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DEPRESSION IN YOUNG PEOPLE
A desktop guide for primary care health professionals
A summary of the Clinical Practice Guidelines:
Depression in adolescents and young adults

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1 Engaging with young people
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INTRODUCTION

Depression affects the lives of many young Australians. It can seriously lower quality of life for young people and their families, increases the risk of suicide, and often worsens the outcomes of other physical or mental health problems. Up to one in five adolescent girls and one in nine adolescent boys report having high levels of depression symptoms.

Many factors are associated with an increased risk of depression. Whether or not young people develop depression is influenced by the way they manage current challenges, which in turn is affected by their past experiences, personality, stage of development and social and cultural background. Young people who have been through difficult circumstances or feel marginalised by society are particularly at risk — this may include young people who are Aboriginal and Torres Strait Islander, are from a sexual minority and gender diverse group, have resettled in Australia under a refugee program, or are homeless or institutionalised.

Awareness of depression in young people has grown significantly over the past decade. However, depression is still not always identified and even when it is detected, young people may not receive the help they need to recover and stay well. Managing depression can be particularly hard for young people who have other mental or physical health problems, such as alcohol and drug problems, a disability or a chronic illness.

This Guide is based on Guidelines developed by beyondblue to assist health professionals in primary care to identify accurately and treat effectively depression among adolescents and young adults aged 13 to 24 years. This includes primary care health professionals who care for young people, such as general practitioners (GPs), psychologists, mental health nurses and other mental health professionals, nurses, community healthcare workers and Aboriginal and Torres Strait Islander health workers. The Guidelines are based on the best available current evidence where this exists, and on lower quality research and clinical expertise where it does not.

The approach to care outlined in this Guide places young people and their families and carers at the centre of care, wherever it is provided.

The information in this guide is derived from the beyondblue (2011) Clinical Practice Guidelines: Depression in adolescents and young adults. Melbourne: beyondblue

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OVERVIEW OF MENTAL HEALTH CARE FOR YOUNG PEOPLE

Young person makes contact with healthcare service

ENGAGEMENT (Section 1)
- Establish rapport
- Explain confidentiality
- Involve family/carer

INITIAL ASSESSMENT: CONTEXT (Section 2)
Identify strengths and risk and protective factors
Identify sociocultural factors

INITIAL ASSESSMENT: SYMPTOMS (Section 3)
- Conduct assessment interview
- Consider use of assessment tools
- Consider symptoms, other possible causes and co-occurring conditions
- Assess risk of suicide

Determine level and type of support needed (Section 4)

MAJOR DEPRESSIVE DISORDER

BIPOLAR DISORDER

INITIAL APPROACHES (Section 4)
Good clinical care, non-directive support, guided self-help

PSYCHOLOGICAL THERAPIES (Section 4)
Add CBT or IPT as first-line treatment (if available)

Psychological therapy effective

CONTINUING CARE (Section 5)
- Provide maintenance treatment
- Develop relapse prevention plan

Psychological therapy not effective or not available

PHARMACOLOGICAL TREATMENT (Section 4)
- Add fluoxetine*
- Recommend continued CBT
- Monitor for suicidal thinking

Notes: * If appropriately trained and seeking expert advice where necessary. CBT = cognitive behavioural therapy IPT = interpersonal psychotherapy.

KEY
- Discussion based on evidence from the SLR
- Discussion based on lower quality evidence, international guidelines and/or best practice clinical judgement

OUT OF DATE
ENGAGING WITH YOUNG PEOPLE

A supportive and collaborative relationship between health professionals, young people and their parents or carers is likely to provide a stable, accepting and supportive context within which treatment may take place. Best practice in establishing an effective therapeutic relationship is to ensure that services are youth-friendly and meet the needs of sociocultural groups within their community, and that health professionals have appropriate communication skills, are caring and respectful, and are able to gain young people’s trust.

PROVIDING YOUTH-FRIENDLY SERVICES

Regardless of their background or circumstances, young people are more likely to actively participate in their treatment in a setting where they feel comfortable and safe.

Health care facilities:
- provide a safe environment at a convenient location with an appealing ambience
- have convenient working hours
- offer privacy and avoid stigma
- have processes to ensure easy and confidential registration, retrieval and storage of records
- provide consultations for young people with or without an appointment and aim for short waiting times and (where necessary) swift referral.

Health care professionals:
- are trained and technically competent in youth-specific areas, and offer health promotion, prevention, treatment and care relevant to each young person’s level of maturity and social circumstances
- have good interpersonal and communication skills
- are motivated and supported
- are non-judgemental and considerate, easy to relate to and trustworthy
- devote adequate time to the young person’s needs
- act in the best interests of young people
- treat all people with equal care and respect
- provide information and support to enable each young person to make the right free choices for his or her unique needs.

Support staff:
- are understanding and considerate
- treat each young person with equal care and respect
- are competent, motivated and well supported.

Involvement:
- young people are well informed about services and their rights, encouraged to respect the rights of others, and involved in service assessment and provision
- community involvement promotes the value of health services and encourages parental and community support.

Health care provided:
- addresses each young person’s physical, social and psychological health and development needs
- makes available a comprehensive package of health care and referral to other relevant services
- does not include unnecessary procedures
- is guided by evidence-based protocols and guidelines.
ENSURING SERVICES RESPOND TO SOCIOCULTURAL NEEDS

To engage young people from a wide range of backgrounds, health services should ensure that they address the needs of sociocultural groups within their community. This includes:

- taking a ‘step-down’, non-expert position that encourages all young people to be open about their situation, whatever their background or circumstances
- acknowledging customs of the individual and family’s culture of origin
- understanding differences in inter-family relating (e.g. young person’s relationships with parents and with other authority figures) and the possibility of religious and spiritual factors
- having a basic knowledge about challenges facing young people who experience mental health problems at a disproportionate rate compared with their peers (e.g. Aboriginal and Torres Strait Islander youth, young people from a sexual minority and gender diverse group, refugee and homeless youth).

Factors that may assist in improving access to services for specific sociocultural groups

**Aboriginal and Torres Strait Islander youth**

- Employing Aboriginal and Torres Strait Islander staff as health workers, on reception and as liaison
- Ensuring cultural responsiveness of health professionals
- Providing culturally appropriate resources (including adaptation of materials for local use)
- Providing a culturally appropriate waiting room (e.g. culturally appropriate posters and artifacts)
- Disseminating information about services available within the health service
- Promoting intersectoral collaboration

**Youth from a sexual minority and gender diverse group**

- Educating staff about issues that may affect individuals from a sexual minority and gender diverse group and ways to facilitate staff-client communication
- Recommending procedures for confidentiality and for sexual minority and gender diverse inclusive documentation
- Developing and reviewing a directory of appropriate or specific counselling services, medical services and support groups to which young people can be referred as needed

**Refugee youth**

- Providing social support, for example through ethno-specific cultural liaison officers
- Ensuring cultural responsiveness among health professionals
- Providing education, including linguistically appropriate information
- Developing culturally appropriate resources, including resources in spoken format for young people who lack literacy in their own languages, and access to interpreter services during appointments

**Young people leaving foster care or who are homeless**

- Investigating ongoing developmental and financial support for young people leaving formal care
- Providing specific teams/centres for young people at risk of homelessness or who are homeless
## Establishing an Effective Therapeutic Relationship

At an individual level, health professionals engage with young people through a therapeutic relationship. Effective therapeutic relationships are likely to be particularly important in this age group, as young people may enter into therapy unaware of their problems, in conflict with their parents, and/or resistant to change.

Health professionals can assist development of the therapeutic relationship by:

- being aware that young people are unlikely to talk openly if they feel they are being judged or patronised
- using the different experiences and beliefs brought to the relationship by the young person and family to address any deficiencies in their own knowledge, as well as to gain insight about the seriousness of the symptoms and the young person's context
- considering creative approaches such as visual art, music, creative writing and journalling that are consistent with young people's usual experiences and may be perceived as less threatening than talking about their current challenges.

There should be open discussion with all those involved if it is proving difficult to establish an effective relationship with the young person and/or parents/carers. Consideration should be given to referring the family to an alternative health professional; however, this should never be done suddenly.

