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Depression in Young People

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Contact us:
Mail: P.O. Box 6032, Dunedin
Email: editor@bpac.org.nz
Free-fax: 0800 27 22 69

www.bpac.org.nz

PURPOSE OF JOURNAL

This journal focuses on the management of depression in children and adolescents and is based on the relevant material in the Evidence Based Practice Guideline for the Identification of Common Mental Disorders and management of depression in primary care, published in July 2008 by the New Zealand Guidelines Group.[1]

The journal is also a supporting information resource for the *bestpractice* Decision Support Module. This module is freely available to all New Zealand General Practices. Please contact *bestpractice* Decision Support for further information.

Depression in Young People

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This journal is the first of three follow-up publications which supplement the Adult Depression Journal published in June 2009. Future bpac[nz] publications in this series:

- Management of depression during pregnancy, breastfeeding and postnatal depression
- Management of depression in elderly people

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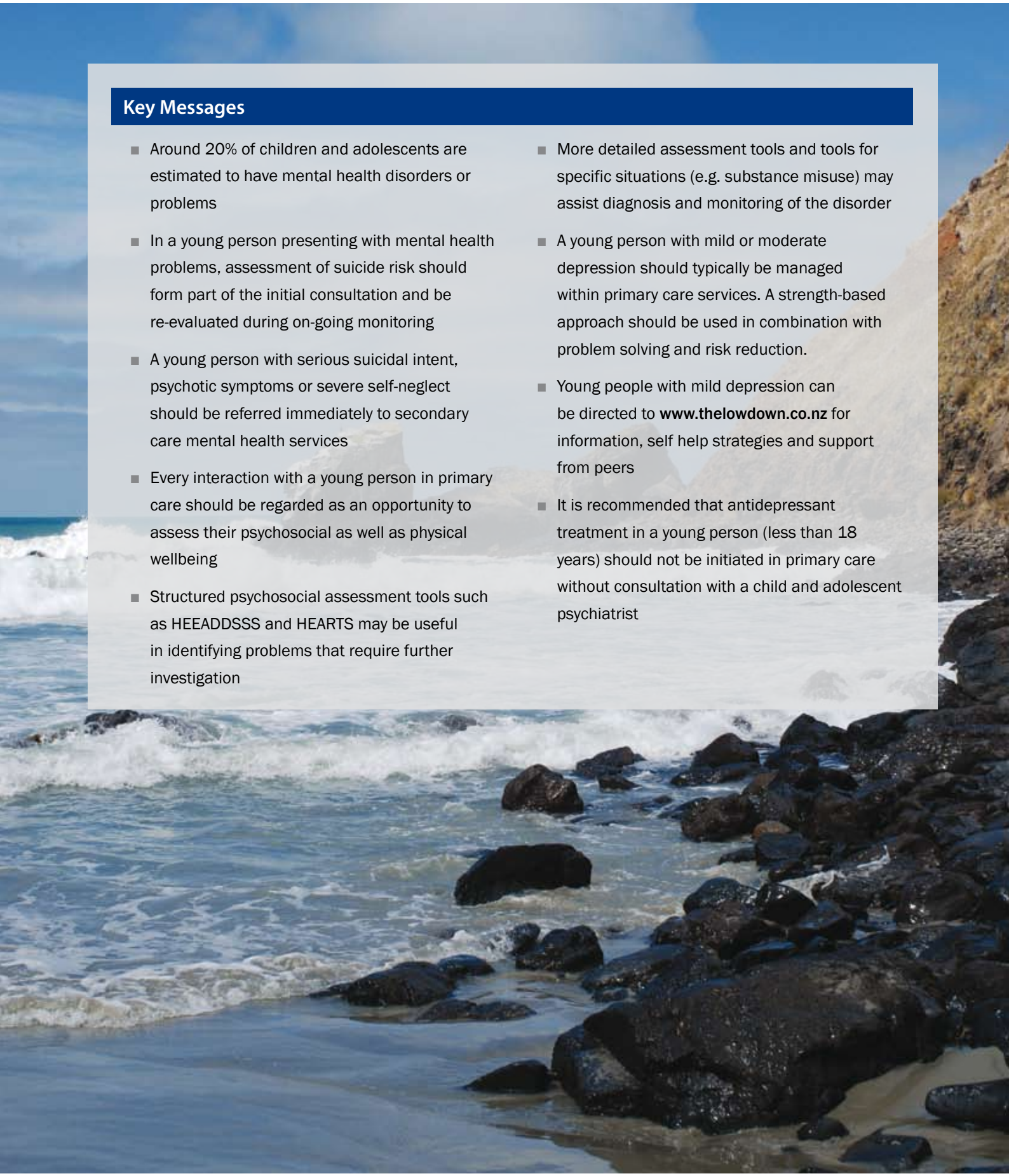


Key Messages

- Around 20% of children and adolescents are estimated to have mental health disorders or problems
- In a young person presenting with mental health problems, assessment of suicide risk should form part of the initial consultation and be re-evaluated during on-going monitoring
- A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services
- Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing
- Structured psychosocial assessment tools such as HEEADDSSS and HEARTS may be useful in identifying problems that require further investigation
- More detailed assessment tools and tools for specific situations (e.g. substance misuse) may assist diagnosis and monitoring of the disorder
- A young person with mild or moderate depression should typically be managed within primary care services. A strength-based approach should be used in combination with problem solving and risk reduction.
- Young people with mild depression can be directed to **www.thelowdown.co.nz** for information, self help strategies and support from peers
- It is recommended that antidepressant treatment in a young person (less than 18 years) should not be initiated in primary care without consultation with a child and adolescent psychiatrist

Introduction

EVIDENCE INDICATES that early interventions in a number of mental health conditions for children and young people can result in better outcomes. Due to the high prevalence of mental health disorders in young people, every interaction or consultation should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing.

From a general practice perspective, many children will have important psychological problems at a subclinical level which would benefit from intervention, and may be the precursors to adult disorders. These include behaviour and conduct problems, significant school refusal and the excessively anxious child.

Prevalence and epidemiology of common mental health disorders in young people in New Zealand

Mental disorders in young people are common

Around 20% of children and adolescents are estimated to have mental health disorders or problems, with similar types of disorders being reported across cultures. About half of mental health disorders begin before the age of 14 years.

A 2006 epidemiological study in New Zealanders found the 12-month prevalence for major mental health disorders, in the age band 16 to 24 years, to be 29% (Table 1).

The most prevalent mental health disorders among young people in New Zealand are anxiety disorders, depression, conduct disorder and substance abuse. The gender-specific prevalence of disorders varies with age, with an overall increase up to the age of 18 years (Table 2). In

Table 1: New Zealand mental Health Survey: 12-month prevalence of any disorder and severity by age. (Adapted from Oakley Browne 2006 [2])

Age group (years)	Twelve-month prevalence of any disorder % (95% CI)	Prevalence of serious disorder % (95% CI)
16–24	28.6 (25.1, 32.3)	7.2 (5.7, 9.0)
25–44	25.1 (23.2, 27.1)	5.8 (5.0, 6.6)
45–64	17.4 (15.7,19.2)	3.8 (3.1, 4.5)
65 and over	7.1 (5.7, 8.8)	1.1 (0.5, 2.0)

Disorder includes: anxiety disorders, mood disorders, substance use disorders and eating disorders.

childhood and early adolescence, males are at greater risk, with higher rates of conduct disorder, attention-deficit hyperactivity disorder, and depressive disorder (depression and dysthymia). In adolescence, the rates of depression/dysthymia and anxiety disorders increase dramatically in females, while the rate of substance abuse is higher in males.[1]

Childhood anxiety commonly precedes adolescent depression. In the presence of both anxiety and depression, there is an increased risk of developing a comorbid substance use disorder and treatment responsiveness is reduced.[1]

Late puberty is commonly associated with experimentation with drugs (usually alcohol and marijuana) and also with a three-fold increase in substance misuse. Multiple substance misuse is also common. Two-thirds of New Zealand adolescents with marijuana dependence are also alcohol dependent. Clinicians tend to underestimate adolescent substance-related pathology and this is probably the most commonly missed diagnosis in this age group.[1]

Mental disorders in young people lead to emotional distress, impaired functioning, physical ill-health and increased suicide risk. They also carry a high risk of a pattern of recovery and recurrence (more likely in females) or unremitting persistence (more likely in males) into adult life.[1]

Mental health problems in pre-school children and infants.

