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Bad, Sad Or Mad?

Common Mental Health Problems Among Youth In Custody

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Case 1

- In 2019, V (16 years old) was diagnosed with Adjustment Disorder with mixed disorder of conduct and emotions.
- Since her admission to the Home, her mood is observed to be stable and her behaviour is good. She has been able to follow most of the Home's rules and regulations, and is now focused on attaining her GCE O Level certificate. She also reported not to have thoughts of self-harming or suicide.
- Reason for referral: To assess if her diagnosis is still valid and if she needs to continue with treatment

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Disorders of emotion

Diagnosis	Clinical features/Treatment
Adjustment Disorder	Emotional/behavioural symptoms in response to stressor Not severe enough to meet diagnosis of depression Treatment usually is counseling, support with respect to stressor
Major Depressive Disorder/Depression	Depressed mood, loss of interest/pleasure, irritable/agitated, fatigue, feeling worthless/guilt, poor concentration, suicidal thoughts, reduce appetite, weight loss, insomnia Treatment: psychological therapy, antidepressant medication (risk!), individual counseling, family therapy **Young people tend to be more sensitive**
Dysthymia (persistent depressive disorder)	At least 1 year persistent depressed mood, not severe enough to meet criteria for depression above
Bereavement	

Case 2: Rage

- V, 16-year old girl, alleged victim of trauma
- Angry that she was ‘punished’ instead of perpetuator
- Worse after she absconded, affected by bereavement
- Became hostile, aggressive, had to be transferred to high security ward in IMH – needed to be restrained, fought police officers
- Is she ‘bad’, ‘sad’ or ‘mad’?

Case 2: Rage

- Observation: will fight ‘authorities’ including nurses, professionals
- Examination: restrained to bed, no bedsheet
  - Angry, shouted, as we talked – cried, felt guilty she couldn’t send godbro off
  - She spoke to elderly health attendant
  - Stages: off restraint, mattress without bedding, writing materials, limited staff contact including personnel from Girls’ Home
- Was diagnosed with agitated depression, high doses of meds
- Collaboration with Girls’ Home
- Discharged to Girls’ Home, took N levels, discharged

Case 3: A riot that shook SBH

- U, a 16-year old male
- Sentenced to SBH for multiple offences
- Participated in riot in 2018, caused injuries and damaged property, diagnosed conduct disorder
- Soon after, his behaviour became periodically disorganized, aggressive
- ?Is there any mental illness (Is he ‘bad’ or ‘mad’?)

Disruptive Behavioural Disorders

- Conduct Disorder

Pattern of severe conduc problems:

  - Aggression to people and animals
  - Destruction of property
  - Deceitfulness or theft
  - Serious Violation of rules

- Oppositional Defiant Disorder

Pattern of negativistic, hostile and defiant behaviour

  - Loses temper
  - Argues with adults
  - Defies requests and rules
  - Deliberately annoys people
  - Blames others
  - Touchy, easily annoyed
  - Angry and resentful
  - vindictive

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Treatment

- Community based programs
  - Multi-systemic therapy
- Family Therapy
- Parent training
- Child: individual counseling support
- Medication rarely needed unless recurrent aggression

Psychotic disorders (Psychoses)

- Symptoms
  - Hallucination and delusion (abnormal belief)
  - Disorganized behaviour (eg. hoarding)
  - Disorganized speech

Types of Psychosis (or psychotic disorders)

Schizophrenia-spectrum disorders

- Brief Psychotic Disorder (<1 month)
- Schizophreniform Disorder (1-6 months)
- Schizophrenia (>6 months)
- Schizoaffective Disorder

Others

- Delusional Disorder
- Mood Disorders
  - Bipolar disorder
  - Psychotic depression (a form of severe depression)

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Psychotic disorders (Psychoses)

- Bipolar disorder
  - Mood disorder with recurrent mania and depression
  - Mania: elevated mood, energetic, grandiose delusion, reduced sleep, talkativeness
  - Treatment: mood stabilizer (medication)

