Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds

GP RESOURCE KIT
2ND EDITION
Enhancing the skills of General Practitioners in caring for young people from culturally diverse backgrounds

GP RESOURCE KIT
2ND EDITION

caah
the children’s hospital at Westmead
NSW Centre for the Advancement of Adolescent Health

Transcultural
Mental Health Centre
Peter Chown  BSc Psych (Hons)  MAPS
Psychologist and Consultant, Bangalow Professional Centre, Bangalow; NSW CAAH Honorary Consultant

Peter Chown has 25 years experience as a Psychologist. He was formerly head of Cellblock Youth Health Centre - a pioneering multidisciplinary health service for adolescents at risk - at Camperdown Children’s Hospital, Sydney. Peter has extensive experience in the areas of adolescent health, the development of youth-friendly health services and programs and training of health professionals. He has worked as a consultant for the World Health Organisation, UNFPA and UNESCO on adolescent health programs in more than a dozen developing countries in Asia, Africa and the Pacific. He has written numerous publications on adolescent health for schools, GPs and counsellors. Peter works in private practice as a Psychologist in northern NSW, where he specialises in working with adolescents at risk and their families.

Dr Melissa Kang  MBBS MCH
Lecturer, Department of General Practice, The University of Sydney; NSW CAAH Honorary Consultant

Melissa trained in general practice and has worked exclusively in youth health since 1993. She has worked clinically in community and hospital settings, and currently works in a youth health centre with high risk and homeless young people. Her research activity covers adolescent sexual health (including her doctoral study on Chlamydia and other sexually transmitted infections), adolescent sexuality and access to primary health care among young people. Melissa teaches postgraduate courses in adolescent sexual health at the University of Sydney.

Melissa has worked extensively in training of professionals from a wide range of disciplines. Melissa has written the ‘Dolly Doctor’ column for Dolly magazine for the past 15 years and has appeared on national radio and television talking about young people and sexual health. She is a co-author of ‘Dolly Doctor: your body, your life, every question answered’, and ‘Dolly Doctor: the boy book’.

Dr Lena Sanci  MBBS PhD FRACGP
Senior Lecturer, Department of General Practice, The University of Melbourne

Lena trained as a GP then worked in youth health at the Centre for Adolescent Health in Melbourne. Here she completed a PhD in designing and evaluating an educational intervention for GPs in adolescent health care principles. This research won a prestigious award at the Society for Adolescent Medicine in North America. Lena now heads a Young People in Primary Care research stream in the Primary care Research Unit, Department of General Practice, University of Melbourne. Lena has been instrumental in developing curriculum and training resources in adolescent health for the Royal Australian College of General Practitioners and has helped deliver the national Dr-Link Program. She continues to be involved in researching the health of young people in primary care, teaching medical students and providing professional development for GPs in adolescent health.

Verity Newnham  B(Nurs) RN MRCNA
Research Assistant and Policy Adviser, PHCRED Practice Nurse Research Fellow
The Primary Care PARTY Project (Prevention, Access & Risk Taking in Young People)
Primary Care Research Unit, Department of General Practice, The University of Melbourne

Verity has a background in nursing, politics and adolescent health policy. She has previously worked as a PHCRED Practice Nurse Research Fellow, the Principal Advisor for Adolescent Health and Coordinator of the National Divisions Youth Alliance for the Australian Divisions of General Practice, as the Political Adviser for Youth Affairs for the Federal Parliamentary Labor Party and as a registered nurse and a youth and community development worker. Verity has also worked as a freelance consultant and website developer and is currently completing her Masters of Primary Health Care researching the role of practice nurses in adolescent health care. Her other research interests include systems innovation in general practice.

Clinical Professor David Bennett AO  MBBS FRACP FSAM
NSW CAAH Head, The Children's Hospital at Westmead

David has devoted his career to the practice and promotion of Adolescent Medicine, both within Australia and internationally. Having pioneered comprehensive and creative models of care for young people and their families at both primary and secondary/tertiary levels, he now works actively to advance the health of young people via professional training, applied research, networking and advocacy. David is the co-author, with Dr Leanne Rowe, of ‘What to do when your children turn into teenagers’ and ‘You can’t make me: Seven simple rules for parenting teenagers’ in addition to numerous other books, monographs, chapters and professional articles in the field of adolescent medicine.
acknowledgements

Ms Evelyn Camilleri
Administrative Officer, NSW Centre for the Advancement of Adolescent Health, for her tireless administrative support.

Dr Trina Gregory
GP, Member of the E-health Ministerial Advisory Group, Clinical Leaders Program National E-health Transition Authority and Hastings Maclay General Practice Network Mental Health Committee. Consultant, Complete Primary Care GP. For her contribution to reviewing the section on Collaborative Care and Medicare, and the Adolescent Health Check Template.

Mr Michael Janssen
Consultant, Complete Primary Care GP, for his contribution to reviewing the section on Collaborative Care and Medicare, and the Adolescent Health Check Template.

Ms Jan Kang
Program Coordinator, Global Health Institute, Diversity Health Institute, for her overall support of this project and feedback on drafts of the Kit.

Ms Rebecca Kang
NSW Law Reform Commission, for her review of the medicolegal chapter.

Dr Michael Kohn
Senior Staff Specialist, Department of Adolescent Medicine, The Children’s Hospital at Westmead, for his feedback on the section on eating-disorders (Chapter 10)

Ms Elaine Krek
Brand Manager, Endocrine Care Team, Pfizer Global Pharmaceuticals, Pfizer Australia, for providing the Growth Charts for inclusion in the Kit.

A/Prof Abd Malak
Executive Director, Workforce and Organisational Development Director, Diversity Health Institute, for his support of this project.

Ms Fiona Robards
Coordinator, NSW Centre for the Advancement of Adolescent Health, for her contribution to Section 1 (young people and their health needs statistics), and her amiable approach in coordinating this project.

Ms Linda Ramsbottom
Project Officer, Professional Education and Development, NSW Centre for the Advancement of Adolescent Health, for her contribution to ‘The role of Practice Nurses in working with Adolescents’ (Section 1).

Ms Adrine Santos
Adolescent Mental Health Projects Officer, Transcultural Mental Health Centre, for her support of this project.

Dr Robert Trigger
General Practitioner, Medical Educator, North Coast GP Training, for his practical ideas and feedback on the contents of the original Kit.

Dr Susan Towns
Senior Staff Specialist and Head, Department of Adolescent Medicine, The Children’s Hospital at Westmead, for her feedback on Chapter 11, ‘Adolescent with Chronic Conditions’.

Ms Wui-Ken Yap
Project Officer, Communications and Promotion, NSW Centre for the Advancement of Adolescent Health, for her energy and amazing organisational skills and creativity in supporting this project.

Northern Rivers General Practice Network, for providing feedback on the contents of the original Kit.

St George Division of General Practice, for organising the focus group discussion with GPs.
'Adolescent health: GP Resource Kit 2nd Edition' is a useful and practical tool for general practitioners, practice nurses and other health professionals working with adolescents. Adolescents are a challenging group to work with. For some, the relationships with health professionals are influenced by long term illness, developing maturity, changing life experience or the propensity for risk taking behaviours.

As children grow into young adults, they assume greater personal responsibility for accessing their own health care. Emphasis on whole person care within a biopsychosocial model is important and developing systems of care, both within the practice as well as within the consultation, can be difficult. This guide will assist general practitioners view their adolescent patients' needs within this complex therapeutic relationship and provides practical tips and techniques for intervention and care.

Associated Professor Ron Tomlins
Chair, National Standing Committee for Quality Care
The Royal Australian College of General Practitioners

General Practice NSW (GP NSW) is the State Based Organisation (SBO) for Divisions of General Practice in NSW. The role of GP NSW is to build the capacity of Divisions in their work of supporting general practice and promoting effective local health care provision. GP NSW does this by providing leadership, support and advocacy of Divisions and General Practice at a state level.

The majority of adolescent health problems result from exposure to health risks and lifestyle behaviours. A comprehensive approach to treatment is needed to address the complex nature of adolescent health issues as well as to promote healthy development of young people. GPs in Australia see approximately 2 million young people under the age of 25 each year during 11 million consultations. GPs are the most accessible primary health care provider for young people and usually their first point of contact with the health system.

GPs also face new challenges with more young people coming from a wider-than-ever range of culturally and linguistically diverse (CALD) backgrounds, including refugee youth - the Kit is designed to enhance the skills of GPs in caring for young people from culturally diverse backgrounds. The revised edition has also increased the emphasis on communication and youth-friendly consultation skills; revised and expanded sections on substance use, mental health, cultural competency, medico-legal issues, collaborative care, and the use of Medicare item numbers.

Given the evidence about usefulness of the first edition of the GP Resource Kit and our awareness of the training needs of GPs, the release of the second edition is timely. This Kit will serve as a valuable teaching resource for Divisions of General Practice, medical educators, GP education & training providers, University Medical Faculties, and youth health services.

GP NSW is therefore pleased to warmly endorse the Kit and encourage its use by GPs and the Divisions network.

Dr Linda McQueen
Chair
General Practice NSW (formerly Alliance of NSW Divisions)
contents

Introduction .................................................................................................................... 7

Section One – Understanding Adolescents ................................................................. 9
1. Young People and Their Health Needs ................................................................. 10
2. Adolescent Developmental Issues ......................................................................... 17
3. Cultural Diversity and Adolescence ....................................................................... 19
4. Adolescents and General Practice ........................................................................ 22

Section Two – Skills for Youth Friendly General Practice ......................................... 27
Chapter 1  Conducting a Youth Friendly Consultation .................................................. 29
Chapter 2  Conducting a Psychosocial Assessment ...................................................... 39
Chapter 3  Negotiating a Management Plan ................................................................. 47
Chapter 4  Conducting a Physical Examination ........................................................... 51
Chapter 5  Risk Taking and Health Promotion ........................................................... 55
Chapter 6  Medico-Legal Issues .................................................................................. 67
Chapter 7  Culturally Competent Practice ................................................................. 77
Chapter 8  Treating Substance Abuse ....................................................................... 85
Chapter 9  Sexual Health ............................................................................................ 95
Chapter 10 Adolescent Mental Health ....................................................................... 103
Chapter 11 Adolescents with Chronic Conditions .................................................... 127
Chapter 12 Enhancing Compliance ......................................................................... 135
Chapter 13 Collaborative Care and Medicare ............................................................ 139

Section Three – Creating a Youth Friendly Practice ................................................. 151

Section Four – Youth Health Resources and Contacts ............................................ 155
Appendix 1 .................................................................................................................. 165
Adolescent Health Check Template

Appendix 2 .................................................................................................................. 168
Youth Health Risk Assessment (HEEADSSS)

Appendix 3 .................................................................................................................. 172
Youth Friendly Practice Review
introduction

Guidelines for working with adolescents in general practice

This Kit is a practical guide to providing effective health care to adolescents in general practice. It identifies strategies and practical steps that GPs can take:

- for engaging and communicating effectively with adolescent patients
- for understanding the social and cultural diversity of adolescents
- for assessing young people’s health risks
- for management and follow-up of adolescent health problems
- for making medical practices ‘youth-friendly’ and accessible to young people

Adolescent health problems are often complex and require a comprehensive, biopsychosocial approach. This Kit outlines the skills needed for working with the young person and their family, while addressing the developmental, cultural and environmental factors that influence their health status.

Changes to the New Edition

Though the Kit is primarily focussed on the NSW situation, this updated version has been expanded to include more of an Australia-wide perspective - in terms of data, services and contact details. The majority of the content contained in the Kit is applicable to GPs working anywhere in Australia.

The GP Resource Kit can also be downloaded from the NSW CAAH website - www.caah.chw.edu.au

The Kit is divided into four sections:

Section One: Understanding Adolescents

provides an overview of:
- major health problems affecting young people
- adolescent developmental issues
- cultural diversity and the impact of culture on adolescent development

Section Two: Skills for Youth Friendly General Practice

provides strategies and skills for engaging and communicating with adolescents, as well as guidelines for:
- establishing a trusting relationship with young people
- conducting a psychosocial risk assessment
- understanding medicolegal issues
- cultural sensitivity in dealing with adolescent patients
- providing health education to reduce risk behaviours
- managing key adolescent health problems
- collaborative case management

Section Three: Creating a Youth Friendly General Practice

describes practical approaches for:
- creating a youth friendly and culturally sensitive practice
- improving young people’s access to GPs

Section Four: Youth Health Resources and Contacts

provides information on:
- youth health services
- resource and education materials
- useful websites and other contact information

Each chapter in the Kit begins with a ‘Flashcard’ which summarises the key practice points for that particular chapter.
Understanding Adolescents

This section provides a framework for understanding adolescents and their health needs. It also identifies the major issues to be addressed in order to make general practice more accessible for young people. It provides an overview of:

- Adolescent developmental issues
- Adolescent health problems
- The social and cultural diversity of young people
- Barriers young people face in accessing health care
- The key roles GPs can play in providing accessible, comprehensive health care to adolescents.
1. Young People and Their Health Needs

Young People in Australia

This Kit uses the terms ‘adolescents’ and ‘young people’ interchangeably to refer to the age group 12-24 years:

A snapshot of young people in Australia (based on the ABS 2006 Census):
- There are nearly 3.7 million young people aged 12-24 in Australia (1.9 million males and 1.8 million females) – representing 18% of the total population
- Approximately 116,698 Indigenous young people aged 12-24 made up 3.4% of young people
- In 2005, 68% of young people lived in major cities, 20% in inner regional areas and 9% in outer regional areas. Those living in remote and very remote areas accounted for just over 2% of young people

Culturally Diverse Young People

- Australia has large and growing numbers of young people from Culturally and Linguistically Diverse Backgrounds (CALD). Young people from culturally diverse backgrounds comprise:
  - those who were born overseas
  - those whose parents were born overseas

Young people born overseas
- In 2006 – 15.5% of Australian 15-24 year olds were born overseas.
- Of young people born overseas aged 15-24 – 6% were not proficient in speaking English.
- Of young people aged 15-24 who were born overseas – 74% came from non-English speaking countries.
- In 2006 almost 40% of overseas-born young people had arrived in Australia in the past five years

Young people whose parents were born overseas
- 41% of dependent Australian young people aged 13-24 indicated that one or both of their parents were born overseas.

Young people's ancestry
Table 2 shows data from the 2006 census on young people's ancestry – how young people themselves identify their cultural background – more than 60% of responses indicated an ancestry other than Australian. (NB. Multiple responses were possible).

| Table 1 - Dependent young people aged 13-24 whose parents were born overseas (2006 census) |
|---------------------------------|----------------|----------|
| Both parents born overseas      | 373,709        | 24.2     |
| Father only born overseas       | 134,279        | 9.5      |
| Mother only born overseas       | 105,540        | 7.4      |
| Both parents born in Australia  | 797,855        | 56.2     |
| Parents country of birth not stated | 37,521    | 2.6      |
| Total dependant young people    | 1,418,904      | 100.0    |

| Table 2 - The ancestry of dependent young people aged 13-24 (2006 census)* |
|-----------------|----------------|----------|
| Australian      | 681,150        | 36.3     |
| Australian Aboriginal | 7,540 | 0.4      |
| Other than Australian | 1,136,340  | 60.5     |
| Ancestry not stated | 53,021      | 2.8      |
| Total responses  | 1,878,051      | 100.0    |
| Total dependant young people | 1,418,904  |          |

* Based on number of responses. Multiple responses were possible - i.e. they could identify as having more than one cultural background.
Refugee Young People

The Diversity Health Institute describes a refugee as “an individual who has fled his or her home country due to a genuine fear of persecution based on race, religion, nationality, membership of a particular social groups or political opinion.”

The following tables 3 - 6 present data for humanitarian entrants (refugees) over the 5 year period from 1 Jan 2002 until 31 Dec 2006, obtained from the Settlement database of the Department of Immigration and Citizenship.

- The past five years has seen increasing numbers of young people arriving as humanitarian entrants in Australia
  - 25,083 young refugees aged 10 to 29 arrived in Australia from 2002 to 2006
  - 72% of all humanitarian entrants were under 30 years of age and 48% of humanitarian entrants were aged from 10 to 29 years old

Table 3 - Age and sex Distribution for Humanitarian Entrants (Refugees) in Australia 2002-2006

NSW and Victoria accepted more refugees than other states and territories over the same timeframe.

Table 4 - State Distribution of Humanitarian Entrants Arriving in Australia 2002-2006

- Over the past 5 years, refugees most frequently came from the Sudan, Iraq, Afghanistan, other Central and West African countries and former Yugoslavia

Table 5 - Top 10 Countries of Birth for Humanitarian Entrants Arriving in Australia 2002-2006

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudan</td>
<td>33.4%</td>
</tr>
<tr>
<td>Iraq</td>
<td>15.4%</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>10.0%</td>
</tr>
<tr>
<td>Other Central and West Africa</td>
<td>5.7%</td>
</tr>
<tr>
<td>Former Yugoslavia not further defined</td>
<td>3.9%</td>
</tr>
<tr>
<td>Iran</td>
<td>3.8%</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>3.5%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>3.1%</td>
</tr>
<tr>
<td>Kenya</td>
<td>2.6%</td>
</tr>
<tr>
<td>Egypt</td>
<td>2.4%</td>
</tr>
<tr>
<td>Others</td>
<td>16.2%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The most commonly spoken languages for newly arrived refugees were Arabic and African languages.

Table 6 - Top Ten Languages Spoken for Humanitarian Entrants Arriving in Australia 2002-2006

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>31.2%</td>
</tr>
<tr>
<td>African Languages, n</td>
<td>10.4%</td>
</tr>
<tr>
<td>Dari</td>
<td>7.5%</td>
</tr>
<tr>
<td>Dinka</td>
<td>6.3%</td>
</tr>
<tr>
<td>Assyrian</td>
<td>4.4%</td>
</tr>
<tr>
<td>Serbian</td>
<td>3.6%</td>
</tr>
<tr>
<td>Persian</td>
<td>3.3%</td>
</tr>
<tr>
<td>English</td>
<td>2.8%</td>
</tr>
<tr>
<td>OTHER LANGUAGES</td>
<td>2.6%</td>
</tr>
<tr>
<td>Burmese/Myammar</td>
<td>2.1%</td>
</tr>
<tr>
<td>Others</td>
<td>25.7%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Young People from Indigenous Backgrounds

- There were around 99,300 young people aged 15-19 of Aboriginal and Torres Strait Islander background that identified as indigenous in the 2006 Census
- This is 19% of the total population of Indigenous people in Australia and 3.5% of the total population of young people the same age
Adolescent Health Status

Young people have specific health problems and developmental needs that differ from those of children or adults:

- The causes of ill-health in young people are mostly psychosocial rather than biological.
- Young people often engage in health risk behaviours that reflect the adolescent developmental processes of experimentation and exploration.
- Young people often lack awareness of the harm associated with risk behaviours, and the skills to protect themselves.
- Young people lack knowledge about how and where to seek help for their health concerns.
- Developmental difficulties and conditions related to pubertal growth commonly occur in adolescence.

Young people’s health status is also strongly influenced by family, social and cultural factors as well as environmental hazards to which they are exposed, e.g.:

- socio-economic status
- cultural background
- family breakdown
- physical / sexual abuse and neglect
- homelessness

Key Adolescent Health Problems

The Australian Institute of Health and Welfare’s third comprehensive national report on the health of young people aged 12-24 years –Young Australians: Their Health and Wellbeing 2007 –, found that overall the health of young Australians has improved over the last 20 years.

However, significant numbers (around 22%) of young people experience major health problems, some of which may be life threatening.

Positive Health Trends

A number of positive health trends were identified:

- Death rates among young people aged 12-24 years halved over the last 20 years – largely due to decreases in deaths due to injury.
- Suicide and transport accident deaths declined by 40% and 35% respectively between 1995 and 2004.
- Large declines over the last decade in notification rates for a number of communicable diseases including measles, rubella, Hepatitis A and B, and for meningococcal disease since 2003.
- Declines in the prevalence of some chronic conditions, notably asthma and melanoma, over the last decade.

Deaths of Young People

In 2004, more than half of all deaths of young men and nearly half of young women aged 12-24 years were due to suicide, transport accidents or accidental drug overdoses (i.e. 788 deaths from these causes). These are all due to risk behaviours where earlier medical intervention may have prevented these deaths.

The leading causes of death and illness in the age group 12 – 24 years are:

- Accidents and injuries (both unintentional and self-inflicted)
- Mental health problems (depression and suicide)
- Behavioural problems (including substance abuse)

The following ‘snapshots’ provide an overview of key adolescent health problems among Australian young people:

Accidents and injuries

- Accidents and injuries account for more than two-thirds of all deaths among 12 – 24 year olds. This includes road traffic accidents, self-inflicted injuries and suicide.

Mental health

- Mental health and behavioural disorders account for 49% of the disease burden among adolescents.
- Mental health is an area where the situation of young people appears to be worsening.
- Up to 20% of adolescents suffer from a mental disorder at any given time.
- The rates of young people aged 18-24 years reporting high or very high levels of stress increased from 7% to 12% between 1997 and 2004-05 for males, and from 13% to 19% for females.
- In 2004, 272 young people aged 12-24 committed suicide.
- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004. These Australian trends are reflected in NSW rates as described in Table 7.
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW (Table 8).

- Hospitalisation rates for suicide attempts are consistently higher in females than in males.
**Substance use**

- In 2004, 17% of young people aged 12-24 years old were current smokers.
- 5% of 12-15 year olds, 22% of 16-19 year olds, and 27% of 20-24 year olds report having used marijuana in the last 12 months.
- Illicit drugs and alcohol are the risk factors accounting for the greatest amount of burden among young people aged 15-24 years.
- Overall, 31% of 12-24 year olds drank once or more a month, at levels that put them at risk or high risk of alcohol-related harm in the short term, and 11% drank at levels that put them at risk or high risk of alcohol-related harm in the long term.
- Table 9 shows the proportion of young people whose drinking leads to short and long term harm.

**Table 7** - Suicide and self-inflicted injury deaths by sex, persons of all ages and 15-24 years, NSW 1985 to 2004

**Table 8** - Attempted suicide hospital separations by sex, persons of all ages and 15-24 years, NSW 1989-90 to 2004-05

**Table 9** - Proportion of young people who drink at risky or high-risk levels for short-term and long-term harm, 2004
**Co-Morbidity**
- There is a strong evidence that the prevalence of co-morbid disorders is increasing among young people – especially substance abuse and mental health problems
- There is a high incidence of mental health disorders among young drug users
- In 2004–05, there were over 8,021 hospital separations for mental and behavioural disorders due to psychoactive substance use among young people aged 12–24 years

**Nutrition and physical activity**
- Up to 30% of males and 22% females 12–24 years old are overweight or obese
- Physical activity is declining in young people – in 2004-2005 only 46% on males and 30% females aged 15-24 participated in recommended levels of physical activity
- Only 26% of young people aged 12-18 eat the recommended 3 pieces of fruit per day
- Only 67% of males and 59% of females in Year 10 eat breakfast (NSW data)
- Related disorders, such as Type 2 Diabetes, are increasing

**Sexual health/ infectious diseases**
- Blood borne and sexually transmitted infections such as HIV, HPV, Hepatitis C and Chlamydia affect young people disproportionately
- Chlamydia is the main sexually transmitted infection among young people – notifications have steadily increased over time particularly between 2001 and 2005 when the rates for young people doubled – in 2005 over 50% of all Chlamydia notifications were for young people
- Notifications of gonococcal infection among young people have been increasing steadily, with a twofold increase for young people between 1995 and 2005 – in 2005, 43% of all gonococcal infection notifications were for young people
- The rates of Hepatitis A, B and C are declining. Most notifications for Hepatitis C are in the 18-24 year age group with an increase in females compared to males
- Teenager pregnancy and childbirth rates have declined since 1971 - however teenage abortions as a proportion of teenage pregnancies are among the highest in the Western world\(^1\). Pregnant young women and young mothers are more likely to smoke than older pregnant women and mothers

**Chronic Illness**
- Around 10-20% of adolescents have one or more chronic illnesses such as asthma; diabetes; cystic fibrosis

**Long-Term Medical Conditions**
- In 2004–05 – 63% of young Australians aged 12-24 reported a long term condition (i.e. ‘conditions lasting, or expected to last, 6 months or more’)
- Multiple long term conditions were reported by 34% of young people
- The most prevalent long-term medical conditions affecting young people are:
  - Hay fever (14%)
  - Short-sightedness (12%)
  - Asthma (9%)

**Physical and Sexual Assault**
- In 2005, 8.9% of young people were victims of an assault including physical and sexual violence – this prevalence rate was slightly higher for young people aged 15-19 (9.9%) than for those aged 20-24 (7.9%)

---

**Table 10 - Proportion of young people aged 15-24 years who are underweight, overweight or obese, 2004-2005**

<table>
<thead>
<tr>
<th></th>
<th>Underweight</th>
<th>Overweight (not obese)</th>
<th>Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-17 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24 yrs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Note:**
- Year 10 data for breakfast consumption
- Types of cancers are not identified in the Australian Institute of Health and Welfare (AIHW) data
- Australian National Drug and Alcohol Data Report (2006) shows a decline in reported injecting in young people aged 15-24 years
Who young people turn to when they need advice and support most commonly were – friend/s (86.4%), parent/s (74.2%) and a relative/family friend (64%). The Internet ranked fourth at 16.8%.

Socio-Cultural Factors Affecting Young People’s Health

Some groups of young people are disproportionately affected by particular health conditions and risks because of social, cultural and environmental factors, and socioeconomic disadvantage:

**Indigenous Young People¹**

- Death rates for indigenous young people are 4 times higher than non-indigenous young people
- The death rate for young indigenous males is twice the rate for young indigenous females
- 23% of indigenous Australians aged 18-24 have a disability or long term health condition – 1.5 times the rate of non-indigenous young people
- Young male indigenous people are treated in hospital for injuries due to assault at a rate 4 times greater than non-indigenous young people, while the rate for young indigenous females is 33 times that of non-indigenous females
- Young indigenous Australians are more likely to experience health risk factors such as obesity, physical inactivity, smoking, imprisonment, and lower educational attainment
- Hospital separations due to mental and behavioural disorders in selected states (Queensland; Western Australia; South Australia & Northern Territory) – are 1.6 times higher than that of other young Australians
  - the main disorders were schizophrenia (in males); substance abuse (including alcohol use); and reaction to severe stress and adjustment disorder
- 50% of Indigenous young people aged 18–24 years were daily smokers, compared with 26% of non-Indigenous young people
- Indigenous young people are less likely to access primary health care services and are more likely to access tertiary health care services than non-indigenous young people.

These inequalities reflect the relative social and economic disadvantage of many indigenous people and their lack of access to adequate and culturally appropriate health care¹⁴.
Young People of Culturally and Linguistically Diverse Backgrounds (CALD)

- Young people aged 15-24 years born overseas have lower mortality and morbidity rates than Australian-born youth – this may be due in part to the protective influence of family and cultural support.
- Some CALD 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, as well as exposure to traumatic experiences. These stressors include:
  - settlement and adaptation difficulties
  - English language difficulties
  - conflict between traditional cultural values and those of the new society
  - refugee experience
  - experience of torture or trauma
  - exposure to racism or discrimination
  - isolation
  - lack of access to culturally appropriate mental health services

Gay/Lesbian/Bisexual/Transgender (GLBT) Young People

- Evidence suggests that GLBT young people are exposed to increased risk of depression, substance use, isolation and injury due to violence.
- There is an increased risk of suicidal behaviour among young people who identify as gay, lesbian, bisexual or transgender.

Socio-economically Disadvantaged groups

- Young people who are socially and economically disadvantaged have higher death and hospitalisation rates.
- Young people aged 15–24 years in the most socially and economically disadvantaged areas of Australia had death rates almost twice as high as those from the least disadvantaged areas.
- Socioeconomic disadvantage can include low income, poor education, unemployment, limited access to health services, living in poor housing, and working in an unsafe, unrewarding and menial job.

Differences between males and females

- Young males are twice as likely to die than young females – mostly due to accidents and suicide.
- Rates of depressive disorders are 4 times higher for young females than for males.
- The rate of substance abuse disorders is twice as high for females.
- Male suicide rate is 3 times higher than female rate.
- Females are 2.5 times more likely than males to be hospitalised for self inflicted injuries than males.

Young Carers

- Approximately 300,900 people aged under 25 years (4.5% of all young people under 25 years) were caring for a household member with a long-term health condition or disability, or for an older household member in 2003.

Rural Young People

- Young people living in rural and remote areas make up some 31% of the total Australian population of 15-24 year olds.
- Young people living in rural and remote areas have higher death and hospitalisation rates than those in metropolitan areas.
- The death rates of young males from accidents, injuries and suicide increases markedly with increasing geographical remoteness.
- The death rates for young Australians in very Remote areas was almost 5 times that for Major Cities in 2002–2004.
- Young people aged 15 to 24 in very remote areas were admitted to hospital for injuries due to assaults at a rate 8.5 times that of young people in major cities.
- The proportions of risky and high risk drinking among 12–24 year olds increased with remoteness – from 30% in Major Cities to 37% in Remote and Very Remote areas.

Gay/Lesbian/Bisexual/Transgender (GLBT) Young People

- Evidence suggests that GLBT young people are exposed to increased risk of depression, substance use, isolation and injury due to violence.
- There is an increased risk of suicidal behaviour among young people who identify as gay, lesbian, bisexual or transgender.

Socio-economically Disadvantaged groups

- Young people who are socially and economically disadvantaged have higher death and hospitalisation rates.
- Young people aged 15–24 years in the most socially and economically disadvantaged areas of Australia had death rates almost twice as high as those from the least disadvantaged areas.
- Socioeconomic disadvantage can include low income, poor education, unemployment, limited access to health services, living in poor housing, and working in an unsafe, unrewarding and menial job.

Differences between males and females

- Young males are twice as likely to die than young females – mostly due to accidents and suicide.
- Rates of depressive disorders are 4 times higher for young females than for males.
- The rate of substance abuse disorders is twice as high for males.
- Male suicide rate is 3 times higher than female rate.
- Females are 2.5 times more likely than males to be hospitalised for self inflicted injuries than males.

Young Carers

- Approximately 300,900 people aged under 25 years (4.5% of all young people under 25 years) were caring for a household member with a long-term health condition or disability, or for an older household member in 2003.

Gay/Lesbian/Bisexual/Transgender (GLBT) Young People

- Evidence suggests that GLBT young people are exposed to increased risk of depression, substance use, isolation and injury due to violence.
- There is an increased risk of suicidal behaviour among young people who identify as gay, lesbian, bisexual or transgender.

Socio-economically Disadvantaged groups

- Young people who are socially and economically disadvantaged have higher death and hospitalisation rates.
- Young people aged 15–24 years in the most socially and economically disadvantaged areas of Australia had death rates almost twice as high as those from the least disadvantaged areas.
- Socioeconomic disadvantage can include low income, poor education, unemployment, limited access to health services, living in poor housing, and working in an unsafe, unrewarding and menial job.

Differences between males and females

- Young males are twice as likely to die than young females – mostly due to accidents and suicide.
- Rates of depressive disorders are 4 times higher for young females than for males.
- The rate of substance abuse disorders is twice as high for males.
- Male suicide rate is 3 times higher than female rate.
- Females are 2.5 times more likely than males to be hospitalised for self inflicted injuries than males.

Young Carers

- Approximately 300,900 people aged under 25 years (4.5% of all young people under 25 years) were caring for a household member with a long-term health condition or disability, or for an older household member in 2003.

Gay/Lesbian/Bisexual/Transgender (GLBT) Young People

- Evidence suggests that GLBT young people are exposed to increased risk of depression, substance use, isolation and injury due to violence.
- There is an increased risk of suicidal behaviour among young people who identify as gay, lesbian, bisexual or transgender.

Socio-economically Disadvantaged groups

- Young people who are socially and economically disadvantaged have higher death and hospitalisation rates.
- Young people aged 15–24 years in the most socially and economically disadvantaged areas of Australia had death rates almost twice as high as those from the least disadvantaged areas.
- Socioeconomic disadvantage can include low income, poor education, unemployment, limited access to health services, living in poor housing, and working in an unsafe, unrewarding and menial job.

Differences between males and females

- Young males are twice as likely to die than young females – mostly due to accidents and suicide.
- Rates of depressive disorders are 4 times higher for young females than for males.
- The rate of substance abuse disorders is twice as high for males.
- Male suicide rate is 3 times higher than female rate.
- Females are 2.5 times more likely than males to be hospitalised for self inflicted injuries than males.

Young Carers

- Approximately 300,900 people aged under 25 years (4.5% of all young people under 25 years) were caring for a household member with a long-term health condition or disability, or for an older household member in 2003.
2. Adolescent Developmental Issues

Definition of Adolescence

The developmental period between childhood and adulthood – beginning with the changes associated with puberty and culminating in the acquisition of adult roles and responsibilities.

Adolescence is a dynamic period of development characterised by rapid change in the following areas:

- physical – onset of puberty (physical growth, development of secondary sexual characteristics and reproductive capability)
- psychological – development of autonomy, independent identity and value system
- cognitive – moving from concrete to abstract thought
- emotional – moodiness; shifting from self-centredness to empathy in relationships
- social – peer group influences, formation of intimate relationships, decisions about future vocation

Adolescence is a biologically universal phenomenon. However, the concept of ‘adolescence’ is defined differently in different cultures:

- Cultural norms and life experiences (such as being a refugee) can affect the timing of developmental milestones (e.g. puberty) and expectations of what is considered ‘normal’ in terms of the adolescent’s response to these changes
- The expectations, roles and duration of adolescence can vary greatly between different cultures

The transition from childhood to adolescence is not a continuous, uniform process:

- While adolescence can be a stressful period, the majority of adolescents cope well with this developmental process and do not have any lasting problems.\(^{18}\)

The Experience of Puberty

Puberty involves the most rapid and dramatic physical changes that occur during the entire life-span outside the womb.\(^{19}\):

- 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
- It is important for GPs to be aware not only of normal pubertal development but also of its variations

See Section 2, Chapter 4 – Conducting a Physical Examination for more information about puberty.

Developmental Tasks

Adolescence is a developmental period in which the young person must negotiate fundamental psychosocial tasks in their development towards maturity and independence.

