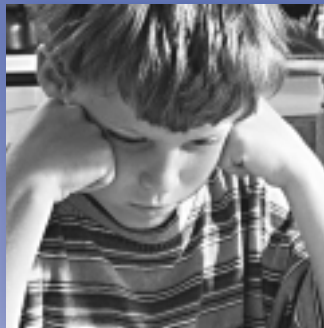


Recognizing depression in youth

A key to solving
one of Oregon's most
serious problems:
Youth Suicide

Kirk D. Wolfe, M.D. — Summer 2000



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Recognizing depression in youth

A key to **solving** one of Oregon’s most
serious problems: Youth Suicide

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Depression in youth can be tragic. It is a common and yet largely unrecognized medical illness in Oregon.

One of the keys to preventing youth suicide is for parents, school personnel, health professionals and others to learn to recognize the subtle signs of depression in our young people.

Knowing and recognizing these signs may save the life of a child, adolescent or young adult you live or work with.

This publication provides critical information for Oregonians about how to prevent youth suicide. This is a practical guide that helps adults recognize the warning signs of depression in youth as well as understand what it takes for these youth to improve their lives.

To quote Governor Kitzhaber’s 1996 Executive Order, “Each time we fail to prevent this tragedy, families suffer and our future is diminished. We will not fulfill our duty to our youth if we do not make every effort to reduce the factors that drive our young people to this most desperate act.” This publication is an important step in the right direction.

Melvin Kohn, M.D., M.P.H.
State Epidemiologist
Oregon Health Division

Clinical depression is a medical illness that will cause youth to have problems at home, with peers, in the classroom and/or on the job. With treatment, these problems can be eliminated.



Oregon has one of the highest youth suicide rates in the country. Our state's youth suicide rate has been reaching epidemic proportions:

- Oregon's youth suicide rate is 30-40% above the U.S. national rate this decade.
- Oregon's suicide rate for older adolescents has increased 400% over the last four decades.
- Suicide is Oregon's number two cause of death among youth.
- On average, 75 youth aged 10-24 have killed themselves in Oregon every year during the last decade.

Research on suicidal youth has made it clear: adolescents who die by suicide are most likely to be clinically depressed when they complete suicide. The statewide youth suicide prevention plan developed by the Oregon Health Division underscores one of the keys to reducing our youth suicide rate—we all must be able to recognize the warning signs of depression in youth.

Impact of Youth Depression on Oregon

Clearly, suicide and homicide are the most tragic results of depression in youth. However, this medical illness also has a much greater impact on our youth, families, schools, juvenile justice system, workplaces, communities and state than most of us realize, with serious consequences on emotional and physical health, and financial well-being. *It is critical that we recognize the far-reaching, devastating impact of depression in youth if we are to meaningfully improve the health of Oregonians.*

Emotional Disruption

Depression has a negative emotional impact on the affected youth and family when the young person withdraws from or aggravates family members. Depressed youth will tend to hang around peers who are

having similar problems, increasing the chances for further disruption. These problems may include doing poorly in school, running away, developing legal problems, having a child as an adolescent, developing a smoking habit, abusing alcohol or drugs, and attempting suicide or homicide.

Our schools are similarly affected by students who are depressed. Youth with untreated depression are more likely to struggle with classwork, avoid or drop out of school or get suspended due to disruptive behavior.

Our legal system is impacted by depressed youth. Too many youth are required to live at juvenile detention centers like Hillcrest or MacLaren for several years as a result of criminal behavior directly influenced by clinical depression. Other youth develop depression while in juvenile detention facilities or adult prisons, the consequences of which can be deadly. Hillcrest deserves credit for putting a much higher priority on the mental health evaluation and treatment of their youth following the five suicides that occurred several years ago.

Take the time to talk with someone who has lost a family member or friend to suicide or homicide. Their pain and suffering lasts an entire lifetime.

Physical Impact

While people tend to focus on the emotional impact of depression in youth, it is equally important that we recognize the numerous physical consequences that can result from unrecognized and untreated clinical depression.

