Orygen

The National Centre of Excellence in Youth Mental Health

Clinical practice guide

Physical & mental health

Guidance, resources & tools for prevention and early intervention in cardiometabolic and sexual health issues

Contents

About

Purpose and scope of this clinical practice guide

This clinical practice guide covers the screening, assessment and management of physical health problems in young people, with a specific focus on cardiometabolic health and sexual health. The purpose of this guide is to provide an overview of the evidence relating to cardiometabolic and sexual health in young people with mental health problems, and to provide guidance around appropriate and effective interventions.

This guide is intended for clinicians and workers who have an interest in working with young people experiencing mental ill-health. It is not intended to be a comprehensive guide, as the evidence for working with young people and physical health issues continues to emerge. Guidance and resources are based on the best available evidence and guidelines for young people and adults.

Why is physical health important?

The window of highest onset of mental ill-health is between the ages of 12 and 25 years. The onset of mental ill-health brings with it greater risks of poorer physical health outcomes, including sexual and oral health issues (Correll, Datraux, Lepeleire, et al. 2015). Despite the increased need to provide holistic health service following the onset of mental ill-health, the main presenting symptoms of mental ill-health often becomes the single focus, which is often to the detriment of a young person's physical and sexual health.

Weight gain, obesity, and dyslipidemia

Weight gain is a well-established side effect of antipsychotic medications, and particularly second generation antipsychotics. In addition, those young people treated with antidepressant and mood stabilising medications may also be at increased risk of developing diabetes, dyslipidemia – i.e. problematic levels of lipids in the blood – weight gain, and a host of other physical health problems (Correll, Detraux, Lepeleire, et al. 2015).

Diabetes risk

Recent findings from the 2010 Australian National Survey of Psychosis found that people with schizophrenia share familial risk factors for type 2 diabetes (Foley, Mackinnon, Morgan, et al. 2016). This suggests that young people with psychosis are more likely to be at higher risk for diabetes even before being prescribed antipsychotic medication. Therefore, it is not just that people with psychosis are at higher risk of developing diabetes as a result of being prescribed antipsychotic medications, but also the increased risk precedes this. It is important to note that impaired glucose function can begin very early in the course of treatment, and can have disastrous effects in the longer term. The leading cause of death in people with diabetes is cardiovascular disease, and many other physical health complications can arise as a result of diabetes (Diabetes Australia 2017). Diabetes Australia has more information about diabetes risk, diagnosis, and living with diabetes.

Table 1 on page 5 presents prevalence data from the 2010 Australian National Survey of Psychosis. This data is for people with an ICD-10 psychotic disorder (n=1642/1825) who also gave a fasting blood sample (n=1155/1642) based on current fasting plasma glucose level at the time of survey or prescription of diabetic medication during the month prior to survey (Foley, MacKinnon, Morgan, et al. 2014).

Looking at those aged 18–25 years living with psychosis, 5.8% (or 1 in 17) meet criteria for type 2 diabetes and another 10.7% (or 1 in 10) meet criteria for pre-diabetes. Combined, that is 16.3% (or around 1 in 6) in those aged 18–25 years living with psychosis (Foley, MacKinnon, Morgan, et al. 2014).

Table 1: Prevalence of people with a psychotic disorder meeting criteria for pre-diabetes or type 2 diabetes by age.

Age	Euglycaemia		Pre-diabetes		Type 2 Diabetes		Total	
	N	%	N	%	N	%	N	%
18–24	101	83.5	13	**10.7**	7	**5.8**	121	10.5
25–34	280	76.1	62	16.8	26	7.1	368	31.9
35–44	211	66.6	69	21.8	37	11.7	317	27.4
45–54	144	59.3	47	19.3	52	21.4	244	21.1
55–64	58	55.8	28	26.9	18	17.3	105	9.1
Total	794	68.9	219	19.0	140	12.1	1155	100.00

Unpublished table, provided by DL Foley, 2016, based on data from the second Australian national survey of psychosis. (Foley, Mackinnon, Morgan, et al. 2014).

Physical and sexual health problems in young people with mental ill-health

What is the relationship between mental ill-health on cardiovascular health?

In a systematic review of 18 research papers, McCloughlan et al. (2012) found that comorbid mental–physical illnesses and conditions are evident across the age span. People with a mental illness experience higher rates of physical illness than the rest of the population and die up to three decades earlier (Chesney, Goodwin & Fazel 2014; Correll, Datraux, Lepeleire, et al. 2015). The association between mental ill-health and poor physical health is not unique to any one mental disorder or group of disorders; it is found across the spectrum of mental illness diagnoses (McCloughan 2012). This is why it's important that we concentrate our early interventions on physical health interventions to help prevent this discrepancy in life expectancy regardless of which mental health diagnosis a person may receive.

Data on the rates of physical activity in Australian young people report that approximately 53% of young Australians meet the physical activity guidelines (ABS, 2011-2012). When comparing this to data about young people presenting to a community mental health service, only 6% of young people currently met the guidelines (Parker et al. 2016). Physical activity, good diet, and overall healthy lifestyle patterns have wide-reaching benefits for all people. The most obvious is reduced risk of developing cardiovascular disease, cancer, and diabetes (Ward, White & Druss 2015).

Early research suggests that physical activity interventions can be effective as a form of treatment for mental ill-health (Parker, et al. 2016; Rosenbaum, Tiedemann, Sherrington, et al. 2014).There is good evidence to support physical activity and exercise and positive correlation with improvements in symptoms of depression, psychosis, and post-traumatic stress disorder (Beebe, et al. 2005; Davenport 2017; Malchow et al. 2013; Rosenbaum, et al. 2014; Scheewe, et al. 2013; Whiteworth, Craft, Dunsiger, et al. 2017) and some evidence to suggest that it is correlated with improvements in overall global functioning among people experiencing mental ill-health (Lee, Hui, Chang, et al. 2013). Increased aerobic fitness has also been associated with improvements in neurocognition and subjective quality of life in persons with serious mental ill-health (Malchow, et al. 2013; Rosenbaum, et al. 2014; Vancampfort, et al. 2012; Wolff, et al. 2011).

Orygen has produced the free online learning module 'Interaction between physical and mental health' to provide more information about the interaction between physical and mental health in young people.

What is the impact of mental ill-health on sexual health?

There is a demonstrated association between risky sexual behaviour and common psychiatric disorders in young people. Young people are generally more likely to behave in ways that put their physical and sexual health at risk, even though they are cognitively able to weigh up the risks and consequences of their actions (Smith, Chein & Steinberg 2014). Peer influence can increase risk-taking behaviour in young people, even when the negative consequences of actions are known (Smith, Chein & Steinberg 2014). It is important to keep this in mind when discussing physical and sexual health behaviours with young people.

One study examined the relationship between psychiatric disorders and risky sexual behaviour among 21-year-olds (n=992) in New Zealand (Ramrakha et al. 2000). The results showed that compared to young people with no psychiatric disorder:

- Young people diagnosed with substance dependence, schizophrenia spectrum, depressive, or antisocial disorders were more likely to:
  i) participate in risky sexual intercourse (this was defined as three or more sexual partners in the preceding 12 months and 'never', or 'only sometimes' used a condom)
  ii) contract sexually transmitted infections (STIs) and
  iii) first have sexual intercourse at an early age (i.e. prior to 16-years-old).
- Young people with anxiety disorders were more likely to report having STIs.
- Young people with mania were more likely to report risky sexual intercourse and have an STI.

The study also found that young people's likelihood of engaging in risky sexual behaviour was increased if they met criteria for more than one mental illness (i.e. by psychiatric comorbidity).

Another large survey of adolescents and their parents (Brown et al. 2010) found that:

- Adolescents who met diagnostic criteria for mania, externalising disorders (oppositional defiant, conduct, and attention-deficit/hyperactivity disorders), or who met criteria for both an externalising and internalising disorder (major depressive, generalised anxiety, and post-traumatic stress disorders) were significantly more likely to report a lifetime history of vaginal or anal sex than those who did not meet criteria for any psychiatric disorder.
- Those meeting the criteria for mania were significantly more likely to have had two or more sexual partners in the previous 90 days and to test positive for an STI, compared to those who did not meet the criteria for a psychiatric disorder.

What are the rates of sexual dysfunction in people with a mental illness?

Sexual dysfunction refers to difficulties that occur during the sexual response cycle that prevent the individual from experiencing satisfaction from sexual activity (Chen 2013). Information about rates of sexual dysfunction in young people with mental ill-health is difficult to find, however, sexual dysfunction affects an estimated 43% of adult women and 31% of adult men in the general population in the US (Laumann, Paik & Rosen 1999).

Similarly in Australia, cross-sectional studies have suggested that up to 55% of men and 60.5% of women reported at least one sexual problem in the preceding year, with more serious sexual dysfunction observed in 13.2% of men and 19.7% of women (Boyle, Cook, Purdie et al. 2003). Prevalence of sexual dysfunction is known to be higher in individuals with mental ill-health than those without, and to be particularly high among people being treated with psychotropic medications (Clayton & Balon 2009; Zemishlany & Weizman 2008).

