

Mental disorders in adolescents — general issues

Introduction

While much of the information about the management of mental disorders in adults also applies to adolescents, there are significant differences. This section briefly describes these differences.

Prevalence

The rates of mental disorder in adolescents are similar to or higher than those in adults. The rates of all mental disorders (psychosis, depression, post-traumatic stress disorder, substance misuse) are substantially higher in young offenders than in young people in the community. This is to be expected as so many of them have experienced events in their lives that are known to increase the risk of mental disorder. Over one-third have been 'looked after' children in Local Authority care. The levels of previous physical, sexual and emotional abuse, school exclusion, low educational achievement and unemployment are all high and many are teenage parents. In addition, a significant group of young people are exposed to further victimisation (eg bullying, violence, unwanted sexual attention) while in prison.

The prevalence of antisocial, paranoid or emotionally unstable ('borderline') personality disorders (or combinations of these) in the 16–21-year group is also very high. The prevalence of mental retardation and pervasive developmental disorders (eg autism) in adolescents in prison in England and Wales is not known, but levels in delinquent populations are significantly higher than in the general population. Specific learning difficulties such as dyslexia (reading disorder) and difficulties with spoken communication are over-represented among young offenders in prison. Reading problems are strongly linked with psychiatric problems in general and behavioural problems in particular.

For a summary of the epidemiological information about psychiatric morbidity in young offenders, see page 117.

Issues in assessment

To identify what is abnormal, it is necessary to have an understanding of normal development. Adolescents are engaged in particular developmental tasks (eg becoming independent from others while still maintaining appropriate emotional closeness to them; developing a sense of identity, including a sexual and cultural identity, a body image and self-esteem). The behavioural problems that peak in the teenage years such as delinquency, substance misuse, deliberate self-harm and anorexia nervosa often involve exaggerated and unresolved versions of ordinary adolescent development. As a result, abnormal behaviour in adolescents is more likely to be interpreted or dismissed as a normal response to life events by healthcare professionals, teachers, parents and the patients themselves, resulting in missed or late diagnoses. A good working knowledge of adolescent development can help prevent this, as can a thorough assessment that includes information from a variety of informants.

Carrying out the assessment

Where a young person is thought to have a mental disorder, the assessment should include taking a history and an assessment of the mental state (see **Assessment**, page 165), in addition to the following.

- Explain the limits of confidentiality. Many adolescents want a promise of secrecy.
- Interview several informants if possible. The family, social services staff, educational staff and residential staff can all contribute important information from their different perspectives. Residential staff will have information about the individual's mood and behaviour, any incidents of self-harm, relationships with staff and peers, participation in association and education, whether the individual has a job, and the reasons for any adjudications and episodes in the segregation block.
- Expect and look for comorbidity. Emotional problems are often overlooked in the presence of aggressive and disruptive behaviour. Substance misuse may be a consequence of conduct disorder or a way of self-medicating for emotional disorders. Between 30 and 50% of individuals with early onset conduct disorder also have attention deficit hyperactivity disorder (ADHD)/hyperkinetic disorder. Systematically, you should ask about:
 - worries, phobias, obsessions
 - depressive symptoms
 - inattention, impulsivity, excessive activity

- aggressive, delinquent and rule-breaking behaviour
- problems with learning
- bizarre or strange ideas and behaviour
- use of substances and
- relationships with parents, siblings and peers.
- Ask about suicidal thoughts and self-harming behaviours.
 - The principles of assessing and managing suicide and self-injury are generally applicable to young people (see page 204).
 - Suicide is a leading cause of death in people aged 15–24. Self-harm is most frequent during adolescence.
 - Ask direct questions.
- Ask about bullying/abuse/debt. Focus on current and recent abuse to prevent further harm.
- Assess the impairment in functioning (eg can the individual maintain former levels of self-care such as grooming and eating, as well as relationships with others and work/education).
- Identify the strengths and resources in the individual and their network of family, friends and staff. Ask if there is any adult in the young offenders' institute (YOI) who they trust and have a good relationship with. This is important for developing the management plan.

Which professional (or combination of professionals) carries out this assessment will vary according to the composition of the healthcare team. Where the team includes mental-health nurses, they are likely to be involved.

Tests of cognitive functioning and academic achievement

Developmental disabilities (eg learning disability, autism), specific learning difficulties (eg dyslexia, dyspraxia) and communication difficulties (eg stammering, getting words muddled) are all more common in young offenders. The appropriate tests are usually administered by clinical psychologists, education staff or speech and language therapists and may be conducted as part of the individual's initial screening. Where they have not been done and a problem in one of these areas is suspected, request an assessment from the local Learning Disability Trust (for developmental disabilities). Assessments for specific learning difficulties may need to be obtained under contract from Local Authority Educational Psychology Departments. Appropriate treatment can improve the outcome of any mental disorders.

Summary of the areas to consider in an assessment of young offenders

Psychiatric disorders, eg depressive disorder, substance misuse

Specific delays in development, eg dyslexia

Intellectual level, eg mild mental retardation

Medical condition(s), eg epilepsy

Psychosocial adversity, eg institutional upbringing

Functioning in day-to-day life, eg serious problems relating to others

Strengths and resources, eg enjoys art, has a trusting relationship with a probation officer in the home area

Issues in management

Emotional and behavioural disorders in young people are to a greater extent symptoms of disordered relationships within the family, peer group or wing/unit than symptoms of a disorder within the individual. Consequently, the following may be found.

- Medication plays a lesser role than in adult disorders (with the exception of ADHD/hyperkinetic disorder).
- Interventions that attempt to change the young person's environment and relationships or help him/her to cope better with them play a greater role. The larger part of management consists of helping others (residential staff, teachers, other staff) to develop and carry through a management plan. See the guidelines for particular disorders for details.
- Interventions that aim to increase the young person's emotional resilience or increase their self-esteem are protective against further deterioration of mental state and should always form part of the management plan.
- Although particularly difficult to achieve in the YOI context, the family should be involved in treatment wherever possible, especially with a younger adolescent who still lives at home. Contact with the youth justice worker, probation officer or social worker from the home area is also likely to be helpful.