Some depressed youth will overeat and become overweight, increasing their risk for high blood pressure, heart attacks, diabetes and other serious health conditions. Youth who turn to smoking to deal with their depression can eventually develop lung cancer or emphysema. Depressed youth who turn to alcohol or drugs to deal with their depression put themselves at significant

risk for cirrhosis of the liver, heart disease and other serious health conditions, should chemical dependence develop over time. Musselman, *et al.*, noted that depression itself has a significant impact on the progression of heart disease and death after a heart attack.

The World Health Organization's Global Burden of Disease study indicated that clinical depression will be the second most burdensome illness in the world by the year 2020. One can understand why the Oregon Medical Association supports mental health parity with physical health insurance coverage, given the relatively limited coverage health plans currently offer to treat mental illness.

Financial Consequences

The **financial impact** of untreated depression also weighs heavily on our state. With more than 17 million Americans across the country experiencing depression every year, the economic consequences of untreated depression are serious.

An important study by Greenburg, *et al.*, estimated the cost of depression to employers in the United States to be \$23.8 billion in absenteeism and lost productivity in 1990. One can appreciate the cost to our education system for those students who need special education services due to emotional problems related to their depression—services that might not have been needed had the youth's depression been recognized and treated early in its course. The costs to Services for Children and Families (SCF) and the Oregon Youth Authority (OYA) are also significant, as depressed, irritable, aggressive or runaway youth may need out-of-home placement or require placement in a juvenile justice center. The costs of treating other medical illnesses related to unrecognized depression, alcohol abuse, drug abuse, and suicide and homicide attempts, are enormous. In the long run, they account for significant expense through

the Oregon Health Plan and private insurance. For many reasons, your legislative representatives need to understand that you want them to put mental health on full par with physical health in insurance plans.

Notes on Depression and Suicide

Youth depression affects many more children, adolescents and young adults in Oregon than most people realize.

One study by Lewinsohn, *et al.*, at the University of Oregon showed that more than 20% of a relatively large sample of high school students in our state had experienced at least one episode of major depression, either past or current. Based on this study, if you are a teacher with 30 students in your class, *at least six of your students will have experienced clinically significant depression by adulthood—depression that causes problems at home, with peers, in the classroom and/or on the job.* Of the several different types of depression, major depression is the most severe form and the one we need to be most aware of.

Upon reaching puberty, girls are affected by clinical depression twice as often as boys. Youth have been at increased risk for developing mild-to-moderate depression during the latter part of this century, showing some correlation with the sharp increase in the suicide rate during this time. Depression also affects children starting at a younger age than in the past—children as young as four years of age have been treated for depression.

While girls are three times more likely to attempt suicide, boys are three times more likely to die by suicide, in part because boys tend to use more lethal means (e.g., guns). Children younger than five years of age have been known to try to kill themselves; the youngest completed suicide in our state was that of a seven-year-old. **Many of these deaths can be**



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prevented if youth, parents and other adults learn to recognize the warning signs of depression and have the youth referred for mental health evaluation and treatment.

Depression is a medical illness that will likely affect the youth later in life, even after the initial episode improves. *Youth who experience a major depressive episode have a 70% chance of having a second major depressive episode within five years.* Many of the same problems that occurred with the first episode are likely to return, and may worsen.

Why Youth Become Depressed

In order to develop the optimal treatment for a depressed youth, it is important to look at three areas as part of the **biopsychosocial approach** to understanding what contributed to the depression.

The first area is the **biological perspective**. Since depression is often inherited genetically, it is important to look at a family history of depression. Medical disorders such as hypothyroidism and mononucleosis can mimic or exacerbate depression, underscoring the need for a complete physical exam by a primary care physician for any youth who may be depressed.

The second area is the **psychological perspective**. Depressed youth tend to think negatively, minimizing what they do well and blowing less important events out of proportion. Depressed children tend to have poor coping skills, which worsens the problems associated with depression.

The **social perspective** is the final area, looking at environmental reasons why youth become depressed. Parental conflict, separation, divorce or death, financial problems, harassment from peers, physical and sexual abuse, and

family health problems (including mental health problems) are some of the stressors that can lead a youth to become depressed.