### Tips for fostering engagement with young people

- Explain confidentiality (see section 1.5).
- Speak to the young person directly, as well as to parents or carers (where appropriate).
- Treat the young person as responsible and capable of contributing to decision-making.
- Take a curious, non-intrusive and respectful stance.
- Be open and honest as much as possible.
- Clarify what the young person wants from you.
- Establish agreed goals or explain clearly why you cannot help.
- Balance talking about what the young person wants with what you think might help.
- Be honestly interested in what the young person has to say.
- Be yourself, don’t fake it.
- Use metaphor and humour (when appropriate) to build rapport.
- Use language that is clear and easily understood and avoid jargon; overuse of slang is probably worse than not using it at all.
- Check regularly that the young person has understood what you are saying.
- Provide information.
- Warn the young person if you are going to ask questions about topics that may be difficult (e.g. sexual matters).
- Be flexible; tailor what you do and how you do it to the situation.
- Avoid being judgemental by showing empathy and tolerance while still expressing concern for the young person’s safety or wellbeing.
- Avoid getting into a controlling, authoritarian position by explaining your concerns if and when they arise and the rationale behind your actions.
- Remember, engagement might wax and wane, and requires attention throughout the care of an individual.
PARENT/CARER INVOLVEMENT

In most cases it is beneficial to involve the young person's parents/carers in discussions about his or her care. However, the degree of involvement will depend on the young person's age, stage of development, wishes and circumstances.

Although the relationship between young people and their parents/carers changes during adolescence, people in this role remain influential in a young person's life. In younger adolescents, a therapeutic relationship with both the young person and parents/carers may support ongoing care. As the young person develops, there is less reliance on the parents/carers — when this occurs depends on the young person's maturity and his or her wishes. If a young person has an intellectual disability, parent/carer involvement is likely to continue.

Treating a young person without involving parents/carers might be necessary when:

- the young person cannot rely on their support or they contribute to the stresses the young person is experiencing (e.g., through abuse, homophobia)
- they are opposed to the young person's wishes or are likely to undermine effective treatments (to which the young person is able to give informed consent)
- the parent(s) have mental health problems that affect presentation and engagement
- the young person does not live with his or her family of origin (e.g., is homeless or in foster care).

It is useful to establish early what the young person prefers and whether there are specific reasons for not wanting parent/carer involvement. Initial refusal to include family members can be revisited at a later date, especially when any issues of stigma or shame have been addressed.

Where parents/carers are involved, it can be helpful to:

- allow them to attend the first and last few minutes of any appointment, particularly if the young person has trouble articulating his or her feelings and moods
- use this time to question both on how things have gone since the last appointment and then discuss what action may be required before the next appointment
- consider family therapy, particularly if parents/carers have a limited understanding of mental health issues and worry about jeopardising the young person's recovery by saying or doing the wrong thing
- ensure all involved understand that the safety of the young person and others is paramount and that 'duty of care' will prevail.

Where parents/carers are not involved, it can be helpful to:

- facilitate the involvement of others (e.g., friends), to enhance the young person's level of social support
- ensure that involving peers takes place without an authoritarian/expert stance and with the young person's consent and cooperation
- take care not to place excessive or unrealistic expectations in terms of the contribution from the peer. A peer 'taking on' his or her friend's distress may, in some cases, lead to the unacceptable outcome of that peer developing feelings of lowered mood or hopelessness.

PARTNER INVOLVEMENT

Particularly in young adults, it is likely that a partner rather than parents/carers may wish to be involved in care. Involving the partner may be beneficial, but must follow appropriate consent. Again, safety to the individual and others and duty of care are fundamental considerations. While having a partner is often a protective factor, the young person may experience stresses associated with maintaining the relationship, negotiating employment and/or education goals, dealing with family and parenting issues, and/or differences in leisure priorities. Understanding these systemic issues is important for management planning.
CONFIDENTIALITY

Young people are acutely aware of confidentiality issues. Health professionals should have a clear understanding of such issues and the training and skills to discuss confidentiality with young people. Confidentiality policies should be fully explained in the first session.

Key points to cover include:

- discussions between patients and health professionals are private and any information shared between them is treated with respect
- health professionals are used to discussing sensitive issues and being open and honest will benefit the young person
- the young person can request information or phone calls not to go to his or her home
- permission will be sought if the health professional feels that sharing information about the young person with other professionals or health services may improve care
- confidentiality may not be kept if there is a concern that the young person may harm him or herself or another person, or is experiencing abuse or neglect
- in the above situations, only information relevant to the risk will be shared and the young person can be involved so that it is done in the best possible way for him or her.

When considering confidentiality of younger adolescents, the rights of parents should be respected. In older adolescents and young adults, achieving a balance between confidentiality and parent/carer involvement is particularly important.

Reporting requirements for health professionals vary by jurisdiction, depending on the mental health and child protection acts in that State/Territory.

PRACTICE GUIDE — ENGAGEMENT

DO...

✓ learn about challenges facing young people in your community, particularly groups that experience high rates of mental health problems.
✓ take time to establish relationships with young people in which they feel they can talk freely without being patronised or judged and will receive care and understanding, information and advice.
✓ involve parents/carers in discussions about the care of young people, according to the young person's wishes where possible.

DON'T...

✗ overlook customs of the culture of origin, differences in youth relationships with parents and with other authority figures and the possibility of religious and spiritual considerations.
✗ neglect to explain confidentiality issues, including that confidentiality will only be breached if there is a risk of harm to the young person or others.
✗ involve others in the young person's care without learning his or her preferences about who should be involved.
## UNDERSTANDING THE YOUNG PERSON’S CONTEXT

An initial step in assessing a young person for depression is to aim for understanding of his or her developmental, familial and sociocultural context. It is important to look at the whole picture for individuals and to help them make sense of normal feelings, such as sadness or grief, as well as assessing whether or not they meet the clinical criteria for a depressive disorder.

### Common depressive signs and symptoms

<table>
<thead>
<tr>
<th>Emotional changes</th>
<th>Cognitive changes</th>
<th>Behavioural changes</th>
<th>Physical changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness or hopelessness</td>
<td>Inefficient thinking, usually with a pronounced self-critical focus</td>
<td>Decreased participation in school</td>
<td>Fatigue, lack of energy, poor motivation</td>
</tr>
<tr>
<td>Irritability, anger or hostility</td>
<td>Loss of concentration, poor attention and an inability to make decisions</td>
<td>Disinterest in general appearance</td>
<td>Increase or decrease in appetite (resulting in weight gain or loss)</td>
</tr>
<tr>
<td>Tearfulness or frequent crying</td>
<td>Low self-esteem</td>
<td>Decreased participation with peers and normally enjoyed activities</td>
<td>Disrupted sleep rhythms (resulting in insomnia at night or hypersomnia during the day)</td>
</tr>
</tbody>
</table>

- Loss of pleasure in activities (anhedonia)
- Feelings of worthlessness and guilt
- Lack of enthusiasm and motivation
- Negative body image
- Apathy
- Thoughts of death or suicide
- Avoidance of family interactions and activities
- More withdrawn behaviour including clearly more time spent alone
- Lowered libido
- Restlessness and agitation
- Unexplained aches and pains

### Characterisation of depressive disorders

- **Dysthymia**: Depressed mood or irritability, on most days for most of the day, lasting for at least **one year**, together with **two other symptoms** such as:
  - changes in appetite and weight
  - changes in sleep
  - problems with decision-making and concentration
  - low self-esteem, energy and hope.

- **Major depressive disorder**: A depressive episode of at least **two weeks** duration consisting of either sad or irritable mood or anhedonia (loss of the normal pleasure response), together with **at least five other symptoms** such as:
  - social withdrawal
  - worthlessness
  - guilt
  - suicidal thinking or behaviour
  - sleep increase or decrease
  - increased or decreased appetite.

  For a diagnosis of major depressive disorder, these symptoms must cause clinically significant distress or impaired social, occupational or other functioning, represent a change from previous functioning, and must not be attributable to substance use, medication or other psychiatric or medical illness.

- **Bipolar I disorder**: History of manic or hypomanic episodes. Usually also a history of one or more episodes of major depressive disorder.

- **Bipolar II disorder**: At least one hypomanic episode and at least one major depressive episode. Depressive episodes are more frequent and more intense than manic episodes.
ASSESSING RISK AND RESILIENCE

Risk factors

The wide range of factors that contribute to the development of depression includes past and current biological factors (e.g. neonatal health problems, pubertal development, sleeping difficulties), individual factors (e.g. self-esteem, body image, attributional style, cognitive style and school performance) and family factors (e.g. parental depression, emotional neglect or poor parenting style and delinquency or suicide of a family member).

Social factors

Factors such as experiencing bullying or violence, difficulties with adjusting to sexual development or same-gender sexual orientation are widely recognised as contributing to the development of depression.

Interaction of risk and protective factors

Risk factors for depression often co-occur, and the probability of a negative outcome increases as the number of risk factors increases. However, many children and adolescents with risk factors do not develop depression or even depressive symptoms. Protective factors appear to be beneficial at all levels of risk, but there may be limits to the effects of some protective factors at the highest level of risk (e.g. in young people facing multiple adversities).