Comorbidity

- Separate treatment is required for associated problems.
- Substance misuse by adolescents is less likely to require medical treatment for dependence and more likely to be a symptom of a behavioural disorder. Treatment, therefore, will be less substance-oriented and will involve a broader range of interventions.¹

Medication

- There is generally less information about the efficacy and side-effects of drugs in adolescents than in adults.
- The dosage may need to be modified according to the adolescent's weight.
- Poor compliance and overdosing are common issues with adolescents. The stigma of being diagnosed and treated for a mental disorder is a major issue that needs discussion.

Informed consent

This is more complex with young people (see page 300).

Confidentiality

Adolescents are often particularly concerned about their privacy (for a discussion of the issue, see page 304).

Referral and aftercare

- Prepare the individual for a referral to a mental-health professional. Emphasise that referral does not mean that they are 'mental' or crazy. Emphasise the collaborative nature of psychological therapy.
- Generally, if the young person is at school or under the age of 17, the parents should be involved in the referral process where possible. Where there is a conflict of interest, the interests of the patient take precedence over those of the family.
- Where possible, seek to involve the NHS mental-health services in the area to which the young person is to be released at least 6 weeks before release.
- See the guidelines for specific disorders for referral criteria. In general, young people identified as being acutely psychotic, severely depressed and those with a severe personality disorder should, wherever possible, be swiftly transferred to and accepted by outside hospitals.
- For more information on liaison, referral and aftercare, including the Care Programme Approach, see page 151.

In-house mental-health services

Primary-care staff require the support of specialist services. To achieve equivalence with out-patient child and adolescent mental-health services in the community, the establishment would need the support of a multidisciplinary team including psychiatry, clinical psychology, nursing, and individual and family therapy. Strong links between these, the primary-care staff, drug project team, chaplain and probation officers are needed. Direct access by young prisoners and prison officers and other staff is desirable. The development towards this is likely to be incremental.

¹ Merrill J, Peters L. Substance misuse. In Gowers SG (ed.), *Adolescent Psychiatry in Clinical Practice*. London: Arnold, 2001.

Adolescent conduct disorder — F91#

Introduction

Many young offenders meet the diagnostic criteria for conduct disorder simply by virtue of their persistent criminal activities. Unless their behaviour is regarded as abnormal by the individuals themselves, their peers or family, healthcare intervention is unwelcome and cooperation unlikely. This guideline, therefore, aims to help primary-care staff to do the following.

- Identify and treat associated mental disorders.
- Support and advise other staff who form the mainstay of the management of these individuals.
- Identify those individuals who may benefit from further assessment and treatment for their behavioural problems by specialists.
- Participate effectively in the multidisciplinary management of individuals with more severe disorder, thus reducing or preventing associated problems such as psychiatric disorders, self-harm and violence, and reducing the probability of the individual developing lifelong personality disorder.

Presenting complaints

Most individuals present associated problems rather than the conduct disorder itself, eg depression, deliberate self-harm or repeatedly seeking psychotropic medication. Others, particularly prisoners on remand, may ask for help in controlling their anger. Staff or other inmates may express concern about the individual's behaviour, eg persistent disruptive behaviour ('something to calm him down'), social isolation, bullying or being the victim of bullying.

Diagnostic features

There is a pattern of persistently excessive antisocial behaviour lasting at least 6 months and usually much longer. Symptoms may include vandalism, cruelty to both people and animals, bullying, lying or cheating (to con others), starting physical fights, using weapons during fights, stealing outside the home, setting fires to cause damage, repeated truancy, and forcing others to perform sexual acts against their will.

Conduct problems involve three overlapping domains: defiance of authority, aggressiveness and antisocial behaviour that violates other people's rights, property or person. These behaviours, to a certain degree, are a part of normal child and adolescent development. A diagnosis should only be made when the behaviours are extreme and persistent or result in impairment in everyday functioning.

Two groups of young people with antisocial behaviour have been identified.¹

- **Late onset** antisocial behaviour begins during adolescence and is associated strongly with social factors such as a family history of criminality, the influence of peers and substance misuse. The early history is often unremarkable, with a conflict with authority, which may be normal within the delinquent subculture, becoming apparent as the child enters adolescence. Young offenders thought of by staff as 'normal' may fall into this category.
- **Lifetime persistent**: this group displays antisocial and disturbed behaviour often from early childhood. There is a much higher incidence of impaired social functioning, emotional problems, psychiatric illness, self-harm and substance misuse. The group is at particular risk of developing adult antisocial personality disorder.

Differential diagnosis

- Occasional antisocial acts do not warrant this diagnosis.
- Adjustment reaction (if antisocial behaviour lasts no more than 6 months and follows a stressor such as family breakdown, bereavement, trauma, abuse or adoption).
- Depression or bipolar disorder (where irritability and aggression are not part of a long-standing pattern of behaviour and other symptoms of depression are present).
- Early onset schizophrenia: behavioural disturbance that mimics conduct disorder may be part of the early (prodromal) phase of schizophrenia. Suspect the early stages of a severe mental illness where there is a clear change in social functioning (eg a decline in work or school performance) and any changes in thinking (eg a preoccupation with odd ideas, increased suspiciousness), behaviour (eg increased withdrawal) or mood (eg rapid mood changes, inappropriate moods) (see **Early onset psychosis**, page 131).
- Autism spectrum disorders, generalised learning disability (mental retardation) and other pervasive developmental disorders are frequently accompanied by behavioural problems. Autistic individuals may be identified by their lack of a

capacity to socialise, severely restricted language or odd style of speech, and preoccupation or obsession with sameness (see **Learning disability**, page 255).

- Personality disorder: a diagnosis of 'personality disorder' is generally not appropriate in adolescents under the age of 18.

Essential information for the patient and the primary support group

- The way the institution is run affects outcomes for young people. The beneficial effects of incarceration may be derived from education and training that open up opportunities on release, from help for drug misuse, from a pro-social ethos with good relationships and role models, from encouraging strong, regular links with families, and from encouraging the young people to do things for themselves and to feel proud of any achievements they make.²
- In severe cases, the young person is likely to be temperamentally different from others and therefore cannot easily control his/her actions.
- Antisocial behaviour is in part learned and can be corrected (unlearned). However, this requires substantial motivation, effort and support — especially where the behaviours are long-standing, severe and persistent.
- Disruptive individuals tend to externalise distress and conflict. They may have trouble recognising fear or sadness in themselves. They also frequently have difficulties in using negotiation skills or problem-solving skills as alternatives to aggression. Adults who can model or teach these skills can be helpful.
- The long-term prognosis is not good without intervention. Individuals do not 'grow out of it'. However, there may be improvements with appropriate management. Some factors known to help protect against a poor outcome may be available within a young offenders' institute (YOI). They include:
 - having a caring, supportive relationship with at least one adult
 - having friends who do not get into trouble
 - experience of achievement in some sort of activity (eg sport, any form of education or training, a responsibility within the institution)
 - absence of (or successful interventions for) learning problems, such as dyslexia
 - absence (or successful treatment) of other mental disorders (especially substance misuse and attention deficit hyperactivity disorder [ADHD])
 - experience of establishing a stable work record and
 - remaining at school until the age of compulsory school end or longer.

