MANUAL MANAGING MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS FOR PRIMARY HEALTH CARE PROVIDERS

Prepared By:

FAMILY HEALTH DEVELOPMENT DIVISION
MINISTRY OF HEALTH, MALAYSIA

In Collaboration With

World Health Organization
Western Pacific Region
2014
MANUAL
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The WHO does not warrant that the information contain in this manual is complete and correct and shall not be responsible for any losses incurred due to the use of this manual.
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Foreword

I would like to congratulate the Family Health Development Division, World Health Organisation (WHO) and all the consultants, contributors and editors who have been instrumental in developing this "Manual on Managing Mental Health Problems Among Adolescents for Primary Health Care Providers".

Adolescents are vulnerable to various mental health, psychosocial and behavioral problems. Mental health disorders among adolescents are on the rise. Anxiety, depression and other mood disorders as well as behavioural disorders are among the most common mental health problems faced by adolescents. WHO reports that half of all lifetime cases of mental disorders begin by the age of 14. Mental health problems affect 10-20% of children and young people worldwide.

In Malaysia, mental health problems among children and adolescents (5-15 yrs) rose from 13% in 1996 and 19.4% in 2006 to 20.3% in 2011. The recent Global School – based Student Health Survey (GSHS) 2012 revealed 7.9% of student aged 13-17 years ever seriously considered attempted suicide while 6.7% students actually attempted suicide one or more times during the past 12 months. This worsening trend in mental health of adolescent is worrying as this will affect the development of the nation’s assets.

There is increasing evidence on the effectiveness and cost-effectiveness of early interventions in promoting mental health and preventing mental disorders in children and adolescents.

This manual will be a useful guide and reference for primary health care providers in identifying and managing mental health problems among adolescents. It will also empower health care providers to effectively manage the increasing challenges related to adolescent mental health.

I hope this initiative will contribute to the vision of Mental Health for Malaysia as a nation of happy, resilient and productive people with social, emotional and spiritual well-being within supportive family and community environments.

Thank you.

DATUK DR. NOOR HISHAM BIN ABDULLAH
Director General of Health
Malaysia
Adolescents are an asset to nation building. Realising the importance of adolescent health, the Ministry of Health has introduced the Adolescent Health Programme since 1996 as an expanded scope of the Maternal and Child Health Programme. Comprehensive promotive, preventive, curative and rehabilitative services were provided at primary healthcare facilities nationwide which include mental health services for the adolescents. In order to effectively manage the adolescent mental health, various modules, manuals and guidelines have been developed to increase the knowledge, attitude and skill of primary health care providers.

Ministry Of Health (MOH) works in smart partnership with various agencies to implement programs and services to address the mental health issues among adolescents at the clinic, school and community settings. In order to enhance the knowledge and skills in adolescent mental health of various categories of primary health care providers, the Family Health Development Division, Ministry Of Health has taken the initiative to develop this manual.

This manual has been developed in three sections namely introduction to the use of the manual, possible diagnoses and appropriate interventions. A schematic approach has been taken using case scenarios, tables, flowcharts and presentation tools. It is a practical and user-friendly guide in managing common mental health problems.

Finally, I wish to thank Datin Dr Hjh Fauzi Ismail and all the consultants, specialists, counselors, psychologists and paramedics for their hard work and commitment in developing this manual. A special appreciation goes to World Health Organisation (WHO) in particular Dr Graham Harrison, the WHO Regional Director and his team, for their valuable support and assistance towards making this project a success.

TO’ PUAN DR. SAFURAH BT. JAAFAR
Director
Family Health Development Division
Ministry of Health
# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>ATS</td>
<td>Amphetamine-Type Stimulants</td>
</tr>
<tr>
<td>BSSK</td>
<td>Borang Saringan Status Kesihatan</td>
</tr>
<tr>
<td>CD</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>DASS</td>
<td>Depression, Anxiety and Stress Screening</td>
</tr>
<tr>
<td>DSH</td>
<td>Deliberate Self-Harm</td>
</tr>
<tr>
<td>DSM IV</td>
<td>Diagnostics and Statistical Manual of Mental Disorders, 4th Edition</td>
</tr>
<tr>
<td>FMS</td>
<td>Family Medicine Specialist</td>
</tr>
<tr>
<td>Fx</td>
<td>Function</td>
</tr>
<tr>
<td>GAD</td>
<td>Generalized Anxiety Disorder</td>
</tr>
<tr>
<td>GSBSHS</td>
<td>Global School-based Student Health Survey</td>
</tr>
<tr>
<td>HEADSS</td>
<td>Acronym “Home, Education, Employment, Activities, Drugs, Sexuality, Sex, Spirituality”</td>
</tr>
<tr>
<td>Hx</td>
<td>History</td>
</tr>
<tr>
<td>ICD 10</td>
<td>International Classification of Diseases, 10th edition</td>
</tr>
<tr>
<td>MDD</td>
<td>Major Depressive Disorder</td>
</tr>
<tr>
<td>MKKM</td>
<td>Modul Kemahiran Kesihatan Mental</td>
</tr>
<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health, Malaysia</td>
</tr>
<tr>
<td>MSE</td>
<td>Mental State Examination</td>
</tr>
<tr>
<td>NHMS</td>
<td>National Health and Morbidity Survey</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>ODD</td>
<td>Oppositional Defiant Disorder</td>
</tr>
<tr>
<td>PE</td>
<td>Physical Examination</td>
</tr>
<tr>
<td>PHCP</td>
<td>Primary Health Care Providers</td>
</tr>
<tr>
<td>Rx</td>
<td>Treatment</td>
</tr>
<tr>
<td>SDQ</td>
<td>Strength and Difficulty Questionnaires</td>
</tr>
<tr>
<td>SSRI</td>
<td>Selective Serotonin Reuptake Inhibitors</td>
</tr>
<tr>
<td>Sx</td>
<td>Symptom</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
SECTION

Introduction
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○ 1.2 INTRODUCTION TO ADOLESCENT MENTAL HEALTH 5
○ 1.3 MENTAL HEALTH SCREENING FOR ADOLESCENTS 6
MANAGING MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS FOR PRIMARY HEALTH CARE PROVIDERS

1. SECTION I : INTRODUCTION

1.1 INTRODUCTION TO THE MANUAL

The Purpose
The purpose of this manual is to enable the healthcare providers to identify and manage mental health problems among adolescents in the primary care setting. It is also for health care providers to respond more effectively to the adolescents and with greater sensitivity.

The Content
It contains guidance about more commonly occurring adolescent mental health issues and disorders. It highlights special considerations in dealing with conditions specific to adolescents. This module comprises of 3 sections:

- Section I : Introduction
- Section II : Possible Diagnoses
- Section III : Interventions

The Relation to Other Ministry Of Health Malaysia (MOH) Guidelines
This manual is consistent with and complimentary to the existing MOH guidelines and adolescent related documents in the following areas:

i. Screening tools for adolescent's mental health
ii. Mental health issues and disorders among adolescents
iii. Methods of mental health interventions for adolescents

A list of references is included in this manual. These documents should be used to provide basic understanding of adolescent mental health.

Using the Manual

i. Familiarize with the content.
ii. Understand the content of this manual, and relate it to your daily work with adolescents. If necessary, discuss the application of this manual with your colleagues.
iii. Identify the significant complaints or symptoms of the adolescents.
iv. Refer to the format in Section II according to the identified complaints or symptoms. Each complaint or symptom has an attached flowchart to facilitate use of the format.
v. Follow through the format in Section II to make a possible diagnoses. Start with the column PRESENTING PROBLEM and continue until the REFERENCE column. Complete reading each column before moving to the next.
vi. Once a possible diagnoses is made, refer to Section III for the intervention.
vii. As a quick guide, each column is colour coded as follows
1.2 INTRODUCTION TO ADOLESCENT MENTAL HEALTH

Mental Health

Mental Health describes a level of psychological well-being, or an absence of a mental disorder. It may include an individual’s ability to enjoy life and create a balance between life activities and efforts to achieve a psychological resilience.

World Health Organization (WHO) defines Mental Health as ‘A state of well-being in which the individual realizes his own abilities, able to cope with normal stresses of life, work productively and fruitfully, and is able to make a contribution to his community’. Data from the National Health and Morbidity Survey (NHMS) in Malaysia has shown a rise in psychiatric morbidity among adolescents. In 1996 the psychiatric morbidity was 13.0%, rising to 19.4% in 2006 and 20.3% in 2011.

Knowledge of how to provide effective mental health care has become imperative worldwide. The MOH has developed various adolescent mental health modules and manuals which have been widely used. This is another effort to produce a simplified, user friendly manual to empower primary health care providers in raising awareness and managing mental health issues among the adolescents. The information from this manual can also be imparted to the parents and care givers.

This document is to be used by paramedics and doctors in the primary health care setting. Training is required before using the manual.

Mental Illness

Mental illness is a term used to refer to a wide range of mental disorders that can be diagnosed using either ICD 10 or DSM IV criteria. In adolescents, Mental Health Disorders can be divided into 3 categories:

<table>
<thead>
<tr>
<th>Onset from childhood (1-9 yrs old)</th>
<th>Onset during early/middle adolescence (10-14 yrs old)</th>
<th>Onset during late adolescence (15-19 yrs old)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autism</td>
<td>Bipolar Mood Disorder</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>Depression</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>Oppositional Defiance Disorder</td>
<td>Obsessive Compulsive Disorders</td>
</tr>
<tr>
<td></td>
<td>Anxiety Disorder</td>
<td>Conversion Disorders</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse</td>
<td>Eating Disorders</td>
</tr>
<tr>
<td></td>
<td>Conduct Disorders</td>
<td>Conduct Disorders</td>
</tr>
</tbody>
</table>
However, this manual focuses on the common mental health disorders below:

i. Anxiety disorders
ii. Mood disorders
iii. Psychosis
iv. Attention Deficit Hyperactivity Disorder
v. Oppositional Defiance Disorder
vi. Conduct disorders

Chronic stressors such as relationship problems, communication difficulties, academic demands and peer pressures are often risk factors in developing mental illnesses. Such problems need to be addressed once identified in the adolescents.

1.3 MENTAL HEALTH SCREENING FOR ADOLESCENTS

To facilitate screening for the adolescents, the following techniques and tools are applied. These techniques and tools are available in the MOH website www.moh.gov.my. Training is necessary for all health care providers using these tools.

a. Techniques
   i. HEADSS (psycho-social framework)

b. Tools
   i. BSSK (*Borang Saringan Status Kesihatan*)
   ii. DASS (Depression, Anxiety and Stress Screening)
   iii. SDQ (Strength and Difficulty Questionnaires)

HEADSS

This is a psychosocial framework for engaging and assessing adolescents, beginning with a general to a more sensitive and specific questions. This screening acronym stands for:

- Home
- Education, Employment, Eating
- Activities
- Drugs
- Sexuality, Safety, Suicide
- Spirituality

It is used as an interview technique to assist in eliciting history from the adolescent. This technique is used as a structured approach when engaging with the adolescents. It can also be used when the adolescents are unable or reluctant to express their symptoms.

BSSK (*Borang Saringan Status Kesihatan*)

It is a self-administered questionnaire designed by the Ministry Of Health and used in the primary health care settings as a first line general screening tool to identify the risk of health disorders among adolescents. The components of this screening tool include:
physical, mental, nutritional, sexual and high risk behaviours. Early intervention will be given if any answer alerts a mental health disorder. Referral will be made if necessary.

**DASS (Depression, Anxiety, Stress Scale)**

This tool is used as screening for depression, anxiety and stress among children aged 12 years and above. It is a self-administered questionnaire. Those scoring between mild to moderate will be managed by the paramedics, while those with a score of severe to very severe will be referred to a doctor.

**SDQ (Strengths and Difficulties Questionnaire)**

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire for children between the age 3 – 16 years. It has 5 scales of emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behavior.

