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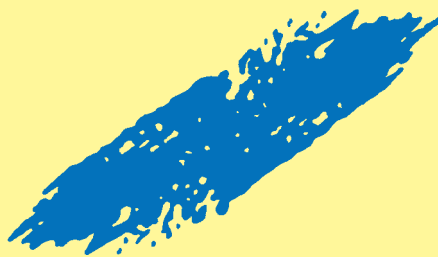


## Clinical Practice Guidelines

# Depression in young people

A guide for General  
Practitioners

March 1997



National Health and Medical Research Council

**NHMRC**

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# Depression in young people

## A guide for General Practitioners

This document is a general guide to appropriate practice, to be followed only subject to the General Practitioner's clinical judgement in each individual case.

The guidelines are designed to provide information to assist decision making and are based on the best possible information at the time of publication.

National Health and Medical Research Council

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# About this guide

This document contains information drawn from the *Clinical practice guidelines: depression in young people* - a set of clinical practice guidelines developed by the National Health and Medical Research Council (NHMRC). The original guidelines and modified versions for consumers, general practitioners and mental health professionals, have all been developed by an NHMRC working party with representatives from general practice, adolescent health, psychiatry, psychology, the consumer movement and Aboriginal and Torres Strait Islander people.

Young people are defined in the guidelines and the guides as between 13 and 20 years of age.

Should you wish to obtain further copies of this guide, the full clinical practice guidelines or the guide for mental health professionals, they can be purchased by contacting:

The Australian Government Publishing Service  
GPO Box 84  
CANBERRA ACT 2601

Phone: 132 447 (free call)

Fax: (06) 295 4888

The two consumers' publications (*Getting up from feeling down. Young people and depression* and *Blue daze. A comic book for young people*) are available free of charge. For more information about how to obtain your copy phone 1800 020103.

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# Foreword

In recognition of the need for procedures which ensure effective clinical practice and thereby improve health outcomes, the National Health and Medical Research Council has embarked on a national program to develop clinical practice guidelines. The objective of the guidelines is not only to assist practitioners to make decisions about appropriate health care for specific clinical circumstances, but also to assist consumers by providing them with comprehensive information about choices available in their treatment.

One of the basic premises of guideline development is that guidelines should be based on the best available evidence. The adoption of a multidisciplinary approach, involving all stakeholders, is a further key principle.

The identification and management of depression in young people was chosen as one of the first areas for guideline development. This is an appropriate choice, given that it is an increasing problem in the Australian community and that the presentation of depression in young people can be complex. It may not be recognised by parents, medical practitioners, teachers, welfare workers or others and, when it is recognised, the approaches to management vary considerably.

Depression is a deeply distressing and disabling condition and I am confident that this guide will assist general practitioners to reduce the suffering associated with depression in young people. The successful identification and treatment of depression should reduce the alarmingly high incidence of suicide in young Australians.

Richard Smallwood  
Chairman  
National Health and Medical Research Council

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# Working party on the identification, assessment, diagnosis, prevention and management of depression in young people

## Terms of reference

Undertake the development and implementation of clinical practice guidelines for the diagnosis and treatment of depression in young people, following the procedures recommended by the then Quality of Health Care Committee (now the Quality of Care and Health Outcomes Committee) draft first edition of *Guidelines for the development and implementation of clinical practice guidelines*, as follows:

- Review the evidence on relative effectiveness and appropriateness of interventions for diagnosis and treatment of depression in young people.
- Evaluate the strength of the evidence and decide which level of guideline can be developed and what questions need further research.
- Review any existing guidelines.
- Write the guideline documents for the identified target groups.
- Undertake wider consultation and pilot testing.
- Develop a strategy for dissemination and implementation.
- Make recommendations for monitoring/evaluating/reviewing/updating.

Provide advice on this process to the Quality of Care and Health Outcomes Committee.

## Membership

|  |   |
|--|---|
| Professor Beverley Raphael<br>(Chairman)       | Psychiatrist; member of the Quality of Care and Health Outcomes Committee |
| Dr Tony Arklay                                 | General Practitioner  |
| Professor Marie Bashir                         | Psychiatrist  |
| Professor Glenn Bowes                          | Physician   |
| Mr Charles Curran<br>(from August 1996)        | Mental Health Branch, Department of Health and Family Services            |
| Ms Christian McClelland<br>(until August 1996) | Mental Health Branch, Department of Health and Family Services            |

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|                                 |   |
|---------------------------------|---|
| Professor Joseph Rey            | Psychiatrist, Royal Australian and New Zealand College of Psychiatrists nominee |
| Ms Denise Ryan                  | Queensland Mental Health Consumer Advisory Group nominee                        |
| Dr Meg Smith                    | Consumers' Health Forum nominee   |
| Associate Professor Sue Spence  | Psychologist, Australian Psychological Society nominee                          |
| Ms Pat Swan                     | Policy adviser, Aboriginal Health   |
| Associate Professor Doris Young | General practitioner, Royal Australian College of General Practitioners nominee |

### **Secretariat**

|                   |  |
|-------------------|--|
| Mrs Cathy Clutton | Secretary, Quality of Care and Health Outcomes Committee   |
| Ms Kerry Pearce   | Secretary, Working Party on the identification, assessment, diagnosis, prevention and management of depression in young people |

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# Introduction

*Depression is common in young people, and is probably becoming more common. It causes significant morbidity and is a major risk factor for youth suicide. Between one half and three quarters of all suicides are linked to depression. Australia has the fourth highest youth suicide rate in the industrialised world. Over 400 young people under 25 years of age complete suicide and 80,000 attempt suicide in Australia each year (1). Apart from suicide risk, depression in young people can profoundly affect their psychosocial development. School failure, family and peer disengagement and substance abuse are some of the major morbidities associated with adolescent depression. Many will endure relapses of depressive episodes. There is strong evidence to say that adolescent depression and suicidal intent are often undetected and need to be better managed.*

## Origin and aim of this guide

To assist doctors and mental health professionals in the prevention, detection, assessment and care of young people with depression, the National Health and Medical Research Council (NHMRC) has produced *Clinical Practice Guidelines: Depression in young people*, which reviews comprehensively all available scientific evidence and information on the subject.

*Depression in young people: A guide for General Practitioners* is a summary of the main text, and has been designed to allow for quick reference and revision of the main principles. It comes with a flow chart which summarises the key steps in the detection, assessment and management of an adolescent who is depressed. This booklet does not include references to the evidence on which it is based. These can be obtained from the main document. Some material included in this summary, because of its utility in clinical practice, does not appear in the main document. This material is separately referenced and has not been systematically evaluated with the scientific evidence in the main document.