Identification and arrangement of treatment for associated conditions

Coexistent disorders are easily missed and should be carefully assessed.

- **Alcohol and drug misuse:** substance misuse appears not to cause conduct disorder (which usually precedes substance misuse), but it may exacerbate and perpetuate it. In most cases uncomplicated by more severe psychopathology, the successful treatment of drug and alcohol problems will probably do most to reduce the likelihood of problems persisting into adulthood.
- **Specific reading retardation (dyslexia):** achievement and employment both predict good outcomes in conduct disorder, so referral for interventions for dyslexia is of great practical importance. Difficulties with spoken language (eg stuttering, getting words muddled) are also common in the young offender population and interfere with successes in work and education.^{3,4}
- **Hyperkinetic disorder/ADHD:** rates of comorbid ADHD have been reported to be as high as 30% of boys and 59% of girls with conduct disorder.⁵ ADHD is a developmental risk factor for conduct disorder.⁶ The prognosis for young people with both disorders is poorer, so it is essential to diagnose and treat ADHD.
- **Depression:** rates of comorbidity are reported as being between 23 and 36%.⁷ Depression requires treatment in its own right. Behaviour problems do not usually reduce after treatment of depression.

See the guidelines for relevant disorders for information on diagnosis and management.

Advice and support for the patient and the primary support group

Behavioural management is most likely to be effective where the individual is of a younger age and does not have a 'callous, unemotional' interpersonal style, and where the regime and staff behaviours consistently support appropriate behaviours and do not tolerate inappropriate ones. Staff should be encouraged to do the following.

- **Develop a regimen where staff model the appropriate behaviour,** eg dealing with aggression by 'talking down' in the first instance, bullying is not tolerated and opportunities for constructive activity and achievement are plentiful.

- **Encourage positive strengths**, eg work, sport, art, education, continued family contact, other relationships. Anything that allows achievement and raises self-esteem is likely to be helpful.
- **Where possible, develop a relationship with the young person**, eg identify a shared interest and spend a short time as often as possible discussing or doing the activity together (eg football). Aim to interact with the young person in ways other than giving orders.
- **Set clear rules and give short, specific commands about the desired behaviour, not prohibitions about undesired behaviour**, eg 'please walk calmly' rather than 'don't run'.
- **Where staff have a positive relationship with a young person, help him/her try to find alternative strategies to replace those that lead to trouble**, eg 'If someone else confronts you, rather than hitting him first, ask why he is angry or go and tell someone you trust.' Praise and reward any progress.
- **Provide consistent and calm consequences for misbehaviour**. The wing minor report system can be used to mark overstepping behavioural boundaries. Avoid getting into arguments or explanations with the individual as this only provides more attention for the misbehaviour. Conversely, ignoring minor problems such as defiant language may be effective.

Severe, long-standing behavioural problems

- Assess the risk to yourself, the individual and to others. Self-harm is common in this group (see **Assessing and managing people at risk of suicide** and **Dealing with aggression**, pages 204 and 282).
- Discuss the most challenging individuals with those delivering regimes in the prison to see if a package of activities can be organised to help the individuals structure their day.
- For further management advice, see **Antisocial personality disorder** and **Managing prisoners with complex presentations and very difficult behaviour**, pages 70 and 202).

Medication

No drugs have shown an effectiveness as treatments for antisocial behaviours in general or for aggression in particular. The psychostimulant methylphenidate is effective for comorbid hyperactivity and can reduce aggression⁸ — but **only** if hyperkinetic disorder/ADHD is present. See the guideline on hyperkinetic disorder/ADHD.

Psychological treatment

There is no conclusive evidence about the effectiveness of any single intervention. The Thinking Skills programme offered under the Prison Service's Offending Behaviour programme has been shown to reduce the risk of re-offending among 'ordinary' young offenders. However, multimodal, well-structured, intensive, lengthy programmes that are cognitive-behavioural in orientation have proven most effective with adolescents who show severe antisocial behaviour and are at highest risk of developing adult personality disorder.⁹

Treatments that have shown the most promise are listed below.

- **Cognitive-behavioural programmes**, especially multimodal ones incorporating anger control, problem-solving, self-control and moral reasoning ability.¹⁰
- **Multisystemic therapy**.^{11,12}
- **Family therapy**.¹³
- **Behavioural management training**: more appropriate for a younger age group or where the adolescent is actively involved in developing and agreeing the programme.¹⁴

Currently, thinking skills and problem-solving skills training may be available under the Prison Service's Offending Behaviour programme. Multisystemic therapy is not yet available in the UK. Family therapy and behavioural management training is often available from the adolescent mental-health services, both the general and forensic services.

Where symptoms are severe, the individual is motivated and the service exists, treatment may be offered in a residential setting. Results are best if the programme is structured, the atmosphere warm, there are high expectations, there are positive staff and adolescent relationships, and the programme lasts for more than a year.¹⁵

Referral and resettlement

Prisoners with conduct disorder come to the attention of wing staff, probation officers, education officers, and health and workplace staff. Sentence planning pulls all these threads together. Health staff should ensure that their skills are part of sentence planning. Where an individual's behaviour is leading to impairment and distress, regular multidisciplinary case conferences and a care plan are recommended.

Consider referring to in-house or local adolescent mental-health services

- suspected hyperkinetic disorder/ADHD
- comorbid severe psychiatric illness
- where there is serious risk to self or others.

Consider referring to the adolescent forensic services (if available) the most severe cases where there is evidence of sadism or sexually inappropriate behaviour or where there is severe social isolation. Interventions work best with patients who are willing to engage in therapy. In practice, choosing whether to refer the most severe cases or more motivated patients with less severe problems is a practical trade-off between the likely responsiveness to treatment and the seriousness of the disorder.