Some recent studies indicate that mental health problems are present in pre-school children and infants. A cohort study carried out in Denmark reported a prevalence of mental health problems of 16 – 18% in children aged 1.5 years of age. The most common problems were emotional, behavioural and eating disorders. Psychosocial problems and parent-child disturbances appear to be risk factors for the development of a disorder in a very young child.[3] In a recent review the overall prevalence of disorders in children aged 2 – 5 years was reported as about 16% with a similar spectrum of disorders to older children and adults. The prevalence distribution within each disorder was different; for example, depression is more common in older children and adults but oppositional defiant disorder (ODD) is more common in pre-schoolers.[4]

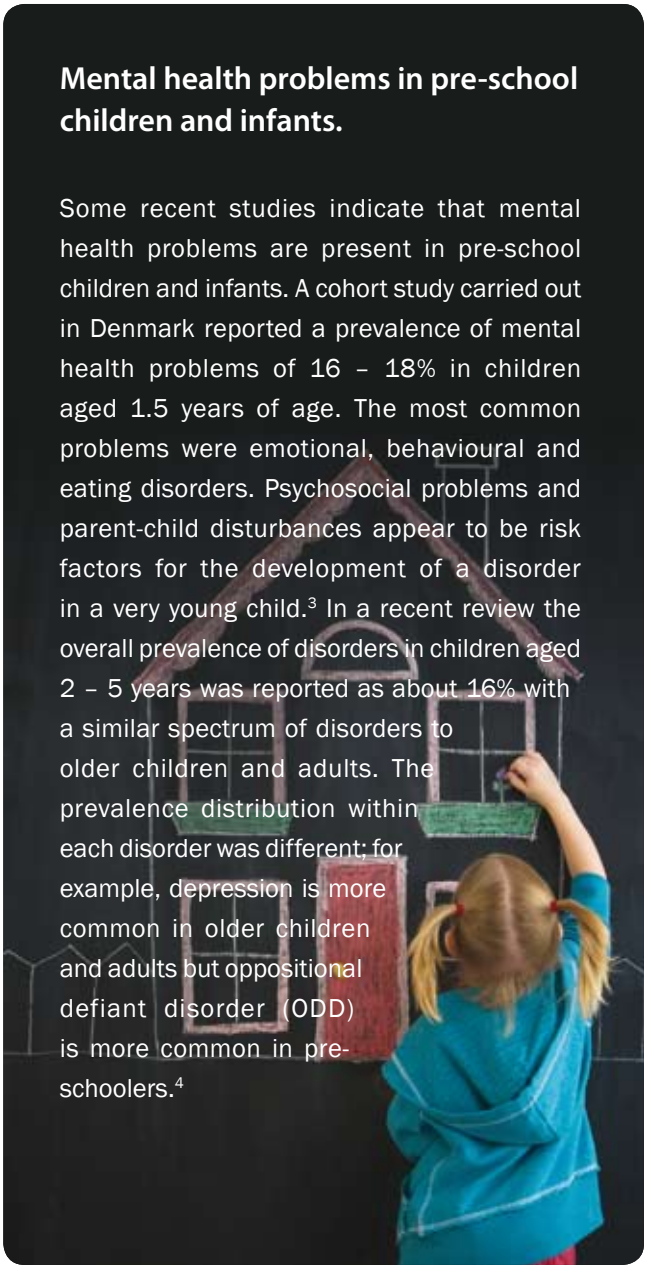


Table 2: Prevalence of common mental disorders in children and adolescents.[1]

Disorder (in order of prevalence)	Estimated population prevalence (%)		
	Total	Boys	Girls
Preschool (also see box previous page)			
Preschool mental health problems (parent rated)	16	17	14
Hyperactive behaviour disorder	2	2	2
Primary school age			
Attention-deficit hyperactivity disorder	14	19	9
Anxiety disorder (especially separation anxiety)	5	no data	no data
Conduct disorder	3	5	2
Depression/dysthymia	3	4	2
Pre-adolescence (11 years)			
Conduct/oppositional disorder	9	12	5
Attention-deficit hyperactivity disorder	5	no data	no data
Separation anxiety	4	2	5
Overanxious disorder	3	4	2
Depression/dysthymia	2	3	<1
Any mental disorder	18	20	17
Mid-adolescence (15 years)			
Anxiety disorder	13	7	19
Conduct disorder	5	7	3
Depression/dysthymia	6	3	9
Any mental disorder	22	16	18
Late adolescence (18 years)			
Alcohol or substance abuse/dependence	24	29	20
Depression/dysthymia	18	10	27
Anxiety disorder	17	12	22
Any mental disorder	42	39	45

NZ data have been used where available

Common mental disorders often co-exist

Young people presenting with one disorder (e.g. depression) are at increased risk of having other disorders (e.g. substance misuse or conduct disorder). Research conducted in New Zealand showed that 40% of 18 years olds who met the criteria for a mental disorder had more than one disorder.[1]

New Zealand Suicide rates

Every year approximately 100 young New Zealanders (aged 15–24 years) die by suicide. This accounts for about a fifth of the total number of suicides each year. While the rate of suicide for young people has declined by around 30% since its peak in the late 1990's, it continues to be a significant cause of death accounting for approximately 25% of all deaths in this age group.[5]

Men and Māori youth are particularly affected by suicide. Based on 2006 figures, young men have a rate of 31 per 100,000 population, which is significantly higher than the total population rate of 12 deaths per 100,000.[5] The Māori youth rate is 33 per 100,000 population compared with the non-Māori youth rate of 15 per 100,000.[6]

Suicide in children under the age of 10 is very rare, and uncommon in those aged 10–14 years.

International comparisons

New Zealand has one of the highest youth suicide rates among developed countries. This was highlighted in a 2009 WHO publication[7] which showed New Zealand teenagers (aged 15–19 years) had the highest rates of suicide in the OECD for both men and women. Caution needs to be taken when making international comparisons of suicide rates because many factors affect the recording and classification of suicide and can result in undercounting of suicide in other countries. Key factors influencing reporting rates are the level of proof that is required for classification of a suicide, which is very thorough in New Zealand and is made after a Coroner's investigation. This means compared to other countries New Zealand has a low number of "undetermined deaths". The stigma associated with suicide may also influence reporting rates as it deters the classification of a death as a suicide in some countries.

However, it is a significant concern that many young people die by suicide in this country and primary care needs to be responsive to ensuring young people are provided with best practice assessment, treatment and management of suicide risk and mental disorders.

Recognition and assessment of **common mental disorders** in young people

Key Points

- A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services
- In a young person, hopelessness is recognised as a strong prognostic indication for severe depression and warrants urgent referral. Other indications of severe depression are persistent symptoms, other serious mental or substance use disorders and significant functional impairment
- Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing
- In a young person presenting with mental health problems, assessment of suicide risk should form part of the initial consultation and be re-evaluated during on-going monitoring
- Psychosocial wellbeing in adolescents can be assessed using a standardised questioning format such as the HEEADSSS (page 11)
- Practitioners involved in the assessment of young people for mental health disorders should endeavor to build a supportive and collaborative relationship with the young person and their family/whānau
- Practitioners should be aware of the cultural identity and health care preferences of young people in their care.

