

SKILLS FOR YOUTH FRIENDLY GENERAL PRACTICE

“The single most crucial role of a GP caring for an adolescent, regardless of their presenting complaint, is to foster and develop a relationship of trust ⁽¹⁾.”

The key to effective consultation with adolescent patients is the establishment of a supportive and trusting relationship. Young people often feel self-conscious, mistrustful, and anxious about seeing a GP. A sensitive approach and the effective use of communication skills can help to overcome these barriers.

This section provides practical strategies and skills for engaging and communicating with adolescents. It also contains guidelines and approaches for the assessment and management of key adolescent health problems.

Taking a Proactive Role

When a young person visits a GP, a unique opportunity exists to provide a positive experience with the health system and to educate them about health care access:

- Explain the GPs’ role and what services you can offer in addition to diagnosis and treatment – e.g. counselling and support; referral to specialist services
- Express your interest and availability to talk about any health or general concerns they have or might have in the future
- You can assist them in their “*rites of passage*” to becoming an independent, adult consumer in the health system by:
 - seeing the young person alone where appropriate
 - assuring their confidentiality
 - educating them about their health care rights
 - creating their own separate file
 - showing them how to apply for their own Medicare card
 - encouraging their active participation in the consultation
- Help parents and families from all cultures understand that adolescence is a special period in life requiring a different approach from what is used with children or adults
- Be sensitive to the young person’s cultural background
 - acknowledge the cultural norms and values of the young person and their family
 - communicate and provide health care in a culturally sensitive manner
- Take the opportunity to explore beyond their presenting complaint – even if it is relatively minor (e.g. a cold; acne).
- Remember that the major health problems for adolescents are psychosocial. Use the *HEADSS* assessment tool to screen for psychosocial risk factors in the young person’s life (*see HEADSS Assessment P. 29*)
- Adolescence is a time of experimenting with new behaviours. Provide the young person with health education about risk behaviours and how to protect themselves
- Work with the young person’s family
 - educate them about adolescence and the changes that their adolescent may be going through
 - engage the parents where appropriate in taking an active role in any treatment / management plan



CHAPTER 1.

CONDUCTING A YOUTH-FRIENDLY CONSULTATION

Consulting with young people requires an understanding of the unique emotional, psychological and cognitive changes of adolescence. GPs also need an appreciation of the enormous variation among adolescents – in age, developmental stage and cultural background. The approach you adopt with a younger adolescent may be very different from how you would deal with an older adolescent.

Good communication skills are an essential tool for effective consultation with both the young person and their family. GPs must balance the need for working with the adolescent within the context of their family and their culture with the need to respect the young person's developing identity and independence.

Steps in Youth Friendly Consultation:

- Spend time engaging the young person
- Negotiate to see the young person alone
- Discuss confidentiality
- Use communication appropriate to the developmental stage of the young person
- Be sensitive to and respect cultural norms when seeing young people from NESB or other cultural backgrounds
- Adopt a non-judgemental and collaborative approach
- Take a comprehensive approach – conduct a psychosocial risk assessment to identify broader concerns in the young person's life
- Consult with the young person on the development of a management plan
- Decide with the young person which issues to discuss with parents/guardians
- Address parents' concerns and involve them where possible

Engaging the Young Person

- Engagement is the process of establishing rapport with the young person and a crucial first step in the development of a trusting relationship
- Engagement involves relating to each young person as a unique individual and connecting with them in a meaningful way

- Many young people will be anxious or reluctant seeing a GP for the first time - you need to demonstrate warmth and openness and be creative in your approach to engaging the young person
- Engagement is an ongoing process – it may take a number of sessions to successfully engage some adolescents
- The initial consultation sets the tone for future interactions. Goals for the first consultation may be to:
 - successfully engage the young person
 - clarify confidentiality
 - make a follow-up appointment
- As the young person returns to your practice over time, your communication style and the focus of the consultation will change as they grow and encounter new developmental challenges
- Begin the process of engaging the young person with the first encounter in the waiting room:
 - greet the young person first and ask them to introduce their parent or other accompanying adult
 - invite them both to see you together in order to outline their concerns and reasons for the visit
- Consultation with a young person may take a little longer – plan your time accordingly and be realistic with what you can achieve in the available time
- By spending time successfully engaging the adolescent, you will have a much better chance of getting them back for a return visit where you can go into issues in greater depth

Effective engagement with adolescents requires:

- understanding of adolescent developmental issues
- effective communication skills
- knowledge of medicolegal issues
- strategies for working with adolescents and their families
- endeavouring to understand the young person's cultural background and how they see themselves within it

Negotiate to See the Young Person Alone

Many adolescents will be accompanied by a parent. In order to establish rapport, it is helpful to see the young person alone at some stage of the consultation

- Seeing the young person alone is:
 - a way of acknowledging the young person's growing independence and need for privacy
 - an opportunity to develop a relationship with them as an individual
 - a chance for the young person to raise issues that they may be reluctant to discuss in front of a parent
- Consultation with the young person alone also provides an opportunity to:
 - assess their developmental stage
 - screen for health risk behaviours
 - provide preventive health information/education
- State at the outset that you would like to see the young person alone at some stage of the consultation:
 - this is one occasion when you can use your authority to state to both adolescent and parent/carer that it is your routine practice to see the young person by themselves

Example: "Mrs Smith, I'd like to see you both together at first to get an idea of what the concerns are for each of you. Then I usually like to see the young person alone for some time. This will help me to get to know Johnny a bit better so I can work out how best to help him. I have found that it helps teenagers learn how to communicate with adults better about their concerns. After I've had a chat with Johnny, I'll ask you to come back in at the end to talk about where to go from here."

- Seeing the parent and adolescent together is also important as it allows you to assess their relationship and how they interact with each other
- Begin the consultation by asking both the young person and parents their reasons for attending
- Listen to the parents' concerns and acknowledge that you have heard and understood their perspective
- See the parent after the interview to wrap up, and discuss management and follow-up issues
 - ensure that the young person has been involved in this and you have clarified with them what they are comfortable with you discussing with their parents

Seeing the Young Person Alone – Considerations

The decision to see the young person alone should be based on the needs of each individual patient, and the degree to which parental involvement is indicated as part of the management plan. GPs need to balance the need to engage the young person in a confidential relationship with the need to involve the parents/guardians who are usually the main caregivers and source of physical and emotional support.

The decision to see the young person alone will depend on:

- *the age and developmental stage of the young person*
- *the nature of the relationship between the young person and parent(s)*
- *whether it is culturally appropriate*
- *the nature of the presenting problem – it may be necessary to involve parents where the consultation concerns major life decisions (even if it is against the young person's wishes) – e.g. whether to keep or terminate a pregnancy; prescription of medications*

Where the presenting complaint is minor (e.g. a sore throat) seeing the young person alone may not be warranted – however, this can also be an opportunity to develop a relationship with the young person that will make it easier for them to independently consult a GP in the future:

- *communicate sensitively and directly to both parents and young person about the need for more / less parental involvement*
- *frame the decision to see the adolescent alone in a positive way – e.g. that it is a sign of healthy development for the young person to begin to establish their own individual relationship with a health professional*
- *respect the wishes of the parent / adolescent should they not want the young person to be seen alone*

SEEING THE YOUNG OR IMMATURE ADOLESCENT

GPs may feel more comfortable seeing adolescents alone at the age of 14 or 16, because the legal status of young people changes at these ages (*see Medicolegal Issues P. 49*).

- With younger or particularly immature adolescents, it may not yet be appropriate to see them by themselves and more involvement with parents/ carers may be needed.

- However by 14 many adolescents are almost fully pubertal and some may have commenced experimenting with health risk behaviours.
 - While most adolescents over the age of 14 have the cognitive ability to process health information in a manner similar to adults, they lack the experience of adults in negotiating relationships with health providers and health systems
 - The onus is on the GP to help the young person acquire the knowledge and skills to engage in a doctor / patient relationship and to make informed decisions
 - Begin to foster an independent relationship with adolescent patients as early as possible in their development
 - Raise the issue of “time alone” and confidentiality early with both the parents/carers and the adolescent, mentioning it as part of routine practice, but acknowledging that the involvement of parents is appropriate at present
 - You can then plan future sessions together to work towards seeing the young person alone at some point:
- Example:** *“Perhaps at our next appointment, I’ll spend 5 minutes with Stephen by himself.”*

Cultural Considerations

In some cultures, a young person may continue to be seen as a “child” well into adulthood. Hence, it may not be appropriate to see the young person alone – especially if they are a younger adolescent. In this case, it is important to include the parents in the consultation process. If you detect a need to see the young person alone, you can raise the issue of seeing the young person by themselves and work towards this over time:

- *continue to develop trust and rapport with the family*
- *sensitively negotiate with them about seeing their adolescent alone*
- *respect the parent’s and adolescent’s wishes not to be seen alone*
- *explain the role of the GP and how seeing the young person alone will benefit the provision of health care to him/her*

Defining Confidentiality

Research has consistently found that adolescents rate confidentiality as the most important element of a health consultation.

- Once you are the alone with the young person, begin the consultation by explaining the terms of confidentiality – this will help to facilitate rapport and lessen their discomfort in talking about private concerns:
- Inform the young person that information they discuss with you will be kept confidential – you may need to explain the meaning of the term “confidentiality”
 - Explain that it may be necessary to share some information with other professionals in order to provide the best possible treatment – stress that you would ask their permission before doing this
 - Explain that the other staff where you work (eg receptionists, other GPs) will also keep their health information (eg the medical record, pathology results) confidential within the practice

Confidentiality - Exceptions:

Explain to the patient that there are three main exceptions to maintaining confidentiality - situations where it may be necessary to break confidentiality for the young person’s safety:

- *If the adolescent is threatening to harm or kill themselves*
- *If someone else is threatening or harming them (e.g. physical/sexual abuse)*
- *If the young person is at risk of harming someone else*

- There may be other reasons for breaching confidentiality (eg notification of infectious diseases) but these can be explained if and when appropriate. For the engagement process, only the above exceptions need to be explained
 - It is helpful to have a format for informing adolescents about confidentiality that enables you to discuss it in a way that feels natural and reflects your own style
- Example:** *“Rebecca, I like to explain to all my patients about confidentiality. Do you know what I mean by confidentiality? This means that what we talk about will be kept private. I won’t tell anyone what you tell me – including your parents – unless you give me permission to do so. There are however a few situations where I might need to talk to other people if I believed that you were in danger in any way. For example: if I was concerned that you might harm yourself or someone else; or if I felt that you were being harmed or at risk of being harmed by somebody else. If any of these situations did happen, it would be my duty to make sure that you are safe. I would talk to you about it first before contacting anyone. Does that sound okay to you?”*

- You may need to reassure the young person about confidentiality at subsequent consultations – especially if you are dealing with sensitive issues such as drug use; sexuality; mental health problems

ACCIDENTAL BREACHES OF CONFIDENTIALITY:

- Confidentiality can be accidentally breached if a GP or practice staff contact the young person at home
- Be careful calling a patient's home or sending them test results or accounts
- Ask the young person about the best way to contact them with test results, reminders, etc.; or ask the patient to phone your office

Confidentiality – Dealing with Parents:

As adolescents become more independent, it is normal for them to not want their parents to know everything they are thinking and doing:

- *You can reframe this in a positive way, explaining to parents that it is a sign of healthy adolescent development*
- *Nevertheless, parents remain the main caregivers for the majority of adolescents, and so should not be alienated from their adolescent's health care – unless it would be dangerous or inappropriate*
- *GPs must balance the need to engage an adolescent in a confidential relationship, and the need to engage their parents who provide support*

Conducting the Initial Interview

The GP's first goal is to establish a trusting relationship in order to help the young person feel at ease to discuss their health concerns and to disclose relevant personal information.

- After discussing confidentiality, ask how he/she feels about coming to see you:

“Young people often feel a bit nervous the first time they see a doctor. I'm wondering if you have any concerns or worries about coming to see me today?”

- Clarify the reasons for their attendance – start with an open-ended question such as:

“How can I help you today?”

or:

“Your mother mentioned a number of things that she's worried about, but I'm wondering what things you would like to talk about today.”

- Summarise their parent's version of the problem and enquire how they feel about that:

“Your mother said that you seem to have lost interest in school and your friends, and she's worried that you might be depressed. I'd really like to hear what you think about that and how you see what's going on.”

- Young people may not perceive that they have a problem at all – or they may define the problem very differently from their parents – explore the presenting complaint with a focus on the young person's view of how they see the problem
- If the young person has come to see you by themselves, compliment them for their initiative.
- Explore their presenting complaint with a focus on the young person's view of how they see the problem
- Take a holistic perspective – try to get a picture of the young person within the context of his/her family, school and social life – explore how the presenting problem relates to other things that may be happening in their life (see the HEADSS Assessment P. 29)
- Identify and agree upon which issues, if any, should be discussed with parents/guardians and decide how to do this

STRATEGIES FOR ESTABLISHING RAPPORT

- Building rapport is the first step in establishing a good relationship with an adolescent patient
- Respond to the adolescent's initial reactions with empathy and by making a reflective statement. For example, if the young person seems uncomfortable or irritated about being there:

“Michael, I understand that you might be feeling nervous about coming to see me today. Are there any questions you'd like to ask about what's going to happen today?”

or:

“My guess is that you're not too happy about being here today and that you're unsure about what is going to happen...”

- Follow this up with a statement that gives the young person a sense of choice and control about the direction of the consultation. For example:

“Michael, I can see that this is difficult for you. Let's see if we can use this time together to identify any concerns you might have about your health right now and to explore how I might help you with any problems happening in your life. Perhaps there are some questions you'd like to ask me about how a GP works and what they can do for young people.”

- Adopt a ‘*person-centred*’ approach rather than a problem-centred approach – this means focussing on the young person in the context of their life and relationships – as opposed to a narrow focus on the “problem”
- Take an interest in the adolescent as a person – find out about their home and school life, and their interests:

“Tell me a little bit about yourself...”
- You can follow this up with specific questions about home, school, friends, interests, etc (*see also the HEADSS Assessment – P. 29 for a structured approach to gathering this information*)
- Identify and compliment them on areas in their life that are going well
- Adopt a relaxed, unhurried, open and flexible approach – remember your goal is not necessarily to diagnose their “problem” – this can lead prematurely to a treatment plan that the young person may not see as relevant to them and their situation
- By showing your interest in them as a person, a trusting relationship will develop which will encourage the young person to disclose areas of concern and allow you to address these issues as they arise in the course of the discussion

COMMUNICATING WITH YOUNG PEOPLE

- Be yourself throughout the interview, while maintaining a professional manner – adolescents expect a doctor to be an authority, but not authoritarian
- Adopt a straightforward and honest approach:
 - use plain language
 - avoid medical terminology and adolescent jargon
- Be sensitive to the young person’s cultural background, values and norms – for example:
 - some NESB young people may initially be reluctant to discuss certain issues, such as their relationship with their parents and family life, as they may think that they do not have the right to complain

(see also “Culturally Sensitive Practice” – P. 57 for approaches to working with young people from other cultural backgrounds)
- Respond to non-verbal as well as verbal cues

- Use an interactive and participatory style of communication:
 - give feedback and let them know what you are thinking
 - foster the young person’s participation by asking for their ideas about their health problems and what to do about them
 - involve them in the decision-making and management process
 - encourage them to ask questions
- Explain the process of what you are doing and why – especially any examination procedures. This demonstrates positive regard and helps to address any fear or discomfort they may be feeling

Example: *“Michael, I understand that talking about these issues is a bit uncomfortable for you. Would it be all right if I ask you some questions about what is happening at home with your parents? This will help me to get a better understanding of the pressures you are dealing with. Perhaps then together we can look at some ways that might help you to cope better with this situation. How does that sound to you?”*

- Take a one-down approach, let the adolescent educate you:

“I’m not sure if I’ve got this right.....was it a bit like....?”
- Be non-judgemental in your approach – adolescents will find it difficult to be open and honest if they believe they will be lectured or admonished
- However, this does not mean condoning risky behaviour
 - share your concerns about any risk behaviours they are engaged in
 - provide information about the health risks of these behaviours – rather than passing judgement about the behaviour

(see Risk and Protective Behaviours, P. 41)
- Provide reassurance – this helps to validate the adolescent’s feelings and establish your role as an advocate for them:

Example: *“I understand that you sometimes get frustrated with your mum. Perhaps I can talk with you and mum together to look at ways that the two of you might get along better.”*

Adolescent developmental stages

Early (10 – 14 years)	Middle (15 – 17 years)	Late (> 17 years)
CENTRAL QUESTION		
“Am I normal?”	“Who am I?” “Where do I belong?”	“Where am I going?”
MAJOR DEVELOPMENTAL ISSUES		
<ul style="list-style-type: none"> ■ coming to terms with puberty ■ struggle for autonomy commences ■ same sex peer relationships all-important ■ mood swings 	<ul style="list-style-type: none"> ■ new intellectual powers ■ new sexual drives ■ experimentation and risk-taking ■ relationships have self-centred quality ■ need for peer group acceptance ■ emergence of sexual identity 	<ul style="list-style-type: none"> ■ independence from parents ■ realistic body image ■ acceptance of sexual identity ■ clear educational and vocational goals, own value system ■ developing mutually caring and responsible relationships
MAIN CONCERNS		
<ul style="list-style-type: none"> ■ anxieties about body shape and changes ■ comparison with peers 	<ul style="list-style-type: none"> ■ influence of peers ■ tensions between family and individual over assertions of autonomy ■ balancing demands of family and peers ■ prone to fad behaviour and risk taking ■ strong need for privacy ■ maintaining ethnic identity while striving to fit in with dominant culture 	<ul style="list-style-type: none"> ■ self-responsibility ■ achieving economic independence ■ developing intimate relationships
COGNITIVE DEVELOPMENT		
<ul style="list-style-type: none"> ■ still fairly concrete thinkers ■ less able to understand subtlety ■ daydreaming common ■ difficulty identifying how their immediate behaviour impacts on the future 	<ul style="list-style-type: none"> ■ able to think more rationally ■ concerned about individual freedom and rights ■ able to accept more responsibility for consequences of own behaviour ■ begins to take on greater responsibility within family as part of cultural identity 	<ul style="list-style-type: none"> ■ longer attention span ■ ability to think more abstractly ■ more able to synthesise information and apply it to themselves ■ able to think into the future and anticipate consequences of their actions
PRACTICE POINTS		
<ul style="list-style-type: none"> ■ Reassure about normality ■ Ask more direct than open-ended questions ■ Make explanations short and simple ■ Base interventions needed on immediate or short-term outcomes ■ Help identify possible adverse outcomes if they continue the undesirable behaviour 	<ul style="list-style-type: none"> ■ Address confidentiality concerns ■ Always assess for health risk behavior ■ Focus interventions on short to medium term outcomes ■ Relate behaviours to immediate physical and social concerns – e.g. effects on appearance; relationships 	<ul style="list-style-type: none"> ■ Ask more open-ended questions ■ Focus interventions on short & long term goals ■ Address prevention more broadly

Assess the Young Person's Developmental Stage

- Be sensitive to the enormous physical, cognitive, emotional and psychosocial changes the young person may be going through
- Assess the developmental stage of the young person – *are they at the 'early, middle, or late' stage of adolescence?*
- This provides an insight into the developmental tasks and issues the young person is dealing with and determines the language and communication style that you use
- For example – younger adolescents are more concrete in their thinking and may need more specific questions rather than general ones:

Example: *"What are your best or worst subjects at school?" rather than "How is school going?"*

- The psychosocial changes of adolescence may be different for NESB adolescents
(See Adolescent Developmental and Sociocultural Issues P. 9 – Section One)

Specific Interviewing Skills

- Adolescents may not disclose the condition for which they are most in need of assistance until trust and rapport have been established – this requires time and the use of specific communication skills to explore beneath the surface
- This may be particularly so for some NESB young people – for whom it may not be culturally appropriate to disclose personal information or discuss family-related issues with another person

Some communication skills that are useful in working with young people are:

ACTIVE LISTENING

- Involves actively encouraging the young person to talk - focusing on both the facts and feelings they are communicating to ensure that you have correctly understood them
- Your *non-verbal communication* shows the young person that you are supportive and listening to them – e.g. a relaxed and attentive body posture; appropriate eye contact
- Pay attention also to the young person's non-verbal communication – their body posture; tone of voice; facial expression

Example: *An adolescent patient tells you that they are fine. Yet you notice they are sitting slumped in the chair, their eyes downcast, and speaking very quietly. You might respond by saying:*

"Mark, you said that you're feeling fine, but I notice that you seem a bit down today. I'm wondering if you're feeling a bit sad or depressed and what's happened for you this week..."

REFLECTING FEELINGS AND PARAPHRASING

- **Paraphrasing** – is a restatement of the content of what the patient has said – in your own words. It helps to clarify what the young person has said and to check the accuracy of your perceptions
- **Reflecting statements** – mirror the adolescents' feelings they are expressing either verbally or non-verbally – it shows empathy towards the young person and helps them identify their emotions
- Both these skills demonstrate acceptance and understanding of the young person and their situation

Example: *"Mark, you've said that you don't seem to be able to get on with the other kids at school and that no-one seems to understand you (Content). It sounds like you're feeling really sad and angry about this (Feelings)"*

ASKING QUESTIONS

Explain and normalise the process of asking questions as 'usual practice':

"I like to ask all my patients about their family background (lifestyle; school; etc) in order to get a better understanding about how these things may be affecting their health...."

- While it is important to ask direct questions about serious health issues, young people feel more in control if their consent is requested:
"I'm concerned that you seem to be very down today – would it be okay if we talk about what's going on?"
"In order for me to work out the best way to help you, I need to know a few things. Would you mind if I asked you about your sexual relationship with your boyfriend?"

Ask questions in a relaxed way that invite the young person to open up, rather than using an interrogative style:

- **Open-ended questions** – encourage the young person to talk about themselves, rather than simply giving a 'yes' or 'no' answer. Open-ended questions enable the patient to express their thoughts and feelings about their situation
- open-ended questions are also very useful in exploring alternatives and assisting the patient with decision-making

- try to avoid ‘why’ questions – these can put the young person on the defensive. Rather, help them to describe thoughts, feelings and events by asking ‘*what*’, ‘*how*’, ‘*where*’ and ‘*when*’ questions

Example: “How do you get along with your parents?”

“What’s happened in the last week that’s made you feel like you want to leave school?”

“What did you think when your parents told you that you had to see a doctor?”

“When you are feeling really sad or down, what do you usually do to cope with this?”

- **Specific questions** – are less open-ended and more direct. They are useful with younger adolescents who are more concrete in their thinking, and with adolescents who are non-talkative

Example: Rather than asking “How is school?”

- You can ask:
- “What do you like/dislike about school?”
- “What are your best/worst subjects at school?”
- “How do you get along with your teachers at school?”

- **Insight Questions** – there are a number of general questions that are useful in getting a broader perspective of the adolescent in the context of their life experience. They also help in establishing rapport with the young person, and give an insight into how the young person sees themselves.

Examples: “What things do you do well?”

“How do you feel about yourself most of the time?”

“What do you like most about yourself?”

“If you had three wishes, what would they be?”

“If you could describe in one word how you feel about your life right now, what would it be?”

“What do you want to do when you finish high school?”

“What are your main interests?”

(See also *Asking Sensitive Questions P. 30*)

Engaging the Difficult Adolescent

GPs often encounter adolescents who are resistant or angry because they have been coerced into attending. The young person may also be silent and withdrawn. The goal for the GP is to still build rapport and encourage the patient to open up:

- Remember that off putting behaviour – such as monosyllabic answers or hostile body language – may be a normal response in the context of their developmental stage, and the circumstances under which they have come to your clinic
- Such behaviour may also be a reflection of their anxiety and inexperience with the health system
- With the young person who is resistant, silent or angry – attempt to engage them by validating their feelings and experience, rather than get involved in a struggle for co-operation

STRATEGIES FOR ENGAGING THE DIFFICULT ADOLESCENT

Rather than trying to coerce the young person to react differently, respond to their situation with empathy. Different adolescents will respond to different approaches. Here are some strategies for engaging uncommunicative or resistant patients:

- **Use reflective listening** – make a reflective statement to acknowledge and validate their feelings. For example:

“I imagine it must feel quite strange to have to come along and talk to someone you don’t know about your problems.....”