Depression is a medical illness whose ultimate cause is a biochemical imbalance in which the brain's neurotransmitter systems (e.g., serotonin and its receptor system) function less effectively. This generally results from a combination of environmental stressors affecting those youth who have a genetic predisposition to depression. The youth's thinking errors further contribute to the depression.

Possible Signs of Depression

Many of the serious behavioral and physical problems that our youth experience can be the result of depression. Often times youth will not tell an adult that they are depressed, although they may express their depression indirectly. *If you see one or more of these surface signs of depression, the youth should receive a thorough mental health evaluation:*

- Low self-esteem
- Anger management problems
- Alienation or withdrawal from family, peers, teachers, co-workers
- Running away from home
- School avoidance
- Doing poorly or dropping out of school
- Cruelty to animals
- Gang involvement and violent behavior
- Fire setting
- Legal problems
- Early pregnancy
- Nutritional deficiencies or obesity
- Persistent headaches or stomachaches
- Increased physical health problems
- Becoming a smoker
- Abusing alcohol or drugs
- Homicide attempts
- Suicide attempts

It is critical that parents, teachers, health practitioners and other individuals look for and ask about these warning signs, so that youth with clinical depression can be recognized and referred for formal mental health evaluation and treatment.



It is important to understand that the brain determines one's mood, thoughts, actions and judgment. When a medical illness like depression affects the brain, the individual's mood and thoughts will be affected, and may also negatively affect their actions and judgement. Many adults view youth who are irritable or acting out as behavior-problem youth, without being aware that a very treatable underlying cause such as depression may be affecting the youth. While youth need to be held accountable for their actions, it is equally important that their depression be recognized, evaluated and treated, if present.

Clues to Recognizing Depression in Youth

Adults who work with young people are usually the first to recognize when a youth is changing for the worse. Too often, however, warning signs are not recognized until after the youth has killed himself or herself. **It is critical that parents, teachers, pediatric health practitioners and other individuals look for and ask about these warning signs, so that youth with clinical depression can be referred for a formal mental health evaluation and treatment.** Preskorn notes in one review by Robins that approximately 70% of adults who died by suicide saw their primary care physician within six weeks prior to the suicide. This underscores the need for practitioners to be able to recognize and refer youth who are depressed for mental health evaluation.

As noted previously, major depression is the most severe form of clinical depression, and the one that has the greatest impact on youth. *According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, a major depressive episode is characterized by a change lasting at least two weeks, during which time an individual has become depressed or irritable, or has lost interest in most activities for most of the day, nearly every day. (Understand that

the change may have occurred months or years ago, though not noted by the family.) The youth also experiences problems at home, in school, with peers or on the job and experiences at least five of the following symptoms nearly every day:

Depressed or irritable mood—look for:

- Directly and indirectly says “I hate my life”
- Easily irritated
- Rebellious behavior
- Seldom looks happy
- Frequent crying spells
- Wears somber clothes
- Listens to music or has themes in writing with depressive or violent undertones
- Hangs around friends who appear depressed or irritable

Marked decrease in interest or pleasure in activities—look for:

- Frequently says “I’m bored”
- Withdraws or spends much time in his or her bedroom
- Declining hygiene
- Changes to a more troubled peer group

Significant change in appetite or weight—look for:

- Becomes a picky eater
- Snacks frequently and eats when stressed
- Quite thin or overweight compared to peers

Significant changes in sleeping habits—look for:

- Takes more than an hour to fall asleep
- Multiple awakenings
- Wakes in the early morning hours and can't return to sleep
- Sleeps more than normal

*Depressed youth
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**Psychomotor agitation or slowing—
look for:**

- Agitated, always moving around
- Mopes around the house or school

Fatigue or loss of energy—look for:

- Too tired to do schoolwork, play or work
- Comes home from school exhausted
- Too tired to cope with conflict

**Feelings of worthlessness or inappropriate
guilt—look for:**

- Describes self as “bad” or “stupid”
- Has no hope or goals for the future
- Always trying to please others
- Blames self for causing divorce or a death, when not to blame