**GUIDE TO USING THE SCREENING TOOLS**

1. HEADSS is used as a tool for engaging with adolescents.
2. BSSK is used as a first line health screening for adolescents.
3. DASS is used when the adolescent shows symptoms of depression or stress or anxiety.
4. SDQ is used to identify strengths and weaknesses in adolescents who show symptoms of low self esteem and/or poor coping skills.
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Possible Diagnoses
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  ◦ 2.1. Format and Flow Chart

○ 2.2 ‘I want to hurt / kill myself…’ 15
  ◦ 2.2. Format and Flow Chart

○ 2.3 ‘I’m worried / feeling anxious…’ 17
  ◦ 2.3. Format and Flow Chart

○ 2.4 ‘I’m angry / easily irritable…’ 20
  ◦ 2.4. Format and Flow Chart

○ 2.5 ‘They say I’m naughty / problematic…’ 23
  ◦ 2.5. Format and Flow Chart

○ 2.6 Abnormal behaviour 26
  ◦ 2.6. Format and Flow Chart
## 2. SECTION II: POSSIBLE DIAGNOSES

### 2.1 ‘I am feeling sad…’

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Possible diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am feeling sad</td>
<td>For at least the last 2 weeks do you have the following symptoms:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or</td>
<td>1. Feeling down or depressed</td>
<td>Look for signs of under nutrition</td>
<td>Major depressive disorder (MDD)</td>
<td>Engaging the adolescent</td>
<td>3.9 (pg 40)</td>
</tr>
<tr>
<td></td>
<td>2. Loss of interest or pleasure</td>
<td>- Pallor</td>
<td>- If adolescent has at least 5 from A</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Change in sleep pattern</td>
<td>- Underweight</td>
<td>Mild</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Change in appetite/weight</td>
<td>- Overweight</td>
<td>- Presence of few</td>
<td>Mild</td>
<td>3.12 (pg 42)</td>
</tr>
<tr>
<td></td>
<td>5. Restless or slowed down</td>
<td>- Look for</td>
<td>symptoms</td>
<td>- Psycho-education</td>
<td>3.16 (pg 46)</td>
</tr>
<tr>
<td></td>
<td>6. Feeling fatigue or loss of energy</td>
<td>- Thyroid swelling</td>
<td>- Minor impairment in</td>
<td>- Supportive counselling</td>
<td>3.13 (pg 43)</td>
</tr>
<tr>
<td></td>
<td>7. Feeling worthless or loss of guilt</td>
<td>- Coarse features</td>
<td>function</td>
<td>- Relaxation techniques</td>
<td>3.2 (pg 35)</td>
</tr>
<tr>
<td></td>
<td>8. Reduced concentration</td>
<td>- Bradycardia</td>
<td></td>
<td>- Stress management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Feeling life is not worth living</td>
<td>- Slow relaxation reflexes</td>
<td></td>
<td>- Coping skills:</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Have you in the past experienced</td>
<td>Look for signs of deliberate self-harm (DSH)</td>
<td>- Problem Solving</td>
<td></td>
<td>3.10 (pg 40)</td>
</tr>
<tr>
<td></td>
<td>1. Excessive happiness</td>
<td>- Signs of injuries, scars</td>
<td>- Time Management</td>
<td></td>
<td>3.3 (pg 36)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Look for</td>
<td>- Assertiveness</td>
<td></td>
<td>3.5 (pg 38)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Needle marks</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>2. Mental state examination</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Appearance and behaviour</td>
<td>Moderate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Eye contact</td>
<td>- Between mild and severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rapport</td>
<td>- Severe</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Cooperativeness</td>
<td>- Severe symptoms</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Restlessness (psychomotor agitation)</td>
<td>- Markedly interfere with function</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Slowed movement</td>
<td>- Presence of suicidality and/or psychotic symptoms</td>
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<td></td>
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</tbody>
</table>

- Engaging the adolescent
- Mild
- Psycho-education
- Supportive counselling
- Relaxation techniques
- Stress management
- Coping skills:
  - Problem Solving
  - Time Management
  - Assertiveness

- Refer Medical officer/FMS
  - If no improvement after 6 weeks or further deterioration
  - Moderate to severe depression
    - Antidepressant e.g: SSRI
    - Fluoxetine
<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Possible diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section II)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Increased energy</td>
<td></td>
<td>(psychomotor retardation)</td>
<td>Bipolar disorder</td>
<td>Refer Medical officer/FMS</td>
<td>3.12 (pg 42)</td>
</tr>
<tr>
<td>3. Being very talkative</td>
<td></td>
<td>• Speech</td>
<td></td>
<td>- Antipsychotic</td>
<td>3.16 (pg 46)</td>
</tr>
<tr>
<td>4. Reduced need for sleep</td>
<td></td>
<td>- Usually normal,</td>
<td></td>
<td>- Mood stabilizer</td>
<td>3.13 (pg 43)</td>
</tr>
<tr>
<td>5. Easily irritable</td>
<td></td>
<td>- Moderate to severely depressed may hardly talk</td>
<td></td>
<td>- Or both</td>
<td>3.2 (pg 35)</td>
</tr>
<tr>
<td>6. C. Do you have</td>
<td></td>
<td>- May have decrease rate /amount of speech</td>
<td>Hypothyroidism</td>
<td>Refer Medical officer/FMS</td>
<td>3.10 (pg 40)</td>
</tr>
<tr>
<td>1. Chronic constipation</td>
<td></td>
<td>- May have delayed reaction time.</td>
<td></td>
<td>- L-thyroxine</td>
<td></td>
</tr>
<tr>
<td>2. Lethargy and malaise</td>
<td></td>
<td>• Mood and affect</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Heavy menses</td>
<td></td>
<td>- Depressed mood</td>
<td>Adjustment disorder with depressed mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sad looking.</td>
<td>- Depressive symptoms not fulfilling criteria for MDD</td>
<td>Psycho-education</td>
<td></td>
</tr>
<tr>
<td>RED FLAG</td>
<td></td>
<td>• Thinking</td>
<td>- Presence of identifiable stressor/preceding event</td>
<td>Supportive counselling</td>
<td></td>
</tr>
<tr>
<td>In cases of high suicide risk, refer to hospital for immediate management</td>
<td></td>
<td>- Preoccupied with the reason for sadness or depression.</td>
<td>Relaxation techniques</td>
<td>3.12 (pg 42)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Suicidal ideas.</td>
<td>Stress management</td>
<td>3.16 (pg 46)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Look for hallucination and delusion</td>
<td>Coping skills</td>
<td>3.13 (pg 43)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- problem solving</td>
<td>3.2 (pg 35)</td>
<td></td>
</tr>
</tbody>
</table>

**Special considerations**

- In irritable and depressed patient don’t forget to rule out substance abuse.
- Always have high index of suspicion for abuse and neglect.
2.1 Flow Chart: ‘I am feeling sad....’

I’m feeling sad
Or
Positive DASS / BSSK/ SDQ

Refer C

Thyroid Problem

Yes

No

MDD

Yes

Refer A ≥ 5 Sx

No

Adjustment Disorder with Depressed Mood

Paramedic (Non-pharmacological Rx)

RED FLAG

No

Refer B

Bipolar Disorder

Yes

MDD

Assess f(x)/psychotic/ suicidal Sx

Severe

Moderate

Mild

No

Improve

Refer FMS/MO

Follow up/ Discharge
### 2.2 “I want to hurt/kill myself…”

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Possible diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
</table>
| I want to hurt/kill myself | **RED FLAG**  
In cases of high suicide risk, refer to hospital for immediate management | 1. Physical examination  
- Look for signs of deliberate self-harm (DSH)  
- Signs of injuries, scars  
- Look for  
  - Needle marks | Major depressive disorder (MDD)  
Carry out risk assessment for all adolescents with suicidal thoughts/self-harm | 3.15 (pg 45) |
| Or |  | 2. Mental state examination  
- Appearance and behaviour  
  - Eye contact  
  - Rapport  
  - Cooperativeness  
  - Restlessness (psychomotor agitation)  
  - Slowed movement (psychomotor retardation) | Abuse and neglect |  |
| I want to die |  |  | Substance abuse |  |
| Or |  |  | Acute stress reaction  
Refer Medical Officer/FMS |  |
| Referred from parents and school for self-harm |  |  |  |  |
| Or | Positive BSSK |  |  |  |
|  | Ask about details of suicidal thoughts: | 1. Intensity and frequency  
2. Any plan (past/current/future)  
3. Can you control the suicidal impulses  
4. Have you actually hurt yourself  
5. Do you hope to survive/to be rescued/expect to die | Major depressive disorder (MDD)  
Carry out risk assessment for all adolescents with suicidal thoughts/self-harm | 3.15 (pg 45) |
|  |  |  | Acute stress reaction  
Refer Medical Officer/FMS |  |
2.2 Flow Chart: “I want to hurt/kill myself…”

I want to hurt/kill myself
Or
I want to die
Or
Referred from parents and school for self harm
Or
Positive BSSK

Suicidal Risk Assessment
Hx, PE, MSE

Yes

Red Flag

Immediate Hospital Referral

No

High Risk

Moderate or low risk

Assess for possible diagnoses

Refer to MO/FMS
### 2.3 ‘I’m worried/feeling anxious...’

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Possible diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel worried all the time (risšu)</td>
<td>A. A1 In the past 6 months, do you: 1. Worry excessively about many things 2. Unable to control the worry</td>
<td>1. Physical examination  - Look for signs of hyperthyroidism  - Sweaty palms, tremors  - Tachycardia. (the heart rate may be irregular)  - Thin/underweight  - Thyroid swelling  - Thyroid eye signs</td>
<td>Generalised Anxiety Disorder:  - If adolescent has all of A1 and at least 3 of A2</td>
<td>Refer MO  - Relaxation technique  - Stress management</td>
<td>3.13 (pg 43)</td>
</tr>
<tr>
<td>Or</td>
<td></td>
<td>2. Mental state examination  - Appearance and behaviour  - Restless  - Fidgety  - Unable to sit still  - Anxious looking  - Speech  - Normal  - Talk very fast</td>
<td>Phobia disorders:  - Specific phobia  - If adolescent has B1  - Social phobia  - If adolescent has B2</td>
<td></td>
<td>3.2 (pg 35)</td>
</tr>
<tr>
<td>I feel my heart beating very fast</td>
<td>B. Do you experience excessive/ unreasonable fear whenever you are exposed towards:  - B1 specific situation/things e.g heights, animals  - B2 crowd/public places</td>
<td></td>
<td>Panic disorder  - If adolescent has episodes of 4 or &gt; symptoms from C which is recurrent (panic attack – when symptoms are not recurrent)</td>
<td></td>
<td>3.8 (pg 39)</td>
</tr>
<tr>
<td>Or</td>
<td>C. Do you feel or have felt really frightened or nervous without apparent reason/ in a situation where others would not feel the same and experienced:  - Heart beats fast  - Sweating  - Trembling or shaking</td>
<td></td>
<td>Obsessive compulsive disorder  - If adolescent has symptoms from D</td>
<td>Refer MO/FMS  - Consider SSRI if non-pharmacological management unsuccessful</td>
<td>3.7 (pg 39)</td>
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<tr>
<td>I’m feeling anxious (resah)</td>
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<td>3.3 (pg 36)</td>
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<tr>
<td>Or</td>
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<td>3.10 (pg 40)</td>
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<tr>
<td>Positive BSSK/ DASS screening</td>
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<tr>
<td>Presenting problems</td>
<td>Other information required (ASK)</td>
<td>What to look for? (LOOK/LISTEN/FEEL)</td>
<td>Possible diagnoses</td>
<td>Management</td>
<td>Intervention (Refer Section III)</td>
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<tr>
<td>4. Shortness of breath</td>
<td></td>
<td></td>
<td>Thyrotoxicosis</td>
<td>Refer MO/FMS</td>
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<tr>
<td>5. Choking feeling</td>
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<td></td>
<td></td>
<td>• Antithyroid</td>
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<td>6. Chest pain/discomfort</td>
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<td>7. Nausea/tummy upset</td>
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<td>8. Dizzy/unsteady</td>
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<td>9. Feelings of unreality</td>
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<td>10. Fear of losing control</td>
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<td>11. Fear of dying</td>
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<td>12. Numbness/tingling sensation</td>
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<td>13. Chills/hot flushes</td>
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<td>D.</td>
<td>Do you have recurrent and persistent thoughts/urges/images</td>
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<td>Special considerations</td>
</tr>
<tr>
<td>1. Which you cannot control?</td>
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<td>Do not forget to rule out</td>
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<td>2. And distress you?</td>
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<tr>
<td>And/or</td>
<td>Did you do something over and over without being able to stop doing it?</td>
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<tr>
<td>1. Handwashing</td>
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<td>2. Checking</td>
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<td>3. Counting</td>
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<td>4. Saying Things Repeatedly</td>
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<td>Did these thoughts or action cause problems to yourself or others?</td>
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<tr>
<td>E.</td>
<td>Do you have?</td>
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<td>1. Increased appetite</td>
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<td>2. Loss of weight</td>
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<td>3. Palpitation</td>
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<td>4. Heat intolerance</td>
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<td>5. Tremors</td>
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</tbody>
</table>
2.3 Flow Chart: ‘I'm worried/feeling anxious...’