However, the nature of these tasks, and the importance placed upon their achievement, can vary greatly between Western and non-Western cultures.

From a Western cultural perspective, the major developmental tasks of adolescence are seen as:

- Achieving independence from parents and other adults
- Development of a realistic, stable, positive self-identity
- Formation of a sexual identity
- Negotiating peer and intimate relationships
- Development of a realistic body image
- Formulation of their own moral/value system
- Acquisition of skills for future economic independence
The Developmental Perspective of Adolescence

It is important for GPs to understand adolescents, their behavior and needs from a developmental perspective. Determining the developmental stage of the adolescent provides a guide to identifying:

- the adolescent’s physical and psychosocial concerns
- the young person’s cognitive abilities and capacity for understanding choices, making decisions and giving informed consent
- appropriate communication strategies – tailoring questions, explanations and instructions to the cognitive and psychological level of the adolescent
- appropriate interventions for treatment and health promotion

Stages of Adolescence

There are three main stages of adolescent development – early, middle and late adolescence. However, psychosocial development can be highly variable in terms of progression from one stage to the next:

- Age in itself does not define maturity in different areas of adolescent development
  - in any particular adolescent, physical, cognitive and psychological changes may be ‘out of sync’

Example: An early developing, mature-looking girl may be physically developed but psychologically immature and emotionally vulnerable. This presents the potential risk of early initiation of sexual intercourse before she has developed the cognitive and psychological capacity to fully understand the potential consequences.

The main developmental concerns, cognitive changes and psychosocial issues for each stage are summarized in Table 11.

<table>
<thead>
<tr>
<th></th>
<th>Early (10 – 13 years)</th>
<th>Middle (14 – 17 years)</th>
<th>Late (17-21 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Question</td>
<td>“Am I normal?”</td>
<td>“Who am I?”</td>
<td>“Where am I going?”</td>
</tr>
<tr>
<td>Major Developmental Issues</td>
<td>• coming to terms with puberty</td>
<td>• new intellectual powers</td>
<td>• independence from parents</td>
</tr>
<tr>
<td></td>
<td>• struggle for autonomy commences</td>
<td>• new sexual drives</td>
<td>• realistic body image</td>
</tr>
<tr>
<td></td>
<td>• same sex peer relationships all important</td>
<td>• experimentation and risk taking</td>
<td>• acceptance of sexual identity</td>
</tr>
<tr>
<td></td>
<td>• mood swings</td>
<td>• relationships have selfcentred quality</td>
<td>• clear educational and vocational goals, own value system</td>
</tr>
<tr>
<td>Main concerns</td>
<td>• anxieties about body shape and changes</td>
<td>• tensions between family and adolescent over independence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• comparison with peers</td>
<td>• balancing demands of family and peers</td>
<td>• deciding on career/vocation options</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• prone to fad behaviour and risk taking</td>
<td>• developing intimate relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• strong need for privacy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• maintaining ethnic identity while striving to fit in with dominant culture</td>
<td></td>
</tr>
<tr>
<td>Cognitive development</td>
<td>• still fairly concrete thinkers</td>
<td>• able to think more rationally</td>
<td>• longer attention span</td>
</tr>
<tr>
<td></td>
<td>• less able to understand subtlety</td>
<td>• concerned about individual freedom and rights</td>
<td>• ability to think more abstractly</td>
</tr>
<tr>
<td></td>
<td>• daydreaming common</td>
<td>• able to accept more responsibility for consequences of own behaviour</td>
<td>• more able to synthesise information and apply it to themselves</td>
</tr>
<tr>
<td></td>
<td>• difficulty identifying how their immediate behaviour impacts on the future</td>
<td>• begins to take on greater responsibility within family as part of cultural identity</td>
<td>• able to think into the future and anticipate consequences of their actions</td>
</tr>
</tbody>
</table>
3. Cultural Diversity and Adolescence

Many adolescents from Culturally and Linguistically Diverse backgrounds (CALD) face the challenge of dealing with the tasks of adolescence while growing up between two cultures. This involves not only two languages but often very different behavioral and social expectations:

- There may be great variation in cultural values and norms regarding the central tasks of adolescence – such as developing a sense of identity and independence.

Example: Within the Australian context, the achievement of independence and an individual identity are highly valued outcomes of adolescent development. This may conflict with the values of some cultures where a competent adolescent is primarily defined as someone who meets his/her obligations to their family.

- Young people tend to adapt to the values and ways of the new culture more readily than their parents do – so the adolescent may be torn between the family's expectations of them to maintain the values and customs of their 'old' culture, while striving to adopt the norms of the new culture in order to fit in with their peers.

- In some cultures, adolescence is a time of strengthening one’s family bonds and taking on increased responsibility and new roles within the family – young people may be more restricted than before and their activities closely monitored.

- Girls in particular may be subject to stricter controls – especially if parents feel threatened by their exposure to the values of the new culture.

- Traditional family roles may change due to the influence of the new culture – e.g. young people may have to adopt an adult role in the family because of their greater capacity with English and familiarity with social norms than their parents.

Identity Development

The development of a healthy individual identity is a major task of adolescence. Young people from CALD backgrounds face the additional challenge of deciding about their cultural identity.

This can lead to an identity crisis as the young person attempts to work out their affiliation to their culture of origin and their place within the dominant culture – e.g. “Am I Australian?” “Am I Chinese?” “Can I be both?”

It can also give rise to potential conflict with their family who may fear losing control of the adolescent.

Even second or third-generation children of migrants may still have an affiliation with their parents’ culture of origin and may therefore face issues related to ethnicity, identity, language and parents’ cultural mores.

Culture is a powerful influence on the development of one’s identity:

- Non-Western cultures generally place less emphasis on the importance of the individual – the family and ethnic identity are valued above the attainment of an individual identity, and play a central role in shaping the development of the adolescent’s identity.

The way in which adolescents resolve these ethnic identity conflicts has important implications for their mental health.

- Young people who manage to retain the most important elements of their ethnic culture, while developing the skills to adapt to the new culture, appear to cope best in their psychosocial adjustment.
Cultural Sensitivity

*Cultural sensitivity entails being aware of the wide range of diversity that exists, both across and within cultures. In order to provide good health care to young people from diverse cultural backgrounds, GPs need to:*

- understand that their assumptions, attitudes and beliefs about culture and different cultural groups are shaped by one's own cultural background and values
- be aware of how the young person’s cultural background may impact upon their developing adolescent identity
- adopt a respectful and non-judgmental approach in dealing with differing cultural norms and practices
- be careful not to label and make assumptions about the young person based on cultural stereotypes – for example, categorizing a young person as having particular cultural characteristics based solely on their parent’s country of birth, or adherence to cultural or religious practices
- consult with specialist CALD services or workers if unsure about cultural issues
- ask the young person themselves how they wish to identify themselves:

*Example:* “Thuy, you said that your parents were born in Vietnam and that you grew up here in Australia. How do you mostly think about yourself – as Australian or Vietnamese, or both?”

Culture plays a central role in shaping people’s identity, values, beliefs, social roles and behaviors. However:

- Within any given culture, there can be enormous diversity – with a variety of ethnic, language, educational, socio-economic and religious backgrounds
- It is misleading to assume that a definitive set of cultural attributes, attitudes, values and practices apply to all people from a particular cultural background
- Ask the young person if they identify with their parent’s culture – and in what ways do they identify with it?

Working with Aboriginal and Torres Strait Islander Young People

- GPs also need to be aware of the health issues and needs of indigenous young people and the impact of culture on the presentation, diagnosis and treatment of their health problems
- It is important to recognise that there is enormous diversity among Aboriginal people – there are many language groups; cultural meanings and practices are complex and vary widely regions and communities
- The concept of family in Aboriginal culture differs from traditional western concepts – it may be necessary to identify and involve important members of the young person’s extended family system in the consultation process
- Where available and appropriate, consult with Aboriginal-specific health services – especially if unsure about what cultural issues might be influencing a clinical presentation

resources

- For further information on the health of indigenous young people – see the [RACGP website](http://www.racgp.org.au) – go to ‘Aboriginal and Torres Strait Islander Health Unit’
- See also, [Royal Australasian College of Physicians (RACP) website](http://www.racp.edu.au) – go to ‘Publications and Communications’
- [National Aboriginal Community Controlled Health Organisation (NACCHO)](http://www.naccho.org.au)
- For details of [Aboriginal Medical Services in each state](http://www.health.gov.au) – see the Department of Health and Ageing website: go to ‘For Consumers’; then click on ‘Indigenous Health’

Culture and Health

*CALD young people may be exposed to a variety of stressors associated with:*

- the conflict of identity between the dominant culture and their family’s culture
- migration
- uncertainty of resettlement
- social isolation
- adaptation to a new culture
Understanding the Role of Family in Different Cultures

Sensitivity is also needed in dealing with the parents of CALD young people:

- In CALD families, parents are usually the first point of contact for reaching adolescents – therefore their support and participation is essential.
- People from a CALD background may have very different expectations and attitudes about health, help-seeking behavior and the role of the doctor, for example:
  - there may be a cultural perception that a GP’s role is to stick to medical complaints and provide medical treatment rather than spend time engaging the young person in conversation.
- Approaches that would normally be adopted with adolescent patients such as confidentiality, seeing the young person alone, and encouraging independent decision-making by the young person may contradict family and cultural values, and so need to be handled carefully.
- The parents and young person may both need information to help them understand adolescence and adolescent development – explain the doctor’s role in treating the young person and respect the parents’ need to remain actively involved, should they wish to do so.

Culture as a Protective Factor

A young person’s experience of belonging to or identifying with a particular culture can also be a major protective factor in promoting their overall wellbeing:

- this sense of belonging, identity and support enables young people and their families not only to survive the hardships, traumas, and losses associated with migration and resettlement, but in fact to be strengthened by these experiences.
- a strong cultural identification enhances the adolescent’s resilience.

The GP’s Role

While it is important to understand cultural influences operating in the young person’s life, it is also important to:

- treat each patient as an individual.
- ask how the young person identifies themselves within mainstream culture and their own culture.
- enquire about the young person’s own particular experiences, cultural beliefs and health practices.
- enquire about traditional cultural views of the causes of illness.
- ask about the beliefs and history of their family – where this is appropriate for gaining a better understanding of the young person’s complaint and background factors that may be influential.

resources

- The **Diversity Health Institute** offers a wide range of multicultural health information: [www.dhi.gov.au](http://www.dhi.gov.au)
- The **Transcultural Mental Health Centre (TMHC)** provides consultation, training and information services to health professionals on transcultural mental health, as well as service provision to people from CALD backgrounds – go to Diversity Health website: [www.dhi.gov.au](http://www.dhi.gov.au) – click link to Transcultural Mental Health Centre.
- See Section Four – for contact details of other resources and service providers in multicultural health.
4. Adolescents and General Practice

GPs are ideally placed to respond to young people’s complex health problems by providing comprehensive health care, and acting as a first point of call in the identification, treatment, follow up and referral of adolescent health problems:

- GPs see approximately two million young people under the age of 25 each year during 11 million consultations
- GPs are the most accessible primary health care provider for young people and usually their first point of contact with the health system
- Young people themselves perceive doctors as one of the most credible sources of health information

However, young people are often reluctant to visit doctors:

- Young people are fearful and embarrassed about discussing sensitive issues such as sexuality, drug use or other psychosocial problems
- Young people are concerned about lack of privacy and confidentiality
- Many young people believe GPs treat only physical ailments, and are unaware that GPs might be able to help them with emotional and psychosocial concerns

Young people often present to GPs with relatively minor complaints:

- The three most common reasons young people consult a GP are for respiratory, skin, and musculoskeletal conditions
- Yet the main causes of adolescent morbidity are psychosocial and behavioural – this discrepancy highlights the fact that young people frequently don’t present to GPs with the problems that are most critical to them.

Major barriers exist to young people obtaining appropriate and timely health care:

- Young people face administrative, psychological and financial barriers to accessing GP services
- This lack of access to health services has been identified as a significant contributor to adolescent morbidity and mortality.

GPs are ideally placed to provide the type of comprehensive health care that young people’s complex health problems require:

- GPs are the most visible primary health care provider
- GPs act as a gateway to the health system and can facilitate young people’s access to other required health and support services
- The quality of an adolescent’s initial contact with a GP influences the way they perceive the health system and their future pattern of utilising health services
- GPs can overcome barriers to young people’s access by making their services and consultations youth friendly

Barriers for Young People

“….You go to someone you know and trust and they know you.”

Numerous studies have identified major barriers to young people’s access to appropriate health care are:

Confidentiality

- The most significant barrier identified by young people is fear about confidentiality and trust. This includes concerns about:
  - the GP disclosing information to their parents
  - lack of privacy in the waiting room
  - reception staff not protecting their confidentiality

GP attitudes and communication style

- Concerns that GPs will have unsympathetic, authoritarian and judgmental attitudes
- The GP’s approach and communication style has a significant impact on the young person’s comfort level and ease of communication

Access and clinic environment

- The clinic environment can have a negative impact on adolescents’ comfort in using the service
- Many young people feel intimidated by:
  - a formal clinic and waiting room environment
  - appointment booking procedures
  - perceived lack of sensitivity and awareness on the part of reception staff.
- Clinic opening hours and long waiting times can lead to young people foregoing health care
The key roles that a GP can play in providing comprehensive health care to adolescents are described in greater detail in Sections Two, Three and Four of this Kit as follows:

- **Provision of comprehensive health care appropriate to the adolescent’s developmental needs and sociocultural background:**
  - Managing the interaction with the young person by devoting the necessary time and using developmentally appropriate communication skills to effectively engage them
  - Providing developmentally appropriate treatment and prevention strategies
  - Providing anticipatory guidance about health matters in simple, clear language
  - Adopting a culturally sensitive approach respectful of the individual and their family

- **Detection, early intervention and education for health risk behaviours:**
  - Screening, identification, and management of psychosocial risk factors and behaviours
  - Using consultations to provide education about health risks and to promote protective behaviours
  - Addressing the social and environmental risk factors in the young person’s life by working with the family, school, and other key people in their lives
  - Providing appropriate treatment of common adolescent health problems

- **Promoting young people’s access to health services:**
  - Making GP practices ‘youth friendly’
  - Acting as a gateway to the health system by helping young people to access other services they require – e.g. specialists; youth workers; psychologists
  - Ensuring that your practice is culturally sensitive in its service provision to young people
- Helping to reduce the barriers young people face in accessing services – especially for young people at high risk and with co-morbid health problems
- Advocating for young people's health needs within the health system, their families, schools, and wider community

Adopting a collaborative approach to patient management
- Promoting effective multidisciplinary health care by ensuring appropriate referral, and coordination with other health professionals involved with the young person
- Effectively using the relevant Medicare item numbers to facilitate the young person's pathways to care – in particular, the use of a GP-Managed Mental Health Care Plan to improve access to mental health services

See Chapters 7, 13 & Section Three

The Role of Practice Nurses in Working with Adolescents
- A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a GP
- Practice nurses are often utilised in general practice to provide initial assessment of patients and for their clinical nursing skills
- The perceived approachability of nurses can be particularly effective in interactions with adolescents as the nurse’s clinical and counselling skills effectively complement the GPs’ role
- Many patients see the GP’s time as more valuable than the practice nurses, and may feel that the nurse is more available to listen to their health concerns – this access can assist in building the rapport necessary to engage the young person and can help to uncover underlying reasons for the patient's visit

See Chapter 13 & Section Four

practice points
- The majority of adolescent health problems are psychosocial – a consequence of health risk behaviours, mental health problems and exposure to social and environmental risk factors
- The leading causes of death and illness in the age group 12 – 24 years are:
  - Accidents and injuries
    – both unintentional and self-inflicted
  - Mental health problems
    – depression and suicide
  - Behavioural problems
    – including substance abuse
- Co-morbidity is common with the occurrence of one health problem raising the risk for a subsequent problem
- Adolescence is a dynamic period of development characterised by rapid physical, psychological, cognitive and social changes
- It is important to determine the developmental stage of the adolescent as a guide to identifying their physical and psychosocial concerns, and to providing appropriate communication, education and intervention strategies
- Young people from Culturally and Linguistically Diverse backgrounds (CALD) face the challenge of dealing with the tasks of adolescence while growing up between two cultures
- CALD young people may be exposed to a variety of stressors that negatively affect their health, including – migration and resettlement difficulties; exposure to trauma as a refugee; social isolation; identity conflicts
- The GP needs to adopt a culturally sensitive approach in dealing with the young patient and their family
- GPs have a key role to play in providing comprehensive health care to adolescents by providing developmentally appropriate consultation and treatment and facilitating a collaborative treatment approach with other service providers

See Chapters 7, 13 & Section Three
Resources

Key Text Books:

Key Organisations:
- NSW Centre for the Advancement of Adolescent Health (NSW CAAH)
  Tel: 02 98453338 – www.caah.chw.edu.au
  - a technical support agency providing a range of education, training, information and resources on youth health issues
- The Diversity Health Institute offers a wide range of multicultural health information and resource, including the Transcultural Mental Health Centre (TMHCC) – www.dhi.gov.au
- The Centre for Adolescent Health, University of Melbourne
  Tel: 03 93455890 – www.rch.org.au/cah
  - provides clinical services; community programs; training, research; resources and distance education programs in Adolescent Health

References:

2. ABS, Census of Population and Housing, Australia (2007). 34150DS0018 Migrants, 2006, Table 3.1 Age group, by country of birth and proficiency in spoken English and year of arrival.
23 Booth, M. et al. (2002). Access to health care among NSW adolescents. NSW Centre for the Advancement of Adolescent Health. The Children's Hospital at Westmead. NSW.
section two

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.”

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.

In this section of the Kit you will find practical information about:

- Skills and strategies for engaging and communicating with adolescents:
  - establishing a trusting relationship with the young person
  - conducting a youth-friendly consultation
  - providing developmentally appropriate intervention
  - adopting a culturally sensitive approach
- Guidelines and approaches for the assessment and management of key adolescent health problems:
  - Risk taking behaviour
  - Substance use
  - Sexual health
  - Mental health
  - Chronic conditions
- Common medico-legal issues and dilemmas in working with adolescents
- Provision of multidisciplinary health care:
  - using the Medicare item numbers to promote young people’s access to services and promote effective collaboration with other health care providers
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:

◆ Be proactive in managing the interaction with the individual young person through devoting time and using communication skills appropriate to the young person's developmental stage
◆ 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 HEEADSSS assessment tool to screen for psychosocial risk factors in the young person's life

See Chapter 2 – Conducting a Psychosocial Assessment

◆ 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
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.

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.

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.

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.

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 observe how they interact with each other
  - facilitate communication between the parent and adolescent

◆ 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 both to 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
Defining Confidentiality

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

Once you are 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 (e.g. receptionists, other GPs) will also keep their health information (e.g. the medical record, pathology results) confidential within the practice

Confidentiality – Exceptions

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

- If the young person discloses suicidal intent or is threatening significant self-harming behaviour
- If someone else is threatening or harming them (e.g. physical, sexual or emotional abuse)
- If the young person is at risk of physically harming someone else (e.g. assault, abuse)

There may be other reasons for breaching confidentiality (e.g. 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

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:
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?”

- If the young person has come to see you by themselves, compliment them for their initiative

- 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.”

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

Accidental breaches of confidentiality

- Confidentiality can be accidentally breached if a GP or practice staff contact the young person at home

- Ask the young person about the best way to contact them with test results, accounts, reminders, etc.; or ask the patient to phone your office

Example: “Rebecca, I’d 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

It is important to be sensitive in how you explain these limits to confidentiality – especially if it is the first occasion you are seeing the young person

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

See Chapter 3 – Negotiating a Management Plan – for further information on dealing with parents
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 his home and school life, and his interests. Spend time trying to establish a relationship with Michael by asking about his interests and what it’s like for him living in the youth refuge:

“Tell me a little bit about yourself…”
“What are your interests? What do you like to do in your free time?”

You can follow this up with specific questions about home, school, friends, activities, etc.

Identify and agree upon which issues, if any, should be discussed with parents/guardians and decide how to do this

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

“Michael, I’m happy to go slowly and use the time today to get to know you a bit until you feel more comfortable talking with me – unless there is something really important or urgent that you’d like to talk about today. Otherwise, I’d like to make another appointment to see you again soon. How is that for you?”

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

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

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

Identify and agree upon which issues, if any, should be discussed with parents/guardians and decide how to do this

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 his home and school life, and his interests. Spend time trying to establish a relationship with Michael by asking about his interests and what it’s like for him living in the youth refuge:

“Tell me a little bit about yourself…”
“What are your interests? What do you like to do in your free time?”

You can follow this up with specific questions about home, school, friends, activities, etc.

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

“Michael, I’m happy to go slowly and use the time today to get to know you a bit until you feel more comfortable talking with me – unless there is something really important or urgent that you’d like to talk about today. Otherwise, I’d like to make another appointment to see you again soon. How is that for you?”

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 CALD 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

Assess the Young Person’s Developmental Stage

- 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

Provide reassurance – this helps to validate the adolescent’s feelings and establish your role as an advocate for them:

- 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

Assess the Young Person’s Developmental Stage

- Be sensitive to the 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?

See Chapter 7 – Culturally Competent Practice – for approaches to working with young people from other cultural backgrounds

See Chapter 5 – Risk Taking and Health Promotion

See Practice Points - Table 1
Table 1 - Adolescent Developmental Stages

<table>
<thead>
<tr>
<th>Central Question</th>
<th>Early (10 – 14 years)</th>
<th>Middle (15 – 17 years)</th>
<th>Late (&gt;17 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Am I normal?”</td>
<td>“Who am I?”</td>
<td>“Where am I going?”</td>
</tr>
<tr>
<td>Major Developmental</td>
<td>coming to terms with</td>
<td>new intellectual powers</td>
<td>independence from</td>
</tr>
<tr>
<td>Issues</td>
<td>puberty</td>
<td>new sexual drives</td>
<td>parents</td>
</tr>
<tr>
<td></td>
<td>struggle for autonomy</td>
<td>experimentation and risk</td>
<td>realistic body image</td>
</tr>
<tr>
<td></td>
<td>commences</td>
<td>taking</td>
<td>acceptance of sexual</td>
</tr>
<tr>
<td></td>
<td>same sex peer</td>
<td>relationships have</td>
<td>identity</td>
</tr>
<tr>
<td></td>
<td>relationships</td>
<td>selfcentred quality</td>
<td>clear educational</td>
</tr>
<tr>
<td></td>
<td>all important</td>
<td>need for peer group</td>
<td>and vocational goals,</td>
</tr>
<tr>
<td></td>
<td>mood swings</td>
<td>acceptance</td>
<td>own value system</td>
</tr>
<tr>
<td>Cognitive development</td>
<td>still fairly</td>
<td>able to think more</td>
<td>developing mutually</td>
</tr>
<tr>
<td></td>
<td>concrete thinkers</td>
<td>rationally concerned</td>
<td>caring and responsible</td>
</tr>
<tr>
<td></td>
<td>less able to understand</td>
<td>about individual</td>
<td>relationships</td>
</tr>
<tr>
<td></td>
<td>subtly</td>
<td>freedom and rights</td>
<td></td>
</tr>
<tr>
<td></td>
<td>daydreaming common</td>
<td>able to accept more</td>
<td></td>
</tr>
<tr>
<td></td>
<td>difficulty identifying</td>
<td>responsibility for</td>
<td></td>
</tr>
<tr>
<td></td>
<td>how their immediate</td>
<td>consequences of own</td>
<td></td>
</tr>
<tr>
<td></td>
<td>behaviour impacts on</td>
<td>behaviour</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the future</td>
<td>begins to take on</td>
<td></td>
</tr>
<tr>
<td>Practice Points</td>
<td>Reassure about normality</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ask more direct than</td>
<td>Address confidentiality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>open-ended questions</td>
<td>concerns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Make explanations</td>
<td>Always assess for health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>short and simple</td>
<td>risk behavior</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Base interventions</td>
<td>Focus interventions on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>needed on immediate or</td>
<td>short to medium term</td>
<td></td>
</tr>
<tr>
<td></td>
<td>short-term outcomes</td>
<td>outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Help identify possible</td>
<td>Relate behaviours to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>adverse outcomes if</td>
<td>immediate physical and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>they continue the</td>
<td>social concerns – e.g.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>undesirable behaviour</td>
<td>effects on appearance,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>relationships</td>
<td></td>
</tr>
</tbody>
</table>

- 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 CALD adolescents

See ‘Cultural Diversity and Adolescence’ – Section One

**Specific Interviewing & Communication 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 CALD 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**

- Actively encourage the young person to talk – listen for 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

◆ 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: 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…”

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 – these are questions that ask the adolescent to reflect upon themselves and describe abstract feelings or concepts
- they 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 views 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 I were to ask your friends, how do you think they would describe you?”
“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?”

Scaling Questions – asking the young person to give a rating on a scale is a useful way of eliciting feelings or moods, or for describing the severity of a symptom of a problem. They are also useful in making comparisons and help the patient to monitor their progress towards achieving treatment goals

Examples:
“On a scale of 1 to 10, with 1 being the worst you feel and 10 being really great and positive, how would you rate your mood today?”
“On a scale of 1 to 10, how angry (depressed, anxious, sad) have you felt on average over the last week?”
“On a scale of 1 to 10, where 1 means little or no control and 10 means total control, how would rate your control over your anger since I last saw you?”

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

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

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?”

See also ‘Asking Sensitive Questions’ – Chapter 2 – Conducting a Psychosocial Assessment
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…”

“When you realised you had to come, you thought…”

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

“But 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…”

Normalising questions or ‘third-person’ approach – by reducing the personal focus of your questions, you can normalise their behaviours and 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?”

“Some young people your age are starting to try out alcohol or drugs. I’m wondering if any of your friends have tried these. What about yourself?”

resources

- NSW Centre for the Advancement of Adolescent Health (NSW CAAH) website has a range of resources for health professionals working with young people and useful links – www.caah.chw.edu.au
- The Centre for Adolescent Health, University of Melbourne – provides training, research, resources and distance education programs in Adolescent Health – www.rch.org.au/cah

practice points

- The key to effective consultation with adolescent patients is the establishment of a supportive and trusting relationship – spend time engaging the young person and building rapport
- Identify the young person’s developmental stage in order to tailor communication, questions and instructions to the appropriate developmental level
- Always explain the terms of confidentiality, and its limits, to the young person at the initial consultation
- Where possible, see the young person on his or her own, even if briefly
- Be sensitive to the young person’s cultural background, values and norms
- Use an interactive style of communication – involve them in decision-making, encourage them to ask questions and foster their participation in the consultation process

References:

This chapter has drawn on the following sources:

chapter two

Conducting a Psychosocial Assessment

For adolescents, a psychosocial assessment of their functioning in key areas of their lives is at least as important as the physical exam\(^1\).

Psychosocial, behavioural and lifestyle problems are the major causes of adolescent morbidity and mortality (See Section One – Key Adolescent Health Problems). Yet adolescents rarely choose to see a GP for psychosocial issues such as drug use, sexual health, mental health, school or family problems\(^3\).

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 ‘HEEADSSS’ Assessment

The HEADSS \(^1\) 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.

The HEEADSSS assessment gives the GP a structure for\(^2\):
- 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

For adolescents, a psychosocial assessment of their functioning in key areas of their lives is at least as important as the physical exam\(^1\).

Psychosocial, behavioural and lifestyle problems are the major causes of adolescent morbidity and mortality (See Section One – Key Adolescent Health Problems). Yet adolescents rarely choose to see a GP for psychosocial issues such as drug use, sexual health, mental health, school or family problems\(^3\).

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 ‘HEEADSSS’ Assessment

The HEADSS \(^1\) 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.

**The HEEADSSS assessment gives the GP a structure for\(^2\):**
- 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 HEEADSSS**

- Before starting the consultation, reassure the young person about confidentiality
- **HEEADSSS** 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 **HEEADSSS** 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 **HEEADSSS** 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 HEEADSSS – below**

\(^1\) HEADSS
\(^2\) HEEADSSS
\(^3\) Additional categories have been recently added to reflect the major causes of adolescent morbidity and mortality.
With Current Patients:

- **HEEADSSS** provides an ideal format for a preventive health check
- A **HEEADSSS** 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 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:

- **HEEADSSS** provides a framework for engaging the young person while taking a full history
- Any young person presenting with a psychosocial complaint (e.g. mental health issue; behavioural problem; sexual health) requires a full **HEEADSSS** 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 **HEEADSSS** 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, CALD 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
  - there may be conflict or violence in the home environment
- Request permission to ask sensitive questions:

  **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 **HEEADSSS** 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
- The **HEEADSSS** assessment will form part of your overall comprehensive assessment of the young person – supplementing the information you gather in your initial interview and rapport-building with the young person, as well as the physical examination, should you conduct one with the young person

**Addressing Specific Health Problems**

- Refer to individual chapters in the Kit for approaches to treating specific health problems identified in your assessment – e.g.:
  - Chapter 8 – Treating Substance Abuse
  - Chapter 9 – Sexual Health
  - Chapter 10 – Mental Health
  - Chapter 11 – Chronic Conditions

**Know your Adolescent Resources**

- Many adolescent health problems (especially complex, co-morbid problems) require a multi-disciplinary approach and referral to allied health professionals or specialist services
- Familiarise yourself with local resources and services for young people, and relevant allied health professionals – e.g.
  - Youth-specific resources – such as youth health centres, youth refuges, hospital based adolescent units
  - Other services relevant to young people’s needs – e.g. alcohol and drug services, sexual assault centres, mental health services, family counselling programs, psychologists and social workers

**Risk Assessment**

- The **HEEADSSS** assessment can be used to specifically screen adolescent patients for risk behaviours and to identify social and environmental risk factors in their lives
- This will enable you to plan appropriate interventions for reducing risk behaviours and addressing risk factors

**See Chapter 4 – Conducting a Physical Examination**

**See Adolescent Health Check pro-forma to document the data you gather about the young person so as to develop a comprehensive profile of the client’s psychosocial background, health issues and areas for intervention**

**See Chapter 5 – Risk Taking and Health Promotion**

**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

**See Section Four – for resources and contact details of specialist services**

**See Chapter 13 – Collaborative Care**

**Further History**

**See Chapter 13 – Collaborative Care**
A Guide To Using HEEADSSS

The following questions provide a guide to conducting a HEEADSSS assessment with a young person. You can use the form contained in Appendix 2 for recording the young person's responses to these questions:

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>H - Home</td>
<td><strong>Explore home situation, family life, relationships and stability:</strong></td>
</tr>
<tr>
<td></td>
<td>Where do you live? Who lives at home with you?</td>
</tr>
<tr>
<td></td>
<td>Who is in your family (parents, siblings, extended family)?</td>
</tr>
<tr>
<td></td>
<td>What is your/your family's cultural background?</td>
</tr>
<tr>
<td></td>
<td>What language is spoken at home? Does the family have friends from outside</td>
</tr>
<tr>
<td></td>
<td>its own cultural group/from the same cultural group?</td>
</tr>
<tr>
<td></td>
<td>Do you have your own room?</td>
</tr>
<tr>
<td></td>
<td>Have there been any recent changes in your family/home recently (moves;</td>
</tr>
<tr>
<td></td>
<td>departures; etc.)?</td>
</tr>
<tr>
<td></td>
<td>How do you get along with mum and dad and other members of your family?</td>
</tr>
<tr>
<td></td>
<td>Are there any fights at home? If so, what do you and/or your family argue</td>
</tr>
<tr>
<td></td>
<td>about the most?</td>
</tr>
<tr>
<td></td>
<td>Who are you closest to in your family?</td>
</tr>
<tr>
<td></td>
<td>Who could you go to if you needed help with a problem?</td>
</tr>
<tr>
<td>E - Education/Employment</td>
<td>**Explore sense of belonging at school/work and relationships with teachers/</td>
</tr>
<tr>
<td></td>
<td>peers/workmates; changes in performance:**</td>
</tr>
<tr>
<td></td>
<td>What do you like/not like about school (work)? What are you good at/ not</td>
</tr>
<tr>
<td></td>
<td>good at?</td>
</tr>
<tr>
<td></td>
<td>How do you get along with teachers/other students/workmates?</td>
</tr>
<tr>
<td></td>
<td>How do you usually perform in different subjects?</td>
</tr>
<tr>
<td></td>
<td>What problems do you experience at school/work?</td>
</tr>
<tr>
<td></td>
<td>Some young people experience bullying at school, have you ever had to put</td>
</tr>
<tr>
<td></td>
<td>up with this?</td>
</tr>
<tr>
<td></td>
<td>What are your goals for future education/employment?</td>
</tr>
<tr>
<td></td>
<td>Any recent changes in education/employment?</td>
</tr>
<tr>
<td>E - Eating and Exercise</td>
<td><strong>Explore how they look after themselves; eating and sleeping patterns:</strong></td>
</tr>
<tr>
<td></td>
<td>What do you usually eat for breakfast/lunch/dinner?</td>
</tr>
<tr>
<td></td>
<td>Sometimes when people are stressed they can overeat, or under-eat – Do</td>
</tr>
<tr>
<td></td>
<td>you ever find yourself doing either of these?</td>
</tr>
<tr>
<td></td>
<td>Have there been any recent changes in your weight? In your dietary habits</td>
</tr>
<tr>
<td></td>
<td>What do you like/not like about your body?</td>
</tr>
<tr>
<td></td>
<td>**If screening more specifically for eating disorders you may ask about</td>
</tr>
<tr>
<td></td>
<td>body image, the use of laxatives, diuretics, vomiting, excessive</td>
</tr>
<tr>
<td></td>
<td>exercise, and rigid dietary restrictions to control weight.**</td>
</tr>
<tr>
<td></td>
<td>What do you do for exercise?</td>
</tr>
<tr>
<td></td>
<td>How much exercise do you get in an average day/week?</td>
</tr>
<tr>
<td>A - Activities and Peer</td>
<td>**Explore their social and interpersonal relationships, risk taking</td>
</tr>
<tr>
<td>Relationships</td>
<td>behaviour, as well as their attitudes about themselves:**</td>
</tr>
<tr>
<td></td>
<td>What sort of things do you do in your free time out of school/work?</td>
</tr>
<tr>
<td></td>
<td>What do you like to do for fun?</td>
</tr>
<tr>
<td></td>
<td>Who are your main friends (at school/out of school)?</td>
</tr>
<tr>
<td></td>
<td>Do you have friends from outside your own cultural group/from the same</td>
</tr>
<tr>
<td></td>
<td>cultural group?</td>
</tr>
<tr>
<td></td>
<td>How do you get on with others your own age?</td>
</tr>
<tr>
<td></td>
<td>How do you think your friends would describe you?</td>
</tr>
<tr>
<td></td>
<td>What are some of the things you like about yourself?</td>
</tr>
<tr>
<td></td>
<td>What sort of things do you like to do with your friends? How much</td>
</tr>
<tr>
<td></td>
<td>television do you watch each night?</td>
</tr>
<tr>
<td></td>
<td>What’s your favourite music?</td>
</tr>
<tr>
<td></td>
<td>Are you involved in sports/hobbies/clubs, etc.?</td>
</tr>
</tbody>
</table>
### D - Drug Use/ Cigarettes/ Alcohol

**Explore the context of substance use (if any) and risk taking behaviours:**
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?** – **if Yes, explore further**
- How much do you use and how often?
- How do you (and your friends) take/use them? – **explore safe/unsafe use; binge drinking; etc.**
- 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?
- Have you had any problems as a result of your alcohol/drug use (with police; school; family; friends)?
- Do other family members take drugs/drink?