Psychosis

- 50% of men and 30% of women with psychotic illness report some form of sexual dysfunction, with 40% never having had a sexual relationship (Bhui, Puffet & Strathdee 1997).
- Decreased libido is a common complaint reported in untreated individuals with schizophrenia (Clayton & Balon 2009). Furthermore, compared to controls, men with schizophrenia report low sexual desire, erectile dysfunction, premature ejaculation, and orgasmic dissatisfaction (MacDonald et al. 2003).
- Individuals experiencing schizophrenia are prone to sexual dysfunction due to the nature of its symptoms. The premorbid personality of people with schizophrenia is often schizoid or schizotypal with limited interpersonal relationship and lack of sexual experience. The negative symptoms of schizophrenia adversely affect the ability to enjoy sexual life. These individuals also face challenges establishing relationships as a consequence of recurrent episodes of psychosis, obesity, and low self-esteem (Zemishlany & Weizman 2008).

Mood and anxiety disorders

- The number of non-medicated people with mood disorders reporting sexual dysfunction is almost double that of the general population (Bossini et al. 2007; Casper et al. 1985), with desire and arousal problems the most common.
- One study of adults (54 females, 49 males) experiencing either a mood or an anxiety disorder found that 87% of participants with depressive illness reported sexual dysfunction. Among those with anxiety disorders, 64% reported sexual dysfunction (Bossini et al. 2007).
- Decreased libido commonly accompanies a major depressive episode. Up to 80–90% of people with major depression reported decreased sexual desire (Bossini et al. 2007; Casper et al. 1985).
- Depression has also been found to be associated with erectile dysfunction, impaired female arousal, and delayed orgasm/ejaculation or anorgasmia (Bonierbale, Lancon & Tignol 2003; Cyranowski et al. 2004; Williams & Reynolds 2006).
- Individuals with depression may also experience lowered ability to maintain sexual arousal or achieve orgasm (Zemishlany & Weizman 2008).

There is a lack of data on the association between mania and sexual dysfunction.

Orygen has produced the free online learning module 'Sexual health in young people with mental health problems' for more information on sexual health and sexuality.

The next section of this guide will focus on assessing physical and sexual health in young people, including recommendations and resources that may be useful in clinical practice.

Assessment

Engagement: talking about physical and sexual health

Discussing physical health is the first important step in understanding and assessing the cardiometabolic and sexual health issues that young people with mental ill-health may be facing or at risk of developing. It is important to include assessment of cardiometabolic health and sexual health as part of the overall engagement and assessment process, and from the beginning of treatment. Discussing these issues as a normal and expected part of healthcare will help young people to feel more comfortable discussing these issues throughout their care.

Where do young people get information about sexual health?

- Young people report getting information about sexuality and relationships from a number of sources, including internet websites (43.6%), school programs (42.7%), a female friend (41.1%), mother (36.4%), and doctor (29.3%) (Mitchell, Patrick, Heywood, et al. 2014).
- One study found that 16% of young males and 10.2% of young females had never sought advice about sexuality and relationships (Mitchell, Patrick, Heywood, et al. 2014).

What stops clinicians asking and talking to young people about sex, sexuality, gender, and relationships issues?

A high-quality review of studies investigating barriers to health professionals within the UK discussing sex and sexuality (Dyer et al. 2013) found a number of structural, organisational, and personal factors got in the way of health professionals talking to clients about sex, including:

- fear about 'opening up a can of worms'
- lack of time
- lack of resources and training
- concern about knowledge and abilities
- worry about causing offense, personal discomfort
- lack of awareness about sexual issues.

These barriers were particularly marked in relation to discussing sexuality with certain groups of clients, including: black and minority ethnic groups, people with intellectual disabilities, older patients, non-heterosexual people, and people who were of the opposite sex to the health professional (Dyer, et al. 2013).

Other studies have found that a professional's ability to discuss sexual and relationship health with young people is influenced by their levels of knowledge and information, their personal beliefs, and the availability of private time and space (Bray 2012). In relation to clinicians' experiences providing sexual health services to LGBTQ young people, one study found (Knight et al. 2014):

- Many clinicians lacked cultural competency, either implicitly (e.g. describing their practice within a heteronormative framework) or explicitly (e.g. clinicians were not provided with enough resources/ training).
- Institutional norms/values were the dominant barriers to offering LGBTQ-tailored services.

Clinicians are able to reduce social and structural barriers to high-quality care by appropriately engaging LGBTQ young people and being culturally competent in their practice. For cultural competency guidance, primary care protocols, and guidelines, please refer to headspace's 'Evidence Summary: Working with same-sex attracted young people – Inclusive practice'.

The National LGBTI Health alliance has produced a cultural competency framework on including LGBTI people in mental health and suicide prevention organisations and Center of Excellence for Transgender Health (California) has produced guidelines for the care of trans and non-binary people.

The resources above, and those provided throughout this guide, should be used to increase awareness and knowledge of sexual health issues facing young people, as well as a guide in providing information and resources to young people themselves.

Assessment

The general principles of assessment and engagement apply to talking with young people about their physical health. A genuine, non-judgemental and empathic approach will help the young person to feel at ease and open up about any concerns they have.

These principles are particularly important in relation to discussing topics that might be embarrassing or shameful. Normalising and validating these experiences is an important first step to assessing physical and sexual health issues. Clinicians should explain the process of assessment and explain to the young person, and anyone accompanying them, that you'll be asking about sex and sexuality. Give reassurance that they only have to say as much as they're comfortable, and provide the option for discussing this topic in private if preferred.

Assessment of cardiometabolic health and sexual health needs to begin with screening. Screening involves identifying non-modifiable and modifiable

risk factors for heart disease, so that the clinician can provide advice and support to prevent issues arising in the longer term.

Refer to Orygen's free online module 'Engagement and Assessment in Youth Mental Health' for more information on assessment and engagement techniques and youth mental health.

Physical health assessment: screening for cardiometabolic risk

As a starting point, all mental health services should screen for non-modifiable risk factors such as family medical history, especially diabetes and cardiovascular disease, ethnicity, gender, and age.

Screening for modifiable risk factors should include:

- Obesity: Height and weight to calculate BMI and waist and hip circumference to estimate ratio.
- High blood pressure: systolic and diastolic blood pressure.
- Blood glucose.
- Fasting lipid profile (total cholesterol, LDL and HDL, and triglycerides).
- Physical activity and exercise rating.
- Dietary screening.
- Tobacco use.
- Alcohol use.

The NSW Health Education and Training Institute has produced an algorithm for metabolic screening and intervention for young people who have been prescribed antipsychotic medication. This algorithm can also be applied to other young people with mental health problems aside from psychosis, who are receiving treatment, and can be used to guide early intervention for addressing cardiometabolic health risks in a cohort of young people who are already at higher risk.

Sexual health assessment: sexual history taking

Sexual health assessment and history taking can be a potentially embarrassing and uncomfortable experience for young people, especially if they haven't had the discussion before with other professionals. In the first instance, explain the concept of confidentiality: this can be a potential barrier to the young person discussing sensitive issues.

The HEADSS psychosocial assessment (Home, Education/employment, peer group Activities, Drugs, Sexuality, and Suicide/depression) is validated for use with young people (Parker, et al. 2010). HEADSS provides a framework for general psychosocial assessment and an opportunity to ask young people about sex and sexuality. Under the structure of the HEADSS assessment, young people are only asked about sex and sexuality toward the end of the assessment, following discussion of topics that are usually perceived to be safer or less confronting to talk about (e.g. home, school, activities). Letting the young person know that you ask every young person you see about issues to do with sex and sexuality is an important first step in taking a sexual history.

Young people are disproportionately affected by sexually transmitted infections (Weinstock, et al. 2004). Failure to diagnose and treat STIs can result in reproductive morbidity (Goyal, et al. 2016), which is why it is important to ask every young person you see about their sexual behaviour. It is also important to create a safe space so that you can have open conversations about sex and sexuality early on. It's not enough to simply ask vague questions about sex and sexual relationships when assessing a young person. Rather, at an initial screening, clinicians should ask about:

- close relationships
- sexual experiences
- number of partners (total and in the last three months)
- gender of sexual partners (don't assume sexual preferences)
- uncomfortable situations, sexual abuse, risk of pregnancy, and previous pregnancies (relevant to males as well as females)
- contraception
- condom use
- STIs.

The clinician and young person can then work together to decide what further investigations may be warranted and what interventions are most suitable for the young person's concerns.

> “You may be the most non-judgemental clinician out there but you don’t have any idea of the barriers I may have faced just to get in the room with you. This could be from finding a gender-neutral toilet to telling the receptionist that I was here to see you and her deciding to call me ‘he’ when that isn’t how I identify.’
>
> Young person

Taking medications into account

Sexual health problems are often confounded by both mental health difficulties as well as medications used to treat these difficulties. An overview of the issues that clinicians need to take into account is presented below.