“I guess you must be wondering how seeing me is going to help you.....”

“You seem pretty upset about being here, but I sense you’re also feeling pretty down about some things in your life right now.....”

- **‘De-personalise’** – Start with a less personal focus by using a narrative approach:

“Tell me what it’s like being a teenager in the world today”

or:

“What do young people think about coming to see a doctor?”

- **Multiple choice questions** – offer choices within a question or sentence and invite them to agree or disagree:

“When that happened I imagine that you might have felt sad / angry / confused / hurt / scared. Can you remember how you felt?”

- **Sentence completion** – use unfinished sentences based on what you know about the young person and their situation to help them express themselves. Ask the young person to complete the sentence:

“Your father was shouting at you and you were thinking.....”

“And so you felt.....”

“And after that you decided to.....”

“When your mother insisted that you come here today, your first response was to.....”

“Then when you realised you had to come, you thought.....”

- **Comparisons** – use comparisons in a question form to elicit a response:

“Do you feel better or worse about yourself than you did before this happened?”

- **Imagine questions** – this can be particularly useful when the *young person* repeatedly responds with “I don’t know”:

“Just for a moment, imagine what you would have been thinking when the teacher kicked you out of the classroom.....”

- **‘Third-person’ approach** – by reducing the personal focus of your questions, you can begin to indirectly explore the young person’s concerns:

“Many young people your age experience problems with their parents. How do you usually get along with your parents?”

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CHAPTER 2. CONDUCTING A PSYCHOSOCIAL RISK ASSESSMENT

Psychosocial, behavioural and lifestyle problems are the major causes of adolescent morbidity and mortality (see *Section One P. 7*). Yet adolescents rarely choose to see a GP for psychosocial issues such as drug use, sexual health, mental health, school or family problems ⁽¹⁾.

Adolescents often present with relatively minor complaints. By exploring beyond the presenting complaint, the GP can assess the young person's psychosocial background and detect underlying health concerns and risk factors. This increases the chance of providing timely intervention and preventive education.

The HEADSS Assessment

The HEADSS ⁽²⁾ screening tool is a structured framework for conducting a comprehensive biopsychosocial assessment of the young person. It provides information about the young person's functioning in key areas of their life:

H – Home

E – Education / Employment / Eating and Exercise

A – Activities and Peer Relationships

D – Drug Use / Cigarettes / Alcohol

S – Sexuality

S – Suicide / Depression / Mood

The HEADSS assessment gives the GP a structure for ⁽³⁾:

- developing rapport with the young person while systematically gathering information about their world – their family; peers, school and inner world
- performing a risk assessment and screening for specific risk behaviours
- identifying areas for intervention and prevention
- developing a picture of the young person's strengths and protective factors

Using HEADSS

- Before starting the consultation, reassure the young person about confidentiality
- HEADSS is a *guide* not a prescription – don't use it as a checklist to be rattled off – be flexible in how you apply it.
- Let the interview flow naturally in an interactive style and come back to any areas not covered
- Use an open-ended questioning style

- The HEADSS assessment is not simply an information gathering exercise – listen carefully to the young person's verbal and non-verbal responses
- Explore in more detail any areas of ambiguity or where a risk is identified – especially in sensitive areas such as drug use and sexual activity
- You may not have time to cover all of the HEADSS areas in the one consultation. If some areas take more time, explain to the young person that what they are telling you is important – make another appointment to explore further with them

(see A Guide to Using HEADSS – below)

With Current Patients:

- HEADSS provides an ideal format for a preventive health check.
- A HEADSS screen can be opportunistically performed when an adolescent patient presents with a minor complaint – explain to them the reasons for the screen and normalise the process:

“Sally, I know you've come to see me for a sore throat but since I haven't seen you for a while I'd just like to check how your life is going in general. If there's anything you'd like to discuss about your health, we can do that now. If there's anything you don't feel comfortable to talk about, that's fine – just let me know. I do with this with all my young patients. Is that okay with you?”

- *Selective screening* – you can apply specific sections of the assessment as appropriate to a particular young person and their circumstances

With New Patients:

- HEADSS provides a framework for engaging the young person while taking a full history
- Any young person presenting with a psychosocial complaint requires a full HEADSS assessment
- Introduce the assessment and explain what you are doing:

“There are many health risks for young people today. In order for me to get a better understanding of each patient, I like to ask them about different areas of their life and how these might affect their health. If it's okay with you, I'd like to ask you a few questions about how things are going in different areas of your life.”

Asking Sensitive Questions

- The *HEADSS* format is designed to start with less sensitive areas of a young person's life and move towards more sensitive
- Bear in mind however, that for some young people, the first item, '*HOME*' can be a difficult and highly sensitive area
 - for example, NESB young people may initially feel uncomfortable talking about their parents and other family issues
 - they may think that they do not have the right to complain or fear being perceived as complaining about their parents

- Request permission to ask sensitive questions, for example:

"I'd like to ask you a few personal questions. You don't have to answer these if you don't feel comfortable. The reason I want to ask you these is because it will help me to get a picture of your life and your overall health and give you a chance to talk about any things that you might be concerned about. Remember that anything we discuss will be kept confidential. Is it OK if I ask you some more questions?"

- Use the '*third person approach*'. This normalises the process of what you are doing and lessens the impact of sensitive questions:

Example: *"Many young people your age are beginning to experiment with drugs or alcohol (or sex). Have you or any of your friends ever tried these (or, had a sexual relationship)?"*

Or:

"Sometimes when people feel very sad they can think about hurting themselves. Have you ever had any thoughts like this?"

- Progress from neutral to more sensitive topics
 - for example, if the adolescent mentions that they have a boyfriend or girlfriend, a further question might be:

"Can I ask what his/her name is? How long have you been going out with him/her? Has the relationship become more sexual? Have you thought about having sex?"

- When exploring the area of *sexuality*, don't assume the young person's sexual orientation
 - enquire about both opposite and same-sex relationships
 - adopt a gender-neutral and non-judgemental approach:

"Have you ever had a relationship with any boys or girls or both?"

Further History

- At the end of the *HEADSS* assessment, the GP should have a profile of:
 - the young person's psychosocial health
 - the overall level of risk of the young person
 - specific risk factors in their lives, as well as protective factors and strengths
 - areas for intervention
- This information will serve as a guide to intervention and the provision of health education (*See also Risk Taking and Health Promotion, P. 41*)
- Other areas of the young person's life to enquire about include:
 - family history
 - cultural background
 - recent life events (e.g. change of schools; separation of parents; death of a relative; migration history; etc)
 - coping skills
 - medical and psychiatric history
 - available support systems
 - personality factors

A Guide to Using HEADSS ^(2,3)

The following questions provide a guide to conducting a *HEADSS* assessment with a young person. You can use the form contained in *Appendix 3* for recording the young person's responses to these questions:

ASSESSMENT AREA	QUESTIONS
H – Home	<p><i>Explore home situation, family life, relationships and stability:</i></p> <p>Where do you live? Who lives at home with you?</p> <p>Who is in your family (parents; siblings; extended family)? What language is spoken at home?</p> <p>Does the family have friends from outside its own cultural group / from the same cultural group?</p> <p>What is your / your family's cultural background?</p> <p>Do you have your own room?</p> <p>Have there been any recent changes in your home environment (moves; departures; etc.)?</p> <p>How do you get along with mum and dad and other members of your family?</p> <p>Who could you go to if you needed help with a problem?</p>

ASSESSMENT AREA	QUESTIONS
E – Education / Employment	<p><i>Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:</i></p> <p>What do you like/ not like about school (work)? What are you good at/ not good at? How do you get along with teachers /other students / workmates? How do you usually perform in different subjects? Some young people experience bullying at school, have you ever had to put up with this? What are your goals for future education/employment? Any recent changes in education/employment?</p>
E – Eating and Exercise	<p><i>Explore how they look after themselves; eating and sleeping patterns:</i></p> <p>What do you usually eat for breakfast/lunch/dinner? Sometimes when people are stressed they can overeat- or under-eat. Do you ever find yourself doing either of these? <i>If screening more specifically for eating disorders you may ask about body image, the use of laxatives, diuretics, vomiting, excessive exercise, and rigid dietary restrictions to control weight.</i> What do you do for exercise?</p>
A – Activities and Peer Relationships	<p><i>Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:</i></p> <p>What sort of things do you do in your free time out of school/work? What do you like to do for fun? Who are your main friends (at school/out of school)? Do you have friends from outside your own cultural group / from the same cultural group? How do you get on with others your own age? How do you think your friends would describe you? What are some of the things you like about yourself? What sort of things do you like to do with your friends? How much television do you watch each night? What’s your favourite music? Are you involved in sports/hobbies/clubs, etc?</p>
D – Drug Use / Cigarettes / Alcohol	<p><i>Explore the context of substance use (if any) and risk taking behaviours:</i></p> <p>Many young people at your age are starting to experiment with cigarettes/ drugs/ alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? How about you, have you tried any? – <i>explore</i> How much are you talking about and how often? What effects does drug taking or smoking or alcohol, have on you? Has your use increased recently? What sort of things do you (& your friends) do when you take drugs /drink? How do you pay for the drugs / alcohol? Do other family members take drugs / drink? <i>S – Sexuality</i> <i>Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour / abuse:</i> Many young people your age become interested in sexual relationships. Have you ever had a sexual relationship with a boy or a girl (or both)? – <i>explore</i> Do you have a boyfriend / girlfriend? How do you feel about relationships in general or about your own sexuality? What do you know about contraception and protection against STDs? Has anyone ever touched you in a way that has made you feel uncomfortable or forced you into a sexual relationship?</p>
S – Suicide / Self-Harm/ Depression / Mood	<p><i>Explore risk of mental health problems, strategies for coping and available support:</i></p> <p>Sometimes when people feel really down they feel like hurting, or even killing themselves. Have you ever felt that way? Have you ever tried? What prevented you from going ahead with it? How did you try to harm / kill yourself? What happened to you after this? What do you do if you are feeling sad, angry or hurt? How do you feel in yourself at the moment on a scale of 1 to 10? Who can you talk to when you’re feeling down? How often do you feel this way? How well do you usually sleep?</p>
<i>You can also explore:</i>	
S – Safety	Sun screen protection; immunisation; bullying; abuse
S – Spirituality	Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?

Case Study – HEADSS

Toby is a 14 year old boy who lives with both parents and an older brother. He presents for the third time in 3 months with upper abdominal pain and fatigue. On each occasion you find nothing on examination and the symptoms are vague with no obvious precipitating factors. You have already performed a full blood count, ESR, general biochemistry, liver function tests and serum amylase all of which are normal. There is no relevant family medical history. Toby's mother is a registered nurse and is very anxious about whether peptic ulcer disease could be the cause. You are wondering what to do next – referral for endoscopy, upper GI ultrasound, Barium studies, although there are absolutely no clinical signs on examination. Toby has now missed a total of 12 school days in the past 3 months. His grades have been going down and he is increasingly anxious about going to school. He confides that he has no friends at school and that other students continually make fun of him.

Management Considerations

- To help Toby return to good health requires a broader exploration of all the factors that could be affecting his health. It also requires a delicate balance between encouraging Toby (and his mother and family) to discuss broader issues while maintaining vigilance around his medical management.

You should consider:

- seeing Toby alone
- seeing his mother alone
- using HEADSS as a tool to take a psychosocial history from Toby and also to build rapport and trust

- It is sometimes worthwhile to order investigations, preferably non-invasive, in the absence of hard signs, as a matter of reassurance as well as to keep his mother (and perhaps Toby and other family members) engaged.

Practical steps:

- Design a management plan with Toby and his mother, inviting his father to participate as well, e.g.
 - weekly medical reviews over one month, during which time symptoms and signs are assessed
 - during this time, use HEADSS to explore psychosocial issues
 - after this period, you should have a fairly clear understanding of where there might be areas of concern in Toby's life that are affecting his health, and his experience of symptoms.
- After a period of more thorough assessment, you might also decide that you would like to have one or two consultations with Toby's parents, or that a referral to a specialist (gastroenterologist, adolescent unit, family counsellor, or all of the above) is warranted. It is possible that Toby's symptoms will begin to subside once other issues get explored.
- You can also raise the issue of Toby's educational disruption, and make contact with Toby's school (with his permission) to open up communication between you as his health 'case manager' and the relevant school personnel as his education advocates.
- Explore the issue of Toby's anxiety and absences from school. Consider referral to a counsellor to assist with these issues.

References:

1. Access SERU. (1999), *Improving young people's access to health care through general practice – A guide for general practitioners and Divisions of General Practice*. Access SERU - Department of General Practice & Public Health, University of Melbourne. Melbourne.
2. Goldenring, J. and Cohen, E. Getting into adolescents' heads. *Contemporary Pediatrics*. 1988, July: 95-90.
3. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.

CHAPTER 3. NEGOTIATING A MANAGEMENT PLAN

As with any patient, it is important that the management plan is developed jointly with the young person, and where appropriate, with their parents.

Providing Feedback

Provide the young person with feedback about your assessment and encourage them to participate in developing a management plan ⁽¹⁾:

- State your understanding of the main concerns and issues as expressed by them
- Provide the young person with information about their growth and development – identify and compliment them on areas of their life where they are doing well (e.g. school; sports; friendships), and reinforce their strengths
- Provide them with reassurance that they are normal. You can do this by normalising, where appropriate, the symptoms or problems they are experiencing:

Example: “Many people experience headaches and sleeplessness when they are under a lot of stress...but we can check this out further to see if there is anything else that may be causing this.”

Or:

“It’s not unusual for young people your age to feel confused and uncertain about sexual feelings and sexual relationships.....perhaps we can talk about this some more and look at any concerns or questions you have about this.”

- Highlight areas of concern where intervention and treatment may be needed.
- Help them understand the connection between symptoms and other problems they may be experiencing. Take a straightforward and honest approach to this:

“Michael, your headaches are something we can deal with by helping you to cope better with stress at school. However, I am concerned about how depressed you’re feeling and I think we need to look at what we can do about this”

- If the young person is engaged in risky behaviours, share your concerns about these and provide information about the risks associated with these behaviours. Discuss ways of protecting themselves from these risks:

“Rebecca there are a few things you’ve mentioned that I’m concerned about – especially your drug use. I know you’ve said that it’s a big part of what you do when you’re with your friends. But I’m wondering how much you know about the effects of marijuana, and some of the risks that it has for young people.

If you like, I can give you some information about this and we can discuss ways to make sure that you are safe.....”

(see also Risk and Protective Behaviours, P. 41)

- Negotiate a management plan with the young person:
 - outline treatment options
 - explain your reasons for recommending certain treatments
 - actively involve them in making decisions about management options
 - A successful management plan consists of treatment that the young person can understand and manage
 - If you are prescribing medication or recommending investigations, explain your reasons for this and what is involved in any procedures
 - Initiate early intervention for problems or risk factors identified in the consultation or HEADSS assessment – for example:
 - health education and information
 - basic counselling
 - family mediation
 - referral to counselling or specialist services
- (See also Enhancing Compliance – P. 87)*

Wrapping Up the Interview ⁽²⁾

- Invite questions or comments from the young person
- Ask if they have any other problems/concerns that have not been raised already in the interview but they would like to talk about
- Identify possible sources of support – who can they talk to about things that are troubling them?
- Adopt an “open door” approach – let them know that they can speak to you about problems and encourage them to contact you if they need assistance.
- Explain how to make an appointment by themselves if they need to see you
- If the young person has come with a parent, discuss what to tell mum or dad, and which areas they don’t want to discuss with their parents.
- Offer to talk to the parent(s) on their behalf about any sensitive issues. Respect the young person’s wishes to not discuss certain issues with parents.

Example: *“Rebecca, before you mother comes back in I’d like to be clear about what to tell her and what not to talk about. What would you like mum to know about what is going on for you? What sort of support would you like to get from mum?”*

or

“If you’d like, I could talk to your mother about some of the things that are happening for you. But I need to be clear about what you’d like me to say or not say to mum.”

(See also *Dealing with Parents – below*)

Follow-Up

- If a follow-up appointment is needed, encourage the young person to return and emphasise that it is important that you see them again
- If you are concerned about the young person keeping an appointment, make a contract with them to return - if appropriate, offer to give them a reminder call
- Ask the young person about the best way to contact them for follow up
- Make a follow-up appointment if further work is required

When booking a follow-up appointment, it is a good idea to walk to the reception desk with the young person and put their name in the reception book, or ask the receptionist to do so – it is more likely that the appointment will be kept this way

- If necessary, facilitate a referral to a specialist or other agency – e.g. counsellor; youth service
(See also *Collaborative Care – P. 89*)

Dealing with Parents ⁽²⁾

For the majority of adolescents parents are the main providers of physical and emotional support. It is important to involve them in any management / treatment plan – especially with younger adolescents or if the young person’s cultural background makes it appropriate:

- The GP must sensitively judge the level of parental involvement required – balancing the young person’s need for confidentiality with the need to keep the parents engaged and involved
- This decision depends on a number of factors:
 - the age and developmental stage of the young person
 - the nature of the relationship between the young person and parent(s)

– the nature of the presenting problem – e.g. parents may sometimes need to be involved where major health issues are concerned (even if it is against the young person’s wishes) – e.g. unplanned pregnancy; prescription of medications; suicidal behaviour

- If a young person has come with a parent, spend some time with the parent – either alone or together with the young person *after* you have seen the adolescent by themselves
- Parents may need information and education about the young person’s concerns, as well as guidance in how best to respond to their adolescent and what role to take in supporting the young person’s treatment
- In particular, they may need support on how to deal with risk-taking behaviours the young person may be involved with – e.g. substance use; sexual activity
- Provide them with reassurance and support to dispel any fears or anxiety
- Be sensitive to the concerns of parents from other cultural backgrounds – respect their wishes to be involved in their adolescent’s health care
- Respond to the parents’ concerns while respecting the adolescent’s right to confidentiality
 - explain that the young person’s need for confidentiality is normal and can be an opportunity for the adolescent to take on more responsibility (rather than a sign of secretiveness)

(See also *Section One – Defining Confidentiality, P. 21*)

INVOLVING PARENTS

- If the young person is adamant that they don’t want their parents to know or be involved, sensitively explore the barriers to this:
 - “What are your fears or concerns about your parents knowing about your situation?”*
 - “How do you think your mother would react if you were to tell her about this problem?”*
- Over time, you can work towards involving parents or another support person:
 - “If you could, what would you like to be able to tell your parents?”*
 - “How would you like your parents to respond so that you felt supported?”*
- Your duty of confidentiality does not preclude encouraging and assisting young people to talk to parents about important issues – this may be the goal of future consultations

- GPs can play a key role in facilitating communication about difficult issues between young people and their parents
- There may be situations where, because of medico-legal issues and/or the age of the adolescent, you need to inform the parents about the young person's situation
- Where possible, however, hand back the choice and responsibility to the young person for the decision of whether to inform parents

Approaches to Communicating with Parents

- Give an overview of the consultation with the young person:

Example:

“Michael and I have had a talk about his health and I have examined him. I also discussed the issue of confidentiality and explained what this means.”

- If it hasn't already been done, explain confidentiality to the parents
- Summarise the main health issues and your management plan – share any relevant information that the young person has agreed to
- Provide information about the young person's growth and development, strengths and achievements, and if appropriate, areas of concern
- Invite questions or comments from the parents
- Reassure the parents that you are aware of their concerns and supportive of their role, even though it is important for you to see the adolescent alone and in confidence
- Guide them in how they can be involved in supporting the management plan and how to respond to any risk taking behaviours that the adolescent is involved in
- Help them to support the developing independence of the adolescent

References:

1. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
2. Bennett, D. L. and Kang, M. Adolescence, in Oates K, Currow K, and Hu W. (2001) *Child Health: a practical manual for general practice*. MacLennan and Petty. Australia.



CHAPTER 4. CONDUCTING A PHYSICAL EXAMINATION

The Process

- Explain why an examination is necessary and ask the young person's consent to do this
- It is reassuring to explain the procedures of the examination before it is performed
- Seek parental permission where appropriate
- Protect the young person's modesty and privacy - leave the room for the adolescent to undress
- Where possible, conduct the examination with the young person partially dressed
- Be thorough, gentle and sensitive - respond to the young person's fears and anxiety about being examined
- Be sensitive to cultural norms and values for young people of NESB or other cultural background
- seek approval from parents to conduct examinations - especially if dealing with girls or younger adolescents

Example: "Kristie, I would like to carry out a physical examination as part of your health assessment. Sometimes people feel a bit embarrassed which is normal. Remember as a doctor this is a routine part of my job. Have you ever had a physical examination before? (If yes – ask what it was like and explore any difficulties). What I'll be doing is (checking your blood pressure, listening to your heart and lungs, feeling your abdomen/ tummy etc). If it would help you to feel more comfortable, you could have another person in the room to support you. How does that sound? Is there anything you'd like to ask me?"

THE EXAMINATION

- Explain what you are doing in each part of the examination (in plain language) as you go along
- Provide reassurance of normality – encourage them to ask questions
- Explain developmental and health matters – take the opportunity to teach them something about their body and how to care for themselves
- Male doctors especially need to be aware of female patient's feelings of discomfort
- Young women especially, may like a support person – such as a friend, a female practice staff member or possibly a parent, with them during the examination – offer this where possible

- For some cultures it may be uncomfortable or even shameful for a male doctor to examine a female patient
 - ask the parents' permission
 - arrange for the girl to be examined by a female practitioner where possible and /or to have a female support person present
- Examination of genitalia or other secondary sex characteristics is not routinely required – unless there is strong suspicion of an endocrine disorder, or the adolescent would like reassurance on parts of their body
- Pap smears and sexual health examinations can be highly embarrassing – explain clearly your reasons for doing such tests and what is involved
- Provide feedback on your findings – be sensitive and straightforward in explaining any negative findings and what these mean – check the adolescent's understanding of your explanation

Medical problems

Medical problems of adolescence cluster in 4 major categories ⁽¹⁾:

- Concerns and conditions related to pubertal growth and development
- Pre-existing conditions complicated by adolescence
- Concerns related to mental health, lifestyle and risk taking behaviour
- Conditions associated with adult morbidity

What to Look For ⁽¹⁾

- Keep in mind some common variations of adolescent development – e.g. unequal breast size in girls; gynaecomastia in boys – provide reassurance of normality
- If conducting a general physical examination, take particular note of physical changes and conditions related to pubertal growth and development:
 - *Document height and weight* with growth charts and determine Body Mass Index (BMI=weight in Kg/height in M²)
 - *Record blood pressure* to exclude secondary causes of hypertension (repeat readings of 130/85 in supine, sitting and standing positions)
 - *Examine skin* for acne (describe as papules, pustules, pits or scarring), hirsutism, and other skin conditions such as warts, atopic eczema, seborrhoea, tinea cruris and scabies

- *Check the thyroid* (enlargement is abnormal and requires investigation) and lymph nodes
- *Determine Tanner Stage ratings* for sexual maturity (see *Tanner Staging* – below)
- In the female adolescent, *palpate breasts* for benign masses such as fibro-adenomas (firm, painless, persisting) or fibrocystic lesions (often multiple, tenderness varying with menstrual cycle)
- *Check for gynaecomastia* in boys
 - common in the early pubescent male as firm, rubbery breast tissue palpable beneath the areola or resembling early normal female breast development
 - rarely reflects an underlying disorder such as Klinefelter’s Syndrome
- *Auscultate heart* for innocent murmurs (most commonly vibratory murmur at LSE or physiological ejection murmur at left 2nd interspace); examine chest for deformity and auscultate lungs for wheeze
- *Palpate abdomen* to distinguish organic from non-organic complaints
- *Examine the skeletal system* to exclude common orthopaedic conditions such as idiopathic scoliosis (rib humps on bending), adolescent kyphosis (Schuermann’s disease), Osgood-Schlatter Disease (tenderness of the tibial tuberosity), and slipped capital femoral epiphysis (hip or knee pain and limp)
- *Conduct a neurological examination* (not routinely needed) in the presence of headaches, clumsiness, poor school performance, personality change or unprovoked emotional outbursts
- *Ask about immunization status*
- *With NESB young people* – be aware of health complications due to refugee or migration experiences, e.g.
 - physical deprivation
 - anaemia
 - malnutrition
 - parasitic infections
 - oral health problems
 - post-traumatic stress and other mental health problems

THE EXPERIENCE OF PUBERTY ⁽¹⁾

- Puberty involves the most rapid and dramatic physical changes that occur during the entire life-span outside the womb

- Average duration is about 3 years and there is great variability in time of onset, velocity of change and age of completion
- Height velocity and weight velocity increase and peak during the growth spurt (early in girls, later in boys)
- The experience of puberty is to have a changing body that feels out of control
- Feelings of helplessness are common and may not abate until about 12 months after the growth spurt has ended
- The typical moodiness, sexual arousal and unpredictable behaviour of the early adolescent are due largely to hormonal changes

TANNER STAGING – MEASURING PUBERTAL DEVELOPMENT

‘Tanner Staging’ is a quick, convenient staging system for monitoring physical changes in puberty ⁽²⁾.