### S - Sexuality

**Explore their knowledge, understanding, experience, sexual orientation and sexual practices – Look for risk taking behaviour/abuse:**
Many young people your age become interested in romance and sometimes sexual relationships.

- Have you been in any romantic relationships or been dating anyone?
- Have you ever had a sexual relationship with a boy or a girl (or both)? – **if Yes, explore further**
- (If sexually active) What do you use to protect yourself (condoms, contraception)?
- What do you know about contraception and protection against STIs?
- How do you feel about relationships in general or about your own sexuality?
- (For older adolescents) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning?
- Have you ever felt pressured or uncomfortable about having sex?

### S - Suicide/ Self Harm/ Depression/ Mood

**Explore risk of mental health problems, strategies for coping and available support:**
Sometimes when people feel really down they feel like hurting, or even killing themselves.

- Have you ever felt that way?
- Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations – e.g. unsafe sex)?
- 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?
- Do you feel sad or down more than usual? How long have you felt that way?
- Have you lost interest in things you usually like?
- 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?
- It's normal to feel anxious in certain situations – do you ever feel very anxious, nervous or stressed (e.g. in social situations)?
- Have you ever felt really anxious all of a sudden – for particular reason?
- Do you worry about your body or your weight? Do you do things to try and mange your weight (e.g. dieting)?
- Sometimes, especially when feeling really stressed, people can hear or see things that others don't seem to hear or see. Has this ever happened to you?
- Have you ever found yourself feeling really high energy or racey, or feeling like you can take on the whole world?

**You can also explore:**
- **S - Safety**
- **S - Spirituality**

Sun screen protection; immunisation; bullying; abuse; traumatic experiences; risky behaviours. Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?
Case Study – Using HEEADSSS

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 ridicule 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 HEEADSSS as a tool to take a psychosocial history from Toby and also to build rapport and trust
- It’s 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 HEEADSSS 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 psychologist/counsellor to address these concerns – you can use the Medicare Mental Health Item Numbers to enable Toby to access appropriate counselling services

See Chapter 13 – Collaborative Care
resources


practice points

- Take the opportunity to explore beyond the young person’s presenting complaint, by assessing their psychosocial background and screening for underlying health concerns and risk factors
- The HEEADSSS assessment provides a systematic framework for conducting a comprehensive psychosocial history and health risk assessment
- HEEADSSS provides a guide for:
  - identifying risk behaviours and protective factors
  - identifying areas for intervention and prevention
- Request permission to ask sensitive questions – use the ‘third person approach’ to normalise the sensitive nature of the topics you are exploring
- Help the young person to identify risks associated with their behaviour and to develop strategies for reducing risks
- Use the findings of your assessment to identify problems and areas for intervention and follow-up

References:

Once you have completed your assessment, develop the management plan in conjunction with the young person, and where appropriate, with their parents. The management plan is a process of shared decision making. By actively engaging the young person in developing a treatment plan, you will empower the young person to be an active partner in the treatment process. This will also increase the likelihood of compliance to the treatment regimen.

Provide Feedback

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

- 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 alcohol 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 alcohol, 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 stay safe...”

See Chapter 5 – Risk Taking and Health Promotion

Negotiate a Management Plan

- 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
- Set realistic treatment and behaviour change goals that are relevant to the patient's health concerns, developmental stage and life circumstances
- Make sure that the 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 HEEADSSS assessment – for example:
  - health education and information
  - basic counselling
  - family mediation
  - referral to counselling or specialist services

See also Chapter 12 – Enhancing Compliance
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 Chapter 13 – Collaborative Care

Involving Parents

For most 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 necessitates it:

- The GP must sensitively judge the level of parental involvement required – balancing the young person’s need for confidentiality and autonomy 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 – parents may need to be involved where major health issues are concerned (e.g. unplanned pregnancy, prescription of medications, suicidal behaviour); or when dealing with problems where the family will play a major role in supporting or implementing the management plan, such as eating disorders or obesity.
- Where possible, make a collaborative decision – discussing the pro’s and con’s with the young person.
- From a medico-legal perspective, this also means taking into account the young person’s capacity for decision-making and informed consent.

See Chapter 6 – Medico-Legal Issues

- Be sensitive to the concerns of parents from cultural backgrounds where health care may be viewed as a family matter.
  - respect their wishes/rights to be involved in their adolescent's health care.

See Chapter 7 – Culturally Competent Practice

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.

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 to say to mum.”

See also Involving Parents (below)
Dealing with Parents

- 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.
- 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).

Addressing Resistance

- If the young person is adamant that they don’t want their parents to know or be involved, carefully 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?”
  “What do you need from your parents to help you with this problem?”

- Your duty of confidentiality does not preclude encouraging and assisting young people to talk to parents about important issues – this may be a 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 the limits of 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.

See Chapter 1 – ‘Defining Confidentiality’, Chapter 1 – Conducting a Youth-Friendly Consultation
practice points

◆ Provide the young person with feedback about your assessment and actively involve them in developing a management plan
◆ Identify risk behaviours and provide relevant information and education
◆ Set realistic treatment goals – appropriate to the young person's health concerns, developmental stage and lifestyle
◆ Where appropriate, discuss with the young person the level of involvement they wish their parents to have
◆ Guide parents in how to support the management plan and ways to respond to their adolescent's risk taking behaviours

References:
chapter four
Conducting a Physical Examination

In the general practice setting, a physical examination might be part of a general screening examination in an asymptomatic young person or might be tailored to a specific presentation. This chapter outlines an approach to a ‘general physical examination’ and discusses pubertal assessment.

The Process

Young people, particularly those going through puberty, are often extremely self-conscious about their bodies and recent physical changes. Part of establishing a relationship of trust with a young person is ensuring that any physical examination is done with consent, care and sensitivity.

- Explain why an examination is necessary
- Explain the procedures of the examination beforehand
- Be sensitive to cultural norms and values for young people and to gender difference. In some cultures it may be uncomfortable or even shameful for a male doctor to examine a female patient
- Ask if there is anything they are particularly worried about and would like checked

Then:

- Offer a chaperone – especially if you are a male doctor with a female patient, or
  - arrange for the girl to be examined by a female practitioner where possible
  - and/or to have a female support person present
- Obtain the young person’s consent
- Seek parental permission where appropriate
- Protect the young person’s modesty and privacy – leave the room for the young person 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:

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 patients’ feelings of discomfort
- Examination of genitalia or other secondary sex characteristics is not routinely required – unless:
  - there is strong suspicion of an endocrine disorder, or
  - the young person specifically requests it, or
  - you are conducting an examination for certain sexually transmitted diseases such as pelvic inflammatory disease, genital warts or herpes

Note: Breast self-examination and testicular self-examination have not been found to detect early cancers – however the young person can be encouraged to be aware of the normal look and feel of their breasts (young women) and testicles (young men).

- Pap smears and sexual health examinations can be highly embarrassing – explain clearly your reasons for doing such tests and what is involved
Screening Investigations in Asymptomatic Young People

- Chlamydia PCR in sexually active people under 25 years
  - add Gonorrhoea PCR and syphilis EIA for sexually active Aboriginal young people

See Chapter 9 – Sexual Health – for more information

- Obtain immunisation history
  - offer Hepatitis B vaccine if indicated
  - offer HPV vaccine to young women under 26 years who have not received it as part of the national school vaccination program
  - offer Varicella Zoster vaccine if no history of infection or vaccination.

The Experience Of Puberty

- Puberty involves the most rapid and dramatic physical changes that occur during the entire lifespan 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

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

What to Look For:

- Assess growth and pubertal development
  - Height, weight; calculate Body Mass Index and plot this on a centile chart
  - Determine Tanner Staging (see below)
  - Waist circumference
  - Be aware of common variations of adolescent development that can cause the young person significant anxiety– e.g. unequal breast size in girls; gynaecomastia in boys – provide reassurance of normality.

- Examine skin for acne, hirsutism, and other skin conditions such as warts, atopic eczema, seborrhoea, fungal infections and pigmented lesions, especially moles in fair-skinned young people
  - Be aware that stretchmarks may appear during puberty and cause distress
  - Examine piercings and tattoos

- Record blood pressure

- Examine mouth and teeth for caries, gingivitis, tongue piercings

- Examine the neck – thyroid enlargement, lymphadenopathy

- Auscultate heart for murmurs

Remember that a PAP smear in Australia is not required until a young woman has turned 18 or 2 years after first intercourse whichever is LATER

Where possible and appropriate (e.g. screening asymptomatic Chlamydia infection in low risk patients) take specimens that do not require a sexual health examination – e.g. first void urine specimens or low vaginal swabs that patients can take themselves for Chlamydia PCR testing

Obtain immunisation history
- offer Hepatitis B vaccine if indicated
- offer HPV vaccine to young women under 26 years who have not received it as part of the national school vaccination program
- offer Varicella Zoster vaccine if no history of infection or vaccination.

Providing feedback on your findings
- Be sensitive and straightforward in explaining any negative findings and what these mean
- Check the young person’s understanding of your explanation

Document the findings from your examination in the Adolescent Health Check pro-forma, along with the outcomes of your psychosocial assessment, to gain a comprehensive profile of the young person’s health status and concerns

PAP smear in Australia is not required until a young woman has turned 18 or 2 years after first intercourse whichever is LATER
This system allows objective comparison over time and between health professionals.

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.

---

**Case Study – Puberty**

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 (e.g. menarche in mother? when did father start shaving? Was father small compared to friends in high school?)
- >60% of adolescents with constitutional 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 (e.g. intracranial hypertension)

---

**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 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 caution in puberty, where hormone changes are dynamic and where dynamic testing may be required
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 that 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

practice points

- Extreme self-consciousness about one’s body is a common and normal aspect of adolescent development
- Gender and cultural differences and norms must be considered prior to conducting a physical examination
- Consent should be obtained from the young person before a physical examination is undertaken

References:

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 activity 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 people's health include:

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

What's Normal and When to Worry

- Normal adolescent behaviours include: moodiness, flare ups, open and talkative with friends, monosyllabic with family, active striving for independence, trying new experiences, need to be like peers, sleeping in, critical and argumentative
- Worrying behaviours include: wild mood swings, dramatic and/or persistent behaviour change, isolation from peers, falling school performance or dropout, violent or aggressive behaviour, dangerous
drug and/or alcohol use, loss of routine, excessive sleeping, withdrawn, secretive

**Screening For Risk Behaviours**

- Routinely screen adolescent patients for risk behaviours – especially if they present with specific psychosocial problems
- Identify social and environmental risk factors – e.g. school failure, socio-economic disadvantage, refugee experience, parental abuse
- This enables you to assess the young person’s overall level of health risk and plan appropriate intervention if required
- Use the **HEEADSSS** psychosocial assessment to identify risk behaviours and determine the young person’s degree of risk

**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:

- **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 experimentation
  - ‘safe 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.

**Adolescent Factors**
- Low self-esteem
- Poor social skills
- Poor problem solving
- Lack of empathy
- Homelessness

**Family Factors**
- Family conflict/breakdown
- Harsh or inconsistent discipline
- Lack of warmth and affection
- Abuse and neglect
- Lack of meaningful relationships with adults

**School Factors**
- School failure/dropout
- Bullying
- Peer rejection
- Deviant peer group

**Community and Cultural Factors**
- Socio-economic disadvantage
- Exposure to violence and crime
- Homelessness
- Refugee experience
- Racism / discrimination
- Intercultural conflict – the adolescent trying to ‘fit in’ and adapt to the new culture
- Lack of support services

**Protective Factors**
Individual and environmental factors that increase resistance to risk factors – including environmental supports, family background, personal skills and internal attitude.

**Adolescent Factors**
- Social competence
- Problem solving skills
- Optimism
- Good coping style
- School achievement
- Strong sense of moral values/spiritual beliefs
- Creativity and imagination

**Family Factors**
- Supportive caring parents
- Secure and stable family
- Supportive relationship with other adult
- Attachment to family

**School Factors**
- Positive school climate
- Prosocial peer group
- Positive achievements and sense of belonging at school
- Opportunities for some success (at sport, study, etc.) or development of a special talent/hobby
- Recognition of achievement

**Community and Cultural Factors**
- Attachment and belonging to community
- Access to support services
- Participation in community group
- Strong cultural identity/pride
- Secure home/housing

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

**Example:** A young person who is involved in antisocial behaviour, at risk of expulsion from school, with frequent alcohol and substance use, and with a lack of family support.

**Table 1 - Examples of Key Risk & Protective Factors for Adolescents**

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics of the young person themselves and their social environment that increase a young person's vulnerability to harm.</td>
<td>Individual and environmental factors that increase resistance to risk factors – including environmental supports, family background, personal skills and internal attitude.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adolescent Factors</th>
<th>Family Factors</th>
<th>School Factors</th>
<th>Community and Cultural Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low self esteem</td>
<td>Family conflict/breakdown</td>
<td>School failure/dropout</td>
<td>Socio-economic disadvantage</td>
</tr>
<tr>
<td>Poor social skills</td>
<td>Harsh or inconsistent discipline</td>
<td>Bullying</td>
<td>Exposure to violence and crime</td>
</tr>
<tr>
<td>Poor problem solving</td>
<td>Lack of warmth and affection</td>
<td>Peer rejection</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Lack of empathy</td>
<td>Abuse and neglect</td>
<td>Deviant peer group</td>
<td>Refugee experience</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Lack of meaningful relationships with adults</td>
<td></td>
<td>Racism / discrimination</td>
</tr>
</tbody>
</table>

**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

**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, conflict with family
- presence of major risk factors and few protective factors
Working With Young People At High Risk

- Young people at high risk present a particular challenge for GPs and health workers
- They are generally marginalised, under-serviced and have few resources
- Their situation is typically characterised by the following features:
  - the presence of multiple risk factors and few protective factors
  - engagement in high-risk behaviours
  - co-morbid health problems — in particular, substance use and mental health disorders
  - their living situation may be in disarray — e.g. homeless, itinerant or living in care
  - their lives are often made more difficult to manage by the ongoing effects of trauma, neglect and abuse, as well as complicated grief reactions stemming from the experience of significant loss
- Young people at risk frequently have to cope with extreme circumstances in their lives, often without adequate support structures — therefore their risk-taking behaviour should be viewed in this light (e.g. substance use as a coping mechanism)

The GP’s role

- High risk young people rarely present to a GP by themselves
- They may be brought along by a youth worker or referred by another health worker or service
- The GP may also come into contact with them if they work in outreach clinics at youth services or in a specialist Youth Health Centre
- A collaborative management approach is essential in working with Young People at high risk
- Engaging the young person in a trusting relationship is possibly the single most important thing that a GP can do in working with this target group — as this will provide the possibility of increasing their access to much needed treatment and services
- Young people at high risk often have chaotic lifestyles, therefore it is important to understand that they may miss appointments — attempt to maintain the relationship and try to re-engage them where possible
- Working with high risk adolescents with complex, co-morbid conditions takes time and commitment

- GPs often will not have the time and resources to provide comprehensive intervention — however, the GP can play a crucial role by providing the following:
  - detection of serious health risks and referral to appropriate services (e.g. specialist substance use or mental health services)
  - effective treatment of minor physical complaints that are common in this group — e.g. colds, skin infections, etc.
  - collaborative case management — e.g. use the Medicare Mental Health Item Numbers to facilitate the young person’s access to allied health or specialist services and initiate a multidisciplinary treatment approach

See Chapter 13 – Collaborative Care for Medicare item numbers

- creating safety nets by promoting access and links to crisis and support services
- familiarise yourself with specialist services for young people in your local area (e.g. drug & alcohol counselling services, psychologists who work with young people, mental health services)

resources

- Refer to individual chapters in this Kit for approaches to treating specific health risk behaviours:
  - Chapter 8 – Substance Abuse
  - Chapter 9 – Sexual Health
  - Chapter 10 – Mental Health
- See also Section Four — for resources and contact details of services for specific health problems
- The YSAS (Youth Substance Abuse Service) website has information about working with high risk, co-morbid young people — www.ysas.org.au
Case Study

Mark is a 19 year old young man who is accompanied by his mother. He presents with symptoms of low mood, anxiety and disordered thoughts. Mark’s life is very chaotic. He lives in his own self-contained flat beneath his mother’s house – but he is often not there, spending days at a time at friend’s places, usually engaging in binge drinking and smoking marijuana. His mother suspects that he and his friends have also been selling drugs. He has an unusual presentation. He is constantly agitated and appears to have difficulty in organizing his thoughts or retaining his line of thinking. He is very thin and his hygiene appears to be poor. His mother explains that this is partially related to his longstanding history of Asperger Syndrome which Mark was diagnosed as a child. It also appears to be exacerbated by his frequent marijuana use which may also be contributing to his low mood, lack of self-care (e.g. poor hygiene), and his difficulties in performing routine tasks (e.g. cooking for himself).

He dropped out of school at a young age. He makes his own jewellery and says that he wants to establish his own business. However, he is very disorganized and has difficulty in following through on plans. This is a source of major ongoing conflict with his mother. She is trying to encourage him to live more independently in his daily life. However, because of his poor level of self-care, she feels that she has to constantly cook and clean for him. Mark resents his mother’s interference and consequently they have frequent arguments during which Mark becomes very aggressive and fixated, causing stress to both parties.

His mother reports that Mark was prescribed medication a couple of years ago for similar problems but he refused to take it. She has approached a community support organization for assistance in finding suitable alternative accommodation for Mark. She says that she can’t have him living with her anymore.

Risk Assessment

◆ Using HEEADSSS, you identify the following risk factors in Mark’s life: substance using peer group; low educational attainment; conflict with mother; unstable living situation; poor social and problem-solving skills; history of mental health difficulties; lifestyle

◆ He is engaged in the following risk behaviours: marijuana use, binge drinking, selling drugs, aggressive behaviour toward his mother

◆ You also identify the following protective factors: a supportive mother; his interest in jewellery; involvement with community support services

Risk Status

As a result of your assessment, you determine that Mark is at a moderate to high level of risk. He has some protective factors in his life, but these are weak compared to his risk factors. You are particularly concerned about his mental health history and his high risk of developing a co-morbid condition of substance abuse and mental illness.

Management Approaches

Your first challenge is to engage Mark in a therapeutic relationship. You praise Mark for attending and being willing to look at addressing the problems in his life. You discuss the risks that you have identified but also acknowledge some of his strengths. You outline a number of interventions for assisting Mark and his mother:

- using the Medicare item numbers, you make a mental health care plan for Mark and refer him to a psychologist for counselling for behavioural issues and to address the conflict with his mother
- you also refer him to a psychiatrist for specialised assessment in regard to Asperger or other possible mental health condition, as well as assessing suitable medication options for Mark

You conduct an assessment of Mark’s general health, diet, sleep, exercise and lifestyle. You provide health education on these issues. You make a follow-up appointment for Mark to review the implementation of the care plan.

See Chapter 13 – Collaborative Care - for relevant Medicare item numbers

- you discuss the possibility with Mark of reducing his alcohol intake and marijuana use and identify specialist services he could attend to assist him with this
**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 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:** While not condoning risky behaviors, it is important to acknowledge that there are usually also positive benefits that the young person attains from engaging in the risk behaviour – e.g. peer acceptance; having fun; relieving anxiety

- Identify alternative ways of achieving the positive benefits of their behaviours

- Identify ways of minimizing the harm associated with the behaviour
- Present 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.\(^3\)

- **Adolescents at no/low risk**
  - **Aim to prevent the emergence of problem behaviour**
    - 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**
  - **Reduce modifiable risk factors/behaviours**
    - 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 and basic counselling
    - referral to specialist treatment and support services
    - interventions that are effective in reducing one risk behaviour are likely to positively affect other risk behaviours
  
  - **Strengthen protective factors**
    - 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

**Table 2 - Interventions for Risk Behaviours**

<table>
<thead>
<tr>
<th>Risk Status</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents at no/low risk</td>
<td><strong>Aim to prevent the emergence of problem behaviour</strong></td>
</tr>
<tr>
<td></td>
<td>- Provide preventative health education and health promotion messages</td>
</tr>
<tr>
<td></td>
<td>- Enquire about their level of knowledge and provide objective information about the health consequences associated with a particular behaviour</td>
</tr>
<tr>
<td></td>
<td>- Build a trusting relationship so that they might return if concerns arise in the future</td>
</tr>
<tr>
<td>Adolescents at moderate/high risk</td>
<td><strong>Reduce modifiable risk factors/behaviours</strong></td>
</tr>
<tr>
<td></td>
<td>- use harm minimisation strategies to help reduce the dangers associated with risky behaviours</td>
</tr>
<tr>
<td></td>
<td>- develop a plan of management in conjunction with the young person to reduce risks associated with their behaviour and find safer alternatives</td>
</tr>
<tr>
<td></td>
<td>- provide health education and basic counselling</td>
</tr>
<tr>
<td></td>
<td>- referral to specialist treatment and support services</td>
</tr>
<tr>
<td></td>
<td>- interventions that are effective in reducing one risk behaviour are likely to positively affect other risk behaviours</td>
</tr>
<tr>
<td></td>
<td><strong>Strengthen protective factors</strong></td>
</tr>
<tr>
<td></td>
<td>- identify and reinforce the young person’s strengths</td>
</tr>
<tr>
<td></td>
<td>- identify ways to enhance protective factors in their lives – e.g. family counselling, school mediation</td>
</tr>
<tr>
<td></td>
<td>- teach the young person protective behaviours to reduce risks</td>
</tr>
<tr>
<td></td>
<td>- e.g. safer sexual practices, refusal and assertiveness skills</td>
</tr>
</tbody>
</table>

See Table 2
Providing Health Education

The risk profile gathered from your HEEADSSS and risk 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:

- **Promote resilience**
  The development of resilience in young people is linked to long term success in life and the prevention of substance abuse, violence and suicide. You can foster resilience by:
  - strengthening a young person’s connectedness in their social environment to their family; school/work; community; culture; peers; meaningful involvement in activities
  - fostering positive self-esteem; teaching social, emotional and cognitive skills

- **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**
  - provide some simple educational material that you can give them on relevant topics (e.g. drug & alcohol use, sexual health, etc.)
  - there are many excellent youth-friendly pamphlets available on these topics

See box below

See Section Four – For resource materials and websites for young people

**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.”

**Intervention Strategies**

- **Promote resilience**

- **Adopt a collaborative approach to management**

- **If the young person does not want to discuss the issue**

**Strategies for Promoting Resilience**

- **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 relationships, connection to their culture

- **Foster a positive self-image and self esteem** – through participation in activities, sports, academic achievement, hobbies, artistic abilities

- **Teach life skills – cognitive/social/emotional competence**
  - Cognitive competence – identify and challenge faulty thinking, develop positive self-talk, decision-making skills
  - 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**
Provided 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, and bad skin is more likely to be effective than emphasizing long-term consequences such as lung cancer or heart disease

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 happening 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 HEEADSSS 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.
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 (SOC) Model

- Recent research has questioned the effectiveness of this model in providing practical intervention strategies for change. However, the Stages of Change model is still useful—especially in the initial contact with an adolescent—as a framework for assessing their status in terms of:
  - their awareness of the problem and acceptance of the need to address it
  - their readiness to attempt to change the behaviour
  - their belief in their capacity ('self efficacy') to make changes
- The SOC model also helps to identify interventions that most closely match where the young person is at in their attempts to change their behaviour. However, the model should be used as a guide to working with patients rather than rigidly applied as a prescriptive formula, or for making clinical predictions.
- Though most widely used with substance use, the SOC model can be applied to a wide range of health behaviours.

Promoting Behaviour Change

A major goal in health education and managing risk behaviours is to promote behaviour change in the young person. It is helpful to have a model or framework for understanding the process of behaviour change—particularly as it applies to health behaviours. Some useful models are:

- Health Belief Model—a states that the probability individuals will change their behaviour to improve or protect their health is directly related to:
  - their awareness and perception of the health issue
  - the perceived risks and consequences
  - the anticipated benefits of the behaviour change
  - their level of skills
- Therefore, to help adolescents modify their behaviour according to his model—provide them with information and basic counselling to:
  - raise their awareness and knowledge about the behaviour and its consequences
  - ‘personalise’ the risk—help them to see how the risk applies to them in their particular situation
  - promote a belief that behaviour change will eliminate or lessen the risk
  - support a belief that they can make and sustain the behaviour change
  - teach them appropriate interpersonal and life skills to help make changes
  - identify and reinforce support for them in making those changes
- The ‘Stages of Change’—According to this model, patients are at different stages of readiness to change their behaviour, and go through a number of stages on their way to making changes.

You also identify the following Protective Factors—success at sport and school; relationship with 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.

The key issues of each stage in the change process and strategies for addressing these issues are outlined in Table 3.

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)?”

See Chapter 8 – Treating Substance Abuse
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

Preparing for change: How confident are you? What has worked in the past?
Making changes: How can we plan for this? What are the likely barriers?
Maintaining changes: How is it going?
Dealing with relapse: What has happened? How to get back on track?

Motivational Interviewing

Motivational interviewing (MI) is a technique that can be used in conjunction with a number of different models of behaviour change:
- MI is a process of preparing young people for change by building their motivation and reinforcing their capacity to make changes (‘self efficacy’)
- MI is patient-centred – it focuses on the concerns and perspectives presented by the patient
- It is based on the belief that the resources and motivation for change already exist within the patient
- MI aims to get the young person doing the talking and voicing the advantages of change, plans for change, readiness for change and confidence in ability to make a change
- The role of GP is to reflectively listen which reinforces the change talk
- MI focuses on understanding the patient’s beliefs and priorities in the following areas:
  - **Problem recognition** – Ask questions that help to define the problem clearly. What is the issue?
  - **Perceived impact on life** – Ask questions that bring out what effect it is having on the patient’s life. What effect is it having?
  - **Beliefs about capacity to change** – Ask questions that explore what patient believes it would be possible to do. What could be done to make the problem better?
  - **Intention to change** – Ask questions to find out whether the patient wants to commit to making changes. What do you think you might be able to do/change in regard to the problem?

Motivational Interviewing can be used with the Stages of Change model to assess the patient’s change potential at different stages – e.g.:
- **Thinking of changing**: What would you like to discuss? Tell me more about...? How do you feel when...?
### Table 3 - Stages of Change

<table>
<thead>
<tr>
<th>Stage of Change</th>
<th>Issues</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Pre-contemplation | Patient doesn't see the problem as an issue  
‘Hasn’t thought about change’ | 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 | Patient thinking about change  
‘Considering the benefits of changing and the risks of not changing’ | 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 | Patient is making a plan to change  
‘Ready to ready to make a change’ | 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 | Patient carries out specific action plans for change  
Dealing with barriers to change | 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 | Developing strategies for sustaining changes | Affirm and support behaviour change  
Teach coping skills  
Foster strengths and protective factors  
Provide reminders  
Identify alternatives  
Social supports |
| Relapse | Re-engagement in problem behaviour | 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 |
The following resources provide further information about conducting Motivational Interviewing:

- The Motivational Interviewing website – www.motivationalinterviewing.org

### Resources

**References:**


---

### Practice Points

- Routinely screen adolescent patients for risk behaviours – especially if they present with specific psychosocial problems
- Risk assessment should take place in the context of understanding that co-morbidity of health risk behaviours is prevalent in young people
- Use the HEEADSSS psychosocial assessment to identify the overall balance of risk and protective factors in the young person's life
- Provide early intervention and health education appropriate to the risk status and developmental stage of the young person
- The main GP roles in working with high risk young people are detection of serious health risks and collaborative case management through referral to appropriate services – use the Medicare Item Numbers to initiate a multidisciplinary treatment approach
- Promote the young person’s resilience by strengthening their connection to supports in their social environment
- Actively promote behaviour change:
  - provide anticipatory counselling and guided decision-making
  - raise awareness of harmful consequences
  - teach skills for minimising risks and promoting protective behaviours
- Motivational Interviewing prepares a young person for change by building their motivation and reinforcing their capacity to make changes
Informed Consent

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

- 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 medical practitioner does not give this information to the patient, 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

The Capacity of Young People to Consent

Across Australia, 18 years is the legal age of majority (‘adulthood’). The law assumes that adults are competent to make decisions about their medical treatment, either consent or refusal, even if their decision is deemed not to be in their best interests. Thus, the specific legal issues surrounding consent to medical treatment for young people applies to legal minors, those under 18 years.

Clinically relevant questions include:

- When can a young person under 18 years make their own decisions about medical treatment?
- Can parents or guardians make decisions about medical treatment for young people under 18?

General practitioners may have concerns about these two questions because:
- they are unsure how to assess a young person’s capacity to give their own consent even if, strictly speaking, the law allows them to
- they are unsure how they stand legally if they accept a young person’s capacity to consent
- they are unsure whether they can, or should, involve parents in decisions about consent
Laws About Consent To Medical Treatment

The Common Law applies across Australia:

The common law states that young people under 18 might be capable of giving informed consent, although the health professional must consider the nature of the treatment and the ability of the young person to understand the treatment.

Background to the Common Law

- The common law position relating to a minor's competency to consent to treatment was established by the English House of Lords decision in a case known as ‘Gillick’ and was approved by the High Court of Australia in a case known as “Marion’s case”. The ‘Gillick case’ holds that the authority of a parent decreases as their child becomes increasingly competent. ‘Gillick’ prescribes that the parental right to determine their child’s treatment terminates once a child under the age of 16 is capable of fully understanding the medical treatment proposed. 1
- Note that in recent times the term “Fraser guidelines” has been substituted for ‘Gillick test’ for competence. Lord Fraser was one of the Law Lords involved in the Gillick case. However the Fraser guidelines are different from the Gillick test as they only relate to the provision of contraception; the Gillick test is broader. 2

Victoria, Australian Capital Territory, Western Australia, Queensland, Tasmania and Northern Territory

There are no specific laws about minors and consent to medical treatment. Thus the Common Law applies for those under 18 years.

Additional Statutory Laws apply in NSW & South Australia 3

New South Wales

- Specific NSW law means that young people aged 14 and over can consent to their own treatment in so far as medical practitioners are protected from charges of assault and battery against a civil action (as distinct from a criminal action) if the young person has given consent. [Minors (Property and Contracts) Act 1970 s49 (2)]
- This needs to be applied with caution, as health professionals should still consider how capable a young person 14 and over is to giving full informed consent
- This NSW law also allows for parents to give consent to medical treatment for an adolescent child under 16 years, even if the young person is themselves competent to consent
- The Guardianship Act in NSW also implies that a young person aged 16 can consent to their own treatment [Guardianship Act 1987 (NSW)]
- Finally the Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

South Australia

- A young person 16 years and over can consent to medical treatment “as validly and effectively as an adult”
- For those under 16, a young person can validly consent to treatment if and when two medical practitioners believe and state in writing that certain treatment is in the best interests of the child and the child is ‘capable of understanding the nature, consequences and risks’ involved (Consent to Medical Treatment and Palliative Care Act 1995; See:

- The Common Law allows for the mature minor assessment to be applied to young people even younger than 14 if relevant.

The right to refuse treatment

- The legal right to refuse treatment for minors is unclear. The Gillick principle that allows for a competent minor to consent to treatment does not allow for a corresponding right to refuse treatment
- Hence, a young person who is competent according to the principles established by Gillick, will generally lack the capacity to refuse lifesaving treatment if his/her parents are prepared to consent to it
A minor’s capacity to consent

- This applies to young people:
  - under the age of 18 in Victoria, Queensland, Tasmania, ACT, NT and Western Australia
  - under the age of 16 in South Australia
  - under the age of 14 - 16 in NSW (this is not absolutely clear, see above)

- For a medical practitioner 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.

The capacity of a young person 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.

Making A Competency Assessment

Medical practitioners must form their own opinion about a patient’s 'intelligence and understanding'.

- A minor 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’ (the Gillick test). This particularly involves considerations about their:
  - age
  - level of independence
  - level of schooling
  - maturity
  - ability to express own wishes

Note: The medical practitioner’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 (or vice versa) because of different cultural expectations about their roles in the family/society (e.g. 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 young person 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 young person’s medical record about the competency assessment – particularly if you found the young person to be competent and subsequently administered treatment on the basis of his/her consent

Dealing with special circumstances

English language

- Be aware that informed consent can only be obtained if the young person understands what is being presented in a language with which they are fluent
- Health care interpreters should be used where 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 131 450. This is a national service provided through the Department of Immigration and Multicultural and Indigenous Affairs and is free to GPs
- TIS is available 24 hours a day, 7 days a week, and is accessible from anywhere in Australia for the cost of a local call.
- Children should not be used as interpreters for their parents

See Section Four – for contact details of relevant services
Young people with intellectual disabilities

- A young person with an intellectual disability is not automatically deemed incompetent to consent to treatment
- The competence of such an individual should be assessed in each case and each situation

Young people who are parents

- A legal minor who is 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

Confidentiality

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

Exemptions

The exemptions to the duty to maintain confidentiality are both legal and ethical.
These are listed below:

Where the patient consents to disclosure

- A patient 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
- Notifications – 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 Mandatory Reporting below

Best interests of the patient

- This exemption relates to a situation where a provider believes there is a real risk of serious harm to the patient – 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 patient 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 patient – the concept of ‘team confidentiality’ can be explained to patients when working within a multidisciplinary team. However, it is advisable to seek a patient’s permission to disclose any non-urgent communications outside these parameters
practice points

- Confidentiality is legally part of the general duty of care to patients
- Health care providers must keep information divulged by the patient confidential, unless an exemption applies
- Special care may need to be taken in explaining to parents of young people from a CALD background about their adolescent child’s right to confidentiality

A Common Medical Issue – Prescribing Contraception

- Hormonal contraception (e.g. the oral contraceptive pill, injectable and implantable hormones) 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’)

Note: That legislation in NSW changed between 2000 and 2005 to remove injectable progesterone from the ‘Special Medical Treatment’ category that required Guardianship Tribunal approval for women under 16 years – thus NSW is now in line with other states and territories as regards this contraceptive.