Consider referral to learning disability services where autism is suspected or where there is a learning disability and a change in behaviour (see **People with learning disability**, page 255). For those with specific learning or communication difficulties, consider organising a special package with the Education Department and with others.

If a release of individuals with severe behavioural problems is planned, contact the local youth offending team and enquire whether there are specific services within the local child and adolescent mental-health service that would be of help to the young person. If no service is available, notify the Public Health Department at the relevant Primary Care Trust. Liaison with a probation officer will also be important. For severely affected individuals, consider the risk to others. Prison Service Order 6450 and Probation Circular 27:2000 set out the arrangements to be made for the release of people who are considered dangerous.

Resources for patients and primary support groups

National Family and Parenting Institute: 020 7424 3460

Young Minds Trust: 020 7336 8445 (office)

102-108 Clerkenwell Road, London EC1M 5SA

(Produces a range of leaflets for young people and their parents. It also runs a **Parent Information Service:** 0800 0182138 (freephone), which provides information and advice for anyone concerned about the mental health of a child or a young person)

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- 3 Bryan K. Survey of speech, language and communication skills in young prisoners. In *HM Inspector's Report of Inspection at HM YOI Swinfen Hall*. London: HMSO, 2000.
- 4 Crowe TA. Speech and hearing status of prisoners. *Bulletin of the College of Speech and Language Therapists* 1991; 466: 2-4.
- 5 Szatmari P, Boyle M, Offord DR. ADHD and conduct disorders: degree of diagnostic overlap and differences among correlates. *Journal of the American Academy of Child and Adolescent Psychiatry* 1989; 28: 865-872. Reports the Ontario Child Health Study and shows that of young people aged 12-16 years, of boys 6.7% had pure conduct disorder, 3.8% had pure ADDH and 2.9% had both disorders; of girls 2.7% had pure conduct disorder, 1.6% had pure ADDH and 1.6% had both disorders.
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Hyperkinetic disorders — F90

Includes attention deficit hyperactivity disorder (ADHD)

Introduction

Attention deficit hyperactivity disorder (ADHD) and hyperkinetic disorder are disorders with a strong genetic component, characterised from an early age (before 7 years) by disturbances in the areas of attention, impulsiveness and hyperactivity.

The disorders are reputed to be more prevalent in the USA than in the UK, but this is largely the result of the use of less strict diagnostic criteria, which include people with less severe symptoms. Hyperkinetic disorder is the name given to the disorder diagnosed using the stricter ICD-10 criteria; 1.7% of primary school children meet these criteria. ADHD is the name given to the disorder diagnosed using the less strict DSM-IV criteria; 3–6% of primary school children meet these criteria. These disorders are more common in boys.

Contrary to what was previously thought, a significant proportion of children with ADHD continue to have the disorder in late adolescence and some still show symptoms 10 years later, though inattention is more frequently prominent in adults than is hyperactivity. The prevalence of ADHD in young offenders' institutes (YOI) and adult prisons is not known. However, the fact that ADHD is frequently accompanied by conduct disorder, substance misuse and specific learning difficulties means that the prevalence is likely to be significantly higher than in the community. Some young people and adults with the disorder will be unrecognised.

Presenting complaints

- The patient may have a pre-existing diagnosis of ADHD/hyperkinetic disorder.
- The patient may be referred by a member of staff concerned about the fact that his/her behaviour is extreme in some or all of the following ways:
 - cannot finish anything he/she starts doing
 - does not seem to listen
 - cannot sit still
 - runs everywhere
 - cannot wait for others
 - is distracted very easily
 - is very loud and noisy and
 - always answers when not asked and butts into conversations; the staff member may think the individual has 'taken something'.
- The patient may attend with frequent injuries: broken bones, falls, scratches.

Adults with ADHD usually have more symptoms of problems with attention than with hyperactivity. They may complain of being unable to organise and plan and of being irritable and fractious.

Diagnostic features

- **Severe and enduring difficulty in maintaining attention**, eg short attention span, has frequent changes of activity, is very easily distracted, is disorganised.
- **Abnormal physical restlessness**, eg fidgeting or whole body movements. These are often most evident in the classroom or at mealtimes, but movements often increase during sleep.
- **Impulsiveness**, eg the individual cannot wait his/her turn or acts without thinking.

Individuals with this disorder are frequently rejected by their peers and show a variety of difficulties in social relationships.

- **For a diagnosis of hyperkinetic disorder**, inattention, overactivity and impulsiveness must all be present, must be clearly excessive for the individual's age, produce significant impairment and be evident in all situations (in the home, young offenders' institute or prison, school, healthcare centre). The behaviours will have been present from before 7 years of age and frequently from before the age of 2 (though diagnosis is frequently made later).
- **For a diagnosis of ADHD**, inattention and/or some combination of the symptoms of hyperactivity and/or impulsivity must be present, must be excessive for the individual's age, must produce impairment and be evident in at least two situations.

Adults and older adolescents are more likely to show predominantly symptoms of inattention rather than of hyperactivity, though they may have been hyperactive when younger.

Where there is no previous diagnosis and ADHD/hyperkinetic disorder is suspected, note the following.

- Laboratory tests (eg electrocardiogram [EEG], tests of attention) are of little assistance in diagnosing this condition.
- In addition to interviewing the patient, ask the patient and staff to monitor the patient's behaviour over time.
- If possible, an informant (eg a family member) should be interviewed with the patient's permission. If this is not possible in the prison/YOI, it could perhaps be done by a professional in the community (eg a general practitioner) or over the telephone. Information about the age of onset and the development of symptoms is essential to diagnosis. The testimony of the patient about their own childhood is not always very reliable and a parent should be asked to describe the patient's behaviour as a child (by age 7). The list of diagnostic criteria provided on the disk may be helpful.
- If on the basis of the available information there is good reason to suspect ADHD/hyperkinetic disorder, refer the patient to a specialist for more detailed assessment. Investigation for specific learning difficulties should be part of the assessment.

Differential diagnosis

The following may be the sole cause of the symptoms displayed. Alternatively, they may be comorbid with them.

