



The National Centre of Excellence
in Youth Mental Health

Clinical practice guide

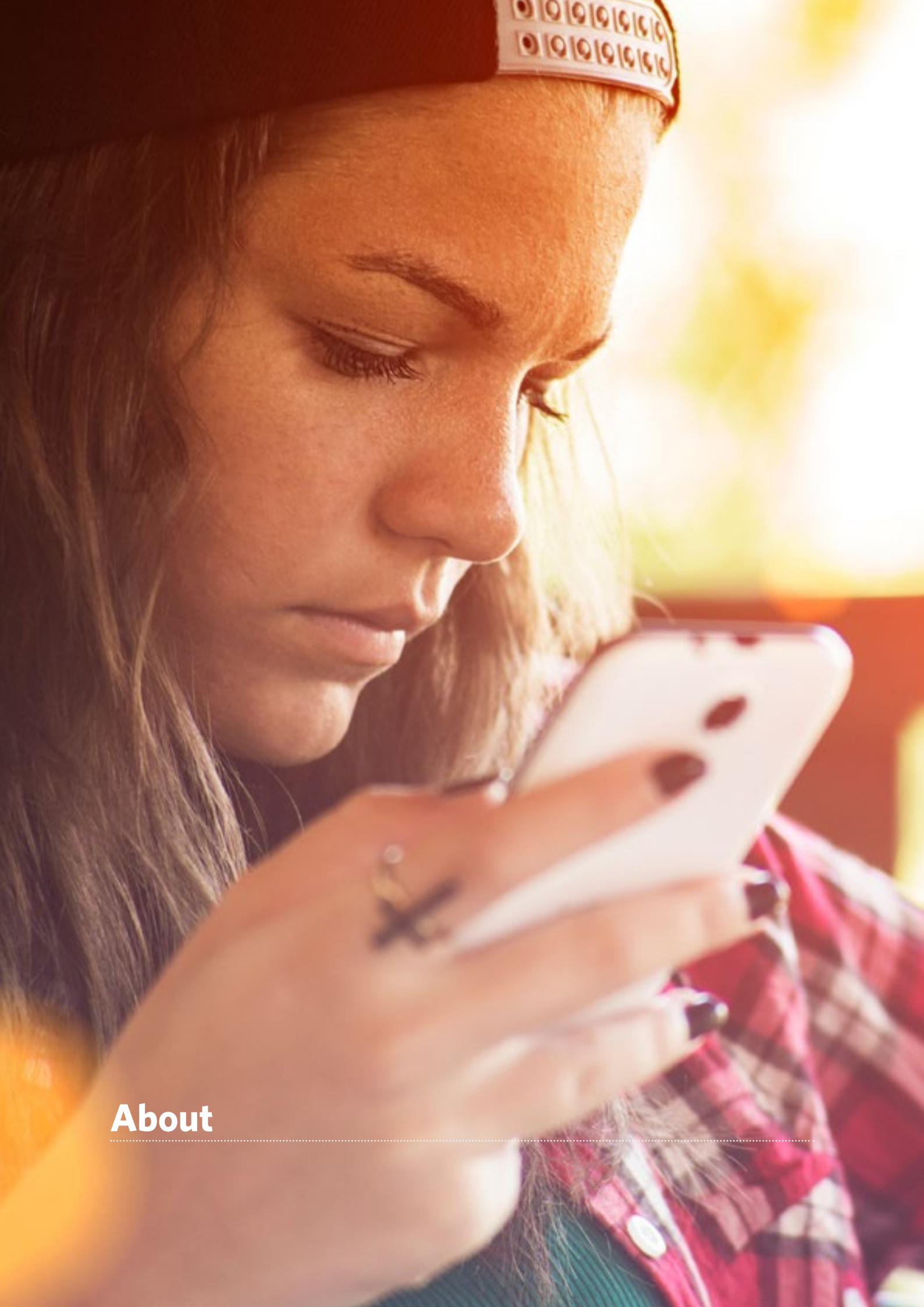
Treating depression in young people

Guidance, resources and tools
for assessment and management



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About

Purpose and scope of this Clinical Practice Guide

This clinical practice guide covers best practice in the assessment and management of depression in young people (aged 12-25 years) as outlined in the relevant [National Institute for Health and Care Excellence \(UK\) guidelines](http://www.nice.org.uk) (www.nice.org.uk). The content aligns to the current diagnostic classifications of depressive disorders in the [Diagnostic and Statistical Manual of Mental Disorders](http://www.psychiatry.org) (DSM-5; see www.psychiatry.org) and the [International Classification of Diseases – 10th Revision](http://www.who.int/en/) (ICD-10; accessible at <http://www.who.int/en/> in the Publications section). The focus is on assessing and managing major depressive disorder (MDD), persistent depressive disorder (dysthymia), and complex depression in young people. Complex depression includes “depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors” (NICE, 2009; p.64). The DSM-5 includes two new depressive disorders: disruptive mood dysregulation disorder and premenstrual dysphoric disorder. Information is provided related to the assessment of these disorders, however the treatment of these disorders is not covered. This is because the current best-practice guidelines for managing depression in young people (NICE, 2009, NICE, 2005) do not yet include these disorders.

Why is early intervention for depression important?

About one in five young people will experience an episode of depression before the age of 25 (Australian Bureau of Statistics, 2010). The peak period for the onset of depression is adolescence and young adulthood, and most adults who suffer from recurrent depression will have first experienced it during this period (Kessler et al., 2007). Depression can be particularly complex and severe when it emerges in adolescence (Zisook et al., 2007). The longer depressive symptoms remain untreated in a young person, the longer they will take to respond to treatment (Curry et al., 2006). In addition, delays in treatment increase the risk of chronic or recurrent symptoms and episodes (Neufeld et al., 2017).

Young people complete a number of key developmental tasks during adolescence and early adulthood, including individuating from their parents, developing new interests and skills, forming and maintaining relationships (especially intimate sexual relationships), completing further study and finding a job. If these tasks are disrupted by illness, young people can “fall out of step” with their peers who are continuing to develop at the usual

rate. The consequences of this can include social isolation, demoralisation and reduced potential for achievements in the future (McGorry et al., 2007, Brent and Birmaher, 2002).