- Sterilisation – e.g. 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

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 of the same age and 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 (e.g. 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, e.g.:

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
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 to be carried out, regardless of her age.

In order to make an informed choice about the 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.

### Child Protection And Mandatory Reporting

**Child protection laws**

Below is a list of the principle child protection laws in each state and territory:

**Australian Capital Territory:**
Children and Young People Act 1999

**New South Wales:**
Children and Young Persons (Care and Protection) Act 1998

**Northern Territory:**
Community Welfare Act 1983; Care and Protection of Children Draft Act (currently before Cabinet)

**Queensland:**
Child Protection Act 1999

**South Australia:**
Children's Protection Act 1993

**Tasmania:**
Children, Young Persons and their Families Act 1997

**Victoria:**
Child, Youth and Families Act 2005

**Western Australia:**
Children and Community Services Act 2004

You can get more information about these and other relevant Acts of law from the following website:


---

### Termination Of Pregnancy

- In Australia abortion is legally available with minor variations from state to state, although the ACT is the only jurisdiction in Australia where it has been decriminalised.
- In some states and territories parental consent for women under 18 is required:
  - **NSW** – parental consent probably required if under 14
  - **Northern Territory** – parental consent required if under 16
  - **Western Australia** – parents must be told if under 16 and must be given the opportunity to be involved in counselling and medical consultations, otherwise the young woman must apply to Children’s Court to maintain confidentiality

---

**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 '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, particularly about female sexuality.
- 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.
For information about which government department in your state or territory is responsible for the care and protection of children and young people, see the following website:

Definition of a child or young person

◆ A child is a person under 16 years of age in NSW, and under 18 years in other states and territories
◆ In NSW, a young person is 16 or 17 years old

What is ‘in need of protection’?

For specific information about how the legislation in your State or Territory defines ‘a child in need of care and protection’ see the following article:

◆ In some states and territories, certain incidents or circumstances may be registered as ‘concerns’ rather than ‘at risk of harm’
◆ Once there is known or suspected harm or ‘risk of harm’, the statutory response to protect the child or young person is effected (i.e. they become a child/young person ‘in need of care and protection’).

‘Risk of harm’

The following is a broad summary of some of the issues that constitute risk of harm but it is important to note that there will be differences depending on the laws in your state or territory. If you feel a child or young person is at risk of harm, it generally means that 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 – e.g. continual scapegoating or rejection
  - psychological abuse involves serious impairment of a child/young person's social, emotional, cognitive or intellectual development; this might be 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

A number of things should be considered 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

Mandatory Reporting

An important component of legislation aimed to protect children and young people includes the mandatory reporting of known or suspected child abuse.
- All States and Territories in Australia have legislation that makes it compulsory for certain professionals to report known or suspected child abuse to a designated authority
- Medical practitioners are mandatory reporters in all states and territories where mandatory reporting is legislated. In November 2007, Western Australia introduced a Bill to amend the Children and Community Services Act (sect 124B) to make medical practitioners and other professionals mandatory reporters. In the Northern Territory everybody is a mandatory reporter
- In NSW, mandatory reporting applies to young people up to the age of 16. In the other states and territories, it applies up to the age of 18 years
- Although each state and territory has slightly different procedures for mandatory reporting, they are broadly similar across Australia.

Resources

The following list provides contact telephone numbers for each State and Territory to report incidences of child abuse:
- Australian Capital Territory – 133 427
- New South Wales – 132 111 (24 hours)
- Northern Territory – 1800 700 250 (24 hours)
- Queensland – Departmental Head Office:
  - (07) 3224 8045
  - Crisis Care: (07) 3235 9999
  - Rural areas: 1800 177 135
- South Australia – 131 478 (24 hours)
- Tasmania – Child and Family Services:
  - 1800 001 219 (24 hours)
- Victoria – Child Protection Crisis Service:
  - 131 278 (24 hours)
- Western Australia – Departmental Head Office:
  - (08) 9222 2555
  - After hours: (08) 9222 3111; 1800 199 008

Note:

If in doubt about a particular cultural practice – consult with a culturally appropriate or bilingual health professional, or contact:
- Diversity Health Institute
  - 02 9840 3800 – www.dhi.gov.au
- Multicultural Mental Health Australia
  - 02 9840 3391 – www.mmha.org.au
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. The legislation protects GPs (and other mandatory reporters) from:

- disclosing your identity and the identity of your practice without your consent
- being sued for making a report
- breaching professional ethics or standards by making a report
- being sued for defamation if you make a report

Note:

- If you have any concerns or are uncertain about whether you should make a report, call the relevant authority in your state or territory and discuss it with them
- Over the past decade or so, legislation and accompanying policies and procedures across Australia have been increasingly taking a supportive and collaborative approach to child protection (rather than a punitive approach towards parents)
- Thus, you are encouraged to work with the relevant child protection authority to support young people

practice points

- All states and territories have legislation that protects the welfare of children
- Medical practitioners are mandatory reporters in all states and territories (see below for Western Australia)
- The definitions of ‘child’ and ‘child in need of protection’ vary slightly between states and territories.

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 you should 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 (e.g. if she gives birth without proper medical or psychosocial care and support). She is 16 and, depending on which state or territory you are practising in, you may be mandated to report this situation. Even if you are not mandated (e.g. in NSW) you may report any of the above concerns for young people aged 17 or 18

The baby’s welfare

In NSW, ACT, Victoria, Queensland, South Australia and Western Australia you can report concerns about an unborn child (not mandatory). These jurisdictions have legislation that specifically deals with such reports.
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, knows that this is the best thing to do, and that she and her family could face harsh retributions within her extended family and community otherwise. Legal and ethical issues, particularly as they relate to human rights conventions (e.g. 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.

Privacy And Medical Records

- Health professionals in the private sector:
  - can share health information for a treatment-related purpose, as long as it would reasonably be expected to happen
  - have the right to charge patients a reasonable fee for access to their medical records
  - can deny a patient access to medical records if giving access would pose a serious threat to the life and health of anyone or where legally required

- Young people under 18 years can exercise their own privacy choices (e.g. not allow parents to see their records) once they become able to understand and make their own decisions (i.e. become competent to consent) 6

Resources

- For further information about relevant laws applying to young people – see the following website – www.austlii.edu.au

References:


Additional References

chapter seven
Culturally Competent Practice

Young people from Culturally and Linguistically Diverse (CALD) backgrounds face the challenge of dealing with the developmental tasks of adolescence while 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 have an appreciation of the range of cultural, ethnic, and social diversity among adolescents.

This does not mean however, that the GP needs to be an ‘expert’ in cultural awareness. It is important to remember that young people from ALL cultural backgrounds require confidential care and a youth-friendly approach. What is most important is the willingness to engage in a dialogue with the young person about their cultural background and its influence, as well as an awareness of your own cultural biases and perceptions.

Successful engagement with CALD young people may take a little longer, especially in terms of gaining the confidence of the family – however, the principles of youth-friendly consultation and communication (as outlined in earlier Chapters) apply to all young people, regardless of their cultural background.

This section provides general guidelines only for working with young people from culturally diverse backgrounds.

For more in-depth information about working with young people from specific cultural or ethnic backgrounds, contact the following organisations or view their websites:

- The Diversity Health Institute offers a wide range of multicultural health information – www.dhi.gov.au
- The Transcultural Mental Health Centre (TMHC) provides consultation, training and information services to health professionals on transcultural mental health, as well as service provision to people from CALD backgrounds – go to Diversity Health website – www.dhi.gov.au (click link to Transcultural Mental Health Centre)
- See also Section Four – for contact details of other resources and service providers in multicultural health

Cald Young People

Some important points to consider when treating young people from CALD backgrounds:

- 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 a definitive set of cultural attributes, attitudes and practices apply to all people from a particular cultural background.
- They may have had experiences that adversely affect their health, development, and identity – e.g. circumstances related to migration or refugee experience; exposure to war and trauma; resettlement difficulties; discrimination; racism.
- These experiences can also 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.
- Other factors to consider are:
  - how long the young person and their family have been in Australia
  - 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
- CALD young people may be at risk of poor mental health as a result of the stresses associated with the experience of migration, resettlement and acculturation, as well as exposure to traumatic experiences\(^1\)
- These stressors include:
  - difficulties adapting to the way of life, language, values, norms and expectations of the new culture
  - intergenerational conflict related to differences between traditional cultural values and those of the new society
  - poverty in some refugee families
  - non-recognition of parents' overseas qualifications
  - exposure to racism or discrimination and isolation.
- It is also important to bear in mind that many young people from CALD backgrounds have coped well with the experience of migration and resettlement

Refugee Young People

- Growing numbers of young people arriving in Australia come from refugee source countries

See Section One – for more background information

- They may have experienced persecution or prolonged periods in refugee camps, often in transition countries
- Many refugee young people and their families will have experienced some or all of the following:
  - forced departure from their country of origin
  - conflict, organized violence and human rights abuses
  - a dangerous escape from their country of origin
  - torture and trauma
- Consequently, the refugee experience is characterized by persecution, displacement, loss and grief, and forced separation from family, home and belongings\(^2\)

For refugee young people the developmental tasks of adolescence are compounded by the traumatic nature of the refugee experience, cultural dislocation, loss of established social networks and the practical demands of resettlement\(^2\)

Refugee young people who do not have family in Australia may be at even greater risk because of their lack of support

Health Issues of Refugee Young People

Young people of refugee background will have typical adolescent health problems. However, they may also have health issues stemming specifically from their refugee experience\(^1\). Common health issues for refugee young people include:

- Nutritional deficiencies and poor overall physical health as a result of living in unsanitary conditions in refugee camps
- Parasitic and infectious diseases (e.g. intestinal parasites; hepatitis B)
- Poor oral health due to poor diet and disruption to oral hygiene
- Limited past exposure to preventative health programs – e.g. immunization; vision and hearing screening
- Mental health concerns are prevalent arising from the deprivation and loss of extended family, friends and home, and the trauma of the refugee experience
- Many refugees are recovering from the effects of torture, trauma or witnessing violence or warfare
- Psychological symptoms – such as depression, anxiety, grief, anger, stress – are often somatized and expressed as physical ailments
- Whatever the presentation, refugee young people (especially new arrivals), should have a thorough physical and psychosocial assessment\(^3\) – focusing on:
  - excluding acute illness
  - immunization status and catch-up
  - symptoms of parasite infection and malaria
  - nutritional status and growth
  - oral health
  - concerns about development, vision and hearing
  - mental health issues
The HIC has released a new Medicare item number to promote comprehensive assessments of newly arrived refugees by general practitioners. A collaborative approach is essential – especially in working with the mental health concerns of refugee young people. Use the Medicare Mental Health Item Numbers to prepare a mental health care plan if required.

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers.

Case Study - Refugee Young Person

AM is a 13 year old girl from Southern Sudan, she was accompanied by her parents and a settlement worker to see you because of burn scars on her trunk and limbs. She speaks Dinka (language spoken in Southern Sudan) and doesn’t speak any English. AM arrived in Australia as a refugee, with her parents and 3 other siblings, 4 weeks ago. She and her family fled Sudan 5 years ago when their family home was torched and she suffered burns. AM’s family spent 4 years in a refugee camp in Kenya with limited safety, health facilities, food and sanitation. AM has problems sleeping and is very self-conscious because of the scars on her body. You conduct a detailed assessment and gather the following history:

History

- **Social**
  - Born at home
  - Fled under militia attack 5 years ago with family
  - Refugee camp 4 years – Northern Kenya

- **Medical**
  - Immunised as baby
  - Malaria in past
  - Burns to trunk & limbs when house torched

- **Psychological**
  - Some sleep disturbance
  - Self-conscious re: scars

- **Social** – assess AM’s school/education level; her peer/family supports or networks

Examination

You also carry out an examination – sensitively explaining the need for this to AM and her parents.

**Note:** It is absolutely essential for a male doctor to provide a female chaperone if conducting an examination of a young girl, or arrange for the girl to be examined by a female practitioner where possible

The main findings from this are:

- Tall, thin
- Well nourished, not pale
- Moderate scarring arms, trunk
- Chest, abdomen normal
- Good teeth
- Ears, vision normal
Cultural Competent Consultation

Cultural competence involves being aware of your own attitudes and beliefs about different cultures and how these impact on the way you perceive and communicate with patients from other cultural backgrounds.

- While it is useful to have a broad understanding of different cultures, cultural competence is really about the ability to communicate with patients across different cultural backgrounds – rather than having an in-depth knowledge of specific characteristics of individual cultures.

- When working with young people from other backgrounds it is important to remember that the most important source of cultural information is the patient themselves.

- Enquire about the adolescent’s cultural background, family history, and how they define their cultural identity and its relevance to their life.

Also assess pubertal development / Tanner staging if possible – the rapid physical changes of puberty may be a reason for her heightened self-consciousness now, or if her pubertal development is delayed from previous illness or malnutrition it is important to give her/ her parents some information about this.

Be aware of the possibility of specific health issues – such as violence, torture and trauma.

- it is important to be sensitive in exploring these issues and not push the young person to disclose information about these experiences.

- the GP’s main role in regard to these issues may be to facilitate referral to specialised services.

Use the relevant Medicare Item Numbers

- Health Assessment for Refugees and Other Humanitarian Entrants – MBS 714 (in surgery) and 716 (home visit)

- GPs can use the Medicare item Number (714) for comprehensive refugee health assessments.

- GPs can also access free interpreting through Telephone Interpreter Service (TIS)

- Some ongoing support and advice may be available from specialised refugee health clinics – e.g. NSW Refugee Health Service – 02 8778 0770 – www.refugeehealth.org.au (or equivalent organisation in each state)

Consultation Issues

The following issues are important to consider in your consultation with AM:

- Language difficulties – if language is a problem, contact the Telephone Interpreter Service for assistance. Do not use a family member as an interpreter.

- Enquire about cultural beliefs and practices – in particular as they may apply to health and illness.

- Trust – gaining the trust of both AM and her parents is essential – take time to build rapport – explain your role as a doctor and answer any questions they may have.

- Explain concepts they may be unfamiliar with – such as:
  - the family doctor and ongoing/preventive care
  - appointments and referral process
  - medical procedures
  - confidentiality and consent
  - the importance of seeing the young person on their own at some point of the consultation (but only after trust has been established).

- Refugee status – it is important to have an awareness that young person has come from a refugee situation – this will sensitise you to
Treat each adolescent as an individual first within the context of their cultural background – for whom ‘culture’ is another dimension to be taken into consideration.

**Tips for Cultural Competency**

- It is helpful to have some awareness of different customs and cultural beliefs in regard to:
  - significant life events/situations – e.g. birth, death, transition to adolescence
  - family relationships and structure – e.g. the role of family authority (e.g. in Vietnamese culture), and decision-making in regard to health care
  - beliefs about illness and the meanings of symptoms; cultural health practices and treatments
  - beliefs around food, use of medications
  - specific cultural or religious practices – e.g. fasting for Ramadan in Moslem cultures

- Remember, however, that the most important source of cultural information is the young person themselves – *How do they view themselves within the context of their culture?*

- Be aware that in adolescent patients, culture can impact greatly on developmental issues and vice-versa

- Cultural competence is about being sensitive to cultural norms and learning to ask the right questions – e.g. “What’s important in your family/culture?”; “How does your family/culture deal with this?”; etc.

- Consult with specialist services or workers if unsure about cultural issues in people from another culture

- Do not use family members as interpreters – if there are language difficulties, use a professional interpreter

**Culturally Sensitive Communication**

Effective communication is the key to addressing many of the cross-cultural issues that arise with CALD young people. 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
- Keep language simple and avoid using 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 CALD young people include:

- 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. HEEADSSS) – enquire about acculturation and identity issues:
  - *How do they view themselves within the context of their culture?*

**Example:** “Thuy, you said that your parents were born in Vietnam and that you grew up here in Australia. How do you mostly think about yourself – as Australian or Vietnamese, or both? What is it like to be you, a Vietnamese teenager growing up in Australia?”

- In which ways do they follow/not follow the norms of their culture?
- How do they feel about their own/parents’ culture/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 e.g. “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?”

- Engage them in a dialogue about their family history and relevant cultural background:
  - enquire about various roles and responsibilities that a young person may have in their family
  - find out how decisions are made in the family/community
Engaging the Family

- In many cultures, participation in health care is a family rather than individual responsibility, and it is common for family members to be involved in decision-making.
- Engaging the family and gaining the trust of parents is critical in treating young people from other cultures.
- 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.
- 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.
- 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.

Cultural Issues around Diagnosis and Treatment

- Where relevant, ask about beliefs within their culture of origin regarding:
  - their symptoms, its cause and management
  - cultural or traditional health practices
- Learn which cultural differences might affect treatment (e.g. attitudes to sexuality; mental health issues; eating habits)
- Find out if there are similarities in ideas and expectations and build on them
- Accommodate cultural issues in the treatment plan without compromising the quality of care provided to the patient
- Explain that you will 'give the best medical care possible', but that you are 'not an expert on their culture' so encourage them to explain their cultural perspective to you
- 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 that the patient has understood instructions 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...?”
- Encourage them to ask questions
- Where there are language difficulties, use a professional interpreter (see below)
- 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

resources

- Translating and Interpreting Service (TIS) – provides free on site and telephone interpreting can be organised through the – available 24 hours a day, 7 days a week
- This service needs to be booked in advance – Telephone the doctors priority line – 1300 131450 (also see Section Four for contact details)
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 Four for a list of services and contact details.
- The [Transcultural Mental Health Centre (TMHC)](https://www.tmhc.org.au) is a state-wide service that provides clinical, consultation services and education and training programs for professionals working with 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 advice and consultation on mental health issues as well as information on cultural/religious, and other general health 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 Clinical Services 1800 648 911 (toll-free).
- Each state has an organisation providing services equivalent to TMHC.

**Practice Points**
- All young people, regardless of cultural background, require confidential care, a youth-friendly approach and routine screening for risk behaviors and protective factors.
- The most important source of cultural information is the patient themselves – enquire about the adolescent’s cultural background, family history, and how they define their cultural identity.
- Refugee young people may be at risk of poor physical and mental health as a result of the stresses associated with their displacement and resettlement, as well as exposure to traumatic experiences.
- Treat each young person as an individual first within the context of their cultural background – enquire about their cultural beliefs, health practices and family history.
- When taking a patient history or conducting a psychosocial assessment – enquire about acculturation and identity issues.
- Develop a management plan that addresses the impact of cultural issues and is culturally acceptable.
- Engaging the family and gaining the trust of parents is critical in treating young people from other cultures.
- Consult with specialist services or workers if unsure about cultural issues, or where there are language difficulties.

**References:**
There is a strong association between substance use and incidence of other health problems in adolescents, especially:
- motor vehicle accidents and other injuries
- sexual risk-taking
- blood-borne viruses (especially Hepatitis C; HIV/AIDS)
- violence and criminal behaviour

Poly-substance use is common among adolescents

**Facts about Adolescent Substance Use**

Recent Surveys show that:
- An estimated 37% of 16–19 year olds and 45% of 20–24 year olds drink at risky or high risk levels for short-term harm
- Marijuana is the commonly used illicit drug most among young people – 5% of 12-15 year olds, 22% of 16-19 year olds and 27% of 20-24 year olds report having used marijuana in the last 12 months
- 17% of 14-19 year olds and 27% of 20-24 year olds are regular or occasional smokers
- Illicit drugs and alcohol are the risk factors accounting for the greatest amount of burden of disease and injury among young people aged 15–24 years

**Adolescent Substance Use**

Substance use is a major threat to young people’s health – illicit drugs and alcohol use are the risk factors accounting for the greatest morbidity among 15–24 year olds. Key features of adolescent substance use include:

- **Alcohol and tobacco** are the substances most commonly used by young people and account for the highest rates of morbidity and mortality
  - high proportions of young people engage in high-risk drinking behaviour – such as binge drinking
- **Illicit drug use** is increasing – mainly:
  - marijuana
  - amphetamines
  - ecstasy
  - hallucinogens
- **Co-morbidity is common** – there is a high prevalence of mental health disorders among young drug users:
  - especially depression, anxiety and other mood disorders
  - substance use is frequently a contributing factor in the early onset of psychosis
  - in 2004–05, there were over 8,021 hospital separations for mental and behavioural disorders due to psychoactive substance use among young people aged 12–24 years

**Resources**

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

- **Australian Drug Information Network** – www.adin.com.au
- **Australian Drug Foundation clearinghouse for information on drugs** – www.druginfo.adf.org.au
- **Centre for Youth Drug Studies** – www.cyds.adf.org.au
- **Youth Substance Abuse Service (YSAS)** – for information about working with high risk, co-morbid young people – www.ysas.org.au
- **National Drug & Alcohol Research Centre (NDARC)** – www.ndarc.med.unsw.edu.au
- **Drug and Alcohol Multicultural Education Centre (DAMEC)** – information and resources on substance abuse and CALD young people – www.damec.org.au

**Risk Factors for Substance Abuse**

A number of risk factors have been linked to substance misuse among young people:

- **Peer use of substances**
- **Family factors**
  - family attitudes favourable to substance use
  - poor parental control and supervision
- **School difficulties and truancy**
- **Early onset of substance use** – especially before the age of 15
- **Unemployment**
- **Low self-esteem and social support**
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:

  **Example:** “If it’s okay with you, I want to ask you some questions about your drug/alcohol use so that I can get a better picture of how it fits into your life. I’d like us to explore what you think the positive effects of your drug use are and what harm it might be causing you. From there you can decide whether you want to do something about your use. How does that sound?”

- Explore the young person’s substance use in an interactive, rather than interrogative, style – this will help him/her to feel safe to open up and share details of their substance use history

- 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** – When/Who with
  - e.g. alone, with friends, parties, when depressed, stressed, angry etc.

---

**Assessment**

- The **HEEADSSS** psychosocial assessment provides a broad assessment for detecting the incidence of alcohol or drug use.

  See Chapter 2 – Conducting a Psychosocial Assessment

- **HEEADSSS** 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 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…”

---

**Emotional and behavioural problems – e.g. depression, anxiety, conduct disorder**

**Childhood physical or sexual abuse**
Effects of use – physical, moods, 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**

**Co-morbidity** – the history should include questioning about possible co-morbid mental health problems. In particular, enquire about:
- mood, anxiety and depressive symptoms
- symptoms suggestive of early psychosis
- if indicated, conduct or refer the patient for a thorough mental health assessment, including past history of mental health symptoms

**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, relationship difficulties

**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
- identify any factors related to cultural background or stresses associated with migration/being a refugee, etc. that may be contributing to substance use

**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 and associated risk behaviours – 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:

Changes in school/work attendance or achievement – frequently absent or late; apathy and lack of effort

Poor physical appearance and an extreme lack of regard for personal hygiene, red eyes, dilated or constricted pupils

Marked changes in emotional state – e.g. unusual aggression, temper flare-ups, sullenness, mood swings

Seeming excessively tired or withdrawn

Withdrawal from usual social, family or recreational activities

A change in peer group and reluctance to introduce friends to the family

Furtive behaviour – including lying, stealing or borrowing money

**Effects of use** – physical, moods, behavioural, social, etc.
Laboratory Investigations

- If the young person 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.

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
- Address co-morbidities – substance use can mask or exacerbate underlying social or psychological difficulties. Where necessary, provide information and education or refer to specialist counselling for:
  - depression and anxiety
  - stress reduction
  - anger management
  - sexual risk-taking
- Provide objective health information about the possible effects of their substance use, and explore with them what impact it is having on their life
- Engage and work with the family where possible – this should first be negotiated with the adolescent themselves
- If the young person is thought to have a substance use disorder, they should be referred to specialised drug and alcohol services for assessment and treatment

A ‘Typical Day’

Asking the young person 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:
- “The information we’ve talked about in this session has given me a bit of an idea about what is going on for you. But I really don’t know a lot about you and the kind of life you lead. I wonder if I could ask you to tell me a little more about your life and the problems you are coping with right now. It would help me to understand the situation better if you could pick a typical day in your life and take me through it from the time you woke up (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.)”

Allow the patient to continue with as little interruption as possible. If necessary, prompt with open-ended questions:
- “What happened then? And before that? And between doing this and that? What next?”
- “What things do you find hard to cope with?” “How do you feel when this/that happens?”
- “Can you tell me where your substance use (drinking, smoking, etc.) fits in to your usual routine?”
- “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.)?”

Review and summarize, and if required ask:
- “Is there anything else about this picture you’ve painted that you would like to tell me?”
The GP’s Role

Many GPs will not have the time or skills to provide the comprehensive intervention required for young people with substance abuse problems – particularly those engaged in high risk behaviours or with complex co-morbid problems. However, the GP can still play a major role in the young person’s treatment by instigating a collaborative treatment approach by:

◆ Identifying the young person’s substance use issues, associated risk behaviours and co-morbid health problems
◆ Referral to specialist services where necessary (drug and alcohol counsellor; Psychologist; etc.)
◆ Ensuring close collaboration with other health professionals/services involved in providing treatment
◆ Maintaining supportive involvement with the young person and monitoring their progress
◆ In more complex cases, where there are co-morbid mental health problems – use the Medicare Item Numbers to facilitate multidisciplinary case management through the development of a Mental Health Care Plan with other health professionals

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 (SOC) model is useful in determining the young person’s awareness about the consequences of their substance use and their readiness to change
◆ It enables GPs to work with the person in terms of ‘where they are at’, rather than expect them to be ready or able to change their substance using behaviour
◆ The model also helps in identifying interventions appropriate to the young person’s stage

See 'Motivational Interviewing' below

While the SOC model is useful as an assessment tool, the technique of Motivational Interviewing provides the GP with a more practical set of strategies for increasing the person’s motivation to change and in assisting the young person to make behavioural changes

Motivational Interviewing  

Motivational Interviewing aims to:

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

The technique of Motivational Interviewing (MI) is based on the following principles:

◆ MI is patient-centred – it focuses on the concerns and perspectives presented by the patient
◆ MI is based on the belief that the resources and motivation for change already exist within the patient
◆ However, the practitioner must also be directive – seeking to elicit these resources and motivation from the client to increase the likelihood they will choose positive behaviour change
◆ MI is based on research which indicates that people who talk about making change are more likely to do so than those who don’t
The core aim of MI is to elicit this ‘change talk’ from patients, so that they hear themselves talk about their reasons, ability and intention to make change.

**Steps in Motivational Interviewing:**

- **Assess the young person's readiness to change** (see ‘Stages of Change’ model)
- Create a favourable climate for change – establish rapport and an atmosphere of collaboration with the young person; adopt a non-judgemental approach.
- Use **communication skills** – such as reflective listening and open-ended questions to identify the patient's concerns – avoid persuasion or coercion.
- Identify the young person's **motivation to change:**
  - “How important would you say it is for you to cut down on your alcohol use?”
  - “On a scale of 1-10 where 0 is not at all important and 10 is extremely important?”
- And – their **belief in their ability to change:**
  - “How confident would you say you are, that if you decided to cut down, you could do it?”
  - Use same scale 0-10 (0 = not at all confident; 10 = extremely confident)
- **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...”
- **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
  - for each individual – identify potential triggers for motivating them to change.
- Assist patient to make the decision to change – engage the patient in a ‘decision balance’ process to tip the balance toward changing:

<table>
<thead>
<tr>
<th>Decision Balance</th>
<th>Reasons Not to Change</th>
<th>Reasons to Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stay the Same</strong></td>
<td><strong>Benefits</strong></td>
<td><strong>Concerns</strong></td>
</tr>
<tr>
<td></td>
<td>“What do you like about (your substance use)?”</td>
<td>“What concerns you about (your substance use)?”</td>
</tr>
<tr>
<td></td>
<td>e.g. Drinking/smoking with my friends; Feeling relaxed/relieving stress Forgetting about my problems Helps me sleep Fun</td>
<td>e.g. Hangovers Can't study Get into fights Poor school performance Appearance – pimples, weight gain, effects on teeth etc. The expense</td>
</tr>
<tr>
<td><strong>Change</strong></td>
<td><strong>Concerns</strong></td>
<td><strong>Benefits</strong></td>
</tr>
<tr>
<td></td>
<td>“What concerns would you have about changing?”</td>
<td>“What benefits might you get from changing?”</td>
</tr>
<tr>
<td></td>
<td>e.g. Lose my friends No fun Stress Not coping with my problems</td>
<td>e.g. No more hangovers Weight loss Improved appearance Can study better Save money</td>
</tr>
</tbody>
</table>

See Decision Balance - Below

- Reinforce the **patient’s self-efficacy** – i.e. their belief and confidence in their ability to make changes or to cope with a specific task or challenge.
- Assist the young person to **learn skills** that will help them to achieve change:
  - developing alternative ways of coping with problems that drive their substance use – e.g. stress, low self-confidence, anxiety or other mood problems
  - identifying risk situations and triggers to substance use and learning new skills for dealing with these – e.g. assertive communication/refusal skills
  - strategies for coping with barriers to changing (e.g. peer pressure, withdrawal symptoms, sleeplessness, etc.)
- Provide **ongoing support** and reinforcement.
**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)
- Focussing on the immediate likely harms resulting from use of a particular substance and works to reduce these potential harms
- Providing information and education on the effects of the substances being used and their potential harms
- Assisting the young person to make healthy choices for reducing these harms

**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
- avoid mixing drugs
- if going to a party or club – go as a group and look after each other
- knowing where to get help if needed

---

**Specific Communication Skills for Motivational Interviewing**

The core skills of Motivational Interviewing can be summarised as follows:

- **The Microskills of MI – “OARS”:**
  - **O** - Open ended questions – these establish rapport, gather information and increase understanding – e.g. “How do you think your drug use affects your health?”
  - **A** - Affirm – “It’s good that you decided to talk to someone about your drug use”
  - **R** - Reflectively listen – “It sounds like you’re starting to…..”
  - **S** - Summarise – “Let me see if I understand what you’re saying…”

- **The types of change and commitment talk to listen for, elicit and reflect back to the client – DARN – C:**
  - **D** – Desire – why the patient would want to make the change
  - **A** – Ability – how they might go about making change
  - **R** – Reason – their reasons for making change
  - **N** – Need – how important making this change is to them
  - **C** – Commitment – statements reflecting intention to make change – e.g. “I will...”; “I intend to...”; “I’m going to...”

---

**Example:**

**D** – Why would you want to make this change?
**A** – If you were to make the change, how might you go about it?
**R** – What are the three main reasons you would want to make this change?
**N** – On a scale of 0-10, how important is it for you right now to make this change? Why are you a 6 and not a 0? (note frame in the positive to elicit change talk from the patient)
**C** – What do you think you will do?
**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 drug and alcohol treatment 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) and use the Medicare Item Numbers to facilitate a collaborative treatment approach

**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
- **Harm minimisation** – providing information and education on ways to reduce drinking and the risks associated with it, such as:
  - alcohol consumption by drinking low alcohol beverages

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers
- 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)

**Collaborative case management**
- you write a Mental Health Care Plan to refer Rob to a private Psychologist/Social Worker for counselling around managing his aggression and anger
- Referral to a youth support officer at the local Centrelink office for assistance with educational and employment options for Rob

**practice points**

- The **HEADSSS** psychosocial assessment provides a broad assessment for detecting the incidence of alcohol or drug use
- **Co-morbidity** – the history should include questioning about possible co-morbid mental health problems. In particular, enquire about:
  - mood, anxiety and depressive symptoms
  - symptoms suggestive of early psychosis
  - if indicated – conduct, or refer the patient for, a thorough mental health assessment, including past history of mental health symptoms
- If the young person is thought to have a substance use disorder, consider referral for specialised assessment and treatment
- The GP’s main role may be to initiate and manage a **collaborative treatment approach** with other specialist providers
- Use the **Medicare Item Numbers** to facilitate multidisciplinary case management – as well as maintaining supportive involvement with the young person and monitoring their progress
- Use a **harm minimisation** approach – to reduce harms/risks associated with their substance use – provide objective health information about the possible effects of their substance use, and explore strategies with them for reducing risks
- Use **Motivational Interviewing** techniques to enhance the patient’s motivation and commitment to change

**References:**

Understanding Adolescent Sexuality

Adolescent sexuality is on the one hand a natural part of healthy development and on the other the cause of much vexation and controversy in the public domain. In the general practice setting, there is much scope for promoting sexual health and positively acknowledging sexuality among young people.

Some features of adolescent sexuality:

- The development of reproductive capability and a sexual identity are fundamental tasks of adolescence
- 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
- Young people’s concerns about sexuality are more commonly about relationships and communication with partners than about biological risks of disease or pregnancy
- Adolescent girls have an increased biological risk compared with older women of acquiring cervical infections such as Chlamydia trachomatis because of exposed transitional epithelium
- Risk of acquiring STIs among young people also relates to number of partners, partner change, issues of power and negotiation with partners and access to contraceptive and health services
- Young people who are gay, lesbian, bisexual or uncertain of their sexual orientation are a particularly vulnerable group

The GP’s Role

Sexual health encompasses a total sense of wellbeing 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 for and treatment of STIs
- counselling about 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

Assessment of Sexual Health

‘The Basics’

- Establish a trusting relationship essential in helping the young person feel comfortable discussing sexual health issues
- Understand that experimentation is normal and that the key issue is protecting their health
- Adopt a non-judgemental approach
- Be prepared to raise the issue and show comfort in discussing the topic
Sexual History Taking

An in-depth sexual history is appropriate
- if the young person presents directly with a sexual health issue – such as a request for contraception; a pregnancy test, and ‘STI check up’ or an HIV test
- once they engage with you in discussing more personal information such as their sexual activity

Questioning includes topics such as:

- Commencement of sexual intercourse
  “How old were you when you first had sexual intercourse?” or “How many months or years since you first had sexual intercourse?”