**Decreased concentration or indecisive-
ness—look for:**

- Often responds “I don’t know”
- Takes much longer to get work done
- Drop in grades
- Headaches, stomachaches
- Poor eye contact

**Recurrent thoughts of death or suicide—
look for:**

- Gives away personal possessions
- Asks if something might cause a person to die
- Wants to join a person in heaven
- Says “I’m going to kill myself”
- Actual suicide attempts

Note that most youth will experience at least one or two of these symptoms at various times. However, when several of these symptoms occur at the same time for two weeks or longer, the medical illness called clinical depression is likely affecting the youth. The youth should receive a formal evaluation for depression, which should then be treated once identified.

Families will also want to keep the following important points in mind when their child is being evaluated by a health practitioner:

- 1) Depression can involve suicidal and homicidal thoughts or actions and errors in judgment that endanger the youth or others. Sufficient steps must be taken to maintain the safety of the youth and others. **All families should be asked about guns in the home; depressed youth tend to show poor judgment and should not have access to guns.** Safety issues also need to be monitored on an ongoing basis by the health practitioner.
- 2) **All youth seeing a health practitioner for any reason should be screened for possible depression.** Health practitioners need to make sure that signs of irritability or withdrawal are not attributed to the youth’s “personality” when there are indications of clinical depression. This distinction is essential, as the youth will remain depressed and continue to have problems if these symptoms are incorrectly attributed to his or her personality (which will often wrongly imply to the practitioner that little can be done to improve the symptoms). Similarly, health practitioners need to make sure that signs of poor concentration and agitation are not incorrectly attributed to attention-deficit/hyperactivity disorder (ADHD), when indications of clinical depression are present. (Note that some youth will experience both clinical depression and ADHD.)
- 3) **Consultation with school personnel is essential as this gives an important perspective on how the youth is doing academically and socially.** If school personnel have not previously identified depression in youth, then, with parent or guardian permission, the clinician should discuss signs of depression with the school staff.

- 4) Co-occurring conditions, including ADHD, anxiety disorders and substance abuse, need to be evaluated as well. Co-occurring conditions are clearly the rule with clinical depression, not the exception.
- 5) It is normal for youth to become depressed after the loss of a family member or close friend. However, if the youth experiences significant problems at home, school or work, has significant suicidal thoughts, or stays depressed for more than two months, the depression is no longer normal and warrants a formal mental health evaluation and treatment.
- 6) A thorough physical exam by the primary care physician is an essential part of the evaluation for depression. This exam can help to optimize the health of the youth, rule out general medical conditions, and, if present, identify the direct physiological effects of substances such as alcohol or drugs.

Distinguishing Clinical Depression from “The Blues”

Parents may inaccurately attribute their child’s depressed mood as a case of “the blues,” when, in fact, their child is clinically depressed. The youth will continue to have problems associated with the depression until it is recognized and treated. These factors distinguish clinical depression from “the blues”:

- 1) Clinical depression is a medical illness, not a normal reaction to life situations causing temporary sadness.
- 2) Clinical depression persists for weeks, months or years and affects not only mood but also how the body functions (e.g., eating, sleeping and energy level) and how the youth thinks. Youth with clinical depression will continue to have problems at

home, with peers, in the classroom, and/or on the job, and may die by suicide. “The blues” will only affect the youth’s mood and functioning briefly and generally does not result in suicidal thinking.

- 3) Clinical depression will generally only improve with psychiatric treatment; “the blues” will improve after talking with a good listener.

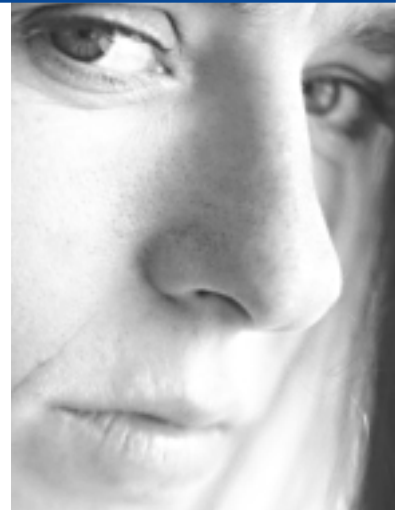
Where to Go for Help

Families can ask their primary care physician or the school’s consulting child psychiatrist, child development specialist, counselor, psychologist or nurse for the names of local mental health practitioners who have successfully treated depression in youth. Families should then ask the mental health practitioner for his or her qualifications and views on evaluating and treating depression in youth.