In this section the clinical features of the common mental disorders are outlined along with a discussion of suicidal behaviours. Assessment of the potential for suicide is an essential part of initial and on-going management. In the final part of this section a number of psychosocial and brief assessment tools are described. These are also included in the *bestpractice* Decision Support module and can be used to assist in the diagnosis, assessment of severity and monitoring of treatment.

The clinical features of the most common disorders are briefly described here. For more information please refer to the New Zealand Guidelines.[1]

Recognising common mental disorders

Anxiety disorders.[1]

Separation anxiety is defined as developmentally inappropriate and excessive worry concerning separation from parent and home, refusal to go to school, reluctance to be home alone, nightmares and/or physical complaints, for at least four weeks. Refusing to go to school differs from truancy in that parents are often aware of the child's absence from school and the child is compliant in other respects.

Generalised anxiety disorder is defined as excessive or uncontrolled worry, difficulty concentrating, restlessness, irritability, sleep problems, fatigue and or muscle tension, for at least six months.

Panic disorder is defined as spontaneous recurrent episodes of panic, with palpitations, sweating, trembling or dry mouth and other physiological and psychological symptoms.

Separation anxiety is more common in young children, while generalised anxiety disorder and panic attacks are more common in adolescents. Related disorders include phobias, obsessive compulsive disorder and post traumatic stress disorder (PTSD). Symptoms often overlap and many young people will meet the criteria for more than one type of anxiety disorder.

Anxiety disorders often present with somatic symptoms and other conditions such as hypoglycaemia, migraine, seizures and other problems must be excluded.

Depressive Disorders.[1]

Depression

The DSM-IV criteria for depression in children are as follows:

- Persistent sad or irritable mood
- Loss of interest in activities once enjoyed
- Substantial change in appetite or body weight, failure to make expected weight gain
- Oversleeping or difficulty sleeping
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Difficulty concentrating
- Recurrent thoughts of death or suicide

Five or more of the DSM symptoms (including at least one of the first two) must persist for two weeks or more and must cause clinically significant distress or functional impairment before major depression can be diagnosed. However, symptoms can be more unstable in young people and some days of normal mood within the two week period does not negate the diagnosis.

Although not specifically listed in the DSM criteria, hopelessness is considered by many practitioners in this area to be the most important prognostic symptom in adolescents in both genders across all ethnic groups.

Irritability and frustration are very important symptoms of depression in children and adolescents and may be more important than low mood. In depression, persistently feeling "grumpy and cross" is commonly reported by both genders. This must be distinguished from normal teenage grumpiness and angst which is usually of short duration. Girls tend to report more internal symptoms such as

loneliness, unhappiness and self-hate, while boys report changes in more overt behaviours such as reluctance to talk, sleeping problems, difficulty in concentrating and decision making.

Somatic complaints are very common in children and adolescents who meet the diagnostic criteria for depression, especially in the younger age group. Adolescent depression is more similar to the adult form, with a greater likelihood of mood symptoms at presentation, but these may still be masked by behavioural problems, substance misuse or somatic symptoms.

Dysthymia

Dysthymia is a chronic lowering of the mood that does not fulfill the criteria for recurrent depressive disorder in terms of either severity or duration of individual episodes. There are variable phases of minor depression and comparative normality but in diagnosing dysthymia it is important to establish that the young person does not meet the criteria for current depression. If depression has preceded the onset of dysthymia, then there must have been full remission of all depressive symptoms for at least two months before the development of dysthymia, to make the diagnosis. By contrast, episodes of depression can be superimposed on dysthymia, in which cases both diagnoses can be given.[1]

Bipolar Disorder

Symptoms of depression with marked melancholic or manic/hypomanic features may signal bipolar depression, especially is there is a family history.

Substance misuse

Substance use and misuse are strongly associated with puberty and uncommon in young children, though the age of initiation is steadily dropping. It is common to underestimate the use of alcohol, tobacco and drugs. Substance use disorder is under-recognised in adolescents despite occurring in approximately 40 % of young people attending mental health services.[8] Young people who disclose that they have used substances during a routine HEEADSSS interview (see next page) should be questioned more directly to determine their level of use.

Conduct Disorder

Conduct disorder consists of a repetitive and persistent pattern of behaviours in which the basic rights of others or major age-appropriate norms or rules of society are violated. Features include bullying, starting fights, cruelty to people and animals, truancy, stealing and damage to property.

Attention-deficit hyperactivity disorder

ADHD, especially when associated with conduct disorder, increases the risk of behavioural problems and substance use disorders in adolescents. ADHD is six times more common in boys than girls. The diagnosis requires information from external sources, such as teachers, and caregivers, and usually involves specialist assessment.

Suicidal behaviours

Suicidal behaviours in young people comprise a spectrum ranging from thoughts and ideas about suicide through suicide attempts of varying severity, to completed suicide.

Suicidal ideation

Suicidal ideation is relatively common. About 16% of the New Zealand population reports a lifetime history of suicidal ideation, with the onset most likely in late adolescence.[2] For most young people, suicidal ideation does not lead to a subsequent suicide. However, those with risk factors and persistent ideation in association with mental health problems are at significantly increased risk of suicide.[9]

Suicidal attempt

A suicide attempt may range from a relatively minor event to a medically severe and life threatening event. Most suicide attempts in young people only result in minor physical harm and do not represent a serious attempt to

die. Females are more likely to make suicide attempts than males of the same age and are more likely to be admitted to hospital following an attempt. This may be due to the higher rate of depression and anxiety in young females compared to males.

Completed suicide

The completed suicide rate is higher in young males than females and the disparity is approximately 3 to 1. The gender difference may in part be due to the fact that males tend to use more lethal methods of suicide attempt such as hanging, carbon monoxide or firearms.[9]

Very few children (under 15 years) die by suicide, but care should still be taken when assessing for suicide and in ensuring their mental health and psychosocial needs are best met.

Assessing common mental disorders

Psychosocial assessment of young people[1]

Mental disorders are highly prevalent in young people and every interaction should be viewed as an opportunity to enquire about psychosocial well-being regardless of the presenting complaint. Such enquiries require good communication skills, empathy, cultural awareness, a willingness to discuss sensitive issues and a non-judgmental approach. Young people may not be forthcoming with their problems and issues, but sensitive questioning can identify the need for further assessment.

Structured clinical assessment

The HEEADSSS and HEARTS are structured question prompting tools to assist in the identification of problems and protective factors. In the *bestpractice* decision support module these are available as a pop-up with a notes field to add details of the assessment.

HEEADSSS

The HEEADSSS is designed for use in adolescents.

Home: relationships, communication, anyone new?

Education/Employment: ask about school grades, work hours, responsibilities

Eating; body image, weight changes, dieting and exercise

Activities: with peers, with family

Drugs: tobacco, alcohol, other drugs – use by friends, family, self

Sexuality: sexual identity, relationships, coercion, contraception, pregnancy, sexually transmitted infections (STIs)

Suicide and depression: sadness, boredom, sleep patterns, anhedonia

Safety: injury, seatbelt use, violence, rape, bullying, weapons

Issues of ethnic identity may also be important particularly among adolescents from minority cultures.

HEARTS

The HEARTS acronym has been suggested as method of psychosocial assessment for young children and their family/whānau.[1]

Home: conduct, general behavior, "manageability"

Education: any concerns about behaviour/progress?