Case 3: A riot that shook SBH

- Initial diagnosis: Brief psychotic disorder
- Episodic disorganized behaviour soon became associated with mood shifts
  - Observed by case worker: crying, irritable/elevated mood, psychomotor agitation
- Diagnosed with Bipolar Disorder
- Learning point: mental illness often undifferentiated in presentation during early stage

Case 4: Schizophrenia Treatment

- S, 19-year old, diagnosed schizophrenia and placed in Girls' Home under APS
- Repeated O-level, did well enough to enter polytechnic
- Medication: Quetiapine (anti-psychotic), sodium valproate (mood stabilizer)

- Case worker followed her to school, explained her condition to teachers
- Teachers monitored her closely in school
- Stress of schooling resulted in severe relapse: suspicious of course-mates
- Despite close support, early medical appointment, increased medication, she could not cope and had to drop out
- Role of Home staff critical to coordinate support, early recognition of relapse

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Anxiety Disorders

Worries and Fears about:	Disorder	Age of onset
Anything and everything	Generalised Anxiety Disorder	Childhood to early adulthood
About specific situations or objects	Phobia	Early childhood to adolescence
About strange situations or people	Social Anxiety Disorder	Early adolescence
No reason (during panic attack, worry about dying)	Panic Disorder	Adolescence-adulthood
Senseless fears (eg contamination)	Obsessive Compulsive Disorder	Childhood to adolescence

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Neurodevelopmental Disorders

- Intellectual disability (old term: mental retardation)
- Specific learning disorder
  - Dyslexia (reading disorder)
- Tic Disorders
  - Tourette's disorder (motor and vocal tics)
- **Autism spectrum disorder**
- **Attention deficit hyperactivity disorder**

Autism Spectrum Disorder

- **DSM-IV TR**

Pervasive Developmental Disorders

  - Autistic Disorder
  - Asperger Syndrome
  - Pervasive Developmental Disorder Not Otherwise Specified
  - Childhood Disintegrative Disorder

- **DSM 5**

Neurodevelopmental Disorders

Autism Spectrum Disorder

Autism Spectrum Disorder

(A) Persistent deficits in social communication and social interaction:

1. Deficits in social-emotional reciprocity

•Abnormal/lack social approach, poor reciprocal conversation, reduced sharing

2. Deficits in nonverbal communicative behaviours

•Abnormal eye contact and body-language, poor nonverbal communication

3. Deficits in developing and maintaining relationships

•Difficulties in sharing, making friends, lack of interest in people

(B) Restricted, repetitive patterns of behaviour, interests:

1. Stereotyped or repetitive speech, motor movements

2. Excessive adherence to routines or rituals or resistance to change

- Motoric rituals, insistence on same route or food, repetitive questioning, distress at small changes

3. Abnormal restricted, fixated interests

- Preoccupation with unusual objects, excessively circumscribed interests

4. Hyper-or hypo-reactivity to sensory input

- Adverse response to specific sounds or textures
- Excessive smelling or touching of objects, fascination with lights or spinning objects

Management

- Educational/Vocational
- Behavioural Intervention
  - Difficulties with transition
- Family Support
- Psychotherapy
  - For targeted symptoms eg. anxiety
- Pharmacotherapy
  - If aggressive
  - For another mental health problem eg. depression

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Attention Deficit Hyperactivity Disorder (ADHD)

- Symptoms of **Inattention** and/or
- Symptoms of **Hyperactivity- Impulsivity**
- Before 7 years of age
- Impairment in two or more settings
- Significant impairment in social, academic or occupational functioning

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Criteria: Inattention

Criterion	Examples
Careless mistakes	Overlooks or misses details, work is inaccurate
Can't sustain attention	Can't remain focused during lectures, conversations or lengthy reading
Doesn't listen	Mind seems elsewhere when no obvious distraction
Can't complete task	Starts tasks but quickly loses focus and easily sidetracked
Can't organize	Difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines
Doesn't like effortful task	Preparing reports, completing forms, reviewing lengthy papers
Loses things	Tools, wallets, keys, paperwork, eyeglasses, mobile phones
Distractible	By unrelated thoughts
Forgetful	Returning calls, paying bills, keeping appointments