I’m worried/ feeling anxious
Or
Positive BSSK/ DASS

Refer E

Thyroid Problem

Refer A

GAD

Refer B
Phobia

Refer C
Panic Disorder

Refer D
OCD

Refer MO
(Pharmaco + Non-Pharmaco Rx)

Improvement

Refer FMS

Follow up/ Discharge
### 2.4 ‘I’m angry/easily irritable...’

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Possible diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m angry/easily irritable</td>
<td>For at least the last 2 weeks do you have the following symptoms: 1. Feeling down or depressed 2. Loss of interest or pleasure 3. Change in sleep pattern 4. Change in appetite/weight 5. Restless or slowed down 6. Feeling fatigue or loss of energy 7. Feeling worthless and excessive guilt 8. Reduced concentration 9. Feeling life is not worth living</td>
<td>Physical examination 1. Look for signs of hyperthyroidism - Sweaty palms - Tremors - Tachycardia (the heart rate may be irregular) - Thin/ underweight - Thyroid swelling - Thyroid eye signs 2. Mental state examination 1. Appearance and behaviour - Eye contact - Rapport - Cooperativeness - Restlessness (psychomotor agitation)</td>
<td>Major depressive disorder (MDD) 1. If adolescent has at least 5 from A 2. Mild - Presence of few symptoms - Minor impairment in function 3. Moderate - Between mild and severe 4. Severe - Severe symptoms - Markedly interfere with function - Presence of suicidality and/or psychotic symptoms</td>
<td>- Engaging the adolescent  - Supportive counselling  - Relaxation techniques  - Stress management  - Anger management</td>
<td>3.9 (pg 40) 3.16 (pg 46) 3.13 (pg 43) 3.2 (pg 35) 3.4 (pg 37)</td>
</tr>
<tr>
<td>Or Referred from parents or school for irritability/aggressive behaviour</td>
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<tr>
<td>Or Positive BSSK/SDQ</td>
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<tr>
<td>Presenting problems</td>
<td>Other information required (ASK)</td>
<td>What to look for? (LOOK/LISTEN/FEEL)</td>
<td>Possible diagnoses</td>
<td>Management</td>
<td>Intervention (Refer Section III)</td>
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<tr>
<td>C. Do you have?</td>
<td></td>
<td>Defiant</td>
<td>Thyrotoxicosis</td>
<td>Refer MO/FMS</td>
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<tr>
<td></td>
<td></td>
<td>Speech</td>
<td></td>
<td>Antithyroid</td>
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<td></td>
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<td>Increased tone</td>
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<td>Pressure of speech</td>
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<td>Flight of ideas</td>
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<tr>
<td></td>
<td></td>
<td>Defiant</td>
<td></td>
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</tr>
<tr>
<td>D. Do you use/abuse?</td>
<td></td>
<td>Mood and affect</td>
<td>Substance use/abuse</td>
<td>Refer MO/FMS</td>
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<tr>
<td></td>
<td></td>
<td>Irritable</td>
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<td></td>
<td></td>
<td>Angry</td>
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<td></td>
<td></td>
<td>Underlying depression</td>
<td></td>
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<td></td>
<td></td>
<td>Thinking</td>
<td>Special considerations</td>
<td></td>
<td>Do not forget to rule out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preoccupied with the reason for anger</td>
<td>1. Behavioural problems (ODD, CD, ADHD)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Revengeful/</td>
<td>2. Family/ school/ peer issues</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>aggressive thoughts</td>
<td>3. Adjustment disorder</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Suicidal/homicidal ideas</td>
<td>4. Psychosis</td>
<td></td>
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<td></td>
<td></td>
<td>Look for hallucination and delusion</td>
<td>5. Abuse and neglect</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(grandiose/ persecutory delusion)</td>
<td></td>
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</tr>
</tbody>
</table>
2.4 Flow Chart: ‘I'm angry/easily irritable...'
2.5 ‘They say I’m naughty / problematic…’

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Differential diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
</table>
| Referred by family /school for disruptive or oppositional behavior (melawan) or Positive BSSK/SDQ | Collaborative history should be taken from carer/teacher  
A.  
A1. Inattention  
1. Do you have difficulty in?  
- Sustaining your attention  
- Organizing and completing tasks / schoolwork  
- Giving close attention to details / make careless mistakes  
2. Do you find yourself easily distracted?  
A2. Hyperactivity-impulsivity  
1. Do you have trouble  
- Sitting still eg for long periods of time  
- Waiting for your turn  
2. Do you often interrupt others?  
B.  
1. Do you often  
- Argue with adults?  
- Behave stubbornly?  | 1. Physical examination  
- Look for signs of  
  - Injuries  
  - Scars  
  - Excioration around the nasal septum  
  - Perioral sores  
  - Needle marks  
  - Drugs withdrawal  
2. Mental state examination  
- Appearance and behaviour  
  - Eye contact  
  - Rapport  
  - Cooperativeness  
  - Fidgety (unable to sit still)  
  - Easily distracted  
- Speech  
  - Usually normal or talkative  | ADHD  
- If adolescent has most of symptoms from A1 + A2  | Refer Medical officer/FMS  
- Behaviour management of ADHD:  
  - General advice  
  - Home  
  - School based intervention  
- Anger management  
- Relaxation technique  
- Psychoeducation:  
  - Building self esteem  
  - Promoting self understanding  | 3.6 (pg 38) |
|                     |                                                                                              |                                                                                                  | Refer paediatric/ psychiatrist/child psychiatrist  
- If non-pharmacological management is unsuccessful  |                                                                                                  | 3.4 (pg 37) |
<p>|                     |                                                                                              |                                                                                                  |                                                                                                  | 3.13 (pg 43)                      | 3.7 (pg 39) |
|                     |                                                                                              |                                                                                                  |                                                                                                  |                                                                                                  | 3.11 (pg 41)                     |
|                     |                                                                                              |                                                                                                  |                                                                                                  |                                                                                                  |                                 |</p>
<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
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<th>Differential diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Lose your temper?</td>
<td></td>
<td>- Mood and affect</td>
<td>Conduct disorder</td>
<td>Refer Medical officer/FMS</td>
<td></td>
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<tr>
<td>- Make people angry with you?</td>
<td></td>
<td>- Usually normal or angry</td>
<td></td>
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<tr>
<td>- Blame others for your mistakes?</td>
<td></td>
<td>- Thinking</td>
<td>Major depressive disorder</td>
<td>Refer to section II - depressed adolescent for diagnoses and management</td>
<td></td>
</tr>
<tr>
<td>- Feel that you need to get even/ revengeful (berdendam) with others?</td>
<td></td>
<td>- No guilt feeling</td>
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<td></td>
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<tr>
<td>- Feel that you are in danger</td>
<td></td>
<td>- Couldn’t care less</td>
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<tr>
<td>2. Do these difficulties cause problems in school/home/relationship with others?</td>
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<td>C. Have you done the following?</td>
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<tr>
<td>1. Aggression to people or animal</td>
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<td>- Involve in fights or initiate it?</td>
<td>Bipolar disorder</td>
<td>Refer Medical officer/FMS</td>
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<tr>
<td>- Bully/threaten others?</td>
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<td>- Used any weapons</td>
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<td>- Cruel to people/animal?</td>
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<td>- Steal with force?</td>
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<td>- Forced someone into sexual activity</td>
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<td>2. Destruction of property</td>
<td></td>
<td>- Set fire with the intention to cause damage?</td>
<td>Adjustment disorder</td>
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<tr>
<td>- Destroyed other’s property?</td>
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<tr>
<td>3. Deceitfulness or theft</td>
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<td>- Broken into a car or house?</td>
<td>Substance use/abuse</td>
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<tr>
<td>- Con others?</td>
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<td>- Stealing without force?</td>
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<td>4. Serious violations of rules</td>
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<td>- Often out at night without permission?</td>
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<td>- Ran away from home overnight at least twice?</td>
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<td>- Often plays truant?</td>
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<tr>
<td>Special considerations</td>
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<tr>
<td>The following diagnoses can be differential diagnoses or coexist together</td>
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<tr>
<td>1. Major depressive disorder</td>
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<td>2. ADHD</td>
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<tr>
<td>3. Substance use/abuse</td>
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<td>4. Family/school/peer issues</td>
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</table>
2.5 Flow Chart: ‘They say I’m naughty / problematic…’

Referred by family / school for disruptive/ oppositional behaviour  
Or  
Positive BSSK/ SDQ

Refer A

Yes  
ADHD

No  
Refer B

ODD

Refer C

Conduct Disorder

Paramedic  
(Non-pharmacological Rx)

Improve

No  
Follow up/ Discharge

Yes  
Refer FMS/MO
### 2.6 Abnormal behaviour

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Other information required (ASK)</th>
<th>What to look for? (LOOK/LISTEN/FEEL)</th>
<th>Differential diagnoses</th>
<th>Management</th>
<th>Intervention (Refer Section III)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred for abnormal behaviour from parents or school</td>
<td><strong>RED FLAGS</strong>&lt;br&gt;- in cases of&lt;br&gt;• Acute psychosis and with risk of harm to self or others</td>
<td>1. <strong>Physical examination</strong>&lt;br&gt;• Look for&lt;br&gt;  - signs of hypo/hyperthyroidism&lt;br&gt;  - Look for signs of deliberate self-harm (DSH)&lt;br&gt;  - Signs of injuries, scars&lt;br&gt;  - Look for&lt;br&gt;  - Needle marks&lt;br&gt;2. <strong>Mental state examination</strong>&lt;br&gt;• Appearance and Behaviour&lt;br&gt;  - Poor personal hygiene&lt;br&gt;  - Poor eye-contact/rapport&lt;br&gt;  - Uncooperative&lt;br&gt;  - Restlessness&lt;br&gt;  - Psychomotor agitation/retardation&lt;br&gt;  - Abnormal behavior/movement&lt;br&gt;• Speech&lt;br&gt;  - Can be normal.&lt;br&gt;  - May have decrease rate/amount of speech&lt;br&gt;  - Irrelevant/-Incomprehensible&lt;br&gt;• Mood and affect&lt;br&gt;  - Restricted/blunted/inappropriate&lt;br&gt;• Perception&lt;br&gt;  - Look for hallucination and delusion&lt;br&gt;• Thinking&lt;br&gt;  - Suicidal/homicidal ideas</td>
<td>Brief psychotic disorder&lt;br&gt;  - if symptoms are at least 1 day but less than a month&lt;br&gt;Schizophreniform disorder&lt;br&gt;  - if symptoms more than 1 month but less than 6 months&lt;br&gt;Schizophrenia&lt;br&gt;  - If symptoms are more than 6 months&lt;br&gt;Substance-induced psychotic disorder&lt;br&gt;  - symptoms develop within a month of substance use&lt;br&gt;Major depressive disorder with psychotic features&lt;br&gt;  - if adolescent has psychotic symptoms and fulfilled the criteria for MDD (refer to depressed adolescent)</td>
<td>Carry out risk assessment for all adolescents with suicidal thoughts/self-harm/violence&lt;br&gt;Refer Medical officer/FMS</td>
<td>• 3.14 (pg 44)&lt;br&gt;• 3.15 (pg 45)</td>
</tr>
</tbody>
</table>
2.6 Flow Chart: Abnormal behaviour

Abnormal Behaviour

Immediate Hospital Referral

RED FLAG

Assess for possible diagnosis

- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Substance-induced Psychotic Disorder
- MDD with psychotic features

Refer to MO/FMS
SECTION III

Intervention
## CONTENTS

### 3. SECTION III: INTERVENTIONS

- **3.1 Spiritual/Moral Awareness**
- **3.2 Stress Management**
- **3.3 Time Management**
- **3.4 Anger Management**
- **3.5 Assertiveness**
- **3.6 Advice To Parent For Behavioural Management Of Adolescent With ADHD**
- **3.7 Building Self Esteem**
- **3.8 Effective Communication Skill**
- **3.9 Engaging Adolescent**
- **3.10 Problem Solving**
- **3.11 Promoting Self Understanding**
- **3.12 Psycho-Education**
- **3.13 Relaxation Technique**
- **3.14 Risk Assessment Of Violence**
- **3.15 Risk Assessment Of Suicide**
- **3.16 Supportive Counseling**
- **3.17 Conflict Resolution**
- **3.18 Resilience**
3. SECTION III: INTERVENTION

INTRODUCTION
This section aims to empower Primary Health Care Provider (PHCP) to understand and effectively manage mental health issues among adolescents. In order to achieve this, PHCP need to understand the attributes of the adolescents as this is a special phase of their life, a transition between childhood and adulthood. When addressing mental health issues with the adolescents, PHCP need to maintain confidentiality and be non-judgmental.