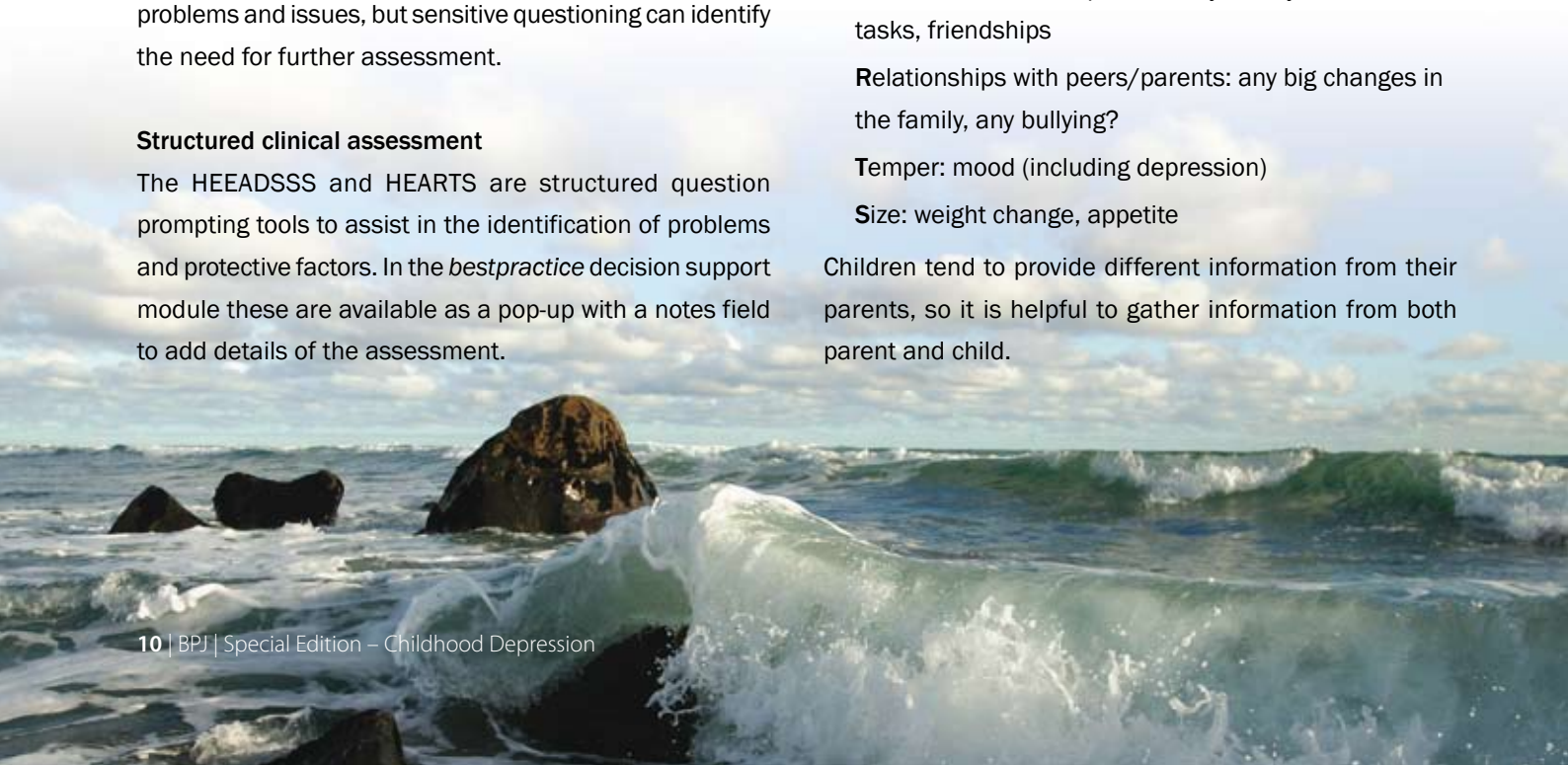
Activities: attention span, anxiety, ability to finish tasks, friendships

Relationships with peers/parents: any big changes in the family, any bullying?

Temper: mood (including depression)

Size: weight change, appetite

Children tend to provide different information from their parents, so it is helpful to gather information from both parent and child.



Other aspects to consider during assessment are:

- **Hopelessness and Helplessness**

  A strong emphasis should be placed on the presence and assessment of these feelings. What is the context of their feelings of hopelessness and how do they view their future? Profound hopelessness is strong risk factor for depression, suicidal ideation and suicidal intent.

- **Family/whānau involvement**

  Assessment of a young person involves working with parents or caregivers and consideration of the wider family/whānau network.

- **Availability of a supportive network.**

  The ability of family/whānau and others to support the young person may be influenced by many factors such as socioeconomic, geographical, relationships and deprivation. Childhood depression is very strongly associated with difficulties within the family and these should be addressed first.

- **Confidentiality**

  A careful discussion of confidentiality helps to build trust between the practitioner and the young person. The practitioner should discuss with a young person their right not to have personal information disclosed without their permission, along with the limits to this right. See box for an example statement that could be used to explain the limits of confidentiality.

Sample confidentiality statement

What we talk about will be kept private and I won't tell other people what you say. The only time this would change would be if I thought you might hurt yourself or someone else, or if I thought someone else might hurt you. If I was worried about you I would do what I needed to do to keep you safe. So I might need to talk to your Mum and Dad, or to other people. If I can I will talk to you about this first.

(**adapted from**[1])

Assessment tools for specific situations

Structured psychosocial assessment may signal a potential mental disorder and problems which warrant further investigation. For example, while using HEEADSSS, an adolescent indicates the presence of family breakdown, poor self-image, lack of motivation at school and regular alcohol use. This would prompt further exploration of the person's ability to function and cope, assessment of feelings of hopelessness and helplessness and direct questioning about suicidal thoughts or attempts. The mention of regular alcohol use would prompt the possible use of SACS or CRAFFT (over page) which specifically evaluate drug and alcohol use.

Assessment of suicide risk.[1]

Assessment of suicide risk can be challenging as there is no evidence of absolute markers that indicate the presence or intensity of suicide risk. Assessment only provides a snapshot of risk at a given time. Therefore assessment of suicide should be on-going during treatment as new triggers can emerge even if a person's mental state is improving or staying the same. For example, chronic risk factors such as family dysfunction or history of physical or sexual abuse remain static, but an acute stressor such as relationship breakdown or alcohol/drug binges may rapidly elevate a person's risk of suicide.

The most important factors to consider are triggers and current mental state:

- Intent/definite plan
- Lethality of likely method
- Access to means
- Presence of risk factors (e.g. mental or physical illness, chronic pain, alcohol use)
- Hopelessness
- Psychosocial triggers
- Lack of protective factors

Deliberate self–harm, such as cutting, refers to behaviours that may or may not result in serious injury, but are not intentionally fatal. There are many explanations for these

behaviours, a common one is that it is used as an attempt to regulate emotions which often occurs as a response to frustration and anger. The emotional distress that leads to self-harm can also lead to suicidal thoughts and actions.

Two assessment tools to assist in assessing suicide risk are available. The simplest tool (available in the *bestpractice* decision support module and in Appendix 1) is not specific for young people but the principles apply to all age groups. A more complex assessment tool and management plan designed for young people is reproduced in Appendix 2.

It is recommended that a broader psychosocial assessment (e.g. HEEADSSS) is carried out in conjunction with these questions.

Strengths and Difficulties Questionnaire (SDQ) – Appendix 3

The SDQ is a brief behavioural screening questionnaire that can be completed by children, adolescents or their parents to assess overall mental health and general functioning. It includes assessments of strengths as well as weaknesses and difficulties. It may be useful in the following situations:

- If HEEADSSS or HEARTS identifies a problem that requires further assessment
- If the patient presents with symptoms suggestive of a mental disorder
- Where it is possible or beneficial to involve parent / caregiver or teacher in the assessment

The *bestpractice* decision support module includes the parent versions of the SDQ for four to ten year olds and 11 – 17 year olds.

