

Steve Iliffe, Ceri Gallant, Tami Kramer, Julia Gledhill, Amanda Bye, Victoria Fernandez, Mar Vila, Lisa Miller and M Elena Garralda

Therapeutic identification of depression in young people:

lessons from the introduction of a new technique in general practice

Abstract

Background

Mild-to-moderate depression in young people is associated with impaired social functioning and high rates of affective disorder in adult life. Earlier recognition of depression in young people has the potential to reduce the burden of depression in adulthood. However, depression in teenagers is underdiagnosed and undertreated.

Aim

To assess the usability and usefulness of a cognitive-behavioural-therapy-based technique for Therapeutic Identification of Depression in Young people (TIDY).

Design and setting

A qualitative study of four group practices in northwest London.

Method

Face-to-face semi-structured interviews were conducted with practitioners who had been trained in the use of the TIDY technique.

Results

Twenty-five GPs and six nurses were interviewed. The key themes that emerged from the interviews were: practitioners were 'making sense of teenage depression' when interpreting signs and symptoms; the training in the technique was variable in its impact on practitioners' attitudes and practice; and time factors constrained practitioners in the application of the technique.

Conclusion

The TIDY technique is usable in routine practice, but only if practitioners are allowed to use it selectively. This need for selectivity arises partly from concerns about time management, and partly to avoid medicalisation of psychological distress in young people. The perceived usefulness of the TIDY technique depends on the practitioner's prior knowledge, experience, and awareness.

Keywords

depression; general practice; intervention, psychological; screening; teenagers.

INTRODUCTION

The prevalence of depressive disorder among young people is 3–8% in community samples,¹ and 20% among young people attending their family doctor.² Of young people who are depressed at the time of GP consultation, over 50% have not recovered 6 months later.³ There is an association between even mild-to-moderate depression in young people and impaired social functioning and high rates of affective disorder in adult life.⁴ Mental distress seems to persist in a considerable proportion of young people, and 'it is insufficient to brush aside traumas and hurt and rely on a time healing process only'.⁵ It is possible, therefore, that early intervention in mild-to-moderate depression, as well as in more severe depression in the teenage years, might alter the experience of mental ill-health in adult life.

Over 50% of registered young persons consult their GP each year.⁶ While depressive disorders are common among young people attending general practice, these individuals typically seek help for physical symptoms. Behavioural or emotional complaints account for only 2% of presentations.²

Although GPs believe that depressive presentations among young people are becoming increasingly common,⁷ they tend to identify and react only to those with severe

psychological symptoms,⁸ and fail to identify a significant number with less-severe depressive disorders.³ This could be explained by the fact that they find it difficult to separate mild-to-moderate depression from 'normal' moodiness.

GPs spend less time in consultation with young people than with adults.⁹ Many GPs feel that young persons differ from adults in the way they use general practice and that they are harder to communicate with,¹⁰ and GPs also worry about over-medicalising young people's lives.^{11,12} A reluctance to discuss psychological problems with young people, even when GPs perceive such problems to be present, contributes to low rates of identification.^{8,13} Even following identification, many young people with psychological disorders receive no specific management or follow-up,⁸ perhaps because health professionals hesitate to address issues when they lack confidence in their own skills, or in the treatments available.¹⁴ An authoritative statement that (in this age group) symptoms of depression are common and often resolve without psychological or medical intervention may have influenced practitioners.¹⁵

While there has been considerable emphasis on training GPs to identify and manage adult psychiatric disorders, little work has addressed psychopathology in

S Iliffe, FRCGP, FRCP, professor of primary care, Department of Primary Care and Population Health, University College London. **C Gallant**, BSc, primary care mental health worker, Central and NW London NHS Foundation Trust/Brent PCT, London. **T Kramer**, MRCPsych, senior lecturer in child & adolescent psychiatry; **J Gledhill**, MRCPsych, senior lecturer in child & adolescent psychiatry; **A Bye**, BSc, research assistant; **V Fernandez**, DrSpPsych, specialist registrar in child & adolescent psychiatry; **M Vila**, DrSpPsych, specialist registrar in child & adolescent psychiatry; **ME Garralda**, MD, FRCPsych, professor of child & adolescent psychiatry, The Academic Unit of Child and Adolescent Psychiatry, Imperial College School of Medicine, London. **L Miller**,

MRCPGP, GP, Lonsdale Medical Centre, London.

Address for correspondence

Professor Steve Iliffe, Research Department of Primary Care and Population Health, UCL, Royal Free Campus, Rowland Hill Street, London, NW3 2PF.