- Partners: number, gender, relationship duration
  “How many sexual partners have you had since you first had sex?”
  “Have your partners been male, female or both?”
  “Tell me a bit about your relationships; how long have you been with your current partner? What about the previous one?” etc.

- Safer sex practices: condom use, contraception
  “What contraception have you and/or your partner used? What about in previous/other relationships?”
  “How often do you and your partner use condoms?”

- History of pregnancy
  “Have you ever been pregnant?” If yes, explore

- History of sexually transmitted infections
  “Have you ever been diagnosed with a sexually transmitted infection?” If yes, explore

- STI screening including HIV antibody testing
  “Have you ever had tests for sexually transmitted infections?” If yes, explore

- STI symptoms (see STI testing in symptomatic young people below)

- Hepatitis B prophylaxis
  “Have you been vaccinated against Hepatitis B?”

- Identify areas of risk, e.g. substance use, unsafe sex, exploitative relationships, sexual abuse, sex for money
  “Have you ever felt unsafe in a sexual relationship?”
  “Have you ever been touched in a sexual way that you didn’t ask for or want?”
  “Have you ever felt pressured into having sex?”
  “Have you ever had sex in exchange for money or some other favour or payment?”

If yes to any – explore.
Sexually Transmitted Infections (STIs)

Most of the common STIs are asymptomatic and not all are amenable to screening (e.g. HPV, HSV). Screening guidelines depend on the young person’s sexual and other practices and the prevalence of different STIs among these subgroups.

Screening asymptomatic, sexually active young people

- Chlamydia PCR testing is recommended for all sexually active young people about once a year. First pass urine Chlamydia PCR is adequate, as is a self-collected lower vaginal swab for Chlamydia PCR. Alternatively an endocervical swab in a female or urethral swab in a male can be done for Chlamydia PCR.

- Chlamydia screening can be done quickly and incorporated into routine preventive health practice, e.g.

  “We are offering a urine test for Chlamydia for all sexually active young people. Would you like to have a test, or ask me anything about Chlamydia?”

- All young people should also be screened and/or offered immunisation for Hepatitis B.

- Check HPV vaccination status among young women and offer as appropriate.

- If the young person is Aboriginal, additional screening for gonorrhoea (first pass urine PCR is adequate for screening) and syphilis is recommended, because these infections are more prevalent among sexually active Aboriginal people. If a urethral or cervical swab are collected, gonorrhoea culture rather than PCR is recommended.

- If the young person requests ‘a total sexual health check up’ it is advisable to take a thorough sexual history. The fact that they have requested such a check up means that they could be at higher risk for STIs. Unless the young person falls into one of the groups below (men who have sex with men, sex worker, person who injects drugs) it is reasonable to screen for Chlamydia, gonorrhoea, HIV and syphilis in this situation. It is also important to find out what they know about STIs. There can be an assumption that a ‘check up’ covers all known STIs, or that a Pap smear is the equivalent of an STI check.

- If the young person is a sex worker of either gender, screening for Chlamydia, gonorrhoea, syphilis and HIV is recommended.
If the **young person is a man who has sex with men (MSM)** screening for Chlamydia, gonorrhoea, syphilis, HIV and Hepatitis A is recommended

If the **young person is an injecting drug user**, screening for Chlamydia, gonorrhoea, syphilis, HIV, Hepatitis A and Hepatitis C is recommended

Enquiring about **sexual practices** (e.g. receptive anal sex, oral sex) will also guide specimen collection; note that to screen for gonorrhoea from the rectum or pharynx, swab for culture is recommended over PCR

**Pap smear screening** should commence in sexually active women (regardless of sexual orientation) after the age of 18, or 2 years after first intercourse whichever is LATER

**Informed consent** must be obtained before performing any STI tests. This involves explaining the tests, what's involved, and what might happen if the test is positive (e.g. antibiotics, partner notification)

### STI testing in symptomatic young people

- STI syndromes include vaginal or urethral discharge, lower abdominal pain in women, epididymitis, acute scrotum, genital ulcers or lumps, genital itch, recurrent urethritis, cervicitis, and proctitis
- A careful sexual history needs to be taken when a sexually active young person presents with symptoms that could be due to an STI, to determine which infections are likely, where specimens should be taken and what tests to order

### Immunisation

- The national immunisation program includes the quadrivalent Human Papilloma Virus vaccine, administered through school vaccination programs. There is a catch-up period until mid-2009 for women up to the age of 26
- Hepatitis B immunity should be checked and the vaccine schedule offered as appropriate

### Genital Examination

**When conducting an examination:**

- Always ask if the young person would like a chaperone or support person – e.g. a friend, relative or female practice staff member
- For some cultures it may be uncomfortable or even shameful for a male doctor to examine a female patient
  - ask the parents' permission
  - sensitively explain the need for the examination
  - 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

### Resources

- **Melbourne Sexual Health Centre** – Provides information for health professionals such as clinical syndromes, how to test, STI notification and management guidelines as well as fact sheets for patients – [www.mshc.org.au](http://www.mshc.org.au)
- **NSW Sexual Health Infoline** – Telephone support services for doctors, nurses and other health professionals who need on the spot technical support during consultations – 1800 451 624
- **Family Planning Association** – provides information about sexual and reproductive health and related services to both the general public and health professionals – [www.fpahealth.org.au](http://www.fpahealth.org.au)

### Immunisation

- The national immunisation program includes the quadrivalent Human Papilloma Virus vaccine, administered through school vaccination programs. There is a catch-up period until mid-2009 for women up to the age of 26
- Hepatitis B immunity should be checked and the vaccine schedule offered as appropriate
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

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
- Provide information/education on safer sexual practices

See also Chapter 4 – Conducting a Physical Examination

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 (including abstinence) and unsafe sexual practices
- 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
Information, counselling and support for gay and lesbian young people:

- **Australia-wide** – [www.glccs.org.au](http://www.glccs.org.au) - provides information and links to Primary Gay and Lesbian telephone counselling service organisations across Australia
- Persons Seeking Telephone Counselling and Support from outside the local call area of State or Territory Capital Cities may call 1800 18 4527 – between 7.30pm and 10.00pm local time
- **Same Sex Attracted Youth website** – [www.latrobe.edu.au/ssay](http://www.latrobe.edu.au/ssay)

Some additional websites:

- **ACT** – [www.qnet.org.au/content/faqs_and_articles/meeting_people/youth_groups.php](http://www.qnet.org.au/content/faqs_and_articles/meeting_people/youth_groups.php)
- **Gender** – [www.gendercentre.org.au](http://www.gendercentre.org.au)

---

**Case Study 1**

Reproduced, with permission from Royal Australian College of General Practitioners. CHECK program of self-assessment: Adolescent Health. RACGP 2006, Melbourne.

Georgia, aged 15 years, came to see you 3 years ago to complete her Hepatitis B immunisation. Her past health has been excellent. She lives with both parents and her sister who is aged 17 years. Georgia's parents are Anglo-Australian. Her father runs a small business and her mother is a part time preschool teacher. They live in a leafy inner city suburb where Georgia and her sister attend a local girls' high school. When you saw Georgia's mother for her Pap test 3 months ago, she commented both her children are fine and doing well at school, and that Georgia still plays netball which keeps her very busy.

Georgia comes to see you on her own complaining of painful urination, urinary frequency and urgency of 2 days duration. After explaining to her the boundaries of confidentiality, you request permission to ask some potentially sensitive question. Georgia readily admits to being sexually active. She tells you that she and her boyfriend Nick, aged 16 years, started having sex one month ago. They last had intercourse 4 days ago. She says they use condoms for contraception 'all the time'. Georgia explains that Nick is her first and only sexual partner, while he has had two previous female sexual partners. Her last period was 12 days ago and her periods are generally regular and unproblematic. She hasn't talked about her sexual relationship with her parents but thinks they are probably aware of it.

Georgia's symptoms are most likely to be caused by a lower urinary tract infection, but acute urethritis (due to Chlamydia trachomatis, N. gonorrhoea or HSV), acute urethral syndrome, non-infectious causes (e.g. trauma from sexual intercourse, or chemical irritants), vulvovaginitis or HSV infection should be excluded.

Because Georgia is symptomatic, it would be ideal to discuss a physical examination and more comprehensive STI testing and obtain...
Case Study 2

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 Anglo-Australian and lives 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 might have been related 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 HEEADSSS 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

See also Chapter 2 – Conducting a Psychosocial Assessment

her consent. This would include: physical examination looking for genital ulcers, inflammation and discharge; first pass urine or cervical swabs for Chlamydia and gonorrhoea PCR; mid stream urine for microscopy, culture and sensitivity; high vaginal swab for T. vaginalis and C.albicans

- If genital examination is normal, your provisional diagnosis would probably be uncomplicated cystitis and you can commence empirical treatment, eg trimethoprim 300mg twice daily for 3 days
- Prevention and other issues you can raise during this consultation include contraception, general STI and Pap screening guidelines for future reference, exploring her relationship with Nick, and also with her parents. You can establish a follow up appointment to conduct a HEEADSSS screen.

See also Chapter 2 – Conducting a Psychosocial Assessment
Websites For Young People On Sexuality & Sexual Health

Sexuality and sexual health:
www.yoursexhealth.org

Sexual and reproductive health – Family Planning websites:
www.fpahealth.org.au
http://www.fpa.org.au/
www.shinesa.org.au
http://www.fpt.asn.au/

Young people’s sexual and reproductive health:
www.likelitis.org.au

Chlamydia websites:
www.getcluedup.com.au
www.couldihaveit.com.au

See Section 4 – For further information and services on sexual health

References:


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 alert to other stressors which increase vulnerability to adverse mental health outcomes – such as family breakdown, bullying, stress, school difficulties.
- Many mental health disorders have their onset in adolescence – such as anxiety, depression, eating disorders.

Mental Health in CALD Young People

- Up to 25% of adolescents experience a mental or substance use disorder at any given time.
- The overall mental health of young people appears to be worsening.
- Anxiety and depression are the leading mental health problems among adolescents – accounting for 17% of the male disease burden and 32% for the female.
- Behavioural disorders, such as ADHD and Conduct Disorder (CD) are common, especially among young males – 8% of young people aged 12-17 years had ADHD and 3% had conduct disorder, with around 16% of those with ADHD or CD having both disorders.
- The mental health of CALD young people may be adversely affected by:
  - language difficulties
  - intergenerational and intercultural conflicts
  - exposure to traumatic experiences – e.g. torture, refugee trauma
  - isolation
  - resettlement experiences
  - racism and discrimination
- Refugee young people are at high risk of mental health problems such as depression, anxiety, post-traumatic stress disorder (PTSD) – arising from the loss of family, friends and home, and the trauma of the refugee experience.
- Many refugees are recovering from the effects of torture, trauma or witnessing violence.
- For specialist assistance in treating young people and families from non-English speaking backgrounds in NSW – contact the Transcultural Mental Health Centre (TMHC).

Resources

- TMHC is a free, 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.
- These can be provided in the language of the client by qualified bilingual health professionals.
- TMHC welcomes referrals from GPs and provides reports on the referred case as well as recommendations regarding care plans.
- Contact on: (02) 98403800 or Clinical Services 1800 648 911 (toll-free) or Website – go to Diversity Health website – www.dhi.gov.au – click link to Transcultural Mental Health Centre.
- Each state has an organisation providing services equivalent to TMHC.

Facts about Adolescent Mental Health

- Up to 25% of adolescents experience a mental or substance use disorder at any given time.
- The overall mental health of young people appears to be worsening.
- Anxiety and depression are the leading mental health problems among adolescents – accounting for 17% of the male disease burden and 32% for the female.
- Behavioural disorders, such as ADHD and Conduct Disorder (CD) are common, especially among young males – 8% of young people aged 12-17 years had ADHD and 3% had conduct disorder, with around 16% of those with ADHD or CD having both disorders.
**The GP’s Role**

More than half of all adolescents who attempt suicide will have visited a GP within the previous month. GPs therefore play a key role in the detection, diagnosis, 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
- Actively promoting young people’s 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

---

**Features of Adolescent Mental Health Problems**

- **Mood disorders** such as depression, and anxiety are the most prevalent mental health problems in adolescents
- **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
  - e.g. the existence of a depressive disorder raises the risk of substance use, sexual risk-taking and suicidal behaviour
  - co-morbid mental health conditions are common – e.g. ADHD and anxiety or depressive disorders
- **Mental health problems often go undetected in adolescents**:
  - young people are generally ill-informed about their mental health
  - less than 25% of young people with a mental health problem will seek help
- **The presentation of mental health problems** in adolescents can differ greatly from adults
  - e.g. signs such as anger, aggression, acting out, drug use, risk behaviours, non-attendance at school – may all be indicators of a mental health problem
- **A high level of morbidity and mortality** is associated with adolescent mental health problems including:
  - damaging lifestyles and behaviour (e.g. substance abuse, self harm)
  - 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 (ADHD); anxiety disorders (e.g. obsessive compulsive disorder)
- **Disorders that have their initial onset during adolescence** – including depressive disorder, anxiety, schizophrenia, eating disorders

See also Chapter 5 – Risk Taking and Health Promotion

- Educating and supporting parents and family members and involving them, as appropriate, in any treatment plans
- Sensitize the young person, and their family, to the need for referral to specialist mental health services
- Collaborating with other mental health professionals in the provision and coordination of comprehensive, multidisciplinary care – use the new Medicare mental health item numbers to develop a coordinated approach to treatment (see below)
- Identifying associated co-morbid health problems (e.g. substance use) and risk factors and providing appropriate treatment and referral
Screening And Assessment

- Routinely enquire about psychological distress, depression and health risk behaviours with adolescent patients
- The HEEADSSS psychosocial assessment provides a broad framework for detecting the presence of risk factors and mental health problems

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 can provide 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 functioning in key areas of their life – e.g. family, school, peer relationships. Where possible, obtain history from other key sources such as parents and teachers
- Adolescents may not always present with obvious symptoms – be sensitive to behavioural presentations such as anger, risk taking, acting-out, truancy, moodiness – which may be indicative of an underlying mental health problem
- Screen for co-morbid health problems – e.g. substance abuse; mood disorders concomitant with behavioural conditions such as ADHD and Conduct Disorder
- 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
- Clarify cultural norms and beliefs about mental illness and the cultural meaning attached to any particular symptoms

Using the Medicare Mental Health Item Numbers

The new Medicare item numbers of the Better Access to Mental Health Care initiative allow GPs to access Psychologists who use evidence based treatments, as well as other specialist mental health care providers:

- The GP has a critical role in initiating a collaborative treatment approach by developing a Mental Health Care Plan for the young person
- This enables the GP to refer to a Psychiatrist or Psychologist for specialist mental health assessment and/or provision of focused psychological treatment for a range of mental health disorders
- The approved focused psychological treatments that can be provided by a Psychologist or Social Worker under the Medicare scheme include:
  - Cognitive Behavioural Therapy (CBT), including both behavioural and cognitive interventions
  - Psycho-education (including motivational interviewing)
  - Relaxation strategies – progressive muscle relaxation; controlled breathing
  - Skills training – problem solving skills and training; anger management; social skills training; communication training; stress management
  - Interpersonal therapy (especially for depression)
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

Conduct a psychosocial assessment using the HEEADSSS tool – in particular, screen for:
- marked changes in usual mood or behaviour – e.g. sleep/appetite disturbance; persistent irritability
- underlying risk factors or precipitating events for onset of depression – e.g. substance use, bullying and victimisation, difficulties in sexual orientation, issues of loss, family conflict, trauma, stress, illness
- relationship difficulties – withdrawal/isolation, conflicts with peers
- family history of depression or other mental illness
- deterioration in school performance; loss of interest in activities and recreational pursuits

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.

Where possible, use diagnostic interviews, self-report questionnaires or rating scales to assist in establishing diagnosis – e.g. K10 (Kessler Psychological Distress Scale); DASS 21 (Depression Anxiety Stress Scale). (See Black Dog Institute website for assessment tools: www.blackdoginstitute.org.au – go to ‘Health Professionals Website’)

Consider the differential diagnosis of depressive disorders and comorbidity – identify the presence of comorbid problems – e.g. substance use, anxiety, other behavioural or mental health problems, sexual abuse.
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.

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 self-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.

Where uncertain, refer to a Child and Adolescent Psychiatrist or Psychologist for more in-depth assessment to assist with diagnosis and treatment options.

This is especially important in distinguishing between depression and other mood disorders such as Bipolar Disorder and Psychotic Depression.

See ‘Referral Options’ (below)

Depression - Diagnostic Signs

According to the Diagnostic and Statistical Manual for Mental Disorders (DSM-IV), a 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
- Change in sleep patterns – insomnia, broken sleep, sleeping 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

Management Approaches

- Developing a 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 alliance 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.
- The treatment of depression in adolescents, particularly severe depression, should ideally involve a collaborative partnership between the patient, the GP and a specialist mental health service provider (e.g. Psychiatrist; Psychologist; adolescent mental health worker).
- Use the new Medicare Mental Health Item Numbers to develop a comprehensive Mental Health Care Plan for the young person – this enables the GP to refer to a Psychiatrist or Psychologist for specialist assessment and treatment.

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers.
Treatment Options

Treatment plans should be based on a thorough assessment – including the type, severity and duration of the depressive episode, and any stressors that contributed to the episode

i. Psychological Treatments

◆ Evidence-based counselling or psychotherapy therapies are generally considered the first line of treatment for adolescents \(^6, 9, 11\) – although their effectiveness may be enhanced when used in conjunction with appropriate medication. Evidence-based psychological treatments include:
  - Cognitive Behavioural Therapy (CBT) has proven efficacy in the treatment of depression
  - Interpersonal Psychotherapy (IPT) may be helpful for older adolescents
  - Family Therapy

◆ Use the new Medicare Mental Health Item Numbers to refer to a Psychologist or other counsellor trained in evidence-based psychological treatments

ii. Anti-Depressant Medication

◆ Recently the role of medication in the treatment of depression in adolescents has been under review, with reports of increased risk of agitation and suicidal behaviour in this age group with the use of Selective Serotonin Reuptake Inhibitors (SSRIs) \(^12\)

◆ The potential of these negative side-effects suggests the need for a cautious and judicious use of medication – especially with younger adolescents

◆ Nevertheless, available evidence suggests that for selected patients, antidepressants are an effective component of the successful treatment of certain depression and anxiety disorders in children and adolescents

◆ The Australian Adverse Drug Reactions Advisory Committee (ADRAC) has released three recommendations on the use of SSRIs with children and adolescents \(^10\):
  - any SSRI use in adolescents with major depressive disorder (MDD) should be undertaken only within the context of comprehensive management of the patient – such management should include careful monitoring for the emergence of suicidal ideation and behaviour
  - the choice of SSRI for adolescents should be made taking into account the recent evaluations of clinical trial data and product information
  - adolescents who are currently being treated for MDD with an SSRI should not have their medication ceased abruptly

◆ Other criteria that should be considered in prescribing medication include recommendation from the NHMRC Clinical Practice Guidelines for Depression in Young People \(^8\) that medication should only be prescribed if:
  - 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

◆ The key to successful antidepressant drug treatment in adolescents is frequent review by the GP to monitor response, compliance and side effects, preferably with the use of a depression symptom checklist in the context of providing psychological support

See the box below for more specific guidelines on the use of anti-depressant medications with adolescents

resources

◆ The Black Dog Institute provides a range of assessment tools, resources and management guidelines for GPs in the treatment of depression and other mood disorders – www.blackdoginstitute.org.au


◆ The Royal Australian and New Zealand College of Psychiatrists has developed clinical practice guidelines for the treatment of depression and other disorders – www.ranzcp.org/publicarea/cpg.asp - go to ‘Clinical Practice Guidelines’

◆ DepressionNet – provides information and resources to patients about causes, symptoms and various treatment options in managing depression – www.depressionnet.com.au

◆ beyondblue – the National Depression Initiative has resources for professionals and the public, including a specific site for young people – www.beyondblue.org.au

◆ Reachout – provides information, resources and support for both young people and GPs – www.reachout.com.au
Guidelines for Use of Anti-Depressant Medication\textsuperscript{8,9,10,12}

\begin{itemize}
\item Prescription of medication to adolescents should be based on a \textit{comprehensive assessment} of the young person, taking into account factors such as:
  \begin{itemize}
  \item severity of condition
  \item lifestyle
  \item co-morbid conditions – e.g. substance use and other risk factors
  \item developmental age of young person and their capacity to understand and comply to treatment regime
  \item degree of family and social support available to them
  \end{itemize}
\item When prescribing antidepressants for adolescents, GPs should:
  \begin{itemize}
  \item discuss the medication with the young person and/or parent to ensure they are comfortable with the treatment
  \item \textit{explain potential side effects} including suicidality
  \item discuss the importance of taking the medication as prescribed and the impact that other substances may have
  \end{itemize}
\item Where uncertain, prescription of medication should be done in \textit{consultation with, or referral to a psychiatrist} – especially if the depression is severe
\item \textbf{Selective serotonin re-uptake inhibitors (SSRIs)} – are preferred with adolescents because they are quicker acting, have fewer side-effects, are relatively safe in overdose and have lower cardiotoxicity than tricyclics.
\item \textbf{Specific recommendations} for commencement of an adolescent on SSRIs are (adapted from the RACGP clinical guidelines\textsuperscript{10}):
  \begin{itemize}
  \item \textbf{Start with a low dose} and build up gradually
  \item Carefully \textit{monitor} the patient, especially in the early weeks, for the emergence of \textit{behavioural activation}, suicide risk and harmful side effects
  \item Be available for contact in case of emergence of adverse reactions – where possible, \textbf{see the young person on a weekly basis} for the first few weeks of treatment
  \item \textbf{Sensitize patients, parents and others} living with the young person to be aware of potential activation symptoms and other warning signs – including the possible emergence of suicidal thoughts early in treatment
  \end{itemize}
\end{itemize}

- In the case of \textbf{non-response} or significant deterioration, \textbf{consult}, where possible, with a child and adolescent psychiatrist or developmental paediatrician
- Following recovery, the antidepressant should be continued for a period of six to twelve months to prevent relapse or recurrence
- Sudden cessation of SSRIs should be avoided in order to avoid discontinuation syndrome
- \textbf{Tricyclics} and \textbf{MAOIs} have a generally higher risk of adverse effects and much greater toxicity in overdose. Prescribing of these antidepressants to children and adolescents should not be initiated by general practitioners
- Consult with a 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

\begin{itemize}
\item Referral to other specialist services is a crucial part of providing a shared care approach
\item Referral should be discussed sensitively with the young person and the reasons clearly explained
\item Obtain their permission to share information with the other referral body
\item Reassure them that they are welcome to return if the referral does not work out, so that other options can be explored
\item The role of counsellor/psychologist may need to be explained to adolescents and families from CALD backgrounds as these services may not exist among some cultural groups
\item Use the new \textbf{Medicare Mental Health Item Numbers} to develop a \textbf{Mental Health Care Plan} to facilitate referral to a Psychiatrist or Psychologist
\end{itemize}

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers
v. Monitoring Daily Activities

- Withdrawal from pleasurable or routine activities is a common feature of depression.
- Set the young person homework tasks to identify and monitor their daily activities over the period of a week.
- 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
- Use the new Medicare Mental Health Item Numbers to develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach.

See Section 4 – for contact details of other mental health services

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
  - emotional self-management
- Consider referral to a Psychologist or counsellor to provide psycho-education strategies to the young person on how to manage their depression, moods and negative cognitive styles.

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers
Some of the changes seen during this phase include:
- Changes in **affect** such as anxiety, irritability and depression
- Changes in **cognition** such as difficulty in concentration or memory
- Changes in **thought content** – such as preoccupation with new ideas often of an unusual nature
- **Physical changes** such as sleep disturbance and loss of energy
- **Social withdrawal** and impairment of **role functioning**

The person may also experience some **attenuated** positive symptoms such as mild thought disorder, ideas of reference, suspiciousness, odd beliefs and perceptual disorders that are not quite of psychotic intensity or duration

### The Acute Phase of Psychosis

- The acute phase of psychosis is characterized by the presence of positive psychotic symptoms which include thought disorder, delusions and hallucinations:
  - **Hallucinations** – are sensory perceptions in the absence of external stimulus
  - **Delusions** – are fixed, false beliefs out of keeping with the person's cultural environment
  - **Thought disorder** – refers to a pattern of vague or disorganized thinking.

- An underlying psychological disturbance should always be considered in a young person presenting with persistent or ill-defined somatic complaints such as tiredness, repeated headaches or insomnia in the absence of demonstrable physical pathology on examination

### Screening for Psychosis

- If a young person is experiencing significant psychosocial difficulties, and displaying symptoms of depression, anxiety or substance misuse, it is important to consider the possibility that such symptoms are part of a psychotic disorder

- **The following prompts may be helpful in screening for psychosis:**
  - Have you ever had any trouble with your thought processes recently? Do they seem speeded up or confused?
  - **Checking for thought disorder**
treatment and adjusting medication in consultation with the psychiatrist.

For acute symptoms of psychosis – a referral should be made to your Area Mental Health service and/or a private psychiatry service.

Psychiatric Emergency

- Contact your local Mental Health (Acute Care) Crisis Service
- Consider other options, including:
  - Filling out a Scheduling form
  - Referral to local Emergency Department with appropriate escort

Suicide And Self Harm

Facts about Suicide in Young People\(^1,2,6\)

- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004
- In 2004, 272 young people aged 12-24 committed suicide
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW
- Hospitalisation rates for suicide attempts are up to three times higher in young females than in males, while death rates from suicide are about 3-4 times greater in males than in females – this is mainly due to males using more lethal methods than females
- 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
- In 2002 a survey of young people in year 10 and 11 found 6% had deliberately self harmed in the past 12 months and 12% reported having done so at some point in their life

Suicidal and Self Harming 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

Assessment

- Where possible, conduct a thorough psychiatric and medical assessment
- Obtain a collateral history from family/friends etc.
- Assess for co-morbid issues requiring treatment – especially substance use
- In any psychiatric assessment it is essential to assess for suicide risk and whether the person is at risk to others
- Refer to specialist mental health services and/or psychiatrist for more in-depth assessment

Management

- Effective management of a young person with psychosis requires a multidisciplinary approach through collaboration between primary care and specialist mental health services
- The GP’s main role may be to coordinate a collaborative treatment approach and facilitate referral to specialist services
- Discuss referral to specialist mental health services with the young person and/or their family – where possible involve the young person, family and friends in treatment planning
- Use the Medicare Mental Health Item Numbers to develop a care plan for the young person and to facilitate referral

---

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia, and agitation
- Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime
- The GP may be responsible for maintaining suicidal and self harming behaviour in consultation with the psychiatrist.

For acute symptoms of psychosis – a referral should be made to your Area Mental Health service and/or a private psychiatry service.

Psychiatric Emergency

- Contact your local Mental Health (Acute Care) Crisis Service
- Consider other options, including:
  - Filling out a Scheduling form
  - Referral to local Emergency Department with appropriate escort

Suicide And Self Harm

Facts about Suicide in Young People\(^1,2,6\)

- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004
- In 2004, 272 young people aged 12-24 committed suicide
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW
- Hospitalisation rates for suicide attempts are up to three times higher in young females than in males, while death rates from suicide are about 3-4 times greater in males than in females – this is mainly due to males using more lethal methods than females
- 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
- In 2002 a survey of young people in year 10 and 11 found 6% had deliberately self harmed in the past 12 months and 12% reported having done so at some point in their life

Suicidal and Self Harming 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

Assessment

- Where possible, conduct a thorough psychiatric and medical assessment
- Obtain a collateral history from family/friends etc.
- Assess for co-morbid issues requiring treatment – especially substance use
- In any psychiatric assessment it is essential to assess for suicide risk and whether the person is at risk to others
- Refer to specialist mental health services and/or psychiatrist for more in-depth assessment

Management

- Effective management of a young person with psychosis requires a multidisciplinary approach through collaboration between primary care and specialist mental health services
- The GP’s main role may be to coordinate a collaborative treatment approach and facilitate referral to specialist services
- Discuss referral to specialist mental health services with the young person and/or their family – where possible involve the young person, family and friends in treatment planning
- Use the Medicare Mental Health Item Numbers to develop a care plan for the young person and to facilitate referral

---

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia, and agitation
- Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime
- The GP may be responsible for maintaining suicidal and self harming behaviour in consultation with the psychiatrist.

For acute symptoms of psychosis – a referral should be made to your Area Mental Health service and/or a private psychiatry service.

Psychiatric Emergency

- Contact your local Mental Health (Acute Care) Crisis Service
- Consider other options, including:
  - Filling out a Scheduling form
  - Referral to local Emergency Department with appropriate escort

Suicide And Self Harm

Facts about Suicide in Young People\(^1,2,6\)

- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004
- In 2004, 272 young people aged 12-24 committed suicide
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW
- Hospitalisation rates for suicide attempts are up to three times higher in young females than in males, while death rates from suicide are about 3-4 times greater in males than in females – this is mainly due to males using more lethal methods than females
- 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
- In 2002 a survey of young people in year 10 and 11 found 6% had deliberately self harmed in the past 12 months and 12% reported having done so at some point in their life

Suicidal and Self Harming 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

Assessment

- Where possible, conduct a thorough psychiatric and medical assessment
- Obtain a collateral history from family/friends etc.
- Assess for co-morbid issues requiring treatment – especially substance use
- In any psychiatric assessment it is essential to assess for suicide risk and whether the person is at risk to others
- Refer to specialist mental health services and/or psychiatrist for more in-depth assessment

Management

- Effective management of a young person with psychosis requires a multidisciplinary approach through collaboration between primary care and specialist mental health services
- The GP’s main role may be to coordinate a collaborative treatment approach and facilitate referral to specialist services
- Discuss referral to specialist mental health services with the young person and/or their family – where possible involve the young person, family and friends in treatment planning
- Use the Medicare Mental Health Item Numbers to develop a care plan for the young person and to facilitate referral

---

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

- The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia, and agitation
- Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime
- The GP may be responsible for maintaining suicidal and self harming behaviour in consultation with the psychiatrist.

For acute symptoms of psychosis – a referral should be made to your Area Mental Health service and/or a private psychiatry service.

Psychiatric Emergency

- Contact your local Mental Health (Acute Care) Crisis Service
- Consider other options, including:
  - Filling out a Scheduling form
  - Referral to local Emergency Department with appropriate escort

Suicide And Self Harm

Facts about Suicide in Young People\(^1,2,6\)

- The rate of young male deaths from suicide declined by over 50% from 1997 to 2004
- In 2004, 272 young people aged 12-24 committed suicide
- There has been a large rise in young females needing hospital treatment for suicide attempts in NSW
- Hospitalisation rates for suicide attempts are up to three times higher in young females than in males, while death rates from suicide are about 3-4 times greater in males than in females – this is mainly due to males using more lethal methods than females
- 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
- In 2002 a survey of young people in year 10 and 11 found 6% had deliberately self harmed in the past 12 months and 12% reported having done so at some point in their life

Suicidal and Self Harming 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.
- Self-harming 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 should be screened for depression and suicide risk.

Assessing Suicide Risk

- A comprehensive psychosocial risk assessment using the HEEADSSS screening tool can help to identify presence of suicidal ideation and behaviour – it also allows you to determine risk and protective factors in the adolescent's life.

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.

Example: “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 thought of harming 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.
- Empathise with the young person and show your concern and interest – use reflective listening to encourage them 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.
section two - chapter ten

iv. Identify 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

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?

Example: “Have you thought about how you would hurt or kill yourself?”
“Have you actually done anything to harm yourself?”
“Have you made plans or preparations?”
“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?”
“What has stopped you from acting on your thoughts so far?”

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
- Co-morbid 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

The HEEADSSS assessment can also help in identifying these risk factors

Example: “What has happened recently that has made you feel so awful?”
“What things are really worrying you now?”
“Do you know anyone who has ever killed or tried to kill themselves?”
“Have you ever tried to harm/kill yourself before?”
“What triggered your previous attempts?”

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?”
“If you could look to the future, what do you think you could look forward to?”
“What are your thoughts about staying alive?”

- cultural issues – e.g. acculturation problems; experience of racism/discrimination; non-acceptance/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
- Seek permission to obtain relevant history from significant others – parents, family members, teachers
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 so that we can get you through this difficult time."