Note: Tanner Staging would not routinely be conducted with the majority of adolescent patients unless you suspect some variation in development.

- *Stage 1* is pre-puberty and *Stage 5* is full adult physical development
- Changes to breasts, pubic hair and male genitalia can be staged
- This system allows objective comparison over time and between health professionals (see *Tanner Charts – Appendices*)
- Adolescents can also accurately grade their own development from these diagrams – this is useful when the young person is reluctant to be examined.

Unless clinically indicated, it is usually not necessary to undress the adolescent. If you have a chart available, most young people will accurately point to the diagram that best matches their Tanner stage.

Practice Points

- Pubertal (secondary sexual) development before 8 years in girls and 9 years in boys is abnormal and must be assessed by a specialist - there is no place for expectant treatment.
- The most common pubertal disorders seen in clinical practice - which are in fact variants of normal - are mild maturational delay in the male and gynaecomastia in the male - active intervention is rarely required.
- In females, menstrual concerns and signs of possible androgen excess (hirsutism, acne, menstrual irregularity) are common presentations. Polycystic ovarian syndrome must be excluded.

- Height growth velocity and final height are linked to developmental and osseous age rather than chronological age - there is no absolute cut off age for further height growth
- Random or 'spot' hormone tests need to be interpreted with care and caution in puberty, where hormone changes are dynamic and where dynamic testing may be required.

Tanner Charts can be obtained from Pfizer Australia - 07 34269777. Growth charts for use on a computer can also be downloaded free from the following website:

www.htl.co.nz/cms/site/home/medtechglobal/downloads.php?PHPSESSID=240

Case study: Puberty - Tom

Tom is a 14 year, 2 month, old boy who comes to see you because he has not yet commenced puberty. His medical history is completely normal. He has only ever presented to you for routine immunisations and minor illnesses such as sporting sprains and colds. He lives at home with both parents and a younger sister, aged 12, who has started puberty. He is in Year 8 at the local high school and says that all his friends are taller than him, and he feels very self-conscious because he's the only one with a squeaky voice. On examination he is a Caucasian boy, measuring 147cm (<5th centile) and weighing 37kg (<5th centile). His testes measure 1.5ml (Tanner stage 1) and he has no pubic hair (Tanner stage 1). His physical examination is otherwise normal.

Tom has *delayed puberty* (absence of any pubertal development by age 14 in boys, 13 in girls). Your assessment should include:

History:

- Growth record – plotting his height and weight to see whether and when his growth might have deviated
- Family history –parents' and siblings' heights; when parents and other family members started puberty, or went through particular pubertal events (eg menarche in mother? when did father start shaving? Was father small compared to friends in high school?)
Note: >60% of adolescents with constitutionally delayed puberty have a positive family history

- Systems review – to exclude systemic illness
- Nutritional history and eating habits – to exclude chronic malnutrition

Physical Examination

- Height and weight
- General appearance and nutritional status
- Sexual Maturity Rating (Tanner stage)
- Thyroid – evidence of goiter, signs of hypothyroidism
- Chest – evidence of chronic pulmonary disease
- Heart – evidence of congenital heart disease
- Abdomen – evidence of liver or spleen enlargement as a sign of a chronic systemic disorder
- Neurological examination – especially looking for signs of intracranial pathology (eg intracranial hypertension)

Laboratory Investigations

- FBC – exclude anaemia, leucocytosis
- ESR – exclude systemic disease
- Serum biochemistry – electrolytes, creatinine, glucose, calcium, phosphorus, liver function (including albumin, protein)
- Bone age – this is very useful in conjunction with chronologic age and height/ weight. Bone age is delayed in constitutional delayed puberty (as well as hypopituitarism, hypothyroidism, chronic illness) but may be normal in Turner's syndrome
- T4 and TSH
- Gonadotrophins

Note: 90 – 95 % of delayed puberty is constitutionally delayed puberty, but this is a diagnosis of exclusion. The above serves as a guide only, and other investigations and/ or referral to an endocrinologist may be warranted.

Management of constitutionally delayed puberty includes:

- Explanation and reassurance
- Follow-up and review – medical and psychosocial, to ensure the puberty does begin, to be certain that any other abnormality was not overlooked, and to review the psychosocial impact of delayed puberty on the adolescent. Hormonal intervention is rarely warranted, but could be explored if severe psychological problems arise.

References:

1. Bennett, D. L. and Kang, M. Adolescence, in Oates K, Currow K, and Hu W. (2001) *Child Health: a practical manual for general practice*. Maclellan and Petty. Australia.
2. Tanner, J. and Davis, PSW. *Journal of Paediatrics*. 1985:107.



CHAPTER 5. RISK TAKING AND HEALTH PROMOTION

Psychosocial problems and risk-taking behaviours account for the majority of adolescent death and illness ⁽¹⁾:

- Accidents and injuries
- Substance use
- Mental health problems

Risk taking behaviour is central to the onset of many major adolescent health problems. GPs can play a vital role in prevention and health promotion by using their consultations to:

- screen for health risk factors in the young person's life
- provide early intervention and health education appropriate to the developmental stage of the young person

Risk Taking

Risk taking is a normal part of adolescent development. Young people typically experiment with new behaviours as they explore their emerging identity and independence. While risk taking is almost always viewed in negative terms by adults, not all risk taking is dangerous and detrimental to the young person's health. In fact, a certain degree of risk taking is essential for personal growth and development. It enables a young person to test their limits, learn new skills, develop competence and self worth, and assume greater responsibility for their life ⁽²⁾.

However, risk taking behaviour can be problematic and requires intervention when it:

- interferes with normal adolescent development
- poses serious risks to the young person's health and safety
- impairs healthy functioning
- becomes an established part of the young person's lifestyle

Adolescent risk taking behaviour poses a greater threat when it is characterised by:

- ignorance – lack of prior experience or adequate information
- impulsiveness and thrill-seeking
- cognitive immaturity – inability to comprehend the consequences of behaviour
- low self worth and feelings of inadequacy

UNDERSTANDING RISK TAKING

- For some young people, risk taking may be a way of resolving developmental challenges – e.g. *a young adolescent male who drinks heavily to prove that he is as grown-up as his peers.*
- For others, risk taking may be a way of dealing with problems or escaping unhappy situations or feelings – e.g. *a young woman who engages in sexual behaviour in response to her low self-esteem and feelings of worthlessness.*
- While risk taking behaviour can constitute a major health problem in itself, it may also be an indicator of an underlying problem in the young person's life – e.g. *angry, acting-out behaviour that is masking underlying depression*

Some examples of negative risk taking behaviours which have serious implications for young peoples' health include:

- early and/or high risk sexual activity
- drink driving
- unprotected sexual activity
- substance or alcohol abuse
- runaway behaviour
- suicide or self-harming behaviour
- school dropout
- criminal activity
- severe dieting

Screening for Risk Behaviours

- Routinely screen adolescent patients for risk behaviours – especially if they present with specific psychosocial problems
- This enables you to assess the young person's overall level of health risk and plan appropriate intervention if required.
- Use the *HEADSS* psychosocial assessment to identify risk behaviours and determine the young person's degree of risk.

(see Conducting a Psychosocial Risk Assessment, P. 29)

IDENTIFY RISK AND PROTECTIVE FACTORS

The degree of health risk attached to a young person's behaviour depends in part on the balance of *risk and protective factors* in a young person's life ⁽³⁾:

- When screening for risk factors it is also important to identify protective factors in the young person's life

- Research has shown that protective factors are crucial to the development of resiliency in young people
- The presence of certain protective factors (such as a stable, positive relationship with at least one adult) can outweigh the effects of risk factors
- The *HEADSS* assessment gives a profile of the overall balance of risk and protective factors in a young person's life.

Assessing the Degree of Risk

The more risk factors in a young person's life, the more likely they are to experience harmful consequences from their risk-taking behaviour.

In assessing risk status, consider the following:

- *How much is the behaviour compromising the young person's safety, health, and development?*
- *The range and severity of risk factors – the presence of one risk behaviour may increase the risk for the occurrence of others (e.g. substance abuse and sexual risk-taking; school drop-out and the development of anti-social behaviour)*
- *How severe is the risk behaviour and is it escalating?*
- *How aware is the young person of the consequences of their behaviour?*
- *How entrenched is the behaviour in the young person's lifestyle?*

- *What strategies do they know or use to minimise the harm associated with the risk behaviour?*
- *What protective factors exist in the young person's life to safeguard them against the consequences of risk behaviours?*

RISK STATUS

Having identified the young person's risk and protective factors, their overall risk status can be classified as follows ⁽³⁾:

- **No risk** – *not yet engaged in risk behaviours*
 - 'well adjusted'
 - family, school and social functioning are stable and positive
 - presence of a number of protective factors
- **Low risk** – *engaged in safe experimentation*
 - 'healthy experimenter'
 - risk taking is sporadic, recreational and experimental
 - family, social and school profile is stable
 - protective factors outweigh risk behaviours
 - may need monitoring if individual or environmental risk factors present

Example – *a young person who has experimented with marijuana with peers, but who has stable family and peer relationships, and is doing well at school.*

Risk Factors *Characteristics of the young person themselves and their social environment that increase a young person's vulnerability to harm*

Common risk factors for adolescents include:

- socio-economic disadvantage
- poor parenting
- family conflict/ breakdown
- school failure
- bullying
- lack of meaningful relationships with adults/peers
- exposure to violence and crime
- individual characteristics – such as low self-esteem, poor social skills
- refugee experience
- racism
- intercultural conflict – the adolescent trying to 'fit in' and adapt to the new culture

Protective Factors *Individual and environmental factors that increase resistance to risk factors – including environmental supports, family background, personal skills and internal attitudes. They act as a buffer to the negative effects of risk behaviors and can protect against the initial occurrence of a risk factor*

Key protective factors for adolescents include:

- supportive relationship with a caring adult
- attachment to family
- supportive/effective parenting
- positive achievements and sense of belonging at school
- attachment and belonging to community/culture
- strong sense of moral values / spiritual beliefs
- social skills and competence
- success (at sport; study; etc) or development of a special talent/ hobby
- creativity and imagination

- **Moderate risk** – engaged in behaviours with harmful consequences – e.g. impairment of positive functioning and developmental tasks
 - ‘vulnerable’
 - presence of social/environmental risk factors – family problems; peer group influences; or other risk factors – e.g. adolescent with low self-esteem and family history of depression
 - presence of some protective factors – e.g. positive family, school, or peer support
 - requires intervention

Example – a depressed young person with low self-esteem and a family of history of depression, who occasionally smokes marijuana by himself.

- **High risk** – major disruption or risk to health, safety or life
 - ‘troubled’ or ‘out of control’
 - persistent and/or escalating harmful behaviours
 - persistent and/or negative consequences – e.g. disruption of relationships; poor school performance; trouble with the police
 - presence of major risk factors and few protective factors

Example – a young person who is involved in anti-social behaviour, at risk of expulsion from school, with frequent alcohol and substance use, and with a lack of family support.

Intervention

- When exploring risk factors and planning interventions, adopt a non-judgemental approach
- Explain the health risks in objective and simple terms
- Explore the health and social consequences of these risks in an interactive and non-judgmental style:

“Jason, you said that when you get together with your friends and smoke lots of dope you have a lot of fun and you forget about your problems. I’m wondering how you feel the next day. What do your body and your mind feel like? What’s it like trying to go to school after you’ve had such a big night?”

- Help the young person explore the reasons behind their behaviour and what function it might fulfill in their life:

“How does smoking marijuana help you to deal with some of your problems?”

Note: It is important to acknowledge that there are usually also positive benefits that the young person gains from engaging in the risk behaviour – e.g. peer acceptance; having fun; relieving anxiety

- Identify alternatives and ways of minimizing the harm associated with their behaviour
- Feedback your concerns about their behaviour, but allow the adolescent to make their own decisions
- Attempt to maintain contact with the young person even if they continue with their risky behaviour
 - this can serve as a major protective factor in their life
 - let them know that your relationship with them is important and that you want to continue to be their doctor:

“I’m interested in you and your wellbeing. It’s my job as a doctor to let you know if something is a risk to your health, but what you do about that is your choice. I can help you look at some other alternatives if you like. Whatever you decide, I want to continue seeing you……”

GOALS OF INTERVENTION

Some risk taking behaviours may only require the provision of health education. Others may need more proactive intervention, particularly if the young person is at high risk. The level of intervention required depends on the balance of risk and protective factors and the severity of the risk taking behaviour ⁽³⁾:

Risk Status	Interventions
Adolescents at no/low risk	<ul style="list-style-type: none"> ■ Aim to prevent the emergence of problem behaviour <ul style="list-style-type: none"> – Provide preventative health education and health promotion messages – Enquire about their level of knowledge and provide objective information about the health consequences associated with a particular behaviour – Build a trusting relationship so that they might return if concerns arise in the future
Adolescents at moderate/high risk	<ul style="list-style-type: none"> ■ Reduce modifiable risk factors / behaviours <ul style="list-style-type: none"> – use harm minimisation strategies to help reduce the dangers associated with risky behaviours – develop a plan of management in conjunction with the young person to reduce risks associated with their behaviour and find safer alternatives – provide health education, basic counselling and referral to support services – interventions that are effective in reducing one risk behaviour are likely to positively effect other risk behaviours ■ Strengthen protective factors <ul style="list-style-type: none"> – identify and reinforce the young person's strengths – identify ways to enhance protective factors in their lives - e.g. family counselling; school mediation – teach the young person protective behaviours to reduce risks – e.g. safer sexual practices; refusal and assertiveness skills

INTERVENTION STRATEGIES

- Promote resiliency
 - research has shown that a sense of ‘connect- edness’ or belonging is central to the develop- ment of resiliency in young people ⁽⁴⁾
 - you can foster resiliency by strengthening a young person’s connectedness ⁽⁵⁾:
 - in their social environment – to their family; school/work; community; culture; peers; meaningful involvement in activities
 - within themselves – by fostering positive self- esteem; teaching social, emotional and cogni- tive skills (see box below)
- Adopt a collaborative approach to management
 - identify existing support structures in the young person’s life and work together with these where possible – e.g. school; youth worker
 - provide referral to specialist services if needed – counsellor; youth service; etc
 - where appropriate, involve the family if the young person is willing
- If the young person does not want to discuss the issue
 - have some simple information that you can give them on relevant topics (e.g. drug & alco- hol use; sexual health; etc)
 - there are many excellent youth-friendly pam- phlets available on these topics (see Appendix for information about health education materials)

Example

“Jason, what do you know about the effects of marijuana? If you like, I’ll give you a bit of information on what we know about the effects of marijuana on your body and your brain. This might help you in making decisions and in keeping yourself safe.”

Strategies for Promoting Resiliency ^(5;6)

- Adopt a strengths perspective – focus on strengths not just problems:
 - help the young person to recognise and affirm existing strengths & personal assets
- Enhance and reinforce protective factors in the young person’s life – e.g. family support; connection to school; positive peer relation- ships; connection to their culture
- Foster a positive self-image and self esteem – through participation in activities; sports; aca- demic achievement; hobbies; artistic abilities
- Teach life skills – cognitive / social / emotion- al competence
 - Cognitive competence – identify and chal- lenge cognitive distortions and develop positive self-talk; decision-making

- Emotional self-management – identify and regulate emotions; encourage appropriate expression of emotions
- Social competency – interpersonal and communication skills
- Teach protective behaviors – e.g. safe sexual practices; assertiveness and refusal skills
- Encourage the young person to find a sense of meaning and purpose – exploring creativity; spirituality; relationships
- Encourage appropriate help-seeking behaviour

Providing Health Education

The risk profile gathered from the HEADSS assessment provides a guide to areas where the young person may need health education. Information should be targeted to the specific behaviors, needs and developmental stage of the particular young person.

Effective strategies for providing health education to young people include:

- *Provide information/education in an interactive style – adolescents will tune out if you start lecturing or giving a didactic monologue*
 - invite the young person to share what they know about the particular behaviour, health risk or problem
 - tailor information to the young person’s developmental stage and cultural background
 - adopt a non-judgmental approach
 - encourage them to ask questions
- *Focus health messages on the immediate effects on their lifestyle*
 - focus on the *short-term consequences* of behaviours
 - e.g. with cigarette smoking – focusing on bad breath; stained fingers and teeth; bad skin is more likely to be effective than emphasizing long-term consequences such as lung cancer
- *Provide anticipatory counseling*
 - help the young person to anticipate potential harmful consequences of their behaviour – e.g. *driving to a party where they may be drinking; drinking or using drugs at a party and the risks of unsafe sex*
 - help them to anticipate the barriers they may face in attempting to change a behaviour that is part of their lifestyle, such as substance use – e.g. *peer pressure; withdrawal symptoms*

- help them to identify strategies and develop skills for reducing harmful consequences and dealing with barriers to change – e.g. *assertive communication; planning ahead, decision-making skills*
- use ‘*cognitive rehearsal*’ to help the young person anticipate the risks they may encounter in different situations and to think about strategies they could use:

Example

“What would you do if you were at a party with your friends who all had a lot of alcohol to drink and wanted to drive home? How do you think your friends might react if you said that you weren’t going to ride with them? What could you do to make sure you were safe in that situation?”

- *Guided decision-making*

- engage the young person in identifying and weighing up the perceived benefits and disadvantages of their risk-taking behaviour – e.g. *the risks of excessive drug use Vs. the benefits of acceptance by a peer group*
- it is important to acknowledge the perceived benefits of the risk behaviour for the young person – e.g. *using marijuana to relieve stress*
- identify alternative ways that the young person might achieve some of the same benefits – e.g. *relaxation techniques*
- allow the young person to make the actual decisions
- respect and support their developing maturity and independence

Case Study

Sam is a sixteen year old boy who sees you for a sprained ankle. On your follow-up consultation, you conduct a brief psychosocial screen and discover that he drinks most weekends – often getting drunk with his mates and smokes marijuana several times a week, usually on his own. He is sexually active with his girlfriend of one year. Usually he uses condoms but occasionally when he and his girlfriend have both been drinking they have unprotected sex. Sam does well at school although recently his grades have begun to drop. He is editor of the school magazine and plans to go to university. He plays football and is one of the top players in the team. He gets on well with his parents and they have always taken a keen interest in his sport and school progress. However, his parents are having a lot of conflict in their relationship and Sam is feeling upset and

worried that they are going to separate. They fight frequently and when this happens Sam withdraws to his room. He deals with the stress of this situation by smoking marijuana. He finds it difficult to talk about what he is going through with his parents. He says that his girlfriend has been complaining lately that he is always in a bad mood and doesn't talk to her.

Risk Assessment

Using the **HEADSS** assessment, you identify the following *Risk Factors* in Sam's life – binge drinking; marijuana use; unsafe sex; parental conflict; decline in his grades; lack of communication skills; lack of emotional coping skills.

You also identify the following *Protective Factors* – success at sport and school; connection to his parents; relationship with his girlfriend; connection to his school; his sense of purpose.

Risk Status

As a result of your risk assessment, you determine that Sam is at a *moderate* level of risk – although he has a number of protective factors in his life, Sam is vulnerable because of his escalating risk behaviour and the threat of the conflict in his parents' relationship.

Management Approaches

You work on building rapport with Sam and sensitively feed back your assessment of the risks in his life at the moment. You share your concerns while acknowledging his strengths. You identify some ways that you can support him to reduce the risks in his life and to promote his resiliency. These include:

- health education and anticipatory counselling regarding his alcohol and drug use
- education regarding safer sexual practices
- referral to a counsellor for assistance in dealing with his parents' conflict and to develop more effective communication and emotional coping skills

You negotiate with Sam about contacting his parents to share some of your concerns and to gain their support for him to attend counselling.

Promoting Behaviour Change

A major goal in health education and managing risk behaviours is to promote behaviour change in the young person. The "*Stages of Change*" model is helpful in understanding the steps involved in the behaviour change process (7).

According to this model, patients are at different of readiness to change their behaviour, and go through a number of stages on their way to making changes. Consequently:

- many people are not ready/able to change their behaviour when they first come into contact with a health professional
- interventions should be matched to the patient's current stage of preparedness to change
- the objective is to assist patients in moving from one stage to the next, and not push them prematurely into action

USING THE STAGES OF CHANGE MODEL

The "*Stages of Change*" model helps the GP to:

- a. assess the young person's readiness to change
- b. select interventions that most closely match the young person's stage

The key issues of each stage in the change process and strategies for addressing these issues are outlined on following page.

INTERVENTIONS

Once you have an idea of the young person's readiness to change, intervention can focus on:

- promoting the young person's motivation to change
- "What are your concerns about your (drug use; sexual behaviour; etc)?"*
- "What benefits do you think you might get by cutting down or stopping (the behaviour)?"*
- assisting them in moving through the different stages of change
 - assisting the young person to set goals and make decisions about changing their behaviour
 - promoting the young person's self-efficacy for making change
 - identifying practical strategies for making changes and overcoming barriers to change
 - teaching coping skills for supporting and maintaining change

Stage of Change	Issues	Strategies
Pre-contemplation	<ul style="list-style-type: none"> ■ Patient doesn't see the problem as an issue <i>'hasn't thought about change'</i> 	<ul style="list-style-type: none"> ■ Increase awareness of risks associated with current behaviour ■ Identify risks and benefits of their behaviour ■ Identify effects on others ■ Provide information on health/social consequences
Contemplation	<ul style="list-style-type: none"> ■ Patient thinking about change <i>'considering the benefits of changing and the risks of not changing'</i> 	<ul style="list-style-type: none"> ■ Reinforce benefits of changing ■ Elicit patient's own reasons for changing ■ Motivate, encourage to make goals for change ■ Examine pros and cons of changing ■ Support young person to reduce risks associated with their behavior
Decision / Determination	<ul style="list-style-type: none"> ■ Patient is making a plan to change <i>'ready to ready to make a change'</i> 	<ul style="list-style-type: none"> ■ Strengthen patient's belief in their ability to change ■ Provide a range of options for action ■ Assist in developing concrete action plans, setting gradual goals
Action	<ul style="list-style-type: none"> ■ Patient carries out specific action plans for change ■ Dealing with barriers to change 	<ul style="list-style-type: none"> ■ Provide positive reinforcement ■ Assist with problem solving ■ Identify barriers to change ■ Identify social supports ■ Teach coping skills ■ Harm reduction strategies ■ Referral to specialist services
Maintenance	<ul style="list-style-type: none"> ■ Developing strategies for sustaining changes 	<ul style="list-style-type: none"> ■ Affirm and support behaviour change ■ Teach coping skills ■ Foster strengths and protective factors ■ Provide reminders ■ Identify alternatives ■ Social supports
Relapse	<ul style="list-style-type: none"> ■ Re-engagement in problem behaviour 	<ul style="list-style-type: none"> ■ Empathize and normalize as part of the change process ■ Assist in resuming the change process ■ Return to 'Determination' and 'Action' stages ■ Avoid guilt, blame and demoralisation

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CHAPTER 6. MEDICO-LEGAL ISSUES

This chapter gives an overview of general medico-legal principles and how they might apply in clinical situations with young people – it is *not* a prescriptive statement of the law:

- If you are faced with a situation in which you are unsure about how the law applies – consult with your *Medical Defence* organisation
- The following website provides further information about the relevant laws: www.austlii.edu.au

Adolescents and the Law

Legal and ethical issues are fundamental to professional conduct and practice in any area of health care. Working with young people involves additional considerations in day-to-day practice, because of their legal status and their stage of development.