## **The role of general practitioners**

The NHMRC recognises that general practitioners see more young people than any other doctor, and often have the advantage of knowing the family and the community in which the young person lives. General practitioner services are often more accessible and seen as less stigmatising than a mental health service for a young person with a mental health issue. General practitioners are therefore well placed to detect, initiate management and where appropriate provide continuing care for a young person with depression. Many young people with mental health issues may present to their general practitioner with another issue. Routine mental health screening may help detect depression when it is not obvious.

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Many general practitioners work in areas with little access to support from mental health services, and may face time constraints. It is hoped that this guide can support general practitioners in the detection and management of young people with depression.

### ***A call for unified action***

Detection of youth depression and prevention of youth suicide is not the responsibility of just one professional group. The aim of this national initiative is to inform all health and other professionals dealing with young people about depression in adolescence. Australian communities may then better detect and help young people who are depressed before they suffer major current and ongoing morbidity or seek to suicide.

# 1 About depression in young people

## 1.1 Prevalence

Depression is common in young people and is under-recognised. Young people are defined in this guide as between 13 and 20 years of age.

About 40% of young people suffer prolonged periods of sadness or unhappiness in any six month period. Although not a clinical disorder, this lowered mood is important because it may be a risk factor for long term social problems and for clinical depression.

Clinical depression affects between 1% and 3% of young people at any one time. It is more common in older adolescents and females. Up to 24% of adolescents will have had a major depression by the age of 18.

Historically, adolescence has been thought of as a time of storm and stress. Modern understanding of adolescent developmental psychology emphasises that depression does exist, and is not a normal stage of teenage angst.

The rest of this booklet deals with clinical depression, a depressive disorder which we will refer to simply as depression.

## 1.2 Types of depression

Depressive disorders in adolescents include unipolar and bipolar disorders and other variants:

A. Types of unipolar depression are:

- **Major depressive disorder:** a sad mood with four or more other depressive symptoms (see below) for at least two weeks duration.
- **Dysthymia:** a chronically depressed mood with at least two other depressive symptoms present for at least a year. Cognitive and somatic symptoms may be present but are of lower grade. It may precede an episode of major depressive disorder.

B. **Bipolar depression:** In young people the depressive episode more commonly occurs before the first manic episode. Family history of the disorder can help predict the condition, along with acute onset, psychotic features, psychomotor retardation and onset of manic symptoms after treatment with antidepressants.

- C. Depression can also be associated with, or caused by, **medical conditions** and their treatments or **substance abuse**.
- D. **Adjustment disorder**: depressed mood with tearfulness, feelings of hopelessness, and impairment of social, academic, and occupational functioning within 3 months of and clearly linked to a specific stressful event (excluding bereavement).

## 1.3 Presentations

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, depression presents as one or more of the following signs or symptoms, which should be present most of the day, nearly every day for at least two weeks duration:

- Depressed or irritable mood.
- Markedly diminished interest or pleasure in most activities.
- Significant change in weight or appetite.
- Sleeping too little or too much.
- Psychomotor agitation or retardation.
- Fatigue or loss of energy.
- Feelings of worthlessness or guilt.
- Impaired thinking, concentration or decision making.
- Recurrent thoughts of death or suicide.

DSM-IV indicates that these core features are the same for children and adolescents as for adults. Adolescent presentations may more often feature somatic symptoms, irritability and social withdrawal with consequent loss of peer support. They are not always sad.

### **Common presentations of depression in young people**

- Depressed mood.
- Loss of interest and pleasure in activities/life, everything described as pervasively 'boring'.
- Somatic symptoms including fatigue.
- Irritability.
- Social withdrawal.
- Acting out behaviour, family conflict, declining school grades.
- Substance abuse.

Depressed adolescents may present in general practice in less obvious ways such as with complaints of headache, tiredness and abdominal pains and, when asked, may describe everything in their lives as pervasively 'boring' (10).

Teenagers may express inner conflict by acting out. Parents or others involved with the teenager may complain of increased family conflict, deteriorating school performance, antisocial or delinquent acting out behaviour or substance abuse.

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## ***Less common presentations***

- Psychomotor symptoms, psychosis, appetite and sleep disturbance.

Beware of the young person who presents frequently with apparent trivial complaints: clinical experience has shown that they may have underlying emotional issues (6).

## ***Practice points***

- Consider emotional issues in young people who present frequently to general practice with trivial complaints.
- All young people presenting to a general practitioner should be asked how life is going in general to maximise the chances of detecting depression.
- Comorbidity is an important feature of adolescent depression. Screen for depression in young people with any mental health issues, substance abuse, behavioural disorder and medical illnesses.

It is important to ask all young people who present in general practice for any reason, how things are going with them in general, to optimise chances for young people to express concerns that may indicate an undetected depression.

Comorbidity is also an important feature of adolescent depression and should raise the index of suspicion:

- Anxiety disorders.
- Substance abuse related disorders.
- Conduct disorder.
- Eating disorders.
- Attention deficit/hyperactivity disorder.
- Viral illnesses such as infectious mononucleosis and hepatitis.
- Chronic illnesses such as diabetes mellitus, schizophrenia and cancers.
- Abuse – sexual, physical and emotional.

Less common are appetite changes and sleep disorder but adolescents may present complaining of fatigue.

Rarely, the young person may present with psychomotor retardation or delusional beliefs, such as thinking their insides are dead, or that they have done something terrible and need to be punished.

Most young people with depression receive no management for it, because much of it goes unrecognised. A high index of suspicion is required especially with presence of comorbid factors or trivial complaints. Adolescence is not normally all storm and stress.

## 1.4 Natural history and prognosis

The first episode of a major depression usually occurs in mid to late adolescence. Most episodes resolve within a year, although the duration can vary from two weeks to several years. Depression is likely to last longer when there is more severe depression, the presence of suicidal ideation, stressful family environments and possibly in girls or young people with other conditions.

About 20% of adolescents who suffer a major depression will go on to have manic episodes.

At least 50% of adolescents who suffer a depression will have one or more recurrences of depression.

### ***Natural history and prognosis***

- Duration varies from two weeks to two years.
- 20% will have manic episodes.
- 50% will have one or more recurrences.
- Morbidity can be high.
- One third will attempt suicide and 3% will complete it within 2 years.

Morbidity from depression includes: increased reliance on others, exposure to more stressful events, alcohol/cigarette use, decline in family relationships, increased delinquency and lower self-esteem.

About a third of adolescents who suffer depression will attempt suicide in the next two decades. About 3% will die by suicide in that period.