- **Restlessness, agitation and impaired concentration due to depression, anxiety or mania** (where symptoms usually follow an episodic course and lack the early onset and chronicity of ADHD). Depression may also result from problems caused by ADHD.
- **Conduct disorder only** (the individual exhibits disruptive behaviour **without** inattentiveness). ADHD commonly coexists with conduct disorder.
- **Mild learning disability** (where poor educational achievement is due solely to low intelligence). ADHD may coexist with learning disability.
- **Severe problems in family relationships** (attachment disorders), where symptoms arose in reaction to or were made worse by, for example, neglect, abuse and multiple care placements. A careful history and multiple informants are essential to identify this problem. It may coexist with ADHD.
- **Autism** (social/language impairment and stereotyped behaviour are also present). Autism may coexist with ADHD.
- **Brain injury** (if there is a history of head injury and symptoms of ADHD are evident following the injury and not before). ADHD may coexist with brain injury.
- **Specific rare physical disorders.**

Identification and arrangement of treatment for associated problems

See 'Differential diagnosis' above. The following are particularly common in association with ADHD/hyperkinetic disorder.

- Conduct disorder: ADHD can be understood as a developmental path to conduct disorder.
- Substance misuse: adolescents and adults with ADHD use tobacco, cannabis and multiple drugs at an earlier age two to three times more commonly and they become dependent more quickly than those without the disorder.
- Developmental disorders such as dyslexia-specific reading disorder and dyspraxia, developmental coordination disorder and educational underachievement.
- Tourette's syndrome (multiple motor tics and one or more vocal tics, eg grunts, swear words, throat clearing). Mild forms do not require treatment. Where impairment is significant, medication will be required. Seek advice from a specialist.

Associated conditions require management separately. The successful treatment of dyslexia and other specific learning difficulties can improve the outcome in both adolescents and adults. Successful treatment of ADHD can improve outcomes in substance misuse and conduct disorder.

Essential information for the patient and the primary support group

- Hyperkinetic behaviour is not the patient's fault. It is most likely that genetic factors play a very important role in this disorder as 70–80% of cases are estimated to be inherited.¹ The way that family, teachers, staff and others respond to the child is thought to interact with the behaviours and make more or less likely the development of associated problems such as delinquent and antisocial behaviour, substance misuse and underachieving at school.
- Many hyperactive children make a satisfactory adjustment, but some continue to have difficulties into adulthood. The outcome is better if parents, teachers and other adults can be calm, accepting, have realistic expectations of the individual and avoid reinforcing the individual's disruptive behaviour.

- Behavioural treatment is important and the role of parents, teachers and other adults/staff is central. It is important to persevere even though behavioural management is time-consuming and the results are not immediate. Medication may increase the effectiveness of other treatments such as for behaviour therapy.

Management advice for the patient and the primary support group

The patient's behaviour is likely to be causing problems in all areas — on the Residential Unit, in education and in the workplace. A consistent, multidisciplinary plan that the patient is actively involved in developing is essential. Staff can be assisted with the following.

- To understand that the patient's behaviour is due to a disorder and not to wilful misconduct.
- To expect problems with concentration and therefore to set short tasks the patient can handle. Hyperactive individuals require particularly clear instructions. Short, specific commands about the desired behaviour are best rather than prohibitions about undesired behaviour, eg 'please walk calmly' rather than 'don't run'.
- Focus on the immediate, consistent, positive response to desired behaviour rather than on critical comments or punishment for the undesirable behaviour.
- Create a predictable routine. The prison regime will be beneficial in this respect, but the individual will need help in planning activity during any long spells in their cell or association.
- Encourage staff (eg teachers, personal officers) to spend time with the individual engaged in activities that require attention (eg completing a jigsaw) and to give positive feedback or recognition when the individual pays attention.
- Minimise distractions (eg in education, have the individual sit at the front of the class, work one-to-one or in a small group).
- Keep the individual busy and encourage sports and other constructive activity.
- Where possible, ignore non-dangerous, disruptive behaviour, eg defiant language.
- Monitor progress, identify problem areas and consider the options for addressing them. (For example, if problems arise during association, consider ways of reducing stimulation, eg talk with only one friend at a time.) Progress charts can help with this.

There is some evidence that some patients are better when specific foods (eg artificial colourings and other additives) are excluded from their diet.² However, formal dietary exclusion programmes are only very rarely indicated. If the patient is motivated to explore possible links between food and behaviour, keeping a food diary can be helpful. The advice of a dietitian is important before instigating exclusion diets.

Adults may be helped by education about the disorder and with counselling that focuses on helping them to recognise and build on their strengths, and to develop ways of coping with difficulties and problem-solving. ADD information service (see **Resources** below) may be helpful.

Medication

For more severe cases, stimulant medication (methylphenidate, dexamphetamine) may improve attention, reduce overactivity^{3,4} and reduce drug misuse. Medication may be one part of a comprehensive package of treatment. Stimulants have been most extensively studied in children under 16. In older adolescents and adults, the rates of improvement in symptoms may be lower and higher doses may be required.⁵ The need for medication should be reassessed periodically. Individuals may respond to one drug but not to another.

Medication for ADHD/hyperkinetic disorder should be initiated by a specialist. General practitioners and generic mental-health services should use only methylphenidate and dexamphetamine, with the use of other drugs and combinations confined to specialist centres. If a patient enters prison/YOI on a combination of drugs and is under the care of a specialist centre, then this can be continued with monitoring and on-going advice from the specialist.

Stimulants are given orally two or three times per day and should be tailored to individual needs. The effects typically appear less than 1 hour after ingestion. The duration of effect is 3–4 hours, but there is considerable individual variation. If the individual is still growing, his/her height and weight should be measured at regular intervals.

The potential side-effects include the following.

- A mild loss of appetite, nervousness and insomnia (the most common side-effects). These usually diminish after 2–3 months. Dose readjustment or changing the time of day when the medication is taken is often enough to reduce sleep difficulties.
- Blood pressure changes (rare in adults): should be monitored carefully when treatment begins and then at regular intervals.

- Tics (more common in children than in adolescents and adults): if they occur, medication should be stopped. Stimulant medication does not seem to cause Tourette's disorder, but may trigger the onset in predisposed individuals.
- Allergic reactions such as rashes and psychotic reactions are unusual but sometimes occur. Psychotic reactions have not been reported in adults.

Whether or not the patient has a history of substance misuse, medication use should be regularly monitored and independent ratings of behaviour obtained to ensure that positive effects are being maintained.

Referral and resettlement

General: refer to the specialist mental-health services

- For confirmation of diagnosis and for detailed assessment (where a hyperkinetic disorder is diagnosed for the first time in an adolescent or adult).
- Where autism, Tourette's syndrome or brain injury are suspected.
- Before starting a drug treatment.