In comparison to other types of mental health disorders, depressive disorders have a particularly negative impact on young people’s ability to live their day-to-day life (Lawrence et al., 2015). In an Australian study, over 40% of children and adolescents with depression reported that their symptoms had a severe impact on their daily functioning, and an additional 35% reported moderate impact (Lawrence et al., 2015). This can be very problematic and have long-lasting effects on a young person’s life including reduced workforce participation, lower income and lower living standards in adulthood (Gibb et al., 2010). Young people who experience multiple episodes of a mental health disorder are particularly vulnerable to experiencing all of these disadvantages in adulthood (Gibb et al., 2010). Because depression tends to first occur early in life and is often recurrent, it places a larger burden on the community than any other illness (Gore et al., 2011). Therefore, effectively treating depression when it begins in youth is of utmost importance.

For these reasons, early intervention for depression focuses not only on symptom reduction, but also on restoring the young person’s developmental trajectory (e.g., getting them back to work/study, engaging with their peers). This has the potential to reduce disruption to relationships within the family, difficulties with employment and education, the need for inpatient care, the risk of suicide, and the likelihood of social isolation (Hetrick et al., 2008).

Symptoms of depression

The following summary of common signs and symptoms of depression in young people (see Table 1) is provided in [beyondblue’s Clinical Practice Guidelines: Depression in Adolescents and Young Adults](http://www.beyondblue.org.au) (beyondblue, 2010, p.4-5; originally adapted from NICE 2005 guidelines for Depression in Children and Young People; accessible at www.beyondblue.org.au).

Table 1: Common signs and symptoms of depression in young people

| Core changes | Specific symptoms |
|--------------|---|
| Emotional | <ul style="list-style-type: none"> ▪ sadness or hopelessness ▪ irritability, anger or hostility ▪ tearfulness or frequent crying ▪ loss of pleasure in activities (anhedonia) ▪ feelings of worthlessness and guilt ▪ lack of enthusiasm and motivation |
| Cognitive | <ul style="list-style-type: none"> ▪ inefficient thinking (usually with a pronounced self-critical focus) ▪ loss of concentration, poor attention and inability to make a decision ▪ low self-esteem ▪ negative body image ▪ apathy ▪ thoughts of death or suicide |
| Behavioural | <ul style="list-style-type: none"> ▪ decreased participation in school ▪ disinterest in general appearance ▪ decreased participation with peers and enjoyment in regular activities ▪ self-harm or deteriorated self-care or promiscuity ▪ avoidance of family interactions and activities ▪ more withdrawn behaviour including clearly more time spent alone |
| Physical | <ul style="list-style-type: none"> ▪ fatigue, lack of energy, poor motivation ▪ increase or decrease in appetite (resulting in weight gain or loss) ▪ disrupted sleep rhythms (resulting in insomnia at night or hypersomnia) ▪ lowered libido ▪ restlessness and agitation ▪ unexplained aches and pains |

Different types of depression

Formal systems for the diagnosis of mental illness (DSM-5; ICD-10 - see F40-F48) define a number of different types of depressive disorder, including:

- major depressive disorder
- persistent depressive disorder (includes what was diagnosed as chronic major depression, and dysthymia in DSM-IV)
- disruptive mood dysregulation disorder (initial diagnosis must be made between 6 and 18 years of age)
- premenstrual dysphoric disorder
- substance/medication-induced depressive disorder
- depressive disorder due to another medical condition
- other specified mood disorder
- unspecified mood disorder.

All of these disorders share the following core features:

- mood disturbance – a sad, empty or irritable mood
- physical/biological changes – e.g., sleep disturbance, appetite disturbance
- changes in the way a person thinks (i.e. cognitive changes) – dominated by negative patterns of thinking.

Note: Bipolar disorder is now classified separately to depressive disorders in the DSM-5.

Brief summary of the core symptoms of different depressive disorders

Table 2 provides a summary of the core symptoms of the most prevalent depressive disorders (as defined by the DSM-5). To meet threshold for diagnosis of any depressive disorder, symptoms must either cause significant distress or make it difficult for the person to function effectively in their day-to-day life (e.g., difficulty attending or keeping up at school/work, social isolation).

Table 2: Core symptoms of different types of depressive disorders*

| Depressive disorder | Core symptoms |
|---|---|
| Major depressive disorder (MDD) | <p>One or more major depressive episodes which are characterised by one of the following core symptoms:</p> <ul style="list-style-type: none"> depressed mood in young adults; depressed or irritable mood in adolescents; OR loss of interest or pleasure in most things (anhedonia). <p>Accompanied by several other symptoms such as</p> <ul style="list-style-type: none"> appetite disturbance or significant weight change sleep disturbance fatigue restlessness or feelings of being slowed down worthlessness or guilt difficulty concentrating and/or making decisions recurrent suicidal ideation or suicidal behaviour. <p>Additional notes:</p> <ul style="list-style-type: none"> Before diagnosing MDD, it is important to exclude past episodes of mania/hypomania, psychotic disorders and mood disorders due to a medical condition or substance use. Note that in DSM-5 MDD can be diagnosed at any time following a bereavement if the person meets the diagnostic criteria. Clinical judgement should be used and cultural norms taken into consideration in distinguishing grief from a major depressive episode. Severity criteria (mild/moderate/severe) are provided in DSM-5. |
| Persistent depressive disorder (dysthymia) | <p>For adolescents, the primary symptom is at least one year of irritable or depressed mood most days, most of the day. For young adults (aged 18-25 years) the primary symptom is at least two years of depressed mood on most days, most of the day. Some other depressive symptoms are also present (e.g., sleep disturbance, fatigue).</p> <p>Additional notes:</p> <ul style="list-style-type: none"> Severity criteria (mild/moderate/severe) are provided in DSM-5. This diagnosis includes both chronic MDD and what used to be called dysthymia (in DSM-IV). |
| Disruptive mood dysregulation disorder (should only be diagnosed up to 18 years of age) | <p>Characterised by chronic, severe irritability or angry mood with frequent and severe verbal or non-verbal temper outbursts (onset before age 10 years). These outbursts are both grossly out of proportion with the perceived trigger, and not in keeping with age-appropriate behaviour.</p> <p>Additional assessment considerations for disruptive mood dysregulation disorder (from DSM-5):</p> <ul style="list-style-type: none"> Careful assessment is needed to distinguish this disorder from other DSM-5 disorders, particularly, from childhood-onset bipolar disorder and oppositional defiant disorder (see DSM-5 for guidance). Early intervention is important because the risk of functional decline is significant. Risk assessment should be prioritised because suicidal behaviour, severe aggression and deterioration in functioning are common. This disorder is thought to be more common in children (aged 6-12 years) than adolescents. |
| Premenstrual dysphoric disorder | <p>Characterised by mood disturbance (dysphoria, mood swings, irritability or anxiety) that repeatedly occur during the premenstrual phase and remit within a few days of onset of menses (i.e., a period). These symptoms are of a similar severity to those seen in other mood disorders.</p> <p>Premenstrual dysphoric disorder should not be confused with premenstrual syndrome (which is generally characterised by fewer, less severe symptoms, and may not include mood disturbance).</p> |

Adapted from DSM-5 (American Psychiatric Association, 2013)

*Please note, this table does not include all depressive disorders or the full diagnostic criteria for the included disorders. Moreover, it is inappropriate to use this information in isolation to inform diagnostic practice.

