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Depression in young people

A guide for mental health professionals

This document is a general guide to appropriate practice, to be followed only subject to the mental health professional's 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

NHMRC

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The strategic intent of the NHMRC is to work with others for the health of all Australians, by promoting informed debate on ethics and policy, providing knowledge based advice, fostering a high quality and internationally recognised research base, and applying research rigour to health issues.

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About this guide

This document is intended as a brief reference guide to assist mental health professionals in detecting and treating depression in young people aged between 13 and 20 years of age. It could also be useful for parents, community workers and others interested in the problems facing young people and some of the ways of helping them.

The guide 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). Specialist mental health practitioners, such as clinical psychologists and psychiatrists, are advised to consult the full guidelines for additional relevant information not summarised in this guide (such as diagnosis, differential diagnosis, detailed information about treatment and the supporting literature reviews).

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. References for all statements made in this booklet are available in the full guidelines.

Should you wish to obtain further copies of this guide, the guide for general practitioners or the full guidelines, 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 (*Blue daze: A comic for young people* and *Getting up from feeling down: Young people and depression*) are available free of charge. For information about how to obtain your copy phone 1800 020103.

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 mental health professionals 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

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.

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(Chairman)

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Glossary

Assessment

Ongoing process beginning with first client contact and continuing throughout the intervention and maintenance phases to termination of contact. The major goals of assessment are:

- identification of vulnerable or likely cases
- diagnosis
- choice of optimal treatment
- evaluation of the effectiveness of the treatment.

Bipolar disorder

A mood disorder characterised by the presence or history of manic (or hypomanic) episodes, usually alternated with depressive episodes. A history of depressive episodes is not required for all categories of bipolar disorder.

Cognitive behavioural therapy

Cognitive behavioural therapy is a process of helping people learn more positive thinking. Clients are encouraged to examine their negative perceptions and interpretations of their experiences. It involves multiple treatment components in which the young person is taught to replace maladaptive thinking patterns with adaptive thoughts, to increase levels of self-reinforcement and to explicitly schedule pleasurable activities. Cognitive behavioural therapy is available from psychologists and psychiatrists trained in the technique.

Conduct disorder

Condition characterised by aggressive, destructive, deceitful and rule-breaking behaviours. Defined according to standard psychiatric criteria.

Cyclothymia

A mood disorder of at least two years' duration [one year in adolescents] characterised by numerous periods of mild depressive symptoms not sufficient in duration or severity to meet criteria for major depressive episodes, interspersed with periods of hypomania (Depression Guideline Panel, 1993a, pp 101-102).

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Depressive disorder

A constellation of disturbances in emotional, behavioural, somatic and cognitive functioning.

Depressive mood

A sad or unhappy mood.

Dysthymia

A mood disorder characterised by depressed mood and loss of interest or pleasure in customary activities, with some additional signs and symptoms of depression, that is present most of the time for at least two years in adults and one year in adolescents (Depression Guideline Panel, 1993a, p 102).

Electroconvulsive therapy

A low-voltage alternating current sent to the brain to induce a convulsion or seizure, which is intended to produce a therapeutic effect in the depressed person. It takes place under general anaesthesia, so the client feels nothing (Depression Guideline Panel, 1993a, p 102).

Hypomania

An episode of illness that resembles mania, but is less intense and less disabling. The state is characterised by a euphoric mood, unrealistic optimism, increased speech and activity, and a decreased need for sleep. For some, there is increased creativity, while others show poor judgement and impaired function (Depression Guideline Panel, 1993a, p 102).

Management

An ongoing process beginning with initial client contact and encompassing all practitioner actions in relation to a particular client. Includes assessment/evaluation, education of the young person and family, diagnosis, treatment, addressing problems of adherence, and liaison with or referral to other agencies.

Mania

An illness characterised by hyperexcitability, euphoria and hyperactivity. Rapid thinking and speaking, agitation, a decreased need for sleep, and a marked increase in energy are almost always present. During manic episodes, some patients also experience hallucinations or delusions (Depression Guideline Panel, 1993a, p 102).