At the end of this section, there is a special mention about resilience and steps to develop it.

Confidentiality can be breached when the adolescent:
- may harm him/herself
- may be harmed by others
- may harm others
- gives consent to disclose

Being non-judgmental means avoiding from making any biased assessment based on your personal views and values, before understanding the true circumstances.

In addition, PHCP should make positive and sincere remarks to encourage better engagement and response.

Adolescence is a phase full of changes and adjustments, therefore PHCP need to be familiar about:

1. Adolescent culture and slang
Adolescents appear to adhere and behave according to a set of social rules and behavioral routines. They engage in activities that focus on themes that are repeated and recognized by their peers. Adolescent culture have certain positive or negative characteristics. PHCP need to learn to accept adolescents unconditionally and familiarize with recent development in adolescent culture and slang. However, the PHCP must guide them towards positive behaviours.

2. Body language
Adolescents often feel threatened and secretive, hence PHCP should be alert and sensitive to their body language. Body language can be expressed through tone of voice, facial expressions, hand movements and body posture. PHCP should not only listen to what is being said, but they also need to observe the body language. If the body language and the spoken words are not consistent, further exploration is needed.

3. Non-pharmacological Management
This section looks only into the non-pharmacological aspect of management of mental health issues, applying various methods including:
3.1 Spiritual/Moral Awareness
3.2 Stress Management
3.3 Time Management
3.4 Anger Management
3.5 Assertiveness
3.6 Advice To Parent For Behavioural Management Of Adolescent With ADHD
3.7 Building Self Esteem
3.8 Effective Communication Skill
3.9 Engaging Adolescent
3.10 Problem Solving
3.11 Promoting Self Understanding
3.12 Psycho-education
3.13 Relaxation Technique
3.14 Risk Assessment Of Violence
3.15 Risk Assessment Of Suicide
3.16 Supportive Counseling
3.17 Conflict Resolution
3.18 Resilience

It is important for PHCP emphasize the holistic approaches of bio-psychosocial model in managing adolescent with mental health problem.
3.1 SPIRITUAL/MORAL AWARENESS

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help the adolescent to be aware of the importance of:</td>
<td>Measures to emphasis the importance of spirituality or morality:</td>
</tr>
<tr>
<td>• Spirituality</td>
<td>• Family or community related religious activities</td>
</tr>
<tr>
<td></td>
<td>• Reading spiritual or moral books</td>
</tr>
<tr>
<td></td>
<td>• Charity and volunteer activities</td>
</tr>
<tr>
<td></td>
<td>• Spiritual science related web surfing</td>
</tr>
<tr>
<td></td>
<td>• Discussions with religious teachers</td>
</tr>
<tr>
<td></td>
<td>• Attending religious talks or activities</td>
</tr>
<tr>
<td>• Practicing good values</td>
<td>Cultivate and inculcate good values in everyday life, e.g.:</td>
</tr>
<tr>
<td></td>
<td>• Say “please”, “thank you” and “sorry” where appropriate</td>
</tr>
<tr>
<td></td>
<td>• Respect the elderly</td>
</tr>
<tr>
<td></td>
<td>• Help the needy</td>
</tr>
</tbody>
</table>
### 3.2 STRESS MANAGEMENT

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help adolescent identify:</td>
<td></td>
</tr>
</tbody>
</table>
| • Causes of stress | • **Identify the causes of stress, e.g.:**  
  - conflict between the adolescents, their parents, peers and teachers  
  - changes in the environment,  
  - unable to achieve targets set |
| • Effect of stress | • **Understand the effects of stress which can be positive or negative e.g.:**  
  - Positive effects:  
    • Increase motivation  
    • Able to face challenges  
    • Improve performance  
  - Negative effects:  
    • Feeling unloved  
    • Withdrawn  
    • Rebellious  
    • Increase in risk taking behaviour |
| • Ways to manage stress | • **Maintain a healthy lifestyle:**  
  - Exercise  
  - Healthy eating  
  - Avoid smoking, alcohol and drugs  
  - **Practice ‘10B’ strategies:**  
    1. Bertenang (calm down)  
    2. Berfikiran positif (positive thinking)  
    3. Bercakap dengan seseorang (talk to someone)  
    4. Berehat (rest)  
    5. Berurat (massage)  
    6. Bersantai (relax)  
    7. Beriadah (recreation)  
    8. Beribadah (spiritual activities)  
    9. Bersifat asertif (assertiveness)  
    10. Bermatlamat yang realistik (set realistic goals) |
3.3 TIME MANAGEMENT

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help adolescent to:</td>
<td>Good time management:</td>
</tr>
<tr>
<td>• Understand the concept of time management</td>
<td>1. Make a “To Do” List Every Day.</td>
</tr>
<tr>
<td>• Assist adolescent in managing time effectively.</td>
<td>- Put things that are most important at the top and do them first.</td>
</tr>
<tr>
<td></td>
<td>2. Use Spare Minutes Wisely.</td>
</tr>
<tr>
<td></td>
<td>- Get some reading done on the bus ride home from school.</td>
</tr>
<tr>
<td></td>
<td>3. Learn to say “No” to activities that distract you from your priority, e.g.:</td>
</tr>
<tr>
<td></td>
<td>- If phone calls are proving to be a distraction, tell your friends that you take social calls from 8:30 to 9:00 pm</td>
</tr>
<tr>
<td></td>
<td>4. Find the Right Time.</td>
</tr>
<tr>
<td></td>
<td>- Try to figure out the best time you will work more efficiently</td>
</tr>
<tr>
<td></td>
<td>- Make a time table</td>
</tr>
<tr>
<td></td>
<td>5. Do not procrastinate</td>
</tr>
<tr>
<td></td>
<td>6. Don’t push yourself too much:</td>
</tr>
<tr>
<td></td>
<td>- Set achievable goals</td>
</tr>
<tr>
<td></td>
<td>7. Get a Good Night’s Sleep.</td>
</tr>
</tbody>
</table>
### 3.4 ANGER MANAGEMENT

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHCP should:</strong></td>
<td><strong>Recognize symptoms of anger:</strong></td>
</tr>
<tr>
<td>• Understand the concept and issues of anger management</td>
<td>• <strong>Physical:</strong></td>
</tr>
<tr>
<td>• Assist adolescent managing anger in a positive way</td>
<td>- Palpitation</td>
</tr>
<tr>
<td>• Assist parents in helping adolescent managing anger and implement self-control skills.</td>
<td>- Breathlessness</td>
</tr>
<tr>
<td></td>
<td>- Tremors</td>
</tr>
<tr>
<td></td>
<td>- Sweating</td>
</tr>
<tr>
<td></td>
<td>- Flushed face</td>
</tr>
<tr>
<td></td>
<td>• <strong>Emotional:</strong></td>
</tr>
<tr>
<td></td>
<td>- Reduce concentration</td>
</tr>
<tr>
<td></td>
<td>- Feeling sad</td>
</tr>
<tr>
<td></td>
<td>- Anger</td>
</tr>
<tr>
<td></td>
<td>• <strong>Behavioural:</strong></td>
</tr>
<tr>
<td></td>
<td>- Withdrawn</td>
</tr>
<tr>
<td></td>
<td>- Sleep disturbance</td>
</tr>
<tr>
<td></td>
<td>- Tendency to substance abuse</td>
</tr>
<tr>
<td></td>
<td>- Physical aggressiveness</td>
</tr>
<tr>
<td></td>
<td>- Verbally abusive</td>
</tr>
</tbody>
</table>

**Anger management techniques:**

1. Identify situations and experiences that triggers anger and take steps to avoid them
2. Recognize warning signs of anger and use self-control skills to de-escalate the situation or feelings
4. Breathe deeply - Breathing deeply will stop the adrenalin rush, calm the breathing, slow the heart rate and allow the brain to resume rational thoughts
5. Know when to walk away. Remove yourself from the situation until you’re able to calm down. This is known as time out
6. Analyze and define the problem to clearly understand the real issues that cause the anger
7. Learn problem solving skills.
3.5 ASSERTIVENESS

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should:</td>
<td>Steps to improve personal assertiveness:</td>
</tr>
<tr>
<td>• Understand the concept and issues of assertiveness.</td>
<td>1. State your needs and feelings without threatening others.</td>
</tr>
<tr>
<td>• Assist the adolescent to develop a good assertive skills</td>
<td>2. Express your feelings and use “I” statements instead of “You” statements.</td>
</tr>
<tr>
<td>• Assist parents in helping the development of assertive skills in adolescent.</td>
<td>3. Make a clear, direct and straightforward request in a non-aggressive manner.</td>
</tr>
<tr>
<td><strong>Being assertive means that you can:</strong></td>
<td>4. State positive remarks upon gaining the person’s cooperation.</td>
</tr>
<tr>
<td>• Give an opinion or say how you feel. You can ask for what you want or need.</td>
<td></td>
</tr>
<tr>
<td>• Disagree respectfully and you can also offer your ideas and suggestions.</td>
<td></td>
</tr>
<tr>
<td>• Say no without feeling guilty and you can also speak up for someone else.</td>
<td></td>
</tr>
<tr>
<td>• Protect your rights while protecting and respecting the rights of others</td>
<td></td>
</tr>
</tbody>
</table>

3.6 ADVICE TO PARENT FOR BEHAVIOURAL MANAGEMENT OF ADOLESCENT WITH ADHD

**GENERAL**

1. You are his best and most important teacher.
2. Remain calm and in control.
3. Schedule one to one time with your adolescent child every day to let her/him know how important he or she is to you. Even 10 to 15 minutes regularly will make a difference.
4. Be aware of and notice your adolescent’s good quality and look for opportunities to praise him.
5. Be aware that children with ADHD benefit from more frequent feedback.
6. Target one to three behaviours at a time for changing.
7. Model the behaviour you would like to see from your adolescent child.
8. Discuss the behavioural goals with your adolescent child and track his response
9. Discuss the behavioural target(s), expectation and the feedback with your adolescent child’s other caretakers so he gets a consistent message.
10. Use desired activities (television, video games) as privileges/rewards for success on behavioural targets
11. Use schedules and routines. Ensure regular mealtimes and good rest for your child and you
12. Post lists and reminders for the routines in places they will be seen.
13. Give directions one at a time.
### 3.7 BUILDING SELF ESTEEM

*Self-esteem refers to a person’s overall evaluation towards himself*

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should:</td>
<td>Measures to improve self-esteem:</td>
</tr>
<tr>
<td>• Understand the concept and issues of self-esteem.</td>
<td>1. Think positively and avoid negative thoughts.</td>
</tr>
<tr>
<td>• Assist adolescent develop positive self-esteem</td>
<td>2. Take pride in minor achievements. Small success is still a success</td>
</tr>
<tr>
<td>• Assist parents in helping adolescent develop positive self-esteem</td>
<td>3. See mistakes as learning opportunities, do not be discouraged</td>
</tr>
<tr>
<td></td>
<td>4. Learn new skills to improve self-esteem.</td>
</tr>
<tr>
<td></td>
<td>5. Identify what can and cannot be change and be realistic</td>
</tr>
<tr>
<td></td>
<td>6. Set achievable goals</td>
</tr>
<tr>
<td></td>
<td>7. Express your opinion freely, do not feel disappointed if your opinion is not accepted</td>
</tr>
<tr>
<td></td>
<td>8. Involve in positive activities that can improve your self-esteem (sports, art and craft, music, etc.).</td>
</tr>
</tbody>
</table>

### 3.8 EFFECTIVE COMMUNICATION SKILL

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should:</td>
<td>Help adolescent to communicate effectively by:</td>
</tr>
<tr>
<td>• enhance adolescent to improve their skills of effective communication.</td>
<td>• Controlling their emotions.</td>
</tr>
<tr>
<td>• be more alert of factors that can enhance or erode the effectiveness of communication.</td>
<td>• Using an appropriate tone of voice.</td>
</tr>
<tr>
<td></td>
<td>• Asking for clarification if the information is not clear. Do not assume</td>
</tr>
<tr>
<td></td>
<td>• Listen attentively before you respond.</td>
</tr>
<tr>
<td></td>
<td>• Avoid making negative remarks or criticism</td>
</tr>
<tr>
<td></td>
<td>• Practice two way communication.</td>
</tr>
<tr>
<td></td>
<td>• Be aware and acknowledge non-verbal communication, as it fosters positive interaction.</td>
</tr>
</tbody>
</table>
3.9 ENGAGING ADOLESCENT