For full diagnostic criteria on these and other depressive disorders, please refer to the [DSM-5](#) (accessible at www.psychiatry.org) or the [ICD-10](#) (accessible at <http://www.who.int/en/> in the Publications section). Depressive disorders can only be diagnosed by qualified mental health clinicians who are trained to assess and diagnose mental illness – GPs, mental health professionals and clinicians working in Child and Adolescent Mental Health Services (beyondblue, 2010).

Sub-threshold presentations of depression

If a young person presents with sub-threshold depressive symptoms, consider:

- Whether a diagnosis of adjustment disorder with depressed mood is warranted in young people with sub-threshold depressive symptoms presenting in the context of a recent psychosocial stressor (e.g., family breakdown, bullying, a relationship break-up; American Psychiatric Association, 2013).
 - Whether a diagnosis of an unspecified depressive disorder is warranted among young people with sub-threshold symptoms in the presence of clinically significant distress or marked impairment in functioning (American Psychiatric Association, 2013).
-



Engagement and assessment

Engagement

Engagement with a young person is critical to being able to undertake a meaningful assessment and engage a young person in treatment. It is essential for young people to feel listened to, respected, safe, to have a sense of autonomy and perceive that their clinician is trustworthy, kind and caring when seeking help for mental health issues, otherwise there can be no benefit. In other words, young people must be ENGAGED in the process of help-seeking. To build engagement, it is particularly important to:

- build strong therapeutic relationships
- address confidentiality issues and concerns
- involve caregivers if possible, taking into consideration the young person's age, stage of development, wishes and circumstances.

Some young people are at increased risk of experiencing depression including those with a family history of depression, those with a personal history of depression and those from marginalised groups (Schubert et al., 2017; Brown et al., 2016). It is important to stress that increased risk among marginalised groups is not caused by a young person's cultural, gender or sexual identity or where they live, but by increased exposure to other stressors (e.g., discrimination, marginalisation, trauma). Marginalised groups of young people include those:

- from Culturally and Linguistically Diverse (CALD) backgrounds including Aboriginal and Torres Strait Islander young people
- identifying as Lesbian, Gay, Bisexual, Transgender, Intersex, Queer or Questioning (LGBTIQ)
- experiencing homelessness
- living in rural communities
- with comorbid substance use problems (see Brown et al., 2016).

It is important to be mindful that these groups of young people also experience additional barriers to accessing mental healthcare. The reasons for this are that services are often not easily available, are not close enough, and/or they are not culturally sensitive or culturally safe (Brown et al., 2016). This means that services need to actively implement strategies to make it easier for these young people to engage with them (e.g., providing outreach, ensuring they are providing a culturally-sensitive service, increased opening hours); and clinicians need to be sensitive to their experiences. This may include asking young people about previous experiences of help-seeking, validating any negative experiences such as discrimination, letting them know that you will do your best to ensure that you are working in a way that they are comfortable with, and

that you will try to support them in addressing barriers to care that may arise.

Adolescents with a history of moderate to severe depression who are showing signs of a recurrence should be promptly referred to a mental health clinician for further assessment and should be prioritised for mental health review (NICE, 2005).

Assessment

Diagnosis of a depressive disorder is based on clinical judgement, informed by both diagnostic criteria (DSM-5 or ICD-10) and severity of depressive symptoms.

Issues for consideration

- Depressed mood may be described as sad, "down in the dumps", hopeless or discouraged, feeling numb, having "no feelings" or manifest in somatic complaints. Irritable mood may be described as feeling angry all the time, getting really frustrated over small things, or being blaming of others (American Psychiatric Association, 2013).
- Loss of interest and/or pleasure in activities is very common and may be described as "no longer caring" about things (American Psychiatric Association, 2013).
- Sleep disturbance and fatigue are often identified as the presenting complaint and depression may be missed if further exploration of depressive symptoms is not conducted (American Psychiatric Association, 2013).
- Be cautious in how you interpret results of any assessment that has been conducted without the young person being adequately engaged because the assessment may not be able to provide an accurate picture of their experiences.

Best-practice in assessing young people

- Only assess a young person for depression if you are competent and trained to do so.
- It is good practice to ensure that young people have other support people (parents, other adults) involved in their care. Support people may have a role in providing information that might be important in the assessment of the young person, bearing in mind that ideally, the young person should consent, and that without consent it may be difficult to maintain engagement with the young person. For 12-18 year olds, this is particularly recommended (NICE, 2005).

- Every assessment should include asking a young person about past experiences of bullying, trauma, substance-use, self-harm and suicidal ideation and behaviour (NICE, 2005).
- **Assessing the young person's suicidal thinking, and self-harm, including suicide attempt (here referred to as suicidality) should be prioritised.** Immediately assess and manage risk and involve caregivers if necessary. **Assessment and management of suicidality, is covered in the Intervention section of this Clinical Practice Guide.** This is because the management of suicidality needs to be an immediate priority. Therefore, assessment and intervention need to be considered together.
- Provide the young person and their caregivers with information about the assessment and treatment planning process (for an example of how to do this see Orygen's factsheets on [Assessment and Diagnosis](#) and [Treatment](#) accessible at www.oyh.org.au).
- Always provide good, age-appropriate self-help and psychoeducation information and encouragement on sleep hygiene, maintaining a healthy diet and the benefits of regular exercise (NICE, 2005). For a range of youth-friendly resources that may be helpful see the Resources section of this Clinical Practice Guide.
- Be mindful that self-help should only be offered to adolescents as part of a supported and planned package of care (NICE, 2005).
- Use a **strengths-based approach** and convey a sense of hope and optimism for the future. For example, ask the young person about what is helping them to cope (e.g., "It sounds like things have been really tough, what do you think is getting you through? What helped you to come here today despite how bad you've been feeling and how nervous you were about coming in? Can you tell me about a time when things were going better for you? What did you like to do back then?")