## 1.5 Risk factors for depression

*Confirmed risk factors for adolescent depression:*

- Conditions/symptoms such as anxiety, conduct disorder, substance abuse, eating disorder
- Being older (15-19) as opposed to younger adolescents
- Being female
- Having a depressed parent
- Previous history of clinical or subclinical depression earlier in life

*Probable risk factors for adolescent depression:*

- Having a close biological relative with depression
- Stressful life events – chronic and acute
- Living in later decades of the century

*Possible risk factors needing further investigation:*

- Poor self-esteem/vulnerability because of negative thinking, poor self-control, social incompetence, neuroticism/vulnerable temperament or personality

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- Parents divorced, separated or in marital conflict and controlling parental style
- Early childhood sexual and physical abuse
- Aboriginal or Torres Strait Islander descent, residing in rural areas, low socioeconomic status, being homeless or in custody, non-English speaking background or refugee status, intellectual disability
- Poor peer relationships
- Decreasing school performance, having learning difficulties
- Prior history of suicide attempt
- Hormonal changes of puberty, sleep dysfunction
- Medical and physical conditions and ailments

*Unlikely risk factors but requiring further investigation:*

- Parental death during childhood

## 1.6 Protective factors

There are factors that may provide protection against depression, including:

- good peer relationships
- a good relationship with at least one parent
- being employed.

## 1.7 Prevention strategies

Prevention of depression in young people is possible, although it must be said that the intervention trials have not been rigorously evaluated. Opportunities for prevention present themselves in early childhood and at various times throughout childhood and adolescence.

Doctors may help prevent depression in young people by working with their families, from a very early stage, to:

- improve self-esteem of parents and children
- encourage positive thinking and learned optimism in young people
- increase social skills in young people
- deal with and lessen family conflict
- increase positive parent-adolescent relationships
- enhance parental problem-solving skills in dealing with their children
- encourage adolescents at high risk for depression to participate in group cognitive behavioural therapy
- be alert to those medical conditions which may precede or accompany depression, eg infectious mononucleosis, or life-threatening disorders such as blood dyscrasias.

## 2 Recognising and assessing depression

Screening of any young person for depression involves:

1. Establishing rapport
2. Diagnosis – recognising depression
3. Assessing suicide risk
4. Formulating a management plan (see part 3)

The role of the first consultation is largely to establish rapport, make a presumptive diagnosis, assess suicide risk and formulate a management plan. Initial management plans involve a prioritisation for urgent treatment and need for referral. A risk of imminent suicide requires urgent and immediate management at the first consultation (see page 16). Subsequent longer consultations will be required to explore issues in greater depth and to discuss, modify and initiate management.

### 2.1 Establishing rapport

An essential first step in dealing effectively with a young person who may be depressed is establishing rapport in order to communicate and maintain contact with them.

Young people often perceive barriers when contemplating a visit to a doctor. These include: fears that confidentiality will be broken; that the doctor will be judgemental, insensitive, lack empathy; and, that communication will be difficult because the doctor will use complex language or medical jargon. Many young people also find the potential cost of a consultation a barrier, especially if they do not have their own Medicare card, and may find it difficult to make an appointment.

#### ***Barriers young people perceive when accessing their general practitioner***

- Confidentiality – fears it will be broken.
- Judgemental or insensitive attitudes.
- Communication difficulties – complex language, medical jargon.
- Cost of consultation, not having own Medicare card.
- Long waiting times, unsuitable appointment times/travelling to clinic.

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To effectively establish rapport, it helps to have a friendly, relaxed, open and honest interviewing style and to appear unhurried. Adolescents will respond if they are made to feel important, allowed to express themselves and if they are listened to.

### ***Establishing rapport***

- Be friendly, non-judgemental.
- Appear unhurried.
- Active listening.
- See adolescent alone.
- Define confidentiality and the limitations .
- Ask permission before delving into sensitive areas.
- Feedback to adolescent, compliment their strengths.
- Involve family/carers from early stage with adolescent's permission.

Some practical tips include the following:

- Appear unhurried.
- Greet the young person first and invite them to introduce the accompanying adults.
- Interview the young person alone before speaking to adults alone, as failure to do so may, in the young person's mind, align the doctor with the other adults.
- See the young person alone at some point of the consultation.
- Explain the concept of confidentiality and its exceptions.
- Explore the young person's feelings about the presenting issue .
- Ask permission before questioning about sensitive areas.
- Agree with the young person what issues need to be discussed with the. parents or guardians, and how this should be tackled.
- Provide feedback to the young person on your impressions of their presentation.
- Consult the young person about all decisions and encourage him or her to take part in formulating the management plan.
- Compliment the young person on his or her positive qualities and strengths.

Ideally, support people and/or parents should be involved from the early stages of care (see “working with families” **on page 20**). The young person's permission for this should be obtained, except in the case of serious suicide risk. In these cases, others must be informed as the need for safety overrides the duty of confidentiality. To minimise his or her distress in these situations, it may be helpful to invite the young person to inform others with the doctor.

### Confidentiality and its exceptions

The doctor must keep all information gained from the young person confidential, **except** if there is a danger to life (suicide or homicide), or evidence of physical or sexual abuse. In these cases, others will need to be informed to keep the young person safe. Otherwise, only the express permission of the patient can enable information to be disclosed, even to family. With younger adolescents, judgement is required as to the maturity of the individual.

It is usual practice, when discussing confidentiality with young people at the start of the interview, that the exceptions are also outlined. This does not act as a deterrent to disclosure of suicidal intent (see later) and avoids the dilemma of needing to break promises.

See Appendix E for tips on making the surgery more “adolescent friendly”.

## 2.2 Diagnosis – recognising depression

Better recognition of depression occurs when the doctor, in addition to establishing rapport with the adolescent, asks questions with a psychological or social content (3). Important areas of an adolescent’s life must be explored – home life, school life, peer relationships and activities and the young person’s inner feelings and perceptions of how they are going.

### *Diagnosis – recognising depression*

- Ask questions with a psychosocial content.
- Questions may need to be direct rather than open-ended with younger teens.
- Enquire about: home, school, peers, activities, recent life events and young person’s perception about how their life is going.

Many adolescents, especially younger ones, by contrast with adults, do not respond well to open-ended questions because they may not have the language, experience or confidence to express their emotions. If the adolescent is not able to expand, ask more direct and specific questions, offer a few alternatives to choose from in a question or make a statement of what you see the situation to be and allow the adolescent to agree or offer an alternative explanation – for example:

#### *Specific questioning*

- “Where do you live? Who lives with you? How do you get along with them?”