Groups at higher risk

Young people from particular social and cultural backgrounds may be more likely to experience depression, including Aboriginal and Torres Strait Islander youth, youth from a sexual minority or gender-diverse group, refugee young people, and homeless or institutionalised youth.

SUMMARY OF MAJOR RISK FACTORS

The following table summarises factors that may increase the risk of depressive symptoms or depression.

<table>
<thead>
<tr>
<th>BIOLOGICAL</th>
<th>INDIVIDUAL</th>
<th>FAMILY</th>
<th>PEERS AND SOCIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genetics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low birth weight (females)</td>
<td>Parent-child attachment issue</td>
<td>Maternal or paternal depression</td>
<td>Peer delinquency</td>
</tr>
<tr>
<td>Neonatal health problems (particularly in males)</td>
<td>Temperament</td>
<td>Emotional neglect</td>
<td>Bullying or violence</td>
</tr>
<tr>
<td>No incubated care (if indicated) (females)</td>
<td>Poor emotional regulation</td>
<td>Parenting style</td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pubertal development</td>
<td>Self-esteem</td>
<td>Suicide of family member</td>
<td>Suicide of peer</td>
</tr>
<tr>
<td>Sleeping difficulties</td>
<td>Body image</td>
<td></td>
<td>Relationship quality</td>
</tr>
<tr>
<td>Health concerns</td>
<td>Attributional style</td>
<td></td>
<td>Teenage pregnancy</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>Cognitive style</td>
<td></td>
<td>Bullying or violence</td>
</tr>
<tr>
<td></td>
<td>Poor school performance</td>
<td></td>
<td>Same-gender sexual orientation</td>
</tr>
<tr>
<td></td>
<td>Adjustment to sexual development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Evidence from the systematic literature review (SLR) undertaken for the Guidelines is shaded in orange; factors that are also recognised as contributing to the development of depression are highlighted in red.
**SOCIOCULTURAL BACKGROUND AND RISK OF DEPRESSION**

**Aboriginal and Torres Strait Islander youth**

Any consideration of mental health in Aboriginal and Torres Strait Islander communities needs to be placed within a social and historical context that takes into account the traditional holistic understanding of health, incorporating the physical, social, emotional and cultural wellbeing of the whole community.

However, it is clear that many young people are exposed to multiple risk factors for depression, including:

- parental depression (in turn influenced by transgenerational effects of separation and dispossession of culture and land)
- separation from parents
- severe stress from chronic, multiple and traumatic losses, abuse and family violence, racial discrimination and criminalisation and detention in custody
- physical health problems with or without associated learning difficulties and interruption to education
- alcohol and other substance misuse
- poverty and unemployment.

**Youth from a sexual minority and gender diverse group**

Despite increasing acceptance in society and greater visibility in the media and public life of individuals from sexual minority and gender diverse groups, prejudice and misunderstanding can still be a common experience. Many still experience social isolation, discrimination, harassment and violence in a range of settings including work, school and social situations, and have to manage the effects of this on a daily basis throughout their lives.

Experiences with systemic discrimination and stigmatisation can lead to greater vulnerability to emotional distress, depression and anxiety.

Young people with a history of verbal, sexual and/or physical victimisation and abuse have higher levels of mental health problems than non-heterosexual young people — including sexual risk-taking, risky use of alcohol and drugs, dropping out of school, homelessness, self-harm and attempted suicide

Young people who have experienced trauma

Young people who have settled in Australia under a refugee program (particularly those who have been exposed to torture and trauma) are at very high risk of depression and other mental health disorders, because they have been exposed to traumatic experiences, such as loss and ongoing conflict; at a time when they are also going through the normal developmental tasks of adolescence.

These youth are exposed to a range of factors affecting mental health and wellbeing including the impact of trauma on the family, intergenerational issues, negotiating more than one culture, dealing with a past history of exposure to violence, displacement and hardship and dealing with the challenges of settlement.

**Homeless youth**

Homeless youth includes those who regularly spend nights in shelters or on the street without adult supervision, as well as those who are episodically homeless and those who move from house to house. Most youth state that family conflict is the primary reason for their homelessness, and report neglect, and verbal, physical and sexual abuse as common experiences. Often as a result of continuing conflict and trauma, they are also less likely to have protective factors such as positive coping skills and psychological resilience.

Aspects of homelessness such as poor social integration, victimisation and alcohol and drug use increase vulnerability to depression. Attempting to meet basic needs while dealing with past and present trauma can compound mental health problems and depressive symptoms can worsen.

**Young people in the criminal justice system**

Young people who are in custody have high levels of risk-taking behaviours, especially where there is a background involving disadvantage, instability, social exclusion, parental imprisonment, living away from the family home, being taken into care as a child, and living with a person with a physical or mental disability. Repeated offenders convicted of serious and violent crime tend to have high levels of long-standing depressive disorder, including repeated undisclosed suicide attempts.

**PRACTICE GUIDE — CONTEXT**

**DO...**

 ✓ consider the benefits of an ongoing therapeutic relationship for young people at risk of or experiencing depression.
 ✓ consider family-focused interventions, which include parents, for children at risk of a major disorder.

**DON’T...**

✗ overlook opportunities to raise mental health literacy among young people.
✗ overlook sociocultural factors including sexuality and life events affecting mental health and wellbeing.
✗ disregard strengths and factors that protect against the development of depression.
ASSESSING SYMPTOMS

A range of approaches, including psychosocial assessment, clinical interview and standardised questionnaires, can be used to assess young people for depression. If depressive symptoms are present, an immediate task is to assess the likelihood of suicide or self-harm and ensure the safety of the young person. Before a diagnosis is made, ensure other mental health and physical conditions that may cause depressive symptoms are excluded. It is also important to examine the frequency, duration and strength of symptoms and use clinical judgement in assessing their impact on the young person’s functioning.

ASSESSMENT PROCESS

When young people are experiencing distress or depressive symptoms, there may be explanations other than depression, such as grief and loss, trauma or distressing life events, or difficulties in expressing and managing anger, sadness, fear and shame. The assessment process involves helping young people to make sense of their experience of normal feelings and reactions, as well as identifying the presence and assessing the severity of symptoms. A diagnosis of depression, when it is indicated, should not be seen as a label, but a ‘flag’ to guide further actions by the health professional and the young person, and his or her parents or carers.

The assessment process comprises:

• an initial assessment that aims for understanding of the young person's developmental, familial and sociocultural context as well as his or her mental state
• assessment for depressive symptoms, which may involve the use of assessment tools, and includes considering other mental health and physical conditions that may cause depressive symptoms.

Assessment for risk of suicide is an immediate task if depressive symptoms are identified in a young person, with involvement of parents/carers where possible.

GATHERING INFORMATION ABOUT A YOUNG PERSON’S SYMPTOMS

Psychosocial assessment

Asking about a young person’s life more broadly, starting with ‘safe’ issues and progressing to sensitive topics, promotes engagement between the health professional and the young person. It also provides relevant information about the young person’s current social context, behaviours and emotional status.

Assessment tools

Clinical assessment scales and consumer self-reports may be useful as initial measures of generalised distress and depressive symptoms. The HEADSS tool is a common framework for psychosocial assessment in young people. These tools do not provide a diagnosis, but can assist in decision-making about the need for further assessment.

Other sources of information

While individuals are the best informants of their own mood state and cognitions, parents/carers/partners, teachers and school counsellors can provide reliable information on changes in the young person’s behaviour and functional status. When appropriate, Aboriginal and Torres Strait Islander health workers or mental health professionals can also be an invaluable source of collateral history.
PROCESS OF ASSESSING DEPRESSIVE SYMPTOMS IN YOUNG PEOPLE

**Initial assessment**
Establish parameters of assessment (e.g., confidentiality) and rapport.
Take a history of the presenting difficulties, including onset of symptoms.
Investigate context (e.g., current and past medical history, family history, family and parent support and/or conflict, drug and alcohol issues, quality of peer relationships, romantic relationships, and school and/or employment issues); consider use of a psychosocial assessment framework (e.g., HEADSS).
Assess mental state (e.g., appearance, behaviour, speech, mood, recent typical thought processes, attention, memory and level of consciousness).

**Possible depressive symptoms**
Conduct clinical interview (e.g., assess for presence of symptoms consistent with diagnostic criteria for depression, in line with major international classification systems for depressive conditions (e.g., DSM-IV-TR)).
Consider use of a validated assessment tool (e.g., Children’s Depression Inventory, Reynolds Adolescent Depression Scale).