<table>
<thead>
<tr>
<th><strong>AIMS</strong></th>
<th><strong>METHODS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>To help PHCP build effective relationship with adolescent by:</td>
<td>To have a good relationship:</td>
</tr>
<tr>
<td>• Two way communication</td>
<td>• Always remain calm and attentive</td>
</tr>
<tr>
<td>• Working in partnership with adolescent</td>
<td>• Be conscious of your body language</td>
</tr>
<tr>
<td>• Being flexible but consistent</td>
<td>• Be sincere in reaching out to them.</td>
</tr>
<tr>
<td>• Be yourself</td>
<td>Understand their culture, slang and interests.</td>
</tr>
<tr>
<td>• Bring yourself to their level.</td>
<td></td>
</tr>
<tr>
<td>• Active listening</td>
<td>To enhance positive relationship maintain:</td>
</tr>
<tr>
<td>• Consistency in behaviour, thought &amp; feeling</td>
<td>• Confidentiality</td>
</tr>
<tr>
<td>• Be honest, warm &amp; friendly</td>
<td>• Rapport</td>
</tr>
<tr>
<td></td>
<td>• Empathy</td>
</tr>
<tr>
<td></td>
<td>• Trust</td>
</tr>
</tbody>
</table>

3.10 PROBLEM SOLVING

<table>
<thead>
<tr>
<th><strong>AIMS</strong></th>
<th><strong>METHODS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help adolescent:</td>
<td>Using the IDEAL approach:</td>
</tr>
<tr>
<td>• Identify problems and causes (if possible)</td>
<td>I (Identify):</td>
</tr>
<tr>
<td>• Improve problem-solving skills</td>
<td>Identify the real problem</td>
</tr>
<tr>
<td></td>
<td>D (Describe):</td>
</tr>
<tr>
<td></td>
<td>Describe or find solutions to existing proposals</td>
</tr>
<tr>
<td></td>
<td>E (Evaluate):</td>
</tr>
<tr>
<td></td>
<td>Evaluate each proposal, the advantages and disadvantages</td>
</tr>
<tr>
<td></td>
<td>A (Act):</td>
</tr>
<tr>
<td></td>
<td>Act on the options available</td>
</tr>
<tr>
<td></td>
<td>L (Learn):</td>
</tr>
<tr>
<td></td>
<td>Learn from the experience whether outcome is successful or not</td>
</tr>
<tr>
<td></td>
<td>The first step in problem solving is decision making. For good decision making:</td>
</tr>
<tr>
<td></td>
<td>1. Get help from those who are more senior or experienced</td>
</tr>
<tr>
<td></td>
<td>2. Do not hesitate to carry out the decision made</td>
</tr>
<tr>
<td></td>
<td>3. Avoid making decisions in a hurry or based on emotions</td>
</tr>
</tbody>
</table>

PHCP: Primary Health Care Provider
### 3.11 PROMOTING SELF UNDERSTANDING

Self-understanding is defined as the ability to understand one’s own action its effects and consequences.

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should:</td>
<td>Steps to improve self understanding:</td>
</tr>
</tbody>
</table>
| • assist adolescent to develop positive self-understanding and feel good about themselves | 1. Help adolescent to be aware of their own emotions, actions and reactions.  
2. Avoid self-judgment and condemnation, instead try to understand the reasons for the mistakes.  
3. Teach adolescent that they need to learn to care for themselves and others  
4. Know when and how to ask for help |

**Guide for parents.**

1. Discuss actions that may help an adolescent feel better immediately such as a hug, a walk etc  
2. Teach adolescent the importance of planning ahead, learning to be patient and sharing with others.  
3. Parents should always make an adolescent feel worthy despite their failures.  
4. Parents should accept an adolescent unconditionally, advise them honestly, correct their behavior positively
### 3.12 PSYCHO-EDUCATION

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help adolescent to:</td>
<td>Understand the nature of the problems/issues by:</td>
</tr>
<tr>
<td>- Understand the nature of their problems/issues - eg. relationship, academic, psychosocial</td>
<td>• Explore the adolescent’s understanding of the problems/issues.</td>
</tr>
<tr>
<td>- Prevent problems/issues from reoccurring.</td>
<td>• Provide appropriate explanation.</td>
</tr>
<tr>
<td>- Manage their emotions.</td>
<td>- i.e. the normal duration of symptoms and the appropriateness of reactions and when to seek help.</td>
</tr>
</tbody>
</table>

- Educate adolescent to prevent adverse consequences by identifying:
  - Protective factors
    - Stable and mature personality
    - Minimal life events
    - Absence of physical and/or mental illness
    - Strong psychosocial network
  - Vulnerable factors
    - Unstable and immature personality
    - Major life events
    - Presence of physical and/or mental illness
    - Weak psychosocial network

- Manage emotions by:
  - Better understanding about their problems/issues.
  - Working through conflict and managing anger
  - Stress management.
  - Increasing Self-esteem.
3.13 RELAXATION TECHNIQUE

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should train the adolescent on either one of the relaxation techniques:</td>
<td></td>
</tr>
</tbody>
</table>
| 1. Cognitive technique | Cognitive techniques:  
  • Remove your negative thoughts.  
  • Imagine you are in a peaceful place / situation. Eg. by the beach / in a park / under a shower  
  • Give full attention to that place in your mind  
  • Use all your senses to enjoy the moment for 5-10 minutes  
  • Proceed to positive self-talk |
| 2. Breathing exercises and techniques | Breathing exercise techniques:  
  • Breathe in through your nose using the diaphragm  
  • Hold breath for 4-8 seconds  
  • Breathe out through the mouth  
  • Repeat the above steps for 30-60 seconds |
| 3. Jacobsonian | Jacobsonian technique:  
  • Sit or lie down  
  • Close your eyes  
  • Tighten the facial muscles for 10-15 seconds  
  • Feel the tension  
  • Relax the muscle slowly and appreciate the difference between tensed and relaxed muscle  
  • Repeat the above steps with the other muscle groups. Eg. hands and feet |
3.14 RISK ASSESSMENT OF VIOLENCE

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
</table>
| To assist PHCP to determine risk factors and possibility of violence | • Remain calm and adopt a non-threatening approach  
• Ensure safety of adolescent and yourself at all times  
• Take adolescent’s problem seriously  
• Be supportive and listen to the adolescent  
• Use Table 1 to determine the level of risk |

Table 1 - Triaging risk of violence in patients

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Reported</th>
<th>Observed</th>
<th>Action</th>
</tr>
</thead>
</table>
| Low to moderate | • No history of violence  
• No history of substance abuse or dependence  
• No history of criminal or police record  
• Positive personality traits | • Female  
• Able to calm down  
• Not Hostile  
• May be Restless  
• Behaviour in response to crisis | • Get collaborative history from family  
• Ensure good social support and family availability  
• Maintain to be calm  
• Reassess after 1 week  
If unsure to refer to specialist |
| High | • Early exposure to violence  
• Personality :  
  - Impulsive  
  - Psychopathic  
• History of violence and crime  
• History of substance abuse or dependence  
• Psychotic  
• History of criminal or police record | • Male  
• In Distress  
• Agitated / restless  
• Angry and hostile  
• Uncooperative  
• Physical appearance - tattoo, scar  
• Speech  
  - Increased tone  
  - Abusive words/threatening  
• Provoking behavior  
• Intoxicated and or having drug withdrawal  
• Commanding hallucinations to harm self and/ or others  
• Persecutory delusion  
• Delusion of control  
• Access to of dangerous objects/weapons | • Appear calm and listen to the adolescent  
• Never make promises you cannot keep  
• Appear empathic, concerned and un critical  
• Speak softly in a non provocative and non judgemental manner  
• Make sure there is adequate space between you and adolescent time  
Avoid staring for a long time. |
### 3.15 RISK ASSESSMENT OF SUICIDE

<table>
<thead>
<tr>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
</table>
| To assist PHCP to determine risk factors and risk level for suicide | • Remain calm and adopt a non-threatening approach  
• Ensure safety of adolescent  
• Listen and take adolescent’s complaints seriously  
• Be supportive of the adolescent  
• Use Table 2 to determine the level of suicidal risk |

#### Table 2 - Triaging patients with suicide risks

<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Reported</th>
<th>Observed</th>
<th>Action</th>
</tr>
</thead>
</table>
| Low           | • Some mild or passive suicide ideation, with no intent or plan  
• No history of suicide attempt  
• Available social support | • Cooperative; communicative; compliant with instructions  
• No agitation/restlessness  
• Irritable without aggression  
• Gives coherent history | • Get collaborative history from family  
• Ensure good social support and family availability  
• Reassess after 1 week  
• If unsure to refer to specialist |
| Moderate      | • Suicide ideation with some level of suicide intent, but who have taken no action on the plan  
• No other acute risk factors  
• History of psychiatric illness & receiving treatment | • Agitated/restless  
• Intrusive behaviour; bizarre/disordered behaviour  
• Confused; withdrawn/uncommunicative  
• Ambivalence about treatment | • Ensure safety of adolescent and yourself  
• Do not leave the adolescent alone  
• Urgent referral for admission |
| High          | • Made a serious or nearly lethal suicide attempt  
• Persistent suicide ideation or intermittent ideation with intent and/or planning  
• Psychosis, including command hallucinations  
• Other signs of acute risk  
• Recent onset of major psychiatric syndromes, especially depression  
• Been recently discharged from a psychiatric in patient unit  
• History of acts/threats of aggression or impulsivity | • Extreme agitation/restlessness  
• Physically/verbally aggressive  
• Confused/unable to cooperate  
• Requires restraint  
• Violent behaviour  
• Possession of a weapon  
• Self-destruction in department |
### 3.16 SUPPORTIVE COUNSELING

<table>
<thead>
<tr>
<th><strong>AIMS</strong></th>
<th><strong>METHODS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Help PHCP to:</td>
<td>Help adolescent to:</td>
</tr>
<tr>
<td>• Guide adolescent to make changes by focusing on their strength.</td>
<td>• Explore and identify their strength i.e. talents, skills and abilities</td>
</tr>
<tr>
<td>• Educate and increase adolescent knowledge in dealing with the problems/ issues.</td>
<td>• Prioritize the strength that can be used to solve/ deal with problems</td>
</tr>
<tr>
<td></td>
<td>• Encourage to use their strength when opportunities arise</td>
</tr>
<tr>
<td></td>
<td>• Feel good about their talents and abilities</td>
</tr>
</tbody>
</table>

**Can be implemented through:**
• Reading articles related to problem/ issues faced.
• Share the problem/ issues with other adolescents/ adults.
• Put in practice the knowledge learned

### 3.17 CONFLICT RESOLUTION

Conflict is defined as a state where there is disagreement between self or person. Disagreements may be on beliefs, facts or values. One of the outcome of conflict is anger

<table>
<thead>
<tr>
<th><strong>AIMS</strong></th>
<th><strong>METHODS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PHCP should help adolescent to:</td>
<td>Steps in resolving conflict:</td>
</tr>
<tr>
<td>• Understand the concept and issues of conflict resolution</td>
<td>• Admit “I have a conflict”</td>
</tr>
<tr>
<td>• Resolve conflict in a positive way.</td>
<td>• Agree to resolve conflict without delay</td>
</tr>
<tr>
<td>PHCP should assist parents to:</td>
<td>• Determine the causes of conflict:</td>
</tr>
<tr>
<td>• help adolescents to resolve conflict and implement self control skills.</td>
<td>o Within self</td>
</tr>
<tr>
<td></td>
<td>o In the family</td>
</tr>
<tr>
<td></td>
<td>o External environment</td>
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<tr>
<td></td>
<td>• Understand one’s own action; its effects and its consequence</td>
</tr>
<tr>
<td></td>
<td>• Analyze and define the conflict</td>
</tr>
<tr>
<td></td>
<td>• Learn problem solving skills, anger management and conflict resolution</td>
</tr>
</tbody>
</table>
3.18 RESILIENCE

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>AIMS</th>
<th>METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Help PHCP to:</td>
<td>Teach adolescent about 10 steps to develop resilience:</td>
</tr>
<tr>
<td></td>
<td>• Make adolescent understand what</td>
<td>1. Make connection with others including family members and peers</td>
</tr>
<tr>
<td></td>
<td>resilience is.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Educate and increase adolescent’s</td>
<td>2. Avoid seeing a crisis as a problem</td>
</tr>
<tr>
<td></td>
<td>knowledge in developing resilience.</td>
<td></td>
</tr>
<tr>
<td>Types of adverse life events:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chronic illness</td>
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<td></td>
<td>• Handicap</td>
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<tr>
<td></td>
<td>• Injuries</td>
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<tr>
<td></td>
<td>• Abuse</td>
<td></td>
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<tr>
<td>2. Family</td>
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<td></td>
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<td></td>
<td>• Divorce</td>
<td></td>
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<tr>
<td></td>
<td>• Death</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical or Mental illnesses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unemployment or loss of job</td>
<td></td>
</tr>
<tr>
<td>3. Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Flood</td>
<td></td>
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<tr>
<td></td>
<td>• Famine</td>
<td></td>
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<tr>
<td></td>
<td>• War</td>
<td></td>
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<tr>
<td></td>
<td>• Poverty</td>
<td></td>
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<tr>
<td></td>
<td>• Homelessness</td>
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</tbody>
</table>

With resilience, adolescents can triumph over trauma. Without it, trauma or adversity triumphs: we are in control of a situation and not situation controls us.