E-mail: s.iliffe@ucl.ac.uk

Submitted: 12 June 2011; **Editor's response:**

7 July 2011; **final acceptance:** 26 October 2011.

©British Journal of General Practice

This is the full-length article (published online 27 Feb 2011) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2012;**

DOI: 10.3399/bjgp12X630061

How this fits in

National Institute for Health and Clinical Excellence guidelines on depression in children and young people (September 2005) argue for the need for enhanced detection and risk profiling in community settings. There is little guidance on how to achieve this. Depressed mood is common in young people, and even mild-to-moderate depression can have a lasting impact on mental health in adulthood. However, young people do not engage readily with psychological and psychiatric services. Therapeutic Identification of Depression in Young people (TIDY) is a technique designed to blend diagnosis of depression with a cognitive-behavioural-therapy-based psychological intervention, in a single consultation in primary care. GPs and practice nurses can use the TIDY technique to identify depression, but vary in consistency of use because of time constraints and the desire to avoid medicalisation of moodiness in teenagers.

children and young people. The National Institute for Health and Clinical Excellence (NICE) guidelines on depression in children and young people (September 2005) argue for enhanced detection and risk profiling (stage 1 tasks) in community settings (tier 1 services).¹⁶ They specifically recommend that primary care professionals should be trained in the detection of depression but there has been little systematic study of how this can be achieved.

There are two problems that must be overcome if the NICE guidelines are to be implemented. First, young people with psychological morbidity are difficult to engage in psychological therapies,¹⁷ although such therapies appear to be effective in reducing symptoms and case prevalence.¹⁸ Second, specialist child and young people's mental health services are already struggling to meet the demand for services. It is therefore important that specialist services are focused on those with the more severe disorder.

Improved skills in primary care would improve identification of those with severe depression requiring referral, and facilitate intervention for mild-to-moderate depressive disorders within the primary care setting, thus broadening access to treatment for many young people. While there is at least one suitable and valid screening instrument for detecting depression in young people in primary care,¹⁹ there is no solution to the problem of engaging young people in therapy.

An approach that supports GPs in both identifying hidden psychological morbidity and engaging young persons in therapy ('therapeutic identification') in an opportunistic way during routine consultations would fit the NICE proposals.

Such an intervention has been developed in a joint project between specialists in adolescent psychiatry and GPs,²⁰ and consists of a workplace-based training programme to facilitate a systematic approach to the identification and treatment of psychological morbidity in young people within a single consultation. This 'therapeutic identification' of depressive symptoms was constructed from cognitive-behavioural and interpersonal psychotherapeutic techniques known to be effective in treating young persons attending psychiatric services,^{21,22} and from the NICE guidelines.¹⁶ The techniques were framed around standardised International Classification of Diseases (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV diagnostic criteria for depressive disorder.²² Use in a single consultation was chosen because of the known difficulty of engagement with depressed young people.

A complete diagnostic and intervention protocol from the Therapeutic Identification of Depression in Young people (TIDY) programme is shown in Box 1. The design of the intervention was informed by an awareness of the characteristics of those innovations that are taken up by clinicians,^{23,24} as shown in Box 2. Practitioners were encouraged to vary the language used and the sequence of questions and steps, as they felt appropriate, employing the full depth of the intervention only when the young person's response suggested significant psychological distress. A full description of the development and content of the TIDY intervention is available elsewhere.^{25,26}

A pilot study in a single general practice, targeting the 13 to 17 years age range, demonstrated that this approach was feasible and improved identification rates.²⁵ The intervention significantly increased the case-identification rate among GPs, and they were well received in the small group of young people with whom management strategies were used. The intervention has been developed in conjunction with specialist services as recommended for the management of adult depressive disorders in primary care,²⁷ and was awarded the *BMJ* Primary Care Team of the Year Award in 2010.²⁸

The aim of this study was to evaluate the usability and usefulness of the TIDY

Box 1. Protocol for the Therapeutic Identification of Depression in Young People (TIDY): a 'single shot' treatment

1. The transitional question:

Other than your ... how have you been? Sometimes ... can get worse if you are worried or stressed. Is there anything particular bothering you at the moment?

2. General psychiatric screen:

Do you have any other difficulties of worries at the moment? Is anything else bothering you? Do you see yourself as mainly a happy or a sad person?

3. Screen for depression:

Have you felt sad or miserable or down in the dumps lately? ... More moody than usual? Have you been feeling more tearful than usual or crying more than usual? Have you been feeling more angry or irritable or fed up than usual?

4. Diagnose depression: clarify core symptom; that is, frequency and duration of mood change or anger/irritability.

How often do you feel this way? How long does the feeling last? When did you start to feel this way?

