Identifying and managing young people with mental health problems

Peer group discussion based on the young people's mental health series published in BPJ 71, (Oct, 2015); BPJ 72, (Dec, 2015) and BPJ 74, (Mar, 2016)

Adolescence is a time of physical and psychological maturation, changing social roles and greater independence and responsibility. It may bring increased exposure to risky behaviours involving sex, alcohol, drugs and motor vehicles, as well as worries about body image, relationships, peer pressure and educational achievements. From puberty the incidence of mental health conditions increases, including depression, anxiety, psychosis and suicidal ideation; young people in New Zealand have one of the highest rates of suicide in the developed world. Clinicians in primary care are in a unique position to help young people navigate this transition in life.

Risk factors for mental health issues in young people include childhood trauma, physical or sexual abuse, poverty and social deprivation. In addition, young people of Māori or Pacific ethnicity and those who identify as lesbian, gay, bisexual, transgender or intersex are at increased risk. Opportunistic assessment for mental health problems in primary care, e.g. with a HEADS assessment, is a key strategy to detect young people in need of assistance.

A strengths-based approach is useful to both prevent and treat mental health issues, and can form a part of every consultation with young people. This approach takes into account the person's circumstances and personal characteristics, e.g. aspects of their family environment, social circles and wider community connections, to encourage resiliency and promote wellbeing. Non-pharmacological strategies for preventing and treating mental health issues in all young people include advice on improving sleep, exercise and diet, all of which can influence their mood and psychological outlook.

For young people with anxiety or depression, psychological approaches are preferred first line treatments for patients with mild to moderate symptoms. These can include the use of self-help resources, such as online e-therapy tools, brief interventions in primary care, structured problem solving, counselling or therapies delivered by a trained psychologist such as cognitive behavioural therapy. For young people with severe symptoms of anxiety or depression, substance or alcohol use disorders, or eating disorders, referral to an appropriate service in secondary care is recommended.

In some circumstances young people with severe or ongoing depression may require antidepressant treatment alongside psychological treatment. There are no medicines currently approved for the treatment of depression in patients aged under 18 years in New Zealand, and clinicians should be mindful that adverse effects may be more common and more serious than in older patients, e.g. an increased risk of suicidal ideation.

Before trialling an antidepressant medicine, consider whether consultation with a child and adolescent psychiatrist is required, or an experienced colleague in primary care if this is not possible. Check that the patient is not already taking an antidepressant prescribed by another clinician and establish a plan for follow-up and monitoring.

Fluoxetine, initially 10 mg, daily, is the only medicine general practitioners should initiate for the treatment of depression in patients aged under 18 years, unless a child and adolescent psychiatrist recommends an alternative antidepressant. Fluoxetine can be increased to 20 mg, daily, after one week if necessary. Follow up should be weekly for the first month, then monthly.

Peer group discussion points:

1. Do you regularly assess young patients for mental health issues? Which tools have you found most effective and why?
2. What strategies do you use to encourage or facilitate engagement with young people about mental health issues?
3. Do you feel confident managing mental health issues in young people? Which aspects are particularly challenging? Have you had any training which helped improve your skills in this area?
4. Have you tried using structured problem solving with a young person with mental health issues? Have you found this an effective technique?
5. Do you prescribe antidepressants to patients aged under 18 years? If yes, which antidepressant is generally your first-line choice and why?
6. What plans for follow-up do you put in place when initiating an antidepressant?