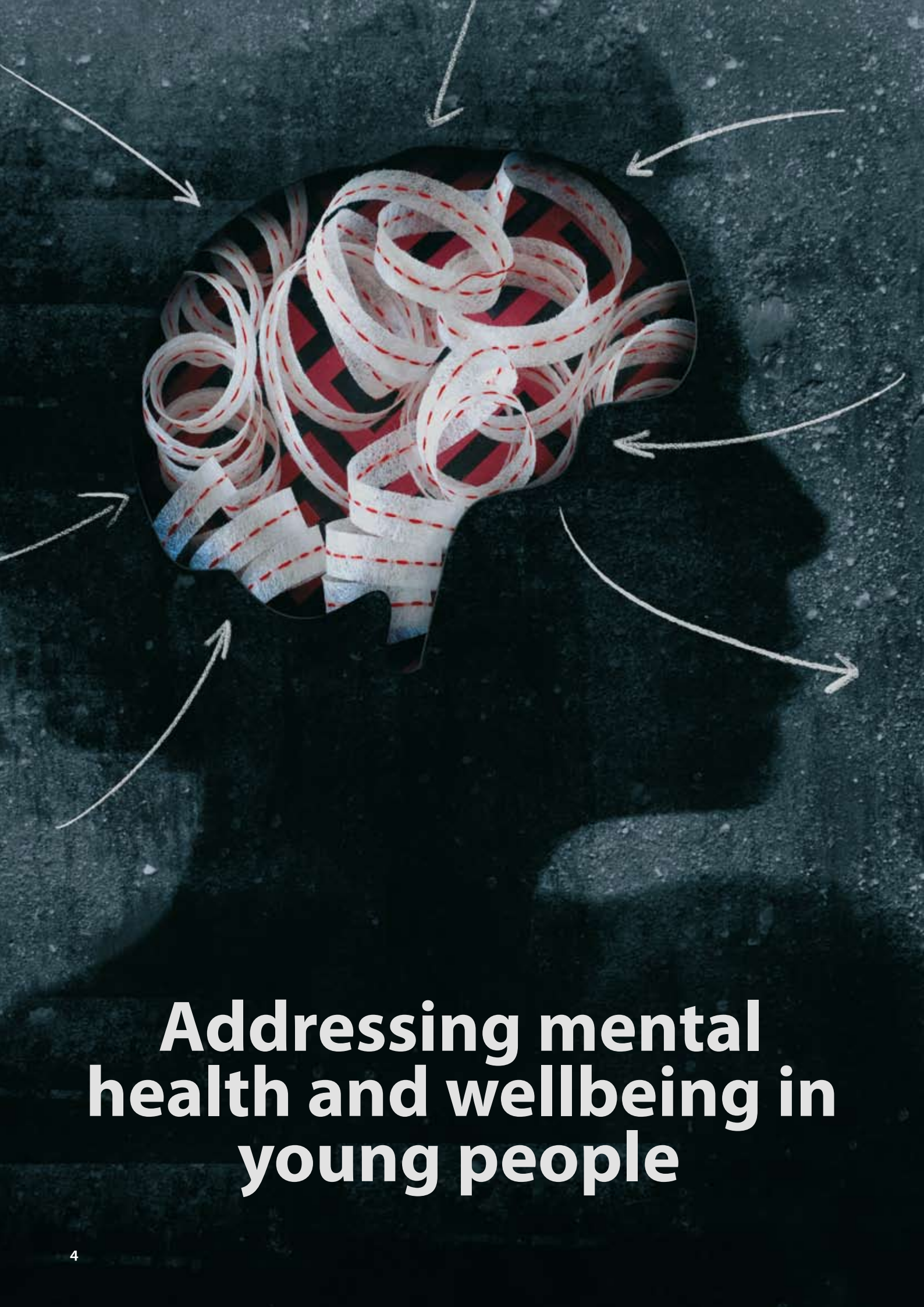


Addressing mental health and wellbeing in young people

This is the first of a series of articles which will examine the diverse theme of mental health in young people. Adolescence is a time of physical and psychological maturation, changing social roles and a move away from childhood towards greater independence and responsibility. It may bring increased exposure to risky behaviours involving sex, alcohol, drugs and motor vehicles, as well as worries about body image, relationships, peer pressures and educational achievements. From puberty the incidence of mental health conditions increases, including depression, anxiety, psychosis and suicidal ideation; young people in New Zealand have one of the highest rates of suicide in the developed world. Clinicians in primary care are in a unique position to help young people navigate this transition in life.