**Depressive symptoms present**
Assess risk of suicide and manage any immediate risk (see Table 1).
Assess whether symptoms are attributable to:
- direct effects of a medical disorder (e.g., infections, endocrine, central nervous system and metabolic disorders)
- direct effects of a substance (e.g., alcohol use or withdrawal, drug use; certain medications)
- a non-mood psychiatric condition (e.g., eating disorder, anxiety disorder or post-traumatic stress disorder, attention deficit-hyperactivity disorder (ADHD), conduct disorder, antisocial behaviour, personality traits)
- bipolar disorder (e.g., is there a history or symptoms of mania or hypomania)
- recent experience of loss (in situations of loss, young people may suffer from normal grief, depression, post-traumatic stress reactions or all three).

**Symptoms not attributable to other causes**
Assess whether the symptoms meet criteria for major depressive disorder or dysthymia (e.g., DSM-IV-TR).

**Symptoms do not meet criteria for major depressive disorder or dysthymia**
Assess whether the symptoms are attributable to an adjustment disorder (consider whether symptoms developed within three months of a stressor, how long they persisted and level of distress and impairment).

**Symptoms are not attributable to adjustment disorder and are clinically significant**
Consider a diagnosis of depressive disorder not otherwise specified.

Notes: DSM-IV-TR= Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, text revision; HEADSS= Home, Education, Activities, Drugs, Sexuality and Suicide and Depression

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**Common depressive signs and symptoms**

**Characterisation of depressive disorders**

**Process of differential diagnosis**

**HEADSS assessment tool**

**Examples of validated assessment tools**
ASSESSING AND RESPONDING TO THE RISK OF SUICIDE

Suicidal thinking

Enquiry into suicidal thinking, planning and self-harm behaviour and any past suicide attempt does not induce thoughts of suicide, rather it provides an opportunity to ensure the young person’s safety and arrange appropriate follow-up care.

Other considerations

Risk and protective factors, mental state, current misuse of alcohol or other drugs and the availability and capacity of supports also influence the risk of suicide.

Family involvement

With the young person’s consent, parents/carers/partners can provide valuable information on his or her recent behaviour and usual coping capacity.

Assessing the risk of suicide

Assessment of risk involves making enquiry into the extent of the young person’s suicidal thinking and intent, including:
- suicidal thinking – if suicidal thinking is present, how frequent and persistent is it?
- plan – if the person has a plan, how detailed and realistic is it?
- lethality – what method has the person chosen, and how lethal is it?
- means – does the person have the means to carry out the method?
- past history – has the person ever planned or attempted suicide?
- suicide of family member or peer – has someone close to the person attempted or completed suicide?

Consideration should also be given to:
- risk and protective factors
- mental state – hopelessness, despair, psychosis, agitation, shame, anger, guilt, impulsivity
- substance use – current misuse of alcohol or other drugs
- strengths and supports – availability, willingness and capacity of supports.

Developing a safety plan

Health professionals should be practiced at collaboratively reaching a safety plan with a young person who is expressing suicidal thinking or planning, or who has recently been involved in suicidal behaviour.

A safety plan is a prioritised written list of coping strategies and sources of support that young people can use when they experience suicidal thinking. The development of a safety plan involves assisting the young person to identify:
- warning signs that he or she may be at risk of imminent suicide (e.g. feeling trapped, worthless or hopeless)
- internal coping strategies that decrease the level of risk
- people within the young person’s network who can assist in times of need
- health professionals and agencies that can be contacted for help.

Safety plans should be frequently revisited and modified as needed.

General responses to identified risk of suicide

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW RISK</td>
<td>Discuss available support and treatment options.</td>
</tr>
<tr>
<td>MEDIUM RISK</td>
<td>Ensure that the young person is in an appropriately safe and secure environment.</td>
</tr>
<tr>
<td>HIGH RISK</td>
<td>Ensure that the young person is in an appropriately safe and secure environment.</td>
</tr>
</tbody>
</table>

ASK

Fleeting thoughts of self-harm or suicide but no current plan or means

Suicidal thoughts and intent but no current plan or immediate means

Continual/specific suicidal thoughts, intent, plan and means

LOW RISK

- Discuss available support and treatment options.
- Arrange follow-up consultation (timing of this will be based on clinical judgement).
- Identify relevant community resources and provide contact details.

MEDIUM RISK

- Discuss available support and treatment options.
- Organise re-assessment within 1 week.
- Identify relevant community resources and provide contact details.

HIGH RISK

- Ensure that the young person is in an appropriately safe and secure environment.
- Organise re-assessment within 24 hours and monitoring for this period.
- Follow-up outcome of assessment.
### EXCLUDING OTHER CAUSES OF DEPRESSIVE SYMPTOMS

#### Physical conditions

Mental health symptoms, including depression and mania, may be the initial or dominant presenting symptom for a range of physical conditions, such as infections (e.g. glandular fever), endocrine disorders (e.g. diabetes, hypothyroidism), metabolic abnormalities, neoplasms or central nervous system disorders (e.g. multiple sclerosis, temporal lobe epilepsy).

#### Drug and alcohol use

Depressive symptoms may be experienced with acute and chronic drug use (e.g. alcohol or marijuana), during drug withdrawal (e.g. amphetamines and cocaine), or as a reaction to the wider psychosocial implications of substance use.

#### Other mental health conditions

Many mental health conditions present with symptoms of irritability and depression. Some of these are disorders in which a mood disorder or depressive symptoms are the main problem (e.g. adjustment disorders), whereas others are conditions in which non-mood symptoms better account for the observed symptoms (e.g. eating disorders, anxiety disorders, attention deficit-hyperactivity disorder (ADHD), conduct disorder).

#### History or symptoms of mania

A depressive episode may be a precursor to bipolar disorder. In young people, bipolar disorder should not be diagnosed in the absence of episodes of mania that consist of a distinct change in mood accompanied by persistent elevation of mood and associated behaviour.

#### Loss or trauma

When young people are experiencing distress or depressive symptoms, there may be explanations other than depression, such as grief and loss, trauma or distressing life events, or difficulties in expressing and managing anger, sadness, fear and shame. These may also be associated with changes to sleep, appetite and behaviour.

### PRACTICE GUIDE — ASSESSMENT

**DO…**

- conduct assessments in a suitable quiet, confidential space where interruptions are unlikely.
- consider the use of assessment tools that provide a framework for psychosocial assessment (e.g. HEADSS) or assist in the process of diagnosis (e.g. Beck Depression Inventory).
- use accepted criteria for depression or dysthymia (DSM-IV-TR or ICD-10) to inform diagnosis if depressive symptoms are present and other causes excluded.
- ask young people with depressive symptoms about suicidal thinking and have a planned response to any identified risk.
- document major findings, disclosures, family and peer perspectives and alterations in presentation.
- explore other causes of depressive symptoms such as bereavement, an undiagnosed physical or mental health condition (including bipolar disorder), substance use or a known co-occurring condition.
- assist the young person to develop a safety plan if he or she is experiencing suicidal thinking.
- keep in mind Medicare items for mental health care and care planning.

**DON’T…**

- overlook the value of enquiring about other aspects of the young person’s situation, his or her strengths and place in the family, school, employment and the local environment before asking about depression.
- allow the use of tools to override clinical judgement, particularly if there is a severe manifestation of any one symptom.
MANAGING DEPRESSION IN YOUNG PEOPLE

For young people not in immediate danger of suicidal behaviour, management of major depressive disorder is likely to include a number of approaches, starting with psycho-education and supportive management, with the addition of psychological therapy. Pharmacological treatment (e.g. antidepressant medications) may be warranted in certain situations. The length of treatment required for effective remission varies — depressive conditions may require up to 36 weeks of active treatment. Before treatment is discontinued, factors that may contribute to relapse and recurrence need to be addressed.

DEVELOPING A MANAGEMENT PLAN

The aim of management is to achieve a reduction in depressive symptoms and return to functioning, then an absence of significant symptoms for a defined period of time. Primary care health professionals should support young people and their families to choose appropriate treatments, taking into account the severity of symptoms and any co-occurring conditions, as well as the young person’s circumstances, preferences and resources.

Psychological therapy (specifically Cognitive behavioural therapy (CBT) and Interpersonal psychotherapy (IPT)) and pharmacological treatment (specifically fluoxetine) are both effective in treating major depressive disorder in young people. Unless symptoms are severe, CBT or IPT should be first-line treatment for all young people with major depressive disorder. The dangers of not treating moderate to severe depression should be highlighted, as depression is the major risk factor for suicide.