Special considerations in assessing adolescents (aged 12-18 years)

- Parental mental illness is often associated with depression in children and adolescents and needs to be treated for the adolescent to fully benefit from treatment (NICE, 2005). When assessing adolescents with depression, try to assess whether their parents may also be experiencing or have a history of mental illness. Offer further assessment, support (e.g., self-help, support groups), and onward referral to parents as indicated.

Psychosocial assessment tools

A helpful way to conduct a mental health assessment with young people is to first gain an overall understanding of their circumstances and then follow-up on areas that seem to be of concern. This demonstrates interest in, and empathy with the young person and allows time for rapport to develop before more stressful topics are tackled. It is important to systematically cover a wide range of domains because young people may not volunteer comprehensive information for a variety of reasons.

A comprehensive assessment involves asking questions about a range of aspects of a person's life including their:

- home and environment
- education and employment
- activities
- drugs and alcohol
- relationships and sexuality
- conduct difficulties and risk-taking
- anxiety and eating
- depression symptoms and suicide risk
- psychosis and mania symptoms
- strengths and supports.

For more information and guidance on how to do this, see the [headspace psychosocial assessment interview](#) (accessible at www.headspace.org.au - in the Clinical Toolkit section).

It is helpful to let the young person know that you need to get a clear and comprehensive picture of their situation and history, and how they see the problem, in order to be able to help them. Tell them that this can take some time, that it will probably seem like a lot of questions and that you will check in with them along the way to make sure you are getting a correct understanding of the issues. It is also good to explain that you will summarise your ideas about the nature and causes of the problems at the end of the assessment, and that this will be the basis of a treatment plan. It is very important to make sure that (i) you have a shared understanding of the problem, (ii) you are working towards achieving the young person's goals for treatment, and (iii) that treatment is provided in a collaborative way.

Don't forget to maintain a strength-based approach by ensuring that you ask the young person about their strengths.

Screening tools

- There are several assessment tools available that can assist in screening for and assessing depressive disorders. There is debate in the literature about how useful these are, and concern that they could be used inappropriately (e.g., as a sole assessment tool; NICE, 2005).
- Screening tools should never be used in isolation to assess for depression. They can be a useful tool to use as part of a thorough assessment because clinicians very often miss/don't detect depression. For this reason, screening tools have been advocated for (particularly for use in GP clinics).
- Only use tools that are valid for the person and situation you are using them in (e.g., in primary care settings).
- Be mindful that the use of screening tools may not be appropriate for use among culturally and linguistically diverse young people, and particularly among Aboriginal and Torres Strait Islander young people (Walker et al., 2014).
- One freely available self-report tool that is suitable to use with young people is the [Patient Health Questionnaire-9](#) (PHQ-9; available to download at www.phqscreeners.com; Richardson et al., 2010, Allgaier et al., 2012, Hetrick et al., 2017). There is now a version that has been modified for adolescents: [Patient Health Questionnaire-9 Adolescents](#) which has been identified as an "emerging measure" in the DSM-5 (to download and access more information see (www.psychiatry.org - search 'online assessment measures' and go to the Disorder Specific Severity Measures section).
- [The Mood Feeling Questionnaire](#) is identified as one of the best tools to use with adolescents in the NICE guidelines, and suitable to use (as one source of information) in monitoring progress. It is free to download (from <http://devepi.duhs.duke.edu/index.html>), and has child and adolescent versions (the recommended clinical cut off is greater or equal to 27; NICE, 2005).
- Due to the high comorbidity between anxiety and depression in young people, the [Revised Child Anxiety and Depression Scale \(RCADS\) for adolescents](#) (up to 18 years) should be considered (NICE, 2013). The RCAD screens for both anxiety and depression. It can also be used to monitor response to treatment. The RCADS is also free to download (from www.childfirst.ucla.edu under the Resources tab).

The NICE guidelines (2009) recommend asking people (aged 18 and over) who may have depression two questions, specifically:

1. "During the last month, have you often been bothered by feeling down, depressed or hopeless?"
2. "During the last month, have you often been bothered by having little interest or pleasure in doing things?"

If the answer is 'yes' to either question:

- Conduct a further assessment if you are competent to do so, or refer on to a mental health clinician.
- Consider using a validated screening tool as one source of information (see above).

More information

To access more resources to guide your practice in the assessment and engagement of young people with depression please see the More Information section of this Clinical Practice Guide.



Intervention

Core principles

Early detection and treatment of depressive disorders can reduce their adverse effects. Early intervention is particularly important as these disorders often become apparent at critical stages of development in childhood, adolescence and early adulthood.

The management plan developed for a young person with depression will be dependent upon a range of factors including:

- the severity of symptoms
- the impact of symptoms on their functioning
- past and current suicidal thinking, behaviour and self-harm
- health services available, both in terms of actual services available to refer to and the skills and experiences of workers involved
- other presenting health issues
- the support network available, including family and friends, or school supports
- the young person's preference for a particular treatment approach.

The treatment of depression should focus on more than just depressive symptoms. Reducing comorbid symptoms, promoting age-appropriate social and emotional development, helping young people re-engage or perform to the best of their ability at school/university/work, reducing family distress, and preventing or reducing the risk of relapse are very important (NICE 2005, p.38). Treatment should always be delivered in a culturally sensitive way.

Engaging a young person, developing a positive relationship with them in which they feel heard, respected, safe, and supported and working collaboratively with them so that they maintain a sense of agency is the foundation for any successful treatment. The use of shared-decision making is a helpful approach that can facilitate this process.

Shared decision making in treatment planning

Young people should be supported to have an active role in making decisions about their mental health care. Shared decision making is a conscious, semi-structured approach to helping the young person make decisions about their treatment, based on the most relevant evidence and their unique needs, preferences and values. To learn more about the benefits of shared decision making and how you can use it in your practice with young people see [Orygen's Clinical practice point: Shared decision making in youth mental health](#) (accessible at www.orygen.org.au).

In the next section, best-practice in managing adolescents experiencing depression will be discussed, followed by best-practice in managing young adults experiencing depression as the NICE treatment recommendations for these age-groups differ.

Treating adolescents (aged 12-18 years) experiencing depression using the NICE guidelines

Which guideline should I use?