Adolescence, the transition from childhood to adulthood, is full of both physical and psychological changes. Young people may change schools, social circles, and face pressures to fit in with peers. In later years they develop greater independence, and with it increased exposure to risky behaviours involving sex, alcohol, drugs and motor vehicles, as well as worries about choosing a future path beyond school. In the course of all this, young people go through internal changes and develop their own sense of identity and views about themselves and the world around them; they may feel a conflict between their growing sense of identity and expectations of them.

Whatever our experiences of adolescence were, young people today face a transition from childhood to adulthood that is in many ways different to our own. Internet and mobile phone technology enables new forms of interaction, ranging from useful, positive developments in education and communication, to cyber-bullying and "sexting". The ease of using the internet and mobile phones can amplify the nature of peer pressure due to their "always on" presence. These technologies have also undermined censorship laws; young people can easily access explicit sexual, violent or drug-related content that was previously subject to age-appropriate restrictions. In addition, the visual nature of internet content can further increase exposure to idealised body types and reinforce body image concerns.

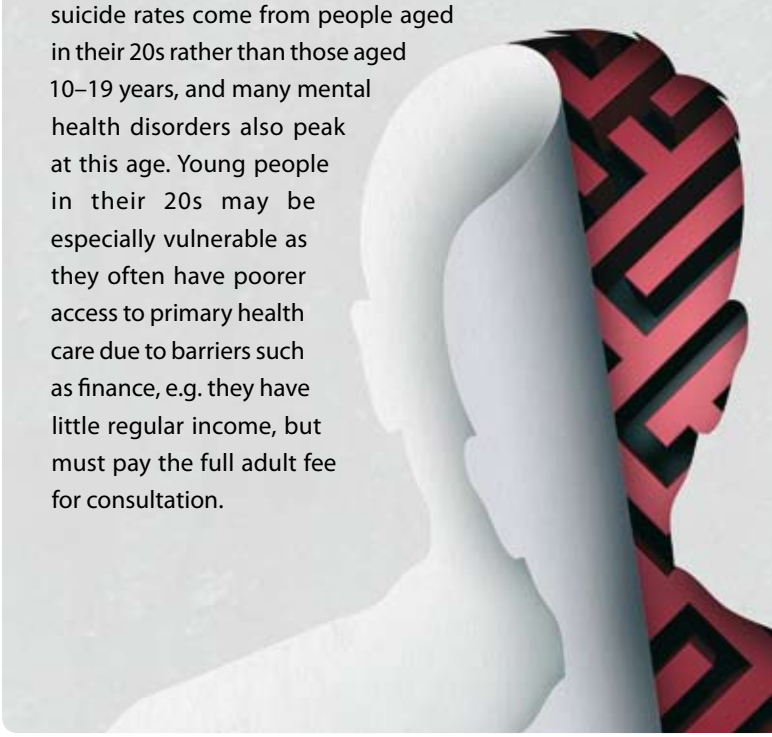
A generation or two ago, it was not unusual for teenagers to leave school early and join the workforce in paid apprenticeships. Educational requirements, the job market, and societal expectations have now changed. Teenagers having problems at school may feel trapped in "the system", and even students who enjoy their school days may feel daunted by the pressure to plan their future when they are still unsure of who they are and wish to be. Others may have a strong desire to get out of the education system and start earning their own

What is a "young person"?

Terms to describe young people are often used interchangeably, and a variety of official definitions exist. The World Health Organisation defines the terminology using the following age groups:

- Adolescent – age 10 – 19 years
- Youth – age 15 – 24 years
- Young people – age 10 – 24 years

It is important to remember when considering the mental health and wellbeing of young people that those aged in their early 20s are often still navigating the same emotional and developmental issues as younger adolescents. Many of the adverse sexual health statistics and high suicide rates come from people aged in their 20s rather than those aged 10–19 years, and many mental health disorders also peak at this age. Young people in their 20s may be especially vulnerable as they often have poorer access to primary health care due to barriers such as finance, e.g. they have little regular income, but must pay the full adult fee for consultation.



money as a means of gaining independence and getting away from problems at home or in their neighbourhood.