Antidepressants

Sexual dysfunction has been associated with antidepressant medications. For example, the results of one study (Clayton, et al. 2002) of people being treated with antidepressants showed that 37% of participants reported significant sexual dysfunction. Men were significantly more likely to report a lack of sexual desire and orgasmic dysfunction, and women more likely to report arousal problems (Clayton, McGarvey & Clavet 1997). Other studies have found that to 78% of individuals with depression report sexual dysfunction while being treated with antidepressants (Clayton et al. 2002; Osvath et al. 2003; Rosen, Lane & Menza 1999).

Antipsychotics

Many studies clearly show that people being treated with antipsychotic medications have reported sexual dysfunction at all stages of the sexual response cycle (Clayton & Balon 2009; Park, Kim & Lee 2012). Clayton and Balon (2009) found that sexual dysfunction has been identified in 40–70% of patients being treated for psychotic illness. Other studies show that sexual dysfunction has been reported in 30–60% of individuals with schizophrenia treated with antipsychotic medications (Peuskens, Sienaert & De Hert 1998).

Benzodiazepines

Very little research has investigated the impact of benzodiazepines on sexual health. One study reported that benzodiazepine use does not appear to be associated with sexual dysfunction in men, however, some limited data suggests increased sexual dysfunction in women (Clayton & Balon 2009). There is no data specifically for young people, so we don’t know if sexual dysfunction is a potential adverse side effect of benzodiazepine use for young people. More research is required before we can say what, if any, effect benzodiazepine use has on young people’s sexual functioning. In any case, be aware of a potential effect and raise this issue with young people if they are taking benzodiazepines.

Risk factors for unhealthy relationships, sexual violence, and intimate partner violence

Sexual violence ‘broadly refers to acts ranging from sexual harassment to rape’ and ‘can be perpetrated by a romantic partner [or] someone else’ (Ybarra, et al. 2013), unlike intimate partner violence (IPV), which occurs by definition within an existing intimate relationship. While young women are more commonly the victims of IPV and sexual violence, young men and young people in non-heterosexual relationships can also be the victims of IPV and sexual violence (Ybarra & Mitchell 2013; Krahe, et al. 2014). Similarly, both young men and young women can perpetrate sexual violence (Ybarra & Mitchell 2013).

Within intimate relationships, IPV may be mutual (Haynie, et al. 2013). Among women, adolescents and young women experience higher rates of IPV than older women (Stockl, et al. 2014). A very large study, which followed a sample of over 5,500 adolescents from the ages of 12–18 years until they were 18–25 years, found that being a victim of IPV in adolescence had a significant and lasting impact on the health outcomes of both young men and young women into early adulthood. Negative outcomes included increased risk of suicidal ideation, mental ill-health, and substance use at aged 18–35 years (Exner-Cortens, Eckenrode & Rothman 2013). Moreover, for both genders, experiencing IPV in adolescence was associated with increased risk of experiencing IPV as adults (Exner-Cortnens, Eckenrode & Rothman 2013).

A recent systematic review of intimate partner violence and sexual violence perpetrated by adolescent boys against adolescent girls in heterosexual relationships (Lundgren & Amin 2015) investigated the risk of risk and protective factors for intimate partner violence among adolescent girls. It’s results are described in Table 2 on page 12.

Table 2: Risk and protective factors for intimate partner and sexual violence among adolescents (based on evidence in the literature).

Perpetration by men	Both perpetration by men and victimisation of women	Victimisation of women
Individual		
• Antisocial personality	• Harmful alcohol and substance use • Witnessing or being a victim of violence • Belief that violence is justified/tolerable • Low education	• Socioeconomic status (weak) • Risky sexual practices • Young age • Marital status • Depression
Relationship and family		
• Bullying and homophobic teasing • Academic achievement • Partner has concurrent relationships	• Violence within family • Connectedness with adults • Divorced/separated parents • Poor parenting practices (harsh discipline, lack of supervision, and low affective proximity) • Friends with delinquent behaviours who approve of or experience IPV • Relationships characterised by power imbalances • Relationship conflict	• Forced/unwanted first sex

Beyond this summary, more detailed description of the risks and benefits of adolescent relationships are discussed in headspace's evidence summary Adolescent Romantic Relationships – Why are they important? And should they be encouraged or avoided?

Clinicians should also encourage young people to visit Love: the good, the bad, the ugly, an Australian website developed by the Domestic Violence Resource Centre Victoria. It has advice and stories for young people about all aspects of romantic relationships.

Complexities of working with sexual violence and IPV

Assessing and working with young people who are experiencing or who have experienced sexual violence and/or IPV, and working with young people who have perpetrated sexual violence and/or IPV can be very complex and challenging. These young people may have complex mental health presentations and physical and sexual health risks.

Work within your professional competencies, engage other health professionals in a young person's care, and to refer young people on to more specialised services as appropriate. Addressing the complexities in assessing and managing the physical and mental health needs of this group, as well as considering the potential risks of harm to the self, harm to others, and of victimisation is beyond the scope of this resource. Clinicians are strongly encouraged to seek further training and clinical supervision in this area.

The next section of this guide focuses on evidence-based interventions for managing cardiometabolic health and sexual health issues.

Intervention

Lifestyle interventions targeting healthy eating, increasing physical activity, exercise, and behaviour modification are a major part of the prevention and treatment of obesity and related comorbidities (Ward, White & Druss 2015). Emerging evidence suggests that early intervention in physical health issues for young people with mental ill-health is important, and has the potential to prevent long-term physical health complications (Alvarez-Jimenez, Martinez-Garcia, Perez-Iglesias, et al. 2010; Curtis, Watkins & Rosenbaum, et al. 2015). The interventions described below are a guide only, and are intended to be used as preventative measures, or at least as early intervention.

Education

Education is an important aspect of providing holistic healthcare. The education process aims to empower the individual with the knowledge to make decisions about their lifestyle and choices that will support their health. Education about ways to improve health through lifestyle changes can be a delicate topic for clinicians and young people, and should always be approached with sensitivity and collaboration. Simply providing information, resources, or links to more information is unlikely to change a young person's behaviour, but maintaining an empathic and non-judgemental approach, coaching, and guiding the young person to make healthier decisions is likely to have a greater impact.

A range of strategies and approaches are described in this section, which can incorporate education about health behaviours. Links to resources and other websites are provided as a reference point for clinicians looking for more information, or to share with young people directly. Education should form the start of the young person's engagement in the interventions described below as it is unlikely to have any effect if used as a stand-alone intervention.

Shared decision-making

Shared decision-making is an approach to clinical practice that involves the clinician and the patient working together to understand the best available evidence for treatment of a problem or condition, and collaboratively working through the options to work towards implementing the preferred options for the patient (Elwyn, Frosch, Thomson, et al. 2012). Young people should and must be collaboratively involved in decisions and discussions about the risks and benefits of treatment, especially medication. Shared decision-making promotes engagement in the therapeutic process, and can increase satisfaction in treatment decisions for both the clinician and young person.

For more information on shared decision-making and how to embed it in your practice, please refer to Orygen's clinical practice point Shared decision-making and Orygen's Evidence summary: shared decision-making for mental health.

Sexual and reproductive health

Young people with mental health problems are likely to experience greater barriers in accessing appropriate sexual and reproductive healthcare. Young people who are already engaged with health and welfare agencies should be actively supported to access, attend, and receive care from general practitioners or appropriate sexual healthcare specialists.

Young people need to be supported to access accurate information and advice about sexual and reproductive health, including:

- General sexual health, puberty, and normal development
- Prevention, including human papilloma virus (HPV) vaccination
- Sexual health screening, including cervical screening and testing for sexually transmitted infections (STIs) and bloodborne viruses (BBVs)
- Prevention of STIs and BBVs
- Access to emergency contraception
- Contraception, including oral contraception and long-acting reversible contraception
- Pregnancy and abortion
- How and where to access health services.

There are a range of websites and services around Australia dedicated to sexual and reproductive healthcare. For example, Family Planning Victoria have a range of resources for professionals and communities on sexual and reproductive health

Family planning and prevention of sexually transmitted infections and bloodborne viruses

As mentioned earlier, young people presenting with mental health problems and substance use are more likely to engage in more risky sexual behaviours than their peers, placing them at higher risk of contracting STIs and BBVs. It is important to raise the possible outcomes of unprotected sexual interactions as part of the overall treatment and engagement with services.

Sexually transmitted infections are common in young people. In particular, ABS data from 2011 indicated that rates of chlamydia were highest in young women aged 15–19 and 20–24, and had increased significantly over the past 10 years, with the overall rate for young people

tripling over the same time period (ABS 2011). Similarly, other infections, such as syphilis and gonorrhoea, have increased over the past 10 years (ABS 2011). Left untreated, these conditions can cause long-term complications for reproductive and general health.

Support young people to access screening and treatment for STIs, and to proactively discuss safe sexual health practices, such as using condoms. The Third National Sexually Transmissible Infections Strategy 2014–2017 outlines Australia's priority populations and recommends actions for the reduction of sexually transmitted infections and viruses.