The law is not clear-cut in many aspects relating to the rights of the minor (below the age of 18 years) – much is left to the judgement of the physician as to the maturity of the young person and their ability to consent.

GPs need to have a broad understanding of the law as it applies to adolescents, and in particular:

- The *capacity* of adolescents to *consent* to medical procedures on their own behalf
- *Parental authority* for treatment
- *Confidentiality*
- *Mandatory Reporting*

The Capacity of Adolescents to Consent

The issue of consent to medical treatment *and young people* relates to the legal concept of ‘*minors*’. In Australia, a minor is a person under the age of 18 years.

- In NSW a person aged from 14-16 years is considered capable of giving informed consent for medical or dental treatment (Reference: Australasian Legal Information Institute)
- People under 14 years may also be capable of giving informed consent, although the health worker must consider the nature of the treatment and the ability of the young person to understand the treatment (Reference: Australasian Legal Information Institute)
- The capacity of an adolescent to consent is also considered to be related to the *gravity* of the treatment being proposed. Thus, procedures such as sterilisation and gender reassignment require court approval because of

the need to consider a young persons’ ability to fully appreciate the consequences of a certain treatment and impact on their life into the long term. Parental consent in these cases is not sufficient

Nevertheless, for a doctor to obtain consent to treatment from a minor, they must make a *competency assessment* – see below

- This means that a medical practitioner *does not have to seek parental consent* to treat a minor who is deemed competent
- Generally, consent from a parent or guardian is asked for if the young person is *14 years or under* – *unless the young person objects*
- A minor who is themselves a parent can give valid consent for their own child

MAKING A COMPETENCY ASSESSMENT

- Medical practitioners must form their own opinion about a patient’s “*intelligence and understanding*”. A person who is below 18 may be legally competent to consent to medical treatment if he or she “*achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed*” – this is sometimes referred to as the *Gillick* test, because it was first formulated by the English House of Lords in the *Gillick* case. For an adolescent, this particularly involves considerations about their:
 - age
 - level of independence
 - level of schooling
 - maturity
 - ability to express own wishes

Note: the doctor’s assessment about these factors could be influenced by cultural differences between the doctor and the young person. A cognitively mature adolescent may come across as socially or emotionally immature because of different cultural expectations about their roles in the family/ society (eg they may seem less independent), or differences in the way their thoughts or wishes are communicated. If in doubt, seek advice from a colleague or an appropriate agency.

- You should be satisfied that the adolescent has a full understanding of the following:
 - what the treatment is for and why the treatment is necessary
 - any treatment options

- what the treatment involves
- likely effects and possible side effects / risks
- the gravity/seriousness of the treatment
- consequences of not treating
- consequences of discovery of treatment by parents/guardians
- If you are unsure whether a minor is competent:
 - seek the opinion of a colleague
 - or obtain the consent of the minor’s parents/guardians
- Make a file note about your assessment
 - make a note on the adolescent’s medical record about the competency assessment – particularly if you found the patient to be competent and subsequently administered treatment on the basis of his/her consent

INFORMED CONSENT

For any age group, the term ‘*consent to medical treatment*’ means the patient makes a decision about their treatment based on information and advice given by the health worker:

- The patient must be given information as to the general nature of the treatment and also on ‘material risks’ to consider – which they may regard as significant in deciding whether or not to undergo treatment
- If the health care worker does not give this information to the consumer, they may be held to be negligent

Consent must have certain qualities to be valid:

- the patient must have *capacity*
- the patient must have *ability to understand* the treatment proposed
- the consent must cover *the act performed*
- consent must be *voluntary*

Case Example: Josie

A 15 year old young woman requests a prescription for the oral contraceptive pill and doesn’t want her parents to know. A thorough history reveals that she is involved in her first sexual relationship, it is consensual and with a young man the same age at the same school.

Legal issues to consider:

- **Consent:** Is the young woman competent to give her own consent to treatment?
 - If *yes* – there is no legal imperative to seek parental permission
 - If *no, or unsure* – the GP may first seek advice from colleagues and /or may not prescribe the treatment, but this *does not mean* the GP has the legal obligation nor the right to breach confidentiality about the consultation – unless the young woman is deemed to be at risk of, or is being, abused.
 - **Confidentiality:** The GP must maintain her confidentiality unless the young woman gives permission for others (eg parents) to know

Health care issues to consider:

- Building and maintaining a relationship of trust with Josie – this entails assurances of confidentiality, with the exceptions also explained
- Performing a comprehensive assessment and giving appropriate information and advice
- Working within the family context – although there may not be a legal imperative to involve the young woman’s parents (and it may be illegal to do so due to breaches in confidentiality), it is still reasonable, if not favourable, to have a discussion with the young woman about her family relationships, eg:

“Josie, you’ve told me that you don’t want your parents to know about your sexual relationship and going on the pill, and I can assure you that I will be able to maintain confidentiality as I explained earlier. However, I am still interested in talking to you about your parents and family particularly in relation to how you get on with them, what kind of support you feel you need from them, and so on. What would happen, for example, if your Mum discovered the pill in your school bag? Or if she found out somehow that you and (boyfriend) were having sex? Do you think you’d be able to talk to her about it? Young people have the right to privacy, and

sex is obviously a private matter, but when you still live at home with your parents, and they still want and need to care for you, then it can be useful to think about how to deal with issues like this if they arise.”

Cultural Considerations:

An issue like this can be strongly influenced by the young woman’s family and cultural background:

- If Josie is a middle-class Anglo-Australian with educated, ‘liberal’ parents, the issues of secrecy, discovery and teenage sex might not be as concerning to Josie as if she is from a migrant family from a Middle Eastern background with strong religious beliefs
- The legal issues facing the GP, however, will be the same
- The health care issues need to take into consideration possible reactions and consequences if Josie’s sexual activity is discovered by her parents
- You need to discuss this with her carefully
- Her cultural background may also present a source of emotional distress for her, as she may feel torn between the values of her family and community, and her own feelings towards her friends, boyfriend and herself as a young Australian

CONFIDENTIALITY

Confidentiality can be defined in the health care setting as “an agreement between [client] and provider that information discussed during or after the encounter will not be shared with other parties without the explicit permission of the [client]”.

- Confidentiality is considered legally and ethically to be part of the general duty of care to clients – health professionals owe this duty to their clients to keep information divulged by the client confidential, unless an exemption applies
- Special care may need to be taken in explaining to parents of NESB young people about their adolescent child’s right to confidentiality.

Exemptions

The exemptions to the duty to maintain confidentiality are both legal and ethical.

These are listed below:

Where the client consents to disclosure

- A client can give expressed verbal or written permission or *implied permission* for their health provider to disclose information to a third party

- e.g. a parent, or another professional involved in their care –such consent should not be coerced

Where the provider is compelled by law to disclose
 Note that in these instances, information disclosed is kept in confidence and not divulged to outside parties:

- Court proceedings – these may involve a provider giving evidence in court or producing health records under subpoena
- Medical practitioners’ have specific requirements to notify the following (*note these may vary between States and Territories and this is not necessarily complete*):
 - evidence of a notifiable disease (including HIV infection, AIDS, all forms of hepatitis, tuberculosis, and several others)
 - reporting of blood alcohol level test results for patients admitted to hospital after a motor accident
 - births and deaths
- Mandatory reporting – see Section 6.2 below

Best interests of the client

This exemption relates to a situation where a provider believes there is a real risk of serious harm to the client – e.g. a young person at risk of suicide

Public interest

In practice, this could translate into a situation where a provider is made aware by a client that they have committed, or intend to commit, a serious criminal offence

Where disclosure is necessary to treat a client

If there are multiple providers involved in a person’s health care, it can be considered reasonable that communication between providers would serve in the best interests of the client – the concept of ‘team confidentiality’ can be explained to clients when working within a multidisciplinary team – it is advisable to seek a client’s permission to disclose any non-urgent communications outside these parameters.

DEALING WITH SPECIAL CIRCUMSTANCES:

English language

- Be aware that informed consent can only be obtained if the client understands what is being presented in a language with which they are fluent
- Health interpreters should be used when appropriate – particularly if you are working with a family from a non-English speaking background (*see Section 4 for contact details*)

- Over the telephone interpreting is available through the *Translating and Interpreting Service (TIS) – Telephone 131450*. This service is free to GPs – see Section 4 for contact details
- Children should not be used as interpreters for their parents

Young people with intellectual disabilities

- A young person with an disability is not automatically deemed incompetent to consent to treatment.
- When assessing a young person's capacity to give consent, consideration needs to be given to the different communication needs of a young person with a disability. To promote communication, practitioners can provide information in a variety of ways such as using physical models, low literacy resources, line drawings and photos as well as demonstrating any equipment to be used in a medical treatment. It is also important to allow the young person enough time to understand what they are being told and to express themselves.
- If a young person with a disability over the age of 16 years cannot consent to medical treatment, the NSW Guardianship Act (1987) provides a mechanism for obtaining valid consent. Parents or relatives cannot automatically be regarded as the person responsible for, or able to give consent on behalf of a young person with a disability. The Guardianship Act establishes who can give a valid substitute consent on behalf of a person who is 16 years and over and unable to give consent, when treatment can occur without consent, the penalties that apply when someone does not gain substitute consent in appropriate circumstances.
- Under the Act, medical treatments are categorised as Minor, Major and Special. Special medical treatments include (but are not limited to) termination of pregnancy and sterilisation, and these treatments require the consent of the Guardianship Tribunal.
- To find out more about practitioner responsibilities under the Guardianship Act, contact the Guardianship Tribunal phone: 1800 463 928 / (02) 9555 8500 or online: www.gt.nsw.gov.au. Alternatively, the Office of the Public Guardian on phone 1800 451 510 / (02) 9265 1443 or at www.lawlink.nsw.gov.au/opg.nsf/ can also provide information and advice.

Young people who are parents

- A legal minor who is themselves a parent has the legal capacity to consent to treatment for his or her child, in the same way as adult parents
- However the minor may not necessarily have legal capacity to consent to his or her own treatment.

A COMMON MEDICAL ISSUE – PRESCRIBING CONTRACEPTION

- The oral contraceptive pill can be prescribed for a minor, regardless of the reason/s why, without parental consent, provided that the young woman is deemed competent by her doctor to give informed consent. This is also true for emergency hormonal contraception (“morning after pill”)
- Injectable progestagens (eg “Depo-Provera”) – prescribing and administering long-acting injectable progestagens (such as Depo-Provera) is illegal for women under 16 years without the consent of the Guardianship Tribunal in NSW. The law varies between states and territories
- Implantable progestagens (eg “Implanon”) – because implantable hormone contraceptives are reversible upon removal of the implant, they do not come under the same category as the long-acting injectable progestagens. Thus the same legal principles which apply for consent would apply here.
- Sterilisation – eg tubal ligation, vasectomy – these procedures cannot be performed on a minor without the authority of the Guardianship Tribunal, Family Court of Australia or Supreme Court.

TERMINATION OF PREGNANCY

In Australia abortion is legally available with minor variations from state to state, including the need for parental consent in some states:

- The same laws governing *consent and confidentiality* will apply in the case of a young woman seeking termination, as with any other form of health care
- The legal onus falls on the abortionist, invariably a medical practitioner, to ensure that *informed consent* is obtained from a woman on whom a termination is carried out, regardless of her age.
- In order to make an informed choice about their decision to terminate pregnancy, the woman should be given thorough pre-termination counselling and explanation of all possible adverse effects
- A doctor (or other health provider) can refuse to discuss, refer or assist a termination based on their own religious or personal beliefs, without risk of anti-discrimination action. *However the provider would be obliged under duty of care, to take appropriate action to explain and offer alternatives to their client.*

Case Study – “Leah”

Leah is a 16 year old girl who lives at home with both parents, a paternal grandmother and 4 siblings. She is third out of 5 children. She is in Year 10 at the local high school. Both her parents are unemployed. She is brought to you by a youth worker from a local youth centre and tells you that she is 6 months pregnant. The only other person who knows is her school principal. She says that the father of the baby is a 17 year old boy, a family friend, who also doesn't know. Leah is quite tall (170cm) and of large build so that her pregnant abdomen is quite well hidden. She tells you that she wants to give the baby up for adoption without anyone in her family or school knowing, and that she intends to “run away” for a couple of weeks around the time of confinement. She is willing to be referred to the local hospital for booking in and antenatal care, and is willing to receive assistance to help her find accommodation and support necessary to deliver the baby and organise the adoption.

Leah strikes you as being somewhat emotionally detached from the whole situation and you are unsure as to whether she is an immature 16 yr old, whether she is in a strong state of denial, or whether she might have a mild cognitive impairment.

What are the legal and ethical issues that you would consider in this case?

Points to consider:

Leah's welfare

- It is concerning that Leah is so adamant about not telling anyone in her family. The reasons for this need to be more carefully explored and work towards ways of supporting Leah to tell her parents
- It is important to rally a comprehensive support network – the obstetric and relevant psychosocial support team and adoption agency, the youth worker, the school principal and hopefully family support.
- It is critical to ensure that Leah is as fully informed about her adoption decision as possible – the antenatal team should be active in this as well.
- With all the above in train, you must also decide whether Leah is a young person at risk – of homelessness, or physical and emotional harm (eg if she gives birth without proper medical or psychosocial care and support). Although she is 16 and you are not obliged to report any suspicions to DoCS, under NSW Child Protection laws you may report any of the above concerns for young people aged 17 or 18.

The baby's welfare

Under the new (1998) Child Protection legislation you can (not mandatory) report concerns about an unborn child.

Cultural considerations

What if Leah is from a Pacific Islander background living with an extended family in a small community of other Islanders? She tells you that this is a highly significant factor in her wishing to maintain secrecy around her pregnancy and confinement. She says that she has made her own decision, and knows that this is the best thing to do, that she and her family could face harsh recriminations within her extended family and community otherwise.

Legal and ethical issues, particularly as they relate to human rights conventions (eg Rights of the Child), should override other cultural considerations. It is sometimes easy to ‘hide behind culture’, or to use ‘culture’ as an “excuse” not to act. Leah's anxieties about the impact of her ‘secret’ upon her family and community may be well founded, and these can be explored, possibly with the assistance of transcultural experts. However, Leah's and her baby's safety remain paramount, and there may be many other reasons besides her cultural background, as to why Leah is anxious about secrecy.

Mandatory Reporting of Child Abuse and Neglect

The *Children and Young Persons (Care and Protection) Act 1998* came into effect in NSW in December 2000. Under this Act, GPs are legally obliged to report any case where they suspect that a child is at *risk of harm* from abuse or neglect to the *Department of Community Services (DoCS)*.

MANDATORY REPORTERS

- A *mandatory reporter* is someone who is required by law to make a report to DoCS if they have current concerns about the safety, welfare or wellbeing of a *child*.
- A mandatory reporter is any person who delivers services to children and/or families as part of their paid or professional work.
- There are penalties for failing to make a report.
- *GPs are mandatory reporters.*

DEFINITION OF A CHILD OR YOUNG PERSON

- A *child* is a person under 16 years of age.
- A *young person* is 16 or 17 years old.
- GPs are only mandated to report *children under 16 years*.
- You can also report concerns about the safety or wellbeing of a *young person* – but this is up to your discretion and should take into account the level of maturity and the wishes of the young person.

WHAT IS 'RISK OF HARM'?

Risk of harm means you have *current concerns* about the safety, welfare or wellbeing of a child or young person because of the presence of any one or more of the following circumstances:

- Their *basic physical or psychological needs are not being met* or are at risk of not being met (*neglect*). A key indicator of *neglect* is where the care of the child is continually or persistently being ignored. These basic needs include:
 - food
 - shelter
 - hygiene
 - safety from harm
 - insufficient or inappropriate interaction or stimulation from parents/caregivers
 - emotional neglect
- They are not receiving *necessary health or medical care*
 - where parents/caregivers cannot or will not arrange required medical care
- They have been, or are at risk of being, *physically or sexually abused, or ill treated*. This includes:
 - *physical abuse* – an assault or non-accidental injury by parent/caregiver such as severe beating or shaking; excessive discipline; bruising; lacerations, burns; fractures; etc
 - *physical assault* – a hostile act by an adult towards a child or young person, even if the adult has not meant to harm – including pushing; shoving; hitting; throwing objects; rough handling, grabbing around the throat, any threatening behaviour. It is now illegal for a parent to hit a child above the shoulders or with an implement.
 - *sexual abuse* – any sexual act imposed on a child or young person; that exploits their dependency or immaturity

- They are living in a household where they have been incidents of *domestic violence* and as a consequence, are at risk of serious physical or psychological harm:
 - domestic violence is violent, abusive and intimidating behaviour by one person against another in a personal intimate relationship – including physical, psychological, sexual, social and economic abuse
- They have suffered, or are at risk of suffering, *serious psychological harm* from the behaviour of a parent/caregiver:
 - *serious psychological harm* is behaviour by a parent/caregiver which results in emotional deprivation or trauma-eg. Continual scapegoating or rejection.
 - *psychological abuse* involves serious impairment of a child/young person's social, emotional, cognitive or intellectual development. This maybe because of their exposure to a parent's ongoing mental health problems
- They are *homeless* and at risk of harm. This may occur if they do not have access to food or shelter or if they are living in a situation where they are unsafe. This includes living without family assistance in any of the following circumstances:
 - no accommodation; 'roofless'
 - temporary or transient accommodation
 - emergency, refuge or crisis accommodation
 - accommodation where they do not have access to basic utilities (power; running water)

RECOGNISING RISK OF HARM

There are a number of things that you can consider in determining whether a child/young person is at risk of harm, including:

- past professional experiences
- the age, development, functioning, and vulnerability of the child/young person
- behaviours of a child that suggest they may have been harmed by another person – e.g. mimicking violence; sexualised behaviour, unexplained physical complaints.
- behaviour of another person which might have a negative impact on healthy development, safety or wellbeing (e.g. drug abuse; domestic violence)
- physical signs of abuse or ill-treatment – e.g. bruises; lacerations; burns; fractures or other injuries
- concern about other family members – such as recent abuse or neglect of a sibling, or parents experiencing mental health problems

CULTURAL ISSUES

Some traditional cultural practices may place a young person at risk of harm. For example, the practice of female genital mutilation (FGM), which is practised in a number of countries, is a criminal offence which the GP is mandated to report.

- It is important to be aware of different cultural practices and to determine whether there is any risk of harm to the young person *before* reporting such practices
- Handle such situations sensitively – explain to patients that legal and ethical issues may override cultural considerations and that all Australians are bound by Australian law, regardless of cultural traditions

Note: Some children/young people from some ethnic communities have been wrongly assessed as suffering from abuse as a result of culturally determined health practices (e.g.: “coining” or “cupping” in Vietnamese; Lao communities) – which are in fact acceptable and safe practices within the Australian context

- If in doubt about a particular cultural practice – consult with a bilingual health professional or contact the Transcultural Mental Health Centre (TMHC) – (02) 98403800 or 1800 648911 (rural areas)
- See Section 4 for list of multicultural services

MAKING A REPORT

GPs must report a child they suspect to be at risk of harm *as soon as* they form an opinion that there are current concerns for the child’s safety, welfare or wellbeing. According to the Act:

- Your identity and the identity of your practice will not be disclosed without your consent
- You cannot be sued for making a report to DoCS
- You are not breaching professional ethics or standards by making a report
- You cannot be sued for defamation if you make a report
- The only time your report can be used in court is during a care application in the Children’s Court or if the file is subpoenaed. Your name and identity will not be disclosed to any party other than the presiding magistrate or judge, who is also bound to protect your identity by law.

(See Appendix 2 for the Reporting Checklist – it provides a guide to help you decide if you need to make a report.)

HOW TO MAKE A REPORT

There are two ways to make a report:

- *By telephone* – a confidential number has been set up specifically for mandatory reporters in NSW – at the DoCS Helpline contact 13 3627
 - a Child Protection Case Worker will take information from you and guide you through the reporting process
 - have available all relevant information about the child/young person’s details and situation
- *By fax* – you can also make a report by fax – contact (02) 9633 7666. When making a report by fax you must include:
 - all relevant information about the child/young person – including their full name, age and contact details
 - significant details about the risk of harm that you have identified for the child/young person
 - other relevant background information

WHAT TO EXPECT

- You may be contacted later for further information about your report
- DoCS may carry out any investigations or assessments considered necessary, including referral to other departments or agencies for services
- DoCS must provide you as a reporter with feedback about the child/young person’s safety and wellbeing if you make an enquiry about the report that you have made

References:

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2. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
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CHAPTER 7. CULTURALLY SENSITIVE PRACTICE

Young people from non-English speaking backgrounds (NESB) are dealing not only with the developmental tasks of adolescence, but also the experience of growing up between two cultures. The concept of ‘adolescence’ – and the expectations, roles and duration of adolescence – may be defined differently in different cultures.

GPs and practice staff need to be sensitive to the cultural influences operating in an adolescent’s life and to have an appreciation of the range of cultural, ethnic, and social diversity among adolescents.

- This section provides general guidelines only for working with young people from non-English speaking backgrounds
- For more in-depth information about working with young people from specific cultural backgrounds, contact the *Transcultural Mental Health Centre* (see Section 4 - for contact details)
- The TMHC website is: www.tmhc.nsw.gov.au
- See also the www.diversityinhealth.com website
- See also Section One – “*Culture and Adolescence*” P. 9 for more background information)

NESB Young People

Some important points to consider when treating NESB young people:

- Young people may not only have different cultural backgrounds but also different ethnic, language and religious backgrounds
- Avoid cultural stereotyping – it is misleading to assume that people from a particular cultural or language background share the same set of cultural attributes, beliefs and practices ⁽¹⁾
- They may have had experiences that adversely affect their health and development, their and their identity – e.g. migration; refugee experience; exposure to war and trauma; language difficulties; discrimination; racism ⁽¹⁾
- These experiences can also can lead to the young person developing resilience and coping strategies as a consequence of overcoming adversity
- Consider how the patient’s life experience, ethnicity, religious beliefs or sociocultural background are relevant in the case presentation, diagnosis and management
- The most important source of cultural information is the patient themselves ⁽²⁾ – enquire about the adolescent’s cultural background, family history, and how *they* define their cultural identity

- GPs need to be aware of their own attitudes and beliefs about different cultures and cultural practices – and how these impact on the care they provide to people from other cultural backgrounds ⁽²⁾

- Other factors to consider are:

- how long the young person and their family have been in Australia
- stress associated with acculturation – i.e. the process of adapting to the way of life, language, values, norms and expectations of the new culture
- how they got to Australia – e.g. migration; via a refugee camp – and the physical/psychological effects of this process
- physical and mental health issues associated with their pre-migration experience – e.g. effects of malnutrition; deprivation; oral health; parasitic infections; post-traumatic stress associated with torture or other traumatic experiences; etc.
- experiences of health services in their country of origin

- NESB young people may experience a variety of psychosocial problems associated with the migration experience, and the conflict of different cultural expectation between the ‘new’ and the ‘old’ cultures – for example:

- *poverty in some refugee families*
- *non-recognition of parents’ overseas qualifications*
- *unrealistic expectations by parents for academic achievement*

- If in doubt about how to work with a particular young person – *consult with bilingual health professionals* (see Section 4 for list of multicultural services)

- See also the www.diversityinhealth.com website for information on providing health care to people from a range of cultural backgrounds

Culturally Appropriate Consultation

Effective communication is the key to addressing many of the cross-cultural issues that arise with NESB young people ^(1; 2). The skills required to communicate in a culturally appropriate manner are the same generic skills that apply to consultation with any young person:

- Adopt an open, non-judgemental approach
- Show positive regard and respect for differing values
- Provide reassurance about confidentiality
- Conduct interviews in an empathetic, sensitive way

- Ask questions in an open-ended style and avoid use of medical jargon
- Provide reassurance of normality and allay fears and anxieties

However, GPs also need to consider the cultural context of the young person in order to understand their presenting problems and behaviour, and communicate effectively with them. Practical approaches to consultation with NESB young people include:

- Treat each patient as an *individual* first within the context of their cultural background – engage them in a dialogue about their cultural beliefs, health practices, and family history
- Ask the young person his or her preferred form of address – do your best to pronounce their name correctly
- When taking a patient history or conducting a psychosocial assessment (e.g. *HEADSS*) – enquire about *acculturation and identity* issues:
 - *How do they view themselves within the context of their culture?*
 - *In which ways do they follow/not follow the norms of their culture?*
 - *How do they feel about their own/parents’ culture? / the host culture?*
 - *What has changed since they became an adolescent? Are they treated differently by parents, siblings, relatives?*
 - *Assess whether intergenerational and cultural differences are impacting on their health and development eg “What expectations do your parents have for you? How do you see things differently? Who supports you in the family (or outside)? When you feel down, who do you talk to? How do your parents feel about this?”*
- Ask about beliefs within their culture of origin about their illness/symptoms, its cause and management
- Check their understanding of the diagnosis and treatment instructions
- Where language is an issue – it is important to check out whether the young person/parents have clearly understood the questions/information given to them
 - be sensitive to signs of misunderstanding – e.g. a puzzled expression or unusual response
 - check what the patient has understood and ask them to repeat back the key points – e.g. “Now tell what you are going to eat...”
 - clarify what the patient means – e.g. “What do you mean when you say..?”
- Where there are language difficulties, use a professional interpreter

- **Both on site and telephone interpreting can be organised through the Translating and Interpreting Service (TIS) – Telephone 131450**

Note that this service needs to be booked in advance - see Section 4 for contact details.