STAGES OF THE MANAGEMENT PLAN

<table>
<thead>
<tr>
<th>Stage</th>
<th>Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate phase</td>
<td>Comprehensive mental health assessment to clarify diagnosis and specific screening for risk of suicide or self-harm to ensure immediate safety.</td>
</tr>
<tr>
<td>Acute phase</td>
<td>Strengthen therapeutic relationship. Achieve response and recovery – first a reduction in depressive symptoms, then an absence of significant symptoms for a defined period of time (remission). Monitor risk and progress. Minimise impairment.</td>
</tr>
<tr>
<td>Continuation and maintenance</td>
<td>Consolidate response and avoid relapse. Build relapse prevention skills and supports. Monitor progress of young people who have had more severe episodes. Prevent recurrence.</td>
</tr>
</tbody>
</table>

ALGORITHM FOR MANAGING MAJOR DEPRESSIVE DISORDER IN YOUNG PEOPLE

The following diagram represents some general principles for managing major depressive disorder in young people. Individual care pathways will be informed by clinical judgement and will need to be adapted to the local setting. For more complex cases, case management may involve a range of health professionals providing aspects of care for which they have the appropriate expertise.
DEVELOPING A MANAGEMENT PLAN

Psychosocial support
Guided self-help, non-directive support, information and lifestyle advice are useful initial approaches that can also supplement other treatments. Health professionals should maintain the treatment relationship and monitor the young person’s progress, whether they provide treatment or refer the young person to a mental health specialist.

Collaboration
Development of a management plan involves working with the young person (and if appropriate, his or her parents/carers/partner) to develop a plan that is tailored to his or her preferences and situation. This involves full discussion of what the treatment involves (including likely benefits and possible adverse effects). Any problems that might make treatment less likely to succeed should be reviewed and dealt with where possible. Health professionals, young people and their families should be aware of the dangers of not treating moderate to severe depression—depression is the major risk factor for suicide.

Complex presentations
A more sophisticated management plan is needed for complex presentations, such as young people with bipolar disorder or co-occurring mental health conditions. Approaches may include prioritising which disorder (or symptoms) to treat first. Multiple interventions delivered by different health professionals and/or services may be required. Having one health professional act as case manager, with collaboration between all health professionals involved, helps to ensure integrated, continuous care.

Monitoring and review
Once a young person is established on a program of treatment, continuing monitoring and review is required to identify response to treatment and early signs of relapse (re-emergence of the treated depressive episode), limit any illness-related impairment, attempt to prevent recurrence (onset of a second or subsequent depressive episode), and assist the young person to return to pre-illness levels of functioning.

PSYCHOLOGICAL THERAPIES

Choice of therapy
General talking approaches can be helpful, but CBT and IPT are effective in reducing depressive symptoms and improving global and social functioning and are well accepted among young people with depression. These therapies should only be provided by health professionals with specific training in the therapy and experience in working with young people. The therapy should be applied in line with evidence-based practice manuals and continuing maintenance of therapy skills is essential.

Suitability
Psychological therapy is not suitable for all young people. Factors including the young person’s preferences, age, education level, intellectual capacity, language and/or cultural factors and motivation have a variable impact on the young person’s suitability to engage in psychological interventions.

PHARMACOLOGICAL TREATMENT

Need for pharmacological treatment in a young person with clinically diagnosed major depressive disorder
If symptoms are severe, or if symptoms are moderate to severe and psychological therapy has not been effective, is not available or is refused, prescription of the selective serotonin reuptake inhibitor (SSRI) antidepressant fluoxetine should be considered for reducing depression symptoms in the short term.

Prescribing
If pharmacological therapy is warranted, it needs to be prescribed by those trained to do so, who are very familiar with the range of adverse effects and able to monitor the young person appropriately.

Adverse effects
SSRIs are associated with a range of adverse effects including irritability or depressed mood, anxiety, fatigue or sedation and sexual dysfunction. There is also a risk that a manic episode be precipitated following initiation of SSRI treatment.

Risk of suicide
There appears to be an age-related mechanism linking SSRI treatment with increased risk of suicidal thinking, with adolescents being at greatest increased risk. Suicidal thinking associated with SSRI treatment may be reduced by adding or continuing CBT.

Need for monitoring
Because of an increased risk of suicidal thinking after antidepressants are first taken, a young person prescribed SSRIs requires close medical monitoring, especially during the first four weeks.

OUT OF DATE
## KEY ACTIONS IN RESPONSE TO DIAGNOSIS

<table>
<thead>
<tr>
<th>Diagnosis and actions for primary care health professionals</th>
<th>Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms of depression</strong></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>• Provide youth-friendly information about depression, its causes and treatments (e.g. beyondblue fact sheets)</td>
</tr>
<tr>
<td>Guided self-help</td>
<td>• Provide advice on self-help strategies (e.g. online CBT)</td>
</tr>
<tr>
<td>Non-directive support</td>
<td>• Use active listening, person-centred discussion and empathy</td>
</tr>
<tr>
<td>Lifestyle advice</td>
<td>• Provide advice on sleep, relaxation and physical activity</td>
</tr>
<tr>
<td><strong>Dysthymia or mild major depressive disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>• Consider non-directive support, guided self-help, group CBT</td>
</tr>
<tr>
<td><strong>Mild to moderate major depressive disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>• Consider non-directive support, guided self-help, group CBT</td>
</tr>
<tr>
<td>Psychological therapy</td>
<td>• Consider CBT or IPT if available</td>
</tr>
<tr>
<td><strong>Moderate to severe major depressive disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Psychological therapy</td>
<td>• Consider CBT or IPT if available</td>
</tr>
<tr>
<td>Medication (see Table 1)</td>
<td>• Consider fluoxetine if necessary</td>
</tr>
<tr>
<td><strong>Severe major depressive disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Psychological therapy</td>
<td>• Consider CBT or IPT if available</td>
</tr>
<tr>
<td>Medication (see Table 1)</td>
<td>• Consider fluoxetine to reduce symptoms in the short-term</td>
</tr>
<tr>
<td><strong>Depression unresponsive to treatment/recurrent depression</strong></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>• Refer for intensive psychological intervention</td>
</tr>
<tr>
<td>Medication (see Table 1)</td>
<td>• Consider fluoxetine if necessary</td>
</tr>
<tr>
<td><strong>Depressed phase bipolar disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>• Refer to or consult a specialist in the field for individual advice</td>
</tr>
<tr>
<td><strong>Psychotic depression</strong></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>• Refer urgently to specialist services</td>
</tr>
<tr>
<td>Inpatient care</td>
<td>• Consider a more intensive treatment setting</td>
</tr>
<tr>
<td>Re-evaluation</td>
<td>• Consider alternative diagnosis (bipolar)</td>
</tr>
</tbody>
</table>

**Notes:** CBT=cognitive behavioural therapy; IPT=interpersonal psychotherapy
### Considerations When Deciding Whether to Recommend Pharmacological Treatment

<table>
<thead>
<tr>
<th><strong>Severity</strong></th>
<th><strong>Patient’s previous treatments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Does the severity of the young person’s depression warrant pharmacological treatment and outweigh the risk of adverse events?</td>
<td>• Has the young person taken medication previously for depression?</td>
</tr>
<tr>
<td>• Does the young person receive an adequate dose of medication for an appropriate period of time?</td>
<td>• Did the young person receive an adequate dose of medication for an appropriate period of time?</td>
</tr>
<tr>
<td>• What was the response to treatment? Was the medication tolerated?</td>
<td>• Did the young person adhere to his/her medication regime? If not, why not?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other family members’ responses</strong></th>
<th><strong>Recurrent depression</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do parents/carers or other people of influence support the use of medication?</td>
<td>• Is depression recurrent despite an adequate psychological intervention?</td>
</tr>
<tr>
<td>• Has the young person taken medication previously for depression?</td>
<td>• In previous episodes, did the young person receive medication and did he/she find it beneficial?</td>
</tr>
<tr>
<td>• Did the young person adhere to his/her medication regime? If not, why not?</td>
<td>• If medications have been used previously, did the young person experience adverse effects, including manic switch?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Response to psychotherapy</strong></th>
<th><strong>Convenience and affordability for young person or family</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• If psychological therapy has not been tried and the severity of depression is not such that it warrants immediate medication, a trial of a specific psychological therapy (CBT or IPT) should be considered.</td>
<td>• Does the young person (if independent) or the family have financial means to obtain medications?</td>
</tr>
<tr>
<td>• If psychological therapy has been tried, was adequate time and effort given to produce results? Was the therapy specific (e.g. CBT/IPT or non-directed) and provided by a health professional with expertise in these approaches?</td>
<td>• Is psychological therapy unavailable or inconvenient due to the amount of time required?</td>
</tr>
</tbody>
</table>

### Monitoring Young People Taking the SSRI Fluoxetine

#### Baseline Assessment
- Monitor for symptoms that might be subsequently interpreted as side effects for 7 days before prescribing (unless medication needs to be started immediately).
- Agree on a monitoring protocol if young person has psychological therapy with another health professional.
- If young person declines psychological therapy, reinforce the need for regular close monitoring of progress by the prescribing doctor.
- Medication regime begins at the lowest possible indicated dose.