Having discussions about preventing unplanned pregnancy

In addition to the prevention of infections and viruses, young people should be involved in discussions about preventing unplanned pregnancy. Although these discussions are usually targeted towards young women, young men must also be educated about their responsibility in using barrier contraceptive methods, such as condoms. Remember that both young men and young women may benefit from accessing perinatal and postnatal mental health support in the case of an unplanned pregnancy. For guidance on best practice in perinatal health, beyondblue has produced a number of resources for pregnancy, maternal mental health, and wellbeing.

Using shared decision-making to discuss potentially harmful side effects

Conception and pregnancy can be a positive time for young people but can also present challenges including isolation and lack of understanding from friends and family, health complications, financial pressures, and emotional distress; these may negatively impact on mental health. In addition, many psychotropic medications may have rare but harmful effects on a developing foetus, including malformation, neonatal toxicity, longer term neurobehavioral effects, and increased risk of physical health problems in adult life (Taylor, Paton & Kapur 2015).

Although there are a range of other risk factors in pregnancy, and psychotropic medication only accounts for a small proportion, it is important to discuss these risks with young women in particular during their treatment (Taylor, Paton & Kapur 2015).

Using a shared decision-making approach in discussing treatments with potentially harmful side effects can be a useful way of deciding which treatments are acceptable for the young person.

For more information on shared decision-making and how to embed it in your practice, please refer to Orygen's clinical practice point Shared decision-making and Orygen's Evidence summary: shared decision-making for mental health.

Sexual safety and consent

Young people need access to clear information about the legal boundaries of sex to help them decide for themselves whether they want to engage in sexual activity and to protect people who may be vulnerable. Help young people find information that is relevant and accurate for their circumstances. Young people are unlikely to be aware of legislation in relation to sexual interactions they may be faced with, so it is important to raise these issues with young people, point them in the direction of reliable information, and discuss this information together to ensure they understand.

The sexual health service website links provided in the Resources section are a good starting point. Many of these sites have related links to legal information, such as Victoria Legal Aid, that provide more in-depth information.

Please note that this content is not intended to provide a best-practice guide on how to discuss sexual safety and consent with young people and how to respond if a young person working with you has experienced sexual victimisation or perpetrated sexual assault. Comprehensively covering these issues is beyond the scope of this resource. Clinicians are strongly encouraged to seek further training in this area, to work within the bounds of their professional competency, and to refer on to specialised services as required. All health professionals also need to ensure that they are working within the ethical and professional guidelines of their profession and that they are familiar with the laws related to these issues.

Gender diversity

The World Health Organization defines gender as 'the result of socially constructed ideas about the behaviour, actions, and roles a particular sex performs. The beliefs, values and attitudes taken up and exhibited by them is as per the agreeable norms of the society'.

Language in the gender diverse community is constantly changing. Though there are accepted meanings, we have to respect that all terms will mean something unique and specific to the person using them. There are also a large number of culturally distinct terms that are used and should be respected. Generally speaking, it is useful to ask which terms young people may prefer, as well as the pronouns they use (e.g. 'he/him/his', 'they/them'), and respect their choices. For more information regarding gender identity, refer to these online resources:

- Rainbow Network
- The Gender Centre
- trans101

Clinicians should ask young people how they want to be referred to and not presume – they may choose a traditionally male or female pronoun, but equally they may choose a neutral one, such as 'they/them'. Clinicians then have a responsibility to advocate for the young person to ensure that other professionals and peers are also respecting the young person's wishes.

Labels

Many people do not feel the need to have a label to express or explain their sexuality or gender identity. There is debate that sexuality and gender identity is not fixed and is malleable throughout life. So it may be helpful to refrain from labelling young people in terms of their sexuality and gender identity.

> "It is always important to do some research, there is a lot of stuff out there. If someone says something and you don't know what it means, Google is your friend, if you don't have time to do that, you can ask. It is really important to ask, 'Hey, what does that mean?'
>
> Young person

All professionals working with young people are placed well to reduce social and organisational barriers by appropriately engaging LGBTQ young people, which can only enhance the identity and coping strategies of a young person coming to terms with their sexual or gender identity. It is also crucial to explore if anything has changed for young people and to establish particularly if risk behaviour has changed in any way. All young people have the right to feel safe in expressing their sexual and gender identity and talking about any issues. They also have the right to feel safe from acts that compromise or breach their sexual safety.

Sexual health and promoting healthy conversations about sex, sexuality, and gender diversity can be part of the recovery process of mental ill-health. Some practical ways to ensure you promote sexual health in your organisation include:

- Ask the young people you work with how comfortable they are speaking about sexuality with you. They may be waiting for reassurance that it is okay to talk about it.
- Be aware of your limitations and own cultural beliefs and values – make sure you regularly get supervision and support.
- Engagement and psychoeducation about sexual health are an ongoing part of assessment and treatment.
- Consider keeping a checklist of any assessments or conversations you have with young people in regard to their sexual health, and any screening tests that have been required. This will not only aid treatment but will save the young person being asked about sensitive issues twice.
- Sexual health screening should be routinely discussed. Consider helping young people to access and attend services for sexual health screening.
- If a young person is taking sexual risks, use a non-judgemental approach to try to change thoughts regarding risky behaviour.
- If appropriate, peer support can be helpful.
- Don't presume to know a young person's sexual identity, sexual attraction, or gender identity. Always ask who they are attracted to, ask how they identity themselves, and, if appropriate, which pronouns they prefer. Most young people are happy to answer questions provided you tell them why you are asking.
- Give young people the power to refuse to answer questions.
- Advocate for young people and explore what LGBTQ support services or groups are available in the local community.
- Discuss confidentiality from the beginning. Ensure that the young person knows what is confidential and when you may have to break that confidence (e.g. if they or someone one else is at risk of sexual harm or exploitation).
- Cultural background must be considered when discussing sex or sexuality with young people.
- Don't assume that young people need to focus on sexuality as part of their therapy, and avoid pathologising a young person's sexuality or preferences.

Legal issues for young people

A more comprehensive guide about common legal issues for young people in Victoria can be found on the Victoria Legal Aid website. Each state and territory has different legislation in relation to young people and sex, and it is recommended that you seek similar resources in relation to your own state or territory legislation.

Consent

In relation to consent, Family Planning Victoria has a short video explaining consent, which may be useful for practitioners who are looking for a way to open up the conversation with young people they are working with.

Positive cardiometabolic health

Simply providing advice on increasing physical activity or changing other lifestyle factors does not work. The interventions discussed below are likely to be ineffective if they are provided as education to the individual. A tailored and proactive approach to addressing these issues is needed for young people with mental health problems to succeed in preventing chronic physical health issues in the future.

Physical activity

Physical activity, and its structured subset exercise, is important for the health, growth, and development in young people and adults. Physical activity and exercise play a key role in minimising cardiometabolic risk factors in people with serious mental ill-health (Vancampfort, Knapen, De Hert, et al. 2009). Australia's Physical Activity and Sedentary Behaviour Guidelines suggest the following:

Ages 13–17 years

- At least 60 mins moderate to vigorous exercise per day.
- Muscle and bone strengthening activities three times per week.
- Reduce screen/TV and sitting time and engage in more activity – up to several hours per day.

Resources

- Fact sheet: Australia's Physical Activity and Sedentary Behaviour Guidelines (ages 13–17 years)
- Tips and ideas for incorporating physical activity in young people's lived (ages 13–17 years)

Ages 18+ years

- 30 mins moderate exercise on most, preferably all, days
- 150–300 mins moderate or 75–150 mins vigorous intensity each week
- Muscle strengthening activities two times a week
- Minimise prolonged periods of sitting

Resources

- Fact sheet: Australia's Physical Activity and Sedentary Behaviour Guidelines (ages 18–64 years)
- Tips and ideas for incorporating physical activity in young people's lived (ages 18–64 years)

Challenges of implementing physical heath interventions

The challenge of implementing physical heath interventions into routine care of young people with mental health problems continues. Managing this issue effectively is likely to require a combination of strategies targeting the condition itself, as well as the systemic issues of service fragmentation and delivery (Docherty, Stubbs & Gaughran 2016).

Health services and primary care providers rarely have the facilities or resources to set up specific programs to address this issue, however, a recent review of integrated physical activity interventions in Australian mental health settings suggested six key components were needed for effective implementation, which included (Lederman, Suetani, Stanton, et al. 2017):

- early intervention
- regular and routine metabolic monitoring
- a multidisciplinary approach
- incorporation of behaviour-change strategies
- individualised approach to counselling
- exercise programs and professional supervision.

Furthermore, personalised interventions with multiple components, frequent face-to-face contact, and trained treatment providers are associated with best outcomes (Ward, White, Druss, et al. 2015). There is a key role for mental health service providers and primary care providers to work together to facilitate access to services, engagement with treatment plans, and referral and engagement with allied professionals, such as accredited exercise physiologists to improve the physical activity engagement of young people with mental health problems (Docherty, Stubbs & Gaughran 2016).

Diet

There is evidence to suggest poor diet is a modifiable risk factor for poor physical health outcomes (Scanlon, et al. 2015). Food choices can be discussed in a non-judgemental way that utilises a curious, Socratic questioning style, which is likely to be more helpful in uncovering opportunities for change.