#### *Multiple choice question*

- “Did that make you feel scared, angry or sad?”

#### *Making a tentative statement*

- “I think you are a bit depressed....what do you think?” (6, 8)

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## Exploring further in a depressed adolescent

- Past and family history of psychiatric illness/social problems.
- Medication/illicit drugs/ alcohol.
- Sexual history/pregnancy.
- Current/chronic stressors, including physical illness.
- Level of functioning in peer group, family, school.
- Cultural difficulties.
- Available supports.

The key features which allow a presumptive diagnosis of depression are discussed **on page 4** under 'Presentations'. In addition, some practitioners have reported it useful to allow the young person to rate their level of depression on a scale of 1-10 to help in the assessment of severity (6,12).

If there is any possibility that the patient may be depressed, then further understanding of the young person is needed to help guide management decisions including:

- current signs and symptoms (nature, severity, duration, presence of psychotic phenomena)
- current level of social functioning amongst peers, school and family
- recent and chronic stressors
- use of medications, alcohol and illegal drugs
- sexual history including recent pregnancy
- family situation
- family history of depression and other mental illness
- past psychosocial and medical problems
- history of schooling and relationships
- cultural issues causing alienation
- available social support and other resources

## 2.3 Assessment of suicide risk

This should be undertaken in any depressed young person. It follows the principle of the 4R's\* (4). Note that this framework is not from the evidence-based content in the main guideline document. It has been included here as a simple and straightforward checklist for clinical practice).

- |                                 |                             |
|---------------------------------|-----------------------------|
| 1. <b>Recognising the signs</b> | 2. <b>Raising the issue</b> |
| 3. <b>Risk assessment</b>       | 4. <b>Responding</b>        |

(The 4R's\* is a registered trademark of SJ Edwards)

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### 2.3.1 Recognising the signs

The **major antecedents** for youth suicide are:

- depression
- acts of deliberate self-harm
- past suicide attempts
- substance abuse
- recent loss, situational crisis, family history of suicidal behaviour
- antisocial/aggressive behaviour, having a firearm

**Behaviours** which may be signs of potential suicide are:

- numerous accidents
- dangerous/risky behaviours
- discussing death/morbid themes
- giving away favourite possessions

These and other risk factors appear in the following table and should be considered in risk assessment.

#### **Categories of risk for youth suicide**

|                                 |   |
|---------------------------------|---|
| <b>Psychiatric difficulties</b> | Depression<br>Substance abuse<br>Conduct problems<br>Psychosis<br>Past or present suicidal ideation, threats or attempts  |
| <b>Poor social adjustment</b>   | Academic failure<br>Social isolation<br>Legal problems<br>Interpersonal conflict  |
| <b>Family or environment</b>    | Interpersonal loss<br>Abuse or neglect<br>Family history of psychiatric disorder or suicide<br>Cultural conflict<br>Unemployment or financial problems<br>Exposure to suicide |
| <b>Physical health</b>          | Change in health status (ie diagnosis of a sexually transmitted disease or HIV/AIDS, pregnancy, onset of a chronic illness such as diabetes)                                  |

(4)

### 2.3.2 Raising the issue

Asking young people about suicide in the context of a medical consultation after rapport has been established will not cause them to become suicidal. Most are relieved that someone has allowed them to unburden the pressure of these thoughts and has

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offered some help. Even informing the young person that suicidal intent is a time you will need to break confidentiality (see above) rarely impedes disclosure.

- Ask directly about suicidal thoughts/behaviour.
- Talk to the young person alone.
- Allow sufficient time.
- Acknowledge that it may be difficult to talk about sensitive topics.
- Ask permission when enquiring about sensitive topics which were not part of the presenting problem.
- Do not swear secrecy.
- Discuss the limits of confidentiality.
- Ask permission from the young person to obtain a collaborative history from significant others.

(4)

The practitioner must also be aware of their own feelings toward suicide and not allow them to interfere with the clinical evaluation. Possible emotional reactions can include:

- feeling unprepared
- anxiety/fear of misdiagnosis or mismanagement
- anger at patients who engage in acts of repeated deliberate self-harm
- denial of possibility of suicide risk in patients the general practitioner knows well or identifies with.

(4)

### 2.3.3 Risk assessment

The aim is to collect information that allows an assessment of current level of risk and urgency for intervention. The presence of risk factors is important. During the assessment, the doctor must ask themselves the following questions:

- How hopeless, helpless or futile does this young person feel about life?
- How prominent are the suicidal thoughts?
- Are plans clear and lethal?
- Are the means available?
- What steps have been taken to implement the plan?
- How dangerous were previous attempts and what triggered them?
- Has this previously depressed young person suddenly become happy, or started giving away prized possessions? These young people have often made the decision to die.

(10)

The risk of suicide increases when the suicide plan is detailed, the method is likely to be lethal and readily available, and the plan minimises the prospect of help from others. **(5)**

*The following question can assess whether suicidal ideation is present:*

- Have you ever had feelings so bad that you've thought you didn't want to go on, or that you might want to kill yourself?

*Questions to weigh up level of risk:*

- Is this unhappy feeling so strong you ever wish you were dead?
- How often have you had these thoughts?
- Has anything happened recently to make you feel like this?
- Have you ever thought about how you would kill yourself?
- Is the method that you might use readily available to you?
- Have you planned a time for this?
- Have you ever tried to kill or harm yourself before?
- Did things change as a result of these attempts?
- Who would you like to support you through this time?
- Is there anything that would stop you killing yourself?
- Looking to the future, what do you feel you can look forward to?

**(5)**

The last three questions also explore the possible factors that are deterring the young person from suiciding and their degree of belief in these factors.

- Doctors cannot cause suicidal behaviours by asking about them.
- Talk of suicide should never be ignored or dismissed
- Suicidal thoughts or plans should be explored and evaluated, in association with other indicators of the depth of depression and risk factors. Depression, deliberate self-harm, attempted suicide and substance abuse are major risk factors for completed suicide.
- Urgent action may be required

### 2.3.4 Responding

The management of an acutely suicidal person is a *medical emergency*.

General practitioners should acquaint themselves with their local resources and procedures for referral of an acutely suicidal patient *before* the situation arises (see Appendix C).