#### Initial Monitoring — Within 7 Days
- Monitor for emergent adverse effects as well as agitation, suicidal thinking and behaviour and manic symptoms, review mental state, general progress and any change in suicidal thoughts or behaviours.

#### Regular Review — Every Week for At Least 4 Weeks
- Observe patients closely for clinical worsening, suicidal thoughts, or unusual changes in behaviour such as sleeplessness, agitation, or withdrawal from normal social situations; watch for symptoms of mania or psychosis.

#### Monitoring and Relapse Prevention
- Continue to assess regularly — the precise frequency will need to be decided on an individual basis, and recorded in the notes.
**PRACTICE GUIDE — MANAGEMENT**

**DO...**
- ✓ provide psychoeducation (information and guided self-help) and lifestyle advice (e.g. on stress management, exercise, nutrition, sleep) to young people experiencing depressive symptoms.
- ✓ provide information specific to proposed treatments including strengths, initial effects, possible adverse effects and risks, elements central to treatment success and the likely duration of treatment, and seek consent for treatments.
- ✓ monitor young people for the onset of or increase in suicidal thinking following initiation of the SSRI fluoxetine, particularly in the first four weeks.
- ✓ review diagnosis, co-occurring conditions, drug and alcohol use and adverse circumstances if there is no response after 6–10 sessions of individual or group CBT/IPT and/or 8 weeks of fluoxetine.
- ✓ offer CBT or IPT as first-line treatment for young people with major depressive disorder, taking into consideration the suitability of the selected therapy for the individual.
- ✓ consider treatment with fluoxetine for young people with severe symptoms, or for young people with moderate to severe major depressive disorder, where psychological therapy has been unsuccessful, is not available, or is refused.
- ✓ add/continue CBT to medication therapy to reduce suicidal thinking and improve functioning.
- ✓ discontinue medication immediately if there is a sudden or unexpected increase in suicidal thinking in the first 7–10 days after initiating treatment or increasing the dose.
- ✓ seek advice from a mental health specialist if a moderate to severe depressive disorder fails to respond to fluoxetine plus CBT/IPT approach.

**DON’T...**
- ✗ use SSRIs, including fluoxetine or other antidepressants for treatment of mild depression in young people.
- ✗ prescribe TCAs or new antidepressants for the treatment of depressive disorder in young people.
- ✗ neglect to maintain the therapeutic alliance, discuss symptoms and problems, continue contact and encourage a collaborative approach regardless of whether you are providing a treatment or referring the young person.
CONTINUING CARE

Even after symptoms lessen, active treatment of depression should continue for at least six months. The goals of continuing care are to identify signs of relapse, promote functioning, address illness-related impairment and assist the young person to return to his or her previous, pre-illness level of functioning. While maintenance treatment in adults may involve continuing pharmacological treatment, this is usually not appropriate in young people, as major depressive disorder may not continue to be a problem in adulthood.

REVIEWING AND MONITORING TREATMENTS

Treatment duration

Most CBT and IPT programs range from around 10 to 16 sessions, which allows time to cover key elements of CBT content. Weekly monitoring of depression symptoms enables the health professional and young person to decide whether further sessions are required. While there is a small evidence base, current good clinical practice suggests continuing medication therapy for six months post-remission, to consolidate remission of symptoms and to prevent relapse.

Inadequate response to treatment

If a young person does not respond to an adequate treatment dose (psychological therapy and/or pharmacological treatment) after an appropriate period of time, the diagnosis should be reviewed and consideration given to co-occurring conditions, drug or alcohol use or ongoing adverse circumstances. Where there is doubt about how to proceed, specialist advice or a second opinion should be sought.

Discontinuing treatment

Whether pharmacological or psychological, discontinuing therapy depends on a range of factors that may contribute to relapse and recurrence, including psychosocial stressors, the individual situation (e.g. school year or workload) and the presence of chronic and/or recurrent depression.

Inpatient care

Community care is preferable for young people with depressive disorders. However, inpatient care may be beneficial in some situations. If possible, it is preferable to anticipate the need for admission before the situation reaches the stage of being a crisis. However, both planned and crisis admissions have a role in care.

PREVENTING RELAPSE

Predictors of relapse

While few studies have consistently demonstrated predictors of relapse, young people with risk factors for depression and/or co-occurring physical or mental health conditions may be at greater risk of relapse.

Effect of treatment success on relapse

Treatment effectiveness may influence the likelihood of relapse. Young people with depressive disorders have a better prognosis if they have had fewer previous depressive episodes, have a minor depressive disorder rather than major depressive disorder, have a shorter depressive episode and have lower severity of depressive symptoms.

The following strategies for relapse prevention may be useful for young people.

- Learn about depression and the effective use of treatments.
- Monitor mood changes and identify personal warning signs (e.g. sleep changes, feelings of hopelessness).
- Identify activities that have a positive impact on mood (e.g. listening to music, visiting friends) and include these as routine activities.
- Follow the management plan, even when mood starts to improve — for example, take medication for the period advised by the doctor and keep attending psychological therapy sessions.
- Follow a healthy lifestyle, including exercise, proper nutrition and good sleep habits.
- Try a range of strategies for coping with stress.
- Maintain contact with friends and family and try to avoid spending too much time alone.

section continued >
PRACTICE GUIDE — CONTINUING CARE

DO...
✓ encourage young people to continue treatment for an appropriate period of time.
✓ arrange for admission to an environment designed for young people if inpatient care is required.
✓ maintain the therapeutic relationship with young people beyond the duration of active treatment.
✓ work with young people to identify situations or events that may trigger a relapse, as well as strategies for avoiding or managing these triggers.
✓ seek specialist advice about young people who do not respond after an appropriate period of adequate treatment.
✓ assist young people to develop a relapse prevention plan, which includes a range of self-care strategies.

DON'T...
✗ neglect to consider factors that may contribute to relapse or recurrence if medication is discontinued.
✗ neglect to consider risk factors or co-occurring conditions that may increase the likelihood of relapse.
headspace What works?
www.headspace.org.au/what-works

The headspace What works? web page provides up-to-date information about treatment interventions and models of care for young people with mental health and substance use issues. It is designed for professionals who work with young people, as well as researchers and academics and members of the community who are interested in youth mental health. Resources include evidence summaries and Mythbusters.

The Black Dog Institute
www.blackdoginstitute.org.au/healthprofessionals

The Black Dog Institute is a not-for-profit, educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder. It offers education and training programs, resources and online learning for health professionals.

square – Suicide, Questions, Answers and Resources
www.square.org.au

square is an integrated suicide prevention resource developed by General Practice SA and Relationships Australia (SA) in conjunction with the Federal and State Governments. It is part of the National Suicide Prevention Strategy and was jointly funded by the Australian Government and the Government of South Australia.

Living Is For Everyone
www.livingisforeveryone.com.au

The Living Is For Everyone (LIFE) website is a suicide and self-harm prevention resource, dedicated to providing the best available evidence and resources to guide activities aimed at reducing the rate at which people take their lives in Australia. The LIFE website is designed for people across the community who are involved in suicide and self-harm prevention activities.

Mental Health First Aid
www.mhfa.com.au

Mental Health First Aid is an example of a training course to help people identify others with mental health issues.
Clinical practice guidelines for depression in adolescents and young adults

Depression in young people: A guide for primary care health professionals

Fact Sheet – Engaging young people in health care: A guide for primary care health professionals

Assessment and management of depression in young people: A guide for primary care health professionals
RESOURCES FOR YOUNG PEOPLE

beyondblue
1300 22 4636
www.beyondblue.org.au
www.youthbeyondblue.com
Learn more about anxiety, depression and suicide prevention, or talk through your concerns with our Support Service. Our trained mental health professionals will listen, provide information and advice, and point you in the right direction so you can seek further support.

Free resources for consumers, carers and health professionals can also be ordered via the beyondblue website or Support Service.

mindhealthconnect
www.mindhealthconnect.org.au
Access to online programs and trusted information on depression, stress or anxiety from Australia’s leading mental health organisations.