Other things to consider include the following.

- Where there is a pre-existing diagnosis of ADHD/hyperkinetic disorder, involve the community service in advising on treatment in the YOI/prison.
- Referral for specific cognitive-behavioural treatment,⁶ if available, can improve attention and self-control. It can be particularly helpful if there are associated mood difficulties.
- If the patient is of school age, discuss with the education manager the involvement of the Educational Psychology services. Many affected children have special educational needs.
- Where possible, involve the adolescent community mental-health services in the patient's home area well before release. The services may undertake preparatory work with the patient's family.

Resources for patients and primary support groups

ADD Information Services: 020 8906 9068

(Extensive catalogue of books and videos on ADHD)

LADDER (National Learning and Attention Deficit Disorders Association):

01902 336272

(Parents' and family support group)

Young Minds Trust: 020 7336 8445 (office)

102–108 Clerkenwell Road, London EC1M 5SA

(Produces a range of leaflets for young people and their parents. It also runs a **Parent Information Service:** 0800 0182138 (freephone), which provides information and advice for anyone concerned about the mental health of a child)

Kate Kelly and Peggy Ramundo. *You Mean I'm Not Lazy, Stupid or Crazy?!*: A Self Help Book for Adults with Attention Deficit Disorder. New York: Simon & Schuster, 1993. An American book written for people with ADHD. It is lengthy but may be helpful for staff wishing to understand the disorder

- 1 Taylor E, Sergeant J, Doepfner M *et al.* Clinical guidelines for hyperkinetic disorder. *European Child and Adolescent Psychiatry* 1998; 7: 184–200. Suggests a heritability estimate of 80% for hyperkinetic disorder.
- 2 Kavale KA, Forness SR. Hyperactivity and diet treatment: a meta-analysis of the Feingold hypothesis. *Journal of Learning Disabilities* 1983; 16: 324–330.
- 3 Spencer T, Biederman J, Wilens T *et al.* Pharmacotherapy of Attention-Deficit Hyperactivity Disorder across the life cycle. *Journal of the American Academy of Child Adolescence Psychiatry* 1996; 35: 409–432.
- 4 National Institute for Clinical Evidence. Guideline on the use of methylphenidate (Ritalin, Equasym) for Attention Deficit Hyperactivity Disorder (ADHD) in childhood. October 2000. Available on the NICE website: URL: <http://www.nice.org.uk/> The guideline only considers evidence on children below 16 years of age.
- 5 Joughin C, Zwi M. Focus on the use of stimulants in children with attention deficit/hyperactivity disorder. In *Primary Evidence-based Briefing No. 1*. London: Royal College of Psychiatrists, 1999.
- 6 Miller A, Lee S, Raina P, Zupancic J, Olsen L. *A Review of Therapies for Attention-Deficit/Hyperactivity Disorder*. Ottawa: Canadian Coordinating Office for Health Technology Assessment (CCOHTA), 1998.

Emotional disorders in young people — F93

Introduction

Emotional disorders are often associated with conduct problems. Many young people detained in custodial settings have had poor experiences of parenting and have not developed skills in identifying and managing their own emotional states. They tend to be impulsive and, when distressed, frequently use maladaptive coping strategies such as:

- aggressive behaviour
- deliberate self-harm
- substance misuse and
- somatisation.

Such young people frequently find it difficult to cope even with minor events. This renders them at increased risk of developing emotional disorders such as depression and anxiety disorders.

Adults (officers, teachers, family, health professionals) often underestimate the degree of depression in young people.

There are many similarities in the presentation and treatment of emotional disorders in young people and adults. This guideline outlines the key differences. It is meant to be read in conjunction with the guidelines for adults, in particular **Depression, Generalised anxiety, Phobias, Panic disorder, Post-traumatic stress disorder** and **Suicide and Self-injury**.

Presenting complaints

Patients may present initially with one or more physical symptoms, eg 'tired all the time' or irritability. They may also present with panic attacks, sleep disturbance, nightmares, self-harm and social withdrawal. They may present with substance dependence, with the underlying emotional disorders becoming apparent following withdrawal.

Diagnostic features

The diagnostic criteria for individual disorders are the same for adults and adolescents, but presentation may vary. See the guidelines for individual disorders for details. Mixed presentations are the norm.

Depression

Differences include the following.

- Young people often appear irritable and grouchy rather than sad or unhappy.
- 'Atypical' presentations are more common, eg sleeping more than usual, increased appetite, agitation.
- Rates of comorbidity with other disorders are higher, especially anxiety disorders (38%), conduct disorders (15–30%) and substance misuse (20–50%).¹

Adolescents with a depressive disorder usually have multiple problems.

Anxiety

Worries and self-doubt are more common in young people than in adults, eg most adolescents are concerned about being disliked, rejected or criticised by their peers. An anxiety disorder is likely if such worries become intense or pervasive and cause substantial impairment in functioning. Diagnostic criteria are as adult disorders. Differences include the following.

- The focus of anxiety in adolescents is often on the fear of social situations, on social embarrassment, on worrying about catastrophic events or on performance anxiety.
- Young people with an anxiety disorder may also be overly conforming, perfectionist and unsure of themselves. They may constantly seek approval and require excessive reassurance.
- Particularly in a custodial setting, a young person typically will seek to hide worries and associated physical symptoms from his/her peers.
- Obsessional thoughts and/or compulsive rituals (eg washing rituals, checking rituals) frequently start in childhood or adolescence. Sufferers may go to great length to hide their symptoms.

Differential diagnosis

- Certain physical conditions (eg thyrotoxicosis) can cause anxiety symptoms, especially symptoms of panic (for more details, see **Panic disorder**, page 67).

- Use of alcohol and drugs may cause symptoms of anxiety and depression. Alternatively, they may mask these disorders that emerge following withdrawal/detoxification.
- **Acute psychotic disorder — F23** (page 11) if hallucinations, eg hearing voices, or delusions, eg strange or unusual beliefs, are present. The most common age for psychotic disorders to develop is the late teens and early 20s. Some individuals develop transient psychotic disorders in response to stress. Never assume that psychosis in an individual who is also abusing substances is necessarily substance-induced. Review the symptoms at intervals following detoxification.
- **Bipolar disorder — F31**: if the patient has manic episodes (eg excitement, rapid speech, elevated mood), periods of depression or mood swings.