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Prevalence

The percentage of the population suffering from a disorder. The point prevalence is the percentage of the population currently suffering from a disorder. The period prevalence is the percentage of the population suffering from the disorder at some time during a specified period such as six months, 12 months or a lifetime.

Preventive interventions

Programs designed to decrease the incidence, prevalence and negative outcomes of depression. Universal preventive programs are applied to the entire population. Selective preventive programs are applied to groups or individuals at high risk of developing the disorder. Indicated preventive programs are targeted at high risk individuals on the basis of the individual's minimal, but detectable behaviours or symptoms that could later develop into a full blown disorder (Mrazek & Haggerty, 1994, p 219).

Risk factors

Those characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder (Mrazek & Haggerty, 1994, p 127).

Supportive therapy

Psychotherapy that focuses on the management and resolution of current difficulties and life decisions using the patient's strengths and available resources (Depression Guideline Panel, 1993a, p 103).

Unipolar depression

A mood disorder characterised by depressive episodes without mania.

Young people

People aged between 13 and 20 years of age.

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1 Depression in young people

Depression is common in young people, and is probably becoming more common. Yet there is strong evidence to say that it is under diagnosed, and possibly not treated as well as it could be when detected.

Apart from the harm from depression alone, it is a major risk factor for suicide. Australia has the highest rate of suicide in the industrialised world, and youth suicide is a particular and growing problem.

All adults are in a position to detect depression in adolescents, as long it is realised that depression exists, and is something more than teenage angst. In particular, mental health professionals should be aware that between 60% and 96% of young people who attempt suicide are depressed.

Mental health professionals are in the ideal position to detect, assess and care for young people with depression. Mental health professionals also know the community supports and services available, allowing quick action.

Between 60% and 90% of young people who attempt suicide are depressed

1.1 Prevalence

Many young people - about 40% in any six month period - suffer prolonged periods of sadness or unhappiness which may affect their ability to cope. 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 - more commonly older adolescents than younger ones, and more commonly females than males. Up to 24% of adolescents will have had a major depression by the age of 18.

While depression is common, it is problematic and requires treatment. Deep unhappiness, irritability, disordered mood, disordered sleep, feelings of hopelessness or helplessness and thoughts of suicide are signs of illness, not a natural stage of adolescence.

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 are either unipolar, involving depression only, or bipolar, in which manic episodes also occur.

The common symptoms of manic episodes are:

- elevated mood
- increased energy and over-activity
- reduced need for sleep
- irritability
- rapid thinking and speech
- lack of inhibitions
- grandiose plans and beliefs.

It is important to clarify if these symptoms have occurred so that the diagnosis of bipolar disorder is not missed.

The main types of unipolar depression are:

- major depressive disorder, which involves five or more depressive symptoms (see below) for at least two weeks
- dysthymia, which involves at least three depressive symptoms throughout most of a year.

Depression can also be associated with, or caused by, medical conditions or substance abuse.

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:

- Depressed or irritable mood.
- Markedly diminished interest or pleasure in most activities.
- Significant change in weight or appetite.
- Insufficient or excessive sleep.
- 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.

For a diagnosis of major depressive disorder to be made, the following criteria must be met:

- At least **five** of the symptoms to be present **daily for at least two weeks**; one of these must be either depressed or irritable mood **or** diminished interest or pleasure in activities.
- The symptoms cause significant distress or impairment.

However, it seems that many young people do not readily reveal these signs and symptoms to the primary care practitioner or other health care professional. More common presenting problems may be irritability, decreased sociability, abdominal pain, headache, tiredness, family conflict, poor school performance and attempted suicide.

Depression frequently occurs in combination with:

- anxiety disorders
- substance-related disorders
- conduct disorder
- eating disorders
- attention deficit/hyperactivity disorder.

Depression should also be considered in young people with medical conditions such as viral illnesses (for example, glandular fever and hepatitis) and chronic conditions (for example, diabetes mellitus and cancers).