Black Dog Institute
www.blackdoginstitute.org.au
Information on depression and bipolar disorder – specifically causes, treatments, symptoms, getting help and current research findings.

headspace
www.headspace.org.au
Information on mental health problems and stories from others, plus local services for young people.

Kids Help Line
1800 55 1800
www.kidshelp.com.au
Free call from a land line; 24 hours. Website lists services that are either free of charge or low cost.

Reach Out
www.reachout.com
Information and support for young people going through tough times.

Carers Australia
1800 242 636
www.carersaustralia.com.au
Family carer support and counselling in each state and territory.

This Way Up Clinic
www.thiswayup.org.au/clinic
Information and internet-based education and treatment programs for people with depression and/or anxiety.

e-couch
www.ecouch.anu.edu.au
Online psychological therapy.

Lifeline
13 11 14
www.lifeline.org.au
24-hour counselling, information and referral (local call).

MoodGYM
www.moodgym.anu.edu.au
Online psychological therapy.

Relationships Australia
1300 364 277
www.relationships.org.au
Support and counselling for people with relationship problems.

SANE Australia Helpline
1800 18 7263
www.sane.org
Information about mental illness, treatments, where to go for support and help for carers.

Suicide Call Back Service
1300 659 467
www.suicidecallbackservice.org.au
Telephone support and online counselling for those at risk of suicide, their carers, and those bereaved by suicide.

For mental health support that is lesbian, gay, bisexual, transexual and intersex (LGBTI) inclusive and respectful, contact local gay and lesbian counselling services. Visit www.beyondblue.org.au/lgbti and click on Helpful contacts and websites for more information or call the beyondblue Support Service on 1300 22 4636.

Aboriginal and Torres Strait Islander people should contact their local Aboriginal Community Controlled Health Organisation or Aboriginal Health Worker at their local health service.

section continued >
RESOURCES FOR YOUNG PEOPLE

Anxiety and depression in young people: What you need to know

Flipper card - Concerned about a friend? You can help

Fact Sheet - Self-harm and self-injury

Fact Sheet - Suicide prevention: Knowing the signs

Fact Sheet - Bullying and cyberbullying

Fact Sheet - Drugs, alcohol and mental health

A guide to what works for depression in young people

The beyondblue guide for carers: Supporting and caring for a person with anxiety and depression

To download PDF files click on the links opposite. To order hard copies of available information resources please visit: www.beyondblue.org.au/resources to access beyondblue’s online ordering catalogue.

www.youthbeyondblue.com beyondblue’s website for young people aged 12 to 25 with information on anxiety and depression, how to get help or support a friend.

OUT OF DATE
Overview of mental health care for young people

Young person makes contact with healthcare service

ENGAGEMENT (Section 1)
- Establish rapport
- Explain confidentiality
- Involve family/carer

INITIAL ASSESSMENT: CONTEXT (Section 2)
Identify strengths and risk and protective factors
Identify sociocultural factors

INITIAL ASSESSMENT: SYMPTOMS (Section 3)
- Conduct assessment interview
- Consider use of assessment tools
- Consider symptoms, other possible causes and co-occurring conditions
- Assess risk of suicide

Determine level and type of support needed (Section 4)

MAJOR DEPRESSIVE DISORDER

BIPOLAR DISORDER

INITIAL APPROACHES (Section 4)
Good clinical care, non-directive support, guided self-help

PSYCHOLOGICAL THERAPIES (Section 4)
Add CBT or IPT as first-line treatment (if available)

Psychological therapy effective
- Provide maintenance treatment
- Develop relapse prevention plan

Psychological therapy not effective or not available

CONTINUING CARE (Section 5)

PHARMACOLOGICAL TREATMENT (Section 4)
- Add fluoxetine*
- Recommend continued CBT
- Monitor for suicidal thinking

KEY
- Discussion based on evidence from the SLR
- Discussion based on lower quality evidence, international guidelines and/or best practice clinical judgement

Notes: * If appropriately trained and seeking expert advice where necessary. CBT=cognitive behavioural therapy  IPT=interpersonal psychotherapy.
Factors to consider in encounters with young people

- **Lifestyle**
  - Smoking, alcohol, drug use, internet use affecting sleep

- **Life events**
  - Bereavement, separation from loved ones, divorce, trauma

- **Connection with society**
  - Marginalisation, homelessness, refugee status, fostering

- **Family situation**
  - Domestic violence, poverty, family discord, sexual or physical abuse

- **Health**
  - Co-occurring mental or physical condition, physical or intellectual disability

- **Personality**
  - Self-esteem, attributional style, cognitive style, body image, social competence

- **Developmental**
  - Stage of puberty and schooling, transition into workforce and independent living

- **Cultural background**
  - Language problems, generational culture clashes, cultural non-recognition of mental health problems, stresses from living between two cultures

- **Sexuality and gender identity**
  - Uncertainty, fear of rejection by family and friends, desire to 'fit in' with perceived societal expectations, being bullied, being subjected to homophobic abuse

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Are the symptoms attributable to the direct effects of a medical disorder?  
*Consider: infections, endocrine, central nervous system and metabolic disorders*

- No

Are the symptoms attributable to the direct effects of a substance?  
*Consider: alcohol misuse or withdrawal, substance misuse; certain medications*

- No

Are there symptoms of a non-mood psychiatric condition?  
*Eating disorders: look for common behavioural symptoms (vomiting, fasting)*
*Anxiety disorders or post-traumatic stress disorder: common symptoms include worry, ruminations, irritability, sleep and concentration disturbances, fears, flashbacks, hyperarousal*
*ADHD: need to distinguish from mania — young people with ADHD have generally had persistent symptoms since early childhood and disorganisation without mood symptoms*
*Conduct disorder/antisocial behaviour: distinguish from mania — young people with conduct disorder have generally had disruptive behaviour since childhood*

- No

Is there a history or symptoms of mania or hypomania?  
Young people with major depressive disorder who have psychotic symptoms are more likely to develop bipolar than those without psychotic symptoms

- Yes

Has the young person recently experienced loss?  
In situations of loss, young people may suffer from normal grief, depression, post-traumatic stress reactions or all three

- No

Do the symptoms meet criteria for major depressive disorder or dysthymia?  

- Yes

Are the symptoms associated with a stressor?  
*Consider whether:*
  - symptoms developed within 3 months of a stressor
  - symptoms persisted for no longer than 6 months after the stressor and
  - the young person is excessively distressed or impaired at school, work or socially

- No

Are symptoms clinically significant? dysthymia?

- Yes
**HOME**

- Who lives with the young person? Where?
- Do they have their own room?
- What are relationships like at home?
- What do parents and relatives do for a living?
- Ever institutionalised? Incarcerated?
- Recent moves? Running away?
- New people in home environment?

**EDUCATION AND EMPLOYMENT**

- School/grade performance — any recent changes? Any dramatic past changes?
- Favourite subjects — worst subjects? (include results)
- Any years repeated/classes failed?
- Suspension, termination, dropping out?
- Future education/employment plans?
- Any current or past employment?
- Relations with teachers, employers — school, work attendance?

**ACTIVITIES**

- On own, with peers (what do you do for fun? where? when?)
- With family?
- Sports — regular exercise?
- Church attendance, clubs, projects?
- Hobbies — other activities?
- Reading for fun — what?
- TV — how much weekly — favorite shows?
- Favourite music?
- Does young person have car, use seat belts?
- History of arrests — acting out — crime?

**DRUGS**

- Use by peers? Use by young person? (include tobacco, alcohol)
- Use by family members? (include tobacco, alcohol)
- Amounts, frequency, patterns of use/misuse, and car use while intoxicated?
- Source — how paid for?

**SEXUALITY**

- Orientation?
- Degree and types of sexual experience and acts?
- Number of partners?
- Masturbation? (normalise)
- History of pregnancy/abortion?
- Sexually transmitted diseases — knowledge and prevention?
- Contraception?
- Frequency of use?
- Comfort with sexual activity, enjoyment/pleasure obtained?
- History of sexual/physical abuse?

**SUICIDE/DEPRESSION**

- Sleep disorders (usually induction problems, also early/frequent waking or greatly increased sleep and complaints of increasing fatigue)?
- Appetite/eating behaviour changes?
- Feelings of ‘boredom’?
- Emotional outbursts and highly impulsive behavior?
- History of withdrawal/isolation?
- Hopeless/helpless feelings?
- History of past suicide attempts, depression, psychological counselling?
- History of suicide attempts in family or peers?
- History of recurrent serious ‘accidents’?
- Psychosomatic symptomatology?
- Suicidal thinking (including significant current and past losses)?
- Decreased affect on interview, avoidance of eye contact — depression posturing?
- Preoccupation with death (clothing, media, music, art)?