Count as positive if:

- symptom duration >2 weeks
- symptom intensity >3 hours three times a week

5. Clarify associated symptoms:

I am going to ask you about other changes that you might have noticed while you have been feeling sad or miserable ...

- *Change in weight or appetite? Tired or lacking in energy? Change in sleep pattern?*
- *Restless or slowed up? Hard to pay attention? Not enjoying things or lost interest?*
- *You are to blame for things? Hopeless or self-harm or wished yourself dead?*

One mark for each point; a score of 2 or more triggers the final screen for impairment

6. Clarify impairment:

- Feelings interfering with schooling
- Feelings affecting relationships with family
- Feelings affecting friendships

One mark for each positive answer

7. Scoring: minimum score to confirm diagnosis is: *low mood or anger/irritability*, plus *two* from 'associated symptoms' and one from 'impairment'. If positive, proceed to treatment

8. Treatment:

Give feedback

- Name it (as depression)
- Describe it (in terms of mood, physical symptoms, behaviour)
- Link it (to situations and circumstances)
- Give information (about how to respond to depression)
- Give leaflet (reinforcing the verbal information)

Coping strategies

- Mobilise help/identify confidant (why, who, seeking feedback)
- Activity scheduling and self-reinforcement (*plan to achieve something important, congratulate yourself when you achieve it*)
- Give positive reinforcement (*you are right to talk about depression, and seek help for it, and this means you are fighting it*)

Remind and invite back

Depression is usually a self-limiting disorder; it will go away! Come back if things don't get better

intervention in four general practices in inner London, by interviewing practitioners who participated in the feasibility study.

METHOD

Data were collected during interviews with GPs and practice nurses involved in the TIDY feasibility study. The study was carried out from January to June 2009 in four group practices in inner London.

Face-to-face interviews at the end of the study were selected as the optimal method

for eliciting insider perspectives and frameworks of meaning²⁹ on the TIDY programme and were carried out by one researcher. All practitioners who had been involved in testing the intervention were invited to participate in the interviews which took place within the practice; the same schedule was used for all interviews. A semi-structured interview schedule was developed following a review of the literature on obstacles to recognition of adolescent depression. Interviews lasted between 40 and 60 minutes and were tape-recorded; the tapes were transcribed verbatim for analysis. Computer software was not used for this analysis.

A grounded hermeneutic approach was used to understand the data obtained.³⁰ Analysis was carried out by close examination of the transcribed texts and identification of the meanings embedded within them, all transcripts being read and key items of content identified by all authors independently, prior to group discussion. Individual items of content were combined into themes, about which working hypotheses or interpretations could be generated. An analytic induction technique was used, with initial hypotheses being checked against empirical data, particularly for falsifying evidence. These interpretations were revised and reapplied to the data by the researchers individually and in group discussion, until agreement was reached about the meanings and relationships of interpretations, and the researchers were satisfied that negative or deviant cases had been identified and incorporated into the analysis.³¹ Through a process of progressive focusing on the research question, the research team identified the overarching themes arising from the interviews.

RESULTS

Thirty-one practitioners from four practices in the London Borough of Brent participated in the study: 23 GPs, six nurses, and two GP registrars. There were 11 males and 20 females. Their ages ranged from 27 to 58 years, with a mean age of 43 years (standard deviation [SD] = 9.9 years). The sample comprised 45% white, 10% black, 34% Asian, and 10% mixed and other individuals, and ethnicity data were missing for two practitioners. The length of time since qualification ranged from 4 to 35 years, with a mean of 17.7 years (SD = 10.3 years). Ten of the practitioners had a psychiatry job as part of their practitioner training but only two had experienced child psychiatry as part of their practitioner training. Four of the practitioners had undertaken postgraduate

Box 2. Attributes of an innovation that may determine its uptake

Compatibility

Innovations that are compatible with the values, norms, and perceived needs of intended adopters will be more easily adopted and implemented.

Complexity/ease of use

Innovations that are perceived by key players as simple to use will be more easily adopted and implemented. The perceived complexity of an innovation can be reduced by practical experience and demonstration (the degree to which the innovation is expected to be free of effort).

Relative advantage

Innovations that have a clear, unambiguous advantage in terms of either effectiveness or cost-effectiveness will be more easily adopted and implemented. This advantage must be recognised and acknowledged by all key players. If a potential user sees no relative advantage in the innovation, he or she does not generally consider it further: in other words, relative advantage is a *sine qua non* for adoption. Relative advantage is a socially constructed phenomenon: in other words, even so-called 'evidence-based' innovations go through a lengthy period of negotiation among potential adopters, in which their meaning is discussed, contested, and reframed; such discourse can either increase or decrease the perceived relative advantage of the innovation.