If 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. 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

For young people 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 of mental health services

- 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 address 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 (e.g., 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

◆ 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

◆ If a patient is at high risk of suicide or self harm or in an emergency situation, contact your local Mental Health (Acute Care) Crisis Service
◆ In NSW, each Area Health Service has a 24-hour mental health contact line
  - This service will put you directly into contact with a local Mental Health Worker, or they will take a referral for follow-up
◆ Alternatively, contact the Emergency Department of your local hospital and ask to be put in touch with the Mental Health Crisis Service
◆ For contact details of mental crisis services in other states – contact your local Department of Health or Area Mental Health service
◆ See the following for resources on managing depression and suicide risk in young people:
  - The Black Dog Institute
    – www.blackdoginstitute.org.au
  - The Royal Australian and New Zealand College of Psychiatrists
    – www.ranzcp.org/publicarea/cpg.asp
    – go to ‘Clinical Practice Guidelines’

See Section 4 – for contact details of mental health services
Case Study - Mark

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. 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 in his studies that he thinks it is too hard to catch up. 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 is 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:

◆ Develop of a Mental Health Care Plan to refer Mark to a Psychologist/Social Worker for counselling 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
◆ Schedule a longer follow-up consultation to further assess and monitor Mark's condition and consider the use of medication
**Bipolar Disorder**

- **Bipolar 1 disorder (BP-1)** affects around 1% of the population\(^{13}\)
- Recently, there has been increasing recognition of a so called milder condition, **Bipolar II disorder (BP-II)**, where the lifetime prevalence may be up to 5%\(^{13}\)
- Bipolar disorder is associated with high rates of morbidity and mortality, high suicide rates and high levels of social disruption\(^{14}\) (employment, relationships, etc)
- The **initial presentation** of Bipolar disorder usually occurs in young adults – therefore GPs have a key role in early identification and intervention with young people developing Bipolar disorder
- **Co-morbidity** – anxiety disorders and substance abuse are common in people with bipolar disorder
- There appears to be a strong **genetic component** in Bipolar disorder – about 50% of people with bipolar disorder have a first degree relative with a mood disorder\(^{13}\)

**Assessment and Diagnosis**\(^{13, 14}\)

- Patients with Bipolar disorder may have periods of mania, hypomania, as well as depressive episodes or mixed episodes over many years
- **BP-I** is distinguished from BP-II by the intensity of its manic highs – which may include psychotic features – and which tend to last longer and/or necessitate hospitalization
- In **BP-II**, the individual has episodes of ‘hypomanic’ highs – less severe, not associated with psychotic features, and not necessarily distinctly impairing, sometimes even enjoyable
- **Bipolar highs** are usually high energy states, although some people will describe irritability or anger
- **Depressive episodes** occur in both types – the depressive phases are usually marked by the biological features that underpin melancholic and psychotic depression – no energy, a non-reactive and anhedonic mood; and diurnal variation with mood and energy worse in the morning\(^{13}\)
- People with Bipolar disorder are **commonly misdiagnosed** – it can be difficult to distinguish between other presentations such as anxiety, schizophrenia and personality disorders
- Correct diagnosis is crucial in providing effective treatment – **referral to a Psychiatrist** is recommended to assist with differential diagnosis

**Management Approaches**

- Treatment involves a mix of both medication and psychological therapies
- Medication is the primary course of treatment
- **Mood stabilisers** (eg. lithium, valproate, carbamazepine, lamotrigine) – have proven effectiveness in the management of Bipolar disorder\(^{14}\)
- Anti-depressants (SSRIs) are typically used in the management of Bipolar depression and may also have mood stabilizing properties\(^{13}\)
- **Note** – the use of medication with adolescents should be carefully assessed – as in the treatment of adolescent depression (see **Guidelines for Use of Anti-Depressant Medication**, above)
- Consultation with a **Psychiatrist** for assistance with diagnosis and prescription of medication is recommended
- **Psychological therapies** are also an essential component of the treatment – Cognitive Behavioural Therapy (CBT), psycho-education and Interpersonal Therapy (IPT) are useful in assisting the patient with:
  - symptom management and prevention of relapse
  - mood monitoring and management
  - reducing stresses that often trigger episodes
  - managing interpersonal relationships
- It is also important to provide education and support to family members

The Black Dog Institute has a range of excellent resources for both professionals and the public in the management of Bipolar disorder (see below).

- As with other adolescent mental health problems, a **collaborative, multidisciplinary approach** is recommended
- GPs can take a key role in this by formulating a **Mental Health Care Plan** for initiating a shared care approach involving a Psychiatrist, Psychologist or other relevant mental health professionals

**resources**

- **The Black Dog Institute** website has a range of tools for **assessment and screening** – including a 27 item bipolar self-assessment test with high sensitivity (74%) and specificity (98%), which differentiates bipolar or unipolar disorder accurately in about 90% of cases – [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au)

---

**See Chapter 13 – Collaborative Care – for relevant Medicare item numbers**
Anxiety Disorders

- An estimated 10% of young people 18–24 years old experience anxiety disorders.
- Anxiety disorders often have their onset in childhood or early adolescence.
- Common anxiety disorders in adolescents include social anxiety, generalized anxiety disorder, Obsessive-Compulsive Disorder (OCD).
- Co-morbidity is common with anxiety – particularly depression; substance abuse; ADHD.
- Many adolescent patients display features of more than one anxiety disorder.

Assessment and Diagnosis

- Adolescents with anxiety often present in general practice with somatic complaints, or complex family or school problems.
- Conduct a psychosocial assessment using the HEEADSSS tool – in particular, screen for:
  - risk factors or precipitating events that may have contributed to the onset and maintenance of anxiety – e.g. peer conflicts; bullying and victimisation; issues of loss; family difficulties; illness; trauma.
  - the presence of co-morbid conditions.

- family background – as there is often a strong family history of anxiety or affective disorders.

See Chapter 2 – Conducting a Psychosocial Assessment

- It is important to understand the psychosocial context of the young person’s anxiety. Explore the situations in which the anxiety symptoms occur – e.g. peer relationships; school refusal; social situations.
- It is important to rule out medical conditions or other physical causes of symptoms.
- Where uncertain, refer to a Child and Adolescent Psychiatrist or Psychologist for more in-depth assessment to assist with diagnosis and treatment options.

Symptoms of Anxiety Disorders

Anxiety disorders are characterized by the following:

- **Generalized Anxiety disorder** – 6 months of anxiety/worries.
- **Social Phobia** – interpersonal sensitivity; fear of making a fool of oneself.
- **Specific Phobia** – specific fear stimulus (e.g. fear of traveling on planes).
- **Panic disorder** – panic attacks with characteristic cognitions such as fear of dying; fear of losing control or suffering a personal catastrophe.
- **Obsessive Compulsive Disorder (OCD)** – presence of obsessive thoughts and accompanying compulsive behaviours – e.g. fear of contamination and hand washing; fear of catastrophic consequences and ritualized behaviours (e.g. stepping over cracks in a specific pattern; counting in particular patterns).
- **Cognitive symptoms** – worry about the future, one’s health, one’s relationships, decreased attention and concentration.
- **Behaviours** – avoidance, withdrawal, self-medication with drugs or alcohol.
- **Somatic symptoms** – palpitations, tachycardia, flushing, hyperventilation, tiredness, nausea, sleep difficulties, sweats, shortness of breath, muscular tension.
- Symptoms are present at a level that markedly impairs interpersonal, social, academic and occupational functioning.
Attention Deficit Hyperactivity Disorder

- Up to 8% of young people aged 12-17 years have Attention Deficit Hyperactivity Disorder (ADHD) – ADHD is much more common in boys
- ADHD is a developmental behavioral disorder characterized by persistent patterns of inattention, poor concentration, hyperactivity and impulsivity
- Symptoms usually appear before the age of seven and cause significant disruption to both home and school environments
- If not treated, ADHD is associated with a high risk of future problems, including school difficulties, work difficulties, relationship problems, substance abuse and adult mental health disorders

Diagnosis

- ADHD can be difficult to diagnose – there is no specific psychological test for ADHD, and it often requires detailed assessment
- Co-morbidity is common – ADHD frequently co-occurs with anxiety and depressive symptoms, as well as other behavioral disorders such as oppositional-defiant or conduct disorders
- Common presentations of ADHD include:
  - inattention symptoms – difficulty concentrating and sustaining attention; difficulty organizing tasks; easily distracted; not listening when spoken to
  - hyperactivity symptoms – fidgeting; inability to remain seated; poor impulse control runs about or climbs in inappropriate situations
- Most often, the diagnosis of ADHD is made by a Pediatrician or Child Psychiatrist
- Information should be gathered from both the school and family to assist in assessment and diagnosis

Management

- Stimulant medications are usually the first line of treatment for ADHD – such as methylphenidate (e.g. Ritalin; Concerta)
- There is also growing evidence for the effectiveness of psychological interventions – such as Cognitive Behavioural Therapy (CBT), which can assist in addressing issues such as self-esteem, impulse control, behavioural management, social skills and organisational difficulties
- Counselling interventions can also assist in the treatment of co-morbid conditions such as anxiety and depression

Management Approaches

- As with other adolescent health problems, development of a caring, trusting relationship with the adolescent is a key component in the management of their anxiety
- Key management strategies include psychological and pharmacological approaches
- Psychological treatments, especially Cognitive Behavioural Therapy (CBT), are effective in the treatment of anxiety
  - e.g. Exposure and Response Prevention treatment is the recommended treatment psychological treatment for OCD
- The use of medication for anxiety, while having proven effectiveness, should be used judiciously with adolescents (as in the treatment of adolescent depression) and should be based on a comprehensive assessment of the young person symptoms and circumstances

See ‘Management Approaches’ for depression (above) – for approaches to managing anxiety in adolescents

- A multidisciplinary approach to treatment, incorporating referral to a Psychiatrist and/or Psychologist input is recommended
  - use the new Medicare Mental Health Item Numbers to develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers

resources

- The following websites contain information for consumers and health professionals on anxiety:
  - ‘beyondblue’ – the National Depression Initiative – www.beyondblue.org.au
  - Anxiety Disorders Association of Victoria – provides resources and detailed information about panic disorder, social phobia, agoraphobia, generalised anxiety and depression – www.adavic.org

See Chapter 13 – Collaborative Care – for relevant Medicare item numbers
Young people with ADHD usually also require intensive learning interventions at school to assist them with attention and learning difficulties, as well as behavioural management.

The GP has a significant role to play in assessment and coordinating a multidisciplinary approach to treatment – this can include referral to a Psychiatrist and/or Pediatrician for assistance in diagnosis and prescription of medication.

Use the new Medicare Mental Health Item Numbers to develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach – incorporating referral to a Psychiatrist and/or Psychologist for assessment and treatment.

The GP has a significant role to play in assessment and coordinating a multidisciplinary approach to treatment – this can include referral to a Psychiatrist and/or Pediatrician for assistance in diagnosis and prescription of medication.

Use the new Medicare Mental Health Item Numbers to develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach – incorporating referral to a Psychiatrist and/or Psychologist for assessment and treatment.

It is also important to provide education and support to the family, as well as possible referral for family counseling – as ADHD can be severely disruptive to the family environment.

The Royal Australian College of Physicians (RACP) – is currently redeveloping comprehensive treatment guidelines on ADHD see the RACP website – www.racp.edu.au

See also the Australian Psychological Society (APS) – for treatment guidelines regarding ADHD – www.psychology.org.au

Eating Disorders

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

The three major eating disordered patterns are:

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

Facts about Eating Disorders

- **Anorexia nervosa**
  - affects 0.5-1% of adolescent girls
  - third most common chronic illness in adolescent girls
  - affects girls at 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 again around 17 years

- **Bulimia nervosa**
  - affects 1-5% girls/young 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 a young person if they:**
  - 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, e.g. 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 unusually 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 Chapter 13 – Collaborative Care – for relevant Medicare item numbers

See Chapter 1 – Conducting a Youth Friendly Consultation – for approaches to engaging the young person
**History**

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

- **Nutritional history**
  
  “How much do you weigh now?” (Young person with eating disorder often knows their weight precisely, however be aware that they may feign a lack of interest in or knowledge of their weight).

  “Has your weight increased or decreased at all over the past year?” – if yes, explore the nature of this. (Young person with eating disorder will often be able to give a vivid description of changes or fluctuations in weight over recent months or even years).

  - nutritional intake – e.g.
    
    24 hour dietary recall – enquire about avoidance of particular foods or food groups (e.g. ‘junk food’, ‘meat’).

  - weight loss and methods used – e.g.
    
    “Have you ever tried to lose weight?” “What have you done to try to lose weight?”

---

**DSM IV Diagnostic criteria - Eating Disorders:**

**Anorexia nervosa (AN)**

- Refusal to maintain body weight at or above 85% of expected weight for height and age
- Intense fear of gaining weight or becoming fat, even though underweight
- Distorted body image (weight or shape), denial of being underweight
- Amenorrhea – i.e. the absence of at least three consecutive menstrual cycles
- *Restricting type AN* – restrictive eating and 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

---

**Conduct a general psychosocial assessment using the HEEADSSS screening tool to identify the risk of an eating disorder**

See Chapter 2 – Conducting a Psychosocial Assessment

- 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

- Refer to DSM IV diagnostic criteria for signs of eating disorders (see Table below)

- Refer to a Psychiatrist, Paediatrician or specialist eating disorders service (where available) where there is uncertainty about diagnosis or management

- Initiate early referral to optimise treatment outcomes

---

- 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 purging behaviours to maintain weight (e.g. 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 to maintain weight – but does not regularly engage in purging

---

**History**

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

- **Nutritional history**
  
  “How much do you weigh now?” (Young person with eating disorder often knows their weight precisely, however be aware that they may feign a lack of interest in or knowledge of their weight).

  “Has your weight increased or decreased at all over the past year?” – if yes, explore the nature of this. (Young person with eating disorder will often be able to give a vivid description of changes or fluctuations in weight over recent months or even years).

  - nutritional intake – e.g.
    
    24 hour dietary recall – enquire about avoidance of particular foods or food groups (e.g. ‘junk food’, ‘meat’).

  - weight loss and methods used – e.g.
    
    “Have you ever tried to lose weight?” “What have you done to try to lose weight?”

---

**DSM IV Diagnostic criteria - Eating Disorders:**

**Anorexia nervosa (AN)**

- Refusal to maintain body weight at or above 85% of expected weight for height and age
- Intense fear of gaining weight or becoming fat, even though underweight
- Distorted body image (weight or shape), denial of being underweight
- Amenorrhea – i.e. the absence of at least three consecutive menstrual cycles
- *Restricting type AN* – restrictive eating and 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 purging behaviours to maintain weight (e.g. 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 to maintain weight – but does not regularly engage in purging

---

**History**

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

- **Nutritional history**
  
  “How much do you weigh now?” (Young person with eating disorder often knows their weight precisely, however be aware that they may feign a lack of interest in or knowledge of their weight).

  “Has your weight increased or decreased at all over the past year?” – if yes, explore the nature of this. (Young person with eating disorder will often be able to give a vivid description of changes or fluctuations in weight over recent months or even years).

  - nutritional intake – e.g.
    
    24 hour dietary recall – enquire about avoidance of particular foods or food groups (e.g. ‘junk food’, ‘meat’).

  - weight loss and methods used – e.g.
    
    “Have you ever tried to lose weight?” “What have you done to try to lose weight?”

---

**DSM IV Diagnostic criteria - Eating Disorders:**

**Anorexia nervosa (AN)**

- Refusal to maintain body weight at or above 85% of expected weight for height and age
- Intense fear of gaining weight or becoming fat, even though underweight
- Distorted body image (weight or shape), denial of being underweight
- Amenorrhea – i.e. the absence of at least three consecutive menstrual cycles
- *Restricting type AN* – restrictive eating and 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
- eating and purging behaviours and patterns – e.g.
  “In the past few months have you ever been on a diet to try to control your weight?”
  “Have you cut out certain foods in your diet to control weight, what specifically?”
  “Have you started skipping meals?” “How often do you skip meals?” “Which meals do you skip?”
  “Have you ever binged on food, by that I mean eaten much more than you consider a normal amount and felt like it was a bit out of control?” “How often have you binged?”
  “Have you ever made yourself vomit, or used laxatives, or done excessive amounts of exercise after you’ve eaten, because you feel guilty about eating?”
- exercise and activity
  “Can you tell me about your exercise patterns and whether they’ve changed in the past few months?”
  “Do you do sit ups or other exercises in your bedroom? How many a day?”

◆ Medical assessment
- Menstruation – ask about amenorrhoea or change in menstrual patterns
- Symptom review to exclude organic disease such as inflammatory bowel disease, peptic ulcer disease and hyperthyroidism

◆ Physical Examination
- height, weight and BMI
- vital signs (e.g. indications for admission include – hypothermia < 36 degC; orthostatic change HR <50bpm or > 100bpm; BP < 80/50 or postural drop > 20mmHg)
  - 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
  - systems review to exclude other organic illness

◆ Investigations
- full blood count
- electrolytes, urea, creatinine
- blood sugar
- amylase
- ECG
- thyroid Function Tests; T3RIA is depressed with protein calorie malnutrition

◆ Psychological assessment
- body image – ‘ideal’ weight; specific body parts; fear of weight gain – e.g.
  “What’s your ideal weight?”
  “If you got to that weight, how do you think you’d feel?”
A young person with an eating disorder will often say that they would probably want to lose more weight; You can continue this line of questioning – e.g.
  “So you think you’d still think you were fat, how much more would you want to lose then?” “And how do you think you’d feel if you got to that weight?”
A young person with an eating disorder may reach an ‘ideal weight’ that is clearly unrealistic; if they have established anorexia nervosa, their ‘ideal weight’ may in fact not be compatible with life
  “Are there specific parts of your body you are unhappy with?”
- presence of co-morbid conditions – e.g. depression, anxiety, obsessive compulsive disorder, substance abuse, self-harm
- interpersonal relationships and family functioning

Management\textsuperscript{15, 16, 17}

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
  - co-morbid psychological issues
  - family dysfunction
Use the Medicare Mental Health Item Numbers to develop a Mental Health Care Plan for initiating a collaborative treatment approach.

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

Contacting 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

Resources
- The Eating Disorder Service in the Department of Adolescent Medicine, Children’s Hospital Westmead can provide assistance with assessment and treatment – telephone (02) 9845 2446
- The Eating Disorders Foundation – provides a range of information and support for families:
  - in NSW – www.edf.org.au
  - in Victoria – www.eatingdisorders.org.au

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
One of the most important roles of the GP is to ensure the young person’s safety. Be alert to specific warning signs that may indicate the need for hospitalisation.
Hospital referral should be considered in the following cases:
- Abnormality of vital signs – e.g.
  - hypothermia < 36 degC
  - orthostatic change HR <50bpm or > 100bpm
  - BP < 80/50 or postural drop > 20mmHg
- BMI approaching 5th percentile – e.g.
  - approaching 14 in a 12 year old female, < 18 in an 18 year old female
  - refer to growth charts in Appendices of this Kit
Case Study - Martina

Reproduced, with permission from Royal Australian College of General Practitioners. CHECK program of self-assessment: Adolescent Health. RACGP 2006, Melbourne.

Lorraine comes to see you as she is worried about her daughter, Martina, aged 14 years, who has been losing weight. Lorraine says Martina is ‘not eating much’ and refuses to eat meat. She is worried there may be something ‘going on’ because Martina is irritable and moody at home and refuses to see you. You know Martina (and Lorraine) quite well, and are aware that she is a bright girl currently in year 8 of secondary school.

Given Lorraine’s concerns, you ask to see Martina so you can find out more about the weight loss. Lorraine brings Martina in the next day but Martina protests nothing is wrong with her and says she ‘doesn’t need to see a doctor’. When you ask about Martina’s weight loss she says she ‘just wants to be healthier’. She has cut out junk food (such as chips, chocolate and soft drink) from her diet and become a vegetarian. She also jogs on most days for up to 1 hour and does sit ups.

Initial Management Approaches
◆ Seeing Martina alone is important to establish rapport and to begin gentle interrogation about her eating, exercise and body image concerns. Acknowledging her reluctance to being there is also helpful.
◆ Given the presentation a thorough history and physical examination as outlined above are important.

Further history and examination
◆ Martina admits during your individual interview she is worried her hips are too big. She also feels guilty after eating certain foods and needs to exercise straight away.

Practice points
◆ A young person with an eating disorder may naturally be secretive or reluctant to discuss eating, exercise or weight issues. However a sensitive and careful history, which is crucial, often reveals distorted body image and fear of gaining weight.
◆ Managing eating disorders is almost always a multidisciplinary effort and the GP can play a central role in coordinating care and providing long term continuity of care.
References:


Around 10-20% of adolescents have one or more chronic illnesses such as asthma, diabetes or cystic fibrosis:
- the majority of chronic illness originates during childhood
- medical and surgical advances are continually improving survival
- approximately 80% of children with chronic illness survive into adulthood – increasing the importance of a smooth transition to adult care
- 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 the young person’s 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’
- In managing chronic conditions in adolescents, it is essential to understand the developmental context of the illness – that is:
  - the impact of the illness on the young person’s development, and
  - the impact of ‘normal’ adolescent developmental issues on the illness and its management
- Young people with chronic conditions experience the same health and social issues as their healthier peers – therefore it is important to address a range of concerns such as growth and development, mental health, sexuality, nutrition, exercise and health risk behaviours such as drug and alcohol use²
- You can use the **HEEADSSS** psychosocial assessment to identify concerns in different areas of the adolescent’s life and to detect the presence of risk and protective factors

**Chronic Illness and Adolescence**

Young people with a chronic illness may experience additional difficulties on top of the normal developmental challenges of adolescence¹–⁴. It is important to consider the impact of the condition on the young person’s development⁵:
- Chronic illness can impede the fulfilment of the normal bio-psychosocial developmental tasks of adolescence – e.g.
  - **Biological** – impact on growth and puberty
  - **Psychological** – impact on identity formation, body image, cognitive development
  - **Social** – impact upon development of autonomy, family relationships, peer relationships, sexuality, educational and vocational achievements
- Chronic illness can prolong adolescence for physical and/or psychosocial reasons:
  - pubertal development may be slowed down, particularly related to undernutrition
  - 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

**See Chapter 2 – Conducting a Psychosocial Assessment**

- Pay particular attention to maintaining the young person’s confidentiality and gaining informed consent as they traverse different systems and engage with different health professionals³
Impact of Chronic Illness at Different Stages of Adolescence

- The impact of chronic illness, and the challenges they face, can differ according to the young person's stage of development – e.g.
  - Early – there may be pubertal delay, 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 possibility of having children predominate

The Adolescent With A Chronic Illness

In managing a young person with a chronic illness, it is also important to recognise that adolescent developmental issues can impact on the progress of the chronic condition, and the young person's adherence to management regimes:

- Chronic conditions can become exacerbated or unstable as a result of behaviours and adherence issues arising out of otherwise normal adolescent developmental processes – e.g. the struggle for identity, autonomy and the effects of peer relationships and sexual development can compromise adherence to management plans
- Adolescents who have lived with chronic illness since childhood may experience less negative impact of their illness as they go through adolescence
- The course of an illness can change during adolescence
  - epilepsy may commence or worsen
  - asthma may worsen with the impact of stress, non-adherence or smoking
  - diabetes mellitus frequently becomes more brittle and difficult to control
- Be prepared to address sexuality and concerns about relationships – 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

- 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 in helping the young person to cope with their illness
  - extreme hostility, panic, withdrawal or suicidal behaviour are clearly maladaptive and require more active psychological intervention
- Promote 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 or part time employment if appropriate
  - promote self-perception as not handicapped

Issues Related to the Condition

- Age of the young person – the early adolescent going through puberty appears to be most vulnerable
- Visibility of the condition – a more visible disability is often associated with less stress and psychological distress
- 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

- 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
- Use a developmentally appropriate approach – taking into account the age and developmental stage of the young person
Asthma

- Asthma is the second most common chronic illness of the teenage years (16 per cent of 12 to 15 year olds are diagnosed with asthma) 6
- Adolescents with asthma are a vulnerable group at high risk of experiencing complications of their illness 6
- Because of competing lifestyle and developmental priorities, young people have a tendency to ignore their symptoms and may have trouble taking medication regularly

Diabetes

- A number of typical adolescent lifestyle and risk behaviours can potentially compromise effective control and management of diabetes – e.g. eating habits; alcohol use
- Specialist consultation and collaboration with a multidisciplinary team is essential in management of diabetes, especially Diabetes Mellitus Type 2 7

Management of Specific Conditions

It is beyond the scope of this Kit to provide in-depth guidelines for management of specific chronic conditions. However, a number of excellent resources exist which provide treatment guidelines for different conditions.
It is important to include the young person and their family as active participants in the transition process.

Confidentiality should be maintained for the adolescent as they traverse systems and engage with different health professionals.8

**GMCT Transition Care Network**

- The Greater Metropolitan Clinical Taskforce Transition Network (GMCT) commenced in 2004 – the program extends across all Area Health Services in NSW
- It aims at improving the continuity of care for young people with chronic health problems as they move from paediatric to adult health services
- The GMCT can assist GPs by:
  - helping to find appropriate adult health services
  - helping to prepare young people and their family for the move to adult health services
  - providing information and support when they transfer from children's services and follow up to help make sure they stay engaged in adult services
- There are three Transition Care Coordinators based in the three paediatric health care networks at Westmead, Royal Prince Alfred, and John Hunter Hospitals who can be contacted for support with transition care:
  - The Western Area – (02) 9845 7787
  - South Eastern Area – (02) 9515 6382
  - Hunter New England Area – (02) 4925 7866

The Children's Hospital at Westmead has a Transition Co-ordinator and Transition to Adult Care Committee that facilitates transition for adolescents attending the hospital and works closely with the adult hospital-based Transition co-ordinators – (02) 9845 2446.

**Transition Care**

The transition from child or adolescent-focused health services to more independently oriented adult services can be challenging for young people and their families, as well as for the health professionals that support them.8

Transition is defined by the Society for Adolescent Medicine as “the purposeful planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health care systems”.8

The ultimate aim of transition is to promote the young person’s capacity for self-management of their chronic condition – particularly during the early teenage years (12-16 yrs – preparation phase) and to facilitate a smooth transition to adult care (16-18 yrs – active transition phase) thereby improving long term health outcomes.8

During the active phase, it has been shown that visiting adult services, joint clinics between adult and paediatric services and having their first appointment arranged are very helpful in assisting the young person’s transition.9

- GPs can play a key role in assisting an adolescent patient in their transfer to adult health services by:
  - taking an active role in case management or shared care with specialist teams
  - collaborating with other professionals and services in the process of the young person’s transition
  - addressing their holistic health care needs

**Resources**

The following websites provide resources for diabetes sufferers and their families, as well as resources and guidelines for GPs and health professionals:

- Australian Diabetes Educators Association – www.adea.com.au
- Australasian Paediatric Endocrine Group – www.ape.g.org
- CME on Diabetes Australia – www.cmeondiabetes.com.au

**NSW Health’s Transition Care Website** provides a range of support and resource materials for young people and their families

- It also provides resources and guidelines for health professionals – www.health.nsw.gov.au/gmct/transition
- **CHIPS** – Chronic Illness peer support program for young people – www.rch.org.au/chips
- **The Children’s Hospital at Westmead Website** has information for parents and adolescents – www.chw.edu.au – go to ‘Parents/fact sheets/chronic illness/transition’
Managing Obesity

Obesity can be considered both as a disease, with its own significant morbidity and mortality, and as a risk factor for other non-communicable diseases, including type 2 diabetes and cardiovascular disease.\(^9\)

- Up to 30% of males and 22% females\(^{12-24}\) years old are overweight or obese\(^{10}\) – making overweight one of the most common chronic disorders of adolescence\(^{11}\).
- Physical activity is declining in young people – in 2004-2005 only 46% on males and 30% females aged 15-24 participated in recommended levels of physical activity.
- Adolescence is one of the critical life periods for the development of obesity.
- Obese adolescents have a greater than 80% risk of becoming obese adults\(^9\).
- There are many physical, psychosocial and developmental complications of overweight and obesity in adolescence.

Raising the Issue of Weight Problems

Young people are generally very sensitive about their body image. They may be reluctant or embarrassed to discuss the issue of their weight. Therefore, it is important to engage the young person in a trusting relationship which will allow you to sensitively raise the issue of their weight.

Strategies for engaging the young person about their weight:\(^{11}\)

- Use feeling well and being fit as engagement language.
- Make the conversation relevant to what is concerning the patient (e.g. improving the chances of playing in team sport, clearing the skin, feeling more in control and less tired).
- Make time to obtain an adequate assessment of their personal situation – young people are generally very happy to talk about themselves and valuable management insights will be gained – you can use the HEEDSSS Assessment to assist with this.

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 HEEDSSS assessment will help to explore the above (and other) psychosocial issues – e.g. sexuality, relationships, peer groups, etc.
Avoid the desire to use the argument about future health issues – parents are likely to be worried about these but not the young person.
With both young people and their parents:
- avoid stigmatizing or blaming
- stay solution-focused and supportive

**Assessment**

- A full weight history will need to be taken over several consultations.
- Explore lifestyle – including eating habits, exercise patterns and leisure time/recreation (e.g. hours spent watching television; computer use; etc.)
- Obtain a more in-depth history of their dietary habits and food intake – this can include the young person keeping a food and activity diary.
- Explore in detail the factors influencing physical activity, sedentary behavior and dietary intake.
- Obtain family history – particularly any history of overweight, type 2 diabetes, dyslipidaemia, early heart disease and hypertension.
- Screen for the presence of depression or other mood disorders and psychosocial problems.
- A physical examination should be performed – height and weight should be measured and body mass index (BMI) calculated and plotted on a BMI-for-age chart.
- Overweight is considered >85th BMI percentile and obesity >95th BMI percentile.
- Laboratory investigations may be necessary to identify metabolic risk factors, or to exclude secondary causes of overweight or obesity.
- It is also important to consider cultural background, as some ethnic groups may be at greater risk of diabetes.

**Management**

- Obesity is a chronic disorder of energy imbalance – focus on promoting changes to both sides of the energy equation – energy in and energy out.
- Adopt a developmentally appropriate approach:
  - for younger adolescents – work with the parents and adolescent together
  - for older adolescents – work with them individually (as well as with parents) – to tailor interventions around their priorities, motivation for change and developmental concerns (such as peer acceptance, self-image, need for independence).
- Actively involve the parents (and other family members) as agents of change in terms of both dietary and exercise habits, as well as supporting the young person in their behavior change program.
- Lifestyle change is the basis of weight management – the NHMRC guidelines suggest using a combination of the standard behavioral interventions:
  - dietary modification
  - reduction in sedentary behaviors
  - an increase in physical activity and behavior modification.

**Set realistic behavior change and weight loss goals** – help the young person to feel comfortable with their body image and self-esteem, while at the same time promoting behavior and lifestyle change.
- Address underlying or contributing psychological and psychosocial issues, such as depression and anxiety – where necessary, refer to a Psychologist or Social Worker to address these issues.
- Plan for a long-term intervention – as the required behavior change will take time.
- More intensive therapies for more severe degrees of overweight may require specialist consultation.

---

**Behavioural Management of Obesity**

Be specific in setting behavior change goals – for example:

1. **Long term dietary change**
   - reduce energy intake
   - choose lower fat foods
   - reduce intake of high sugar foods and drinks
   - avoid severe dietary restriction

2. **Increase in physical activity**
   - increase incidental activity
   - choose active transport options (e.g. walking, cycling)
   - participate in more physical lifestyle activities (e.g. sports)
   - participate in more organized activities

3. **Decrease in sedentary behaviour**
   - decreased use of television, computer and other electronic entertainment
   - use alternatives to motorized transport
Much of the material presented above is drawn from the following articles, which provide in-depth approaches to assessment and management of obesity:


In managing chronic conditions in young people, it is essential to consider the impact of the illness on the young person’s physical and psychosocial development.

It is also important to recognise that adolescent developmental issues can affect the chronic condition, and the young person’s adherence to management plans – e.g. the struggle for identity, autonomy and the effects of peer relationships and sexual development can compromise adherence to management plans.

Focus on the individual young person and their capacity for healthy functioning rather than the disease per se.

Encourage autonomy, self-reliance and responsibility for self-management of the illness.

Use the relevant *Medicare Item Numbers* to promote a collaborative treatment approach for asthma, diabetes and other chronic conditions.

GPs play a key role in assisting an adolescent patient in their transition to adult health services by:
- taking an active role in case management or shared care with specialist teams
- collaborating with other professionals and services in the process of the young person’s transition
- addressing their holistic health care needs

Obesity is a chronic disorder of energy imbalance – focus on promoting changes to both sides of the energy equation – energy in and energy out.

Measure the adolescent’s body mass index (BMI) and plot on a BMI-for-age chart.

**Lifestyle change** is the basis of weight management:
- dietary modification
- reduction in sedentary behaviours
- an increase in physical activity and behaviour modification

Adopt a **developmentally appropriate approach**:
- for younger adolescents – work with the parents and adolescent together
- for older adolescents – work with them individually as well as with parents.
References:


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

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:
- 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

Young people 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
- identify what could assist them to comply

Strategies For Enhancing Compliance

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 'Motivational Interviewing', Chapter 5 – Risk Taking and Health Promotion – for approaches to increasing patient motivation

See Chapter 1 – Conducting a Youth Friendly Consultation – for approaches to communicating with adolescents

see Chapter twelve

Enhancing Compliance
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 CALD 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

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

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

Involves 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 whom 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 CALD young people – e.g. beliefs and attitudes about illness; values and norms about particular treatments – e.g. use of medications
- with many CALD 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

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.”

Example: “Let’s have a look at what you could do about taking your medication if you are going to a party.”

See Section 4 for 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 9840 3800 or 1800 648 911
Compliance In Young People At High Risk

Young people at high risk may have particular difficulty in maintaining compliance to treatment regimes – because of their often fragmented and unstable lifestyles, engagement in risk behaviours and isolation.

Compliance with medication can be particularly difficult – other treatment approaches (such as counselling; group therapy) should be encouraged.

This may be especially so for adolescents with co-morbid substance use and mental health problems who may find comprehension of information more difficult due to the nature of their condition.

Decisions around the use of medications for young people at high risk should be based on a variety of factors including:
- current type and severity of substance use
- severity of mental health condition
- motivation for change or treatment
- the developmental age of the young person
- current lifestyle and risk behaviours
- available social and professional support systems

It is important to collaborate closely with other workers who have an ongoing involvement with the young person (e.g. youth workers; accommodation workers) to engage them in supporting the treatment regime.

See Chapter 5 – Risk Taking and Health Promotion – for strategies on working with young people at high risk
Young people are more likely to comply with a treatment plan if:
- a relationship of trust has been developed with the GP
- they understand the nature of and reasons for medications/treatments
- they are given some input into decision-making about treatment options

Actively involve the young person in the development of an individualised treatment plan

Keep treatment regimes simple

Provide information and instructions in easy-to-understand language, appropriate to the young person's developmental stage

Build motivation to comply by helping the young person to set health and treatment goals that fit in with their lifestyle and relationships

Where appropriate, involve other key people such as family members, youth workers, etc. in supporting the young person in their treatment regime

Address non-adherence in pro-active but non-judgemental way – engage the young person in a dialogue about the barriers to compliance and re-negotiate treatment options

Be sensitive to any cultural background factors that may impact on the young person’s capacity to comply with treatment

References:
Adolescent health problems can be complex and multidimensional, requiring both time and specialist skills. GPs are often both the facilitator and coordinator of multi-disciplinary care, working with the patient to involve other health professionals. This ensures a sustainable, coordinated approach and continuity of care.