### Examples of validated assessment tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>Type</th>
<th>Measures</th>
<th>Main features</th>
</tr>
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</table>
| Beck Depression Inventory (BDI)  
(Beck et al 1961) | Multiple-choice self-report scale  
Used in those aged over 13 years | Cognitive, behavioural, affective, and somatic | Discriminates between depressed and non-depressed teenagers with good sensitivity and specificity  
No items relevant to school  
No parent or teacher rating forms |
| Center for Epidemiologic Studies Depression Scale (CES-D)  
(Radloff 1977) | Self-report scale  
Used in those aged over 13 years | Depressive mood; feelings of guilt and worthlessness; psychomotor retardation; loss of appetite; sleep disturbance | A valuable tool for identifying a group at risk of depression and for studying the relationship between depressive symptoms and other variables  
Discriminant validity tests found CES-D to be less successful in differentiating between depression and other types of emotional responses (anger, fear, boredom) |
| Children’s Depression Inventory (CDI)  
(Kovacs & Beck 1977; Kovacs 1981) | Self-report scale  
Used in children aged 7 to 17 years | Dysphoric mood; acting out; loss of personal and social interest; self-deprecation; vegetative symptoms | Most frequently used and best studied scale for depression in children  
Response format comparing three choices may not be suitable for some children  
Discriminant validity poor with a high false negative rate |
| Hamilton Rating Scale for Depression (HRSD)  
(Hamilton 1960) | Clinician-rated multiple-choice scale used to rate severity of depression | Rates the severity of symptoms observed in depression such as low mood, insomnia, agitation, anxiety and weight loss | Excellent internal reliability and interrater reliability, some discriminant validity  
Further assessment of psychometric functioning is needed to assure suitability for teenagers  
Emphasis on somatic and anxiety symptoms may mean poor discrimination from anxiety disorders |
| HANDS  
(Baer et al 2000) | Self-report scale | Signs and symptoms of depression in the last 2 weeks | Good internal consistency and validity  
Adult scale |
| Hospital Anxiety and Depression Scale (HADS)  
(Snaith 2003) | Self-report scale | Severity of depression and generalised anxiety | Adequate test-retest reliability and factor structure  
No physical items, may be more useful for individuals with co-occurring medical conditions |
| Reynolds Adolescent Depression Scale (RADS)  
(Reynolds 2002) | Used for adolescents aged 12 years and above | Dysphoric mood, anhedonia/negative affect, negative self-evaluation, somatic complaints | Demonstrated reliability and validity  
Well suited for individual or group assessment in clinical or school situations |
| Reynolds Child Depression Scale (RCDS)  
(Reynolds 1989) | Self-report scale  
Used for children | Depression symptoms | Demonstrated reliability and validity  
Can be used in schools or clinical settings |
Examples of validated assessment tools

Semi-structured scales/interviews

Examples include:

- Kiddie-Schedule for Affective Disorders and Schizophrenia (Chambers et al 1985)
- Diagnostic Interview for Children and Adolescents-IV (DICA-IV) (Reich 2000)
- Clinical Interview Schedule-revised (CIS-R) (Lewis et al 1992)
- Structured Clinical Interview for DSM-IV Axis I disorder clinician version (SCI-D) (First 1996) and patient version (SCID-I/P) (First 2002).

Measures of broader mental health problems or associated symptoms

Examples include:

- Strengths and Difficulties Questionnaire (SDQ) (Goodman et al 2003)
- K6/K10 (Kessler et al 2002)
- Child Behaviour Checklist (CBCL) (Clarke et al 1992)
Algorithm for managing major depressive disorder in young people

YOUNG PERSON DIAGNOSED WITH MAJOR DEPRESSIVE DISORDER

Psychological therapies available

OFFER CBT OR IPT

Accepted

Response

No response

Psychological therapies not available

Declined

REVIEW MANAGEMENT PLAN, CONSIDER REFERRAL TO SPECIALIST

Other cause of depressive symptoms

Not warranted

Warranted

Provide information

Offer fluoxetine

Declined

Accepted

Consider whether pharmacological treatment is warranted

Major depressive disorder

Review diagnosis

GOOD STANDARD OF CARE AND ONGOING COLLABORATION WITH YOUNG PERSON AND FAMILY

OUT OF DATE

PROVIDE MAINTENANCE TREATMENT AND DEVELOP RELAPSE PREVENTION PLAN

Monitor for suicidal thinking/plans and adverse effects (weekly for a month)

Recommend continuation of CBT

Medication for 6–12 months after symptom reduction

Review

No response

Response

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Psychosocial support

Keep building the therapeutic relationship, in particular ensuring that services are welcoming, and adopt an honest, empathic and non-judgemental approach.

Involve the young person and parents/carers in developing the management plan and consider physical, mental, family, social, spiritual and cultural factors relevant to the young person.

Provide a good standard of care at all times by continuing contact, discussing symptoms and problems, and encouraging a collaborative approach.

Psychological therapies

Consider suitability of the therapy for the individual young person taking into consideration his or her preferences, age, education level, intellectual capacity, language and/or cultural factors and motivation.

Discuss the chosen therapy (e.g. number of sessions, homework, costs) with the young person and his or her parents/carers/partner.

Only provide therapy if trained in the relevant therapy and experienced in working with young people. Apply the therapy in line with evidence-based practice manuals.

Monitor adherence to therapy tasks and enhance therapy adherence.

Provide therapy for an adequate duration — most CBT and IPT programs range from 10 to 16 sessions.

Adapt/review therapy if the young person is unresponsive.

Pharmacological treatment

Only prescribe medication if you are trained to do so or have sought advice, familiar with the range of adverse effects and able to closely monitor the young person, particularly during the first 4 weeks of treatment.

Take into account the young person's preferences, the risk of adverse effects, response to previous treatments, convenience and psychosocial stressors that may maintain the depression.

Support informed decision-making by providing appropriate information on adverse effects, the possibility of the emergence or escalation of suicidal thinking and the need for ongoing monitoring during treatment.

Continue medication therapy for 6 months post-remission.
## Practice algorithm for use of SSRIS by young people

### If: young person experiencing severe symptoms, or has moderate to severe depression and is unresponsive to psychological therapy

**Step 1 — Assessment** (see Section 3)
- Review diagnosis
- Ensure all relevant factors including co-occurring conditions, family and social environment, cultural and at-risk population factors and possible bipolar disorder have been considered

### If: pharmacological treatment is warranted (see Section 4.4)

**Step 2 — Discussion and information provision** (see Section 4)
- Discuss the rationale for the medication, the delay in onset of effect, the time course of treatment, the possible adverse effects (including emergence or escalation of suicidal thinking), and the need to take medication as prescribed
- Recommend continuation of psychological therapy
- Advise parents/carers of the need for close observation and regular communication with the treating health professional
- Advise the young person and parents/carers to seek medical advice and evaluation promptly if the young person experiences nervousness, agitation, irritability, mood instability, or sleeplessness that either emerges or worsens during treatment with SSRI medication
- Give instructions for urgent contact with the prescribing doctor or other pre-arranged contact point(s) in the event of self-harm, or suicidal thinking or behaviour

**Step 3 — Baseline assessment**
- Monitor symptoms that might be subsequently interpreted as adverse effects for 7 days before prescribing (unless medication needs to be started immediately)
- Agree on a monitoring protocol if young person has psychological therapy with another health professional
- If young person declines psychological therapy, reinforce the need for regular close monitoring of progress by the prescribing doctor
- Medication regime begins at the lowest possible indicated dose

**Step 4 — Initial monitoring — within 7 days**
- Monitor for emergent adverse effects as well as agitation, suicidal thinking and behaviour and manic symptoms; review mental state, general progress and any change in suicidal thinking or behaviour

**Step 5 — Regular review — every week for 4 weeks**
- Observe patients closely for clinical worsening, suicidal thinking, or unusual changes in behaviour such as sleeplessness, agitation, or withdrawal from normal social situations; watch for symptoms of mania or psychosis

**Step 6 — Monitoring and relapse prevention**
- Continue to assess regularly — the precise frequency will need to be decided on an individual basis, and recorded in the notes

**Step 7 — Discontinuation**
- The medication should be discontinued immediately if there is a sudden or unexpected increase in suicidal thinking over the first 7–10 days after initiating treatment or increasing the dose
- Following a successful treatment and continuing treatment for a further 6 months (see Section 4), a slow discontinuation of 2–12 weeks is recommended, depending on the clinical circumstances
- During discontinuation, monitor for relapse of depressive symptoms and discontinuation syndrome

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