It is no wonder that this time in life is associated with an increased risk of mental health issues. Even young people who are otherwise happy and healthy may need help from time to time with issues relating to peers, family, relationships and their place in the world that they find overwhelming to face on their own.

Mental health in young people in New Zealand

Most young people in New Zealand are relatively happy and healthy. In the Youth '12 survey, which assessed the health and wellbeing of students in a random sample of secondary schools (covering 3% of all secondary school students in 2012), 82% of males and 71% of females reported good emotional wellbeing.[1] However, most classrooms in New Zealand will have students in them with some form of mental health concern (Table 1). In young adults aged 15 to 24 years participating in the 2013/2014 New Zealand Health Survey, 7% reported high levels of psychological distress, with higher rates in females (10%) than males (5%).[2] A sample of 1,388 students across six secondary schools in Auckland found that 37% reported sleep problems lasting longer than one month, with 19% of students reporting depression and 17% reporting anxiety.[3] Rates of mental health conditions are higher in students attending alternative education schools (for students aged 13 to 16 who have become alienated from mainstream education), with 25% of male students and 53% of female students in alternative education reporting being depressed for two weeks or more in the previous year, and 23% reporting that they had seriously thought about suicide in the last year.[4]

Rates of youth suicide in New Zealand are among the highest in the world. Data published in 2012 show that among 32 OECD countries, New Zealand had the highest rate of suicide for males aged 15–19 years, the fourth highest rate for females aged 15–19 years and the third highest rate for males or females aged 20–24 years.[5] In the Youth '12 survey, one in five females and one in ten males had seriously thought about suicide in the last 12 months, with 6% of females and 2% of males having attempted suicide.[1] Suicide accounts for approximately one quarter of all deaths in people aged between 15 and 24 years in New Zealand.[6]

Self-harm is also common among young people in New Zealand. In the Youth '12 survey, 29% of females and 18% of males had deliberately harmed themselves in the previous 12 months.[1] Self-harm behaviours vary, and some types of self-harm behaviour, e.g. cutting or burning the skin in a non-lethal manner, are distinct from self-harm with suicidal intent.[7] A survey of 1,162 students in the Wellington region found that approximately 50% of students reported having tried some form of non-suicidal self-harm at least once, suggesting that experimenting with self-harm could be regarded as characteristic of adolescent behaviour. However, only a minority of young people engage in these behaviours repeatedly: 3.7% of students reported having cut their skin many times and 2.1% having burned themselves with a lighter or cigarette many times.[7] Ongoing self-harming behaviour was associated with other aspects of poor mental health, such as low self-esteem, depression, anxiety or being bullied.[7] Self-harm behaviours can also lead to other psychological issues such as embarrassment, the need to cover the body part affected, and fear of it being discovered.[7]

Risk factors for mental health issues in young people include events early in life, such as childhood trauma or physical or sexual abuse, poverty and social deprivation.[8] In New Zealand, Māori and Pacific peoples are at increased risk: the Youth '12 survey found that Māori were more likely to have attempted suicide (odds ratio 1.97, 95% CI 1.40, 2.76).[9] Recently released provisional suicide statistics for 2014/15 showed the rate amongst Māori was the highest since records began in 2007/08.[10] Young people who identify as LGBTI (lesbian, gay, bisexual, transgender or intersex) are at increased risk of mental health issues. In the Youth '12 survey, LGBTI students were found to have poorer mental health and wellbeing compared to non-transgender, exclusively heterosexual students, such as higher rates of being bullied, having depressive symptoms and attempting suicide.[11, 12]

Table 1: Key mental health statistics for young people in New Zealand, 2008–2012[1, 5]

	Females	Males
Report clinically significant depressive symptoms	16%	9%
Deliberately self-harmed	29%	18%
Seriously thought about suicide in the last 12 months	21%	10%
Attempted suicide in last 12 months	6%	2%
Suicides per 100,000 people in each age band:		
Ages 15 – 19 years	6	23
Ages 20 – 24 years	10	33

Maximising engagement with young people in primary care

Against a backdrop of high rates of mental health issues among young people in New Zealand compared to other OECD countries, it is important to ensure that opportunities to engage in primary care are maximised, and healthcare is provided which is accessible and appropriate to a young person's needs.