Most young people with depression receive no treatment for it, probably because much of it goes unrecognised. Mental health professionals should maintain a high index of suspicion.

Young people with depression often present with irritability, decreased sociability, abdominal pain, headache, tiredness, family conflict, poor school performance or attempted suicide. Most young people with depression receive no treatment for it, because much of it goes unrecognised. Care and sensitivity in interviewing the young person can elicit the signs.

1.4 Natural history

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. It is likely to last longer when it is more severe, when suicidality is present, in difficult family environments and, possibly, in younger people, females and those with other conditions.

Depression can be associated with severe psychological distress, social withdrawal, a breakdown in family and social relationships, poor work and academic performance, increased delinquency, lower self-esteem, substance abuse and eating disorders.

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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.

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

Depression is more common in adolescents who have a family history of depression, or who have had depression previously. It is also more common in adolescents who are anxious, who have a conduct disorder, who misuse drugs and alcohol or who have concerns about their sexuality.

Depression is also more likely to occur in adolescents who suffer negative life events, such as parental conflict, separation or divorce, break-ups in relationships, exam failure or sexual, physical or emotional abuse.

Certain circumstances and experiences associated with loss, deprivation or disadvantage – such as being homeless, being of Aboriginal or Torres Strait Islander descent, being from an immigrant refugee experience or being in custody – may make adolescents susceptible to depression.

1.6 Protective factors

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

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

1.7 Prevention

Prevention of depression in young people is possible, although it must be said that there are few intervention trials which have been adequately evaluated. Opportunities for prevention present themselves in early childhood, and at multiple points throughout childhood and adolescence.

Mental health professionals 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
- deal with problems related to stressful life events.

Psychologists or mental health teams with the available resources might consider running group cognitive behavioural therapy programs for selected adolescents since such programs have been found to be effective.

Volunteers who work with professional care-givers and befriend families at risk can help build up a person's confidence and reduce their sense of isolation and lack of control.

2 Assessment

A most important part of working with a young person who may be depressed is engagement – the ability to establish good communication and maintain contact. This requires the establishment of a good relationship based on respect, care and open discussion.

The young person's needs must be addressed as a priority. Young people generally prefer to be spoken to directly, rather than through their parents.

Some practical tips:

- Greet the young person before acknowledging the parents.
- Do not interview the parents alone until after speaking to the young person.
- See the young person by himself or herself at some point of the consultation.
- Agree with the young person what issues need to be discussed with the parents, and how this should be tackled.
- Consult the young person about all decisions, and encourage him or her to take part in formulating the management plan.
- Explain the process to the client and his or her family early on, to decrease concern.

If the client agrees, support people and/or parents should be involved from the early stages of care. However, all discussions with young people must remain confidential, and this should be made clear to the client. Information will not be disclosed to anybody, including family, unless there is danger to life or evidence of physical or sexual abuse. Only the express permission of the client can ease this restriction. With younger adolescents, judgement is required as to the maturity of the individual.

Young people are more likely to seek help if:

- mental health professionals and associated staff have a caring approach and positive attitude to young people
- suitable appointment times are available
- suitable reading material is available in waiting rooms
- they are aware that they are eligible for their own Medicare card from the age of 15
- they are aware that they can be bulk-billed for appropriate services without the family Medicare card by ringing a Medicare hotline number – **132 011** from anywhere in Australia (no prefix needed).

A visit to the client's home can provide a wealth of information, as well as boosting rapport by seeing the young person in an environment where they may be more able to relax.

2.1 Diagnosis

A careful interview is essential to elicit symptoms of depression. Key questions concerning the features listed on **page 2** (under Presentations section 1.3) can be used to make a possible diagnosis of depression. Look for feelings of sadness or unhappiness, irritability, lack of interest in or pleasure from life, changes in appetite or weight, sleeping difficulties, psychomotor agitation or retardation, fatigue, feelings of worthlessness or guilt, feelings of hopelessness, impaired thinking, concentration or decision making, or recurrent thoughts of death or suicide. There may also be a fear of harm befalling oneself or a loved one.