The SDQ does not assess substance use behavior and its consequences and therefore may underestimate the prevalence of substance use in adolescents.

Substances and Choices Scale (SACS) – Appendix 4

SACS is used for assessing and monitoring the pattern of use and impact of alcohol and drugs in young people. It can identify problem areas that warrant further in-depth assessment. As it measures behaviour over the last month, it can also be used on a frequent basis to assess progress during treatment and measure outcome. Completion of the SACS helps young people and clinicians to plan treatment goals and review progress. For more information see **www.sacsinfo.com/Questionnaires.html**

SACS is available in a community and clinician version. The community version is shorter and may be less intimidating to complete than the clinician version which provides a comprehensive list of substances that can be misused.

The *bestpractice* decision support module includes the shortened community version. However, clinicians are encouraged to enquire about the use of other substances such as party pills, herbal highs and sedatives.

The SACS is preferred to the CRAFFT (see below) as it was developed and validated in the New Zealand population and also has a scoring and rating system.

CRAFFT – Appendix 5

CRAFFT is an acronym for a set of questions that has been validated for the detection of alcohol and substance abuse in adolescents in primary care.

The CRAFFT tool is designed specifically for adolescents for detecting alcohol and substance abuse, and dependence. The disadvantage with CRAFFT is that it does not have a scoring system and therefore cannot be used to monitor treatment outcome.

PHQ-9 – Appendix 6

The PHQ 9 is specific for depression and can be used following psychosocial assessment or a more general brief assessment tool such as the SDQ. Although the PHQ-9 has not been formally validated for use in adolescents and children, there is no lower age cut off for its use.

Brief assessment tools may be helpful as an aid to diagnosis but do not replace the need for a full clinical evaluation.

Recognising risk of suicide in young people

The risk of suicide is comprised of background risk factors which are mainly static, and changeable risk factors which can increase overall vulnerability.

Background risk factors

- Social and educational disadvantage
- Past trauma including physical or sexual abuse
- A history of exposure to a dysfunctional family life
- Identity issues e.g. ethnicity, sexual orientation
- Development of significant mental health problems and/or personality difficulties

(Adapted from [9,10])

Dynamic (changeable) risk factors

The risk of suicide is sensitive to dynamic factors which can increase vulnerability. For example, a male with a history of sexual abuse has background risk factors for suicide which might be increased by onset of alcohol or drug binges, or relationship breakdown.

Accumulative risk of suicidal behaviour

Suicidal behaviour in young people is unlikely to be solely due to a stressful life event or psychiatric disorder, but rather, a response to an unhappy or adverse life course which has been characterised by the accumulation of risk factors during childhood and adolescence.[9]

Ethnicity and suicide risk

Māori ethnicity is associated with increased suicide risk and practitioners should be aware of the possibility of heightened risk.[9] For assessment of suicide risk see page 11.

Previous suicide attempt increases on-going risk[1]

If there has been previous attempt at suicide the risk of subsequent suicide is increased.

Risk factors include:

- older males
- current mental disorder
- disordered mental state (e.g., mood disorder, particularly when complicated by substance misuse or dependency)
- issues around sexual identity
- continued wish to die
- use of a method other than drug ingestion or superfi cial cutting
- signs of instability, agitation or psychosis

Management of depression in young people in primary care

Key recommendations:[1]

Management

- A young person with mild or moderate depression should typically be managed within primary care services
- A strength-based approach should be used in combination with problem solving and risk reduction
- Practitioners involved in the management of a young person with depression, should endeavor to build a supportive and collaborative relationship with the young person and their family/whānau
- Practitioners should consider involving support services such as school guidance counsellors or family services in the management of a young person with depression
- Young people with mild depression can be directed to www.thelowdown.co.nz for information, self help strategies and support from peers
- It is recommended that antidepressant treatment in a young person (less than 18 years) should not be initiated in primary care without consultation with a child and adolescent psychiatrist

Referral

- If a young person with depression does not report substantial improvement after six to eight weeks of treatment, they should be referred to secondary care mental health services
- A young person with severe depression should be referred urgently to secondary mental health services
- At any stage in treatment, a young person with serious suicidal intent, psychotic symptoms or severe neglect should be referred immediately to secondary care mental health services

General approach to management

An algorithm that summarises the management of depression of young people in primary care is in Appendix 7.

A stepped care approach is used with the intensity of treatment adjusted according to the response to treatment. A combination of risk management and strength-based strategies is recommended. Co-morbidities such as substance use disorders should be managed at the same time as they often exacerbate depression.

Most young people with mild or moderate depression can be managed in primary care using a range of therapies from advice, active support and monitoring to more intensive psychological treatments, including computer-based cognitive behaviour therapy programmes (e-therapy).

Strengths-based approach

A strengths-based approach focuses on enhancing resiliency and minimising obstacles to healthy development. This contrasts with the traditional biomedical model which focuses on problem identification and risk management.

There is increasing evidence that a strength–based approach is an effective strategy in the treatment and prevention of mental health disorders in children and adolescents. Risk reduction and risk management should be combined with the recognition and development of strengths and positive attributes. The strength-based approach is an integral component of psychosocial and psychological therapies of depression and other mental disorders.

Some important components of a strength-based model are;

- Identification and development of skills and strengths. These might not always be obvious or recognised by the young person or the people around them.
- Building motivation to deal with problems
- Increasing social interaction and enhancing relationships. It is important to encourage social interactions with family/whānau, friends, school/work contacts and people in general. Social connectedness has been identified as a strong protective factor against mental disorder.

A strengths-based approach may be less feasible in a young person with severe depression, but once recovering they may benefit from this model.[1]

Active support and monitoring

This involves setting up an effective collaborative relationship between the practitioner, the young person and their family/whānau. Good communication is essential; this includes providing information about the features of depression, the treatment options, how to recognise worsening of the disorder and how to access help if necessary. It is equally important to encourage the young person to be open about their progress in dealing with their problems, and how they are managing to develop positive aspects and strengths in their approach to life.

For young Māori, recovery may include a cultural dimension that is shaped around Māori values, knowledge and social systems within the concept of Whānau Ora. A secure cultural identity helps strengthen resilience to mental disorder even in the presence of adverse socioeconomic conditions.

Self management advice

Self-management options for people with depression include exercise, sleep hygiene, organising and scheduling activities, keeping a diary, stress management and reducing the use of alcohol and other drugs. A web site for young people with free downloadable self-management resources is **www.thelowdown.co.nz** This site is backed up by a team of youth counsellors who provide free online and text-based support services as part of the New Zealand National Depression Initiative.

The supporting website **www.depression.org.nz** includes information, case studies and video stories, and will be providing access to an online self-management programme fronted by John Kirwan from June 2010.

Additional information, self-management and guided self-help resources include;

www.outoftheblue.org.nz Mental Health Foundation of New Zealand, features information and personal stories.
http://www.comh.ca/publications/pages/dwd/ Cognitive behavioural therapy resources.

Managing feelings
Young people may have an expectation that there is something wrong if they do not feel good for most of the time. They might benefit from learning that being "good at feelings" is as important as feeling good.[11]

Management of mild to moderate depression.[1]

A young person with mild to moderate depression can usually be managed in primary care using a psychosocial approach (active support and self-management). The addition of a simple psychotherapeutic intervention such as structured problem solving therapy may also be beneficial.

Initial management should include active listening, identification of current problems, discussion of simple self-management strategies and active monitoring. Factors that encourage resilience and social competence should be strongly encouraged. This includes enhancing positive connections with a parent/caregiver or other trusted adults, involvement with community activities and sports and taking responsibility through "helpfulness" such as chores and community/family responsibilities.