Following a diet or weight-centric approach might be unhelpful to some young people because it could lead to patterns of shame or guilt around food. Concerns regarding costs of a healthy diet may arise, however Australian research has shown that people who follow a Mediterranean diet spent less money (Opie, et al. 2015).

It may be helpful to consider initially setting the scene and normalising a conversation around diet using a motivational interviewing approach, exploring the link between mood and food. Food diaries can assist the

young person to start to look at patterns of food and mood and avoid talking about weight gain, focusing instead on the impact of food on health. It's important to be mindful of disordered eating patterns and avoid young people feeling pressured to follow diets or to reduce food intake. Instead, talk about how healthier options can assist in managing hunger and energy levels.

Hunger cues are also difficult to tune into and it is easy to fail to notice hunger cues and then become so hungry we also miss fullness cues (Teasdale, Samaras, Wade, et al. 2017). Talking about fullness and hunger cues with young people and encouraging them to tune into the more subtle signs in their body and act on these signs may be helpful. Many young people also lack the skills required to plan and prepare meals independently. Supporting the development of these skills may also reduce reliance on convenience meals, and improve overall diet quality (Teasdale, Samaras, Wade, et al. 2017).

Individual dietetic consultation and nutrition counselling is considered the gold-standard intervention for people experiencing mental ill-health, as is the case for the majority of populations (Teasdale, Samaras, Wade, et al. 2017). Young people who are experiencing early warning signs of metabolic risk (such as weight gain), should be supported to access the expertise of a dietitian.

The guidelines below are presented to assist clinicians to determine whether a young person they are working with would benefit from further intervention. Please note that this content is not intended to provide a best-practice guide on how to intervene in diet or weight, and comprehensively covering these issues is beyond the scope of this resource. Clinicians are strongly encouraged to seek further training in this area, to work within the bounds of their professional competency, and to refer on to specialised services as required.

Australian Dietary Guidelines

The Australian Dietary Guidelines are the same for 2–18 years and 18+ except for:

- reduced fat diets are not recommended for children under 2-years-old
- adults guidelines include advice on alcohol intake.

The guidelines recommend enjoying a wide variety of these foods daily:

- vegetables (various types and colours)
- legumes and beans
- fruit
- grain (cereal) foods, mostly wholegrain and high fibre
- lean meats, poultry, fish, eggs, and tofu
- nuts and seeds
- milk, yoghurt, cheese and/or alternatives, mostly reduced fat
- drink plenty of water
- limit intake of foods containing saturated fat, added salt, added sugars, and alcohol.

Refer to the 'Healthy eating' section on the Heart Foundation website for more information about food and nutrition, food labels, and healthy recipes.

The Dietitians Association of Australia also provides easy-to-read and understandable resources on healthy eating, eating for weight management, and advice for children and young people.

Tobacco, alcohol, and other substances

Use of tobacco, alcohol, and other drugs frequently coincide with mental health difficulties. Often, tobacco and alcohol consumption can be overlooked in treatment, especially if the young person is presenting with serious mental health difficulties.

Tobacco

Tobacco is often overlooked as a health risk in young people presenting with mental health issues. Mental health clinicians may instead focus on illicit substances and alcohol because of their more obvious impacts on mental wellbeing and recovery, however, all people who are currently smoking should be offered assistance with quitting. Young people are likely to feel more comfortable engaging with technology, and there are a number of mobile phone apps that can be useful in helping young people think through their tobacco use or provide support to quit. For more information go to the Quit Now website.

Alcohol

Many young people will at some stage drink alcohol to levels that are harmful to their health. A large Danish study investigating premature mortality in people recently discharged from psychiatric inpatient care found that the people were at highest risk of death by suicide, followed by alcohol-related death (Walter, Carr, Mok, et al. 2017). For more information, refer to the guidelines for consuming alcohol and reducing related health risks developed by the National Health and Medical Research Council.

Other substance use

Not only do illicit substances affect mental state, they can also impact on nutrition, weight, dental health, and increase risk of exposure to a host of other diseases and infections. Young people should be supported to discuss their substance use, ways to minimise or reduce the harm associated with using, and be offered continual support to cease their use. NB: the interventions described in the 'Psychological approaches' below can use used to address substance use as well as other lifestyle factors.

We know that one of the key predictors of early mortality among young people with mental ill-health is substance use (Walter, Carr, Mok, et al. 2017). Early intervention for problematic substance use is a particularly important intervention in providing holistic healthcare to this group, however, as this treatment guide focuses on cardiometabolic health and sexual health, substance use interventions and best practice in managing the significant physical health and early mortality risks associated with substance use are not covered.

To support discussions around substance use, refer to Harm Reduction Victoria's range of resources for specific substance use harm reduction strategies.

Psychological approaches

A range of psychological approaches can be modified to assist young people to make changes to their lifestyle. An overview of some of these approaches is outlined below, however, a full review is beyond the scope of this resource. Clinicians are strongly encouraged to seek further training in this area, to work within the bounds of their professional competency, and to refer on to specialised services as required.

Motivational interviewing

Conversations about change happen every day (Miller & Rollnick 2012). We ask things of each other and are attuned to the discrete aspects of natural language that signal reluctance, willingness, and commitment. Motivational interviewing (MI) involves attention to natural language about change with implications for how to have more affective conversations, particularly in contexts where one person is acting as a helping professional (Miller & Rollnick 2012).

Conversations about changing aspects of a young person's diet or activity routine with the intention of improvement in mental and physical health can be challenging. No-one likes to be 'told' we should be changing our diet or going to the gym, and added to the natural resistance to being advised on how to improve our physical health, we also have to consider that young people are possibly given a lot of instruction (or are rebelling against instruction) in other areas of their lives.

Four key processes in MI

The four key processes in MI are briefly described below:

- **Engaging** is the process of establishing a helpful connection and a working relationship.
- **Focusing** is the process by which you develop and maintain specific direction in the conversation about change.
- **Evoking** involves eliciting the young person's own motivation for change and lies at the heart of MI.
- **Planning** encompasses both developing commitment to change and formulating a concrete plan of action.

Five key skills in MI

Five key skills used in motivational interviewing are:

- Asking open questions
- Affirming
- Reflecting
- Summarising
- Providing information.

Aims of MI

The key aims of motivational interviewing are to:

- talk about change in behaviours and bring this into the young person's awareness
- develop some discrepancy between the young person's goals or values and their current behaviour.

This approach is particularly helpful when the young person is ambivalent about change, or not wanting to change their behaviour. For example, if a young person is not interested in quitting, rather than discussing the downsides of smoking tobacco, it can be more helpful to discuss the benefits of smoking (from the young person's perspective) to open up a conversation about smoking in general. This can then be used as a way to understand the young person's experience and slowly open up a conversation about changing this behaviour, by drawing on the young person's values and beliefs in other areas of their life.

By addressing ambivalence in this way, clinicians roll with any resistance and keep the conversation about change going, rather than go into battle about those things the young person doesn't want to address immediately. Some other examples are provided below:

- Validating the young person's experience
  'You are telling me that you are thinking about exercising but you aren't ready to do this right now, have I got this right?'

- Acknowledge the young person is in control
  'It is up to you if you decide if and when you are ready to do this.'
- Clarify the young person's perspective of the pros and cons (cost/benefit analysis) of lifestyle changes
  'Let's have a go at writing this down and look at the pros and cons.'
- Encourage further self-exploration
  'Think about it at home this week and let's talk about it more next week – there is no rush.'
- Restate your position
  'This is totally up to you to decide. I am here to support you to make your own decisions.'
- Leave the door open to move into preparation phase
  'If you decide you want to look at changing some of the aspects of your lifestyle, we won't just jump in, we will plan it together.'

If a young person makes the decision that they want to make some lifestyle changes and acknowledges that change may be helpful for them, it is important to plan the next phase carefully.

- Reinforce the decision and give praise that they have come to the decision independently
  'It is fantastic that you feel good about your decision, you are making huge steps to improve your physical and mental health.'
- Prioritise opportunities to try out the new behaviour
  'Maybe it would be a good idea to spend half an hour building up your activity levels and being outside walking is a great start.'
- Identify barriers and obstacles
  'Have you tried this before? How did it go? What helped or didn't help? How could you deal with that now?'
- Consider small steps
  'So, initially you are going to be outside for half an hour, three times a week walking your dog?'
- Get support from friends and family where possible
  'Do you think your sister will walk with you at first, or can you ask a friend?'

Monitoring progress in MI

Progress can be monitored using the same approach throughout sessions and being mindful of where the young person is on the cycle of change. Refer to Orygen's Evidence summary: effectiveness of MI for young people engaging in problematic substance use. Additional resources for general practitioners and other health professionals can be found in the 'Resources' section.

Behavioural Activation

Behavioural Activation (BA) is an intervention based on the work by Martell, Addis and Jacobson (2001). It is primarily a behavioural intervention focusing on the link between activity and mood. Depression is associated with a lack of active, enjoyable activity, and improvements in mood have been associated with increased engagement in such activity.