Essential information for the patient and the primary support group

- Reassure the patient that he/she is not 'going mad'. Emotional disorders are common and help is available for their symptoms.
- Treatment consists mainly of helping the patient to deal with the problems that have triggered the disorder (eg bullying) or are maintaining it (eg problems with relationships with peers or debt). The patient has an important role to play in this, as have any adults (eg staff) that they can trust. More severe disorders may require a form of psychotherapy or family therapy. Medication only has a limited role.

Advice and support for the patient and the primary support group

- Assess the risk of suicide and self-harm. Ask a series of questions about thoughts, plans and intent (eg Has the patient often thought of death or dying? Does the patient have a specific suicide plan? Has he/she made suicide attempts in the past? Can the patient be sure not to act on suicidal ideas? How sure/safe does he/she feel? For how long does he/she feel sure to be able to resist suicidal ideas?). Involve the mental-health team. Close supervision by officers or friends, moving the patient to a healthcare centre or the use of a care suite may be needed (see **Assessing and managing people at risk of suicide**, page 204).
- Especially where symptoms are severe or long-standing, obtain information from as many informants as possible (with the patient's permission) including their family, residential staff, teachers and workshop supervisors.
- Identify current life problems or social stresses, including precipitating factors. Ask about family relationships and peer/social relationships. Identify what help the individual needs to address them.
- Identify any appropriate positive or enjoyable factors in the patient's life and seek to help the patient to increase access to these. Exercise and opportunities to be creative (eg art) may be helpful.
- Identify someone the patient can confide in. Encourage him/her to seek practical and emotional help from others. Inform the patient about the role and availability of the prison healthcare team and any other support available (eg chaplain, listener/buddy). Consider supporting him/her in obtaining additional telephone calls to their family and friends outside.
- Support the development of good sleep patterns and encourage a balanced diet (see *Getting a Good Night's Sleep* on the disk).
- Ask the patient if there is a staff member (eg personal officer, residential manager) who he/she trusts and seek permission to involve that person(s) in the management plan. Explain to the patient that as management is largely a matter of solving or ameliorating the relationship and environmental factors associated with the disorder, it will be carried out mostly by non-healthcare staff. Advise the residential staff:
 - to recognise and address bullying — many vulnerable young people with emotional disorders are 'easy targets' for bullies
 - to encourage the development of adaptive skills in coping with stress, eg talking to supportive staff members to elicit help in problem-solving, an activity to distract thoughts, relaxation skills, thinking skills courses
 - to avoid removing resources that can be used to cope, eg radios, telephone contact, association, as this will lead to more use of maladaptive coping
 - to encourage the young person to reflect on the links between stressors and their behavioural responses in debriefing sessions if possible: 'What were you feeling/thinking just before that happened?'; 'Could it be that something has made you feel angry/stressed/sad before you did that'
 - to model appropriate problem-solving skills for them — generate a wide range of solutions, consider the pros and cons of each and choose the most appropriate solution and
 - to help in the development of an emotional vocabulary by labelling emotional states, eg 'I think you could well be feeling angry/sad/anxious/excited now.'

In addition, see the guideline for relevant adult disorder(s) for further management advice.

Medication

- Depressive symptoms in adolescence are frequently related to environmental stressors and the management described above is most helpful— antidepressants may not add anything. Psychological treatments, where available, should be tried before medication.
- If psychological treatment has been ineffective or depression is severe and persistent (especially with biological or psychotic symptoms), use antidepressant medication (see **Depression — F32#**, page 47). Avoid tricyclic antidepressants (TCAs), as they are known to be ineffective in adolescents.² Preliminary findings support the use of fluoxetine in adolescents.³ There are no reported trials in adolescents of noradrenergic and specific serotonergic antidepressants. If there are psychotic symptoms, in addition to an antidepressant the use of an antipsychotic should be considered.
- If there is a good response to medication, the evidence in adults suggests a better outcome from continuing treatment for 4–6 months before a gradual monitored withdrawal.
- In general, both antidepressants and benzodiazepines have proved ineffective in treating anxiety in adolescents. However, in the absence of any large-scale trials, some clinicians support the use of selective serotonin re-uptake inhibitors (SSRIs) in the treatment of severe social phobia and panic disorder (see **Phobic disorders — F40** and **Panic disorder — F41.0**, pages 79 and 67).
- Benzodiazepines are contraindicated.

Referral (including for psychotherapy)

- Refer the patient for an urgent assessment if there are psychotic symptoms or if suicide risk results in the need for frequent observations.
- Refer the patient to specialist mental-health services for assessment if there is a lack of progress despite the above measures and for persistent self-harming behaviour.
- Adolescents with emotional disorders referred for specialist assessment are best assessed by child and adolescent mental-health professionals if possible as the developmental and systemic nature of the problems and the difficulties in communicating with these young people require specialist skills and experience.
- Cognitive-behavioural therapy may be useful for depression⁴ and anxiety,⁵ as may family therapy and interpersonal therapy. Most families will also benefit from sessions that provide general education and support. Access to these therapies may be limited.
- If possible, liaise in good time with providers of services in the community before release (see **Managing the interface with the NHS and other agencies**, page 149).

Resources for patients and primary support groups

Chaplains, listeners/buddies schemes

Who Cares? Linkline: 0500 564570 (helpline: Monday, Wednesday and Thursday, 3:30 pm–6 pm); 020 7251 3117 (administration)

Kemp House, 152–160 City Road, London EC1V 2NP

(Telephone information and support for young people who are or have been in care, and for carers)

Young Minds Trust: 020 7336 8445 (office)

102–108 Clerkenwell Road, London EC1M 5SA

(Produces a range of leaflets for young people and their parents. It also runs a **Parent Information Service:** 0800 0182138 (freephone), which provides information and advice for anyone concerned about the mental health of a child)

Youth Access: 020 8772 9900 (office hours: Monday–Friday, 9 am–1 pm, 2 pm–5 pm)

2 Taylors Yard, 67 Alderbrook Road, London SW12 8AD

(National umbrella for youth information, advice, counselling and personal support agencies [YIACs]. It gives information on and referrals to appropriate local YIACs, including youth counselling services that help with self-injury)

P Graham and C Hughes. *So Young, So Sad, So Listen*. London: Gaskell, 1995. £6.00

