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.