If there is any possibility, based on those questions, that the client may be depressed, you should take a detailed history concerning:

- all current signs and symptoms, not restricted to those of depression
- current level of social functioning
- past psychosocial and health problems
- recent stressors
- use of medications and illegal drugs
- sexual history
- recent pregnancy
- family situation
- family history of depression and other mental illness
- school or work history
- available social support and other resources
- relevant cultural issues.

2.2 Assessment of suicide risk

Suicide risk should be assessed in every young person with depression. The main risk factors for suicide attempts are a previous suicide attempt, depression, a family history of suicidal behaviour, access to lethal means (such as guns, poisons and medications), drug and alcohol abuse, antisocial behaviour or aggressive behaviour.

An attempt at suicide may be triggered by a shameful or humiliating experience, a rejection, a loss, a failure or a conflict. The break-up of a relationship, an exam failure, the death of someone loved or concerns over sexual identity issues are typical examples.

In assessing the suicide risk, you could start with the following question to assess whether any risk exists:

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

If there is a positive response to this question, you could go on to quantify the risk by asking some or all of the following questions:

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- 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?
- On a scale from one to 10, how strong is your desire to kill yourself?
- What would it take to move you one point down the scale?
- Have you ever thought about how you would kill yourself?
- Is the method that you might use readily available?
- 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?
- If you could look to the future, what do you feel you could look forward to?

Talk of suicides should never be ignored or dismissed. Suicidal thoughts or plans should be explored and evaluated, in association with other indicators of the severity of depression. Urgent action may be required to prevent a tragic outcome (see page 9).

3 Management

The mental health professional should build a caring, trusting relationship with the client and be available to offer support, advice and counselling throughout the period of the young person's illness, and afterwards.

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 choice for unipolar depression and depressive symptomatology in young people. Cognitive behavioural therapy 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
- thought processes directly impact on learned behaviour.

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

Cognitive behavioural therapy is available from clinical psychologists, psychiatrists and other mental health professionals trained in the technique. A modified form of cognitive behavioural therapy, which is outlined in **Appendix A**, could be used by all mental health professionals.

Antidepressant drugs are not recommended as a first line therapy. There is generally a lack of evidence of their efficacy in young people and concern about their potential side-effects and the risk of lethal or debilitating overdose.

They 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 the depression is so severe that it is life-threatening. Antidepressant drugs may be effective in older groups (18 years and older).

If drugs are used, the SSRIs (selective serotonin re-uptake inhibitors) may be efficacious and have lower toxicity for young people. However, there is concern about the possibility they may induce suicidal behaviour in some young people.

It is not known whether the new reversible monoamine oxidase inhibitors (MAOIs) are helpful in treating young people's depression, however they may be indicated for older adolescents (18 years and older).

Tricyclics have substantial toxic effects, particularly in overdose, and their efficacy has not been established. They are not recommended at this stage for young people. Irreversible MAOIs are not recommended as a treatment for young people.

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When an antidepressant is prescribed, the choice of antidepressant should be tailored to individual need, and the young person informed fully of all treatments and their potential effects and side-effects. The treatment should be undertaken by a psychiatrist, or by a general practitioner in liaison with a psychiatrist.

Electroconvulsive therapy (ECT) may be useful for young people with very severe depression who have not responded to other appropriate 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. Supportive counselling should be 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 appropriate treatments.

3.3 Medications and the depressed young person

Any young person receiving medication for depression is at risk of using those medication for the purposes of suicide. To minimise the risk where it is significant, doctors should consider prescribing only one week's supply at a time. Regular and timely monitoring and review of the young person's progress is vital.

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

In some regions, community mental health teams are able to visit clients at home and dispense prescribed medications. This may be an option in suitable circumstances.