- Be sensitive to gender issues, particularly the needs of young women when conducting physical examinations or investigating sexual health problems
 - where possible provide a female practitioner, or offer to conduct the examination in the presence of a female nurse or family member (*who is acceptable to the young person*)
- Develop a management plan that addresses the impact of cultural issues and is culturally acceptable
- Create a ‘culturally friendly’ practice environment by:
 - educating practice staff about cultural sensitivity
 - ensuring that the practice is accessible to people from different cultural backgrounds
 - providing multilingual pamphlets on different health topics
 - displaying multilingual posters

Engaging the Family

- In many cultures, participation in health care is a *family* rather than *individual* responsibility ⁽²⁾
- Engaging the family and gaining the trust of parents is critical in treating young people from other cultures ⁽¹⁾
- Respect the parents’ authority with regard to decision-making while helping them to recognise the young person’s growing need for independence appropriate to their age and stage of development ⁽³⁾
 - try to find a suitable balance between engaging the family authority system and supporting the young person’s ability to make decisions for themselves
- You may need to explain the role of the doctor, as this may differ in some cultures
 - explain to the family and the young person that your role is not to separate the child from his/her family
 - rather, it is to work together with both to ensure the young person’s health
- Where the young person is accompanied by a parent, try to spend some time alone with the adolescent – explain to the parents your reasons for doing this
- Understand however, that this may not be possible as it may be culturally inappropriate and disrespectful of the parental role
 - seek parental permission first before you seek the young person’s consent

- Where appropriate, engage the support and involvement of parents/family in treatment – *however never utilise family members as interpreters*

Multicultural Health Services

- A range of multilingual resources and multicultural services are available in NSW (see Section 4 – for list of services and contact details)
- The **Transcultural Mental Health Centre (TMHC)** is a state-wide service that provides clinical, consultation services and education and training programs for people of non-English speaking background including children, young people and families. These services include:
 - clinical assessment and short term intervention provided in the language of the client by qualified bilingual health professionals who are registered by appropriate professional bodies in NSW
 - over the phone telephone advice and consultation on mental health issues as well as information on cultural/religious issues
- TMHC welcomes referrals from GPs and provides reports on the referred case as well as recommendations regarding care plans
- All TMHC services are free of charge both to the GP (or other referring agency) and the patient
- TMHC can be contacted on (02) 9840 3800 or 1800 648911 (rural areas)

References

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2. Allotey, P. and Reidpath, D. Multicultural issues in General Practice. *Current Therapeutics*, December 1999/January 2000, 35-37.
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CHAPTER 8. TREATING SUBSTANCE ABUSE

Facts about Adolescent Substance Use (1; 2)

- Drug-related deaths represent 24% of youth deaths
- Around 70% of 16-17 year olds reported that they drink alcohol
- 25% of 14-19 year olds and 40% of 20-24 year olds are regular or occasional smokers
- 38% of 14-24 year olds reported marijuana use in the previous 12 months

Adolescent Substance Use

Substance use among adolescents has grown in the last decade. Key features of adolescent substance use ⁽³⁾:

- *Alcohol and tobacco* are the substances most commonly used by adolescents and account for the highest rates of morbidity and mortality
- *Illicit drug use* is increasing – mainly:
 - marijuana
 - amphetamines
 - ecstasy
 - hallucinogens
- There is a strong association between substance use and *incidence of other health problems* in adolescents, especially:
 - motor vehicle accidents and other injuries
 - mental health problems
 - sexual risk-taking
 - blood-borne viruses (especially Hepatitis C; HIV/AIDS)
 - violence
- *Polysubstance use* is common among adolescents

The following services provide further information on individual substances and their effects, and fact sheets for patients:

www.adin.com.au – drug information website of the Australian Drug Foundation

www.druginfo.adf.org.au – clearinghouse for information on drugs and drug use

Drug and Alcohol Multicultural Education Centre (DAMEC) – 02 6993552

– information and resources on substance abuse and NESB young people

RISK FACTORS FOR SUBSTANCE ABUSE (4)

A number of risk factors have been linked to substance abuse among adolescents:

- Troubled family relationships
- Poor peer relationships
- School difficulties and truancy
- Unemployment
- Low self-esteem and social support
- Associating with substance using peers
- Depression and anxiety
- Childhood physical or sexual abuse

Assessment

- The *HEADSS* psychosocial assessment provides a broad assessment for detecting the incidence of alcohol or drug use (4) (*see Conducting a Psychosocial Risk Assessment, P. 29*). *HEADSS* will also provide an indication of:
 - how the substance is affecting the young person – e.g. impairment of school functioning and interpersonal relationships
 - the role it plays in the young person's life
 - other risk behaviours associated with its use

- *Spend some time building rapport and discussing less sensitive issues* – this will help the young person to feel more comfortable discussing their substance use.

In exploring the young person's drug use it is important to:

- reassure them of confidentiality
- adopt a non-judgemental approach
- demonstrate interest in the young person themselves not just their substance use
- use a *'third person approach'* to ask sensitive questions:

Example

"Some young people your age have tried alcohol or other drugs. I wonder have you or any of your friends ever tried any drugs or alcohol?"

- If substance use is suspected but not disclosed, and is thought to be having a significant impact on health/life, take a more direct approach:

"I've been wondering about whether the –symptoms/signs – that you/others have described could be related in any way to using drugs. It's up to you whether you'd like to talk about this, but I just want you to know that this is what I've been thinking and I'm concerned about the risks to your health..."

TAKING A DRUG HISTORY

If the presence of substance use is detected, a more in-depth drug history may need to be taken:

- Explain to the young person the reasons for gathering this information – request permission to ask sensitive questions.
- Many young people do not consider alcohol or tobacco to be drugs, so you need to specifically ask about these.

The history should include:

- *What* – what substances are being used?
(Remember that polysubstance use is common among adolescents – specifically ask about each substance)
- enquire about drug use over the previous months including:
 - *licit drugs* – alcohol; tobacco; over the counter and prescribed medications
 - *household products* – glues; aerosols; petrol
 - *illicit drugs* – cannabis; ecstasy; amphetamines; LSD; cocaine
- *How often* – what is the frequency of their use?
- *How much* – the dose used (e.g. *how many drinks on a given occasion; how many times they smoke marijuana in a day/week*)
- *Method of use* – smoking; injection; snorting; etc
- *Patterns of use* – does binge use ever occur?
Common patterns of drug use:
 - *experimental*
 - *recreational*
 - *abuse*
 - *dependence*
 - *recovery/relapse*
- *Context of use* – alone; with friends; parties; when depressed, stressed, angry etc
- *Effects of use* – physical; mood; behavioural; social; etc
- *How they obtain and pay for the substance*
- *Previous attempts to stop* – outcomes of these
- *What they want to do about their drug use*

Important points to address in conducting your assessment ^(3;5):

- *Co-morbidity* – substance abuse has a strong association with mental health problems, such as depression and anxiety
 - therefore the history should include questioning about mood, anxiety, and symptoms suggestive of early psychosis
- *Tolerance* – is the young person developing tolerance to a substance?
“Do you find you need more (of the drug), compared with before, to achieve the same effect?”

- *Problems* – what problems are they experiencing as a consequence of their substance use?
 - e.g. physical health; legal; financial; social; school/work performance
- *Risk behaviours* – have they been involved in any risk behaviours while under the influence of drugs or alcohol – e.g. drink driving; unsafe sex; criminal activity
- *Cultural background* – the context and use of substances can vary greatly in meaning and acceptance across different cultures
 - enquire about the young person’s cultural background and attitudes towards substance use in that culture
- *Morbidity and mortality* – morbidity and mortality from substance abuse arise from three main factors:
 - toxicity from the pharmacological action of the drug itself
 - the mode of drug administration
 - environmental factors – crime; violence; accidents/injuries
- *Heavy use* – where there is a history of heavy use, enquire about:
 - difficulty controlling use of the substance
 - withdrawal symptoms – how they feel when they don’t use the substance
 - overdose – any episodes of drug overdose and how they were managed; accidental or deliberate self-harm?

INDICATORS OF SUBSTANCE ABUSE

The following signs *may* be indicators of substance abuse – be aware however that there may be many other explanations for these changes:

- A change in school attendance or achievement
 - frequently absent or late, sloppy homework, apathy and lack of effort
- A change in peer group and a reluctance to introduce friends to the family
- Poor physical appearance and an extreme lack of regard for personal hygiene; red eyes, dilated or constricted pupils
- A marked change in emotional state, with unusual aggressiveness, temper flare-ups, mood swings or seeming excessively tired or withdrawn
- Furtive behaviour, including lying, stealing or borrowing money
- Physical evidence – rolling papers, pipes, alcohol bottles or cans.

A 'Typical Day'

Asking the adolescent to describe a 'typical day' is a useful way of gaining more in-depth information about their substance use. A 'typical day' assessment:

- encourages disclosure of the individual's story
- provides a clinical picture of quantity & frequency of use
- provides personal context of use
- increases information & builds rapport

Example

- "Can we spend the next few minutes talking about how you typically spend your day (or a typical day at home; a typical night out; etc)?"
- "Tell me about what usually happens from the moment you wake, and move through the day, until the end of your day (or, when you are getting ready for a night out; etc)"
- "And then what happens? And before that? And between doing this and that? What next?"
- "How do you feel when this / that happens?"
- "Are there any times of the day when you use (alcohol; drugs; etc) more than at other times?"
- "How does your day (one of these sessions; etc) usually end? How do you feel at the end of the day (after one of these sessions; etc)?"

LABORATORY INVESTIGATIONS

- If the adolescent gives a history of intravenous drug use – hepatitis B, C and HIV screening should be considered
- The need for further investigations should be determined by the history and physical examination (if any)

Management Approaches

As with all adolescent health problems, a trusting relationship forms the basis for effective treatment of substance abuse. A key principle of management is to adopt a *holistic approach* rather than focusing solely on the drug use. Addressing other areas of concern in the adolescent's life can often ameliorate the substance abuse ⁽⁵⁾.

MANAGEMENT STRATEGIES:

- Formulate a management plan in collaboration with the young person
- Allocate sufficient time – management of substance abuse requires more time than the usual 10 -15 minute general practice consultation

- When a substance use problem is identified, it is essential to book a longer follow-up appointment
 - if the young person does not see a problem with their substance use, it may be better to explain the reason for the follow-up as being for a general health review
- Attend to co-morbidities – substance use can mask underlying social or psychological difficulties. Where necessary, provide counselling for:
 - depression and anxiety
 - stress reduction
 - anger management
 - sexual risk-taking
- Engage and work with the family where possible – *this should first be negotiated with the adolescent themselves*
- Refer to specialist services where necessary (drug and alcohol counsellor; etc.)
- In more complex cases, the GP can use the *Enhanced Primary Care (EPC)* item numbers to facilitate collaborative case management through the development of multidisciplinary care plans or case conferencing with other health professionals (see *Collaborative Care P. 89*)

Interventions

If substance use is identified as *problematic* (rather than 'normal risk taking' or experimental), interventions should be based on the young person's *pattern of substance use*, as well as their readiness and *motivation to change*. The "*Stages of Change*" ⁽⁶⁾ model assists the GP to determine the young person's readiness to change and identify appropriate interventions. (See *Stages of Change Model, P. 46*)

The "*Stages of Change*" model allows the GP to match interventions to the young person's stage of change. For example:

- With an adolescent in the *Pre-contemplation* stage (i.e. not seeing a problem with their substance use and not thinking about changing):
 - offer education about their substance use
 - provide objective information about the potential health and social harms of the substance they are using
 - build motivation to change by exploring the advantages and disadvantages of their substance use
- With an adolescent in the *Action* stage:
 - provide more intensive intervention e.g. cognitive behavioural therapy; referral to a specialist service; detoxification

MOTIVATIONAL INTERVIEWING ⁽⁷⁾

Motivational interviewing aims to:

- enhance the patient’s motivation to change
- provide patients with a range of skills and strategies for decreasing their substance use and modifying risk behaviours.

Steps in motivational interviewing:

- Assess the patient’s readiness to change (see “*Stages of Change*” model P. 46)
- Create a favourable climate for change – establish rapport; use a non-judgemental approach
- Use reflective listening to identify the client’s concerns – avoid persuasion
- Identify the costs and benefits of substance use:
 - ask about the perceived benefits of substance use for them
“What are the good things for you about drinking alcohol/smoking marijuana, etc.?”
 - ask about concerns or disadvantages of their substance use (to their health; their family/relationships; financial; etc)
“Tell me about any concerns you have about how alcohol/marijuana, etc. is affecting your health or any other parts of your life.....”
“How is it affecting your relationships/family?”
“How is it affecting your school/work?”
- Increase motivation to change:
 - provide objective information on the potential health effects and social impact of the substances they are using
 - identify associated risks – e.g. unsafe sexual activity; drink driving
- Assist patient to make the decision to change – engage the patient in a ‘*decision balance*’ process to tip the balance toward changing ⁽⁸⁾:

- Strengthen and reinforce the patient’s self-efficacy – i.e. their belief in their ability to change
- Help the young person to:
 - develop alternative ways of coping with problems that drive their substance use – e.g. stress; low self-confidence
 - identify risk situations and triggers to substance use and learn new skills for dealing with these
 - develop strategies for coping with the barriers to changing (e.g. peer pressure; withdrawal symptoms; sleeplessness; etc.)
- Provide ongoing support and reinforcement

See the University of Toronto website on substance use for ideas on conducting motivational interviewing with adolescents – www.cyberisle.org

HARM MINIMISATION

The goals of *harm minimisation* are to promote *safe usage of a substance* where abstinence is neither possible nor chosen.

Harm minimisation approaches involve:

- Recognizing harm as a continuum from *abstinence* (minimum harm) through to *dependence* (maximum harm)
- Providing education on the effects of the substances being used and the potential harms
- Assisting the young person to make healthy choices to reduce the chances of harming themselves

Decision Balance	Reasons Not to Change	Reasons to Change
Stay the Same	<p style="text-align: center;">BENEFITS</p> <p><i>“What do you like about your substance use?”</i> e.g. Drinking/smoking with my friends; Feeling relaxed/relieving stress Forgetting about my problems Helps me sleep Fun</p>	<p style="text-align: center;">CONCERNS</p> <p><i>“What concerns you about your substance use?”</i> e.g. Hangovers Can’t study Get into fights Poor school performance Appearance – pimples; weight gain; effects on teeth etc The expense</p>
Change	<p style="text-align: center;">CONCERNS</p> <p><i>“What concerns would you have about changing?”</i> e.g. Lose my friends No fun Stress Not coping with my problems</p>	<p style="text-align: center;">BENEFITS</p> <p><i>“What benefits might you get from changing?”</i> e.g. No more hangovers Weight loss Improved appearance Can study better Save money</p>

Harm Minimisation Strategies

Reduce to a minimum the lifestyle risks associated with substance use behavior by promoting safe practice and teaching protective behaviors, e.g.

- safe injecting procedures for IV users
- strategies for reducing alcohol consumption
- safe sex practices such as condom use
- not driving, swimming, climbing while drinking/using
- not using more than one drug at a time
- knowing where to get help if needed

BRIEF INTERVENTIONS

■ *Providing information* – even if the young person chooses not to change their drug use, you can still assist them by providing information and education, e.g.

- the effects of substance use
- safer using strategies
- services available

■ *Monitoring drug use* – monitoring drug use helps the user to recognise the amounts consumed, patterns of use and high risk situations. Monitoring can involve keeping a diary or log book. It should be done over a period of weeks in order to see patterns emerging.

■ *Goal-setting* – develop a shared understanding of the problem and set realistic, achievable goals for change, for example:

- cutting down on alcohol/drug use
- have drug free days
- not combining drugs

COMPREHENSIVE INTERVENTION

Adolescents who have developed substance dependence or an entrenched pattern of abuse require comprehensive management. This may involve:

- referral to specialist services
- supervised detoxification
- in-patient treatment
- substitution – e.g. nicotine chewing gum/patches; methadone replacement therapy (for over 18 year olds)
- collaborative case management – the GP can play a central role in a treating team of professionals (e.g. drug and alcohol services; mental health services; counsellors; school counsellors)

Dealing with the Family

Where possible, involve and work with the family of the young person. Support the parents by providing them with:

- education about substance use
- guidance about parenting strategies and how to respond to their adolescent's substance use
- counselling for their own anxiety, stress, etc.
- referral to specialist services – e.g. family counselling

See Section 4 – for list of drug and alcohol services, resources and contact details

Case Study

Rob is an 18 year old young man whom you have not seen before. He presents to you after sustaining a broken hand following a brawl last weekend. Rob admits to having been drunk. He says that he has been drinking heavily on weekends for the past few months and from time to time gets into fights.

On further drug history you learn that Rob smokes up to 20 cigarettes a day and drinks up to 15 standard drinks on Friday and Saturday nights. He uses marijuana occasionally but no other substances, although has tried speed and ecstasy in the past. He enjoys drinking but is also becoming concerned about the pattern that is now established. His latest girlfriend, whom he says he loved very much, broke up with him after two months saying that she could not tolerate his drinking behaviour.

Rob is unemployed. He currently lives with friends, though this is not working well. He has a longstanding history of family conflict. His father is alcoholic and Rob has little contact with him. Rob finished Year 9 at school and would like to complete his education so that he can look for an apprenticeship.

Management Approaches

You attend to Rob's injured hand, and engage with him about the effects of his alcohol usage. Over the next few months, you see Rob about once a fortnight, although he misses his appointments every now and then. Your interventions include:

- monitoring his drinking and physical and mental health
- motivational interviewing to explore the costs and benefits of his substance use and to explore alternatives to drinking – such as exercise; recreational activities

- providing information and education on ways to reduce drinking and the risks associated with it, such as:
 - alcohol consumption by drinking low alcohol beverages
 - alternating alcoholic with non-alcoholic beverages
 - not drinking on an empty stomach
- referral to a Drug and Alcohol Counsellor at the local community health centre. (*Rob is not interested at this stage in detox. or abstinence but is willing to speak to a counsellor*)
- providing counselling/support around managing his aggression and anger
- consultation with the Youth Officer in the local Centrelink office regarding educational and employment options for Rob

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CHAPTER 9. SEXUAL HEALTH

Facts about Adolescent Sexual Health ⁽¹⁾

- Young people have the highest levels of STIs among all age groups
- There are some 30,000 teenage pregnancies Australia each year
- There are approximately 16,000 teen abortions each year
- Chlamydia is the main sexually transmitted disease among young people – notifications increased from 71 to 196 per 100,000 between 1991-1998

Understanding Adolescent Sexuality ^(2; 3)

The development of reproductive capability and a sexual identity are fundamental tasks of adolescence. Some features of adolescent sexuality are:

- Sexual arousal, feelings and thoughts are a normal part of adolescent development
- Sexual behaviours often begin in adolescence and experimentation is common
- Individual, peer, family and cultural factors influence the nature and extent of an adolescent's sexual behaviour – there is enormous variation within the adolescent age group in terms of knowledge and experience.
- Young people often lack knowledge about their bodies, sexuality and how to protect themselves, and may not appreciate the risks involved with sexual activity
- Adolescents who are sexually active are often at greater risk because they tend to have sex more often with greater numbers of partners.
- Adolescent girls also have an increased risk of acquiring cervical infections such as Chlamydia trachomatis because of exposed transitional epithelium.
- Do not assume that a young person is heterosexual
 - acknowledge that feelings of attraction to the same sex are common and may or may not imply homosexual orientation
 - enquire about both opposite and same-sex relationships
- Young people who are gay, lesbian, bisexual or uncertain of their sexual orientation can be a particularly vulnerable group

THE GP'S ROLE

Sexual health encompasses a total sense of well-being in relation to one's sexuality and sense of sexual self. The GP has a key role to play in adolescent sexual health:

- prevention of sexual health problems through screening and treatment of sexually transmissible infections (STIs); and provision of contraception
- promotion of sexual health through identification of risk behaviours and education about safe and unsafe behaviours
- helping young people understand and feel comfortable with their sexuality and sexual identity

Management Approaches ^(3; 4)

- Establishing a trusting relationship is essential to helping the young person feel comfortable discussing sexual health issues
- Adopt a non-judgemental approach
- Reassure the young person about confidentiality
- Be prepared to raise the issue and show comfort in discussing the topic – this helps the adolescent to overcome their embarrassment
- Adopt a holistic approach that addresses the whole person and their developing relationships with other people rather than focussing only on the prevention of STIs and unwanted pregnancy
- Help the young person recognise that sexuality involves relationships, values, decision-making, and behaviours
 - understand that experimentation is normal and that the key issue is how to protect themselves
- Where necessary, refer to specialist services – e.g.
 - family planning association
 - sexual assault services
 - support services for gay and lesbian young people
 - women's health services

Sexual History Taking

A comprehensive sexual health assessment should include not only information pertaining to 'risk' and screening for STIs and pregnancy but also a broader exploration of the young person's sense of well-being and sexual identity ^(3; 4).

Sexual history taking will vary enormously between individual adolescents.

- Use the *HEADSS* assessment with younger adolescents or for an adolescent who presents with a seemingly unrelated issue. (see *Conducting a Psychosocial Risk Assessment*, P. 29).

- Ask permission to ask sensitive questions and use the ‘third person’ approach to explore sexuality and sexual behaviour:

“Some young people your age have begun to have sex. Have you ever had a sexual relationship?”

“Many young people feel confused about their sexuality. Have you ever felt like that?”

- When taking a sexual history, ask about partners in a gender-neutral way, eg:
 - “Are you in a sexual relationship?” not “Do you have a boyfriend/ girlfriend?”
 - “Have your sexual partners all been male, female or both?”

If the young person presents directly with a sexual health issue – such as a request for contraception; a pregnancy test or an HIV test – it may be necessary to take a more in-depth sexual history, which would include:

- Commencement of sexual intercourse
- Partners: how many, gender, relationship duration
- Safer sex practices: condom use, contraception
- History of pregnancy
- History of sexually transmitted diseases
- STI screening including HIV antibody testing
- Hepatitis B prophylaxis
- Identify areas of risk, e.g.
 - substance use
 - unsafe sex
 - exploitative relationships
 - Indicators of sexual abuse, e.g.
 - overtly sexual behaviours

Sexual Health Counselling in General Practice

Check the young person’s level of knowledge and provide education and counselling about:

- Their body and their sexuality
- Safe and unsafe sexual practices
- Abstinence
- Contraception

AREAS TO EXPLORE:

- Where is the young person at with their sexuality and sexual identity?
- How ready do they feel for sex?
- What do they understand about sexually transmitted infections and unwanted pregnancy risk?
- How comfortable do they feel about negotiating a sexual relationship and communicating their feelings?
- Who are their adult supports? Can they talk to a parent/adult friend/teacher etc?