Treating Depression

The first and foremost consideration in treating depression is assessing the safety of the youth, as well as any threatening thoughts or actions toward family, peers and the community.

- 1) If safety cannot be ensured, psychiatric hospitalization should be seriously considered.
- 2) Depressed youth should not have access to firearms or sharp objects; two-thirds of youth suicides in Oregon occur with guns. **Health practitioners should recommend that all firearms be removed from the home.** Health practitioners should make it clear to parents that if they choose to keep a gun in the home, their child and others are at greatly increased risk of injuries or death. If kept in the home, guns should have a safety lock, and ammunition should be stored separately.



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Parents may need help to understand that depression creates a bigger parent/child barrier, and consequently, greater effort and time commitments are required for a healthy reconnection to occur.

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- 3) All medications in the home of a suicidal youth should be placed in a locked cabinet.
- 4) **Appropriate supervision of clinically depressed youth is essential.** Consultation with the health practitioner treating the youth for depression can help to establish guidelines for supervision.

Further treatment should be tailored to the needs of the youth and family, and should involve an understanding of the biopsychosocial causes of depression for the youth.

Individual psychotherapy with the youth should focus on improving coping skills and helping the youth look at his or her difficulties in getting along with others. Individual therapy should also deal with issues around any trauma, separation or loss. Any thinking errors that contribute to the depression will need to be addressed in individual therapy as well. Individual therapy must be sensitive to the culture of the youth. Note that a small portion of youth will not make good use of therapy until after their depression has been addressed with anti-depressant medication.

Family therapy should work toward improving the understanding and communication between the youth and family members. **It is critical that parents connect with their children; parents may need help to understand that depression creates a bigger parent/child barrier, and consequently, greater effort and time commitments are required for a healthy reconnection to occur.** This should also be a time to determine whether there should be limitations on time spent on TV, video games and computers and with negative peers. **Given the strong hereditary nature of depression, family therapy can also be an opportunity to assess other family members who may suffer from unrecognized depression, so that their depression may also be identified and treated.** Family therapy is also a time for all in the family

to be further educated on the medical basis and signs of depression and on its tendency to recur.

Group therapy can be a particularly helpful form of treatment, given that adolescents are working through separation and individuation issues. Youth are often more amenable to feedback from their peers, so that beneficial change is more likely to occur in this setting. In work at Oregon Health Sciences University, Clarke, *et al.*, developed an adolescent group cognitive/behavioral therapy curriculum specifically tailored to treat adolescent depression.

Other interventions can complement these therapeutic interventions. Efforts should be made to determine a youth's strengths so that he or she can become involved in **activities that improve self-esteem** (depressed youth can be quite creative artists and writers; sports should also be considered). Youth should be involved in **physical exercise** on a regular basis, as determined by the primary care physician. All youth should have **good role models**; innovative programs such as Friends of the Children in Portland provide mentors for young children who have experienced significant problems. For those families that choose to be involved in religious activities, the spiritual benefits of these can be significant for youth. Programs like the Dougy Center in Portland can help grieving children better deal with the death of a family member.

Support groups such as the Oregon Family Support Network, the National Depressive and Manic-Depressive Association and the National Alliance for the Mentally Ill can offer emotional support to youth experiencing depression and other emotional disorders, as well as to their families.

As noted previously, **consultation with school personnel** is essential. Teachers need to make sure that academic expectations are appropriate for youth who are

having concentration difficulties related to their depression. Expectations can be increased as the student's depression improves. Establishing a peer mentor relationship with the depressed student can also be helpful. Parent-teacher communication should occur every 1-2 weeks to make sure the youth is making sufficient progress academically and behaviorally. **Some students with depression may require an individualized educational program.**

A number of youth will continue to be clinically depressed despite receiving these treatment interventions, particularly those youth with a strong family history of depression. **Some youth respond dramatically to anti-depressant medication.** Some of these medications may also treat co-occurring conditions, which, as noted, are the rule, not the exception.