For more resources see the guidelines for particular disorders

- 1 Rohde P, Lewinsohn PM, Seeley JR. Comorbidity of unipolar depression: II. Comorbidity with other mental disorders in adolescents and adults. *Journal of Abnormal Psychology* 1991; 100: 214–222, as quoted in Stanway T, Cotgrove AJ. Affective and emotional disorders. In Gowers SG (ed.), *Adolescent Psychiatry in Clinical Practice* London: Arnold, 2001.
- 2 Hazell P, O'Connell D, Heathcoat D, Robertson J, Henry D. Efficacy of tricyclic drugs in treating child and adolescent depression. *British Medical Journal* 1995; 310: 897–890.
- 3 Emslie G, Rush A, Weinberg W *et al.* A double blind, randomized placebo-controlled trial of fluoxetine in depressed children and adolescents. *Archives of General Psychiatry* 1997; 54: 1031–1037.
- 4 Harrington R, Whittaker J, Shoebridge P. Psychological treatment of depression in children and adolescents: a review of treatment research. *British Journal of Psychiatry* 1998; 173: 291–298.
- 5 Stanway T, Cotgrove AJ. Affective and emotional disorders. In Gowers SG (ed.), *Adolescent Psychiatry in Clinical Practice*. London: Arnold, 2001.

Psychosis in young people

See the **Acute psychosis** guideline. The information below consists only of supplementary information specific to the development of psychotic illness in a young person.

Healthcare staff in young offenders' institutes (YOI) and adult prisons are very likely to see patients who are developing a psychotic illness for the first time and do not have a previous diagnosis as:

- the median age for the experience of a first episode of a psychotic illness is 19 years in men and 22 years in women (with 80% falling within the range 16–30 years)¹ and
- there is some indication that psychosis is caused by a poorly understood combination of biological factors that create a vulnerability to experiencing psychotic symptoms. These symptoms often emerge in response to stress (eg the stress of imprisonment or bullying on the wing) or drug abuse in the vulnerable individual.

Often, there is a long delay before treatment begins for the first episode of psychosis. The longer the illness is left untreated, the greater the disruption to a person's family, friends, study and work. In addition, delays in treatment may lead to slower and less complete recovery.²

Presenting complaints

Staff may send the patient to healthcare because they are concerned about changes in behaviour such as withdrawal, suspiciousness or odd ideas. When the young person appears in the healthcare centre, he/she may deny that there is a problem.

Diagnostic features

The earliest phase of a psychotic disorder can last from a few weeks to up to 2 years. Initially, vague changes may occur that may be difficult to detect and can be mistaken for normal changes of adolescence. The early warning signs ('prodrome') are:

- changes in thinking: a difficulty in concentrating, a poor memory, increased suspiciousness and a preoccupation with odd ideas
- changes in mood: a lack of emotional response, rapid mood changes and inappropriate moods
- changes in behaviour: odd or unusual behaviour
- social changes: withdrawal or isolation (eg spending more time in a cell, not coming out for association) and
- changes in functioning: a decline in performance at school or work.

The onset may be insidious or acute. The disturbed patient with unmistakable hallucinations and delusions is only one mode of presentation (usually late). Just as common is the quietly psychotic patient who gradually slips backwards and whom people may dismiss as being just odd.

Assessment should include information from the family, residential staff, teacher and workshop supervisor as appropriate.

Differential diagnosis and comorbidity

The clinical presentation of psychotic depression, mania and schizophrenic disorders is often very similar in young people. Diagnosis can be complicated by comorbid conduct disorder, drug abuse or other issues, including differences in culture. While early recognition of these problems is essential, it is important to avoid making a definite diagnosis prematurely. The broader term 'psychosis' may be used to cover these disorders in the first instance.

A young person may both abuse substances and be experiencing the first episode of a psychotic illness. The assumption should never be made that a young person who presents with psychotic symptoms for the first time has a 'drug-induced psychosis', even if they abuse drugs. In some instances, the individual may be using substances to help them deal with the distress of the early symptoms of the illness (see **Comorbidity**, page 191).

Find out if there is a record of previous contact with health or other personal and social services' agencies. Take a history and examine the patient, including the nervous system. Look for evidence of endocrine disease (thyroid, pituitary, adrenal), genetic conditions (Huntington's chorea, Wilson's disease with a Kayser-Fleischer ring) or focal neurological abnormality, or other systemic disease (eg systemic lupus erythematosus). Consider puerperal psychosis and a hidden pregnancy.

Advice and support for the patient

- People experiencing a psychotic illness will often be distressed and frightened. Acknowledge that the patient may be nervous or wary and try to find some common ground for discussion, gradually building up towards more specific questions about their psychotic experiences.

- The patient may need time to build up trust and repeat appointments may be needed to reach a diagnosis.
- The patient initially may be willing to accept help for their 'confusion' or 'sleep difficulties' while you 'check things out further', but they may react badly to an abrupt announcement that he/she has schizophrenia.

Referral

- Refer all young people experiencing their first psychotic episode to the mental-health services.
- Where the young person is also abusing drugs, it is ideal for the specialist to have expertise in both areas. Psychiatrists may also make inappropriate assumptions about 'drug-induced psychosis'.
- There is strong evidence for the benefits to be gained from psychosocial treatment and work with the young person's family. The NHS is developing special services for young people who have had a first episode of psychotic illness. Put the individual and their family in touch with this service, if available, as soon as they are diagnosed and certainly before release.
- For patients on the age borders between services for adolescents and adults, it may be helpful for representatives from both services to meet to agree their respective responsibilities and which treatment facility the patient should be transferred to (if appropriate) both now and in the event of any future relapse when the patient will be older.

Medication

People experiencing their first psychotic episode are typically very sensitive to the pharmacological effects of the drugs and to their side-effects. Patients experiencing a first episode of psychosis require lower doses of medication and may benefit from an atypical (ie newer generation) drug. It is important to inform the young person about possible side-effects and build up very gradually to the appropriate dosage.

¹ Birchwood M, McGorry P, Jackson H. Early intervention in schizophrenia [Editorial]. *British Journal of Psychiatry* 1997; 170: 2–5.

² McGorry PD, Edwards J, Mihalopoulos C, Harrigan SM, Jackson HJ, Early Psychosis Prevention and Intervention Centre (EPPIC). An evolving system of early detection and optimal management. *Schizophrenia Bulletin* 1996; 22: 305–326.