Trialability

Innovations that can be experimented with by intended users on a limited basis will be more easily adopted and implemented. Such experimentation can be supported and encouraged through provision of 'trialability space'.

Observability/result demonstrability

If the benefits of an innovation are visible to intended adopters, it will be more easily adopted and implemented. Initiatives to make the benefits of an innovation more visible (for example, through demonstrations) increase the chances of successful adoption.

Reinvention

If a potential adopter can adapt, refine, or otherwise modify the innovation to suit his or her own needs, it will be more easily adopted and implemented. Reinvention is a particularly critical attribute for innovations that arise spontaneously as 'good ideas in practice' and which spread primarily through informal, decentralised, horizontal social networks.

Image

The degree to which an innovation is seen as adding to the user's social approval.

Visibility

The degree to which the innovation is seen to be used by others.

Voluntariness

The degree to which use of the innovation is controlled by the potential user's free will.

Box 3. Changed understanding

'I never really thought about depression and ... the symptoms that you would give there ... not having friends ... I would think ... more of a physical thing ... it was an eye opener.' (PN15)

'Before the training, I didn't know there were so many ... young people with depression ... every time I see a young person, I keep an eye on that kind of issue.' (PN23)

'... it was just having a good structure and knowing what to do afterwards, and not panicking if they were ... depressed, "What do I do about it?". And that was the problem before. You could diagnose that they were depressed, but you ... didn't know which way to turn with it.' (PN25)

'I'm much more likely to be focusing in on the moody teenager, a moody teenager is often depressed ... teenagers are moody but they're moody with their parents ... I don't think most teenagers are moody with their doctor ... if they're moody with me ... I will be pushing a bit harder to see if they're depressed ... they act out, they don't act out to a comparative stranger that they're coming to for help.' (GP43)

'They [young people] didn't think about depression. They thought they were confused, and they have to take decisions ... But they don't know exactly which way to go ... they felt quite overwhelmed by whatever decisions they felt that they needed to take.' (GP45)

training in psychological therapy. The four practices used were the ones that had expressed an interest in the study, from the 70 practices in the West London Research network (WeLReN).

Two overarching themes influenced practitioners' perceptions and the applicability of the TIDY study. The first was a mixture of their understanding of young

people, the visibility of depression in teenagers, the expertise and confidence in dealing with depressed young people, the perceived utility and appropriateness of the TIDY technique, and the perceived likelihood of its beneficial impact. These issues have been grouped under two headings, 'making sense of teenage depression' and 'the impact of training'. The second was that while practitioners' different learning and consulting styles shaped their response to the training, its application was contingent on whether they controlled or were controlled by time.

Quotations from practitioners are shown in boxes, with responders described as GP or PN (practice nurse or nurse practitioner). Numbers refer to the order in which interviews were carried out and do not indicate the responder's practice.

Making sense of teenage depression

For some participants, the project substantially altered their understanding of the psychological problems experienced by young people (Box 3).

However, most participants had more complex and ambivalent views. The most difficult task that practitioners described was defining 'depression in adolescents' and using the word 'depression'; opinions were mixed. Some practitioners felt more comfortable embedding ideas about mood within a heterogeneous picture of the broader social difficulties seen in this group, suggesting some discomfort in singling out mood disturbance or disorder for attention (Box 4).

The impact of training

Testing the therapeutic identification method in practice did seem to alter perceptions, confidence, and skills (Box 5).

Selective use of the technique, triggered by cues, was favoured by many practitioners (Box 6).

What the practitioner brings

Previous training and consultation style mattered in different ways. A GP registrar spoke about his training and experience of psychological approaches, and compared this with the styles of his more senior colleagues:

'I think it's ... a ... bit more difficult for people who haven't had any kind of training in the way that we're being trained now. And to change their whole method of consultation is actually quite difficult ... if you can develop that tool into your actual consultation skills before you ... firmly set them, then it's much

Box 4. Avoiding medicalisation

'I don't think you can ever assume the difference between moodiness and depression ... if you start assuming, "Oh they're just moody" ... it means you automatically cut out 90% of your population that could ... potentially be depressed. I tend ... not to go with the word "depressed", I tend to go with the word "stressed" ... a much easier term for everyone to accept ... not ... stigmatised with ... depression which ... is a really heavy word ... which has a lot of connotations.' (GP24)