Clinicians should adhere to the [National Institute of Care and Health Excellence \(NICE, 2005\) guidelines: Depression in children and young people: Identification and management in primary, community and secondary care](#) (CG28; relevant for adolescents up to 18 years of age; updated September 2017; accessible at www.nice.org.au). [beyondblue's \(2010\) Clinical practice guidelines: Depression in adolescents and young adults](#) may provide some further helpful background information, however, **they are currently out-of-date and should not be used as a primary source of information to inform treatment** (accessible at www.beyondblue.org.au).

The content in this section summarises some of the most pertinent recommendations for the *NICE Guidelines (2005)*. Some additional considerations have been added from the *beyondblue (2010) Clinical Practice Guidelines*. **Please note, the guidance provided is not a full summary of the NICE (2005) guidelines – it is important to read and familiarise yourself with the full recommendations.**

Stepped care for depressive disorders in adolescents

Clinicians working with adolescents (aged 12-18 years) should follow the stepped care NICE guidelines for children and young people (CG28; see recommendation 1.6). These guidelines cover depressive episode (F32) and recurrent depressive episode (F33), with some recommendations applying to dysthymia (F34.1) as defined in the ICD-10. While the guidelines are based on the ICD-10 diagnostic criteria, some of the recommendations have been drawn from research that has used the DSM-IV diagnostic criteria which are "similar but not identical" to the ICD-10 (NICE 2005, p.27). The stepped care approach provided in the guidelines specifies treatment for varying levels of severity of depression in adolescents. Severity is determined by ICD-10 criteria with mild being indicated by four symptoms (depressed or irritable mood, with either tiredness or anhedonia, plus two other symptoms), moderate by five or six symptoms (including depressed mood) and severe by seven or more (see p.31). An overview of the most pertinent treatment recommendations is provided below.

Mild depression (PHQ 5-9)

Following four weeks of 'watchful waiting' (i.e., continuing to monitor the young person's symptoms and making contact with them if they do not attend follow-up appointments - usually another assessment should be offered within two weeks of contact) all adolescents with continuing mild depression, and without significant comorbid difficulties or signs of suicidal ideation should be offered:

- information (particularly about depression, psychoeducation about the role of **exercise, diet, and sleep** in reducing depressive symptoms - factsheets are accessible from www.oyh.org.au) and guided self-help (e.g., **MoodGYM** and **e-couch**; to find out more about these programs see <https://schools.au.reachout.com/>)
- non-directive support or group therapy
- group CBT.

Antidepressants should not be used as an initial treatment for mild depression.

Adolescents with mild symptoms who have not responded after 2-3 months of guided self-help, group CBT or supportive therapy, and those with moderate symptoms, should be referred for review with a mental health clinician and the guidelines for moderate to severe depression should be followed.

Moderate to severe depression (PHQ 10-27; see 1.6.1 and 1.6.2)

As noted in the *beyondblue (2010) Clinical Practice Guidelines*, "health professionals, young people and parents/carers must be aware of the dangers of not treating episodes of moderate to severe depression. Depression is the major risk factor for suicide" (p.28).

Following assessment by a mental health clinician, adolescents with moderate to severe depression should:

- Be offered **at least three months of a first-line specific psychological therapy** (CBT, IPT or a shorter-term family therapy; the recommended number of sessions is not specified).
- As an alternative to the above, combined therapy should be considered (i.e., fluoxetine in combination with one first-line specific psychological intervention).
- If an adolescent is not responding after 4-6 treatment sessions of the above specific psychological therapies (in the absence of antidepressant treatment):
 - They should be referred for a multidisciplinary review.
 - Fluoxetine should be offered in combination with the specific psychological therapy (see below).

- Parental psychological support and alternative psychological therapy for the adolescent should be considered if factors such as comorbid symptoms, persistence of psychosocial risk factors such as parental mental ill-health or family discord are determined to be a maintaining factor.
- If an adolescent declines psychological therapy, antidepressants can be offered but closer monitoring will be required.
- Inpatient treatment should be considered if an adolescent presents with high risk of suicide, serious self-harm, or self-neglect and/or if intensive treatment is unavailable or intensive assessment is warranted (see 1.6.6).

Depression unresponsive to combined treatment (see 1.6.3)

If the adolescent is not responding after a further six sessions of combined psychological treatment and Fluoxetine, or if the adolescent or parents decline Fluoxetine:

- A multidisciplinary team should conduct a **full needs and risk assessment** including review of diagnosis, possible comorbid symptoms, assessment of possible impact of social, family and individual factors in causing depression, assessment of whether there has been a fair trial of treatment, assessment of the need for further psychological therapy for the adolescent and/or additional family support.
 - Following multidisciplinary review; the following should be considered:
 - an alternative first-line specific psychological therapy that has not already been trialed (i.e., CBT, IPT or shorter-term family therapy of at least 3 months duration; recommended number of sessions is not specified)
 - systemic family therapy (at least 15 fortnightly sessions)
 - individual child psychotherapy (approximately 30 sessions)

Medication and adolescents (aged 12-18 years) – a summary (see 1.6.4)

Clinicians working with adolescents should follow the *NICE (2005) Guidelines 1.6 - Steps 4 and 5: Moderate to severe depression* to inform decision-making around medication use.

When to consider prescribing an antidepressant?

- Antidepressants should only be offered to adolescents after assessment and diagnosis by a child and adolescent psychiatrist; and in the context of an ongoing therapeutic relationship and management plan (beyondblue, 2010).
- Antidepressants should never be offered for mild depression.
- Antidepressants should only be offered to adolescents with moderate to severe depression in combination with psychological therapy.
- If an adolescent has mild to moderate depressive symptoms that are not responsive after 4-6 sessions of the recommended specific psychological interventions for this group, antidepressants should only be considered following a multidisciplinary treatment review.
- Antidepressants can still be prescribed if the adolescent declines psychological therapy (but more frequent monitoring of their mental state, suicidal risk and progress will be required).
- Clinicians may find Table C3.4 'Considerations when deciding whether to recommend pharmacological treatment' from [beyondblue's \(2010\) Clinical practice guidelines: Depression in adolescents and young adults](http://www.beyondblue.org.au) (www.beyondblue.org.au) helpful.

Clinical considerations in using antidepressant medications with adolescents

- Fluoxetine is the first-line antidepressant for adolescents.
- All adolescents prescribed anti-depressant medications must be **closely monitored** for adverse reactions, general progress and review of mental state.
- It is important for both the prescribing clinician, the clinician delivering psychological treatment and/or others involved in their care to monitor for the appearance of suicidal behavior, self-harm and hostility. Particularly within the first four weeks of the adolescent commencing an anti-depressant treatment but with continuing vigilance/monitoring throughout the episode of care.
- The frequency of monitoring should be determined on a case-by-case basis (e.g., weekly contact with the adolescent and their parents/carers for the first 4 weeks and fortnightly thereafter).