The young person should be involved in setting the treatment goals which can be reviewed or revised over

Structured problem solving activity

This is based on the principles of cognitive behavioural therapy (CBT) and focuses on identifying and clarifying problems, setting realistic goals, generating and implementing solutions and monitoring progress. This can be delivered by a member of the primary health care team (e.g. GP or practice nurse) with appropriate skill and training in working with this age group.

The STEPS acronym is a useful guide:

Say what the problem is
Think about what you could do
Examine the possibilities and choose one
Put it in to action
See what happens. If it worked – great, if it didn't try again

a planned follow-up schedule. Initially monitoring every two weeks is recommended for most young people but earlier, more frequent contact may be required for some. Monitoring can be face to face or by text, telephone or email.

After the initial consultation the young person should be seen for re-assessment at two to four weeks.

If there is improvement at two to four weeks monitor every one to two months until there is a satisfactory response to treatment, that is remission of symptoms and return to normal function. There should be an action plan in place which advises who to contact and what to do if symptoms recur. Self-management strategies that focus on resiliency to help prevent relapse are encouraged. Suicide risk should be reassessed regularly.

If there is no improvement at two to four weeks the young person should receive an extended appointment for intensified support which includes emotional support, active listening, review of self-management, review of social interactions (including school) and review of depressive symptoms and suicide risk. A simple psychological intervention such as structured problem solving therapy should be offered: four to six half-hour sessions over a six to ten week period is suggested. Referral to support services (e.g. school guidance counsellors or family services) should be considered.

If there is deterioration of symptoms at two to four weeks treatment should be intensified as above or the person should be referred to secondary mental health care services, depending on the severity of the symptoms.

If there is no substantial improvement at six to eight weeks the young person should be referred to secondary mental health care services.

There is evidence to support the use of a course of formal CBT, interpersonal psychotherapy or behavioural activation for young people with moderate depression but access to these therapies is currently limited in primary care.

Treatment with antidepressants should not be started in a young person in primary care except under the advice of a child and adolescent psychiatrist, in accordance with Medsafe advice.[12] (See box, over page). Specialist advice should also be sought when changing or stopping antidepressant treatment in this population.

Management of severe depression

A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary mental health services. An urgent specialist referral is also indicated for a young person with severe depression.

Criteria and considerations for referral

Immediate referral

The following symptoms warrant immediate referral to secondary care:

- serious suicidal intent
- psychotic symptoms (hallucinations and/or delusions)
- severe self-neglect.

Immediate referral to secondary care is defined as referral by the primary care practitioner that day, with the expectation of a same day response to the referral.[1]

Urgent referral

The following factors are likely to indicate severe depression and the need for urgent referral:

- persistent symptoms
- serious suicidal intent
- profound hopelessness
- other serious mental or substance use disorders
- inability to do most daily activities

Urgent referral is defined as referral by the primary care practitioner within 24 hours, with the expectation that the person will be seen within seven to ten days, or sooner depending on service availability.

Other factors to consider when determining whether to refer include, history of depression, family history of mental disorder, lack of caring family relationships or other support services.

Pharmacological Management of depression in young people

General practitioners should only prescribe an antidepressant for a young person in consultation with a Psychiatrist or a Paediatrician.

There are no published trials set in primary care that have assessed the effectiveness of antidepressants for the treatment of depression in young people. Trials conducted in secondary care indicate that fluoxetine is moderately effective in treating moderate to severe depression. However these relatively modest benefits must be balanced against concerns of an increased risk of suicidal ideation or suicide attempt compared with placebo.

From the pooled data of 13 primary studies, the risk of suicidal ideation or suicide attempt has been estimated to approximately double (1–2% to 2–4%) in young people taking fluoxetine compared with placebo.[13]

Other antidepressants including tricyclic antidepressants, venlafaxine and moclobemide are not recommended in young people.

All antidepressant drugs have significant risks when given to children and young people with depression. Evidence supports their cautious and well-monitored use. During the first few months of antidepressant treatment in young people (or at times of dose increase or decrease), the family/whānau and caregivers of the person on antidepressant should be made aware of the importance of seeking help from a health professional if they notice any symptoms of agitation, irritability or unusual changes in behaviour. Such symptoms may be associated with the emergence of suicidality.

Medsafe guidance on the use of the SSRI antidepressants in young people.[12]

Medsafe and the Medicines Adverse Reaction Committee have recently conducted a review on the use of SSRI antidepressants in children and adolescents. Following this review, Medsafe advises the following;

1. The most common reason for suicidality and completed suicide is an untreated or worsening mood disorder.
2. The only antidepressant with overall data indicating efficacy better than placebo in children and adolescents is fluoxetine. This may indicate a positive risk benefit balance for fluoxetine.
3. All SSRIs have consistently been associated with an increase in suicidality in meta-analyses of clinical trials of the use of SSRIs to treat depression in children and adolescents. The term suicidality includes suicidal thinking and suicide attempts, but has not been proven to correlate with or lead to completed suicide.
4. No antidepressant has ministerial consent for the indication of treating depression in children and adolescents. This means informed consent must be obtained from the patient or parent prior to initiating an SSRI for depression in children or adolescents.
5. Any patient diagnosed with depression should be monitored closely for suicidality. If the treatment of a specific patient warrants antidepressant use, this should be considered in consultation with a Psychiatrist or a Paediatrician. Particular care should be taken in the period shortly after initiating antidepressant treatment, after a change in dosage, and after discontinuing treatment.

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Appendix 1 Assessment of suicide risk (NZGG)

Assessment of suicide risk				
Suicide assessment				
Have you had thoughts that life isn't worth living?			☐ Yes	☐ No
Have you thought of harming yourself?			☐ Yes	☐ No
Are you thinking of suicide?			☐ Yes	☐ No
Have you tried to harm yourself in the past? If yes, how many times?			☐ Yes	☐ No
When was the most recent time? ☐ in the last day	☐ in the last week	☐ last month	☐ longer ago (specify)	
How often are you having these thoughts?				
Have you thought about how you would act on these (is there a plan)? (Does this plan seem feasible? Are the methods available? Is it likely to be lethal?)				
Have you thought about when you might act on this plan?				
Are there any things/reasons that stop you from acting on these thoughts?				
Do you know anyone who has recently tried to harm themselves?				
If any answer is 'yes' prompt with: 'Tell me more about that' as discussion will help to convey the extent of risk.				
If a suicide attempt has been made				
What did you hope would happen as a result of your attempt? (Did they want to die, or end their pain?)				
Do you still have access to the method used?			☐ Yes	☐ No
Did you use alcohol or drugs before the attempt?				
What did you use?				
Do you have easy access to a weapon?			☐ Yes	☐ No

Commentary

Consider whether the person is safe to be alone

Risk factors include:

- definite plan
- hopelessness
- severe depression
- psychotic symptoms
- recent discharge from a psychiatric unit
- use of alcohol, street drugs, particularly recent escalation
- recent suicide attempt
- single men: young, older people
- homelessness
- medical illness
- history of childhood abuse
- recent suicide attempt by a whänau/family member or a friend.

Adapted with permission from:
RAPID assessment of patients in distress. In Centre for Mental Health. Mental Health for emergency departments: a reference guide. NSW Department of Health; 2001.

A guideline on the "Assessment and Management of People at Risk of Suicide" can be found at **www.nzgg.org.nz** – enter the guideline title into the search box, then select the publication.