EDUCATION AND PREVENTION

- **Help the adolescent to develop skills for dealing with difficult situations, e.g.**
 - negotiating with a partner who is pressuring them to have sex
 - decision-making
 - talking to parents
- Discuss situations where sexual risk taking behaviour may be occurring – such as with substance use; unprotected sex
- Explore ways to reduce risk taking and how to stay safe, e.g.
 - how to negotiate safe sex or condom use with a partner
 - explain what ‘safe’ and ‘unsafe’ sexual behaviors are
 - reduce substance use
 - encourage both male and female responsibility for contraception and condom use
- Explain correct condom use
 - if available, demonstrate using a penis model

For information on sexual health issues contact FPA Health (Family Planning Association) - 1300 658886 (telephone information line)

Website: www.fpahealth.org.au

GAY AND LESBIAN YOUNG PEOPLE

Many gay and lesbian young people:

- Feel discriminated against and may be particularly vulnerable when seeing a doctor
- Perceive that doctors assume that everyone is heterosexual and feel uncomfortable with homosexuality
- Are at increased risk of isolation, depression, suicide, substance abuse and injury through violence

Practice approaches:

- Reassure the young person about confidentiality
- Discuss and assess their stage of “coming out” and comfort with their sexuality
- Identify their level of support from family, peers, etc.
- Do not push for the young person to ‘come out’ – disclosure of sexuality only enhances a young person’s wellbeing if the people they choose to come out to are supportive
- Screen for psychosocial risks – depression; anxiety; suicidal risk. Provide support or referral for counselling where necessary

- Provide a range of options – opportunity to discuss their sexuality; referral to support services where available; literature
- Provide information/education on safer sexual practices

The following services provide information, counselling and support for gay and lesbian young people:
2010 Gay and Lesbian Youth Services –
1800 652010 or 02 95526130
www.rainbow.net.au/~twenty10/

Gay and Lesbian Counselling Service –
1800 805379 or 02 92072800

Contraception

Where appropriate, provide information about suitable methods of birth control:

- The decision to provide contraception to an adolescent without parental knowledge must be considered in the light of:
 - the doctor’s duty of care to the adolescent patient where confidentiality must be protected unless there are extenuating circumstances
 - the importance of maintaining a trusting relationship with the adolescent
 - the young person’s age, developmental maturity and demonstrated competence
- General contraceptive advice and treatment can be given without parental/guardian consent to an adolescent of any age as long as the doctor makes the judgement that the adolescent is capable of giving informed consent
- Under NSW law, injectable progestagens is illegal for women under 16 years without the consent of the Guardianship Tribunal, whereas implantable progestagens (eg "Implanon") do not require such an order
(See also Medicolegal Issues, P. 49)
- Where possible, encourage the adolescent to talk to a parent/guardian and, if possible, bring them to a consultation
- Point out to the adolescent that the contraceptive pill does not protect against STIs – therefore condom use is also recommended
- Provide education about correct use of contraceptive method
- Be sensitive to cultural norms and beliefs about sexuality and contraception
 - in some NESB groups it may be considered that a girl taking the pill must be sexually active and this would bring shame to the family

- if prescribing the pill for health reasons, some NESB young girls may initially be reluctant or their parents may be reluctant about taking the pill due to these perceptions

Conducting Examinations ⁽³⁾

For the sexually active adolescent, vaginal examination may be indicated for:

- Pap smears – commencing 1-2 years after first sexual intercourse
- STIs – screening or diagnostic
- Pregnancy
- Pelvic pain or other gynaecological symptoms
- Sexual assault – refer to sexual assault service

When conducting an examination:

- Ask if they would like a female support person with them during the examination – e.g. a friend, relative or female practice staff member
- Seek approval from parents if dealing with girls from NESB groups
- For some cultures it may be uncomfortable or even shameful for a male doctor to examine a female patient
 - ask the parents’ permission
 - arrange for the girl to be examined by a female practitioner where possible and /or to have a female support person or family member present
- Take time to explain in detail what you will be doing
- Check that the young woman has understood and gives consent to the procedure
- Allow the patient to undress and cover herself before starting the examination
- Explain what you are doing at each step of the procedure
- Explain that you will stop at any point in the procedure if she wants you to
(see also Conducting a Physical Examination, P. 37)

Case Study

Stephen is a 19 year old young man who has not been to your practice before. He says he wants an HIV test and appears very anxious. You take a sexual history from Stephen and learn that he started having sexual intercourse for the first time 8 months ago. He has had a total of three different partners, all men. Sexual practices have included oral sex and receptive and penetrative anal sex. He has

nearly always used condoms but didn't on one occasion four months ago with his previous partner. He is unsure of the HIV status or other sexual practices of that partner.

Stephen has not had an HIV test before and has had no symptoms.

Stephen is living at home with both parents and two younger sisters. He is at TAFE completing a computer course and works part time. On questioning he tells you that he 'came out' to his family only two weeks ago, although he has "known that he is homosexual" since he was about 12. He tells you that his mother cried but seems OK now and that his father hasn't said much. He has only told one of his friends, a good mate from school. He has found a local support group that meets once a fortnight and is making some friends there. He does not smoke and only drinks socially. He doesn't use any other drugs.

Management Issues and Approaches:

- Stephen's initial anxiety was probably related more to seeing you and fears that you may be judgemental – rather than anxiety about whether he might be HIV positive
- Even though he asked for an HIV test initially, he might not disclose that he is homosexual unless you demonstrate that it is safe to do so by adopting a non-judgemental attitude
- You provide pre-test counselling and then take blood from Stephen for an HIV test
- You then explore other issues such as his home situation, education and employment, and friends (using the *HEADSS* framework) to identify other risk factors that may influence his sexual behaviour
- You screen for depression and suicide risk but he does not appear to have either
- It is important to enquire about whether a homosexual person has come out and to whom, and what social supports are available to them
- You provide some information and education about safer sex practices
- You make an appointment for a follow-up to give him his test results – you use this consultation as an opportunity to provide counselling and support regarding his sexual identity and safer sex practices

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CHAPTER 10. ADOLESCENT MENTAL HEALTH

Facts about Adolescent Mental Health ^(1; 2; 3)

- Up to 25% of adolescents aged 18-24 years suffer from a mental disorder at any given time
- By late adolescence up to 24% of adolescents will have experienced an episode of major depression
- More than 400 young people commit suicide each year

Adolescence and Mental Health

- Adolescence is marked by increased exposure to risk factors and risk-taking behaviours that may predispose young people to poor mental health outcomes – e.g. substance use; peer conflicts
- The rapid social and emotional changes of adolescence can complicate the presentation and recognition of mental health problems in young people
 - behavioural and emotional turmoil is often a part of adolescent development and may be easily dismissed as “transient”
 - mood changes, irritability, poor school performance, or interpersonal conflicts may mask emotional distress or an underlying mental health problem
- Adopt a broad view of mental health with adolescents:
 - be aware of specific disorders which may emerge in adolescence (such as depression; anxiety; etc.)
 - be alert to other stressors which increase vulnerability to adverse mental health outcomes – such as family breakdown; bullying; stress; school difficulties

Mental Health in NESB Young People

Some NESB young people may be at risk of poor mental health outcomes as a result of the stresses associated with the experience of migration, resettlement and acculturation ⁽⁴⁾. NESB adolescents under-utilise mental health services ⁽⁵⁾.

- The mental health of NESB young people may be adversely influenced by:
 - language difficulties
 - intergenerational and intercultural conflict
 - exposure to traumatic experiences – e.g. torture; refugee trauma
 - isolation
 - resettlement experiences
 - racism and discrimination

- For specialist assistance in treating young people and families from non-English speaking backgrounds, contact the **Transcultural Mental Health Centre (TMHC)**
- TMHC is a state-wide service that provides a range of clinical and consultation services including assessment, short term intervention and over the phone telephone advice and consultation on mental health issues
- TMHC welcomes referrals from GPs and all services are free of charge

TMHC can be contacted on (02) 9840 3800 or 1800 648 911 (rural areas)

Features of Adolescent Mental Health Problems

Mental, emotional and behavioural disorders account for over half the disease burden of adolescents:

- *Mood disorders* such as *depression* are common in young people
- *Suicide, suicidal ideation, and self harm behaviours* are increasing among young people
- *Co-morbidity is common* – there is a strong association between mental health problems and the incidence of other risk-taking and behavioural problems – especially substance use; school and family problems ⁽⁶⁾
 - e.g. *the existence of a depressive disorder raises the risk of substance use, sexual risk-taking and suicidal behaviour*
- *Mental health problems often go undetected* in adolescents:
 - young people are generally ill-informed about mental health problems and are often reluctant to seek help
- *A high level of morbidity and mortality* is often associated with adolescent mental health problems including:
 - health damaging lifestyles and behaviour (e.g. substance abuse)
 - impaired development
 - school failure
 - progression into adult disorders

Psychiatric disorders in adolescence consist of:

- *Chronic conditions* that have their onset during childhood – including conduct disorder; attention-deficit/hyperactivity disorder; anxiety disorders (e.g. obsessive compulsive disorder)
- *Disorders that have their initial onset during adolescence* – including depressive disorder; schizophrenia; eating disorders

The GP's Role

More than half of all adolescents who try to kill themselves will have visited a GP within the previous month ⁽³⁾. GPs therefore play a key role in early identification and intervention, treatment and provision of continuing care to young people with mental health problems by:

- Using consultations to screen for depression and other mental health concerns
- Assisting young people to access specialised mental health and other appropriate services
 - **there are a number of internet website support services for young people e.g Reachout:** www.reachout.com.au - which provides information and resource for both young people and GPs (see **Section 4** for contact details of resources and support services)
- Actively promoting young peoples' mental health and resiliency:
 - *teach positive coping strategies* – help the adolescent to identify “things that get them through.” – e.g. a hobby; sports; friendships; spiritual beliefs
 - *strengthen their connectedness* to family, school, peers and community
 - *teach problem solving skills* for more effectively dealing with school, relationship, family and peer problems
 - help the young person to *develop competencies*:
 - *social competency* – communication and interpersonal skills to build relationships
 - *cognitive competence* – identifying negative thinking patterns and irrational beliefs and developing more optimistic and realistic thinking
 - *emotional competence* – identifying and appropriately expressing their emotions, and managing their moods
 (See also *Risk Taking and Health Promotion, P. 41*)
- Educating and supporting parents and family members and involving them, as appropriate, in any treatment plans
- Collaborating with other mental health professionals in the provision and coordination of comprehensive, multidisciplinary care – use the *Medicare item numbers* of the *Better Outcomes in Mental Health Care (BOMHC)* initiative and the *Care Planning/Case Conferencing item numbers* to coordinate a coordinated approach to treatment (see *Using the New Medicare Item Numbers - P. 89*)

Screening and Assessment

- Routinely enquire about psychological distress, depression and health risk behaviours with adolescent patients
- The *HEADSS* psychosocial assessment provides a broad framework for detecting the presence of risk factors and mental health problems (see *Conducting a Psychosocial Risk Assessment, P. 29*)
- A more in-depth assessment may be needed to diagnose specific disorders – this may require referral to a psychologist, psychiatrist or mental health service
- If a young person presents repeatedly with vague or non-specific complaints consider the possibility of depression or other mental health problem
- Clarify the role that risk behaviours play in the young person's life – e.g. alcohol and drug use may be a means of relieving emotional distress
 - this provides a guide to intervention strategies
 - e.g. teaching appropriate coping skills for dealing with emotional distress (instead of substance use)
- It is important to assess any presenting complaint within the overall context of the young person's life – e.g. family; school; peer relationships. Where possible, obtain history from other key sources such as parents and teachers
- Be aware of the young person's cultural background and enquire sensitively about any cultural factors and experiences that may impact on their mental health – e.g. the experience of torture or refugee trauma ⁽⁷⁾
 - clarify cultural norms and beliefs about mental illness and the cultural meaning attached to any particular symptoms
(Visit the *Transcultural Mental Health Centre website* for further information: www.tmhc.nsw.gov.au)
- Adopt a non-judgemental approach when inquiring about the young person's mental health. Be sensitive but direct in your questioning and use language that the young person can relate to:

Example: “Have you been going through a tough time lately?”
“Can you talk about what's been happening inside you lately (your thoughts and feelings about yourself and your life)?”

Specific Conditions

The following section provides general guidelines only for the identification, assessment and management of some major adolescent mental health problems. There are a number of excellent resources available which provide more specific information about the assessment, diagnosis and treatment of adolescent mental health disorders. (See Section 4 for information about these resources)

Depression

Much of the information below has been adapted from the NHMRC Clinical Practice Guidelines: *Depression in Young People – A Guide for General Practitioners*. NHMRC. 2000. ⁽⁸⁾

Depression in Young People ^(8; 9)

- Adolescence is a key period for the onset of depression – up to 24% of adolescents will have suffered an episode of major depression by the age of 18
- Major depressive disorder and dysthymic disorder are common disorders in adolescents
- Depression in adolescents is often masked by other symptoms – e.g. anger; irritability; anxiety; poor school performance
- Depression, therefore, may not be obvious – GPs need to be proactive in enquiring about depressed mood in adolescent patients
- Depression is a major contributing factor in adolescent suicides
- Depression in young people often goes unrecognised and therefore untreated

ASSESSMENT AND DIAGNOSIS

- A trusting relationship forms the basis for the effective diagnosis and management of depression:
 - Establish rapport
 - Define the terms of confidentiality
 - Adopt a non-judgmental approach (See *Conducting a Youth Friendly Consultation*, P. 19 for approaches to engaging the young person)
- Conduct a psychosocial assessment using the HEADSS tool (see *Conducting a Psychosocial Risk Assessment*, P. 29). In particular, screen for:
 - marked changes in usual mood or behaviour – e.g. sleep/appetite disturbance; persistent irritability
 - underlying risk and precipitating factors – e.g. substance use; bullying and victimisation; difficulties in sexual orientation; issues of loss; family conflict

- relationship difficulties; withdrawal/isolation; conflicts with peers
- family history of depression or other mental illness
- deterioration in school performance
- the presence of comorbid problems – e.g. substance use; anxiety; other behavioural or mental health problems; sexual abuse

■ Where depression is suspected, a careful clinical history should be obtained from the young person, with supportive evidence gained from family; friends; teachers; etc. – this requires scheduling a longer consultation

■ A useful approach is to ask the adolescent to rate their own level of depression on a scale from 0 to 10 – where ‘0’ means *no depression* and ‘10’ means *severe depression* ⁽⁹⁾

Example: “On a scale of 0 to 10, where 0 means no depression and 10 being the most depressed you could possibly be, where would you rate yourself at the moment?”

■ A score of up to 5/10 can usually be considered mild depression. A score above 5 may indicate more severe depression

■ It is important to ask the young person what that particular score means for them:

Example: “You said that right now you rate yourself as being 6 out of 10. A six to me sounds like you’re feeling pretty down a lot of the time, and that maybe you’re finding it hard to get out of that feeling of being down or sad. Is that how it is for you at the moment?”

■ When using a rating scale, it is useful to follow it up with questions that translate the young person’s rating into behavioural descriptions:

Example: What is happening in your life right now that makes you feel like it is a six?”

Or,

“What is happening inside yourself right now (your thoughts; feelings) that makes it feel like a six?”

■ A score of 7 and above demands a careful screening for the risk of suicidality ⁽⁹⁾

■ There are various standardised questionnaires and rating scales that detect the presence of depression – where uncertain, referral to a Psychologist or Psychiatrist for more in-depth assessment can assist with diagnosis.

Clinical Presentation ⁽⁸⁾

According to the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV)*, **major depressive disorder** is indicated if at least **five** of the following symptoms are present during the same **2-week period** most of the day, nearly every day; *and* at least one of the symptoms is either *depressed mood* or *loss of interest* or pleasure in activities; or in the case of adolescents, *irritability*:

- Depressed or irritable mood; persistent sadness
- Markedly diminished interest or pleasure in most activities
- Significant change in weight or appetite
- Sleeping too little or too much
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Impaired ability to think, concentrate or make decisions
- Recurrent thoughts of death or suicide, or suicide attempt

PRACTICE POINTS ^(9; 10)

- *Depressed adolescents* may present in general practice with physical complaints – headaches; tiredness; abdominal pains
- Consider *emotional issues* in young people who present frequently to general practice with vague or minor complaints
- It is important to distinguish between sad feelings or unhappiness that is an appropriate reaction to stressful life events (such as death of a loved one; family problems; relationship break up; etc) *and* severe depressive symptoms that may constitute a clinical disorder
- *All* young people should be asked how life is going in general to maximise the chances of detecting depression
- Comorbidity is a common feature of adolescent depression – it is important to screen for depression in young people with anxiety and other mental health issues, substance abuse, behavioural disorders and medical illnesses

MANAGEMENT APPROACHES:

- Developing a caring, trusting relationship with the adolescent is a key component in the management of their depression
- Listening to their concerns and providing support builds a therapeutic relationship which in itself can help the young person to combat their depressed mood
- Such a relationship will also help to facilitate referral to other professionals

Treatment Options:

(i) Counselling or psychotherapy – is the first line of treatment for adolescents ^(8; 9; 10):

- *Cognitive Behavioural Therapy (CBT)* has proven efficacy in the treatment of depression
- *Interpersonal Psychotherapy (IPT)* may be helpful for older adolescents
- *Referral* to a Psychologist or other counsellor is indicated if the GP does not have the skills or time to provide appropriate counselling

(ii) Medication – is the second line of treatment. Medication should only be prescribed if: (*See the box below for medication options*)

- counselling alone is insufficient or is unsuccessful
- the depression is so severe that it interferes with the young person's capacity to engage in counselling
- the depression is life-threatening

Use of Medication ^(8; 9; 10)

- Anti-depressant medication may be less effective in managing depression in adolescents under the age of 18, and is generally not recommended as the first line of treatment
- *Selective serotonin re-uptake inhibitors (SSRIs)* – are preferred because they are quicker acting, have fewer side-effects, are relatively safe in overdose and have lower cardiotoxicity than tricyclics.
- *Reversible monoamine oxidase inhibitors (MAOIs)* – also have fewer side-effects, and work quite quickly
- *Tricyclic antidepressants* – are *not recommended* for adolescents:
 - there is little evidence of efficacy with adolescents
 - there is a higher potential for overdose because of their substantial side-effects and toxicity
- Where uncertain, prescription of medication should be done in consultation with, or referral to a Psychiatrist – especially if the depression is severe
- The choice of anti-depressant should be tailored to individual need, and the young person (and their parents/guardians) fully informed of all treatments and their potential effects
- Monitor a young person on antidepressants carefully, as the therapeutic increase in energy may precipitate suicidal behaviour
- Consult with the Psychiatrist and/or Psychologist about how long the young person needs to remain on medication and develop a strategy for withdrawal from medication

(iii) Referral - to other specialist services is a crucial part of the management process:

- referral should be discussed sensitively with the young person and the reasons clearly explained
- obtain their permission to share information with the other referral body
- reassure them that they are welcome to return if the referral does not work out, so that other options can be explored
- the role of counsellor / psychologist may need to be explained to NESB adolescents and families as they may not exist among some cultural groups

(See box below for referral options)

Referral Options

- Referral to a *Psychiatrist* or community *mental health services* is recommended where there is:
 - severe major depression, particularly with suicidal ideation
 - depression with psychosis
 - family history of bipolar affective disorder
 - serious co-morbidity
 - failure of initial treatment
- Referral to a *Psychologist* or *counsellor* is recommended for:
 - assistance with assessment and diagnosis
 - provision of specialised counselling – e.g. CBT; drug and alcohol counselling where substance use is an issue; dealing with grief or loss
 - family therapy
- **Transcultural Mental Health Centre** is a state-wide (NSW) resource centre, offering advice and /or referral for other professionals and consumers about transcultural and mental health issues (see **Section 4** for contact details)

(iv) Education and Mental Health Promotion

- Young people who are depressed can benefit from education about the nature of their illness, its possible causes and effects on them, and proposed treatments
- Education in the following areas can greatly assist the young person in addressing psychosocial factors contributing to their depression and in developing positive coping skills:
 - social and interpersonal skills
 - appropriate problem-solving and goal setting skills
 - enhancing self-esteem

- Consider referral to a Psychologist or counsellor to educate the young person on how to manage their anxiety and moods

(v) Monitoring Daily Activities

- Withdrawal from pleasurable or routine activities is a common feature of depression
- Identify and monitor daily activities
- Encourage the young person to increase the amount of time spent engaged in doing pleasurable and active things, e.g.:
 - exercise and sport
 - participation in social and recreational activities

(vi) Family Work

- Educate and support parents and family members in understanding their adolescent's depression
- Where the young person is amenable, actively involve the family in the treatment regime
- Refer for specialist family counselling, where family issues/conflicts are a major contributing factor in the onset and maintenance of the depression

(vii) Collaborative Care

- The management of adolescent depression requires a collaborative approach
- The GP can take a lead role in the provision of collaborative care
 - either through coordinating the young person's case management
 - or as part of a treatment team including psychologist; psychiatrist or other mental health specialist; school counsellor; youth workers; etc.
- It is critical to involve other key people in the adolescent's life in supporting the management plan – e.g. family members; teachers; peers
- The GP has a crucial role in monitoring the young person's progress – if there is no improvement it is important to:
 - review the diagnosis
 - check compliance with the treatment plan
 - consider other treatment options.

Suicide and Self Harm

Facts about Suicide in Young People ^(1; 2; 3)

- In 1998 – there were 364 male suicides and 82 female suicides in the 15-24 year age group (ABS, 1998)
- It is estimated that for each completed suicide, there are approximately 30 - 40 attempted suicides
- Young females attempt suicide twice as often as males, while young males are four times more likely to die
- Depression is a major precipitating factor in adolescent suicide
- More than half of all adolescents who try to kill themselves will have visited a GP within the previous month

SUICIDAL AND SELF HARM BEHAVIOUR IN YOUNG PEOPLE

Suicidal and self harming behaviour are maladaptive solutions to emotional, psychological, interpersonal and developmental problems.

- *Suicidal ideation* – refers to conscious thought about ending one's life
- *Suicidal behaviour* – consists of threats and actions involving the intention to kill oneself, which if enacted may lead to serious injury or death. It is useful to distinguish between suicidal and self-harming behaviour
- *Self-harming behaviour* – involves directly and deliberately inflicting bodily harm or injury – including cutting; scratching; burning; abrasions
 - it is a way of dealing with overwhelming feelings and situations
 - alters the person's mood state and reduces psychological tension
 - often repetitive in nature
 - in some cases, it may be associated with personality disorder
 - self-harm behaviour is generally not intended as suicidal - however, involvement in self-harm behaviour may predispose the young person to increased risk of suicide
 - young people engaged in self-harm behaviour should be screened for depression and suicide risk

ASSESSING SUICIDE RISK

- A comprehensive psychosocial risk assessment using the *HEADDs* screening tool can help to identify presence of suicidal ideation and behaviour (*see Conducting a Psychosocial Risk Assessment, P.....*)

- If the young person presents as depressed or if there are indicators of suicidal risk, it is important to enquire directly about suicidal thoughts or behaviour:

Examples: *"I'm wondering because you have been feeling so depressed, whether you have had any thoughts about hurting or killing yourself?"*

"Have you ever felt so bad you've wanted to hurt or kill yourself?"

"Have you ever thought that life was not worth living?"

- If the answer to these questions is "yes", it is important to conduct a *systematic assessment* to identify whether the young person is at *Low; Moderate; or High Risk*
- Ask questions that graduate from exploring current feelings and thoughts to identifying specific plans and actions
- *Direct questioning* is important – most young people feel relieved to have their distress acknowledged – it allows the depressed or suicidal adolescent to express their worries and to feel heard and understood
- Once the assessment of suicidal risk is completed, an appropriate management plan can be put in place

(i) Explore thoughts and feelings:

- The main contributing factors in adolescent suicide are *depression and loss of hope*
- Show your concern and interest – use reflective listening to encourage the young person to express their thoughts and feelings about their current situation

Example: *"It sounds like you're feeling pretty down about your life at the moment..."*

"You seem to feel like it's all too much for you right now and that you're not going to find a way out of this..."

"When you're feeling so down, what sort of thoughts and feelings do you have about yourself and your life?"