- For adolescents with psychotic depression, antipsychotic medication should be considered as an add-on to their treatment plan.
- It can be helpful to use a validated questionnaire to monitor a young person's progress. The PHQ-9 is suitable for this purpose and provides severity ratings (see Assessment section of this Clinical Practice Guide).

Clinicians should consult the full [NICE \(2005\) guidelines: Depression in children and young people: Identification and management in primary, community and secondary care](#) (CG28; relevant for adolescents up to 18 years of age; last updated September 2017) for further information on monitoring, prescribing guidelines, second-line antidepressants to trial and other information.

Treating young adults (18-25 years) experiencing depression using the NICE guidelines

Which guideline should I use?

Clinicians should adhere to the [National Institute of Care and Health Excellence \(NICE, 2009\) Depression in adults: Recognition and management](#) guideline (CG90; last updated April 2016; accessible at www.nice.org.uk).

[beyondblue's \(2010\) Clinical practice guidelines: Depression in adolescents and young adults](#) (accessible at www.beyondblue.org.au) may provide some further helpful background information, however, **they are currently out-of-date and should not be used as a primary source of information to inform treatment.**

The content in this section summarises some of the most pertinent recommendations for the *NICE Guidelines (2009)*. Some additional considerations have been added from the *beyondblue (2010) Clinical Practice Guidelines*. **Please note, the guidance provided is not a full summary of the NICE (2009) guidelines – it is important to read and familiarise yourself with the full recommendations.**

Stepped care for depressive disorders in young adults (aged 18-25 years)

Clinicians should follow the *NICE (2009) Guidelines* stepped care approach (see recommendation 1.2) matching the intensity of treatment to the severity of the young person's symptoms. These guidelines are based on the DSM-IV criteria for depression and use the DSM-IV approach to rating symptom severity, which takes into account the degree of functional

impairment related to symptoms. An overview of the most pertinent treatment recommendations is provided below.

Persistent sub-threshold depressive symptoms (including dysthymia) or mild to moderate depression (see 1.4)

The following should be considered, taking into account the young person's preference:

- Low-intensity psychosocial interventions:
 - 6-8 sessions of individual guided self-help based on the principles of CBT including behavioural activation and problem-solving techniques over 9-12 weeks;
 - Computerised CBT (CCBT, usually over 9-12 weeks including follow-up) supported by a trained practitioner; or
 - A structured group physical activity program (usually three 45min-1hr sessions delivered over 10-14 weeks)
- If low-intensity psychological interventions above are declined, offer:
 - Group CBT (structured, delivered over 10-12 sessions over 3-4 months)
- **Antidepressants should not be used as a first-line intervention** but may be considered in certain circumstances (discussed in the Medication for Young Adults section of this Clinical Practice Guide).
- Referral for further assessment and interventions.

Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial intervention; and moderate or severe depression (see 1.5)

As noted in the *beyondblue's Clinical Practice Guidelines* (2010), "health professionals, young people and parents/carers must be aware of the dangers of not treating episodes of moderate to severe depression. Depression is the major risk factor for suicide" (p.28).

When deciding which of the interventions below to recommend, consider:

- duration of the episode of depression and the trajectory of symptoms
- the person's past experiences of depression and response to past treatment
- likelihood of adherence to the intervention and the potential of adverse side-effects
- the young person's treatment preference and priorities.

For persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to previous treatment. The following interventions should be considered:

- Antidepressants (normally an SSRI); or
- High-intensity psychological interventions, usually one of the following:
 - CBT (16-20 sessions over 3-4 months)
 - Interpersonal therapy (IPT; 16-20 sessions over 3-4 months)
 - Behavioural activation (16-20 sessions over 3-4 months) although there is less evidence to support BA compared to CBT or IPT (NICE, 2009)
 - Behavioural couples therapy (usually based on behavioural principles; 15-20 sessions over 5-6 months) if the young person has a regular partner, and relationship issues are assessed as a possible precipitating or maintaining factor of the depression, or where involving the partner is considered to add therapeutic benefit
- If a young person declines antidepressants, and a first line high-intensity psychological intervention (i.e., CBT, IPT, behavioural activation or behavioural couples therapy - where indicated), consider:
 - counselling for people with persistent sub-threshold depressive symptoms or mild to moderate depression (6-10 sessions over 8-12 weeks)
 - short-term psychodynamic therapy for those with mild to moderate depression (16-20 sessions over 4-6 months)
 - discuss the uncertainty about the effectiveness of counseling and psychodynamic psychotherapy in treating depression

For moderate or severe depression:

- Provide **combined** antidepressant medication and a high-intensity psychological treatment (either CBT or IPT; 16-20 sessions over 3-4 months)

Provide collaborative care if the young person also has a comorbid chronic health condition and/or associated functional impairment - see the full [NICE \(2009\) guideline 'Depression in adults with a chronic physical health problem: treatment and management' \(CG91; accessible at \[www.nice.org.uk\]\(http://www.nice.org.uk\)\)](#).

Complex and severe depression including risk to life and severe self-neglect (see 1.10)

Note: Complex depression includes "depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors" (NICE, 2009; p.64).

- Refer to specialist mental health services for further assessment.

- A thorough assessment should be conducted including assessing for suicidality, previous treatment history, personality factors and significant relationship difficulties and associated comorbidities including substance use and personality disorders.
- Consider reintroducing past treatments that were inadequately delivered or adhered to.
- Medications should be managed under supervision of a consultant psychiatrist. Antipsychotic medication should be considered alongside the existing treatment plan if the young person has depression with psychotic symptoms.
- Consider electro-convulsive therapy (ECT) if depression is life-threatening, severe and has been unresponsive to other treatments (see full NICE (2009) guidelines for considerations and procedure).
- Multi-professional teams including crisis resolution and home treatment teams should be used to manage crises and considered as an option to support early discharge from inpatient care where appropriate.
- Inpatient care including developing a multidisciplinary care plan - if the young person is at significant risk of suicide, self-harm or self-neglect. High-intensity psychological interventions should be offered in inpatient settings and a multi-disciplinary care plan should be developed and shared with all involved.