'I'm always reluctant to ... say ... "Are you depressed?" to adolescents. I don't know why ... I'm quite happy to say that to an adult ... I would ask my questions in a more roundabout sort of way, "How is this affecting you? Do you have low mood?" I think it's just ... in my own mind about ... using the word "depression".' (GP32)

'I think you can only distinguish [between moodiness and depression] when you look back a few years later ... who knows if moodiness is the beginning of bipolar, who knows if they've been taking drugs ... I think it would be unreasonable to anybody to comment and say that this child is or isn't depressed ... all you can say is they've ... got some mood-related issues ... I'm not sure if labels are necessarily helpful, all they want to do is feel better.' (GP12)

'I wonder whether it had been better to be slightly more generic ... if you can work training so it's about working with young people, mental health issues, drug and alcohol issues, sex issues — are the big things. And somehow linking them up. People now in their thirties and forties have these problems from their teenage years ... it says on your stuff [depressed mood] leads to risky sexual behaviour ... drugs ... alcohol ... why not marry those up?' (GP13)

'I think the awareness needs to be there ... especially at this moment when there's a lot of problems ... with knife crime and you've got a lot of the younger generation out on the streets ... I don't really understand where it's ... suddenly come from — because it seems to have suddenly exploded ... I've had so many parents coming in worried about their teenagers who are on the streets ... We need to find out ... why is that happening. So, yes, I think it needs to be implemented everywhere, so that we can then start to try and calm that ... I think a lot of people are getting scared to be out and about.' (GP24)

Box 5. The impact of training

'I've seen two or three young people with depression ... I call them for follow-up appointments about their problem ... when I call them ... I discuss the depression as well. But they don't take treatment for depression ... I just do counselling for them, how to get out from the depression, giving advice ... doing something involving social life ... more physical activity ... don't stay inside ...' (PN23)

'I like it when they come back ... they are not very keen to open the discussion about the depression ... I'm the one who opens the problem ... But some of them ask straight away.' (PN23)

'It was nice to be able to actually do it on them and realise that they didn't have ... depression ... it was like a reverse thing.' (GP13)

'I think it's given me confidence.' (GP22)

'As you got more used to it, it was easy, but it's ... just getting it involved. And it's difficult to ask those sorts of questions ... we're not very good at emotional health, and mental health. I did the intervention on one person and they ... came back ... two weeks afterwards ... we made a little plan that he was going to do this, that ... and he came back to say he felt a lot better ... that sort of brought it all together, like I was doing something of benefit.' (PN25)

easier. I think that's why it's been a bit easier from my side of things ... I'm not having to really change much ... whereas ... someone who has already ... developed their consultation style to a very doctor-centred position, they possibly would find it a bit more difficult.' (GP24)

A practice nurse commented on the effect of learning in a group with varied experiences:

'You could action it immediately ... and we were all there together so we could ask

appropriate questions ... it was also very interesting to be trained with other people because some of the questions that they brought forward you wouldn't have ... thought about.' (PN25)

The technique caused some hesitation, and practitioners needed to modify it in order to integrate it with their underlying understanding or approach (Box 7).

Time

The practitioners' perceptions of and relationship to time constraints featured prominently in the discussions. For some practitioners, the lack of time meant that therapeutic identification of depression in young people was not a realistic option. The demands of other clinical problems were so great that questions about depressed mood in young people would not be asked, and things would not be seen, as shown in the first four quotes in Box 8.

However, not all practitioners described time in that way. For some, the consultation with the young person was an important opportunity, and the perception of not having time could be changed by the experience of trying out 'therapeutic identification'. The last two quotes in Box 8 reflect these different understandings.

DISCUSSION

Summary

The TIDY method provided practitioners with a 'rule of thumb' (heuristic), a widely used form of clinical reasoning used in routine practice.³² The design of the intervention was informed by an awareness of the characteristics of those innovations that are taken up by clinicians (Box 2). The TIDY method could be modified and used selectively (prompted by cues); this was favoured by some practitioners. Participating in the study appeared to enhance awareness of depression in young people. Using the TIDY technique allowed some practitioners to change their views about depression in young people and build self-perceived skills and confidence. However, the training programme did not eliminate entirely anxieties about 'medicalisation' of psychological distress in young people.