**Multidisciplinary Care**

*GPs are in a unique position to coordinate a young person’s health care. They can:*  
- Initiate and coordinate shared care in collaboration with allied health professionals, youth services and specialists  
- Formulate plans with young people for their care including plans for the involvement of other health care providers  
- Make referrals and provide important health information to other services  
- Advocate for a young person and their family in dealing with the health system  
- Receive input into a young person’s care from other health care providers and help the patient understand and access the care and advice of other providers

**Referral to Other Services**

Complex problems usually require involvement of a multidisciplinary team. Referring an adolescent patient to other health service providers needs to be handled in a sensitive manner:

- Explain the GP’s role as coordinator of and referrer to other care providers  
- Explain why each referral is necessary, including why specialised skills are required to deal with their problem  
- Plan for a follow up appointment after the patient has seen the other provider

**Example:** “I want to make sure that you get the best possible health care and to do that, we need other health care providers with specialised skills to be involved in your care”

- Plan 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  
- Explore logistics of travelling to and meeting additional costs of referred services  
- Explain if you need to provide information to other professionals (reassure confidentiality) and obtain their consent to include their health information in the referral  
- 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, mental health nurses, Social Workers and other counsellors  
- Drug and alcohol service  
- Community health centre  
- School nurses or 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 CALD-specific services  
- Aboriginal health services

See also Section 4 – for contact details of other service providers
Using The Medicare Items

Medicare items currently available to general practice can be utilised in the provision of health care and services to young people.

Australian Medicare provides targeted incentive payments to GPs and practices separate and additional to standard Medicare Rebates. Medicare items assist GPs to meet nationally identified health priorities and remunerate general practice to provide comprehensive, quality and/or collaborative care to patients.

◆ All Medicare items 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.
◆ Many of the guidelines revolve around:
  - the need to work from a practice that has met or is working towards meeting the Royal Australian College of General Practitioners (RACGP) Accreditation Standards for General Practice.
  - strict patient eligibility criteria.
  - a plan or cycle of care, collaboration with other care providers and practitioner registration with the initiative.
◆ Medicare items are influenced by a variety of factors including – emerging evidence, national health priorities and the political health landscape to name a few.
◆ The Medicare schedule is dynamic – general practice staff and practitioners can keep abreast of changes to item numbers by visiting:

Medicare Australia website:
www.medicareaustralia.gov.au/providers

MBS On-line website:

You can use the Adolescent Health Check template to document the data you gather about the young person, services referred to and any Medicare item numbers used.

In summary, some Medicare items have been introduced to enable GPs to:
◆ be better remunerated when dealing with chronic and/or complex health conditions.
◆ deliver multidisciplinary health care to patients of all ages and.
◆ target nationally identified health and screening priorities.

Resources
◆ For quick reference to Medicare items available for use with young people – see the ‘Ready Reckoner’ table (see facing page).
◆ These items are explained in more detail in the following pages.

General Practitioner General Attendance Items – 3, 23, 36, 44
◆ General GP attendance items involving individual patient interactions (i.e. episodic care). There are 4 levels (Levels A – D) of complexity for GP attendance items, and the surgery consultation fee varies depending on the level of complexity and/or time.

Practice Incentives Payments (PIP), Service Incentive Payments (SIP) And Service Outcomes Payments (SOP)

Practice Incentive Payments (PIP)
◆ Paid to RACGP accredited general practices to register and set-up administrative systems to support practice infrastructure, capacity building and best practice.
◆ They are generally a one-off or quarterly payment to the practice.
◆ Examples include information management, after hours care, rural status loadings, practice nurse employment, quality prescribing and chronic disease management for registered practices participating in the Commonwealth such as asthma, diabetes and cervical screening programs.

Service Incentive Payments (SIP)
◆ Paid to the GP following the completion of a series of requirements for that item.
◆ SIPs are paid for completion of medical care provided by the individual general practitioner under the Commonwealth asthma, diabetes and cervical screening programs.

See Adolescent Health Check template – Appendix 1
<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>DOCTOR/NURSE NAME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERENCE NO:</td>
<td></td>
</tr>
</tbody>
</table>

### CHARGE

<table>
<thead>
<tr>
<th>Practice Nurse</th>
<th>Items</th>
<th>Asthma</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private</td>
<td>Immunisation</td>
<td>10993</td>
<td>B Surgery</td>
</tr>
<tr>
<td>Bulk Bill</td>
<td>Wound Care</td>
<td>10996</td>
<td>C Surgery</td>
</tr>
<tr>
<td>Work Cover</td>
<td>Pap smear &amp; preventive check</td>
<td>10994</td>
<td>D Surgery</td>
</tr>
<tr>
<td>T.A.C.</td>
<td>Pap smear &amp; preventive check (women aged 20-69yrs old &amp; no smear in last 4yrs)</td>
<td>10995</td>
<td>DIABETES</td>
</tr>
</tbody>
</table>

### CONSULTATION

<table>
<thead>
<tr>
<th>Items</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pap smear only</td>
<td>10998</td>
</tr>
<tr>
<td>Pap smear only (women aged 20-69yrs old &amp; no smear in last 4yrs)</td>
<td>10999</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Items</th>
<th>TEST/PROCEDURE</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy test</td>
<td>73806</td>
<td>D Surgery</td>
</tr>
</tbody>
</table>

### VACCINATION

<table>
<thead>
<tr>
<th>Hep-A adult</th>
<th>CERVICAL</th>
<th>ITEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avaxim (Hep A)</td>
<td></td>
<td>GP MH Care Plan</td>
</tr>
<tr>
<td>Hep-B adult</td>
<td>B Surgery</td>
<td>2501</td>
</tr>
<tr>
<td>Meningococcal C</td>
<td>C Surgery</td>
<td>2504</td>
</tr>
<tr>
<td>Meningococcal (ACWY)</td>
<td>D Surgery</td>
<td>2507</td>
</tr>
</tbody>
</table>

### Asthma Cycle of Care – 2546, 2552, 2558

- SIP paid for patients with moderate to severe asthma to receive quality management to avoid acute exacerbation of the condition.
- At a minimum the Asthma Cycle of Care must include:
  - at least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which i.e. the review consultation, is a consultation that was planned at a previous consultation)
  - documented diagnosis and assessment of level of asthma control and severity of asthma
  - review of the patient's use of and access to asthma related medication and devices
  - provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discuss with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records)
  - provision of asthma self-management education to the patient
  - review of the written or documented asthma action plan

### Diabetes Annual Cycle of Care – 2517, 2521, 2525

- SIP paid for all patients with diabetes to receive minimum national standards of diabetic care to prevent complications.
- SIP can be claimed on completion of annual cycle of care: HbA1c test, lipids, micro albuminuria, weight, BMI, foot check, diet review, eye check, self care, physical activity, smoking status and medication review.

### Cervical Screening

- SIP paid when a pap test is conducted for females aged between 20-69 years who have not had a cervical screen within the last 4 years.
- SIP can be claimed on completion of cervical screen.
- Pap tests can be conducted by GPs or accredited and appropriately trained Practice Nurses (PNs).
**Service Outcomes Payments (SOPs)**
- SOPs are paid to the practices similar to PIP payments when Commonwealth regulated patient care targets are met by a practice.

**Cervical Screening**
- SOP paid for females aged between 20-69 years who have received a cervical screen in the last 24 months.

**Diabetes Annual Cycle of Care**
- SOP paid when 20% of all patients with diabetes have their annual cycle of care completed and claimed within last 12 months.

**Bulk-billing Incentive for Concession Card Holders and Children Under 16 years - 10990, 10991**
Bulk-billed services provided by GPs to a person who is under the age of 16 or has a Commonwealth concession card attract a bulk-billing incentive payment:
- Depending upon the location of the practice (i.e. 10990 metropolitan or 10991 rural, regional or remote, Tasmania or in an area of workforce shortage) as specified by the Medicare guidelines.
- This incentive item is added to each item number claimed during the patient’s visit.

**Enhanced Primary Care (EPC) Chronic Disease Management (CDM) Program – 721, 723, 725, 727, 729**
The Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items provide funding for best practice care to patients with chronic and terminal conditions.
- These items rebate all GPs to manage chronic disease by preparing, coordinating, reviewing or contributing to CDM plans.
- Under these items, patients with chronic or terminal conditions are eligible to receive a GP management Plan (GPMP). Patients with chronic conditions and multidisciplinary care needs can also have a Team Care Arrangement (TCA).
- To be eligible for the GPMP, patients must have a chronic or terminal medical condition, one that has been or is likely to be present for ≥6 months.
- To be eligible for a TCA, a patient must have a chronic or terminal medical condition, one that has been or is likely to be present for ≥6 months, and who requires ongoing care from a multidisciplinary team of at least 3 health or care providers (at least one non doctor).


Examples of 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
- cancer
- musculoskeletal problems

* See also mental health items 2710

**There are 5 CDM items that provide a rebate to GPs and can be used in the care of young people (i.e. items 721, 723, 725, 727, 729, see below)**

**Preparation of a GP Management Plan (GPMP) – 721**
GPMPs are a plan of care developed by GPs in consultation with their patient who has a chronic or terminal medical condition and does not require the input and assistance of other health care professionals.

**Review of a GPMP – 725**
GPMP Reviews are a review of an existing GPMP and are recommended once every 6 months or less if clinically required. GPs may be assisted by a PN in reviewing the patients GPMP, documenting any relevant changes and setting the next review date.

**Where GP coordinates the preparation of Team Care Arrangements (TCA) – 723**
TCAs can be made for patients with chronic (or terminal) medical conditions and complex needs and require ongoing care from a multidisciplinary team consisting of their GP and at least two other health or care providers (one must be a non doctor). The Medicare guidelines recommend TCAs are to be completed once every 2 years and GPs can be assisted by a PN in the development of a TCA.
Consultant Physician (CP) Items – 132, 133

- This item (132) requires referral to the Consultant Physician from a GP or specialist specifically asking for one of these items to be completed
- Patients with at least 2 morbidities, including complex congenital, behavioural or developmental conditions, are eligible
- The CP will conduct an assessment and provide a treatment and management plan to the referring GP
- A second item (133) can be billed by the CP for a review consultation following a 132
- Where the patient is being managed under an Enhanced Primary Care (EPC) GPMP and or TCA, the action taken by the CP should be used to augment the plans
- The CP can make suggestions regarding the EPC care plan if, in his or her judgement, the plan needs to be modified

Where a patient has a multidisciplinary care plan prepared or reviewed by a care provider other than their usual GP – 729

The GP is involved in collaborating with care providers in the preparation and review of the plan and including their contribution with the patient’s records.

Allied Health Chronic Disease Management

The allied health items were introduced to complement the suite of EPC CDM items by expanding the CDM item numbers to allied health professionals.

- Patients that have a GPMPs and TCAs, can receive a rebate for access to 5 allied health visits per calendar year. Allied health services can be used in any combination (i.e. 3 visits to the Dietician and 2 visits to the Diabetes educator)
- In order for the Allied Health items to be claimed, a GPMP and TCA must be claimed first.
  Patients can access up to 5 allied health services per calendar year for a service of at least 20 minutes

Allied Health Care Providers must be registered with the EPC CDM initiative and be classified under one of the following categories:

- Aboriginal health workers
- Audiologist
- Dietician
- Diabetes educator
- Mental health worker
- Occupational therapist
- Physiotherapist
- Podiatrist/Chiropodist
- Chiropractors
- Osteopath
- Psychologist
- Speech pathologist
- Exercise physiologist

Case Conferencing - 740, 742, 744, 759, 762, 765

A case conference is a process by which a GP organises and coordinates or participates as part of a case conference team to carry out the following activities:

- discussing a patient's history; and
- identifying the patient's multidisciplinary care needs; and
- identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
- identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assessing whether previously identified outcomes (if any) have been achieved

Where a case conference is organised and coordinated by the GP, the GP must ensure the patient consents to the case conference taking place and to the people attending the conference.

- The GP must also record:
  - the details of the day on which the conference was held; and the times at which the conference started and ended
  - the names of the participants
  - the outcomes of the conference in the patient’s medical records
section two - chapter thirteen

Eligibility for this item refers to patients with a mental disorder who would benefit from a structured approach to the management of their care needs.

Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual’s cognitive, emotional or social abilities (refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD10 Chapter V Primary Care Version).

Note – Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Care items.

The items available to GPs using this program include:

Developing a GP Mental Health Care Plan – 2710

This item covers both the assessment and preparation of the GP Mental Health Care Plan.

- The item cannot be paid within 12 months of a previous claim for the same item, or within 12 months of a claim for a former 3 Step Mental Health Process except where there has been a significant change in the patient’s clinical condition or care circumstances that requires the preparation of a new GP Mental Health Care Plan.
- An assessment of a patient must include:
  - Recording the patient’s agreement for the GP Mental Health Care Plan service.
  - Taking relevant history (biological, psychological, social) including the presenting complaint.
  - Conducting a mental state examination.
  - Assessing associated risk and any co-morbidity.
  - Making a diagnosis and/or formulation, and
  - Administering an outcome measurement tool, except where it is considered clinically inappropriate.
- In addition to assessment of the patient, preparation of a GP Mental Health Care Plan must include:
  - Discussing the assessment with the patient, including the mental health formulation and/or diagnosis.
  - Identifying and discussing referral and treatment options with the patient, including appropriate support services.

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.

Better Access To Mental Health Care – 2710, 2712 & 2713

- The revised Better Access to Mental Health Care Program, came into effect in November 2006.
- Items under the initiative provide GPs with more support and improved remuneration to undertake intervention, assessment and management (both current & continual) of patients with mental disorders, as well provide improved access to general practice, psychologists, psychiatrists and other allied health professionals for patients with mental disorders.

A summary of outcomes should be provided to attendees and the outcomes should be discussed with the patient and/or patient’s care giver.

All providers must be present for the whole time that the item is claimed for.

When a GP participates in a case conference it must be at the request of the person who organises and coordinates the case conference and includes ensuring that the above activities are completed and documented in the patient’s medical records including the relevant consent given.

- GP Community Case Conference: Organise and Coordinate > 45 minutes – 744.
- GP Case conference: Participate 15 – 30 minutes – 759.
- GP Case conference: Participate 30 – 45 minutes – 762.
- GP Case conference: Participate > 45 minutes – 765.

The case conference cannot be a service associated with items 721 (GP Management Plan) to 731.

See Section 4 – for list of services and contact details.

Better Access To Mental Health Care – 2710, 2712 & 2713

- The revised Better Access to Mental Health Care Program, came into effect in November 2006.
- Items under the initiative provide GPs with more support and improved remuneration to undertake intervention, assessment and management (both current & continual) of patients with mental disorders, as well provide improved access to general practice, psychologists, psychiatrists and other allied health professionals for patients with mental disorders.

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.
- Agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take
- Provision of psycho-education
- A plan for crisis intervention and/or for relapse prevention, if appropriate at this stage
- Making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- Documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient’s GP Mental Health Care Plan

**Treatment options can include:**
- referral to a psychiatrist
- referral to a clinical psychologist for psychological therapies
- or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services
- pharmacological treatments
- and coordination with community support and rehabilitation agencies, mental health services and other health professionals

**Conducting a GP Mental Health Care Plan Review – 2712**

**Conducting a GP Mental Health Care review of the existing GP Mental Health Plan, that is prepared by that same medical practitioner (or an associated medical practitioner)**

**The review must include:**
- Recording the patient's agreement for this service
- A review of the patient's progress against the goals outlined in the GP Mental Health Care Plan
- Modification of the documented GP Mental Health Care Plan if required
- Checking, reinforcing and expanding education
- A plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- Re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate

**The item cannot be paid within 3 months of a previous claim for a review item, or within 4 weeks following a claim for the associated GP Mental Health Care Plan – except where there has been a significant change in the patient’s clinical condition or care circumstances that requires the preparation of a new review of a GP Mental Health Care Plan**

**The recommended frequency for the review service is an initial review, which should occur between 4 weeks to 6 months after the completion of a GP Mental Health Care Plan and if required, a further review can occur 3 months after the first review**

**In general, most patients should not require more than 2 reviews in a 12 month period, with ongoing management through the GP Mental Health Care Consultation and standard consultation items, as required**

**Exceptional Circumstances**

**There are minimum time intervals for payment of rebates for GP Mental Health Care items (as detailed above) – with provision for claims to be made earlier than these minimum intervals in exceptional circumstances**

**‘Exceptional circumstances’ apply where there has been a significant change in the patient’s clinical condition or care circumstances that requires a new GP Mental Health Care Plan or a new Review, rather than, for example, amending the existing GP Mental Health Care Plan**

**Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to briefly indicate the reason why the service involved was required earlier than the minimum time interval for the relevant item (eg annotated as clinically indicated, discharge, exceptional circumstances, significant change etc.)**

**GP Mental Health Care Consultation (ongoing management) – 2713**

**GP Mental Health Care Consultation by the GP involves:**
- taking relevant history, identifying presenting problem(s), providing treatment, advice and/or referral for other services or treatments
- and documenting the outcomes of the consultation, on a patient in relation to a mental disorder and lasting at least 20 minutes as a separate consultation to the development and review of the patient's mental health plan
Access to Allied Mental Health Services

- Patients that have a GP Mental Health Care Plan (2710) may be referred by their GP to a clinical psychologist providing psychological therapies; or an appropriately trained GPs or allied mental health professionals providing Focussed Psychological Strategy (FPS) services for 6 + 6 rebatable sessions in a calendar year.

- A further referral for up to an additional 6 services can be made in exceptional circumstances within the calendar year.

- In the case of exceptional circumstances – both the patient’s mental health care plan and referral should be annotated to briefly indicate the reason why the service involved was required in excess of the 12 services permitted within a calendar year.

- In addition to the above services, patients will also be eligible to claim up to 12 separate services for the provision of group psychotherapy.

- Patients can also be referred for FPS services under Access to Allied Psychological Services (ATAPS), available through Divisions of General Practice.

- Where a patient’s services are not used during the calendar year in which they are referred, the unused services may be used in the next calendar year – where they will count towards the maximum number of services able to be received during that year.

- For example – if a GP prepared a GP Mental Health Care Plan for a client in November 2007 and referred the client for 6 allied mental health services but only 2 of these services were provided by 31 December 2007, the remaining 4 referred services would still be valid into 2008.

- The remaining 4 services could be provided in 2008 using the original referral but would count towards the client’s 2008 calendar year limit for allied mental health services.

- Patients who are being managed by their GP under a GP Mental Health Care Plan who need to access further referred services during a new calendar year do not need to have a new MH Care Plan prepared (unless required by the client’s clinical condition, needs or circumstances).

- All consultations conducted as part of the GP Mental Health Care items must be rendered by the GP. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

Claiming GPMPs and MHCPs

- Where a patient has a mental health condition as identified by an ICD10 classification they can be managed under the new GP Mental Health Care items.

- If a patient has a separate chronic medical condition and a mental health condition, or where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items and the GP Mental Health Care items.

Other MBS Items

Practice Nursing

- Practice Nurses (PNs) provide a valuable resource to the provision of care patient within the general practice setting through contributing to MBS item numbers as appropriate within the Medicare guidelines.

- PNs can assist the GP and provide some of the care in asthma and diabetes SIPs and can assist GPs with developing GPMPs and liaising with allied health professionals as part of the TCA.

- In addition to performing these roles, there are a number of Medicare items that can be claimed by a GP for work undertaken by a PN working on their behalf.

PN Wound Management - 10996

- A practice claims this item when a PN provides a wound management on behalf of a GP.

PN Immunisation - 10993

- A practice claims this item when a PN provides an immunisation service on behalf of a GP.

PN Cervical Screening – 10994, 10995, 10998 and 10999

- A practice can claim this item when a PN provides a pap test on behalf of and under the supervision of a GP. The PN needs to be a RN Division 1 nurse who is a credentialed pap test provider.
Health Assessment Items

**ATSI Child Health Check – 708**

◆ The ATSI Child Health Check Item has been developed for patients who are of Aboriginal or Torres Strait Islander descent and aged between 0 – 14 years inclusive.

**ATSI Adult Health Check – 710**

◆ The ATSI Adult Health Check Item has been developed for patients who are of Aboriginal or Torres Strait Islander descent and aged at least 15 years old and less that 55 years old.

Health Assessment for Refugees and other Humanitarian Entrants – 714

◆ The payments for health assessment for refugees and other humanitarian entrants are payable for a service provided to a patient within 12 months of them arriving in Australia or receiving residency (whichever is the later).

Health Assessment of a Patient with an Intellectual Disability – 718, 719

◆ A GP can conduct a health assessment on a patient with an intellectual disability in their practice (718) or at home (719) provided the item hasn't been claimed in the proceeding 12 months.

**NOTE:**

This chapter highlights a number of key Commonwealth initiatives and incentives currently available to general practice, which can be utilised in the provision of health care and services to young people. All items are subject to MBS guidelines and changes. It is not an exhaustive list and has been produced in good faith. Practitioners and practices making clinical and business decisions resulting from information contained in this chapter should consult the MBS guidelines before making any changes to their current practice and to ensure the accuracy of information presented.
Case Study 1 - Collaborative Care

Eve is a 15 year old young woman with audible wheeze who presents to your clinic with her single mother that she lives with. Eve has a history of mild Asthma since early childhood which was treated inhalers during periods of exacerbation. Eve’s mother very worried that her daughter’s Asthma has become uncontrolled. She expressed frustration at her inability to communicate the seriousness of her condition to her daughter. Eve used to swim competitively but quit a year ago as she no longer wanted to train on Saturday mornings and before school. She has recently started work at a local fast food restaurant where she is often asked to work night shifts. Eve’s mother is also angry as she discovered Eve has lied to her about some of her evening shifts and has been attending parties with much older peer group from work instead. Her mother wants her to quit her job due to this and because it is interfering with her school grades and creating tension in the house. She is also worried as Eve now sleeps most of the day on the weekend and has become overweight and defensive.

After asking her mother for some time alone with Eve, you learn that Eve gave up swimming as she felt that she would never reach her goal of swimming in the national championships like her mum. She also feels that she can’t talk to her mother anymore who was very disappointed with her decision to quit and enjoys the freedom of not having to watch her weight and constantly train, which she has done since she was eight. Eve has found a new group of older friends at work that she smokes marijuana and binge drinks with twice a month at parties. She said that there have been other drugs at these parties but she hadn’t tried them yet. Eve thinks that the smoking has brought on her asthma but worries that her new friends will reject her if she stops. After questioning Eve you learn that she has little knowledge about her asthma and medication use and is constantly losing her inhalers.

You suspect that Eve might be suffering from anxiety with a panic disorder.
Management Approaches

Consult 1

- As it seemed apparent that Eve was only attending the clinic due to the coercion of her mother, your first consideration is to build rapport and gain Eve’s trust.
- After seeing Eve on her own, discussing confidentiality and commencing your HEEADSSS screen and physical assessment, you begin to discuss with her a plan for her care and fill in your Adolescent Health Check template.

You take Eve and introduce her to your practice nurse who is an asthma educator who familiarises herself with Eve’s psychosocial assessment – the nurse also works to develop a rapport with Eve, conducts a spirometry, shows Eve how to conduct and record her peak flows and starts some basic asthma education.

You review Eve’s results and discuss with Eve and her mother about commencing an Asthma cycle of care and a DMMR/HMR referral. You explain the process and obtain consent.

You record MBS item numbers: 23, spirometry and 2 x 10990/1

A pharmacist visits Eve at home and discusses the importance of taking her medications, how her preventatives work, administration and storage of medication, asthma triggers in Eve’s lifestyle and at home.

He also discusses the impact of her smoking and marijuana use and a plan for Eve to remember to carry and locate her puffers with contingencies.

Consult 2 – 2 weeks

- You see Eve and her mother in 2 weeks, assess Eve’s peak flows and review the completed DMMR/HMR having previously communicated with the accredited pharmacist that visited Eve.
- You discuss Eve’s asthma medication plan with Eve and with Eve’s permission, her mother.
- The practice nurse completes Eve’s asthma education, reinforces key concepts and discusses any management concerns that Eve has.
- You record MBS item numbers: 23 and 900 claimed and 2 x 10990/1

Consult 3 – 4 weeks

- The following week you work collaboratively with your practice nurse, Eve and Eve’s Mother to develop an asthma action plan with Eve.
- You record MBS item numbers: Asthma cycle of care which is conducted as part of a standard consultation 2546; spirometry claimed with 2 x 10991.

Consult 4 – 6 weeks

- You see Eve and complete her HEEADSSS check.
- An ICD-10 MH diagnosis for anxiety with panic disorder is confirmed and documented.
- MHCP completed and referral to psychologist actioned.
- You record MBS item numbers: 23 and MHCP 2710 and 2 x 10990/1.

Case Study 2 - Collaborative Care

Kate is 17 years old young woman who has come to visit you in tears as she suspects she is pregnant. She had unprotected sex on several occasions with her 19 year old ex boyfriend who broke off their relationship and she no longer has contact with. Kate dropped out of school and left home to live with her then boyfriend a few months ago after heated arguments with her parents over the relationship. She is currently living with several friends and has no fixed address. Kate feels that she cannot go back to living at her parent’s house as they are very religious and will not support her now that she has left home and had a boyfriend.

Kate also has Chrone’s disease and is currently experiencing a flare-up of her condition.

Management Approaches

Consult 1

- You reassure Kate about patient confidentiality and affirm her attendance at your clinic.
- You complete your HEEADSSS screen, do a pregnancy test and physical assessment and fill in your adolescent health check template.
After speaking with Kate you discuss her positive pregnancy test and physical exam – Kate indicates that she wants to keep pregnancy; and you refer her to the family planning centre and the youth worker at your local community health centre to organise accommodation and further support.

Kate also mentioned that she would like to go back to school to become an art teacher but would need to catch-up on her subjects.

You order blood tests and ask Kate if she would like to come back for an STI screen and pap test.

You commence a GP Management Plan to coordinate Kate’s care which includes seeking the support of Kate’s school welfare coordinator, youth worker and family planning.

You also speak to an adolescent-friendly dietician about Kate’s pregnancy and Chrone’s disease and refer her for 5 allied health visits.

You ask Kate to come back and see you if she is unhappy with her referrals and that you would like to continue seeing her in the future to look after her on-going health.

You record **MBS item numbers: 23, 721, pregnancy test 73806, urine test 73805 and 10990/1**

**Consult 2 – 1 week**

When Kate returns for a second visit, you discuss her blood results having communicated with family planning, the dietician, the youth worker and the school welfare coordinator.

You assess that there is a need to refer Kate to a Gastroenterologist and for a TCA between the Gastroenterologist, Dietician and Obstetrician.

You record **MBS item numbers: 23 and 10990/1**

**Consult 3 – 2 weeks**

You assess, coordinate, discuss management issues with Kate and finalise her plan of care.

You ask Kate to come back and see you if she is unhappy with her referrals and that you would like to continue seeing her in the future to look after her on-going health.

You record **MBS item numbers: 723 and 10992** (possibly with a level B consultation item 23 and 10990/1 depending if any work separate to the TCA was conducted at the same consultation).

---

**References:**

Creating a Youth Friendly Practice

This section contains practical strategies for GPs to make their practices more youth friendly by:

- creating a practice environment that promotes safety and security for young people
- improving young peoples’ access to their service
- fostering ‘youth-friendly’ values and attitudes among practice staff
- ensuring that staff are culturally sensitive in their attitudes and practice

Young people are more likely to use a service if it has a ‘youth friendly’ environment that is psychologically as well as physically accessible. The most important factors identified by adolescents’ in using GP services are:

- confidentiality and privacy
- staff attitudes and communication
- convenience of access
- the physical environment of the service – reception area and waiting room
- costs and billing procedures

See also Section One – ‘Barriers for Young People’
Practice Administration
- Develop a clinic policy on how to deal with young people, covering issues such as confidentiality, consent, crisis calls and billing procedures
- Adopt flexible administrative and appointment booking procedures for young people
- Allow extra time for longer consultation, drop in, crisis situations or case conferencing
- Keep an individual file on adolescent patients (separate from family's file)
- Promote your practice to local schools and youth service networks, etc.
- Reduce waiting times for young people
- Accept drop-in clients
- Provide a simple information sheet for young people that details how to obtain a Medicare card; information about consultation times; making appointments; services that GPs can provide; etc.

Costs
- Bulk bill adolescent patients where possible
- If your practice does not bulk bill, display consult prices and explain the process of payment
- Try to reduce medication costs and use samples where possible
- Discuss the need for any payment with the young person
- GPs and reception staff can inform adolescent patients of their entitlement to apply for their own Medicare card from the age of 15

Obtaining a Medicare Card
- Young people who reside in Australia – excluding Norfolk Island – are eligible to have their own Medicare card if they:
  - hold Australian citizenship
  - have been issued with a permanent visa
  - hold New Zealand citizenship
  - have applied for a permanent visa (excludes an application for a parent visa)
  - are over 15 years of age
- Practice staff can provide young people over the age of 15 years with the Medicare card application form – ‘Copy or Transfer from One Medicare Card to Another’ – and can assist them with filling out their application
- Young people who are new migrants, are enrolling their child, or have been granted or have applied for a permanent visa, will need to fill in a ‘New Enrollment’ form
Exceptional Circumstances

- Young people under 15 years who hold a Centrelink healthcare card and are homeless or estranged from parents, can submit a written request for their own Medicare card to the Enrollment Eligibility Office in their state. The young person is required to post a letter explaining their circumstances and enclose their Medicare application form plus certified copies of their identifying documentation.

Resources


Providing a Youth Specific Service

Some GPs have established a youth-specific service as part of their practice. This may involve:

- Setting aside separate clinic space or waiting areas for adolescent patients
- Opening at hours more convenient for young people – e.g. late afternoon, evenings, weekends or after school
- Offering youth-only clinics – e.g. setting aside a particular time or afternoon for young people only
- Conducting outreach services to youth services, refuges, schools, etc

Examples of primary documents include:

- Birth certificate
- Passport
- Certificate of residence status issues by immigration statement
- Overseas passport with valid entry visa

Note: An alternative primary document could include a letter of introduction on letterhead from a young person’s school or healthcare provider (such as a GP or dentist) stating the young person’s name, address and date of birth, plus a statement that the author has known the applicant for at least six months.

Examples of secondary documents include:

- ATM card
- Recent bank statement
- Student card with photo
- Centrelink card
- Recent bills
- Driver’s licence

Young people, such as those living in rural areas, can choose to post their transfer form to Medicare but must have their identifying documentation certified (e.g. by a GP, a Pharmacist or a Justice of the Peace) and attached to their postal application.

Young people over 15 years don’t need their parent’s signature to apply for their own Medicare Card, however, a new family Medicare card, minus the young person’s name will automatically be sent to their parents. When a young person applies for their own Medicare card, they can be removed from the family Medicare Safety Net if they are no longer fully dependant on their parents.
Is Your Practice ‘Youth Friendly’?

Use the **Youth Friendly Practice Review** to assess the ‘youth friendliness’ of your practice. The Review is a checklist that:

- identifies barriers to young people’s access and use of your service
- provides you with feedback about how responsive your practice is to young people’s needs

The findings can be used to implement changes in order to make your practice more youth friendly.

See Appendix 3 for the Youth Friendly Practice Review

**Note:** The checklist is a general review of youth friendly practice only. It is not an accredited audit process – contact the RACGP or your local Division of General Practice if you wish to undertake an accredited audit.

For further ideas and support for making your practice more youth friendly, contact your local Division of General Practice.

---

**References:**

section four

Youth Health Resources and Contacts

This section contains information about useful resources for GPs in working with young people, including reference materials, websites and contact details for youth services, with a focus on NSW based services.

Use the table at the end of this section to write in contact details of local youth and health services.
Helplines – National

Reporting Child Abuse

Australian Capital Territory (Centralised Intake Service)
- Mandated Reporters: 1300 556 728
- General Public: 1300 556 729
- Crisis Service: 1300 556 729

New South Wales
- 24 hours: 132 111

Northern Territory
- 24 hours: 1800 700 250

Queensland
- Departmental Head Office: (07) 3224 8045
- Crisis Care: (07) 3235 9999
- Rural areas: 1800 177 135

South Australia
- After hours: 131 611
- Business hours: 131 478

Tasmania
- Child Protection Advice and Referral Service (CPAARS): 1300 737 639
- Child Abuse Prevention Service: 24 hours 1800 688 009

Victoria
- Child Protection Crisis Service: 131 278 (24 hours)

Western Australia
- Departmental Head Office: (08) 9222 2555
- After hours: (08) 9223 1111

Sexual Health and Family Planning Australia - www.shfpa.org.au - (02) 6230 5255

Kids Help Line – 1800 551 800
Confidential telephone counselling for young people aged 5-18 – 7days/24 hours
www.kidshelp.com.au (internet counselling)
counsellor@kidshelp.com.au (email counselling)

Lifeline – 131114
Confidential telephone counselling for people of all ages – 7 days/24 hours
www.justask.org.au

National Translation and Interpreting Service (TIS)
- provides telephone and face-to-face interpreting in a number of languages:
  - Free GP Priority Telephone Interpreting Service – available 24 hours: 1300 131 450
  - Free onsite (face to face) interpreting for GPs – Interpreters available 9-4pm: 1300 655 030
    (Book in advance)
  - For eligibility for fee-free interpreting service or any other inquiry, please ring the Client Liaison and Promotions team: 1300 655 820

National Translation and Interpreting Service (TIS) – provides telephone and face-to-face interpreting in a number of languages:
- Free GP Priority Telephone Interpreting Service – available 24 hours: 1300 131 450
- Free onsite (face to face) interpreting for GPs – Interpreters available 9-4pm: 1300 655 030
  (Book in advance)
- For eligibility for fee-free interpreting service or any other inquiry, please ring the Client Liaison and Promotions team: 1300 655 820
State Mental Health Services Directories

Australian Capital Territory – Mental Health ACT Services Directory:  

New South Wales – NSW Health Services Directory:  
http://www2.health.nsw.gov.au/services/

Northern Territory – Department of Health and Community Services – Mental Health Services:  

Queensland – Queensland Health: Mental Health Services:  

South Australia – Directory of Mental Health Services:  

Tasmania – Department of Health and Human Services – Mental Health Services:  

Victoria – Department of Human Services – Victoria’s Mental Health Services:  

Western Australia – Department of Health - The Office of Mental Health:  

Headspace -Australia’s national Youth Mental Health Foundation

Headspace provides 30 funded headspace services located in each state and territory across Australia. These services provide an entry point for young people (aged 12-25) to access a broad range of services which are available in their local community. All of whom have a focus on providing a more integrated service responses.

