiencing homelessness – if not, then she is not at risk of homelessness.

Further information

You ask Heidi about her relationship with her mother, and she reluctantly admits that her mother has been verbally fighting a lot with her new partner. Heidi seems nervous when speaking about her mother, and you consider whether domestic violence may have played a part in her decision to move out of home.

Question 4

Domestic violence can include which one of the following behaviours?

A. Becoming verbally abusive on a regular basis, for example if the perpetrator does not like a meal that has been cooked

B. Repeated sexual coercion or assault of an individual

C. Limiting an individual's access to money

D. All of the above

Question 5

A thorough safety assessment in a young person will include which one of the following features?

A. Asking about self-harm and conducting a physical examination for evidence of physical injury

B. Gathering collateral history from family or friends to assess the young person's risk-taking behaviours

C. Non-judgmental enquiry to assess the risk of self-harm, risk of suicide, exposure to violence, and risk-taking behaviours such as riding with intoxicated drivers

D. Asking the young person to complete the Youth at Risk (YAR10) questionnaire, with a score of ≥10 indicating a high risk of injury

Case 3 – Jeremy

Jeremy, aged 18 years, is brought to see you by his father, who has concerns about Jeremy's mood and irritability. Jeremy has been punching the walls at home when he gets angry. He has been argumentative and at times withdrawn. His father states he found marijuana in Jeremy's bedroom the other day. You ask to see Jeremy alone. Jeremy shows you cigarette burn marks on his wrists and hands that he tells you he did when drunk the other night. He is 'sick of the nagging' at home and just wants to move out. He feels that by burning himself his parents might finally pay attention to him.

Question 6

Which one of the following is a risk factor for self-harming in adolescents?

A. High socioeconomic status

B. Depression

C. Not completing high school

D. Living at home with parents

Further information

You undertake a mental state examination with Jeremy.

Question 7

Which one of the following would **not** indicate that Jeremy may be self-harming?

A. Increased social activity

B. Poor school performance

C. Changes in sleeping patterns

D. Mood swings

Case 4 – Reeva

Reeva, aged 18 years, has been seeing you for treatment of an eating disorder. She has been diagnosed with bulimia nervosa and you are concerned that her episodes of binge eating are becoming more frequent.

Question 8

An average of 4–7 episodes of inappropriate compensatory behaviours per week is typical of which one of the following levels of bulimia nervosa severity?

A. Mild

B. Moderate

C. Severe

D. Extreme

Question 9

Which one of the following is the most commonly occurring comorbidity with eating disorders?

A. Anxiety

B. Diabetes

C. Schizophrenia

D. Irritable bowel syndrome

Further information

During your consultation with Reeva, you employ the principles of trauma-informed care.

Question 10

Which one of the following is **not** important in trauma-informed care?

A. Safety

B. Choice

C. Story telling

D. Empowerment

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