- Common thoughts and feelings include:
 - *sense of hopelessness and/or helplessness*
 - *persistently thinking things will never get better and no-one can help*
 - *feeling overwhelmed by the expectations of others*
 - *loneliness, fear, feelings of abandonment and not being heard*
 - *consistent high levels of anxiety and/or anger*
- It is important to know how frequently their thoughts are centred on killing themselves
 - ask whether thoughts are persistent and/or intrusive – if yes, enquire about plans

(ii) Explore background risk factors

Identify any background factors or precipitating events that may increase their level of distress and put the young person at higher risk, for example:

- stressful life events – such as loss or grief; relationship break up
- family conflict
- cultural issues – e.g. acculturation problems; experience of racism or discrimination; non-acceptance or bullying by peers because of ethnicity
- bullying
- substance abuse and other high risk-taking behaviour
- underlying mental health problem – e.g. depression or anxiety
- previous history of suicide attempts – explore history of any previous attempts:
the frequency of attempts
severity and lethality of attempts
intention of previous attempts
- history of self-harm behaviour
- school performance – e.g. failure at school
- peer relationship difficulties

Example: “What has happened recently that has made you feel so awful?”

“What things are really worrying you at the moment?”

“Do you know anyone who has ever killed or tried to kill themselves?”

“Have you ever tried to harm or kill yourself before?”

“What triggered your previous attempts?”

- The HEADDSS assessment can also help in identifying these risk factors

(iii) Explore plans and actions:

- Explore the extent to which the young person has formulated a clear plan of how they intend to take their lives:
 - what sort of plans has the young person made?
 - are the means available to them?
 - what is their lethality? (e.g. tablets; firearms)
 - what steps has the young person taken to implement the plan?
- Seek permission to obtain relevant history from significant others – parents, family members, teachers

Example: “Have you thought about how you would hurt or kill yourself?”

“Have you actually taken any steps towards getting the pills (or gun; car; etc.)?”

“On a scale from 1 to 10 (where 1 is the lowest and 10 is the highest) – how strong is the feeling of wanting to kill/harm yourself at the moment?”

“What things might stop you from trying to kill yourself?”

(iv) Explore supports, resources and protective factors

- Establish who are the important people in the young person’s life and how available are they to support them
- Identify protective factors:
 - family support
 - access to or belonging to a community or group of peers
 - strong cultural identity
 - positive coping behaviours – e.g. problem-solving skills; self esteem; interpersonal skills
 - spiritual beliefs or faith
 - active help-seeking behaviour

Example: “Who do you usually share problems with?”

“Who do you think could support you through this time?”

“What do you think they would say or do if they knew about your plans?”

“Who would you like to have support you through this?”

“What is helping you to keep going right now?”

“If you could look to the future, what do you think you could look forward to?”

Risk Factors for Suicide

- Previous suicide attempt / self harm
- History of previous attempts in family/friends
- Concrete suicide plan
- Underlying mental disorders – e.g. depression; anxiety
- Substance abuse
- Comorbid conditions – e.g. eating disorder; conduct disorder
 - Recent stressful life events
 - relationship breakdown
 - loss, disappointment or humiliation
 - school or work difficulties
- Ongoing family problems
- Victim of bullying
- Gay, lesbian or bisexual orientation
- Cultural conflicts or concerns

MANAGEMENT OF SUICIDAL BEHAVIOUR

- Build a therapeutic alliance with the young person
- Establish level of risk
- Clarify confidentiality – the presence of serious or imminent threat in this situation overrides the need to maintain confidentiality
 - deal with the situation of confidentiality sensitively but openly and firmly. It is important not to agree to secrecy:

“Mark, you’ve said that you don’t want anyone to know about this. However, I’m very concerned about you at the moment and my first duty really is to make sure that you are safe. In order to make sure you are safe, I need to contact some other people who can help you and myself to get you through this difficult time.”
- When the young person is at *moderate to high risk*, it is important to ensure the young person’s immediate safety:
 - develop a management plan for ensuring the person’s safety
 - contact and mobilize family and social supports
 - remove or limit access to the means of self harm if possible
- Consider the use of a *“no suicide” contract* with the young person to seek help before self harming (*only to be used in conjunction with other therapeutic interventions*)

"No Suicide" Contract

A no-suicide contract is a verbal or written agreement between a practitioner and young person to undertake certain tasks to keep the young person safe until the next scheduled appointment (8). For example:

“Michael, I want to make sure that you are safe until our next appointment. So I’d like to make a contract with you that if you have thoughts of harming or killing yourself before I see you again, that you will immediately telephone (.....the GP; or Helpline; or Mental Health Crisis Team; etc.). Are you willing to agree to that?”

A contract may be used for periods from a few hours to a few days, but should not be used for periods longer than one week without reassessment. If a patient at moderate to high risk cannot agree to a no-suicide contract, hospitalisation may be required. See *Depression in Young People - A Guide for General Practitioners. NHMRC. 2000* - for further information.

- *For those at significant risk:*
 - *affirm the person*
 - *affirm the problem*
 - *negate the maladaptive solution (i.e. suicide)*
- Consider hospitalization (if risk is assessed as very high)
 - treat as medical emergency if acutely suicidal
- Refer for specialist treatment if no safety agreement can be reached
 - e.g. local Mental Health Crisis Service (see Section 4 for contact details)
- Diagnose and treat any underlying mental disorder (if present)
 - consult with Psychiatrist/Psychologist
 - use of medication if necessary
- Young people engaged in self-harm behaviour (e.g. cutting arms, legs, body) should be screened for depression and suicide risk
 - self-harm behaviour is generally not intended as suicidal
 - however, involvement in self-harm behaviour may predispose the young person to increased risk of suicide or accidental death
 - therefore it is important to assess whether the young person is also suicidal
- Once suicidal thoughts/behaviours have been effectively addressed – it is important to treat the underlying or precipitating problems that the suicidal behaviour is attempting to resolve
 - manage the main life problems by providing counselling and support
 - teach cognitive, behavioural and problem-solving skills for better coping
 - develop plans for the future
 - refer for specialist counselling where necessary

Example: *“Right now I know you’re feeling that everything is hopeless. But I also know that some of these feelings will pass and that you can get through this difficult time. Then, I’d like to help you look at ways of dealing with some of these problems that you’re feeling bad about.”*

Management of the suicidal adolescent

- Always take the situation seriously
- Alert parents or guardians – they need to be aware and involved
- Address safety issues – being alone; take steps to limit access to drugs or other means of self harm (consider making a contract around safety with the young person)
- Assess available supports (family, friends, school or work)
- Ascertain further information (from family, friends, school or work)
- Ask for help – seek input from a mental health professional and consider referral if the situation seems unstable or unsafe
- Refer to appropriate support services to provide effective management of suicide risk and ongoing treatment of underlying problems
- Consider hospitalisation in cases of severe risk

SPECIFIC INDICATIONS FOR REFERRAL

Depending on availability of services (eg, adolescent physician, psychiatrist, mental health team), always refer when there is:

- Serious risk of self harm
- An unsupportive or high risk environment
- Failure to respond to initial treatment
- Bipolar disorder or other major psychiatric condition

Warning Signs for Suicide ⁽⁹⁾

- *Changes in behaviour*
 - isolation or withdrawal from others
 - loss of interest in activities
 - risk taking
 - putting affairs in order
 - giving away personal effects or prized possessions
- *Changes in mood*
 - hopelessness
- *Changes in thinking*
 - inappropriate feelings of guilt
 - strange or bizarre thoughts
- *Preoccupation with death*
- *Talk of suicide*
 - plans for suicide
 - asking about methods of suicide
- *Stressful life situations*
 - perceived intolerable loss or stress
- *Apparent resolution*
 - sudden appearance of happiness and/or calmness after a period of some of the characteristics listed above

RESOURCES

There are a number of excellent resources available on managing depression and suicide risk in young people:

- Pfaff, J. and Rooney, M. *Identifying and Managing Suicidal Risk in Youth*. Commonwealth Department of Aging. 2000 – www.iinet.net.au/~suicide
- *Detection and management of young people at risk of suicide*. Royal New Zealand College of General Practitioners. Wellington. New Zealand. 1999 – www.rnzcgp.org.nz_
- *Depression in Young People – A Guide for General Practitioners*. NHMRC. Canberra. 2000.
- *Keep Yourself Alive Project*. SA Royal Australian College of General Practitioners. Adelaide. 1998.

Case Study

Mark is a 16 year old brought in to see you by his mother. She is concerned because Mark seems to have lost interest in school. She is worried that he will drop out and not finish his HSC. She is also concerned because he has no friends, spends most of his time in his room and is irritable most of the time. You haven't seen Mark for almost 2 years and you are surprised by how quiet and withdrawn he seems. You remember him as a bright and active adolescent. You spend some time alone with Mark and discover that he has been feeling down for the last few months. He says he feels like an outsider at school because his best friend recently rejected him and won't talk to him any more. He now hates going to school because he doesn't fit into any peer group. Mark starts to cry as he tells you this. He has missed more than 30 days of school this year with numerous minor ailments. He says he feels bored most of the time outside of school and has dropped out of all his usual sporting and social activities. You also discover that he and his girlfriend split up 2 months ago. They still see each other at school which is hard for him especially as she is now dating someone else. Mark has constant conflicts with his father over his school work. He has fallen so far behind that he thinks it is too hard to catch up. When he tries to study, he can't concentrate. He feels tired all the time and doesn't sleep well. He says that his parents don't really care about him – all they worry about his grades. He can't see any future for himself.

Assessment

- Based on Mark's presentation, you conduct a more in-depth screen for depression taking a clinical history and exploring further for both risk and protective factors in his life
- Mark displays a number of features of depression including:
 - depressed mood and persistent sadness
 - irritability
 - sleeplessness
 - withdrawal from social and pleasurable activities
 - family conflicts
 - difficulty concentrating
- It is vital to conduct a *suicide risk assessment* in any young person who is depressed – enquire about:
 - *thoughts of suicide* – How often? Have they told anyone?
 - *plans for suicide* – Do they have concrete plans? Access to means?
 - *past attempts* – their lethality and intent?
 - *self-harm* – have they attempted to harm themselves in any way?
- Mark admits that he has had thoughts about killing himself, but has never made any attempts. He says that he would never really try to kill himself because he knows how upset his mother would be.

Management

You determine that although Mark is a low suicide risk, he is seriously depressed. You share your concerns with him and ask for his permission to discuss the issue with his mother so as to work out a management plan in collaboration with them. Your interventions include the following:

- Referral to a Psychologist / counsellor to develop strategies for reducing his depression and addressing family conflict
- Contact with the school counsellor to engage the school's support in addressing his social and academic difficulties
- Scheduling a longer follow-up consultation to further assess and monitor Mark's condition and consider the use of medication

Eating Disorders

Eating or dieting disorders are *nutritional, medical and psychological conditions* that severely affect body image and personality, and disrupt family life and relationships.

The three major clinical presentations of eating disorders are:

- *Anorexia nervosa*
- *Bulimia nervosa*
- *Eating disorders not otherwise specified (EDNOS)*

Facts about Eating Disorders ⁽¹⁰⁾

- *Anorexia nervosa*
 - affects 0.5-1% of adolescent girls
 - third most common chronic illness in adolescent girls
 - affects girls to a ratio of 10:1
 - severe medical and psychiatric morbidity and mortality rate of 20% at 20 year follow-up
 - peaks in the early teens (12-14 years) and around 17 years
- *Bulimia nervosa*
 - affects 1-5% young girls/women
 - tends to occur in slightly older age group
- *EDNOS*
 - prevalence unknown
 - 30-60% young women believed to engage in unhealthy weight losing behaviours

ASSESSMENT AND DIAGNOSIS

Consider an eating disorder in an adolescent if they ⁽⁷⁾:

- engage in unhealthy weight-control or restrictive dieting practices
- demonstrate obsessive or rigid thinking about food, weight, shape, body image or exercise
- suddenly convert to vegetarianism
- have irregular menstrual cycles or delayed menarche
- exhibit change in personality and social interests, eg withdrawal
- display evidence of vomiting
- have unexplained weight loss while:
 - denying dieting or hunger
 - needing to eat less than others
 - being reluctant to display weight loss; wearing baggy clothes

- The identification of an eating disorder is often complex, as the initial presentation may be subtle – young people often present to GPs with other physical or emotional complaints

- It is important to spend time establishing rapport and a trusting relationship with the young person (See *Conducting a Youth Friendly Consultation*, P. 19 for approaches to engaging the young person)
- Conduct a general psychosocial assessment using the *HEADDSS* screening tool to identify the risk of an eating disorder (see *Conducting a Psychosocial Risk Assessment*, P. 29)
- If you suspect the young person may have an eating disorder, it is essential to allow time for a thorough medical, nutritional and psychosocial assessment
- 'Normal' dieters are happy when they achieve their desired weight and show off their newly attained body. They are proud of their achievements and they generally become happier and socially more active. Conversely, *eating disorder sufferers* always want to lose more weight and are not satisfied with weight loss achieved thus far
- *Note: Eating disorders are positively diagnosed by medical examination and psychiatric assessment – avoid extensive testing to rule out medical causes symptomatology, as this increases the risk of progression to a more severe and entrenched stage*
- Refer to a psychiatrist or specialist eating disorders service (where available) where there is uncertainty about diagnosis
- Initiate early referral to optimise treatment outcomes

Diagnostic criteria – Eating Disorders ⁽¹⁰⁾: Anorexia nervosa (AN)

- Refusal to maintain body weight at or above a minimally normal weight for height and age
- Intense fear of gaining weight or becoming fat, even though underweight
- Disturbed experience of body weight or shape, with undue influence of body shape or weight on self-evaluation
- Amenorrhea – i.e. the absence of at least three consecutive menstrual cycles
- *Restricting type AN* – restrictive eating and severe dieting behaviours
- *Binge-eating / Purging type AN* – regularly engaging in binge eating and/or purging behaviours (e.g. self-induced vomiting; misuse of laxatives)

Bulimia Nervosa (BN)

- Recurrent episodes of binge eating, characterised by:

- eating a large amount of food in a discrete period of time (e.g. a 2-hour period)
- and
- a sense of lack of control over the eating during the episode
- Recurrent inappropriate compensatory behaviour to prevent weight gain (e.g. self induced vomiting; use of laxatives/medications; fasting)
- The binge eating and inappropriate compensatory behaviours both occur at least twice a week for three months
- Self evaluation is unduly influenced by body shape and weight
- BN does not occur exclusively during episodes of anorexia nervosa
- *Purging type BN* – patient regularly engages in self-induced vomiting or misuse of laxatives, diuretics or enemas
- *Non-purging type BN* – patient uses other inappropriate compensatory behaviours, such as fasting or excessive exercise – but does not regularly engage in purging

EDNOS

- All of the criteria for AN are met *except that*:
 - (for females) menstruation occurs regularly
 - person's current weight falls within the normal range (despite significant weight loss)
- All of the criteria for BN are met *except that*:
 - episodes of binge eating and compensatory behaviour occur at frequency of less than twice a week, *or* for a duration of less than 3 months
- Regular use of inappropriate compensatory behaviour by a person of *normal body weight*, e.g.
 - self-induced vomiting
 - chewing and spitting out food, without swallowing

HISTORY

If an eating disorder is suspected, a comprehensive case history should be taken exploring the following areas:

- **Nutritional history**
 - weight history
 - nutritional intake
 - weight loss and methods used
 - eating and purging behaviours and patterns
 - exercise and activity
- **Medical assessment**
 - menstruation
 - symptom review to exclude organic disease such as inflammatory bowel disease, peptic ulcer disease and hyperthyroidism

■ **Physical Examination**

- height, weight and BMI
- vital signs (bradycardia, hypotension), signs of dehydration
- skin changes such as fine downy body hair and cool mottled extremities
- signs of vomiting – callused fingers, parotidomegaly, altered dentition, muscle weakness and depressed reflexes from hypokalaemia
- systems review to exclude other organic illness

■ **Investigations**

- full blood count – look for anaemia
- electrolytes, urea, creatinine – look for hypokalaemia
- blood sugar
- amylase
- ECG (depending on clinical indicators)
- thyroid Function Tests; T3RIA is depressed with protein calorie malnutrition

■ **Psychological assessment**

- body image – ‘ideal’ weight; specific body parts; fear of weight gain
- presence of co-morbid conditions – e.g. depression; anxiety; obsessive compulsive disorder; substance abuse; self harm
- interpersonal relationships and family functioning

MANAGEMENT (7; 10)

Treatment and management requires a comprehensive, multidisciplinary approach to address the complex biological, psychological and social aspects of eating disorders. Collaboration with other health professionals is essential to the treatment approach:

- refer to a *dietitian* – to assist with nutrition and diet regimens
- refer to a *psychologist/psychiatrist* – for assessment and treatment of underlying psychological problems
 - low self-esteem
 - dysfunctional eating and thinking patterns
 - comorbid psychological issues
 - family dysfunction
- referral to a specialist eating disorders service is recommended where this is available – these provide a comprehensive, shared care approach

THE GP'S ROLE

GPs have a critical role in the early recognition and assessment of eating disorders, and in initiating treatment. *One of the main goals for the GP is to help the young person realise the seriousness of their disorder and to motivate them to participate in treatment. GPs also play a key role in case management and coordinating multidisciplinary care:*

- Establish the need for intervention – through diagnosis, explanation, engagement of the young person
- Address the diet – simple dietary counselling, correct misinformation about food, dieting and exercise
- Institute a food diary
 - Gives patients a positive method of observing and controlling their eating
 - look for dietary patterns and triggers to disordered eating
- Monitor physical signs – weight, vital signs, electrolytes
- Explore psychosocial issues – provide counselling where appropriate to help build self-esteem; improve communication skills; develop coping skills
- Engage the family as partners in care – provide education and support; address their questions and concerns; enlist their help with a resistant adolescent; involve them in the management plan
- Facilitate referral to specialist services and/or coordinate a multidisciplinary treatment team:
 - provide regular medical assessment
 - counselling and support to patient and family
 - ensure a clear management plan is followed by all members of treatment team

Prevention

GPs can also play a major role in prevention:

- Monitor the young person's growth and development – plot their growth on standardised growth charts (over time if young person is known to the practice)
- Deviations from normal can be used to educate them about healthy growth and development – a useful strategy for both anorexia and obesity.

HOSPITALISATION

Hospital referral should be considered in the following cases:

- Significant protein calorie malnutrition – BMI approaching 5th percentile
- Evidence of medical de-compensation such as bradycardia and hypokalaemia
- Significant depression
- Other co-morbid condition – e.g. diabetes

Failure of outpatient treatment

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CHAPTER 11. ADOLESCENTS WITH CHRONIC ILLNESS

The prevalence of chronic illness in adolescents, a permanent condition with residual disability, is between 10-20% ⁽¹⁾:

- the majority of chronic illness originates during childhood – as medical and surgical advances are continually improving survival
- approximately 80% of children with chronic illness survive into adulthood
- serious conditions or injuries, particularly those related to accidents, can also be acquired during adolescence.

Key Principles

- As with all adolescent patients, establish a trusting relationship and recognise their developmental needs
- Relate to the young person first and foremost as a *young person* – that is, treat them as an ‘*adolescent with diabetes (or asthma; etc.)*’, rather than a ‘*diabetic adolescent*’.

Chronic Illness and Adolescence

Young people with a chronic illness may experience additional difficulties on top of the normal developmental challenges of adolescence ^(1, 2):

- Chronic illness can prolong adolescence for physical and/or psychosocial reasons:
 - pubertal development may be slowed down
 - parental overprotection limiting autonomy
 - limitation of peer contacts due to hospitalisations
 - lack of opportunity for employment – particularly if there is a physical disability or shortened life expectancy
 - lack of appropriate role models
- Dependency on parents and other people at a time when independence is an important developmental goal for them
- Isolation because of dislocation from school and peers
- Being perceived as ‘*abnormal*’ at a time when ‘*normality*’ and peer acceptance are crucial concerns for adolescents

IMPACT OF CHRONIC ILLNESS AT DIFFERENT STAGES OF ADOLESCENCE:

- *Early* – there may be distortion of body image and isolation from peers
- *Middle* – enforced dependency and less acceptance by peers are especially difficult to handle
- *Late* – reduced vocational options; concerns about relationships and children predominate

THE ADOLESCENT WITH A CHRONIC ILLNESS ⁽¹⁾

- Adolescents who have lived with chronic illness since childhood experience less negative impact of their illness as they go through adolescence
- Chronic conditions can become exacerbated or unstable as a result of behaviours and compliance issues arising out of otherwise normal adolescent development
- The course of an illness can change during adolescence
 - *epilepsy* may commence or worsen
 - *asthma* may worsen with the impact of stress, non-compliance or smoking
 - *diabetes mellitus* frequently becomes more brittle and difficult to control.
- Be prepared to address sexuality – adolescents even with disabling chronic illness have the same sexual aspirations and fantasies as their peers.
- While it is important to understand the impact of chronic illness on adolescence, do not assume that all adolescents with a chronic illness will be affected in the same way.

COPING WITH CHRONIC ILLNESS ⁽²⁾

- *Psychological responses to illness* – may be viewed as important ways to diffuse or diminish anxiety:
 - responses such as denial, intellectualisation, compensation and regression are generally adaptive
 - extreme hostility, panic, withdrawal or suicidal behaviour are clearly maladaptive and require more active psychological intervention.
- *Enhance positive coping behaviours* – encourage participation in ‘normal’ activities:
 - maintain a network of friends (with and without disability)
 - participate in sports and social activities where possible
 - involvement with household chores
 - promote self-perception as not handicapped

ISSUES RELATED TO THE CONDITION ⁽¹⁾

- *Age of the young person* – the early adolescent going through puberty appears to be most vulnerable
- *Visibility of the condition* – the more visible the disability, the less the stress and psychological suffering and vice versa
- *The degree of functional impairment* – impaired mobility can be demoralising and socially handicapping, with mild gait disturbances causing more emotional difficulties than more severe limitation

- **Prognosis** – the stress of uncertainty is greater than when the course is known, even when the clinical trajectory leads to death
- **Course of the illness** – a stable or predictable course is less distressing than a fluctuating and unpredictable one.

Management Approaches (1;2)

- Focus on the individual young person and their capacity for healthy functioning rather than the disease per se
- Acknowledge that the chronically ill adolescent has the same developmental needs as other young people
- The young person generally places greater emphasis on other aspects of their life (i.e. normal adolescent priorities and concerns) above their illness
- Parents and doctors however, tend to put more emphasis on the young person's symptoms and illness:
 - this has important implications for compliance with treatment regimes which may conflict with their need to participate in social and peer activities
- Provide the young person and parents with strategies for enhancing compliance (see also *Enhancing Compliance P. 87*)
- Encourage autonomy, self-reliance and responsibility for self-management of the illness
- Help them focus on what they *can* do – in terms of their interests; activities; lifestyle – rather than on what they *can't* do
- Limit intrusive medical examinations or procedures
- Provide honest and easily understood information about the condition and its consequences – do not focus solely on negative consequences
- Educate and support parents – help them to reduce over-anxiety, over-attention and over-protectiveness

Case Study – Chronic illness

Mary is a 15 year old girl and in Year 10 at school. She lives with her parents and two older brothers. She has had insulin dependent diabetes since age 8 and has attended your surgery and hospital outpatients regularly, for reviews, with her mother accompanying her. Her diabetes control had been quite stable until a year ago. Two months ago she had an admission to hospital for ketoacidosis.

Mary attends with her mother one afternoon after school. Both seem upset and angry. Her mother says that Mary has been 'eating all sorts of rubbish' and that she cannot understand why she is unable to see the dangers of this and how it could land her back in hospital. Mary argues with her mother in front of you that she only had some Coke and a few lollies when some school friends came over on the weekend.

You suggest to both of them that having diabetes and being a teenager can be very difficult and that Mary might be feeling stressed. Mary looks more defiant at this point and her mother looks even more upset. You suggest that it might be good for you to have a talk to Mary on her own and her mother very reluctantly leaves the room.

Management Approaches

- *It is important to get to know Mary on her own, and in the context of her family, peers and culture, to assess her health risks, health concerns, and strengths. Beginning to separate Mary from her mother during consultations will facilitate this, and should be done sensitively. Her mother remains an important member of the 'management team'.*
- *Some of the following MAY be operating and it will take time to formulate a further management plan. For example:*
 - *Mary may be experiencing significant adjustment difficulties because she is in mid-adolescence and feels 'different' from her peers*
 - *Mary's mother might be overprotective, because she has diabetes and this is causing tensions in their relationship*
 - *Mary might be stressed because she has missed school and a significant part of her Year 10 assessment, due to her illness and hospital admission*
- *Using the HEADSS assessment will help to explore the above (and other) psychosocial issues – e.g. sexuality; relationships; peer groups; etc*

References:

1. Bennett, D. L. and Kang, M. Adolescence, in Oates K, Currow K, and Hu W. (2001) *Child Health: a practical manual for general practice*. MacLennan and Petty. Australia.
2. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.