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The young person's parents or guardians should be informed immediately, and all concerned are required to act to ensure his or her safety. The following steps should be taken by doctor and family/friends, wherever possible, including:

- maintaining contact with the young person
- arranging close supervision and family support
- removing all firearms or other sources of danger
- considering, if the young person is not psychotic, and the risk is not high, the appropriateness of negotiating a “no-suicide” contract (see Appendix D), in which the young person agrees not to harm themselves within a specified, limited period of time until review (5)
- contacting a psychiatrist who can respond quickly
- contacting a crisis team or community mental health team who can respond quickly
- considering hospitalisation or acute care in the community with appropriate supervision
- considering referral to the emergency department of a hospital, if possible, and preferably one with a psychiatric unit.

Suicidal ideation in a depressed young person with low risk of actual suicide requires careful assessment of the severity of their depression and a decision as to whether the general practitioner should manage them or refer (see part 3). Successful management of the depression should resolve suicidal ideation but careful monitoring is essential.

## 3 Management of depression in young people

Management of depression in young people may be enhanced when the doctor can build a caring, trusting relationship with the patient. The doctor must make the commitment to be available to offer support, advice and counselling throughout the period of the young person's illness, and afterwards.

### *Options for a general practitioner include the following:*

- Cognitive behavioural therapy (modified) – **first line** (Appendix A).
- Pharmacological treatment (SSRIs – selective serotonin reuptake inhibitors) – **second line** (Appendix B).
- Referral.
- Education for young person and family.
- Liaison with other agencies (eg school).
- Coordination of and ongoing care.

### *Options undertaken by specialist units*

- Cognitive behavioural therapy (full), interpersonal therapy, psychotherapy, family therapy, group therapy.
- Refining antidepressant therapy and initiating augmentation therapy (lithium, carbamazepine, sodium valproate, thyroid hormone, antipsychotic (12)).
- Phototherapy (for seasonal affective disorder).
- Hospitalisation.
- Electroconvulsive therapy.

Following are the appropriate forms of management for the different types of depression – unipolar and bipolar. Detailed descriptions of management are found in the appendices.

### 3.1 Unipolar depression

Cognitive behavioural therapy is the treatment of **first choice** for unipolar depression in young people because it has proven efficacy.

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Cognitive behavioural therapy (CBT) is a short term goal-oriented psychological treatment. The two guiding principles are that:

- how we behave (including how we feel) is learned through experience, and therefore may often be changed or unlearned; and
- thought processes directly impact on learned behaviour.

Cognitive behaviour therapy is a process of helping people learn more positive thinking. Young people are encouraged to examine their negative perceptions and interpretations of their experiences. They are also taught problem-solving techniques.

The full form of cognitive behavioural therapy is given by clinical psychologists, psychiatrists and others trained in the technique. In Appendix A, a modified form of cognitive behavioural therapy is described which is suitable for general practitioners. It can be used in brief sessions.

Where a practitioner does not provide counselling or CBT, referral is the treatment of choice and should be discussed sensitively with the young person so that they do not interpret referral as rejection. The young person should be made aware that he or she is welcome to return if the referral does not work out, so that other options can be explored.

It is not possible to say how long cognitive behavioural therapy, whether in its full or modified form, should be tried before drugs are prescribed and the young person is referred to a psychiatrist, where possible. As a general guide, a severely depressed young person may be too ill to engage in psychological therapy, and may require drugs and referral immediately. A less severely depressed young person who is not responding to psychological therapy within two to three weeks may need to be referred on at that stage.

In people under the age of 18, antidepressant drugs are generally not recommended as a first line therapy because they have not been shown to be effective.

Medication should be used only if cognitive behavioural therapy is unsuccessful, or if the depression is so severe that it interferes with the young person's capacity to engage in counselling, or if it is life-threatening. In older groups, antidepressant drugs may be more effective in managing depression compared to younger adolescents.

If drugs are used, the selective serotonin reuptake inhibitors (SSRIs) and new reversible monoamine oxidase inhibitors (MAOIs) work quite quickly and are relatively safe in overdose. They are preferred to tricyclics, which have been shown to be ineffective in four randomised controlled trials. Tricyclics also have substantial toxicity and side-effects, particularly in overdose, and are also fairly slow to act. The choice of antidepressant therapy should be tailored to individual need, and the young person fully informed of all treatments and their potential effects.

If depression is severe, and engagement with the young person is not possible, then SSRIs should be considered as a first line treatment. This should be done in liaison with a psychiatrist, closely followed by referral to the psychiatrist. Electroconvulsive therapy (ECT) may be useful for young people with very severe depression who have not responded to other treatments.

## 3.2 Bipolar disorder

Lithium is the treatment of choice in young people with bipolar disorder. Carbamazepine and sodium valproate may be used when lithium has failed or is contraindicated. These medications may be used in association with a major tranquilliser when psychotic symptoms of severe depression are evident. Specialist consultation in such cases is recommended. For details of drug dosages, see Appendix B.

Supportive counselling may also be effective as part of the treatment program for all young people with bipolar disorder.

ECT may be useful for young people with bipolar disorder who have not responded to other treatments.

## 3.3 Safety issues with medication and the depressed young person

Any person who is depressed is at some risk of suicide, and doctors prescribing medications should be aware of this risk. It may be advisable to prescribe only one week's supply at a time where the risk is significant, and to explore whether any other doctor has prescribed medications. Regular and timely monitoring and review of the young person's progress is essential.

In some circumstances it may be appropriate for parents or guardians to have prescriptions filled and dispense doses. In these cases, medications should be kept locked out of reach of the young person.

In some regions, community mental health teams can visit regularly to dispense medications. This may be a good option for young people at high risk of suicide.

## 3.4 When referral should be considered in managing a depressed adolescent

*Referral to a psychiatrist should be considered, where possible, if:*

- the person is suicidal
- the depression is severe
- there are psychotic symptoms
- there is a bipolar disorder

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- the young person's depression is worsening despite treatment
- there has been no response to treatment after two to three weeks.

*Referral to services capable of providing psychological therapy and counselling should be considered:*

- where the general practitioner does not provide/have experience in any form of counselling. There are insufficient specialist adolescent services to accommodate all young people with depression but it is appropriate to refer for CBT and other counselling where services are available and practicable.
- when the case is complex or requires time and multidisciplinary input (eg family therapy in addition to individual)
- where basic counselling has not resulted in improvement

*Referral to a hospital should be considered if the young person:*

- represents a serious threat to themselves
- requires basic care and support which is unavailable at home or in the community
- requires treatment but there is no appropriate local outpatient services
- would benefit from temporary removal from the home
- has severe depression which is unresponsive to treatment
- has severe depression with florid psychotic symptoms.

When referring, seek permission from the patient to exchange information with the referral point and ensure the young person has understood why referral is necessary so that they do not interpret referral as rejection.