Strengths and limitations

One of the strengths of the development of the TIDY programme is the explicit incorporation of evidence-based theory into the design. For example, the consultation can be seen as a 'standard operating procedure' consisting of social behaviour,

Box 6. Selective use

'I'm starting to pick up on cues that maybe I wasn't picking up before ...' (GP24)

'There are ... two aspects to it ... screening for depression and the counselling ... you'll choose to screen or if someone gives you a cue. We're not going to screen everyone. If they give me cues, I would probably screen.' (GP11)

Box 7. Anxieties

'Sometimes it can be easy; occasionally you don't know what you're unravelling.' (GP22)

'... my other concern was the possibility of teenagers seeing it as a bit of a dismissal ... that actually you were trying to deal with it almost too short ... opening something up ... talking ... listening, directing them ... then reassuring and "goodbye". My natural way of working would be to ... try and ensure a follow-up.' (GP43)

'... the further you get away from things, you bend things and you adjust things and change things slightly. So I'm not promising I will use it in exactly the same form, but I think I will use an adapted form ... and continue, because ... once you've changed the way you consult ... you do anyway. You stick with it.' (GP43)

Box 8. Time

'The idea is fantastic ... The problem is just putting it into practice. The only way you can apply it is to cut it down further ... there are so many demands on the GPs time ... Plus you've got a huge amount of external stuff that's coming through us all the time ... if I had half an hour for every patient, it would be easy. So it's like all new ideas ... 100% onboard, but it's just a question of putting it into practice.' (GP12)

'In an ideal world, it should be people like us [who do this work]. What they don't want is someone to ask, "How are you?" ... hear the answer, "I'm depressed" and then say, "Well actually I'm not interested in that now, I'm too busy". So it's almost like you should only ask the question if you can then follow it up with empathy.' (GP12)

'The pressure being what's out there and what is out there in the rest of the day, how many jobs there are to do ... time's a pressure which inhibits you from going down that avenue. You're aware that once you've gone down that avenue, you're stuck for a long time.' (GP21)

'We can ... if we want to ... see the things. It's just whether we have the time to actually sit down and acknowledge them ... once you open that can of worms you could be there for 45 minutes ... it sounds horrible ... but the reality is [we have little time].' (GP24)

'The other ... aspect of the time thing is ... thinking, "Well this is possibly the only time the person's going to turn up" ... that ... re-jigs the priorities in terms of trying to as much as possible there. I didn't think it was that time consuming anyway ... it felt that it fitted ... in ... with a 10-minute consultation.' (GP17)

'At first I thought I'm not going to have time to do this ... but it was a revelation as it brought to light a few things ... But I think teenagers are a bit of a lost group. It's easy because it's an eye opener ... a lot of people come with a blank face ... it helps me with this group.' (GP22)

agreement, rapport building, partnership building, giving directions, giving information, asking questions and counselling. A short consultation of the type that TIDY represents can be described as such an encounter, containing social behaviour to set the context, medical questioning, giving directions for the further consultation and advice in order to solve the problem(s) mentioned.³³ The TIDY method was explicitly designed as a standard operating procedure of this kind.

Many complex interventions in health care and medical education have not been based

on empirically established theory. Reasons for this include inadequate development funding, assumed lack of necessity on the part of the developers, and a limited evidence base. Yet explicit rationales for educational interventions are essential if they are to be evaluated, if the 'black box' effect is to be limited, and the training is to be replicated in other settings. The TIDY project has clarified some of the issues that arise when developing a primary-care-based intervention for depression in young people.

Nevertheless, these characteristics may not be sufficient if they do not find a welcome response from practitioners. The present study provides a perspective on users' views, which need to be taken into account for any research project to be successfully implemented. The responses indicate that, while, as may be expected, the acquisition of a new skill generates both enthusiasm and concern, comments were generally positive and indicative of a willingness to engage in the process and adapt it to personal clinical styles. These positive responses need to be considered in the light of the atypicality of the practitioners involved in the study, who were 'innovators' or 'early adopters'. They may have offered socially desirable answers (although the authors think the range of responses suggests otherwise), and the researchers did not attempt responder validation, to maximise the authenticity of the analysis. It is, therefore, yet to be established if the TIDY intervention is transferable to routine practice.

While the TIDY programme notes that drug and alcohol consumption and sexual risk taking may be associated with persistent depressed mood in this age group, these issues are not specifically addressed within the programme. However, it is flexible enough to accommodate extra components, should practitioners wish to use them.