Improve awareness:[13–15]

- Reach out to where they are: offering clinics, education sessions or presentations in schools improves awareness and helps break down barriers to access for young people; consider if this is something your practice could offer
- Participate in youth awareness and service delivery workshops*, to help your practice provide an experience of coming to a clinic which is positive and welcoming for young people. Ask for feedback from young people to identify areas where you could improve. Also consult the Youth Health Resource Manual† to identify areas of improvement.
- Let young patients know about dedicated local youth health services‡

* For example, the Goodfellow Unit offers continuing medical educations courses for primary care on youth engagement: www.goodfellowlearning.org.nz/course-search?keys=CEP

† The Youth Health Resource Manual: Enhancing the skills of primary care practitioners in caring for all young New Zealanders (2011) is available from the Collaborative for Research and Training in Youth Health and Development Trust for $31. See: www.collaborative.org.nz/index.php?page=youth-health-resource-manual

‡ For a list of "Youth One Stop Shops", see: www.health.govt.nz/our-work/mental-health-and-addictions/youth-mental-health-project/youth-mental-health-project-initiatives/youth-one-stop-shops

Help young people access and engage with your practice:[13–15]

- Let young people know that they do not need anyone's permission to visit the doctor, e.g. a sign in the waiting room. They can make an appointment themselves by calling or emailing the clinic, and can come along by themselves or with a support person
- Consider increasing appointment availability after 3.30pm and having a late opening night so that there is plenty of appointment time available for young people to attend after school
- Provide friendly, no fuss appointments. Young people often rate friendly, non-judgemental reception staff as an important aspect of their experience with healthcare providers[14, 16]
- Display costs for young people in the clinic or online and ensure they know about any local services or funding which may be available from the PHO. Cost barriers might mean that young people need to tell their parent or caregiver they wish to see a doctor, which can act as a further disincentive to accessing care.
- Consider the clinic environment and whether it would be seen as a welcoming, comfortable space for a young person. Having youth-appropriate magazines, posters and health information in the waiting area can let young people know the clinic has them in mind.
- If possible, offer the choice of seeing a male or female clinician; a young person may feel more comfortable discussing problems with someone of their own sex
- Aim for short wait times. Long wait times, especially if seeking help for mental health issues, may lead to young patients second guessing why they have come to the clinic and contemplate leaving, or may be a disincentive to return for follow-up appointments. Reception staff can indicate the expected wait time.

Building trust: the linchpin to engagement with young people

Privacy concerns may limit honesty and openness with healthcare professionals

Young people may not be aware of the strict professional codes and legislation that govern the confidentiality of the information they share with their general practitioner and primary care team, and may hold back due to fear their parents or school could find out about what they share.

Key practice points include:[13, 14, 17]

- Formally declare the privacy of the patient's health information, but do so in youth-appropriate language, e.g. "everything you say to me will be kept private between us"
- Explain that you might want to share information with other health professionals in order to better help the young person, e.g. a colleague or psychologist, but that you will ask their permission first
- Highlight that the only exceptions to confidentiality would be when they or someone else is at risk of getting hurt, e.g. they're threatening suicide or are being abused. Emphasise that in those cases you would try to work with them to identify who should know and how they should be informed.

Tips for communicating with young people

The key to effective communication with young people is listening to what they say, and ensuring that they feel heard and acknowledged. The important part of this skill is to be able to judge the stage of cognitive development of the young person as it does not always correlate with chronological age.

Consider the following:

- The concept of time develops with age. For example, a two-year-old may not understand what tomorrow means but an older child may be able to tell you how many sleeps it is until their birthday and understand how long this will take. It is important to judge how far the young person's concept of time stretches, as to talk beyond that means it is less relevant to them. For example, a 14-year-old may not be able to relate to a conversation about what they will do after they complete their schooling, but may be worried about a social interaction in the next school holidays.
- Where the young person is on the concrete/abstract thinking spectrum. This is important as to ask abstract questions of a concrete thinker will not usually elicit an answer beyond "dunno".
- The young person's ability to think more complexly. This is important to judge how many choices a young person can cope with at one time.