3.4 Management of a suicidal person

The management of an acutely suicidal person is an emergency. If you think a young person is suicidal, you should inform the person's parents or guardians and act immediately to ensure his or her safety. The following steps should be taken, wherever possible. The mental health professional should:

- maintain contact with the young person
- arrange close supervision and family support
- ensure the removal of all firearms or other sources of danger
- consider, if the young person is well enough to participate and where the risk is not high, the appropriateness of negotiating a "no-suicide" contract, in which the young person agrees not to harm themselves within a specified, limited period or time
- contact a psychiatric service or psychiatrist who can respond quickly
- consider acute care in the community with appropriate supervision or hospitalisation.

Written information should be provided to the young person and his or her family or guardian, to encourage better retention of the discussion and emergency contacts.

3.5 Information

Clients should be informed, in the course of their assessment and treatment, about:

- the nature and possible causes of depression
- possible interventions and their benefits, risks, costs and rationale
- the proposed approach to management
- the things they can do to help with the recovery process
- the likely outcomes of treatment
- 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 aspects of care
- the risk of recurrence
- the warning signs of an impending recurrence.

3.6 When referral should be considered

The vast majority of young people with depression are likely to benefit from psychological therapy and counselling from appropriate mental health professionals.

Referral to a psychiatrist or psychiatric service should be considered, where possible, if:

- the person is suicidal
- the depression is severe
- there are psychotic symptoms
- there is a bipolar disorder
- treatments have been unsuccessful.

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 are no appropriate local community mental health services

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would benefit from temporary removal from the home

- has severe depression which is unresponsive to treatment.

Referral to a specialist mental health professional with advanced skills in cognitive behavioural therapy should be considered if the practitioner does not have these skills.

3.7 Working with families with depressed young people

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

- 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 that parents set aside time for their own activities
- describe ways in which parents can help their son or daughter overcome depression.

There are many ways parents and other adults can help the adolescent through depression, and some of these could be suggested in appropriate circumstances. Many of these are general parenting skills, including:

- praising them for their small achievements
- avoiding criticism
- showing the young person they understand and care
- doing things with their child that he or she enjoys
- encouraging their son or daughter to do things he or she enjoys
- being ready to listen at any time, while not forcing their son or daughter to talk trying to work out when their son or daughter needs space and time, and when they would benefit from company.

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
- monitor depressive symptoms without being intrusive
- keeping mental health professionals and doctors informed of the young person'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
- reducing family conflicts

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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 coped with similar problems
- providing positive role models.

Appendix A

Psychological skills

Advanced level training is required for the conduct of intensive cognitive behavioural therapy (CBT) and many mental health professionals reading this guide will already possess the requisite skills. There are, however, several techniques that can be adapted for use by mental health practitioners without the advanced training. These are most likely to be useful in the treatment of young people with mild to moderate levels of depression. With severe levels of depression, intensive cognitive behavioural therapy will probably be required, and the young person should be referred to a practitioner with advanced CBT skills.

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 you and the client, 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.

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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.

- 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

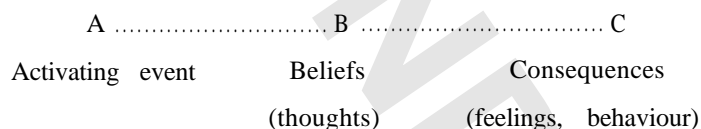
These are techniques which can be used by the mental health professional over a series of meetings.

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 problem 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. These recommendations are subject to the treating medical practitioner's judgement in each situation where a person requires drug treatment.

SSRIs	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.
reversible MAOI	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.

lithium	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.
carbamazepine	100-200 mg bd initially, increasing dose by 100 mg each 2-3 days if required. Check plasma levels after 5-7 days.
sodium valproate	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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1. Depression Guideline Panel 1993a, *Depression in primary care: Volume 1. Treatment of major depression*. Clinical practice guideline, no. 5. US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. AHCPR Publication No. 93-0551, Rockville, MD.
2. Mrazek RJ, Haggerty RJ eds 1994, *Reducing risks for mental disorders. Frontiers for preventive intervention research*. National Academy Press, Washington, DC.

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