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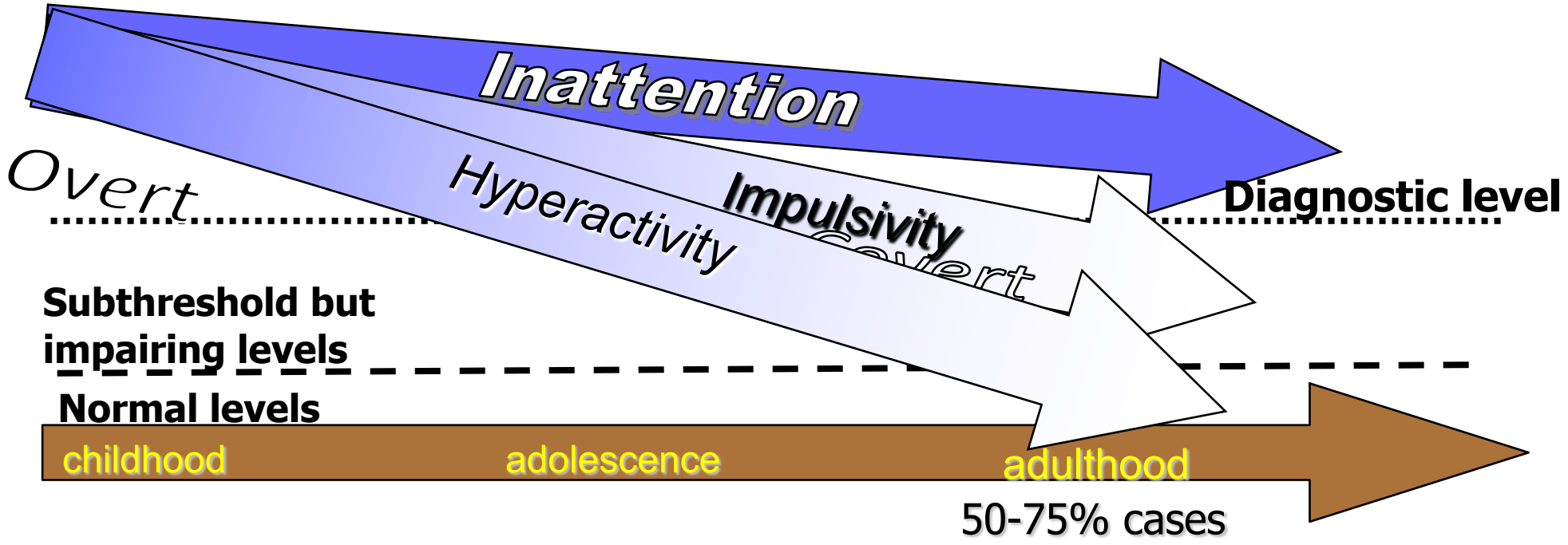
Criteria: Hyperactive-Impulsive

Criterion	Examples
Fidgets in seat	
Leaves seat	Office or other workplace, or situations that require remaining in place
Runs around	May be limited to feeling restless
Do things quietly	
On the go; energetic	Unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with
Talkative	
Blurts answers	Completes other people's sentences; cannot wait for turn in conversation
Can't wait for turn	While waiting in line
Interrupts or intrudes	May intrude into or take over what others are doing

ADHD

- Improves with age



ADHD: Treatment

- Why treat?

  1. Academic/occupational underachievement

  2. Relationship difficulties

  3. Low self-esteem

  4. Social-occupational impairment

  5. Motor accidents

- Treatment
  - **Behavioural**/Environmental Modification
    - Structure, reduce distraction
    - Parenting strategy
  - **Medication**
    - Not cure, for symptom control
    - Methylphenidate

    Side effects: reduced appetite, slower growth rate
    - Atomoxetine

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Insomnia

- Sleep hygiene
  - Avoid caffeinated drinks after late afternoon
  - Avoid alcohol
  - Less daytime naps
  - Regular sleep routines (structure of Home/reduced screen time helps!)
  - Avoid heavy meals
  - Reducing fluids in the evening
- Relaxation exercises
- Medications (short-term)
- Insomnia is not a mental illness

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Thank you

Questions?

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