These developmental aspects are also important when judging capacity to consent, which is based on competency, not age.

Acknowledging the young person as an individual

Reassure young people that their health as an individual is important to you. They may feel that they are seen by clinicians as "the child of their parent/caregiver" rather than as their own person with their own health needs. Only 37% of secondary school students who had seen a healthcare professional in the previous 12 months in the Youth' 12 survey reported having the opportunity to see them in private.[1]

Key practice points include:

- Suggest to the young person and accompanying family members/caregivers that you could start the appointment together and then see the young person in private, or vice versa, and highlight that this is usual clinical practice. This could be raised at the start of an appointment, e.g. "When you are a child we almost always see you with your mum or dad/caregiver and when you are an adult you will usually come by yourself; now you are somewhere in between and we can do something in between"
- Try to build a transition period into consultations, so that the young person becomes more familiar with seeing a doctor on their own and are later able to initiate and attend appointments of their own accord. For example, reinforce that: "I can see you with your parent/caregiver now, and at other times you can make an appointment yourself or come in by yourself when you are ready to do that. This is what most of my patients do as they get older."

Clinicians are likely to be familiar with the potential for parental or caregiver disapproval when discussing sensitive topics with young people, particularly when they are asked to leave the room. Parents or caregivers may need reassurance that the conversation is done with their child's best interests in mind.

The nature of communication is as important as the content

Assessments of young people's attitudes to healthcare and what they value from clinicians highlight that they:[13, 14, 16]

- Value healthcare where they feel like they are heard, listened to and understood
- Want clinicians to give them health information and advice in a straightforward way
- Want clinicians to work in partnership with them to address their health concerns
- Can be discouraged from engaging with clinicians due to fear of being judged, "told off" or lectured to

- May present with a "safe" symptom to begin a consultation before deciding whether the clinician is trustworthy and reveal what is really concerning them

Opportunistic screening for mental health concerns

As young people typically do not engage in health care services as frequently as people in other age groups, any encounter should be considered as an opportunity to discuss their psychological and emotional wellbeing.

Performing a HEADS assessment

HEADS (sometimes referred to with multiple letters, e.g. HEEADDSSS) is a framework for a semi-structured interview conducted during a consultation, which involves asking adolescents about their Home, Education and Employment, Eating and Exercise, Activities and peers, Drugs and Alcohol, Depression and suicide, Sexual health, Safety and Strengths. Questions covering these topics are flexible and intended to guide conversation rather than a rigid set of instructions to follow (Table 2, over page). Raising these issues may help a young person know that their clinician is interested in their psychological and emotional health as well as their medical concerns. Even if a young person has no particular concerns at that time, bringing up issues related to emotional wellbeing can build trust and act as an invitation to discuss these issues in the future.

Clinicians will need to make a judgement based assessment of the psychological development and level of maturity of the young person under their care in order to pitch their line of questioning and approach to the HEADS assessment at an appropriate level. Questions should be framed in a way that avoids simple answers, such as "yes", "no", "ok", "don't know". For example, ask a question that requires a description rather than an opinion, such as: "What do you like about school?" rather than "Do you like school?".

There is no single correct way of performing a HEADS assessment; Table 2 (over page) highlights some of the topics that can be discussed. Questions should be adapted to the circumstances of individual patients, and delivered in a non-judgemental and informal way so that it does not sound like a test. If there is a particular presenting problem, link as many of the questions as possible to this, e.g. exploring issues of sexual health or bullying.