Appendix 2 Assessment of suicide risk (NZGG)

Table 1: Assessment tool to determine the level of risk of suicide for a young person

During the interview with the young person, investigate each of the areas in the column on the left and CIRCLE THE RELEVANT DESCRIPTION OF THE YOUNG PERSON'S CURRENT SITUATION. In investigating any suicide plan (note 4 below), it is important to use direct questions as the young person is likely to be reluctant to volunteer the information. Direct questioning will not aggravate the risk of suicide but failure to fully investigate, categorise the risk and respond appropriately may result in a suicide that could have been avoided. On the basis of the young person's responses, determine which of the three risk levels: LOW, MODERATE or HIGH, best describes the situation. If there is any risk then proceed with the management plan (Table 2).

Areas to Consider	Low Risk	Moderate Risk	High Risk
1. Personal difficulties	▪ No significant stress	▪ Moderate reaction to loss or environmental change	▪ Severe reaction to loss or environmental change
Stressful events Presence of mental disorders depression, substance abuse, conduct disorder, psychosis	▪ Mild: feels slightly down	▪ Moderate: some moodiness, sadness, irritability, loneliness and decrease of energy	▪ Many recent social/personal crises ▪ Overwhelmed with hopelessness, sadness and anger (verbal/ physical), feelings of worthlessness ▪ Extreme mood changes ▪ Delusions, paranoia, lost touch with reality
Ongoing life difficulties Significant trauma Sexual identity issues Family difficulties	▪ Minimal impact but aware of some potential difficulties	▪ Having some impact on everyday life	▪ Major concerns, impacting on many areas of their life
Cultural issues	▪ Minimal impact	▪ Having some impact on everyday life	▪ Major concerns, impacting on many areas of their life
Coping behaviour	▪ Only occasional thoughts about suicide ▪ Daily activities continue as usual with little change	▪ Recurring thoughts of suicide ▪ Intentional self-harming without expressed suicidal intent eg: cutting ▪ Some daily activities disrupted; disturbance in eating, sleeping, school work	▪ May resist help ▪ Constant suicidal thoughts ▪ Significant disturbances in daily functioning ▪ Participation in high risk behaviours (ie: alcohol and drug abuse, potential for accidents etc)
2. Positive resources Family and friends	▪ Help available; significant others concerned and willing to help	▪ Family and friends available but unwilling to help consistently	▪ Family and friends not available or hostile, exhausted, injurious ▪ Significant self neglect
Lifestyle	▪ Stable family relationships, personality and school performance	▪ Recent acting out behaviour and substance abuse ▪ Acute suicidal behaviour in stable personality	▪ Suicidal behaviour in unstable personality; emotional disturbance; repeated difficulty with peers, family
Communication	▪ Direct expression of feelings and suicidal thoughts associated with distress and active help seeking	▪ Interpersonalised suicide goal ("They'll be sorry", "I'll show them", "I don't deserve to live" or "I want to be with someone who has died")	▪ Very indirect or non-verbal expression of internalised suicide goal (guilt, worthlessness)
3. Previous suicide attempts	▪ None or one of low lethality (see 4.4 for lethality)	▪ Multiple of low lethality or one of medium lethality; history of repeated threats (see 4.4 for lethality) ▪ Suicide among family or friends	▪ One of high lethality or multiple of moderate lethality ▪ Several attempts over the last weeks and/or suicide among family or friends
4. Suicide plan 1. Details 2. Availability of means 3. Time 4. Lethality of method 5. Chance of intervention	▪ Vague ▪ Not available ▪ No specific time or in the future ▪ Pills or slash wrists ▪ Others present most of the time	▪ Some specifics ▪ Available, has close by ▪ Within a few hours ▪ Drugs and alcohol, and car accident ▪ Others available if called on	▪ Well thought out; knows when, where, how ▪ Has means at hand ▪ Immediately ▪ Gun, hanging, jumping, carbon monoxide ▪ No one nearby; isolated

Table 2: Managing suicide risk in young people

Select column relevant to level of risk identified in assessment. Suicide risk fluctuates and management needs to be adjusted accordingly.

Action	Low Risk	Moderate Risk	High Risk
Reduce risk	▪ Remove means to harm themselves ▪ Establish an appropriate regime to monitor young person ▪ Check on family's/friends' support as appropriate, provide information on resources centred around the needs of the young person ▪ In collaboration with young person and support people, write a clear action plan	▪ Remove means to harm themselves ▪ Ensure young person has appropriate support eg: family/whānau, friends ▪ Arrange back-up support which is available 24 hours a day ▪ In collaboration with young person and support people, write a clear action plan	▪ Remove means to harm themselves (in extreme circumstances this may mean calling the police) ▪ Involves all management outlined in moderate risk, but urgent action is required ▪ Support and supervise at all times until responsibility is passed to another agency or individual ▪ Make urgent referral to mental health team
Consultation and Referral	▪ Consider discussing case with a colleague or specialist mental health provider ▪ Children, Young Persons and their Families Agency (CYPFA) must be ▪ informed where care and protection are required (under 17 years)* ▪ Check if any other services are involved and who has responsibility for coordination eg: school counsellor, Specialist Education Services, CYPFA or mental health services ▪ Network with school or educational institution	▪ Consult with or refer to specialist cultural health service prior to other agency consultation for Māori ▪ Consult with or refer to mental health services on the same day ▪ Involve family/whānau, friends if permission given or arrange alternative support** ▪ CYPFA must be informed where care and protection are required (for 17 years and under) ▪ Recommend to young person and support people appropriate agencies or other resources, and assist them in accessing these services ▪ Ensure there is a management plan in collaboration with all services involved	▪ If immediate referral is not possible, mobilise professional networks to assist in the management, support and supervision of the young person in consultation with mental health professional ▪ Contact family/whānau, friends if not already present and involve as appropriate ▪ CYPFA must be informed where care and protection are required (for 17 years and under) ▪ Consider arranging assessment under the Mental Health Act if appropriate ▪ Ensure there is a management plan in collaboration with all services involved with explicit handover of responsibility between agencies or professionals
Manage underlying factors	▪ Initiate/optimise treatment of any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties	▪ Must initiate/optimise treatment for any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties	▪ Must initiate/optimise treatment for any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties (undertaken in most cases by the specialist mental health services)
Monitor and follow up	▪ Make regular follow-up appointments ▪ Monitor changes in suicide risk ▪ Telephone contact may suffice ▪ If no improvement in one to two weeks treat as moderate risk	▪ Make regular follow-up appointments ▪ Contact regularly ▪ Monitor changes in suicide risk ▪ Check outcome of any agency referrals	▪ Ensure the following processes are in place and working effectively ▪ Make regular follow-up appointments ▪ Contact regularly ▪ Monitor changes in suicide risk ▪ Check outcome of any agency referrals

(Adapted from Ministry of Education, 1997 Young People at Risk of Suicide: A Guide for Schools)

* This may include family's inability or unwillingness to provide care, support and monitoring.

** If there is serious or imminent threat to the young person's life, permission to contact family/support people is not required, decisions must be made in the interests of safety.

Appendix 3 Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire is copyrighted so we are unable to reproduce it in this Appendix. To access individual copies for printing please visit the web site: **www.sdqinfo.com**

The SDQ tool in the *bestpractice* decision support module links out to an external resource and does not record the information to the PMS. A hard copy can be printed out and kept on record.

What is the SDQ?

The Strengths and Difficulties Questionniare (SDQ) is a brief behavioural screening questionnaire about 3–16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:

A) 25 items on psychological attributes.
All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:

1) emotional symptoms (5 items)
2) conduct problems (5 items)
3) hyperactivity/inattention (5 items)
4) peer relationship problems (5 items)
5) prosocial behaviour (5 items)

added together to generate a total difficulties score (based on 20 items)

- The same 25 items are included in questionnaires for completion by the parents or teachers of 4–16 year olds.
- A slightly modified informant-rated version for the parents or nursery teachers of 3 (and 4) year olds. 22 items are identical, the item on reflectiveness is softened, and 2 items on antisocial behaviour are replaced by items on oppositionality.
- Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different. This self-report version is suitable for young people aged around 11–16, depending on their level of understanding and literacy.