Behavioural activation involves encouraging a young person to engage in behaviour that is reinforcing, enjoyable, and will enhance senses of mastery, accomplishment, and self-esteem (Martell, Addis & Jacobson 2001). The loss of pleasure, energy, or motivation that occurs from depression can cause a young person to cease previously enjoyable activities, such as getting together with friends, participating in sports, or enjoying hobbies. This in turn can worsen the symptoms of depression. For example, if a young person continues to turn down invitations to go out, friends may stop calling and the young person may then feel abandoned, and have more time to ruminate and feel sad. Lack of activity can also worsen problems with loss of energy, leading to increased fatigue and oversleeping.

Aims of a behavioural activation

- Structured, brief psychosocial approach.
- Works on the premise that problems in vulnerable individuals' lives and behavioural responses reduce ability to experience positive reward from their environments.
- Aims to systematically increase activation so as to experience greater contact with sources of reward in their lives and solve life problems.
- Focuses directly on activation and on processes that inhibit activation, such as escape and avoidance behaviours and ruminative thinking.
- Enhance mastery, accomplishment, and self-esteem via action.
- Counters avoidance, withdrawal, and inactivity.
- Provides possibility to experience positive emotions and positive reinforcement.
- Assess current and previously enjoyed activities.

Treatment overview

1. Establish therapeutic relationship and present model of behavioural activation. Use a psychoeducation framework to socialise the young person to the model, specifically looking at links between mood and activity.
2. Goal setting (using a values assessment).
3. Monitor relationship between situation/behaviour and mood using activity logs and functional analysis.

4. Apply new coping strategies consistent with life goals.
5. Treatment review and relapse preventions.

Components of the BA model

Monitor the relationship between situation, behaviour, and mood using activity logs, charts, or apps. Initially, review this retrospectively, but look to the young person seeing the value in the intervention and becoming able to make these links independently. Ask questions such as:

- 'You went to your friend's house on Friday night and played video games, how did you feel?'
- 'You stayed in bed all day on Sunday, how did you feel at the end of the day?'

Discuss avoidance as an adaptive function in the short term, however, in the long term it maintains low mood and prevents addressing the actual triggers to avoidance. It is also important to follow an activity plan rather than basing activity levels on how we feel. A graded task approach based on functional analysis and goals starts off with small tasks and builds up the scale of each task. This reinforces mastery and success over time by helping the young person become more confident in completing tasks.

Target rumination and treat it as a behaviour

Young people who are struggling with their mental health often ruminate about symptoms and find it difficult to problem solve. Rumination often leads to withdrawal, inactivity, and ultimately more rumination. It may be positively or negatively reinforced by others. Behavioural activation treats rumination as a behaviour, rather than engaging or challenging the content of ruminative thoughts.

Block avoidance function of rumination

Ask young people to pay attention to the experience of rumination and try to break rumination by noticing other external factors, such as colours, smells, noises, and other things going on around them.

Cognitive strategies and approaches

Similar to motivational interviewing techniques, cognitive approaches adopt key principles to enhance the motivation of patients to address behavioural changes (Wilson & Schlam 2004).

Such strategies and approaches can include:

- Conceptualisation of motivation as a dynamic entity and as a function of personal, cognitive, behavioural, and environmental determinants.
- A collaborative therapeutic framework as opposed to a confrontational approach.
- Validating experience within the framework of a balance between acceptance and change, firmness, and empathy.
- Exploring the functional analysis of pros and cons of a belief or behaviour because change seems facilitated by communicating in a way that elicits the person's own reasons for the advantages of change.
- Resistance with confrontation is not involved but with a collaborative evaluation of the variables maintaining the dysfunctional behaviour
- The self-efficacy of young people is addressed.

Using cognitive frameworks in physical health interventions

Using a cognitive framework for addressing and discussing physical health interventions would include:

- Psychoeducation around the benefit of the intervention. For example, around exercise and physical activity, and the information available presented in a way that the young person understands and feels able to ask questions and retain the information.
- ABC formulation or Five-step formulation to start to establish links between mood, thoughts and activity (see 'Resources').
- Goal setting
- Activity monitoring and activity scheduling.
- Pinpoint the goal by focusing on physical health interventions. Explore how the young person can work towards this goal and how they will know if they have achieved it.
- Introduce negative automatic thoughts and look for links to activity levels. Support the young person to be able to identify their own negative thoughts around physical health and activity.
- Use thought diaries and practice with the young person how to complete them to ensure they are confident in doing this out of session. Talk about apps that may be appropriate as an alternative to paper records.
- Review thought records and discuss change in mood, link to increase activity levels.

This is a brief overview of psychological approaches and not intended as a comprehensive guide. Clinicians should seek further training in each of these areas and others to effectively implement the interventions and apply them to aspects of physical health. Clinicians are encouraged to use these interventions under the supervision of an experienced therapist.

Resources

Resources for young people

Sexual health

NSW – Family Planning

ACT – Sexual Health and Family Planning

NT – Family Planning Welfare Association

QLD – True: Relationships and Reproductive Health

SA – SHINE (sexual health education & early intervention)

WA – Sexual Health Quarters

Vic. – Family Planning Victoria

Understanding sex: risks, health and contraception – headspace

YEAH Sexual Health Promotion – Red Aware

Gender diversity and identity

The Gender Centre

trans101

Gender identity and mental health – headspace

Perinatal depression and anxiety

PANDA – Perinatal Anxiety & Depression Australia

Consent

Sex and Young People: What Does the Law Say

Lifestyle interventions

CCI – Centre for Clinical interventions

Physical health

Getting help from a general practitioner – headspace

Sleep

Sleep fact sheet – headspace

Practitioner resources

Physical health resources

HeAL declaration

Australian Dietary Guidelines – Eat for Health

Department of Health – Australian Government

Australian Government guidelines for physical activity (13–17 years)

Australian Government guidelines for physical health (18–64 years)

World Heart Federation

Positive cardiometabolic health algorithms

The Eat Well Guide (UK)

Physical Activity Guidelines for Young People

Physical health of young people with a mental illness – Orygen

Sexual Health and youth mental health – Orygen

Sexual health and youth mental health: interventions and case studies – Orygen

Motivational interviewing for lifestyle changes

Motivational interviewing techniques – RACGP

Encouraging Patients to Change Unhealthy Behaviours with Motivational Interviewing – AAFP

Sexual health resources

Sexual health and youth mental health – Orygen

Sexual health and youth mental health: interventions and case studies – Orygen

NSW – Family Planning

ACT – Sexual Health and Family Planning

NT – Family Planning Welfare Association

QLD – True: Relationships and Reproductive Health

SA – SHINE (sexual health education & early intervention)

WA – Sexual Health Quarters

Vic. – Family Planning Victoria

Understanding sex: risks, health and contraception – headspace

YEAH Sexual Health Promotion – Red Aware

Australian STI management guidelines

Melbourne sexual health centre Treatment guidelines

Centre of excellence for Transgender Health

Adolescent Relationships Evidence Summary

LGBTI Health Cultural Competency Implementation Framework

Clinical practice in early psychosis: Promoting sexual health – Orygen

Gender and sexual diversity and inclusion

Writing themselves in 3: The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people – Australian Research Centre in Sex, Health and Society, La Trobe University