In remote areas where referral may not be possible, a shared care may be arranged with the nearest specialist psychiatric service.

### 3.5 Education for young people with depression

The following may be discussed to fully and respectfully inform young people about their illness:

- The nature and possible causes of depression.
- Possible interventions and their benefits, risks, costs and rationale.
- The proposed approach to management.
- The likely outcomes of treatment.
- The things they can do to help the recovery process.
- The expected time to recovery.
- Possible compliance difficulties and suggestions for overcoming them.
- The likely consequences of declining assessment or treatment.
- The degree of uncertainty attached to statements.
- The personnel who will be providing the various elements of care.

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- The risk of recurrence.
- The warning signs of an impending recurrence.
- Where they can get help at any time.

### 3.6 Education – working with families

Parents are likely to feel distressed and guilty about their son's or daughter's depression. To help parents cope, doctors could:

- arrange a meeting with parents and families
- explain the nature of depression
- explain that treatments are usually successful, although recovery may be slow and patience is required
- stress the many causes of depression and that, sometimes, there is no cause
- encourage parents to seek support from family and friends
- emphasise the importance of continuing normal family life, rather than allowing the problem to take over
- suggest parents set aside time for their own activities
- describe ways in which parents can help their child overcome depression.

There are many ways of suggesting how parents and other adults can help the young person through their depression. Many of these are general parenting skills, including:

- praising the young person for all achievements, large or small
- avoiding criticism
- showing young people they understand and care
- doing things with their child that he or she enjoys
- encouraging their child to do things he or she enjoys
- being ready to listen at any time, while not forcing their child to talk
- trying to work out when the young person needs space and time, and when they would benefit from company
- being sensitive to special anniversaries, eg death of a close friend.

In particular, parents can assist the young person's recovery from depression by:

- removing possible causes of self harm such as medications or guns in cases of severe depression and suicide risk
- monitoring depressive symptoms without being intrusive
- keeping you, the doctor, informed of their child's progress, and warning you immediately of any deterioration
- being positive and encouraging about treatment and compliance with it
- creating a calm and relaxed atmosphere at home

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- reducing family conflicts
- attending family counselling sessions where appropriate
- providing healthy food
- putting the young person in touch with consumer consultants or support networks so they can talk to other young people who have come through similar problems
- reducing the personal isolation
- providing positive role models.

### 3.7 Coordination, liaison and ongoing care

During the depression, general practitioners are a central support and point of entry and coordination for the young person accessing the health system. This role includes: liaising with hospitals, psychiatrists and mental health crisis teams, by supporting families and by seeing the young person regularly.

#### ***Coordination, liaison, ongoing care***

- Liaise with specialist psychiatric services/hospitals.
- Supportive counselling/problem solving for future difficulties.
- Ongoing reassessment – 50% relapse at some time.
- Liaise with employers/school/other agencies involved with the young person.
- Work with the young person to list a support network and crisis plan for future needs.

Young people, once they get through the acute illness, will appreciate a doctor who they feel is available, caring and who offers support. Young people will also be looking for options and solutions to ongoing or new problems. Support and counselling with stressful life experiences may also help. Liaising with school counsellors or employers can help create a supportive environment for the young person so their illness is taken into account when appraising the young person's exam or work performance.

Doctors should reassess the young person at subsequent visits to ensure the depression has not returned, and keep in mind that at least 50% of young people with depression will have another episode at some time. It is worth writing down a crisis plan and support network with the young person of people or agencies who can be contacted if needed (Appendix F).

# Appendix A

## Psychological skills for the general practitioner

Although advanced level training is required for the conduct of intensive cognitive behavioural therapy, there are several techniques that can be adapted for use by general practitioners. These are most likely to be useful in the treatment of young people with mild to moderate levels of depression. With more severe levels of depression, intensive cognitive behavioural therapy will probably be required, and the young person should be referred to a specialist.

### General counselling skills

The following approaches are likely to be helpful in the management of depressed young people.

**1. *Establish positive expectancies.***

- Explain that depression is common and that it can be treated successfully. Emphasise that there is a good prospect of a positive outcome.

**2. *Establish a therapeutic alliance.***

- Explain that you can work together to deal with the problem. Stress that you are someone that the young person can talk to and that you are keen to help. However, treatment requires effort from both doctor and patient, and you need to work in partnership.

**3. *Exhibit warmth, empathy and positive regard.***

- Make use of the key counselling skills of warmth, empathy and positive regard that are characteristic of effective, successful therapies.
- Show that you care. Encourage the young person to talk. Ask questions in an open-ended way. Listen and show that you are listening by using eye contact and head nods. Show that you have understood what the young person is telling you, by using summarising statements. In particular, show that you have correctly interpreted their emotions and feelings. Try not to be critical and show that you accept the validity of his or her point of view, even if it is not your own.

**4. *Provide a rationale and framework for understanding depression and its treatment.***

- Provide information about depression – what it is, what causes it and how it can be treated.
- Emphasise the many causes of depression – biological, lack of enjoyable experiences, relationship problems, academic or work problems, negative life events and the influence of ways of thinking about events.

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- Describe cognitive behavioural therapy and how it can help to reduce depression by increasing positive experiences, by teaching people to solve life problems, and by teaching people how to think about events in different ways.

### ***Cognitive behavioural techniques***

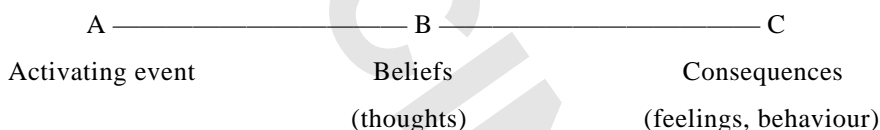
These are techniques which can be used by the general practitioner over a series of consultations.

#### **1. *Increase pleasant events***

- Get the young person to plan an enjoyable activity to be completed during the following week.

#### **2. *Cognitive challenging***

- Ask the young person to keep a written diary each day that records:
  - a time when he/she felt good – what was he/she doing? What was he/she thinking?
  - a time when he/she felt really bad – what was he/she doing? What was he/she thinking?
- Teach the young person to identify the links between events, thoughts and feelings. The ABC model developed by Albert Ellis may be useful.