All qualitative analysis is a process of reduction, and it is recognised that this can compromise the totality of the qualitative data.³⁴ The trustworthiness of the data and their analysis depend on the credibility of findings and interpretations to others with experience of the topic, their dependability (in terms of the depth of description of methods, and peer analysis of data,) and the transferability of the findings to other settings.³⁵

Comparison with existing literature

Moodiness or depression? Zuckerbrodt and colleagues found that primary care practitioners in their sample were positive

about using questionnaires to systematically screen their patients.³⁶ Moreover, specific educational interventions for GPs have been shown to have sustained beneficial effects on the quality of consultations,³⁷ and training primary care practitioners can increase the identification of depression and other psychological disorders in young people.^{38,39} Cockburn and Bernard investigated GPs' perceptions in relation to the mental health of children and young people and found that many responders rated their competence, knowledge, and skills in important areas of child and young person mental health as less than satisfactory; most responders reported an interest in further training.⁴⁰

Both young people and primary care practitioners may be reluctant to discuss psychological difficulties, even when they perceive these are present.⁸ Moving the focus of the consultation from a physical to an emotional/psychological enquiry is key to the TIDY intervention. Professional barriers to raising psychological issues may include concern about the time constraints of the consultation, opening 'Pandora's box' for particularly difficult issues such as suicidal thinking and abuse, lack of confidence in clarifying and addressing the problem, and poor access to counselling and specialist mental health services.⁴¹

Young people have expressed concern about feeling embarrassed, finding the doctor unsympathetic, and being misunderstood, judged, or reprimanded within a GP consultation.⁴²⁻⁴⁴ Difficulties in differentiating a commonly experienced symptom such as moodiness from depression are not exclusive to the mental health field. When is high blood pressure treatable hypertension? When is wheezy bronchitis asthma? When is forgetfulness a sign of dementia? In practice, this can represent a fine clinical judgement, the skill for which is acquired from a synthesis of guidelines, training, and experience.

Practitioners and young people alike may fear stigmatisation.⁴⁵ The TIDY training package, which incorporates a non-judgemental diagnostic approach, and highlights the frequency of the problem, is designed to allay those concerns while providing practical suggestions to comfortably move the focus of the consultation. The joint construction of a narrative by patient and practitioner, although done in a very brief way within TIDY, is consistent with the descriptions of how such narrative construction can enhance the healing potential of the clinical encounter.⁴⁶ Practitioners in this study

clearly describe improved skills and confidence in offering such a method, which fits well with adolescents' preference for self-help approaches.⁴⁷

Learning through practice. The 'ideal' professional development package enables the practitioner to build on existing clinical expertise and knowledge within a busy and demanding work schedule, and is flexible enough to accommodate old and new approaches to education.⁴⁸ A new skill has to be integrated into everyday activity, and therefore needs to function as a form of 'soft technology', that is, a taken-for-granted skill that is brought to bear on routine clinical tasks.⁴⁹ There is some evidence, albeit from self-report, that the TIDY technique could become this kind of 'soft technology', at least for some.

One issue that is particularly relevant to recognising depression in young people is to deal with practitioners' uncertainties, including the fear that diagnostic thinking will medicalise normal moodiness.¹⁰ It has been shown that uncertainty about the significance of symptoms and signs accounts for much of the variation in physician performance. Therefore, training in a new intervention method should explicitly address such issues.⁵⁰

Adjusting to clinicians' consultation styles and to time constraints. Time was a prominent issue in practitioners' narratives about their work. The application of medical science depends on the timescale of disease (the disease process), but its efficacy depends on the timescale of illness (the experience of the individual with the disease).⁵¹ To practise the art of healing, the doctor meets the patient in his or her own time, but to practise the science of medicine and treat the disease, the doctor distances him or herself from the patient and treats them in a different time, the time of medicine. There was a difference between medical time and patient time in this study. Some practitioners were uncomfortable with a 'single-shot' treatment, preferring to arrange a follow-up appointment even when they knew that default was more likely than re-attendance.

When asked about their problems with time, GPs emphasise five main features: the unpredictability of demand; the heavy and apparently increasing workload; the lack of structure of their time; their lack of ability to organise their time effectively; and their personal difficulty in dealing with conflicting calls on their time.⁵² All of these time problems were mentioned by practitioners

Funding

This project was funded by WeLReN and the Academic Unit of Child and Adolescent Psychiatry at Imperial College London.

Ethical approval

Brent Ethics committee 07/Q0408/35.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have stated that there are none.

Acknowledgements

We thank all the practitioners who took part in the TIDY feasibility study.