Outside help is essential in time of trouble but it is usually insufficient. Therefore, inner strengths (support; self confidence; faith) build resilience.

Types of adverse life events:

1. Personal
   • Chronic illness
   • Handicap
   • Injuries
   • Abuse

2. Family
   • Divorce
   • Death
   • Physical or Mental illnesses
   • Unemployment or loss of job

3. Environment
   • Flood
   • Famine
   • War
   • Poverty
   • Homelessness

Teach adolescent about 10 steps to develop resilience:

1. Make connection with others including family members and peers
2. Avoid seeing a crisis as a problem
3. Accept changes that took place as part of living
4. Move towards your goal
5. Take decisive action. Decision making is part of problem solving
6. Look for opportunity for self discovery and learn new skills
7. Positive view of self. See your strengths more than your weakness
9. Maintain a hopeful outcome
10. Take care of yourself physically, mentally, socially and spiritually.
APPENDIX

Case Scenarios
PowerPoint Presentations
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CONTENTS

1. APPENDIX

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○ 4.3 REFERENCES 76
4.1 CASE SCENARIOS

4.1.1 CASE 1

13y/o/F/ currently in Form 1. Brought by parents to the clinic complaining of refusing to go to school for the past 3 months.

In early 2013, she got a place at a boarding school after performing well in her UPSR. She obtained 4As and 1B. Her parents decided she better off to go to boarding school as all other siblings went to boarding school after completed primary education. Patient however thought otherwise. She only attended for 2 months and then she decided to return home. Efforts to make her return to school ended up with argument, tantrum, and physical aggression.

At home, she prefers to isolate herself from family members. Nobody seems to know what is wrong with her or what contribute to her reluctance to go to school. Her parents did not know whether their daughter has been bullied or she has any problem with her peers. Patient is very secretive about everything. Over time she appeared to be unhappy even being at home. She is not sleeping well and she wakes up late the next morning.

Her parents sought traditional treatment which showed improvement for 1 month. The symptom reappeared again when issues of going back to school was addressed to her. No past history of school refusal or reluctance before and her school attendance was good. Patient has been active in and outside school curriculum activities. No suspicious behaviour to suggest that she is under the influence of drug or has been abusing drug. No information regarding boyfriend relationship. No background history of significant medical illnesses or abnormal development.

4.1.2 CASE 2

16y/o/F/school drop-out, came to your clinic for premarital pregnancy at 24 weeks gestation. Accompanied by father who complaint that the girl is isolating herself from family members and having poor appetite.

When the father left the consultation room, patient was more open and willing to share what is bothering her. She feels angry with on and off palpitation because her father did not approve of her plan to marry her boyfriend and restricts her activities after he knew about her daughter’s pregnancy. She feels her father did not understand her and she prefer to share her problem with her boyfriend. Of late, she is becoming lonely and unhappy. She has also loss her appetite.

This is her first pregnancy with her current boyfriend and denies being promiscuous before. She is well aware about the sex and pregnancy issues. She plans to carry on with the pregnancy and to keep the child after delivery. She even plan to marry her boyfriend which her father rejected the idea. She has never and no plan to harm herself.
Her parents divorced and she is currently staying with her father. Her father remarried, however she cannot go along with her step mother.

### 4.1.3 CASE 3

15y/o/F, brought by parents with the following complaints:

1. Change in behaviour for 3 months duration, consist of withdrawn behaviour, becoming argumentative, aggressive as well as being suspicious to all family members.
2. Worsen with deterioration in her day to day functioning. Did not bother to take her regular shower, regular meals, and her sleep pattern has been altered.
3. She has not been going to school since the symptoms appeared. Otherwise, she is a brilliant student.

No history of underlying medical problem, head injury or abusing any legal or illicit drugs. She is the youngest in the family of 5 siblings. No family history of mental illness. In the clinic, this patient appeared to avoid eye to eye contact, covered herself with tudung, and observed to be smiling inappropriately. And in many occasions talking insensible and appearing hallucinating. Parents suspected their daughter is being charmed and have sought many traditional and alternative interventions. However, there was no improvement in her symptoms.

### 4.1.4 CASE 4

16y/o/Form 4 school boy, brought by parents requesting for Methadone Replacement Therapy. He has been on heroin for 2 years and unable to stop despite trying a few times. His heroin intake is twice a day. He also abuse amphetamine sometimes. Parents not willing to report to police or send him to drug rehabilitation centre because he is still studying and will be sitting for SPM next year.

He started playing truant since standard 6, missing school and sneaking out of the house quite often. When reprimanded by parents, he will be verbally abusive and behave aggressively. He frequently demands money from his father and if his request is refused, he will steal money from his family members. He will develop muscle cramps if he could not get his fix. He is the only child.

### 4.1.5 CASE 5

17y/o/school boy was referred to your clinic after been discharged from main hospital for ingesting shampoo. The reason for deliberate ingestion of shampoo was he was upset after being chased away from home by his father. His father regarded him as a failure. Since then, he has been staying with his friend and not going to school. He supported his daily living by taking up a part time job in a restaurant. Despite that, he has not being happy and miserable most of the time. He decided to end his life after his current girlfriend decided to end their relationship.
He has several suicidal attempts before. In addition to that, he also involved in gang and has done several crimes. He was never caught by police. He is the eldest in the family of 3 siblings and has used to become role model in the family.

He came alone to the clinic. No parents accompanied him. Therefore, no further history could be elicited.

4.1.6 CASE 6

17y/o/F, brought by her mother with complaint of becoming more difficult, easily angry and gets annoyed with her mother. Mother noticed her behaviour is becoming more difficult over the past 2 years. She also noticed that her daughter spent a lot of time in her bathroom.

The patient admits that she easily gets annoyed. She prefers her own company. She does not like to go to school though she is doing well in school. She will have feeling of anxiety or worry especially in the morning. She feels that her bathroom is not clean enough. She spent a lot of time in the morning to clean her bathroom. She is worried that she is not clean enough and spent a lot of time cleaning herself. She does have problem sleeping and has poor appetite too.

Answer:

<table>
<thead>
<tr>
<th>Case</th>
<th>Diagnosis</th>
<th>Differential Diagnosis</th>
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<tbody>
<tr>
<td>Case 1</td>
<td>Adjustment Disorder with Depressed Mood</td>
<td>Major Depressive Disorders</td>
</tr>
<tr>
<td>Case 2</td>
<td>Adjustment Disorder with Depressed Mood</td>
<td>Major Depressive Disorders</td>
</tr>
<tr>
<td>Case 2 i.</td>
<td>Family issue</td>
<td></td>
</tr>
<tr>
<td>Case 2 ii.</td>
<td>Teenage Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Case 3</td>
<td>Schizophrenia</td>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>Case 4</td>
<td>Substance Dependent with Conduct Disorder</td>
<td>Oppositional Defiance Disorder</td>
</tr>
<tr>
<td>Case 5</td>
<td>Major Depressive Disorder with Conduct Disorder</td>
<td>Adjustment Disorder</td>
</tr>
<tr>
<td>Case 6</td>
<td>Obsessive Compulsive Disorder</td>
<td>Generalised Anxiety Disorder with Depressive Mood</td>
</tr>
</tbody>
</table>
4.2 POWERPOINT PRESENTATIONS

4.2.1 Section I : Introduction

Isi Kandungan – 3 Seksyen

- I : Introduction
- II : Differential Diagnosis
- III : Intervention

Latar belakang :
- Projek dibayar oleh WHO
- Memakan masa hampir setahun
- Pembentukkan satu
  MANUAL = PANDUAN
- Kumpulan sasar adalah
  - ANGGOTA KESIHATAN PRIMER
  - khususnya PARAMEDIK
- Menggunakan bahan sediada sebagai rujukan

Cara menggunakan :
- Biaskan diri dengan Manual
  - format
  - kod warna
- Mulakan dengan mengenalpasti adunan / keluhan
  - menggunakan format Seksyen II
  - ilut eliran dari PRESENTING PROBLEM
    dan teruskan hingga ke bahagian REFERENCE
  - baca setiap bahagian dengan teliti , sebelum berlebih ke bahagian seterusnya

Case Diagnosis Differential Diagnosis

Case 1 Adjustment Disorder with Depressed Mood
Major Depressive Disorders

Case 2

- i. Family issue
- ii. Teenage Pregnancy
- Major Depressive Disorders

Case 3 Schizophrenia
Bipolar Disorder

Case 4 Substance Dependent with Conduct Disorder
Oppositional Defiance Disorder

Case 5 Major Depressive Disorder with Conduct Disorder
Adjustment Disorder

Case 6 Obsessive Compulsive Disorder
Generalised Anxiety Disorder

**Answer :**

"Screening Tools"

- **HEADSS**
  - digunakan untuk mendampingi dan
    mendapatkan maklumat dari remaja
  - dimulakan dengan soalan am yang tidak
    sensitif kepada soalan yang lebih sensitif.
"Screening Tools"

- **BSSK** — Borang Saringan Status Kesihatan
  - digunakan sebagai kaedah pertama untuk saringan penyakit pada remaja

- **DASS** — Depression, Anxiety and Stress Screen
  - digunakan bila remaja menunjukkan simptom kemurungan, stres atau keresahan

---

"Screening Tools"

- **SDQ** — Strengths & Difficulties Questionnaire
  - digunakan pada remaja yang menunjukkan sikap rendah harga diri & kurang "coping skills"
  - membantu mengenalpasti kekuatan & kelemahan remaja
4.2.2 Section II : Possible Diagnoses

SECTION II:
POSSIBLE DIAGNOSES

MANUAL MANAGING MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS FOR PRIMARY HEALTH CARE PROVIDERS

Mental Health

- Mental health: how we think, feel and act in order to face life’s situation.
- How we handle stress, relate to others, evaluate our options and make choices.
- WHO definition:
  - “a state of well-being in which the individual realizes his own abilities, able to cope with normal stresses of life, work productively and fruitfully, and is able to make appropriate contribution to his community.”

Categories of Mental Health Disorders in Adolescents

<table>
<thead>
<tr>
<th>Aging</th>
<th>Early</th>
<th>Later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>Teen</td>
<td>Adult</td>
</tr>
</tbody>
</table>

- Anxiety Disorder
- Depression
- Schizophrenia

Attention Deficit Hyperactivity Disorder (ADHD)

Learning Disabilities
- Oppositional Defiant Disorder
- Conduct Disorders

Common Mental Health Disorders Focused in the Manual

- Anxiety disorders
- Mood disorders
- Psychotic disorders
- Attention Deficit Hyperactivity Disorder (ADHD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder (CD)

Anxiety Disorder

- Anxiety is a subjective sense of worry, apprehension, fear and distress.

- Can be normal on occasions, thus it is important to distinguish between normal and pathological (abnormal) levels of anxiety.

Presentations of Anxiety

Physical presentations
- Headache
- Nausea
- Vomiting
- Palpitations
- Tremors
- Stomach pain
- Shortness of breath

Emotional presentations
- Nervousness
- Fear
- Apprehensive feelings
Types of Anxiety

- **Generalized Anxiety Disorder**
  - Excessive worry, apprehension, and anxiety occurring most days for a period of 6 months or more over a number of activities or events.
  - Difficult to control.
  - Significant distress and problem in functioning.

- **Panic Disorder**
  - Consists of recurrent unexpected panic attacks with anticipatory anxiety.
  - Frequently associated with agoraphobia.

- **Phobias**
  - Intense irrational fear of a specific object or situation that compels a person to avoid it.
  - Social phobia
  - Specific phobia

- **Obsessive Compulsive Disorder**
  - Unwanted, intrusive, persistent thoughts or repetitive behaviours.
  - Common obsessions concern dirt and contamination, repeated doubts, orderliness, aggressive impulses, disturbing sexual imagery.