Chapter 12. ENHANCING COMPLIANCE

The key to enhancing compliance in adolescents lies in:

- establishing a trusting relationship with the young person
- actively involving them in the development of an individualised treatment plan
- engaging the active support of the family (with the consent of the young person)
- understanding their cultural background and any traditional treatments and explanations of illness in their culture

(See *Section 1 – Conducting a Youth Friendly Consultation* for approaches to communicating with adolescents).

The GP needs to devote as much time to developing a mutually acceptable treatment plan and promoting compliance as to other aspects of the consultation. Research suggests that young people are more likely to comply with treatment regimes if ⁽¹⁾:

- they understand the nature of and reasons for medications/treatments
- treatment is given in the context of an effective doctor-patient relationship
- some choice is offered with respect to treatment where possible

Information and Education (2; 3)

Adolescents are unlikely to adhere to a treatment plan if they do not understand why they should. Simply providing instructions on the required course of treatment is not sufficient. It is essential to:

- discuss with them their condition/problem
- enquire about any cultural factors which may impact on their level of compliance and discuss with the young person and their parents
 - e.g. there may be particular cultural beliefs about the illness or certain treatments that act as a barrier to compliance
- provide treatment options and, where possible, give the young person a choice in selecting treatments
- give reasons for selecting a particular course of treatment
- discuss the likely outcomes of treatment
- discuss possible side-effects of treatment
- educate them about correct use of medication/treatment procedures
- communicate and provide instructions in a way that is appropriate to the age and developmental stage of the young person

Strategies for Enhancing Compliance (1; 2; 3)

The following are practical strategies for promoting compliance with adolescent patients:

- **Listen to the young person's perspective and concerns** – e.g.
 - concern about how a treatment regime might disrupt their school or social life
 - embarrassment about the reactions of peers
- **Negotiate a mutually acceptable and flexible management plan**
 - consider the adolescent's development stage and concerns (e.g. peer pressure; need for independence from parents)
 - involve the young person in developing a treatment plan that is flexible and takes into account their lifestyle, and the broader priorities and realities of their everyday life (e.g. school; sports; peers)
 - be prepared to accept a less than optimal treatment plan (at least initially) so as to maximise the possibility of compliance
 - give the young person a choice in the management plan to be implemented
 - keep it simple and minimise the amount of medications that the young person needs to carry with them

- **Build motivation to comply**

- identify the pros and cons of different treatment options
 - discuss how likely they are to carry out the plan
 - identify possible barriers to compliance with the plan
 - identify what could assist them to comply
- (See also *Motivational Interviewing P. 64* for approaches to increasing patient motivation)

- **Promote and support the young person's decision-making**

- encourage the young person's autonomy and responsibility for following the treatment plan through

- **Educate the young person about the tasks to be performed in plain, jargon-free language**

- keep instructions brief, clear and simple
- repeat important points and check understanding by asking questions
- improve understanding and recall by asking them to repeat instructions
- provide opportunities for practising a task – e.g. use of an asthma puffer; correct use of a condom
- reinforce the information with written material and handouts
- where appropriate, also give the information to parents/caregivers

- **For NESB young people – ensure that their (and their parents’) level of English is proficient enough for them to understand the instructions**
 - if you are unsure, don’t accept what appears to be a “Yes, I understand” answer – e.g. a smile, a nod, a “yes”
 - ask them to repeat the instructions back to you, especially if more than one medication is involved
 - use the **Telephone Interpreter Service (TIS)** if you feel the instructions need to be explained in the patient’s language (*see Section 4 TIS contact details*)
 - also check whether traditional medicine is being used to identify any incompatibility with your prescribed medication
If unsure about this, contact NSW Transcultural Mental Health Centre – 02 98403899 or 1800 648911
- **Set short-term goals**
 - personalised goals provide motivation for complying with the treatment
 - set goals that are concrete and relevant to their current circumstances – such as being able to play sport; go on a camp; or attend a social event

Example: “Michael you said that you really want to go on the school camp this year. Let’s work on getting your asthma under control so that you will be able to attend the camp.”
- **Provide anticipatory guidance**
 - help the young person to identify obstacles and situations where it may be difficult to comply (e.g. pressure from friends; social situations)
 - explore these difficulties by working through realistic scenarios that they may encounter
 - assist the young person to identify strategies for dealing with barriers to compliance

Example: “Let’s have a look at what you could do about taking your medication if you are going to a party.”
- **Address associated problems**
 - help the young person to deal with other problems or concerns in their life beyond treatment issues – e.g. school or family problems; self esteem issues; anxiety/depression; lifestyle disruption
 - help the young person to develop a positive attitude toward their health problem/illness
- **Involve other key people**
 - where appropriate, involve parents and other family members in supporting the young person to carry out their treatment regime
 - ask *the young person* who they think could support them – such as a trusted friend or other significant person

- **Take into account the young person's financial situation**
 - many young people may lack money to pay for scripts
 - where possible, use samples with young patients
- **Address cultural factors**
 - enquire about cultural factors that may influence compliance in NESB young people – e.g. beliefs and attitudes about illness; values and norms about particular treatments – e.g. use of medications
 - with many NESB young people it is essential to involve the parents
 - this must be handled sensitively however, respecting the parents’ authority while supporting the young person’s growing need for independence
- **Maintain contact**
 - provide follow-up support via regular consultations, telephone contact, or by letter
 - encourage the young person to communicate about their successes and difficulties
 - monitor progress and provide feedback and positive reinforcement for their efforts in following the plan.
- **Respond to non-adherence** ^(1, 3)
 - acknowledge in a non-judgmental way that there may be non-adherence

Example: “Many people find it difficult to take their medication exactly as prescribed all of the time. How have you been going with the three times a day dose as we set?”

 - explore reasons for non-adherence in open-ended style
“What were some of the difficulties you had in taking your asthma preventer?”
“When are the times that you are best at remembering to take it?”
“What things help you to remember to take your medication?”
 - help the young person to identify strategies for overcoming their difficulties to compliance
 - praise them for their efforts and any small improvements
 - re-negotiate an alternative treatment regime if necessary

References:

1. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
2. Bennett, D. L. and Kang, M. Adolescence, in Oates K, Currow K, and Hu W. (2001) *Child Health: a practical manual for general practice*. MacLennan and Petty. Australia.
3. Watson, P. and Fleming, T. Enhancing compliance in adolescents. *Current Therapeutics*. Vol. 43, No. 3. March. 2002

CHAPTER 13. COLLABORATIVE CARE

Adolescent health problems are often complex and multidimensional. GPs need to collaborate closely with other health professionals and specialists to ensure a coordinated approach and continuity of care with young people.

Multidisciplinary Care

GPs are in a unique position within the primary health care system to coordinate the multidisciplinary care of a young person's health problems by:

- providing shared care in collaboration with allied health professionals, youth services and specialists
- formulating care plans and case conferencing under the new *Medicare EPC item numbers* to facilitate collaborative care (*see below*)
- facilitating referral to other services
- acting as a point of contact and advocating for the young person and their family in dealing with the health system
- providing case management – coordinating the input of other professionals and facilitating the young person's access to health services

Referral to Other Services

Complex psychosocial or physical problems may require referral to specialists or involvement of a multidisciplinary team. Referring an adolescent patient to other health service providers needs to be handled in a sensitive manner (1):

- explain why the referral is necessary
- be honest and inform them if you don't have the specialised skills required to deal with their problem

Example: *"I want to make sure that you get the best possible health care and I don't have the specialised skills needed to help you with this problem"*

- make the referral / appointment in collaboration with the young person
- support the young person if they are anxious – make the 'handover' as smooth as possible
- if possible, give them the name of a contact person at the other service
- explain if you need to provide information to other professionals (reassure confidentiality)
- tell them that you are available to see them again if they need help or are unhappy with the new service
- provide follow-up support and care where needed

Multidisciplinary Resources

To ensure that a young person receives optimal care, GPs need to establish a referral network of available local services. Some services that may be involved in provision of care to adolescents include:

- Youth workers
- Adolescent mental health service
- Psychiatrists
- Psychologists, Social Workers and other counsellors
- Drug and alcohol service
- Community health centre
- School counsellors; student welfare coordinators
- Youth accommodation services
- Department of Community Services
- Family planning / sexual health service
- Transcultural Mental Health Centre
- Bilingual Counsellors in mental health teams
- Other NESB-specific services
- Aboriginal health services
(*see Appendices for information on available services*)

Using the New Medicare Item Numbers

This section has been compiled with the assistance of Dr Leanne Rowe (2) and Ms. Verity Neunham of the National Divisions Youth Alliance (3).

Australian Medicare item numbers provide targeted incentive payments to GPs and practices separate to the current Medicare Rebate. Item numbers assist GPs to meet nationally identified health priorities and provide additional payments for specialised GP services.

Many Medicare items such as: the EPC care planning & case conferencing; mental health 3 step plan: asthma 3+ plan; diabetes annual care cycle; home (domiciliary) medicine review and cervical screening, may be used for young people.

During consultation with young people, the Medicare rebate in most cases remains at normal level B, C and D consultations and the new item numbers provide for:

- **Practice Incentive Payment (PIP)** – paid to the accredited general practice generally as a one-off payment to register and set-up administrative systems for use of the item
- **an increased Medicare rebate** – e.g. use of focused psychological strategies *and/or*

- **Service Incentive Payment (SIP)** – paid to the GP following the completion of requirements for that item (eg. completion of the 3 steps in the Mental Health or Asthma 3 step plans).

All Medicare item numbers have eligibility requirements and specific criteria attached to their use. GPs and general practices wishing to utilise these payments must familiarise themselves with the item and comply with the associated guidelines for GPs, practices and patients. Many of the guidelines revolve around the need to work from an accredited practice, patient eligibility criteria and practitioner registration with the initiative. All GPs may claim the care planning and case conferencing items.

In summary, Medicare item numbers have been introduced to enable GPs to:

- provide longer consultations and be better remunerated when dealing with some chronic adolescent health conditions
- deliver multidisciplinary health care to adolescents and
- target nationally identified health priorities

EPC- Care Planning and Case Conferencing

Enhanced Primary Care (EPC) item numbers – there are a number of EPC Items on the Medicare Benefits Schedule (MBS), including:

- Multidisciplinary care planning
- Multidisciplinary case conferencing
- Multidisciplinary discharge care planning and case conferencing

Care planning and case conferencing were introduced under the Enhanced Primary Care (EPC)

Medicare Items to:

- provide improved services to clients with chronic conditions and multidisciplinary care needs
- improve the coordination of GP services with other services in the community

Note: A chronic medical condition is one that lasts (or will last) for at least six months, or is terminal.

- *All GPs may claim the care planning and case conferencing items*

Chronic conditions in young people likely to last longer than 6 months which qualify for the items include:

- depression
- psychotic disorders
- anxiety/panic disorders
- drug addiction
- eating disorders
- learning disabilities
- trauma (past history of physical or sexual abuse)
- chronic medical conditions such as asthma and diabetes
- HIV, Hepatitis C and Hepatitis B

Sample forms

- GPs are required to complete a proforma for these items
- Case Conference and Care Plans are available from RACGP Online, Enhanced Primary Care Program – www.racgp.org.au

TABLE I – Medicare Item Numbers for use with young people.

Attendance Item	Group No.	Item Numbers
Care Planning	A.21	720 – 730
Case Conferencing by Consultant Physician	A.24	820 - 838
Case Conferencing (other than Specialist or Consultant Physician)	A.22	734 – 779
Family Group Therapy	A.13	170-172
Asthma 3+ Visit Plan	A.29	2546 – 2559, 2664 – 2677
Focused Psychological Strategies	A.31	2721 – 2727
Mental Health Process – Completion of 3 Step Process	A.30	2574, 2575, 2577, 2578, 2704, 2705, 2707, 2708
Cervical Smears	A.27	2501 – 2509, 2600 – 2616
Diabetes Mellitus, annual care cycle	A.28	2517 – 2526, 2620 – 2635
Domiciliary Medication Management Reviews	A26	900

CARE PLANS

Care planning Medicare items are used when the patient has a *chronic medical condition* and requires multidisciplinary input from at least *two other key health or other providers*.

- A care plan is a comprehensive longitudinal plan of action to meet the patient's multidisciplinary care needs
- Care plans are usually offered annually but are permitted after 6 months if the condition has changed
- Care plans help coordinate the patient's care more effectively
- Formulating a care plan involves:
 - diagnosis and identification of needs
 - establishing agreed upon goals
 - identifying service providers who can best meet the patient's specific needs and goals
 - contacting other service providers – by telephone, fax, email, video conferencing or face to face to discuss the care plan
 - obtaining the patient's consent to the management goals
 - proving the patient with a copy of the care plan
 - setting a time to review the achievement of goals
(see *Checklist* below)
- Alternatively, a *GP can contribute to a care plan* that has been developed by other health care providers
- See **Table 1** for a list of relevant Medicare Item Numbers

For more information see:

<http://www.health.gov.au/epc/careplan.htm>

- Contact your local Area Health Service or Division of General Practice for information regarding local service providers who could participate in Care Plans/Case Conferences - see Section 4 for list of services and contact details.

Care Plan Checklist:

Prior to the appointment:

- Check that the patient meets the criteria
- Check for existing care plans
- Identify and discuss the benefits of a care plan with the patient
- Inform the patient of any costs that will be incurred
- Inform the patient of other care providers to be involved
- Allow the patient to specify any information they do not want shared
- Obtain and record the patient's consent
- Decide if patient will be attending the session

At the session:

- Develop patient diagnosis/problem list
- Complete a bio-psycho-social assessment and identify patients needs
- Establish agreed goals with the patient, in relation to problems/needs
- Identify providers who can best meet patient's specific needs and goals
- Contact providers to discuss care plan; record their agreement to provide services.

To finalise care plan:

- Prepare a written care plan and summary, keep with the patient's record
- Advise patient and/or carer of outcomes and recommendations in care plan
- Give patient a copy of the plan
- Give each provider a copy of care plan identifying patient goals and their tasks
- Schedule date for review to assess achievement of stated goals.

Case Study – Care Plan

Adapted from <http://www.clockhealth.com.au>
 Kylie, aged 16 comes to see Dr Smith. She is clinically depressed, underweight and at risk of leaving home and school. She comes in for her repeat contraceptive pill prescription. Dr Smith notes that Kylie is withdrawn and difficult to engage and is concerned that she is at risk because she also admits to bingeing on alcohol. Dr Smith suggests that it may be helpful for Kylie to return for a longer time, to talk about her underlying problems and for Dr Smith to help her link with other services that may help her. He explains that he understands she is concerned about confidentiality and he would like to have time to explain how he may be able to help in detail. He also reassures her that he will ask for her written permission before he would contact her school, family or other service. She agrees and so Dr Smith arranges for the receptionist to book an appointment for a care plan.

At the care plan appointment and after reassuring Kylie about confidentiality, Dr Smith takes a psychosocial history using the HEADSS Assessment. Dr Smith finds that Kylie is:

- Moderately depressed;
- Having suicidal thoughts but does not have a plan;
- Having unsafe sex with her boyfriend;
- At risk of leaving home because of conflict with her parents;

- *Abusing alcohol and speed at parties;*
- *Smoking;*
- *Frequently missing school due to bullying.*

Dr Smith asks Kylie if she could think of ways that he could help her and offers the following suggestions and options for Kylie to think about:

- *Seeing Kylie regularly so that she receives treatment for her depression*
- *Providing her with information on condoms*
- *Providing information on alcohol and illicit drugs*
- *Providing information on nutrition*
- *Referral to a counsellor at the adolescent mental health service*
- *Referring her and her parents to a family mediator to help them sort out their conflict*
- *Contacting her student welfare coordinator or a trusted teacher to discuss ways to support Kylie at school;*

Dr Smith asks Kylie's consent to pursue some or all of these options. Kylie has agreed to:

- *see the student welfare coordinator to address her school problems*
- *come back to Dr Smith with her mother to talk about the family conflict and her depression*
- *attend the Adolescent Mental Health Service for an assessment*

He then asks the receptionist to book aside time the following day to make some phone calls. He telephones and gets agreement from each of the following: the student welfare counsellor will make a time to see Kylie; the Adolescent Mental Health Service will be able to see Kylie in 2 weeks and that the family is eligible for family mediation and could be seen in 3 weeks. He also contacts the drug and alcohol treatment service to request brochures on the National Alcohol Campaign and illicit drugs so that he can discuss this information with Kylie at the next appointment. He also notes that Kylie is due for a pap smear and will follow up her use of condoms and her smoking in the next consultation. Dr Smith writes this care plan and files it in Kylie's history to provide her with a copy at the next consultation and to ensure her permission is given before it is distributed to the Intake worker, student welfare coordinator and family mediator.

CASE CONFERENCES

A case conference is a meeting held between the GP and *at least two other health or community care providers* to jointly agree on the types of services a patient needs:

- All parties must be able to communicate with each other for the duration of the conference either face to face, by phone or videoconference
- A maximum of 5 case conferences may be arranged per year
- Different MBS item numbers apply, based on the length of the conference and the level of coordination/contribution by the GP – See **Table 1** for a list of relevant Medicare Item Numbers

For more information see:

www.health.gov.au/epc/caseconf.htm

CASE CONFERENCE CHECKLIST:

Prior to the appointment:

- Identify and discuss the benefits of the case conference with the patient
- Inform patient of any cost
- Inform patient of other care providers to be involved
- Allow patient to specify any information they do not want to be shared
- Obtain and record patient's consent
- Develop list of diagnoses/problems and identify patient's health needs and goals
- Involve patient and/or carer in case conference where possible

At the session:

- Introduce participants, establish who will lead discussion, confirm patient's consent
- Outline purpose and goals of conference, patient's problems, identified needs and goals
- Participants contribute additional information
- Identify care needs and outcomes to be achieved
- Develop agreed management plan, identify tasks and allocate to team members
- Arrange how and when the tasks will be reviewed

To finalise a case conference:

- Prepare a written summary and keep with the patient's record
- Discuss recommendations with patient and/or carer
- Give patient/carer a copy of summary of the conference
- Give each provider a copy of summary identifying patient goals and their tasks
- Schedule date for review to assess achievement of stated goals

Case Study – Case Conference

Adapted from <http://www.clockhealth.com.au>

Jill is a 15 year old patient with a learning disability, who has presented to Dr Smith with menorrhagia and dysmenorrhoea. Her mother is concerned that Jill is missing a significant amount of school due to menstrual problems but Dr Smith is concerned that there may be other issues behind her school refusal. Dr Smith suggests that it may be helpful for him to talk to the student welfare coordinator and her paediatrician. Jill and her mother agree.

- Dr Smith asks the practice nurse to contact the student welfare coordinator and paediatrician to organise a time for a teleconference
- At the teleconference, they discuss Jill's history and current needs. It becomes apparent that Jill is very anxious at school and has had a number of panic attacks at school
- Dr Smith agrees to review Jill to take a more detailed history and mood state
- The student welfare coordinator will see Jill for relaxation therapy and the Paediatrician has made a number of practical suggestions to help Jill's learning disability
- It also becomes apparent that Jill's parents have recently separated and that Jill's mother is depressed. Dr Smith will suggest that Jill's mother consult a psychologist.
- Dr Smith then writes a letter outlining the outcomes of the meeting and sends it to the student welfare coordinator, the paediatrician and to Jill and her mother
- He calls Jill and her mother about the outcome of the case conference and arranges a follow-up consultation.

Other Medicare Item Numbers for Use with Young People

For GPs to access the Practice Incentive Payment (PIP), they must first register with the *Practice Incentives Program (PIP) – Telephone 1800 222032* or visit the *HIC website www.hic.gov.au*

- See **Table 1** for a list of relevant Medicare Item Numbers

MENTAL HEALTH

- *What is the Better Outcomes in Mental Health initiative?*

The aim of the BOMHC Initiative is to support GPs in improving the quality of care provided through general practice to Australians with mental health illness by providing mental health education and training for GPs and more support for them from allied health professionals and psychiatrists.

The initiative includes the following components:

1. **Education and training for general practitioners** – GPs need to complete 2 hours training to familiarise themselves with the initiative and Level 1 mental health training to increase their mental health care skills and knowledge, to enable them to register for the 3 step process
2. **The 3 Step Mental Health Process** provides a framework for the management of mental health disorders in a primary care setting, by encouraging effective and holistic patient assessment, mental health planning and review. Eligible GPs who are registered with the HIC for the initiative, will receive a Service Incentive Payment for providing a 3 Step Mental Health Process

Important information on using the 3 step process:

- There must be a minimum of three consultations of more than 20 minutes each (*C or D consultations only*)
- At least 2 of the consultations must be planned visits
- At the *first visit*, the presenting complaint, a biopsychosocial history, a mental state examination, risk assessment and formulation/diagnosis are documented
- At the *second visit*, a written mental health plan is prepared in consultation with the patient
- The first and second consultations are billed as normal Level C or D consultations.
- At *visit 3* (within one to six months of the second consultation or the development of a mental health plan), the new MBS incentive item is charged for the review
- *Proforma are available to guide GPs through the 3 step process and are available through the Australian Divisions of General Practice website: www.adgp.com.au/site/index.cfm?display=1207*

3. **Focused Psychological Strategies (FPS) – GPs that complete 20 hours of accredited Level 2 training in FPS are eligible to receive an increased Medicare rebate for the treatment of mental health patients using FPS.**
4. **Access to Allied Health Services** - GPs registered with the initiative can access focused psychological strategies from specified allied health professionals employed by Divisions to support their patients with mental health problems through time-limited interventions.
5. **Access to Psychiatrist Support-** to better enable psychiatrists and GPs to participate in case conferencing and for psychiatrists to provide timely patient management advice.

ASTHMA

- At least three visits are required to complete an Asthma 3+ plan and at least 2 visits must be planned recalls within 4 months
- The 3 visits must achieve a diagnosis, assessment of severity, review of medication, provision of a written asthma plan and education of the patient.
- Similar to the mental health plan, the first and second visits are normal Level B, C or D items and the third visit is eligible for the new incentive item when the requirements are completed

DIABETES

- The Diabetes item is charged after an annual program of care including measurement of HbA1c, eye examination, body mass index measurement, blood pressure, examination of the feet, blood lipids, microalbuminuria
- Education must also be provided on self care, diet, physical activity, smoking and medication

CERVICAL SCREENING

- The item in relation to cervical screening may be charged when taking a cervical smear from a woman aged 20 to 69 years who has not had a test in the last 4 years
- This includes high risk young women presenting for their first cervical smear after age 20 years

HOME MEDICINES REVIEW (HMR)

- The HMR process involves GPs and accredited pharmacists working together with the patient to achieve safe, effective and appropriate use of medications by detecting and addressing medication-related problems that interfere with desired patient outcomes
- A HMR is available to any patient the GP believes would benefit from a HMR who is living in the community and has not received a HMR service within the last 12 months (unless they have undergone a significant change in condition/medication).

Those patients most likely to benefit are:

- Patients at risk of medication related problems because of:
 - comorbidities, age or social circumstances
 - the characteristics of their medication
 - the complexity of their medication treatment regime
- Patients recently discharged from hospital with changes to therapy.
- Suspected non-compliance or difficulties managing their medication related therapeutic devices

For more information about the use of the new Medicare items with adolescent patients visit the National Divisions Youth Alliance (NDYA) web site: <http://ndya.adgp.org.au>

NDYA is a national program managed under the auspice of the Australian Divisions of General Practice.

References:

1. Sanci, L. (2001) *Adolescent Health Care Principles*. Centre for Adolescent Health. The Royal Australian College of General Practitioners. Melbourne.
2. Rowe, L. and Hodges, C. *Adolescent Health – Easy as EPC*. Centre for Adolescent Health. University of Melbourne. 2003.
3. Newnham, V. *Overview of Item Numbers for Young People 12 – 25yrs*. Article prepared for the National Divisions Youth Alliance website. 2003.