SSRI's (e.g., Prozac, Paxil and Zoloft) can be effective in treating depression in youth and may also treat associated anxiety disorders such as obsessive-compulsive disorder. These medications will generally not address ADHD symptoms, however. Wellbutrin-SR can address both depression and ADHD in some youth; the slow-release form is preferred, given the increased potential for seizures associated with the regular form of Wellbutrin at higher doses. Tricyclic anti-depressants, such as Imipramine and Nortriptyline, are less likely to be beneficial in treating depression in youth and are generally not recommended in treating suicidal youth, as this type of medication may be lethal in an overdose. Medications like hydroxyzine, clonidine and Trazodone should be considered for those youth with significant sleep problems; the relative risk of developing priapism when considering Trazodone in boys needs to be discussed with the family. Medications like lithium, Depakote and Risperdal should be considered for those youth experiencing bipolar depression.

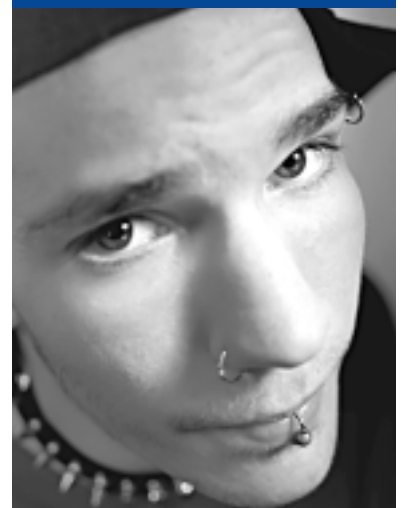
Key points need to be kept in mind when medication is being considered:

- 1) Medication alone is rarely "the answer" in treating depression in youth; instead, youth are most likely to achieve maximum improvement in the quickest timeframe when multiple treatment options are utilized.
- 2) Youth and parents need to be aware of the target goals when a medication is used—an irritable adolescent who skips class, for example, may become less irritable with medication but may continue to skip class unless parents regularly communicate with school personnel, have meaningful consequences for skipping class, etc.
- 3) Parents must make sure their child is taking the medication as prescribed; some parents discover that youth who resist parental direction also resist taking medication.
- 4) Anti-depressant medication generally must be taken as prescribed for the recommended number of weeks or months and at a sufficient dose to be effective.
- 5) It is essential that there be timely communication with the prescribing practitioner if a youth experiences side effects, takes other medications or becomes pregnant.

It is essential for families to understand and comply fully with treatment recommendations. Parents should increase their awareness of their child's friends and activities throughout the day (including use of the computer) so that this information can be communicated regularly to the treatment provider. Further interventions need to be considered if the youth does not begin to show improvement in 4-6 weeks, or sooner, if safety concerns persist.

A second opinion by a health professional trained in recognizing and treating childhood depression can be an important option if problems persist.

*It is essential
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All alcohol and drug treatment providers need to closely evaluate youth for depression in addition to evaluating the substance use problems; otherwise, problems often return after the depressed youth finishes the treatment program.



It is important to recognize that alcohol and drug use can seriously increase depression in youth. A formal substance use evaluation is recommended if the youth may be using alcohol or drugs. The fact that depressed youth who use alcohol or drugs are much more likely to die by suicide cannot be overstated. Note again that all alcohol and drug treatment providers need to closely evaluate youth for depression in addition to evaluating the substance use problems; if this is not done, substance use problems related to undiagnosed depression often return after the youth finishes a treatment program.