Types of Anxiety

- **Anxiety disorder due to general medical condition**
  - When the physiologic consequences of a distinct medical condition is judged to be the cause of prominent anxiety symptoms.

- **Drug-induced anxiety disorder**
  - When the physiologic consequences of the use of a drug or medication is judged to be the cause of prominent anxiety symptoms.

Types of Mood Disorders

- **Adjustment disorder (with depressed mood)**
  - Development of emotional or behavioural symptoms with depressed mood in response to an identifiable stressor, which occur within three months of the stressor.

Types of Mood Disorders

- **Major Depressive Disorder**
  - Characterized by low mood and/or loss of interest or pleasure in activities that are normally enjoyable for at least 2 weeks.

- **SIGECAPS**
  - Sleep — increased or decreased ability to feel rested
  - Interest — real, imagined, or exaggerated
  - Energy — usually decreased
  - Concentration — usually decreased
  - Appetite — increased or decreased
  - Psychomotor — agitated or retarded
  - Suicidal ideation

Mood Disorders

- Include all types of depression and bipolar disorder.
  - Adjustment disorder (with depressed mood)
  - Dysthymia
  - Major depressive disorder

More difficult to diagnose mood disorders in adolescents because they are not always able to express how they feel.
Major Depressive Disorder (cont)

- Often been an overlooked health problem in adolescents
- Specific behaviors in depressive adolescents are different and vary according to the age and developmental level.
  
  — Comparison table

Types of Mood Disorders

Dysthymia (Persistent Depressive Disorder in DSM5)

- Depressed/irritable mood for most of the day as indicated by subjective account or observation by others for at least 2 years, including the presence of two of the following symptoms:

<table>
<thead>
<tr>
<th>Poor appetite/overeating</th>
<th>Poor concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritability/hypersomnia</td>
<td>Difficulty making decisions</td>
</tr>
<tr>
<td>Low energy or fatigue</td>
<td>Feelings of hopelessness</td>
</tr>
</tbody>
</table>

Bipolar Disorder: Presenting complaints

<table>
<thead>
<tr>
<th>Mania</th>
<th>Depressive symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusually happy or silly, or very irritable, angry, agitated</td>
<td>Depressed mood, or irritated</td>
</tr>
<tr>
<td>Unrealistic highs in self esteem</td>
<td>Frequent crying</td>
</tr>
<tr>
<td>Great increase in energy</td>
<td>Loss of interest in hobbies or activities</td>
</tr>
<tr>
<td>Need little sleep or no sleep, without feeling tired</td>
<td>Thought of death or suicide</td>
</tr>
<tr>
<td>Increase in eating (too much, too fast, topic changes quickly)</td>
<td>Frequent complaints of headache, stomachache (symptoms of symptoms)</td>
</tr>
<tr>
<td>Occasional high-risk behavior</td>
<td>Low energy, fatigue</td>
</tr>
<tr>
<td>Agitated and/or in-control behavior</td>
<td>Poor concentration</td>
</tr>
</tbody>
</table>

Bipolar disorder (cont)

- Either mania or depression may predominate
- Episodes may be frequent, or may be separated by periods of normal mood.
- In severe cases, patients may have hallucination or delusions during periods of mania or depression.
**Psychotic disorders**

- Associated with impairment in emotional, cognitive and social functioning
- Early and expert treatment is crucial
- Psychotic symptoms can occur in an isolated episode or as part of an ongoing diagnosed illness such as schizophrenia, bipolar disorder, depression or schizoaffective disorder.
- Symptoms are generally described as either positive or negative

**Positive symptoms**

- Reflect an excess or distortion of normal functions
  - delusions
  - hallucinations
  - disorganized speech
  - grossly disorganized or catatonic behaviour

**Negative symptoms**

- Reflect a diminution or loss of normal functions
- Include restrictions in the range and intensity of:
  - Emotional expression – affective flattening
  - Fluency and productivity of thought and speech – alogia
  - anhedonia
  - Initiation of goal-directed activity – avolition

**Schizophrenia**

- Tends to emerge during adolescence and young adulthood
- More likely to occur in families with a history of serious mental illness

**Diagnostic Criteria of Schizophrenia (DSM IV & DSM 5)**

1. Two or more of the following present for at least a month:
   - Hallucinations
   - Delusions
   - Disorganized thoughts and speech (speech can be incoherent or greatly reduced)
   - Severely disorganized behavior (including catatonia, or severe motor retardation)
   - Negative symptoms

2. Deterioration in social, educational or work functioning

3. Duration of illness of at least six months, including the prodrome, if present

4. Not due to another mental illness such as a mood disorder, or a medical condition

**Differential diagnosis**

- Schizophreniform disorder
- Brief psychotic disorder
- Schizoaffective disorder
- Delusional disorder
- Substance-induced psychotic disorder
- Bipolar disorder
- Major depression with psychotic features
- Medical illnesses that resemble a psychiatric disorder
Attention Deficit Hyperactivity Disorder (ADHD/ADD)

ADHD/ADD

- Most commonly diagnosed disorder of childhood
- Most commonly misunderstood
- Under diagnosed and not managed appropriately

ADHD/ADD

- The core features may exist on their own or in combination:
  1. Inattention
  2. Impulsiveness
  3. Over-activity

  - 3 sub-types of ADHD:
    1. Hyperactive-Impulsive (AD/HD)
    2. Impulsive (ADD)
    3. Combined (ADHD)

ODD vs Conduct disorder

- Oppositional Defiant Disorder (ODD) tends to manifest as resistance and negativity towards authority figures.
- Conduct Disorder (CD) symptoms tend to be broader and represent behaviors that oppose societal rules and/or may represent a violation of the basic rights of others.

Oppositional defiant disorder

- An ongoing pattern of uncooperative, defiant and hostile behavior towards authority figures:
  - Parents
  - Teachers and
  - Others who has authority over them
- Seriously interferes with day-to-day functioning

Presentations of oppositional defiant disorder (ODD)

- Frequent temper tantrums
- Excessive arguing with adults, especially with those with authority.
- Defies or deliberately refuses to follow rules or direction given by adults.
- Deliberate attempts to annoy or upset people
- Blames others for his or her mistakes or misbehavior.
- Seems touchy or easily annoyed by others
- Seems angry & resentful much of the time
- Seeking revenge
**Conduct disorder**

- A repetitive and persistent pattern of behaviour where rights of others or basic social rules are violated.
- Seen at variety of settings: cause significant impairment in functioning (social/academic/family).
- Prevalence boys > girls
- Onset: adolescence/< 10 years if early onset

<table>
<thead>
<tr>
<th>Aggression to people and animals</th>
<th>Destruction of property</th>
<th>Deliberately on duty or theft</th>
<th>Serious violation of rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Often bullied/prevented others</td>
<td>Deliberately engaged in fire with intent to cause serious damage</td>
<td>Often left to obtain goods/services</td>
<td>Often stays out late at night despite parental prohibition (before 13 yrs)</td>
</tr>
<tr>
<td>Often witnessed physical fights</td>
<td>Deliberately destroyed others’ property</td>
<td>Often less than 40 items of sentimental value without confronting victim</td>
<td>Often ran away from home at least 2 weeks leaving no parents home</td>
</tr>
<tr>
<td>Has used a weapon that can cause physical harm</td>
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<td>Has stolen while confronting a victim</td>
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<tr>
<td>Has forced someone into sexual activity</td>
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</table>

**Common presentations**

- How many of you have had contacts with adolescents?
- What difficulties do they come with?
- What are the presenting complaints?

**Common presentations**

- Anger
- Sad
- Worries
- Feeling hopeless, worthless, suicidal
- Problematic → not listening to others, not getting along well with others
- Abnormal behaviour

**Case discussion**

- 16 years old, girl, brought by the teacher: — feeling sad, for weeks — crying spells — deterioration in her studies
- How would you proceed?
- What further questions would you ask to help you with this case?
  - Establish a reasonable diagnosis
  - Rule out other problems
Using Section II of the Manual

- There are 6 common presentations
- Identify the most likely presentation (1st column)
- What questions to ask (2nd column)
- What to look, feel, listen, MSE (3rd column)
- Possible diagnoses to consider (4th column)
- Special considerations and red flag

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<tr>
<th>CONTENTS</th>
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<td>NO.</td>
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<td>2.1</td>
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<td>2.3</td>
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<tr>
<td>2.4</td>
</tr>
<tr>
<td>2.5</td>
</tr>
<tr>
<td>2.6</td>
</tr>
</tbody>
</table>

Flow Chart
Why should use the manual?

- Simple, yet informative guide – check list of the most presenting features, complaints
- Adolescents behavior e.g. depression, suicide and delinquent behavior is very common and numbers have been increasing world wide
- Adolescents frequently use the clinic service

Why should use the manual?

- The manual will help you overcome the fear of seeing, dealing with adolescents
- You will learn to look, listen and see that adolescents do have problems and early intervention works

Key Steps in Managing is Screening, Evaluation, Diagnosis and proper management.
4.2.3 Section III: Interventions

SECTION III: INTERVENTIONS

MANUAL MANAGING MENTAL HEALTH PROBLEMS AMONG ADOLESCENTS FOR PRIMARY HEALTH CARE PROVIDERS

OBJECTIVES

1. To enable and empower the Primary Healthcare Providers (PHCPs) to understand, identify and manage adolescents with mental health problems effectively.

2. Enable PHCPs to respond effectively and sensibly to adolescents with mental health issues.

3. To build up and consolidate skills among PHCPs in helping adolescents.

ROLES OF PHCPs

1. Familiarize with mental health issues related to adolescents.

2. Update knowledge and skills in current and future issues related to adolescents.

3. Feeling comfortable and competent in handling adolescents with mental health issues.

4. Helping adolescents to find better ways to help themselves effectively.

5. Minimizing risk for adolescents from getting mental illnesses.

TAKE NOTE

There is NO right or wrong approach (es)

But

There IS effective and ineffective intervention(s)

RESPONSIBILITY OF PHCPs

1. Familiarize with section 3: Interventions.

2. Understand how to apply the section in relation to daily work with adolescents.

3. Able to share the application with other colleagues.

4. Minimize mistakes when handling adolescents with mental health issues.

5. Maintain confidentiality and behave non-judgmentally.

WHEN TO BREACH CONFIDENTIALITY?

- Everything is kept confidential unless there is significant concern
  - When the adolescent may harm him/her self
  - When others may be harmed
  - When others may harm him/her

- When he/she give consent to disclose

- ONLY relevant information pertaining to the above concern will be disclosed.

*Under the Child Act 2001, there are circumstances where confidentiality needs to be breached irrespectively of child’s view*
WHEN TO BREACH CONFIDENTIALITY?

1. When the adolescent may harm him/herself
2. When others may be harmed
3. When others may harm him/her
4. When he/she give consent to disclose

Ref: Akaz Kamak Kanak 2001

BEING NON - JUDGMENTAL

1. Refrain from making any bias assessment based on your personal views and values before understand the true circumstances.
2. Help adolescent with the sense of openness and clear mind-set

SECTION 3: INTERVENTIONS

1. Non pharmacological approach.
2. Application of variety of methods. (No idea is silly except you keep it from being used)
3. Creative approach is a bonus.
4. Using a manual as a guide and aid
5. Clear aims/ objectives and methods/approaches

SECTION 3: INTERVENTIONS

6. It is important for PHCP to emphasize the holistic approach using Bio-Psycho-Social model in managing adolescent with mental health problems.