Medication for young adults (aged 18-25 years) – a summary of the NICE guidelines (see 1.5, 1.10.3)

When to consider prescribing antidepressants to young adults (aged 18-25 years)

- Antidepressants should not be used as a first-line intervention for mild depression but may be considered if a person has:
 - A history of moderate or severe depression
 - Initial presentation of sub-threshold depressive symptoms that have been present for a long time (typically over two years), or
 - Sub-threshold depressive symptoms have persisted after other interventions.
- Antidepressants should be considered for persistent sub-threshold symptoms or mild to moderate depressive symptoms that are not responsive to a first-line intervention.
- The combination of antidepressant medication and a high-intensity psychological treatment (CBT, IPT, BA or behavioural couples counseling) should be offered to young people with moderate to severe depression.
- Combined treatment (i.e., an SSRI plus a high-intensity psychological intervention) should also be considered if symptoms are non-responsive to either SSRI or psychological treatment alone.

Clinicians may find *Table C3.4 Considerations when deciding whether to recommend pharmacological treatment* from [beyondblue's \(2010\) Adolescent and Young Adult Clinical Practice Guidelines](#) (p.56) helpful.

Clinical considerations in prescribing medications to young adults (aged 18-25 years)

- An SSRI is the first choice of antidepressant type.
- The choice of antidepressant should be discussed with the young person and their parents/carers as appropriate.
- Young people who have been prescribed antidepressants are at increased risk of developing suicidal behaviour.
 - Both the young person and their family/carers should be advised of this risk, advised to be vigilant for changes in the young person's mood, hopelessness, negativity or suicidal ideation and encouraged to contact their clinician/GP if they have concerns
 - Clinicians should particularly note recommendation 1.5.2.7: "A person with depression started on antidepressants who is considered to present an increased suicide risk or is younger than 30 years (because of the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for this group) should normally be seen after one week and frequently thereafter as appropriate until the risk is no longer considered clinically important."
- If an antidepressant is prescribed, **close monitoring** of a young person's mental state, progress, and adverse side-effects is extremely important. Monitoring should be performed by both the prescribing clinician and any other professional/s involved in the young person's care. Young people starting an antidepressant should be seen again for monitoring by the prescribing clinician within one week (even if they are not assessed to be at increased risk of suicide) and continue to be monitored frequently thereafter.
- Prescribing clinicians should consider the toxicity of overdose and/or limit the amount prescribed if the person is assessed to be at-risk of suicide.
- Antipsychotic medications should be considered as an add-on to the existing mental health plan if the young person has moderate or severe depression with psychotic features.

Assessing and managing suicidal thinking, behaviour and self-harm in young people (aged 12-25 years)

Around 50 to 80% of young people diagnosed with MDD are thought to experience suicidality at some point during their experience of mental ill-health (Cash & Bridge, 2009; Hawton et al, 2013). Furthermore, around 60% of young people who die by suicide are thought to have a diagnosable episode of MDD at the time of their death (Fleischmann et al., 2005). Clinicians should be mindful that most people who complete suicide have not made a prior suicide attempt (American Psychiatric Association, 2013). So clinicians should be vigilant even when there is no history of suicide attempt.

Best-practice in assessing and managing self-harm in young people

The current best-practice guideline for managing self-harm in Australian settings is the [Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm](#) (2016; accessible at www.ranzcp.org). This guideline includes recommendations for adolescents and young adults.

Best-practice in assessing and managing suicidal thinking and behaviour in young people

- Assessing and managing suicidality is essential and should be an immediate priority if there is any indication that these are present.
- Clinicians are strongly encouraged to read Orygen's Clinical Practice Point - [Clinical practice in depression and suicide: Assessing and managing ongoing suicidality in young people diagnosed with Major Depressive Disorder](#) for practical guidance on how best to do this (www.orygen.org.au).
- As noted in the *beyondblue Clinical Practice Guidelines (2010)*, "health professionals, young people and parents/carers must be aware of the dangers of not treating episodes of moderate to severe depression. Depression is the major risk factor for suicide" (*beyondblue*, 2010, p.28).

- It is particularly important to monitor for and manage suicidality within the first four weeks of a young person commencing an SSRI, and to continue to be vigilant and monitor suicidality throughout treatment (NICE, 2009, NICE, 2005; see above sections on Medications for Young Adults and Medications for Adolescents for further information).
- Clinicians may find this freely available article helpful - [Development of practice principles for the management of ongoing suicidal ideation in young people diagnosed with major depressive disorder](#) (Rice et al., 2014; accessible from Sage Open at <http://journals.sagepub.com/home/sgo>)

Assessing and managing other types of risks

It is important to remember to assess and manage other risks such as risk of misadventure, exploitation from others, homelessness, deterioration in functioning and risk to others.

More Information

To access more resources to guide your practice in managing depression in young people please see the More Information section of this Clinical Practice Guide.



Resources

Psychoeducation & resources for the young person

For mild, moderate and severe depression

All young people experiencing depressive symptoms should be provided with good, age-appropriate information (ideally in their first language). In particular, they should be offered advice about the benefits of the following in managing their symptoms and encouraged to engage in healthy behaviours:

A healthy diet – (www.oyh.org.au)

Sleep hygiene – (www.oyh.org.au)

Exercising as an important adjunct to treatment – (www.oyh.org.au)

Clients may also benefit from the following resources:

I want to see how my mental health is (www.youthbeyondblue.com - the 'brain quiz' in the 'see what's going on' section)

I want to know more about depression – (www.oyh.org.au)

I want a healthier headspace – (www.headspace.org.au - 'Tips for a healthy headspace' – in the 'resource library' under young people)

I want to feel better after a relationship breakup – (www.headspace.org.au - Breakups factsheet – in the 'resource library' under young people)

I want support around bullying or 'sexting' and image-based abuse – (www.headspace.org.au - factsheets in the 'resource library' under young people)

I want to feel better following a family break-up – (www.youthbeyondblue.org.au - in 'understand what's going on')

I want to know how to cope with feelings of grief and/or loss – (www.youthbeyondblue.org.au - in 'understand what's going on')

I want to understand more about trauma – (www.headspace.org.au - in the 'resource library' under young people)

I want to understand more about who I can get help from and what different professionals like school counsellors, psychologists and psychiatrists do – (www.youthbeyondblue.org.au - in the 'understand what's going on' – see videos)

I want to know more about how I can access mental health support through my GP – (www.headspace.org.au - in the 'resource library' under young people).