- Explain how our feelings are determined by how we think about an event. If we can change negative ways of thinking to more positive ways, we will feel more positive emotions about the events. Use examples from the person's diary that show how he or she interpreted an event in a pessimistic or overly self-critical way (for example, things will always be bad, I am never any good, this is awful, I am useless).
  - Teach the young person to challenge and dispute these thoughts and beliefs. Work together to determine why pessimistic thinking is unrealistic and excessively negative. The aim is to teach the young person to identify more optimistic and realistic ways of interpreting events. Use the person's diary to identify pessimistic thinking that can be challenged and replaced by more optimistic and realistic thinking.
- #### **3. *Problem solving***
- Work with the young person to identify personal problems relating to relationship, school, work, sexual or other difficulties. Problem solving provides a framework within which to encourage people to identify their problems and begin to take control of attempts to resolve their problems if possible. Several steps are involved.

1. What is the problem?
  2. What are my choices?
  3. What are the consequences?
  4. Which choice has a positive outcome?
  5. Try it.
- Set targets for the young person to pick a strategy to try in an attempt to deal with a problematic life situation. Take one problem area at a time, encouraging the young person to learn the steps of problems solving along the way, and to apply them to other situations as they arise.

# Appendix B

## Drug therapy

Please note that this guide is based on evidence available in 1996. The recommendations will need to be revised regularly.

If drugs are used to treat unipolar depression, the preferred drugs and their recommended doses are as follows.

|                        |             |  |
|------------------------|-------------|--|
| <b>SSRIs</b>           | fluoxetine  | 20 mg mane is sufficient for most patients. If it is necessary to increase the dose, 40-80 mg can be given daily in divided doses if required. |
|                        | sertraline  | 50 mg is sufficient for most patients. The dose may be increased each 2-4 weeks to a maximum of 200 mg daily, if required.                     |
|                        | paroxetine  | 20 mg mane is sufficient for most patients. The dose may be increased each 2-4 weeks to a maximum of 50 mg daily, if required.                 |
| <b>reversible MAOI</b> | moclobemide | 300-450 mg daily. If no response after 2-3 weeks, the dose can be increased to 300 mg bd if required.  |

For bipolar depression, the following drugs, with appropriate dosages, are recommended.

|                         |  |
|-------------------------|--|
| <b>lithium</b>          | 750-1 000 mg daily in divided doses initially. Check plasma levels after 5-7 days, then increase dose by 250-500 mg if required. |
| <b>carbamazepine</b>    | 100-200 mg bd initially, increasing dose by 100 mg each 2-3 days if required. Check plasma levels after 5-7 days.                |
| <b>sodium valproate</b> | 200-400 mg bd initially, increasing dose by 200 mg each 2-3 days if required. Check plasma levels after 5-7 days.                |

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# Appendix C

## Response to a suicidal ideation in a young person

### ***Resources for referral or assistance – be prepared before the situation arises***

Psychiatrist

Local psychiatric crisis assessment team (where available)

General practitioner with expertise in adolescent health

Psychiatric registrar or youth suicide social worker of local hospital

Psychiatric ward of local hospital

Community health centre, local mental health clinic

Lifeline (13 1114)

Kids' Help Line (1800 55 1800)

*{ these have a 24-hour information service on nearest mental health resource for general practitioners*

### ***Establishing a support network for the adolescent***

Determine their existing supports: “Other than me, who would you go to if you needed help?”

If they have inadequate supports, work with them to make a list of contacts:

- Yourself
- School counsellor, favourite teacher, sport's coach, religious leader
- Youth or social worker
- Twenty-four hour crisis telephone numbers

### ***Problem management strategies for the adolescent (see Appendix A)***

It is vital that this be a part of ongoing management. Young people rarely want to die; they see suicide as a solution to their immediate pain. Helping young people see other solutions and ways around their problem is a relief to them. Basically the process involves:

- defining the exact nature of the problem (who, what, where, when)
- putting the problem in perspective and only tackling one at a time
- exploring possible solutions that are feasible to the teenager

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- setting goals so that the teenager can imagine the future and what it is like to look back on the situation and view it differently.
- keeping a diary of thoughts and goals (long term management).

### ***Ongoing therapy***

Involves resolving the factors that underlie the suicidal behaviour for long term change. Specialist mental health workers are more likely to carry out this therapy. Some general practitioners may be able to do so if skilled or participate in a share care approach with specialist services.

Adapted from SOS: Adolescent Attempted Suicide in General Practice Workshop 3. Resources available for managing adolescents at risk of suicide. Moderators guide. Oxford Clinical Communications Aust. Pty Limited Vic 1995.

# Appendix D

## The use of a “No-suicide contract”

As per Edwards S, Pfaff J (1996) *Managing Youth Suicidal Behaviour: A Guide for General Practitioners and Community Health Personnel*, Commonwealth Department of Health and Family Services, Canberra.

A no-suicide contract is a verbal or written agreement between a practitioner and young person to undertake certain tasks to keep the young person safe until the next scheduled follow-up appointment. Contract periods range from hours to a few days. It is vital to renegotiate the contract at each subsequent consultation. A young person will only be compliant with a no-suicide contract if a trusting relationship with the practitioner has been formed. In cases where a young person has impaired judgement due to intoxication or a psychosis, a no-suicide contract is contraindicated.

A contract should be viewed as a brief, time-limited management response that provides the young person with coping strategies for impending high risk situations.

**Never use a no-suicide contract as the sole management response. Contracts should only be used following a thorough risk assessment.**

**Example of a suicide prevention contract:**

An agreement between.....and Dr.....

I, .....agree that I will not attempt to harm myself or kill myself from..... to.....

During this period, if I have thoughts of harming or killing myself I agree to take the following safety steps immediately.

1. Do what my general practitioner told me to do (.....).
2. Telephone my general practitioner on....., or if he/she is not available,
3. telephone Helpline on #.....,or
4. telephone my friend,..... on..... .

I, Dr..... agree that, if..... has thoughts of harming or killing him/herself, I will undertake to be available to receive his/her telephone call.

Both parties understand and agree to this contract. The contract will be reviewed

on .....

Sign:..... General practitioner Date:.....

Sign:..... Patient Date:.....

**IMPORTANT** A no-suicide contract should not be used as the sole prevention or treatment strategy with suicidal young people.

A contract may be used for periods of up to two or three days, but should not be employed without reassessment for longer than one week.

If a patient at intermediate to high risk of suicide cannot agree to a no-suicide contract, hospitalisation may be required.