BIO-Psycho-Social Model

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unwilling to talk</td>
<td>Engaging adolescents</td>
<td>Family intervention/therapy</td>
</tr>
<tr>
<td>Group treatment using general and specific medications</td>
<td>Issues of confidentiality and breach of confidentiality</td>
<td>Parent training</td>
</tr>
<tr>
<td>Adherence to treatment</td>
<td>Psycho-education</td>
<td>Collaboration with relevant agencies</td>
</tr>
<tr>
<td>Address any effects adolescent's effects of medication</td>
<td>Counseling</td>
<td>Skills training</td>
</tr>
<tr>
<td>Duration of treatment recommended</td>
<td>Supportive psychology</td>
<td>Social and Welfare services</td>
</tr>
<tr>
<td>Regular follow-up as scheduled</td>
<td>Skill building</td>
<td>Adaptation</td>
</tr>
</tbody>
</table>

BACKGROUND KNOWLEDGE

1. Basic General Psychology
2. Mental health needs in Children and Adolescents (KKM KCHS 2000)
3. Life skills (KKM KCHS 2000)
4. Parenting skills (KKM KCHS 2000)
5. Modul Kemahiran Kesihatan Mental (KKM 2008)
INTRODUCTION:
PROMOTING SELF UNDERSTANDING

Aim:
1. Assist adolescents to develop positive self understanding and feel good about themselves

Self understanding:
"The ability to understand one’s own action its effects and its consequence"
Perception; Feeling; Action; Result (outcome)

INTRODUCTION:
PROMOTING SELF UNDERSTANDING

Methods
- Help adolescents to be aware of their emotions, action and reaction
- Help adolescents to respond instead of react when problem arises
- Avoid self judgment and condemning mistake. Instead try to understand why mistake occur
- Teach adolescent that they need to learn to care for themselves and other people
- Know when and how to ask for help

INTRODUCTION:
PROMOTING SELF UNDERSTANDING

Guides to parents
- Discuss actions that may help adolescents to feel better immediately (e.g.: a hug, a touch or a walk)
- Teach adolescents the importance of planning ahead; learn to be patient and sharing with other
- Parents should always make adolescents feel worthy despite their accomplishments or failures

INTRODUCTION:
PROMOTING SELF UNDERSTANDING

Guides to parents
- Accept adolescents unconditionally
- Advise them honestly
- Correct their behaviour positively

INTRODUCTION:
BUILDING SELF ESTEEM

Aims
1. Understand the concept and self esteem issues
2. Assist adolescents to develop positive self esteem
3. Assist parents in helping adolescent develop positive self esteem

Self esteem:
"A person’s overall evaluation towards himself"
INTERVENTION: BUILDING SELF ESTEEM

- Identify what we can and what we cannot change. Be realistic.
- Set achievable goals.
- Express your opinion freely. Do not feel disappointed if your opinion is not accepted.
- Involve in positive activities that can improve self esteem. (eg: sports, art, craft, music, etc)
- Encouragement from parents, teachers and peers can stimulate positive self esteem.

INTERVENTION: ASSERTIVENESS

Aims
1. Understand the concept and issues of assertiveness
2. Assist adolescents develop a good assertive behaviour
3. Assist parents in helping adolescent to develop assertive behaviour

Assertiveness:
"Ability to express feeling, thinking and opinion clearly without feeling guilty; Able to protect your right while protecting and respecting the rights of others."

INTERVENTION: ASSERTIVENESS

Methods
- State your needs and feelings without threatening others.
- Express your feelings and use "I" statements instead of "You" statements.
- Make a clear, direct and straightforward request in a non-aggressive manner.
- State positive remarks upon gaining the person’s cooperation.

INTERVENTION: EFFECTIVE COMMUNICATION SKILLS

Aims
1. Improve effective communication skills in adolescents.
2. Be more alert of factors that can enhance or erode the effectiveness of communication

Communication:
"All methods of conveying all kinds of thoughts, feeling to other people or of receiving expression of thought/ feeling from others."

INTERVENTION: EFFECTIVE COMMUNICATION SKILLS

Methods
- Control your emotions.
- Use appropriate tone of voice.
- Ask for clarification if the information is not clear. Do not assume.
- Listen attentively before you respond.
- Avoid making negative remark or criticism.
- Practice 2-way communication.
- Be aware and acknowledge non-verbal communication. It fosters positive interaction.

INTERVENTION: PROBLEM SOLVING SKILLS

Aims
- Identify problems and causes (if possible)
- Improve problem solving skills

Problem:
"The biggest problem in the world could have been solved when it was small." — Lao Tzu
INTERVENTION: PROBLEM SOLVING SKILLS

Methods
- Use the I.D.E.A.L approach
  - I = Identify the real problem
  - D = Describe or find solutions to existing proposals
  - E = Evaluate each proposal, the advantages and disadvantages
  - A = Act on the options available
  - L = Learn from the experience whether outcome is successful or not

For good decision making:
1. Get help from more senior and experienced people
2. Do not hesitate to carry out the decision made
3. Avoid making decisions in a hurry or based on emotion

INTERVENTION: SPIRITUAL/MORAL AWARENESS

Aims
- Help adolescents to be aware of the importance of
  a. Spirituality
  b. Practicing good values

Background Knowledge
1. Basic General Psychology
2. Mental health needs in Children and Adolescents (KKM KCHS 2000)
3. Life skills (KKM KCHS 2000)
4. Parenting skills (KKM KCHS 2000)
5. Modul Kemandirian Kesihatan Mental (KKM 2006)
6. Spiritual knowledge

Methods
- Family related religious activities
- Reading spiritual/moral books
- Charity and volunteering activities
- Spiritual science related web surfing
- Discussion with religious teachers
- Attending religious talks/activities

INTERVENTION: MANAGING ANGER

Aims
1. Understand the concept and issues of anger management.
2. Assist adolescents managing anger in a positive way.
3. Assist parents in helping adolescents managing anger and implement self-control skills.
INTERVENTION: MANAGING ANGER

Methods

- Recognize SSx of anger (Physical; Emotion; Behaviour)
- Use anger management techniques:
  - Identify
  - Recognize
  - Rational self talk
  - Breathe deeply
  - Know when to walk away (Time out)
  - Analyze and define the problem
  - Learn problem solving skills

INTERVENTION: MANAGING TIME

Methods

- Make a "To Do List" every day. Prioritize.
- Use spare minutes wisely.
- Learn to say NO to activities that distract you from your priorities.
- Find the Right Time. Figure out the best time you will work more efficiently.
- Do not procrastinate.
- Don't push yourself too much. Set achievable goals.
- Get a good night’s sleep.

INTERVENTION: MANAGING CONFLICTS

Methods

- Admit I have a conflict
- Agree to resolve conflict without delay
- Determine the causes of conflict (within self; in the family; external environment)
- Understand one’s own action: its effects and its consequence
- Analyze and define the conflict
- Learn problem solving skills, anger management and conflict resolution

INTERVENTION: MANAGING STRESS

Methods

- 1. Help adolescents to identify:
  a. Causes of stress
  b. Effects of stress
  c. Ways to manage stress
INTERVENTION: MANAGING STRESS

Methods

- Encourage adolescents to identify the causes of stress (conflict, changes in environment, unable to achieve target set).
- Teach adolescents to understand the effects of stress which can be either positive or negative.
- Maintain a healthy lifestyle which include saying NO to drugs; practice 10B strategies.

INTERVENTION: BEHAVIOURAL MANAGEMENT OF ADHD

Aims:

1. Help adolescents to:
   a. Understand better what ADHD is all about
   b. Effects of untreated / poorly treated ADHD
   c. Ways to manage ADHD effectively

INTERVENTION: BEHAVIOURAL MANAGEMENT OF ADHD

Background Knowledge

1. Basic General Psychology
2. Mental health needs in Children and Adolescents (KKM KCHS 2000)
3. Life skills (KKM KCHS 2000)
4. Parenting skills (KKM KCHS 2000)
5. Modul Kemahiran Kesihatan Mental (KKM 2008)
6. CPG ADHD (KKM 2008)

INTERVENTION: VIOLENCE RISK ASSESSMENT

Aims

1. Assist PHCP to determine risk factors and possibility of violence in adolescents

INTERVENTION: VIOLENCE RISK ASSESSMENT

Background Knowledge

1. Basic General Psychology and Psychiatry
2. Parenting skills (KKM KCHS 2000)
INTERVENTION: VIOLENCE RISK ASSESSMENT

Methods
- Remain calm
- Adopt a non-threatening approach
- Ensure safety of adolescents and yourself at all times
- Listen and take adolescents’ complaints/problems seriously
- Be supportive
- Use table 1 to determine level of violence risk

INTERVENTION: SUICIDE RISK ASSESSMENT

Aims
1. Assist PHCP to determine risk factors and risk levels for suicide in adolescents

INTERVENTION: SUICIDE RISK ASSESSMENT

Background Knowledge
1. Basic General Psychology
2. Parenting skills (KKM KCHS 2000)
3. Guideline on Suicide Risk Management in Hospitals (KKM 2014)
4. Suicide Prevention Protocol for Terengganu (JPKM 2014)
5. Modul Kemahiran Kesihatan Mental (KKM 2008)

INTERVENTION: RELAXATION TECHNIQUES AND STRATEGIES

Aims
1. To train adolescents on relaxation techniques
   a. Cognitive technique
   b. Breathing exercises and techniques
   c. Jacobsonian technique

INTERVENTION: RELAXATION TECHNIQUES AND STRATEGIES

Methods (Cognitive Technique)
- Remove your negative thoughts
- Imagine you are in a peaceful place/situation
- Give full attention to that place in your mind
- Use all your senses to enjoy the moment for 5 – 10 minutes
- Proceed to positive self talk
**INTERVENTION: RELAXATION TECHNIQUES AND STRATEGIES**

**Methods (Breathing Technique)**

- Breathe in through your nose using diaphragm muscle
- Breathe out through the mouth
- Hold breath for 4 – 8 seconds
- Repeat the above steps for 30 – 60 seconds

---

**INTERVENTION: RELAXATION TECHNIQUES AND STRATEGIES**

**Methods (Jacobsonian Technique)**

- Sit or lie down
- Close your eyes
- Tighten facial muscles for 10 – 15 seconds
- Feel the tension
- Relax the muscle slowly and appreciate the difference between tense and relaxed muscle
- Repeat the above steps with other muscle groups

---

**INTERVENTION: SUPPORTIVE COUNSELING**

**Aims**

1. Guide adolescents to make changes by focusing on their strengths
2. Educate them and increase their knowledge in dealing with problems/issues

---

**INTERVENTION: SUPPORTIVE COUNSELING**

**Background Knowledge**

1. Basic General Psychology
2. Life skills (KKM KCHS 2000)
3. Modul Kemahiran Kesihatan Mental (KKM 2008)
4. Basic Counseling Knowledge and Skill

---

**INTERVENTION: SUPPORTIVE COUNSELING**

**Methods**

- Explore and identify their strengths (talents, skills, abilities)
- Prioritize the strength that can be used to solve/deal with problems
- Encourage to use their strengths when opportunities arise
- Feel good about their talents and abilities

---

**INTERVENTION: SUPPORTIVE COUNSELING**

**Can be implemented through:**

- Reading articles related to problems/issues faced
- Share the problems/issues with other adolescents/adults
- Put in practice the knowledge learnt
**INTERVENTION: RESILIENCE**

**Aims:**

1. Help adolescents to:
   a. Understand better what resilience is all about
   b. 10 steps to resilience

**Resilience:**

The human capacity to face, overcome and be strengthened/transformed by the adversities of life.

A relative resistance in facing adverse life events

---

**INTERVENTION: RESILIENCE**

**Background Knowledge**

1. General psychology
2. Life skills (KKM KCHS 2000)
4. Modul Kemahiran Kesihatan Mental (KKM 2008)

---

**RESILIENCE**

- Resilience = Relative resistance to environmental risk experience (Rutter et al.)
- Resilience is not just the social competence or positive mental health

---

**INTERVENTION: RESILIENCE**

**Types of adverse life events:**

1. Personal (Chronic illness; handicap; injuries; abuse, etc)
2. Family (Divorce; death; physical mental illness; unemployment; loss of job; etc)
3. Environment (flood; famine; war; poverty; homelessness; etc)

---

**INTERVENTION: RESILIENCE**

**10 STEPS**

1. Make connection with others (including family members and peers)
2. Avoid seeing a crises as a problem
3. Accept changes that took place as part of living
4. Move towards your goal
5. Take decisive action

---

**INTERVENTION: RESILIENCE**

**With resilience adolescents can triumph trauma; without it trauma (adversity) triumphs.**

**Outside help is essential in time of trouble but it is usually insufficient.**

**Inner strengths (support; self confidence; faith) build resilience**
INTERVENTION: RESILIENCE : 10 STEPS

7. Positive view of self. See your strengths more than your weakness
8. Keep things in perspective
9. Maintain a hopeful outcome
10. Take care of yourself.

TAKE AWAY MESSAGE

- Life skills
- A balance between ICT (Interactive Communication Technology) and SIC (Interactive Social Communication)

CONCLUSION

- Ignorance is so yesterday.
- Problem can be seen as an opportunity.
- Stress is hazardous to your health.
- Doing nothing is not an option.
- Use manual as a guide

Q & A?
4.3 REFERENCES

General Mental Health


Adolescent Mental Health

7. Ministry Of Health Malaysia, 2000. Training Package Promotion of Mental Health, Healthy Lifestyle Campaign, Mental Health Life skills – Adolescents
ACKNOWLEDGEMENTS

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