Why Some Families Hesitate to Get Help

In the last decade, there have been significant advances in the treatment of depression, as well as in educating the public about depression. Despite this, some parents may hesitate to have their child referred for an evaluation. The reasons for this hesitation can include the following:

- **Warning signs are not recognized.** Teachers, physicians, etc. should point out these warning signs to the parents, so that the youth can then receive a formal mental health evaluation.
- **A belief that their child is experiencing “normal” adolescence.** Clinical depression is not a normal part of adolescence. It causes persistent problems until the youth receives sufficient treatment.
- **A perception that their child has “good reason” to be depressed** (e.g., when the youth has another medical illness like cancer, has been abused or is in a juvenile detention facility). It is important to recognize that depression can improve with treatment; it can lead to death if not treated.

- **A concern that the youth might be viewed as “crazy” or weak in character.** Depressed youth are experiencing a medical illness with physical causes, similar to other medical conditions such as diabetes or asthma.
- **The family does not have insurance.** Many low-income youth are eligible for the Oregon Health Plan or CHIP (Children’s Health Insurance Program). Some mental health centers also have sliding scale fees.
- **Hope that their youth will “get over it.”** Unfortunately, depression persists and will continue to cause problems for the youth, family, schools and community until it is treated.
- **One or more family members are clinically depressed.** They may benefit from their own treatment.
- **The youth refuses treatment.** Youth should not have a choice if there are safety concerns or if problems persist.

It is important to note that the earlier depression is evaluated and treated, the easier it is to treat and the less likely it is that tragedies such as death by suicide or homicide will occur.

What You Can Do

- Take suicidal and homicidal talk and preoccupations with violence seriously.
- Know the warning signs of depression. Recognize that the acting-out behavior is what is seen at the surface, with depression potentially being the cause. Patience and understanding are critical.
- If you know a child, adolescent or young adult who shows signs of depression, suicide or homicide:
 - ✓ Show you care. Listen and connect with the youth.
 - ✓ Make it clear that the youth (and others) need to remain safe.

Set limits and review the potential consequences of threats or dangerous behavior to the youth and others.

- ✓ Share with parents your specific concerns, including suicidal or homicidal statements or actions that have the potential for seriously endangering others. When safety of the youth or others is seriously at stake, this should take priority over the need for confidentiality.
- ✓ Talk with the parent or youth about immediate referral for a comprehensive mental health evaluation by a professional trained in recognizing and treating depression in youth.
- ✓ If the parents or youth seem ambivalent, ask why and review this publication with them. Discuss the seriousness of depression in youth and the fact that problems can improve with treatment.
- ✓ Recognize that depressed youth are most likely to achieve maximum improvement in the quickest time-frame when multiple treatment options are utilized.
- ✓ Understand that it is essential for youth and families to understand and fully comply with treatment recommendations.
- ✓ Help to make sure depressed youth do not have access to firearms or other hazardous objects.
- ✓ Share this publication with the youth's teacher and primary care practitioner.
- ✓ Let your legislative representatives in both the Oregon House and Senate know how important it is for Oregon insurance plans to have full parity between mental and physical health needs.

Conclusion

Depression in youth has lifelong emotional and physical consequences, the most serious of which are suicide and homicide. There are also serious financial consequences associated with unrecognized depression. These consequences have a major impact on our youth, families, schools, juvenile justice system, workplace and communities—and on our state.

Individuals who live, work or interact with youth play a crucial role in the early recognition and referral of youth who may be clinically depressed. A significant proportion of youth receiving treatment by Oregon health practitioners for other reasons are also clinically depressed, although their symptoms often are not recognized as the result of depression.

Until those of us who live with, work with or treat youth increase our ability to look and ask for signs and symptoms of depression, depression in youth will continue to be undiagnosed and untreated. Youth who remain depressed will continue to do poorly and will have a negative impact on other youth, their families, the school system, their workplace and the community as a whole. Some of these young people will die by suicide while experiencing depression.

The key is to recognize signs of depression and have the youth referred to a health professional trained in evaluating and treating depressed youth. Treatment needs to be tailored to the youth and his or her family, and addressed from biological, psychological and social perspectives.

With the right treatment, youth who have experienced depression will show significant improvement, and our youth, families, schools, communities and state will benefit. *



With the right treatment, youth who have experienced depression will show significant improvement, and our young people, families, schools, communities and state will benefit.

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