Approaching the HEADS assessment:[19]

- Explain the purpose of the assessment so a young person does not wonder why they are being asked questions unrelated to their visit, e.g. "I ask all the young people I see about how things are going in other areas of their lives, because so many things are important for health, is that okay if we do that now?"
- Reiterate patient confidentiality
- Begin with topics that a young person is likely to find non-threatening: Starting with strengths and activities the young person is good at can help ease into the conversation. Keep in mind that for many young people the order of the questions may begin as non-threatening by starting the discussion with home and education environments before moving onto topics they may be reluctant to discuss such as drug use and sex, but for some young people their home environment may be a source of stress, so flexibility is important
- Asking about the activities of friends or peers can be an entry into sensitive topics such as drug use, i.e. "do any of your friends smoke marijuana?", "do you do it too?"
- Keep in mind that young people with depression may not label their experience as depression, and clinicians should be alert for other signs such as a change in weight, altered behaviour or academic achievement at school, conflict with others at home or other behavioural changes consistent with a diagnosis of depression[20]
- Record potential co-morbidities and the young person's social, educational and family context in their notes [21]

Closing off the HEADS assessment:

- Thank the young person for their answers and their honesty, reinforce their good health behaviours, remind them about the confidentiality of their answers and ask if they have any questions
- Address any immediate safety issues which have been raised
- Reassure the young person – if it is appropriate, normalising their experience can help to place it in context so that they do not feel like they are outliers or in some way unusual, e.g. body image concerns, "fitting in", disagreements with parents or uncertainty about sexuality
- Discuss which items they would like to address now. Acknowledge the emotional content of what they have told you before introducing a logical potential solution; many young people are not yet fully able to use thoughts to control their emotions.
- Make a plan with them for follow-up

N.B. Future articles in the mental health in young people series in Best Practice Journal will cover management strategies for mental health problems identified during HEADS assessment.

Table 2: Examples of HEADS questions (adapted from Wilson *et al*, 2012[18] and Klein *et al*, 2014[19])

Home	Who do you live with? What are your or your family's cultural/spiritual beliefs? Is there someone you can talk with about personal things at home? Do you feel safe at home?
Education and Employment	How are things at school/work? How do you get along with teachers and other students? Have your grades changed recently? Many young people experience bullying at school, have you ever had this?
Eating and exercise	How often do you do some form of physical activity? We all have different body sizes and shapes – do you think about or worry about your weight?
Activities and peers	What do you like to do for fun/ to have a good time? What things do you like to do with friends? Have you sent messages or texts to friends that you later regretted?
Drugs and alcohol	Do any of your friends smoke? What about you? Do any of your friends drink? What about you? What other drugs are people your age using these days? What have you tried?
Depression and suicide	Do you have trouble sleeping? If so, what do you usually think about when awake, is there something that bothers you? Everyone has up days and down days what about you? Do you ever feel overwhelmed or so down you can't cope? Have you ever felt like you want to end it all? Have you ever hurt yourself, i.e. by cutting yourself, to feel better?
Sex	I ask all young people about sexuality because it is an important area of heath, is it okay if I do that? Have you ever been made to do sexual things that you didn't want to do? Have you ever wondered about whether you might be straight or gay? Have you got any questions about sexuality?
Safety	Have you ever been a car where the driver has been drunk or stoned? Is there much violence at your school, in your neighbourhood or at home? Have you ever been in trouble with the police?
Strengths	What is something you're good at, that you like doing? What groups are you part of that you feel you belong in? Does your family spend time together, e.g. eating meals? How would your friends describe you? Do you have a close friend or trusted adult that you can talk to if you're feeling down?

A short video introduction to the HEADS assessment is available at: **www.goodfellowlearning.org.nz/courses/introduction-heeadsss-assessment**

For further information on HEADS assessment, see: **www.bpac.org.nz/BPJ/2012/february/substanceMisuse.aspx**

and

www.werrycentre.org.nz/elearning-courses

Screening for depression, suicide risk and substance use can be incorporated into the HEADS assessment

Depending on the information that is revealed from the HEADS assessment, further exploration of some topics may be warranted, e.g. to examine feelings of depression or suicidal ideation or to assess for alcohol and drug misuse.

There are many different screening tools available for use in this situation; it is recommended that clinicians become familiar with a few in particular that they are most comfortable using. Practices that use the *bestpractice* Decision Support module for depression in young people can access a variety of these tools electronically.

The "depression in young people" module is nationally funded and available for any practice to install, free of charge. For further information, see: **www.bestpractice.net.nz/feat_mod_deprYoung.php**

Research suggests that young people have a high acceptance rate for completing screening questions for psychosocial issues in a self-administered format.[22] Depending on the type of assessment tool being used, consider asking the young person to go through the questions themselves in a private space, with the responses then reviewed by a clinician. Keep in mind that some young people may have literacy issues or speak English as a second language so may require additional help in completing the assessments.