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# Appendix E

## Tips on making general practice surgeries more youth friendly

- Friendly receptionist staff with a positive attitude toward young people. They should be sensitive to young people's developmental issues and be a support and buffer especially if there is a long waiting time to see the doctor. Young people who have difficult issues to discuss can become very distressed by waiting and may feel that it is a personal slight against them and may leave. Simple explanation about the waiting time can relieve anxiety.
- Suitable appointment times (such as before or after school, at lunchtime and weekends).
- Suitable decor and reading materials available in waiting rooms including pamphlets dealing with issues pertinent to youth.
- Ensure young people are aware that they are eligible for their own Medicare card from the age of 15 and have application forms for them.
- Ensure young people are aware that medical practitioners can bulk-bill without the family Medicare card by ringing the Medicare hotline number - young people can phone 132 011 and general practitioners can phone 132 150 from anywhere in Australia (no prefix needed) to find out the Medicare number. (7)

# Appendix F

For information about youth and depression support services in your area advice can be obtained from the following area health services and centres:

## New South Wales

Mental Health Information Service on  
1800 674 200 (Country)

or call

(02) 8916 5688 in the Sydney Metropolitan

or contact the Director of Mental Health in your nearest Health area:

### ***Metropolitan Sydney***

|                      |                |                      |                |
|----------------------|----------------|----------------------|----------------|
| Central Sydney       | (02) 9556 9299 | South Eastern Sydney | (02) 9350 2489 |
| Western Sydney       | (02) 9840 3000 | Northern Sydney      | (02) 9926 8237 |
| South Western Sydney | (02) 9828 4902 | Wentworth            | (047) 242 585  |

### ***Outer metropolitan***

|               |               |
|---------------|---------------|
| Central Coast | (043) 203 170 |
| Hunter        | (049) 246 500 |
| Illawarra     | (042) 952 543 |

### ***Rural NSW***

|                 |                |                 |               |
|-----------------|----------------|-----------------|---------------|
| Far West        | (09) 8087 8800 | Greater Murray  | (060) 584 455 |
| Macquarie       | (068) 81 2200  | Mid North Coast | (065) 51 5111 |
| Mid West        | (063) 60 7700  | New England     | (067) 68 3841 |
| Northern Rivers | (066) 20 2300  | Southern        | (048) 27 3805 |

## Victoria

Centre for Adolescent Health, Parkville      or      Centre for Young People's Mental Health, Parkville  
Phone: 03 9345 5890      Phone: 03 9342 2800

For services close to you, look in the white pages telephone directory under "health" "child and adolescent psychiatric services" or "Human Services, Department of" – "child and adolescent mental health services"

## Queensland

Brisbane Health Services Info Line      or      Kidshelpline  
Phone: 07 3852 2995      Phone: 07 3867 1371

Open Youth Project, Townsville  
Phone: 077 713 648

For mental health services in other parts of the state phone:  
Queensland Association for Mental Health on (07) 3358 4988

For your district health service look under "Health, Queensland Department of" in your local white pages telephone directory.

## South Australia

Second Story Youth Health Centre, Adelaide  
Phone: 08 8232 0233

Streetlink, Youth Health Service, Adelaide  
Phone: 08 8231 4844

For your nearest health service look under "child and adolescent mental health services" in the white pages telephone directory.

## Western Australia

Youth link  
Phone: 09 224 1700

Bentley Child and Adolescent Clinic, Bentley  
Phone: 09 334 3666

Warwick Child and Adolescent Clinic, Warwick  
Phone: 09 448 5544

South Metro Child and Adolescent Service, Fremantle  
Phone: 09 335 3228

You can also look in the white pages telephone directory under "mental health" - "children and adolescents" for the service nearest you.

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## Tasmania

Phone: (03) 6233 2830

or contact:

Child and Adolescent Mental Health Services, Oakrise, Launceston

Phone: 03 6336 2867

Mental Health Child and Adolescent Mental Health Service, Clare House, New Town

Phone: 03 6233 8612

Child and Adolescent Centre, Burnie

Phone: 03 6431 9352

The Link Youth Health Service, Hobart

Phone: 03 6231 2927

Your Place Inc, North Hobart

Phone: 03 6224 0416

## Australian Capital Territory

Phone (06) 205 1469 or (06) 205 1065 (24-hour)

or contact:

Pathways, Canberra City

Phone: 06 257 7433

Mental Health Foundation (ACT) Inc, O'Connor

Phone: 06 247 1936

ACT Child and Adolescent Mental Health Services, Woden

Phone: 06 205 1509

Youth Coalition of ACT

Phone: 06 247 3540

## Northern Territory

Youth Housing, Anglicare

Phone: 0889 482 700

For the nearest health service look under "Territory Health Services" in the white pages telephone directory, then under "mental health" within that listing.

***For 24-hour telephone counselling  
and help in a crisis contact:***

**Lifeline**

Phone: 13 1114 (cost of a local call)

**Kids' Help Line**

Phone: 1800 55 1800 (free call)

# References

1. Australian Bureau of Statistics 1992: for number of suicides and attempted suicides in Australia per year.
2. Birleson P. (1988) Depression and Suicide in adolescence. *Aust. Family Physician* Vol 17, No. 5.
3. Defeat Depression. Prepared by the Management Committee and the Scientific Advisory Committee of the "Defeat Depression" Campaign. Based on: Paykel E S and Priest R G. Recognition and management of depression in general practice: *BMJ* 1992, 305, 1198- 1202.
4. Edwards S, Pfaff J (1996). "Managing Youth Suicidal Behaviour. A Guide for General Practitioners and Community Health Personnel", Commonwealth Department of Health and Family Services, Canberra.
5. Edwards S., Gostelow C., Pfaff J., Baily S., Hyde J., Follett D., Leung P. (1995). "Managing Suicidal Behaviour in General Practice. A Guide for General Practitioners", East Metropolitan Health Authority, Western Australia.
6. Martin G. (1996) Depression in Teenagers. *Current Therapeutics* pp 57-67.
7. Sancil L., Veit F. (1995) Practical strategies to improve access to health care for young people. *Aust. Paediatric Review* Vol 5 No 3:6-7.
8. Sancil L.A., Young D.Y.L. (1995) Engaging the Adolescent Patient. *Aust. Fam. Physician* Vol 4 No11: 2027-2031.
9. SOS: Adolescent Attempted Suicide in General Practice. Workshop 3..Resources available for managing adolescents at risk of suicide. Moderators guide. Oxford Clinical Communications Aust. Pty Limited Vic 1995.
10. Veit F, Schwarz M. (1995) Adolescent Suicide Attempts: a General Practice Perspective. *Aust Fam Physician* Vol 24: 2041-2044.
11. Veit F.C.M., Sancil L.A., Young D.Y.L., Bowes G. (1995) Adolescent Health Care: Perspectives of Victorian General Practitioners. *Med J Aust* Vol 163: 16-18.
12. Walter G. (1996) Depression in Adolescence. *Aust Family Physician* Vol 25, No. 10: 1575-1582.

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