B) An impact supplement
Several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric caseness and the determinants of service use.

C) Follow-up questions
The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, e.g. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

Appendix 4

Substances and choices scale

The SACS is only to be used by health professionals working with young people who are engaged in a treatment agency.

The questions in part A) and B) are about your use of alcohol and drugs over the last month. This does not include tobacco or prescribed medicines. Please answer every question as best you can, even if you are not certain. Tick only one box on each row.

A On how many times did you use each of the following in the last month?	Never	Once a week or less	More than once a week	Most days or more
1. Alcoholic drinks (e.g. beer, wine, spirits etc.)	☐	☐	☐	☐
2. Cannabis (e.g. weed, marijuana, pot, skunk etc.)	☐	☐	☐	☐
3. Other drug. Name_____	☐	☐	☐	☐
4. Other drug. Name_____	☐	☐	☐	☐
5. Other drug. Name_____	☐	☐	☐	☐

B Mark one box (on each row), on the basis of how things have been for you over the last month.	Not True	Somewhat True	Certainly True
1. I took alcohol or drugs when I was alone.	☐	☐	☐
2. I've thought I might be hooked or addicted to alcohol or drugs.	☐	☐	☐
3. I've wanted to cut down on the amount of alcohol and drugs that I am using.	☐	☐	☐
4. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.	☐	☐	☐
5. My alcohol and drug use has stopped me getting important things done.	☐	☐	☐
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers etc.).	☐	☐	☐
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.	☐	☐	☐
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.	☐	☐	☐
9. I did things that could have got me into serious trouble (stealing, vandalism, violence etc) when using alcohol or drugs.	☐	☐	☐
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).	☐	☐	☐
			SACS difficulties scale ☐

C Finally, how often have you used tobacco (e.g. cigarettes, cigars) over the last month?	Never	Once a week or less	More than once a week	Most days or more
	☐	☐	☐	☐

Appendix 5

CRAFFT Tool

CRAFFT Tool	
1. Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs ?	◯
2. Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in ?	◯
3. Do you ever use alcohol or drugs while you are by yourself, **A**lone?	◯
4. Do you ever **F**orget things you did while using alcohol or drugs?	◯
5. Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use ?	◯
6. Have you ever got in to **T**rouble while you were using alcohol or drugs ?	◯

Scoring:

Two or more positive items indicate the need for further assessment

Appendix 6

Patient health questionnaire for depression				
Over the last 2 weeks, how often have you been bothered by any of the following problems? For each question select the option that best describes the amount of time you felt that way.				
In the last 2 weeks	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

PHQ-9 provisional diagnosis

Scoring — add up answers to questions on PHQ-9

Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Total Score	Depression Severity
10–14	Mild
15–19	Moderate depression
≥ 20	Severe depression

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 7

Management of depression in young people in primary care

Immediate referral* !

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

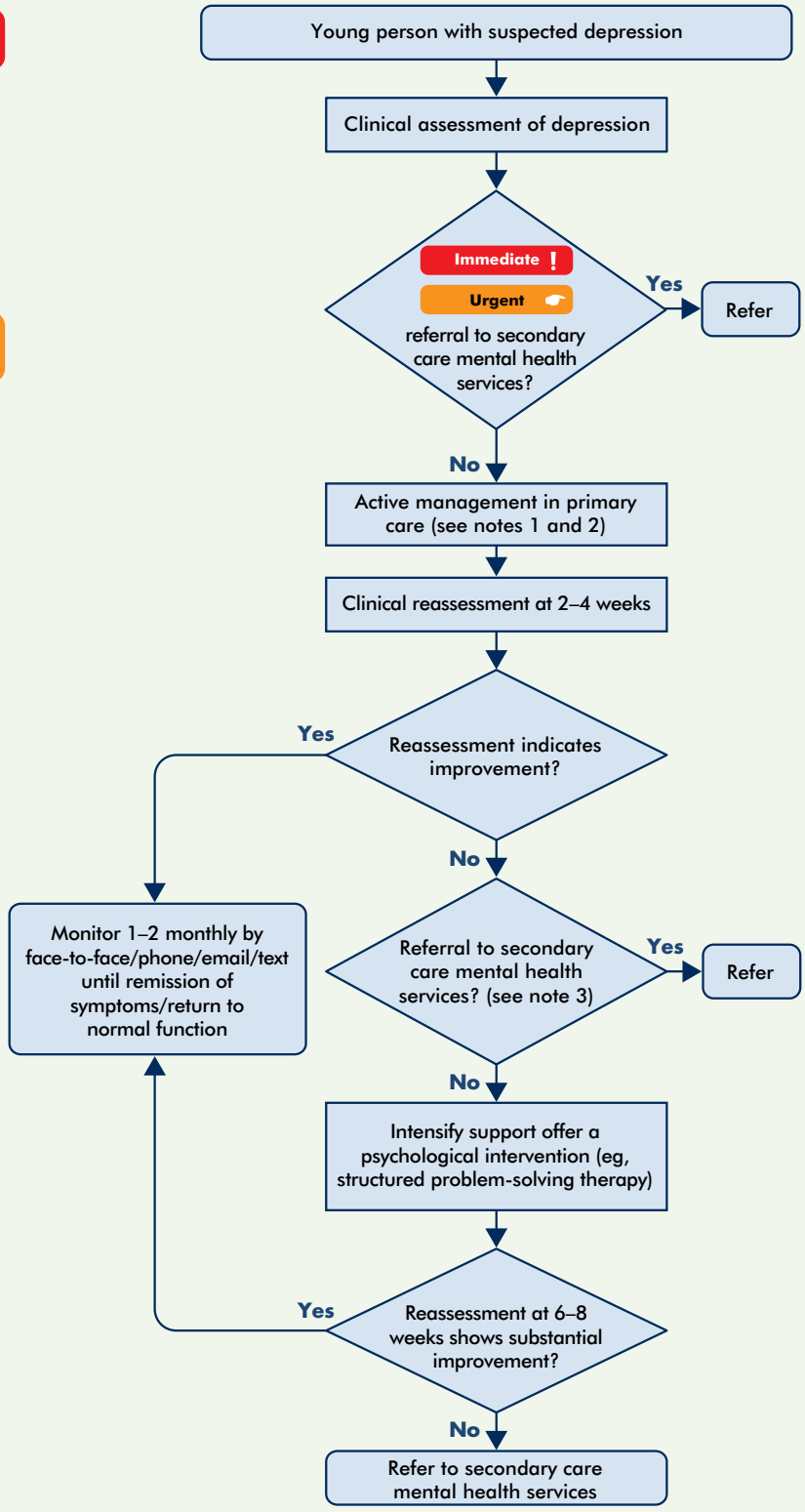
* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

Urgent referral†

Refer at any stage if:

- severe depression
- persistent symptoms
- profound hopelessness
- other serious mental or substance use disorders
- significant functional impairment (eg, unable to do most daily activities)
- suspected bipolar disorder.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability



Note 1

Initial management should include active listening, problem identification, advice about simple self-management strategies and active follow-up (2-weekly monitoring by face-to-face/phone/text/email).

Note 2

Consider involving support services such as school guidance counsellors or family services.

Note 3

Review whether referral is indicated at this point given lack of improvement or other concerns.

Depression in Young People

The *bestpractice* **Depression** module now has different operating modes depending on whether the patient is a young person or adult. The appropriate mode will be triggered automatically.

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