Screening for depression and suicidal ideation

Evidence suggests that directly asking patients about depression and suicide is the best method for detecting and identifying people at risk, rather than relying on patients to volunteer this information themselves.[20]

Examples of quick screening tools which show good sensitivity and specificity in research studies and are suitable for use with young people in primary care include the Patient Health Questionnaire (PHQ-2) and Ask Suicide-Screening Questions (ASQ) tools.

PHQ-2 consists of two questions: "Over the last two weeks, how often have you been bothered by either of the following problems?":[23]

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless

Responses can range from not at all (0 points), to several days (1 point), more than half the days (2 points) or nearly every day (3 points). A combined score ≥3 across the two questions has a good sensitivity and specificity for detecting young people with depression compared to more involved and lengthy screening questionnaires.[23]

ASQ involves asking young people:[24]

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself?

If the patient answers "yes" to Question 4, they should be asked how they tried to kill themselves and when. A "yes" response to any of the questions would prompt further assessment and referral as appropriate.

Screening for alcohol and drug misuse

The CRAFFT screening tool is a validated method of detecting substance use problems in young people, and can be incorporated into a conversation or used as a self-report questionnaire:[25]

- Have you ever been in **car** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to **relax**, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are **alone**?
- Do you ever **forget** things you did while using alcohol or drugs?
- Do your **family or friends** ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into **trouble** while you were using alcohol or drugs?

Two or more "yes" answers indicate the need for a more detailed assessment.

The Substances and Choices Scale (SACS) is another tool that can be used to assess for misuse of alcohol and drugs in young people. It can identify specific areas of concern that would prompt more in-depth assessment. As the tool measures behaviour over the last month, it can also be used to monitor progress and outcomes during treatment for alcohol or substance misuse.

The young person can complete the SACS questionnaire themselves (the community version); there is also a more detailed clinician version available. The main difference between the versions is that the community version only asks about alcohol and cannabis use, with spaces to record other drug use. The clinician version names and asks about a wide range of substances. When the clinician is administering the questionnaire, it is also recommended to ask about the use of other substances not included on the list, such as herbal highs, party pills, sedatives and other latest "fad" drugs.

When the questionnaire is completed, the clinician can score the items to indicate whether further assessment or intervention is indicated. When the questionnaire is used to monitor progress, the ticked boxes are connected with lines and the page turned on its side to see the "SACS difficulties mountain range" and whether progress is "smooth" or "rocky".

SACS was developed and validated in a New Zealand population, therefore is preferred to CRAFFT by some clinicians.

For an electronic version of SACS and a guide for administering and scoring the tool, see: **www.sacsinfo.com**

For further information on additional screening tools for mental health issues in young people, see: **www.bpac.org.nz/BPJ/2010/January/assessment.aspx**

Final thoughts

Young people face many hurdles as they navigate the transition from childhood to adulthood, increasing their susceptibility to emotional and psychological distress. General practitioners are in a unique position to screen for problems, as well as offer support and help for young people and their families. While working with young people can be challenging at times, it is richly rewarding supporting them through this period as they mature, develop resilience and overcome their obstacles.

Acknowledgement: Thank you to **Dr Sue Bagshaw**, Senior Medical Officer Youth Health, Director of the Collaborative for Research and Training in Youth Health and Development Trust, Senior Lecturer, Paediatrics, University of Otago, Christchurch, **Dr Theresa Fleming**, Senior Lecturer, Psychological Medicine and Paediatrics, Chair of the Adolescent Health Research Group, School of Medicine, University of Auckland and **Rebecca Zonneveld**, Nurse Practitioner, Evolve Wellington Youth Service, Lecturer, Graduate School of Nursing, Midwifery and Health, Victoria University for expert review of this article.