References

1. ABS (Australian Bureau of Statistics) 2012, *Health: communicable diseases*, Australian Bureau of Statistics, viewed 6 July 2017, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Communicable%20diseases~232>.
2. ABS (Australian Bureau of Statistics)2011-2012, Australian Health Survey: Physical Activity, viewed 20th July, 2017 http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.004Chapter1002011-12
3. Ackard, D, Eisenberg, M, Neumark-Sztainer, D 2007, 'Long-term Impact of Adolescent Dating Violence on the Behavioral and Psychological Health of Male and Female Youth', *Journal of Paediatrics,* vol. 151, no. 5, pp. 476–481.
4. Álvarez-Jiménez, M, González-Blanch, C, Vázquez-Barquero, JL, Pérez-Iglesias, R, Martínez-García, O, Pérez-Pardal, T, ... & Crespo-Facorro, B 2006, 'Attenuation of antipsychotic-induced weight gain with early behavioural intervention in drug-naive first-episode psychosis patients: A randomized controlled trial', *The Journal of Clinical Psychiatry*, vol. 67, no. 8, pp. 1253–1260.
5. Archer, J 2000, 'Sex differences in aggression between heterosexual partners: A meta-analytic review', *Psychological Bulletin*, vol. 126, no. 5, pp. 651–680, doi:10.1037/0033-2909.126.5.651.
6. Bayard, V, Cross C 2008, 'Consequences of Teen Dating Violence: Understanding Intervening Variables in Ecological Context', *Journal of Violence against Women*, vol. 14, no. 9, pp. 998–1013.
7. Beebe, LH, Tian, L, Morris, N, et al. 2005, 'Effects of exercise on mental and physical health parameters of persons with schizophrenia', *Issues in Mental Health Nursing*, vol. 26, pp. 661–76.
8. Boyle, FM, Cook, MD, Purdie, DM, Najman, JM & Dunne, MP 2003, 'Sexual dysfunction in the Australian population', *Australian Family Physician*, vol. 32, no. 11, pp. 951–4.
9. Bhui, K, Puffet, A & Strathdee, G 1997, 'Sexual and relationship problems amongst patients with severe chronic psychoses', *Social Psychiatry and Psychiatric Epidemiology*, vol. 32, pp. 459–67.
10. Bonierbale, M, Lancon, C & Tignol, J 2003, 'The ELIXIR study: evaluation of sexual dysfunction in 4557 depressed patients in France', *Current Medical Research and Opinion*, vol. 19, pp. 114–24.
11. Bossini, L, Fagiolini, A, Valdagno, M, Polizzotto, NR & Castrogiovanni, P 2007, 'Sexual disorders in subjects treated for mood and anxiety diseases', *Journal of Clinical Psychopharmacology*, vol. 27, pp. 310–2.
12. Bray, L, McKenna, J, Sanders, C, Pritchard, E 2012, 'Discussing sexual and relationship health with young people in an acute children's hospital', *Journal of Research in Nursing,* vol. 17, pp. 231–242, doi:10.1177/1744987110383356.
13. Brown, LK, Hadley, W, Stewart, A, Lescano, C, Whiteley, L, Donenberg, G & DiClemente, R 2010, 'Psychiatric disorders and sexual risk among adolescents in mental health treatment', *Journal of Consulting and Clinical Psychology*, vol. 78, no. 4, pp. 590–97, doi:10.1037/a0019632.
14. Casper, RC, Redmond, DE, Katz, MM, Schaffer, CB, Davis, JM & Koslow, SH 1985, 'Somatic symptoms in primary affective disorder. Presence and relationship to the classification of depression', *Archives of General Psychiatry*, vol. 42, pp. 1098–104.
15. Chen, CH, Lin, YC, Chiu, LH, Chu, YH, Ruan, FF, Liu, WM Wang, PH 2013, 'Female sexual dysfunction: Definition, classification, and debates', *Taiwanese Journal of Obstetrics and Gynaecology*, vol. 52, no. 1, pp. 3–7.
16. Chesney, E, Goodwin, GM, Fazel S 2014, 'Risks of all-cause and suicide mortality in mental disorders: a meta-review', *World Psychiatry,* vol. 13. pp. 153–60
17. Clayton, AH & Balon 2009, 'The impact of mental illness and psychotropic medications on sexual functioning: the evidence and management', *The Journal of Medicine*, vol. 6, pp. 1200–11.
18. Clayton, AH, McGarvey, EL & Clavet, GJ 1997, 'The Changes in Sexual Functioning Questionnaire (CSFQ): Development, reliability, and validity', *Psychopharmacology Bulletin,* vol. 33, pp. 731–45.
19. Clayton, AH, Pradko, JF, Croft, HA, Montano, CB, Leadbetter, RA, Bolden-Watson, C, Bass, KI, Donahue, RM, Jamerson, BD & Metz, A 2002, 'Prevalence of sexual dysfunction among newer antidepressants', *Journal of Clinical Psychiatry*, vol. 63, pp. 357–66.
20. Correll, CU, Detraux, J, Lepeleire, JD, De Hert, M 2015, 'Effects of antipsychotics, antidepressants and mood stabilisers on risk for physical diseases in people with schizophrenia, depression and bipolar disorder', *World Psychiatry,* vol. 14, no. 2, pp. 119–136, doi:10.1002/wps.20204.
21. Commonwealth of Australia 2014, *Third National Sexually Transmissible Infections Strategy 2014–2017*, Australian Government Department of Health, viewed 6 July 2017, <http://www.health.gov.au/internet/main/publishing.nsf/content/ohp-bbvs-sti>.
22. Curtis, J, Watkins, A, Rosenbaum, S, et al. 2015, 'Evaluating an individualised lifestyle and life skills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis', *Early Intervention in Psychiatry*, published online 26 February 2015, doi:10.1111/eip.12230.
23. Cutter-Wilson, E, Richmond, T 2011, 'Understanding teen dating violence: practical screening and intervention strategies for paediatric and adolescent healthcare providers', *Current Opinion in Paediatrics*, vol. 23, pp. 379–383, doi:10.1097/MOP.0b013e32834875d5.
24. Cyranowski, JM, Frank, E, Cherry, C, Houck, P & Kupfer, DJ 2004, 'Prospective assessment of sexual function in women treated for recurrent major depression', *Journal of Psychiatric Research,* vol. 38, pp. 267–73.
25. Dalle Grave, R, Calugi, S, Centis, E, El Ghoch, M & Marchesini, G 2010, 'Cognitive-behavioural strategies to increase the adherence to exercise in the management of obesity', *Journal of Obesity*.
26. Docherty, M, Stubbs, B & Gaughran, F 2016, 'Strategies to deal with comorbid physical illness in psychosis', *Epidemiology and Psychiatric Sciences,* vol. 25, no. 3, pp. 197–204, doi:1017/S2045796016000056.
27. Dyer, K & das Nair, R 2012, 'Why Don't Healthcare Professionals Talk About Sex? A Systematic Review of Recent Qualitative Studies Conducted in the United Kingdom,' *The Journal of Sexual Medicine*, vol. 10, no. 1, pp. 2658–2670, doi:10.1111/j.1743-6109.2012.02856.x.
28. Esan, OB, Kola, L & Gureje, O 2012, 'Mental disorders and earnings: results from the Nigerian National Survey of Mental Health and Well-Being (NSMHW)', *The Journal of Mental Health Policy and Economics*, vol. 15, no. 2, pp. 77–82.
29. Ellis, N, Crone, D, Davey, R, et al. 2007, 'Exercise interventions as an adjunct therapy for psychosis: a critical review', *British Journal of Clinical Psychiatry*, vol. 46, pp. 95–111.
30. Elwyn, G, Frosch, D, Thomson, R, Joseph-Williams, N, Lloyd, A, Kinnersley, P, ..., Barry, M 2012, 'Shared Decision Making: A Model for Clinical Practice', *Journal of General Internal Medicine*, vol. 27, no. 10, pp. 1361–1367, doi:10.1007/s11606-012-2077-6.
31. Exner-Cortens, D, Eckenrode, J & Rothman, E 2013, 'Longitudinal Associations Between Teen Dating Violence Victimisation and Adverse Health Outcomes', *Paediatrics*, vol. 131, no. 1, pp. 71–78.
32. Foley DL, MacKinnon A, Morgan VA, et al. 2014, 'Predictors of type 2 diabetes in a nationally representative sample of adults with psychosis', *World Psychiatry*, vol. 13, pp. 176–183.
33. Goyal, MK, Shea, JA, Hayes, KL, Badolato, G, Chamberlain, JM, Zaoutis, T & Fein, J 2016, 'Development of a Sexual Health Screening Tool for Adolescent Emergency Department Patients', *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine*, vol. 23, no. 7, pp. 809–815.
34. Haynie, DL, Farhat, T, Brooks-Russell, A, Wanf, J, Barbieri, B & Iannotti, R 2013, 'Dating Violence Perpetration and Victimisation among US Adolescents: Prevalence, Patterns, and Associations with Health Complaints and Substance Use', *Journal of Adolescent Health*, vol. 53, no. 2, pp. 194–201.
35. Helfrich C, Fujiura G, Rutkowski-Kmitta, V 2008, 'Mental Health Disorders and Functioning of Women in Domestic Violence Shelters', *Journal of Interpersonal Violence*, vol. 23, pp. 437–453.
36. Knight, RE, Shoveller, JA, Carson, AM & Contreras-Whitney, JG 2014, 'Examining clinicians' experiences providing sexual health services for LGBTQ youth: considering social and structural determinants of health in clinical practice', *Health Education Research*, vol. 29, no. 4, pp. 662–70.
37. Krahe, B, Tomaszewska, P, Kuyper, L & Vanwesenbeeck, I 2014, 'Prevalence of sexual aggression among young people in Europe: A review of the evidence from 27 EU countries', *Aggression and Violent Behaviour*, vol. 19, no. 5, pp. 545–558.
38. Laumann, EO, Paik, A & Rosen, RC 1999, 'Sexual dysfunction in the United States: prevalence and predictors', *The Journal of the American Medical Association*, vol. 281, pp. 537–44.
39. Lederman, O, Suetani, S, Stanton, R, Chapman, J, Korman, N, Rosenbaum, S, ..., Siskind, D 2017, 'Embedding exercise interventions as routine mental health care: Implementation strategies in residential, inpatient and community settings,' *Australasian Psychiatry,* doi:10.1177/1039856217711054.
40. Lee, EH, Hui, CL, Chang, WC, et al. 2013, 'Impact of physical activity on functioning of patient with first-episode psychosis – a six months prospective longitudinal study', *Schizophrenia Research*, vol. 150, pp. 538–41.
41. Lundgren, R, Amin, A 2015, 'Addressing Intimate Partner Violence and Sexual Violence Among Adolescents: Emerging Evidence of Effectiveness', *Journal of Adolescent Health*, vol. 56, pp. S42–S50, doi:10.1016/j.jadohealth.2014.08.012.
42. MacDonald, S, Halliday, J, MacEwan, T, Sharkey, V, Farrington, S, Wall, S & McCreadie, RG 2003, 'Nithsdale schizophrenia surveys 24: sexual dysfunction. Case-control study', *British Journal of Psychiatry,* vol. 182, pp. 50–56.
43. Malchow, B, Reich-Erkelenz, D, Oertel-Knochel V, et al. 2013, 'The effects of physical exercise in schizophrenia and affective disorders', *European Archives of Psychiatry and Clinical Neuroscience,* vol. 263, pp. 451–67.
44. Martell, CR, Addis, ME & Jacobson, NS 2001, *Depression in context: strategies for guided action*, W.W. Norton & Company, New York.
45. McCloughen, A, Foster, K, Huws-Thomas, M & Delgado, C 2012, 'Physical health and wellbeing of emerging and young adults with mental illness: An integrative review of international literature', *International Journal of Mental Health Nursing*, vol. 21, pp. 274–288.
46. Miller, WR & Rollnick, S 2012, *Motivational interviewing: helping people change*, Guilford Press, New York.
47. Mitchell, A, Patrick, K, Heywood, W, Blackman, P, Pitts M 2014, *5th National Survey of Australian Secondary Students and Sexual Health 2013*, ARCSHS Monograph Series no. 97, Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia.
48. Osvath, P, Fekete, S, Voros, V & Vitrai, J 2003, 'Sexual dysfunction among patients treated with antidepressants – a Hungarian retrospective study', *European Psychiatry*, vol. 18, pp. 412–14.
49. Orygen Youth Health Research Centre 2012, *Evidence Summary: Adolescent Romantic Relationships – Why are they important? And should they be encouraged or avoided?*, Orygen Youth Health Research Centre, Melbourne.
50. Physical Health Policy Writing Group 2016, *Physical challenge: wider health impacts for young people with a mental illness,* Orygen, The National Centre of Excellence in Youth Mental Health, Melbourne.
51. Park, YW, Kim, Y & Lee, JH 2012, 'Antipsychotic-Induced Sexual Dysfunction and Its Management', *The World Journal of Men's Health*, vol. 30, no. 3, pp. 153–159, doi:10.5534/wjmh.2012.30.3.153.
52. Parker, AG, Hetrick, SE, Jorm, AF, MacKinnon, AJ, Yung, AR, McGorry, PD, Yung, AR, Scanlan, F, Baird, S, Moller, B & Purcell, R 2016, 'The effectiveness of simple psychological and physical activity interventions for high prevalence mental health problems in young people: a factorial randomised controlled trial, *Journal of Affective Disorders*, vol. 196, pp. 200–9, doi:10.1016/j.jad.2016.02.043.