For headspace services sites: www.headspace.org.au

State Youth Websites

Australian Capital Territory - Youth Interact: www.youth.act.gov.au
New South Wales - Youth NSW: www.youth.nsw.gov.au
Northern Territory - www.youth.nt.gov.au
Queensland - Generate: www.generate.qld.gov.au
South Australia - The Maze: www.maze.sa.gov.au
Tasmania - Linkzone: www.linkzone.tas.gov.au
Victoria - Youth central: www.youthcentral.vic.gov.au
Western Australia -Office for Youth: www.childrenandyouth.wa.gov.au/
Youth and Health Services – NSW

NSW Department of Community Services (DoCS)
DoCS Helpline – 13 3627
Fax Reporting line – (02) 9633 7666

Youth Health Services

Free health services and information for young people – providing a range of services such as medical care, counselling, health education and recreational programs:

- Canterbury Multicultural Youth Health Service ........................................... 02 9718 1485
- Central Coast Youth Health Service (Gosford) ................................................ 02 4356 9333
- CHAIN (Wollongong) ....................................................................................... 02 4226 5816
- Coffs Harbour Outreach Youth Health Service .............................................. 02 6656 7900
- The Corner Youth Health Service (Bankstown) .............................................. 02 9796 8633
- Crossroads Youth Health Service (Shoalhaven) ............................................. 02 4423 1784
- Fairfield Liverpool Youth Health Team (FLYHT) ............................................. 02 8717 1717
- High Street Youth Health Service (Harris Park) .............................................. 02 9687 2544
- Kaleidoscope (Newcastle) ............................................................................... 02 4923 6912
- Kickstart (Port Macquarie) ............................................................................. 02 6584 0430
- Murrallappi, The Settlement Neighbourhood Centre .................................... 02 9698 3087
- Nepean Youth Drug & Alcohol Service .......................................................... 02 4734 1209
- TraXside (Campbelltown) .............................................................................. 02 4625 2525
- The Warehouse (Penrith) ............................................................................... 02 4721 8330
- Western Area Adolescent Team WAAT (Mt Druitt) ......................................... 02 9881 1230
- Y-Central (Gosford) ....................................................................................... 02 4304 7870
- Youthblock Health and Resource Service (Camperdown) ......................... 02 9516 2233

The Department of Adolescent Medicine, Westmead Hospital
Hawkesbury Road, Westmead, NSW 2145.

◆ Contact – Intake Person (02) 9845 6788
◆ Outpatient Clinic Services offered by appointment
◆ Main services offered – Eating Disorders (outpatient, inpatient and day patient programs); Medically complicated learning and attention disorders (assessment and management); Adjustment to chronic illness; Complex adolescent developmental assessments requiring a multidisciplinary team approach
◆ Age criteria: 14 – 18 years or attending high school
◆ Referral from GP required
◆ Cost: Nil. Medicare card required

The Department of Adolescent Medicine – The Children’s Hospital at Westmead
Cnr Hawkesbury Road & Hainsworth Street, Westmead NSW 2145

◆ Contact – Intake Person (02) 9845 2446
◆ Outpatient Clinic Services: Offered by appointment
◆ Main services offered -Inpatient and Outpatient Services; Complex adolescent Clinic eg: Post viral fatigue syndromes; Chronic pain syndromes; Chronic Illness/Transition Services, Nutrition Stream - Eating Disorders Clinic, Weight Management Clinic; Gynaecology Clinic: Inpatient Adolescent Groupwork program; At Risk Youth (Outreach Clinic); Teenlink (Service for teenagers of parents who are on methadone)
◆ Age criteria: 12-16years
◆ Referral from GP Required
◆ Cost: Nil. Medicare care card required
Adolescent and Family Mental Health Services

NSW Department of Health – counselling services for young people up to 18 and their families for emotional, behavioural or social problems – Contact your local Area Health Service/Community Health Centre for information on accessing specialist adolescent services in your area:

- Children’s Hospital at Westmead: 02 9845 2005 or 02 9845 0409
- Greater Southern: 0418 272 907
- Greater Western: 02 6841 2333
- Hunter/New England: 02 4016 4783 or 02 6542 5300
- North Coast: 02 6588 2668
- Northern Sydney/Central Coast: 02 4356 9333
- South Eastern Sydney/Illawarra: 02 9832 3448
- Sydney South West Area Health Service: 02 9515 9600
- Sydney West: 02 9881 1230

Service Directories

- CommunityNet - www.cnet.ngo.net.au
  This is an NSW non-profit NGO provides training, resources and information to the community sector in Western Sydney and information technology services to the sector across NSW. Its website resources and news items are of Australia-wide interest
  provides a range of information and news to the youth, health, housing and welfare sectors
- Service Seeker - www.serviceseeker.com.au

Resources and websites for GPs

Clearinghouses
- Australian Clearinghouse for Youth Studies - www.acys.info/resources.com.au

Chronic Illness
- CHIPS - www.rch.org.au/chips - Chronic illness peer support

Medicolegal
- Australasian Legal Information Institute - www.austlii.edu.au – Medicolegal information
Mental Health

  information for health professionals on mental health and internet-based technology to engage young people in treatment

- **AusEinet** - www.auseinet.com

- **Beyond Blue** - www.beyondblue.org.au
  Education, training and research into treatment and management of depression

- **DepNet** - www.depnet.com.au
  Depression information for professionals, patients and their families

- **Eating Disorders Foundation of NSW** - www.edf.org.au

- **Headroom** - www.headroom.net.au
  Mental health information for professionals and parents

- **Inspire Foundation** - www.inspire.org.au

- **Lifeline** - www.justask.org.au
  Information and referral provision for people with mental health problems, and to friends, relatives and others who want to know how to help

- **Mental Health Association NSW** - www.mentalhealth.asn.au/home.htm
  information, services, education about protecting mental health

- **Multicultural Mental Health Australia** - www.mmha.org.au

- **Royal New Zealand College of General Practitioners, Wellington, New Zealand** - www.rnzcgp.org.nz
  ‘Detection and management of young people at risk of suicide’ 1999 (via search engine)

Multicultural Health Services

- **NSW Transcultural Mental Health Centre** – 02 9840 3767 or 1800 648 911 (rural areas).

  - Hours: 8.30am to 5.00pm Monday to Friday
  - a state-wide service that provides a range of free clinical and consultation services to people from CALD background including children, young people and families, and education and training programs for health professionals
  - services include psychosocial, psychological and psychiatric assessments; information and/or referral to appropriate health and mental health professionals
  - services are provided in the language of the client by qualified bilingual health professionals
  - also offers 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 re care plans

- **NSW Service for the Treatment and Rehabilitation of Torture and Trauma Services (STARTTS)** – 02 9794 1900 - www.startts.org.au

- **NSW Refugee Health Service** – 02 8778 0770 - www.refugeehealth.org.au

- **Drug and Alcohol Multicultural Education Centre in NSW (DAMEC)** – provides information and resources regarding substance abuse and young people from CALD background.
  02 9699 3552 - www.damec.org.au

- **Multicultural Mental Health Australia** - (02) 9840 3333 - www.mmha.org.au

- **Caring for refugee patients in general practice: A desk–top guide (3rd Edition)** - 03 9387 0022
Sexual Health

- **AIDS Council of NSW (ACON)** – 1800 063 060 or 02 9206 2000 – www.acon.org.au
  Information, support and education for people with HIV/AIDS, and those working with them
- **Family Planning NSW** – 02 9716 6099
  1300 658 886 (telephone information line) – www.fpahealth.org.au
  FPA provides a range of sexual and reproductive health services, information and resources. Contact FPA for location of regional FPA services
- **Gay and Lesbian Counselling Service** – 1800 184 527 or 02 8594 9596 - www.glcsnsw.org.au
- **Hepatitis C Council of NSW** – 1800 803 990 or 02 9332 1599 – www.hepatitisc.org.au
  Education, resources and support programs for people affected by Hep C and those working with them
- **Twenty-10 Gay and Lesbian Youth Services** – 1800 652 010 or 02 8594 9555
  - www.twenty10.org.au
  Information, counselling and support for young people and their family

Substance Use

- **Australian Drug Foundation** – www.adin.com.au
  drug information website
- **Drug Info Clearinghouse** – www.druginfo.adf.org.au
  Clearinghouse for information on drugs and drug use prevention
- **Family drug support** – www.fds.org.au
  Service for families
- **Quit line** – www.quitnow.info.au
  Quit smoking information
- **Where's your head at?** – www.drugs.health.gov.au
  Information on drugs and their effects for young people and parents

For further information regarding health services and resources for young people, contact your local Division of General Practice.

Education, Training and Resource Providers

- **NSW Centre for the Advancement of Adolescent Health (NSW CAAH)** - 02 9845 3338
  www.caah.chw.edu.au (Check out the website for useful links)
  NSW CAAH's role as a technical support agency is to build the confidence and capacity of partner agencies in responding to youth health issues through developing/disseminating information and resources, delivering professional education and training, undertaking applied research and contributing to advocacy and policy development.

- **NSW Association for Adolescent Health** - 02 9699 1033 - www.naah.org.au
  NAAH is the peak body for individuals and organisations involved in promoting the health and wellbeing of young people. NAAH provides advocacy, networking and professional development and supports research and the development of services in adolescent health.

- **Family Planning NSW** - 02 9716 6099 - www.fpahealth.org.au
  FPA provides a range of services, information, resource materials and training programs in the area of sexual and reproductive health.

- **The Centre for Adolescent Health, University of Melbourne** - 03 9345 5890 - www.rch.org.au/cah
  Provides clinical services; community programs; training, research; resources and distance education programs in Adolescent Health
Books and Journals

Reference Materials for GPs

The following is a list of reference materials on adolescence and adolescent health:

Books for Parents

Websites for Young People

- **Deadly Mob** - www.deadlymob.org
  Creating online opportunities for Indigenous young people anywhere in Australia, helping young people skill up to participate in community development using Information and Communications Technology

- **Dr link** - www.drlink.com.au
  Providing practical information and advice on ‘how’ and ‘where’ to seek help for emotional problems and strategies on how to get the most out of the services that are available

- **Headspace** - www.headspace.org.au
  Australia’s national Youth Mental Health Foundation

- **Law stuff** - www.lawstuff.org.au
  Information on legal rights for young people under 18

- **Make a Noise** - www.makeanoise.ysp.org.au
  Youth suicide prevention project of NSW

- **Pressurepoint Cyber Youth Clinic** - www.dryes.com.au
  Providing information on health issues affecting young people

- **Reachout!** - www.reachout.com.au
  An internet-based service that aims to improve the mental health and well-being of young people. Reach Out provides resource materials and information that GPs can give to their patients

- **Somazone** - www.somazone.com.au
  An interactive website created by young people and supported by the Australian Drug Foundation

- **Staysafe** - www.health.qld.gov.au/istaysafe
  Website for young people to find out about sexual health

- **The Source** - www.thesource.gov.au
  Youth information, programmes, services, resources and entertainment for young people

- **Twenty 10** - www.twenty10.org.au
  Information and support for gay and lesbian young people

- **Your Sex Health** - www.yoursexhealth.org
  Reproductive and sexual health information
Your Local Services

Write the contact details of services and resources for young people in your local area in the table below:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Type of Services Provided</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
appendix one
Adolescent Health Check Template

Patient Details

<table>
<thead>
<tr>
<th>PROMPTS FOR YOUTH-FRIENDLY PRACTICE: Rapport, Affirm attendance, Confidentiality statement with exceptions, Explain Medicare, Discuss billing policy, Check consent, Separate patient file, Time alone &amp;/vs. time with parent/guardian/partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
</tr>
<tr>
<td>Assessment Date</td>
</tr>
<tr>
<td>DOB</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Culture &amp; Language</td>
</tr>
<tr>
<td>e.g. Aboriginal or TSI; Language spoken at home</td>
</tr>
<tr>
<td>GP</td>
</tr>
<tr>
<td>Other services/adults involved in patient care</td>
</tr>
<tr>
<td>e.g. Parents, guardians, carers, agencies</td>
</tr>
<tr>
<td>Medicare card number</td>
</tr>
<tr>
<td>Health care card number</td>
</tr>
<tr>
<td>Preferred patient contact method &amp; time</td>
</tr>
</tbody>
</table>

General Assessment

<table>
<thead>
<tr>
<th>Health History</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Details – History:</strong></td>
</tr>
<tr>
<td>Summary – Progress Notes (Current):</td>
</tr>
<tr>
<td>Summary – Investigation Results (Selected):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications/Immunisation</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Allergies</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Family History</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Assessment of Early/Middle/Late Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early</td>
</tr>
<tr>
<td>Middle</td>
</tr>
<tr>
<td>Late</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider – rapport, trust, chaperone, normality, explanation &amp; reassurance. Consider assessments- height, weight, BMI, spiro, Tanner staging, BP, pulse, lipid and BGL check if at high risk, cervical smear, STI screen, immunisations) if not already part of progress notes.</td>
</tr>
</tbody>
</table>


**Adolescent Psychosocial Assessment**

**HEEADSSS Psychosocial Assessment**

Explain reasons for delving into sensitive areas and ask permission to proceed

**H- Home** (Consider - living arrangements, transience, relationships with carers/significant others, supervision, childhood experiences, cultural identity)

**E- Education, Employment, Eating, Exercise** (Consider - school/work retention & relationships, bullying, belonging, study/career progress & goals)

**E- Eating, Exercise** (Consider - nutrition, vegetarianism, eating patterns, weight gain/loss, exercise, fitness, energy)

**A- Activities, Hobbies & Peer Relationships** (Consider - free time, hobbies, culture, belonging to peer group, peer activities & venues, lifestyle factors, risk-taking, injury avoidance, sun protection)

**D- Drug Use** (Consider - alcohol, cigarettes, caffeine, prescription/illicit drugs and type, quantity, frequency, administration, interactions, access, increases/decreases- treatments, education, motivational interviewing)

**S- Sexual Activity & Sexuality** (Consider - knowledge, sexual activity, age onset, safe sex practices, same sex attraction, history pap smears/STI screening/abuse, pregnancy/children)

**S- Suicide, Depression & Mental Health** (Consider - normal vs clinical, suicidal ideation/intent/method/past attempts/treatment, anxiety, reaction to stress, sleep- depression score & mental state exam)

**S- Safety, Spirituality** (Consider – sun screen protection, immunization, bullying, abuse, traumatic experiences, risky behaviour, belief, religion; What helps them relax, escape? What gives them a sense of meaning?)

---

**Mental Status Examination**

<table>
<thead>
<tr>
<th>Appearance and General Behaviour</th>
<th>Mood (Depressed/Labile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking (Content/Rate/Disturbances)</td>
<td>Affect (Flat/Blunted)</td>
</tr>
<tr>
<td>Perception (Hallucinations)</td>
<td>Sleep (Initial Insomnia/Early Morning Wakening)</td>
</tr>
<tr>
<td>Cognition (Level of consciousness/delirium/intelligence)</td>
<td>Appetite (Disturbed Eating Patterns)</td>
</tr>
<tr>
<td>Attention/Concentration</td>
<td>Motivation &amp; Energy</td>
</tr>
<tr>
<td>Memory (Short &amp; Long term)</td>
<td>Judgement (Ability to make rational decisions)</td>
</tr>
<tr>
<td>Insight</td>
<td>Anxiety Symptoms (Physical &amp; Emotional)</td>
</tr>
<tr>
<td>Orientation (Time/place/person)</td>
<td>Speech (Volume/Rate/Content)</td>
</tr>
<tr>
<td>Significant cultural factors</td>
<td>Significant support person</td>
</tr>
</tbody>
</table>
Risk Assessment

Consider R.I.S.K. guidelines: 
- **R** - no risk = review;
- **I** - low risk = monitor;
- **S** - moderate risk = intervene;
- **K** - high risk = intervene

<table>
<thead>
<tr>
<th>Current plan</th>
<th>Suicidal ideation</th>
<th>Suicidal intent</th>
<th>Risk of Others</th>
</tr>
</thead>
</table>

**Problem, Diagnosis and Actions**

Feedback – Compliment areas going well, highlight need for on-going contact, negotiate management plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Diagnosis</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Follow Up

**Investigations/treatment/medications:**

**Referrals:** Consider providing information about referral services and associated costs

**Follow up and recall arrangements:**

**MBS items:** Consider use of appropriate MBS items such as GPMPs, TCAs, SIPs, HMRs & Mental Health Plans

**Agreement on information to be shared with third parties:**

This document will be maintained in accordance with the relevant Privacy Legislation.
# Youth Health Risk Assessment

Use this form to record the responses of the young person to the **HEEADSSS** assessment. You may wish to photocopy this form for use with different patients.

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Questions</th>
<th>Patient's Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H - Home</strong></td>
<td>Explore home situation, family life, relationships and stability:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where do you live? Who lives at home with you?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who is in your family (parents, siblings, extended family)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What is your/your family's cultural background?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What language is spoken at home? Does the family have friends from outside its own cultural group/from the same cultural group?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you have your own room?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Have there been any recent changes in your family/home recently (moves, departures, etc.)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do you get along with mum and dad and other members of your family?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are there any fights at home? If so, what do you and/or your family argue about the most?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who are you closest to in your family?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Who could you go to if you needed help with a problem?</td>
<td></td>
</tr>
<tr>
<td><strong>E - Education</strong></td>
<td>Explore sense of belonging at school/work and relationships with teachers/peers/workmates; changes in performance:</td>
<td></td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td>What do you like/ not like about school (work)? What are you good at/ not good at?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do you get along with teachers /other students/workmates?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How do you usually perform in different subjects?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What problems do you experience at school/ work?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some young people experience bullying at school, have you ever had to put up with this?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What are your goals for future education / employment?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any recent changes in education / employment?</td>
<td></td>
</tr>
</tbody>
</table>
## E - Eating and Exercise

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore how they look after themselves; eating and sleeping patterns:</td>
</tr>
<tr>
<td>What do you usually eat for breakfast/lunch/dinner?</td>
</tr>
<tr>
<td>Sometimes when people are stressed they can overeat, or under-eat – Do you ever find yourself doing either of these?</td>
</tr>
<tr>
<td>Have there been any recent changes in your weight? In your dietary habits?</td>
</tr>
<tr>
<td>What do you like/not like about your body?</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>What do you do for exercise?</td>
</tr>
<tr>
<td>How much exercise do you get in average day/week?</td>
</tr>
</tbody>
</table>

## A - Activities and Peer Relationships

<table>
<thead>
<tr>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:</td>
</tr>
<tr>
<td>What sort of things do you do in your free time out of school/work?</td>
</tr>
<tr>
<td>What do you like to do for fun?</td>
</tr>
<tr>
<td>Who are your main friends (at school/out of school)?</td>
</tr>
<tr>
<td>Do you have friends from outside your own cultural group/from the same cultural group?</td>
</tr>
<tr>
<td>How do you get on with others your own age?</td>
</tr>
<tr>
<td>How do you think your friends would describe you?</td>
</tr>
<tr>
<td>What are some of the things you like about yourself?</td>
</tr>
<tr>
<td>What sort of things do you like to do with your friends? How much television do you watch each night?</td>
</tr>
<tr>
<td>What’s your favourite music?</td>
</tr>
<tr>
<td>Are you involved in sports/hobbies/clubs, etc.?</td>
</tr>
<tr>
<td>D - Drug Use</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Cigarettes/Alcohol</td>
</tr>
<tr>
<td>S - Sexuality</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>S - Suicide/ Self-Harm/ Depression/Mood</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>You can also explore:</th>
<th>Sun screen protection, immunisation, bullying, abuse, traumatic experiences, risky behaviours.</th>
</tr>
</thead>
<tbody>
<tr>
<td>S - Safety</td>
<td>Beliefs, religion, What helps them relax, escape? What gives them a sense of meaning?</td>
</tr>
<tr>
<td>S - Spirituality</td>
<td></td>
</tr>
</tbody>
</table>
appendix three

Youth Friendly Practice Review

Use this checklist to assess the “youth-friendliness” of your practice.

Circle the appropriate answers:

### a. Practice Staff

1. Receptionist staff have a friendly and non-judgemental approach to dealing with adolescent patients
   - Yes
   - No
   - Unsure

2. Practice staff respect adolescents’ privacy and confidentiality
   - Yes
   - No
   - Unsure

3. Practice staff have received training on adolescent health issues or dealing with young people
   - Yes
   - No
   - Unsure

4. Practice staff are sensitive to the needs of young people from other cultural backgrounds
   - Yes
   - No
   - Unsure

5. Practice staff have received training on cultural competency or dealing with young people from a CALD background
   - Yes
   - No
   - Unsure

### b. Practice Environment

6. The waiting area has a youth-friendly and welcoming environment for young people
   - Yes
   - No
   - Unsure

7. There are pamphlets and posters displayed in the waiting area dealing with youth-specific health issues
   - Yes
   - No
   - Unsure

8. There are youth-oriented reading materials in the waiting area (e.g. surfing/car/music magazines)
   - Yes
   - No
   - Unsure

9. Posters and resources aimed at specific cultural groups (e.g. CALD, gay and lesbian, indigenous young people) are displayed in the waiting area
   - Yes
   - No
   - Unsure

10. The practice’s confidentiality policy is displayed in the waiting area
    - Yes
    - No
    - Unsure

### c. Practice Administration

11. The practice has a written policy for dealing with young people – covering issues such as confidentiality, consent, crisis calls and billing procedures, etc.
    - Yes
    - No
    - Unsure

12. The practice has a simple information sheet for young people on: how to obtain a Medicare card; making appointments; services a GP can provide; etc.
    - Yes
    - No
    - Unsure

13. Practice staff inform adolescent patients of their entitlement to apply for their own Medicare card from the age of 15
    - Yes
    - No
    - Unsure
14. Practice staff provide Medicare application forms and assist the young person with filling out the application  
Yes No Unsure

15. There are flexible appointment booking procedures for young people  
Yes No Unsure

16. Waiting times for young people are kept to a minimum  
Yes No Unsure

17. Longer consultation times are provided to young people where necessary  
Yes No Unsure

### d. Promoting Access

18. Confidentiality is clearly explained to young people (verbally or via written materials) when they first present  
Yes No Unsure

19. Adolescent patients are bulk-billed  
Yes No Unsure

20. Crisis referrals are accepted  
Yes No Unsure

21. Young people without a Medicare card are accepted  
Yes No Unsure

22. Drop-in appointments are accepted  
Yes No Unsure

23. The practice opens at hours convenient for young people – e.g. late afternoon, evenings, weekends  
Yes No Unsure

24. GPs in our practice promote their services to local youth services, schools, etc.  
Yes No Unsure

25. GPs follow-up when referring young people to other services  
Yes No Unsure

### e. GP Consultation Style

26. GPs explain confidentiality to each new adolescent patient  
Yes No Unsure

27. GPs have received training in adolescent health and consultation with young people  
Yes No Unsure

28. GPs adopt a culturally sensitive approach to dealing with young people from diverse cultural backgrounds  
Yes No Unsure

29. GPs use a non-judgemental and empathetic communication style with young people  
Yes No Unsure

30. GPs encourage young people to make their own decisions  
Yes No Unsure

31. GPs consult the young person on the best way to contact them for follow-up, test results, etc.  
Yes No Unsure

**How ‘youth friendly’ is your practice?**

Discuss the findings of this review with your practice staff to identify ways of making your practice more youth friendly.

*Parts of this review has been adapted from the Keep Yourself Alive project, of the SA Royal Australian College of General Practitioners, 1998.*
**Head Circumference**

**Measuring Technique:** The tape should be placed over the eyebrows, above the ears and over the most prominent part of the occiput taking a direct route. A paper tape is preferable to plastic, which stretches unacceptably under tension. The maximum measurement should be recorded to the nearest 0.1 cm.

**Height Velocity**

The standards are appropriate for velocity calculated over a whole year period, not less, since a smaller period requires wider limits (the 3rd and 97th centiles for a whole year being roughly appropriate for the 10th and 90th centiles over six months). The yearly velocity should be plotted at the mid-point of a year. The centiles given in black are appropriate to children of average maturational tempo, who have their peak velocity at the average age for this event. The red line is the 50th centile line for the child who is two years early in maturity and age at peak height velocity, and the green line refers to a child who is 50th centile in velocity but two years late. The arrows mark the 3rd and 97th centiles at peak velocity for early and late maturers.


The standards are appropriate for velocity calculated over a whole year period, not less, since a smaller period requires wider limits (the 3rd and 97th centiles for a whole year being roughly appropriate for the 10th and 90th centiles over six months). The yearly velocity should be plotted at the mid-point of a year. The centiles given in black are appropriate to children of average maturational tempo, who have their peak velocity at the average age for this event.

The red line is the 50th centile line for the child who is two years early in maturity and aged at peak height velocity, and the green line refers to a child who is 50th centile in velocity but two years late. The arrows mark the 3rd and 97th centiles at peak velocity for early and late maturers.

**Measuring Technique:**
The tape should be placed over the eyebrows, above the ears and over the most prominent part of the occiput taking a direct route. A paper tape is preferable to plastic, which stretches unacceptably under tension.

The maximum measurement should be recorded to the nearest 0.1 cm.

**Data Source:**

**Age (years) vs. Height (cm)**

**BSA (m²) = \sqrt{\frac{Ht\ (cm) \times Wt\ (kg)}{3600}}**


**Supine Length** (recommended up to the age of 3 so that there is overlap with standing height at 2 to 3) is taken on a flat surface, with the child lying on his back. One observer holds the child’s head in contact with a board at the top of the table and another straightens the legs and turns the feet upward to be at right angles to the legs and brings a sliding board in contact with the child’s heels.

**Standing Height** (recommended from age 2 onwards) should be taken without shoes, the child standing with his heels and back in contact with an upright wall. His head is held so that he looks straight forward with the lower borders of the eye sockets in the same horizontal plane as the external auditory meati (i.e. head not with the nose tipped upward). A right-angled block (preferably counterweighted) is then slid down the wall until its bottom surface touches the child’s head and a scale fixed to the wall is read. During the measurement the child should be told to stretch his neck to be as tall as possible, although care must be taken to prevent his heels coming off the ground. Gentle but firm pressure upward should be applied by the measurer under the mastoid processes to help the child stretch. In this way the variation in height from morning to evening is minimised. Standing height should be recorded to the last completed 0.1 cm.

**C = M [1 + L S Z] 1/4**

Where C is the centile required, LMS are those parameters published by CDC and Z is the standard deviation equivalent to the centile required.

1st Centile calculated by Associate Professor Peter Davies, Children’s Nutrition Research Centre, Brisbane.
Weight Percentile

Weight should be taken in the nude, or as near thereto as possible. If a surgical gown or minimum underclothing (vest and pants) is worn, then its estimated weight (about 0.1 kg) must be subtracted before weight is recorded. Weights are conventionally recorded to the last completed 0.1 kg above the age of six months. The bladder should be empty.
Boys 2-18 years

Stages of Puberty

Ages of attainment of successive stages of pubertal sexual development are given in the Height Percentile chart. The stage Pubic Hair 2+ represents the state of a child who shows the pubic hair appearance stage 2 but not stage 3 (see below). The centiles for age at which this state is normally seen are given, the 97th centile being considered as the early limit, the 3rd centile as the late limit. The child’s puberty stages may be plotted at successive ages (Tanner. 1962, Growth at Adolescence, 2nd edn.). Testis sizes are judged by comparison with the Prader orchidometer (Zachmann, Prader, Kind, Haflinger & Budliger. 1974, Helv. Paed. Acta. 29, 61-72).

Genital (Penis) Development

Stage 1.  Pre-adolescent. Testes, scrotum and penis are of about the same size and proportion as in early childhood.
Stage 2.  Enlargement of scrotum and testes. Skin of scrotum reddens and changes in texture. Little or no enlargement of penis at this stage.
Stage 3.  Enlargement of the penis which occurs at first mainly in length. Further growth of the testes and scrotum.
Stage 4.  Increased size of penis with growth in breadth and development of glans. Testes and scrotum larger; scrotal skin darkened.
Stage 5.  Genitalia adult in size and shape.

Pubic Hair Development

Stage 1.  Pre-adolescent. The vellus over the pubes is not further developed than that over the abdominal wall, i.e. no pubic hair.
Stage 2.  Sparse growth of long, slightly pigmented downy hair, straight or slightly curled at the base of the penis.
Stage 3.  Considerably darker, coarser and more curled. The hair spreads sparsely over the junction of the pubes.
Stage 4.  Hair now adult in type, but area covered is still considerably smaller than in the adult. No spread to the medial surface of thighs.
Stage 5.  Adult in quantity and type with distribution of the horizontal (or classically ‘feminine’) pattern. Spread to medial surface of thighs but not up linea alba or elsewhere above the base of the inverse triangle (spread up linea alba occurs late and is rated stage 6).

Genital and Pubic Hair Development Stages

Stretched Penile Length

Measured from the pubo-penile skin junction to the tip of the glans (Shonfeld & Beebe. 1942, Journal of Urology, 48, 759-777).
Head Circumference

**Measuring Technique:** The tape should be placed over the eyebrows, above the ears and over the most prominent part of the occiput taking a direct route. A paper tape is preferable to plastic, which stretches unacceptably under tension. The maximum measurement should be recorded to the nearest 0.1 cm.

Height Velocity

The standards are appropriate for velocity calculated over a whole year period, not less, since a smaller period requires wider limits (the 3rd and 97th centiles for whole year being roughly appropriate for the 10th and 90th centiles over six months). The yearly velocity should be plotted at the mid-point of a year. The centiles given in black are appropriate to children of average maturational tempo, who have their peak velocity at the average age for this event. The red line is the 50th centile line for the child who is two years early in maturity and age at peak height velocity, and the blue line refers to a child who is 50th centile in velocity but two years late. The arrows mark the 3rd and 97th centiles at peak velocity for early and late maturers.

Height Percentile

Mother's Height

Father's Height

Supine Length (recommended up to the age of 3 so that there is overlap with standing height at 2 to 3) is taken on a flat surface, with the child lying on her back. One observer holds the child's head in contact with a board at the top of the table and another straightens the legs and turns the feet upward to be at right angles to the legs and brings a sliding board in contact with the child's heels.

Standing Height (recommended from age 2 onwards) should be taken without shoes, the child standing with her heels and back in contact with an upright wall. Her head is held so that she looks straight forward with the lower borders of the eye sockets in the same horizontal plane as the external auditory meati (i.e. head not with the nose tipped upward). A right-angled block (preferably counterweighted) is then slid down the wall until its bottom surface touches the child's head and a scale fixed to the wall is read. During the measurement the child should be told to stretch her neck to be as tall as possible, though care must be taken to prevent her heels coming off the ground. Gentle but firm pressure upward should be applied by the measurer under the mastoid processes to help the child stretch. In this way the variation in height from morning to evening is minimised. Standing height should be recorded to the last completed 0.1 cm.

C = M[1 + L.S.Z] 1/L

Where C is the centile required, LMS are those parameters published by CDC and Z is the standard deviation equivalent to the centile required.

1st Centile calculated by Associate Professor Peter Davies, Children’s Nutrition Research Centre, Brisbane.

Simplified Calculation of Body Surface Area (BSA)

\[
\text{BSA (m}^2 \) = \sqrt{\frac{\text{Ht (cm)} \times \text{Wt (kg)}}{3600}}
\]


Breast Stage: 56 46 36 26 16 10 6
Pubic Hair Stage: 56 46 36 26 16 10 6
Menarche: 56 46 36 26 16 10 6

DataSource: www.cdc.gov/nchs/about/major/nhanes/growthcharts/datafiles.htm


Weight Percentile

Weight should be taken in the nude, or as near thereto as possible. If a surgical gown or minimum underclothing (vest and pants) is worn, then its estimated weight (about 0.1 kg) must be subtracted before weight is recorded. Weights are conventionally recorded to the last completed 0.1 kg above the age of six months. The bladder should be empty.

Body-Mass Index

Data Source: www.cdc.gov/nchs/about/major/nhanes/growthcharts/datafiles.htm

PUBERTAL STAGES

DATE | AGE | HEIGHT | WEIGHT | HEAD CIRCUM. | BREAST | PUBIC HAIR | MENARCHE

Data Source: www.cdc.gov/nchs/about/major/nhanes/growthcharts/datafiles.htm
Girls 2-18 years
Stages of Puberty

Ages of attainment of successive stages of pubertal sexual development are given in the Height Percentile chart. The stage Pubic Hair 2+ represents the state of a child who shows the pubic hair appearance stage 2 but not stage 3 (see below).

The centiles for age at which this state is normally seen are given, the 97th centile being considered as the early limit, the 3rd centile as the late limit. The child’s puberty stages may be plotted at successive ages (Tanner. 1962, Growth at Adolescence, 2nd edn).

Pubic Hair Development

Stage 1. Pre-adolescent. The vellus over the pubes is not further developed than that over the abdominal wall, i.e. no pubic hair.

Stage 2. Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly along labia.

Stage 3. Considerably darker, coarser and more curled. The hair spreads sparsely over the junction of the pubes.

Stage 4. Hair now adult in type, but area covered is still considerably smaller than in the adult. No spread to the medial surface of thighs.

Stage 5. Adult in quantity and type with distribution of the horizontal (or classically ‘feminine’) pattern. Spread to medial surface of thighs but not up linea alba or elsewhere above the base of the inverse triangle (spread up linea alba occurs late and is rated stage 6).

Breast Development Stages

Stage 1. Prepubertal

Stage 2. Elevation of breasts and papilla

Stage 3. Further elevation and areola but no separation of contours

Stage 4. Areola and papilla form a secondary mound above level of the breast

Stage 5. Areola recesses to the general contour of the breast

The opinions, views and recommendations expressed in this publication do not necessarily reflect those of the sponsor or publisher. Pfizer Australia accepts no responsibility for treatment decisions based upon these charts.

To reorder, please call Pfizer Customer Service 1800 629 921.