References:

1. Clark T, Fleming T, Bullen P, et al. Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012. Auckland, N.Z.: The University of Auckland 2013.
2. Statistics New Zealand. NZ social indicators. Prevalence of psychological distress. 2014. Available from: www.stats.govt.nz (Accessed Oct, 2015).
3. Fernando AT, Samaranayake CB, Blank CJ, et al. Sleep disorders among high school students in New Zealand. J Prim Health Care 2013;5:276–82.
4. Clark T, Smith J, Raphael D, et al. Youth '09: the health and wellbeing of young people in alternative education. Auckland, NZ: University of Auckland 2010. Available from: www.fmhs.auckland.ac.nz (Accessed Oct, 2015).
5. Patton GC, Coffey C, Cappa C, et al. Health of the world's adolescents: a synthesis of internationally comparable data. Lancet 2012;379:1665–75.
6. Office of the Prime Minister's Science Advisory Committee. Improving the transition. Reducing social and psychological morbidity during adolescence. Auckland, N.Z.: Office of the Prime Minister's Science Advisory Committee 2011. Available from: www.pmcsa.org.nz (Accessed Oct, 2015).
7. Garisch JA, Wilson MS. Prevalence, correlates, and prospective predictors of non-suicidal self-injury among New Zealand adolescents: cross-sectional and longitudinal survey data. Child Adolesc Psychiatry Ment Health 2015;9:28.
8. Patel V, Flisher AJ, Hetrick S, et al. Mental health of young people: a global public-health challenge. Lancet 2007;369:1302–13.
9. Crengle S, Clark T, Robinson E, et al. The health and wellbeing of Māori New Zealand secondary school students in 2012. Te Ara Whakapiki Taitamariki, Youth'12. 2013. Available from: https://cdn.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/youth12-Māori-report.pdf (Accessed Oct, 2015).
10. Coroners Court. Provisional Suicide Statistics. Available from: www.justice.govt.nz (Accessed Oct, 2015).
11. Clark TC, Lucassen MFG, Bullen P, et al. The health and well-being of transgender high school students: results from the New Zealand adolescent health survey (Youth'12). Journal of Adolescent Health 2014;55:93–9.
12. Lucassen MF, Clark TC, Denny SJ, et al. What has changed from 2001 to 2012 for sexual minority youth in New Zealand? J Paediatr Child Health 2015;51:410–8.

13. World Health Organisation. Adolescent friendly health services: an agenda for change. Geneva: World Health Organisation 2002. Available from: www.who.int (Accessed Oct, 2015).
14. Kang M, New South Wales. Centre for the Advancement of Adolescent Health, New South Wales, et al. Better practice in youth health: final report on research study Access to health care among young people in New South Wales, phase 2. [Sydney]: NSW Centre for the Advancement of Adolescent Health 2005.
15. Royal College of Paediatrics and Child Health. Bridging the gaps: health care for adolescents. London: Royal College of Paediatrics and Child Health 2003. Available from: www.rcpch.ac.uk (Accessed Oct, 2015).
16. McPherson A. Adolescents in primary care. BMJ 2005;330:465–7.
17. Tylee A, Haller DM, Graham T, et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? Lancet 2007;369:1565–73.
18. Wilson H, Bostock N, Phillip N, et al. Opportunistic adolescent health screening of surgical inpatients. Arch Dis Child 2012;97:919–21.
19. Klein D, Goldenring J, Adelman W. HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media. Contemporary Pediatrics 2014. Available from: www.modernmedicine.com/tag/heeadsss-30-and-sshadess (Accessed Oct, 2015).
20. Zuckerbrot RA, Cheung AH, Jensen PS, et al. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, assessment, and initial management. Pediatrics 2007;120:e1299–312.
21. Hopkins K, Crosland P, Elliott N, et al. Diagnosis and management of depression in children and young people: summary of updated NICE guidance. BMJ 2015;350:h824–h824.
22. Bradford S, Rickwood D. Psychosocial assessments for young people: a systematic review examining acceptability, disclosure and engagement, and predictive utility. Adolesc Health Med Ther 2012;3:111–25.
23. Richardson LP, Rockhill C, Russo JE, et al. Evaluation of the PHQ-2 as a brief screen for detecting major depression among adolescents. Pediatrics 2010;125:e1097–103.
24. Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med 2012;166:1170–6.
25. Dhalla S, Zumbo BD, Poole G. A review of the psychometric properties of the CRAFFT instrument: 1999-2010. Curr Drug Abuse Rev 2011;4:57–64.