53. Parker, A, Hetrick, S & Purcell, R 2010, 'Psychosocial assessment of young people: Refining and evaluating a youth friendly assessment interview', *Australian Family Physician*, vol. 39, no. 8, pp. 585.
54. Purcell, R 2016, 'The effectiveness of simple psychological and physical activity interventions for high prevalence mental health problems in young people: A factorial randomised controlled trial', *Journal of Affective Disorders,* vol. 196, pp. 200–209.
55. Peuskens, J, Sienaert, P & De Hert, M 1998, 'Sexual dysfunction: the unspoken side effects of antipsychotics', *European Psychiatry*, vol. 13, pp. 23s–30s.
56. Ramrakha, S, Caspi, A, Dickson, N, Moffitt, TE & Paul, C 2000, 'Psychiatric disorders and risky sexual behaviour in young adulthood: cross sectional study in birth cohort', *British Medical Journal*, vol. 321, no. 7256, pp. 263–66.
57. Rickert, V, Davison, L, Breitbard, V, Jones, K, Palmetto, N, Rottenberg, L, Jini Tanenhaus, Stevens, L 2009, 'A Randomised Trial of Screening for Relationship Violence in Young Women', *Journal of Adolescent Health*, vol. 45, pp. 163–170.
58. Rosen, RC, Lane, RM, Menza, M 1999, 'Effects of SSRI's on sexual function: a critical review', *Journal of Clinical Psychopharmacology*, vol. 19, pp. 67–85.
59. Rosenbaum, S, Tiedemann, A, Sherrington, C, et al. 2014, 'Physical activity interventions for people with mental illness: a systematic review and meta-analysis', *The Journal of Clinical Psychiatry*, vol. 75, pp. 964–74.
60. Scheewe, TW, Backx, FJ, Takken, T, et al. 2013, 'Exercise therapy improves mental and physical health in schizophrenia: a randomised controlled trial', *Acta Psychiatrica Scandinavica*, vol. 127, pp. 464–73.
61. Silverman, J, Raj, A, Mucci, L, Hathaway, J 2001, 'Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behaviour, Pregnancy and Suicidality', *Journal of American Medical Association,* vol. 286, pp. 572–579.
62. Smith, AR, Chein, J & Steinberg, L 2014, 'Peers Increase Adolescent Risk Taking Even When the Probabilities of Negative Outcomes Are Known', *Developmental Psychology*, vol. 50, no. 5, pp. 1564–1568.
63. Stockl, H, March, L, Pallitto, C & Garcia-Moreno, C 2014, 'Intimate partner violence among adolescents and young women: prevalence and associated factors in nine countries: a cross-sectional study', *BMC Public Health*, vol. 14, pp. 751, doi: 10.1186/1471-2458-14-751.
64. Swahn, M, Simon, T, Hertz, M, Arias, I, Bossarte, R, Ross, J, Gross, L, Iachan, R, Hamburer, M 2008, 'Linking Dating Violence, Peer Violence, and Suicidal Behaviours Among High-Risk Youth', *American Journal of Preventative Medicine*, vol. 34, no. 1, pp. 30–38.
65. Taylor, D, Paton, C & Kapur, S 2015, *The Maudsley Prescribing Guidelines in Psychiatry*, John Wiley & Sons Incorporated, Ebook Central (ProQuest).
66. Teasdale, SB, Samaras, K, Wade, T, Jarman, R, Ward, PB 2017, 'A review of the nutritional challenges experienced by people living with severe mental illness: a role for dietitians in addressing physical health gaps', *Journal of Human Nutrition and Dietetics*, doi:10.1111/jhn.12473.
67. Vancampfort, D, Knapen, J, De Hert, M, et al. 2009, 'Cardiometabolic effects of physical activity interventions for people with schizophrenia', *Physical Therapy Reviews Journal*, vol. 14, pp. 388–398.
68. Vancampfort, D, Vansteelandt, K, Scheewe, T, et al. 2012, 'Yoga in schizophrenia: a systematic review of randomised controlled trials', *Acta Psychiatrica Scandinavica,* vol. 126, pp. 12–20.
69. Ward, MC, White, DT & Druss, BG 2015, 'A meta-review of lifestyle interventions for cardiovascular risk factors in the general medical population: lessons for individuals with serious mental illness', *The Journal of Clinical Psychiatry*, vol. 76, pp. e477–86.
70. Weinstock, H, Berman, S, Cates, W, Jr 2000, 'Sexually transmitted diseases among American youth: incidence and prevalence estimates', *Perspective Sex Reproductive Health,* vol. 36, pp. 6–10.
71. Williams, K & Reynolds MF 2006, 'Sexual dysfunction in major depression', *CNS Spectrums*, vol.11, no. 59, pp. 19–23, doi:10.1017/S1092852900026729.
72. Wilson, GT & Schlam, TR 2004, 'The trans-theoretical model and motivational interviewing in the treatment of eating and weight disorders', *Clinical Psychology Review*, vol. 24, no. 3, pp. 361–378.
73. Whiteside, LK, Walton, M, Stanley, R, Resko, S, Chermack, S, Zimmerman, M, Cunningham, R 2009, 'Dating Aggression and Risk Behaviours among Teenage Girls Seeking Gynaecologic Care', *Society for Academic Emergency Medicine*, vol. 16, no. 7, pp. 632–638.
74. Wolff, E, Gaudlitz, K, von Linderberger, BL, et al. 2011, 'Exercise and physical activity in mental disorders', *European Archives of Psychiatry and Clinical Neuroscience,* vol. 261, suppl. 2, pp. S186–91.
75. World Health Organization (WHO) 2014, 'Gender, women and health: What do we mean by "sex" and "gender"', viewed 7 July 2017, <https://www.legal-tools.org/doc/a33dc3/pdf/>.
76. Ybarra, ML & Mitchell, KJ 2013, 'Prevalence Rates of Male and Female Sexual Violence Perpetrators in a National Sample of Adolescents', *JAMA Paediatrics,* vol. 167, no. 12, pp. 1125–1134, doi:10.1001/jamapediatrics.2013.2629.
77. Zemishlany, Z & Weizman, A 2008, 'The impact of mental illness on sexual dysfunction', *Advances in Psychosomatic Medicine,* vol. 29, pp. 89–106.

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