I want to know more about how headspace can support me – (www.headspace.org.au - in the 'resource library' under young people)

For mild depression only

This should always be offered as part of a planned and supported package of care with monitoring of the young person's progress (NICE)

I want to try some self-help programs (e.g., **MoodGym**, or **E-couch**) or apps (e.g., **Smiling Mind**) – (see <https://schools.au.reachout.com/apps-and-online-tools>)

Note: Health professionals can learn about and access a range of **online self-help tools**, and get advice from young people and professionals on when to use an app, and what to consider before recommending it, through ReachOut.com in the schools section (see <https://schools.au.reachout.com/> - this website is targeted primarily at schools but has a range of helpful resources for professionals working with young people in other settings).

For moderate-severe depression only

I want to try some online counselling – access free and confidential support online or by phone (www.eheadspace.org.au)

I want to know more about antidepressant medication and the possible side-effects (see www.oyh.org.au - factsheets)

Resources for families/carers

eheadspace (www.eheadspace.org.au) can provide specialist support to families/carers

headspace has a range of resources for families/carers – (see www.headspace.org.au - friends and family resources)

Families from culturally and linguistically diverse backgrounds may find the **Victorian Transcultural Mental Health** website helpful (<http://www.vtmh.org.au/>). Some headspace factsheets are also available in different languages (accessible at www.headspace.org.au).

Resources for health professionals

Additional resources for health professionals are included in the More Information section.



[**More information**](#)

International best-practice treatment guidelines

National Institute of Care and Health Excellence (NICE, 2005) guidelines: *Depression in children and young people: Identification and management in primary, community and secondary care* (CG28; relevant for adolescents up to 18 years of age; last updated September 2017; accessible at www.nice.org.au)

National Institute of Care and Health Excellence (NICE, 2009) *Depression in adults: Recognition and management* (CG90; last updated April 2016; accessible at www.nice.org.uk).

The current best-practice guideline for managing self-harm in Australian settings is the *Royal Australian and New Zealand College of Psychiatrists clinical practice guideline for the management of deliberate self-harm* (2016; accessible at www.ranzcp.org). It includes recommendations for adolescents and young adults.

NOTE: *beyondblue's (2010) Clinical practice guidelines: Depression in adolescents and young adults* (www.beyondblue.org.au) are only suitable for background reading as these guidelines are currently out-of-date and should not be used to inform treatment decisions.

Background information on depression

In addition to the international best-practice treatment guidelines (see above), for further background information on depression see:

DSM-5 (www.psychiatry.org)

ICD-10 (<http://www.who.int/en/>)

Engagement

Please note: All of Orygen's resources listed below are available at www.orygen.org.au

To build your skills in this area complete Orygen's online module: *Engagement and assessment in youth mental health*

For more tips on engagement see *Orygen's Clinical Practice Point 'Addressing barriers to engagement: Working with challenging behaviours'*

For more guidance on culturally safe practice see *beyondblue's (2010) Clinical practice guidelines: Depression in adolescents and young adults* (accessible at www.beyondblue.org.au); and *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (accessible at www.telethonkids.org.au)

For more information and tips on engagement, see the *headspace psychosocial assessment interview* (accessible at www.headspace.org.au)

beyondblue's (2010) Clinical practice guidelines: Depression in adolescents and young adults also provide useful tips on engagement and working with marginalised young people (accessible at www.beyondblue.org.au)

Assessment and interventions

Please note: All of Orygen's resources listed below are available at www.orygen.org.au

What does the evidence say?

To search the evidence for preventing and treating depression in young people – see Orygen's *Evidence Finder* (www.orygen.org.au) which allows you to easily search a database of relevant trials, systematic reviews and meta-analyses.

For more information on managing suicidality clinicians may find this freely available article helpful - *Development of practice principles for the management of ongoing suicidal ideation in young people diagnosed with major depressive disorder* (Rice et al., 2014; accessible at Sage Open at <http://journals.sagepub.com/home/sgo>)

Orygen's Evidence Summary: Using SSRIs and other newer anti-depressants to treat depression in young people provides an overview of the evidence in this area and take-home messages for clinicians.

For more information on evidence related to using CBT and 'third-wave' CBT therapies to treat adolescents experiencing depression see Orygen's Research Bulletins:

- *Research Bulletin 08: Treating Adolescents Experiencing Depression: What Aspects of Cognitive-Behaviour Therapy Matter Most?*; and
- *Research Bulletin 09: Stop, observe, and don't judge your thoughts... What's the evidence for third wave cognitive behavioural therapies for depression in young people?*

To learn more about the evidence for shared decision making with young people experiencing mental illness see *Orygen's Evidence summary: Shared decision-making for mental health*

To debunk unhelpful myths that can affect young people with depression see Orygen's Mythbusters:

- [Mythbuster: Sorting fact from fiction on self-harm; and](#)
- [Mythbuster: Suicidal ideation: "Asking young people about suicidal thoughts or behaviours will only put ideas in their heads"](#)

Practical tools and training to guide your practice

Please note: All of Orygen's resources listed below are available at www.orygen.org.au

Orygen's Clinical Practice Point - Clinical practice in depression and suicide: Assessing and managing ongoing suicidality in young people diagnosed with Major Depressive Disorder is essential reading for clinicians working with young people.

Clinicians may also find this freely available article helpful in managing ongoing suicidal ideation - [Development of practice principles for the management of ongoing suicidal ideation in young people diagnosed with major depressive disorder](#) (Rice et al., 2014; accessible at Sage Open at <http://journals.sagepub.com/home/sgo>).

Orygen also has a number of [free online webinars](#) you can access including:

- [Managing persistent or severe depression in young people](#)
- [When depression is not the only concern for young people: Impact and considerations for treating comorbidities](#)
- [Latest developments in antidepressant medication use in young people](#)
- [Do antidepressants have a role in the treatment of youth depression?](#)
- [Treating complex depression in young people](#)
- [Managing complex self-harm in young people](#)

For practical guidance on how to implement CBT with this group see:

- [Orygen's CBT manual: Cognitive-Behavioural Therapy for depression in young people: A modular treatment approach](#)
- Orygen's online module: Modifying cognitive behavioural therapy (CBT) for adolescents experiencing depression

To learn more about the benefits of shared decision making and how you can use it in your practice with young people see [Orygen's Clinical practice point: Shared decision making in youth mental health](#).

There are online tools and apps to help young people to monitor their own mood

- See [ReachOut Schools](#) for recommended tools and descriptions of how and when to use them. The website is primarily targeted at schools, however it has resources relevant to a range of professionals working with young people in different settings (see <https://schools.au.reachout.com/>).

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