Discuss this article

Contribute and read comments about this article on the Discussion Forum: <http://www.rcgp.org.uk/bjgp-discuss>

in this study, but some described how they deployed time in marginal or opportunity forms. 'Marginal time' is the time taken when extra work is added to the consultation, which is less than the time taken to start up a process, indicating that extra tasks (or patients) should be accommodated in a flexible session rather than in an additional session. 'Opportunity time' refers to work that could be done in time saved from other activities.⁵²

Implications for practice and research

The TIDY technique is a promising method of case finding and management for depressed mood in young people. The results from interviewing GPs who had had training show that the technique can be incorporated into consultations, is modifiable by practitioners, and can be used within routine care. The results also indicate that training programmes should be adapted to different styles of learning, as not every practitioner has the same experience, background, and learning styles. The limited resources needed for the TIDY intervention (training and judicious use of case-finding questions) stand in contrast to the extensive resources used in a successful US trial of primary care education about teenage depression. In that study, primary care practitioners were supported by expert clinicians at each site,

and had care managers to provide psychosocial support for young people identified as depressed, in addition to education about evaluation, management, and treatment.⁵³

The effectiveness of promising interventions in reducing current and potentially preventing future psychological morbidity needs to be established. Such complex interventions must be developed, carefully described in detail, and rigorously tested in field studies before embarking on trials.⁵⁴ This study has attempted to do this using the TIDY technique. The TIDY intervention therefore needs to be field tested in a wider variety of settings, in order to establish its feasibility in routine clinical practice prior to a randomised controlled trial.

The TIDY technique is usable in routine practice but it must be understood that practitioners will use it selectively, when cued to do so by some aspect of the consultation with the young person. This need for selectivity arises partly from concerns about time management, and partly to avoid practitioners' concerns about medicalisation of psychological distress in young people. The perceived usefulness of the TIDY technique may depend on the practitioner's prior knowledge, experience, and awareness.

REFERENCES

- Harrington R. Affective disorders. In: Rutter M, Taylor E. *Child and adolescent psychiatry*, 4th edn. Oxford: Blackwell, 2002.
- Kramer T, Garralda ME. Psychiatric disorders in young persons in primary care. *Br J Psychiatry* 1998; **173**: 508–513.
- Gledhill J, Garralda ME. The short-term outcome of depressive disorder in adolescents attending primary care: a cohort study. *Soc Psychiatry Psychiatr Epidemiol* 2011; **46**(10): 993–1002.
- Pine DS, Cohen E, Cohen P, Brook J. Adolescent depressive symptoms as predictors of adult depression: moodiness or mood disorders? *Am J Psychiatry* 1999; **156**(1): 133–135.
- Haavet OR, Sagatun Å, Lien L. Adolescents' adverse experiences and mental health in a prospective perspective. *Scand J Public Health* 2011; **39**(1): 58–63.
- Kramer T, Iliffe S, Murray E, Waterman S. Which young persons attend the general practitioner? *Br J Gen Pract* 1997; **47**(418): 327.
- Vandana J, Ambelas A. General practitioner perceptions and practice related to young person depressive presentations. *Clin Child Psychol Psychiatry* 2004; **9**(3): 341–346.
- Martinez R. Factors that influence the detection of psychological problems in adolescents attending general practices. *Br J Gen Pract* 2006; **56**(529): 594–599.
- Jacobson LD, Wilkinson C, Owen PA. Is the potential of teenage consultations being missed?: a study of consultation times in primary care. *Fam Pract* 1994; **11**(3): 296–299.
- Iliffe S, Williams G, Fernandez V, et al. General practitioners' understanding of depression in young people: qualitative study. *Prim Health Care Res Dev* 2008; **9**: 269–279.
- Iliffe S, Gledhill J, da Cunha F, et al. The recognition of adolescent depression in general practice: issues in the acquisition of new skills. *Prim Care Psychiatry* 2004; **9**(2): 51–56.
- MacFarlane A, McPherson A. Primary health care and adolescence. *BMJ* 1995; **311**(7009): 825–826.
- Olson AL, Kelleher KJ, Kemper KJ, et al. Primary care pediatricians' roles and perceived responsibilities in the identification and management of depression in children and adolescents. *Ambul Pediatr* 2001; **1**(2): 91–98.
- Gask L, Dowrick C, Dixon C, et al. A pragmatic cluster randomised controlled trial of an educational intervention for general practitioners in the assessment and management of depression. *Psych Med* 2004; **34**(1): 63–72.
- Ramchandi P. Treatment of major depressive disorder in children and adolescents. *BMJ* 2004; **328**: 3–4.
- National Institute for Health and Clinical Excellence. *Depression in children and young people. Identification and management in primary, community and secondary care (CG28)*. London: National Institute for Health and Clinical Excellence, 2005. <http://www.nice.org.uk/nicemedia/pdf/word/CG028NICEguideline.doc> [accessed 23 Jan 2012].
- Westman A, Elena Garralda M. Mental health promotion for young young persons in primary care: a feasibility study. *Br J Gen Pract* 1996; **46**(406): 317.
- Harrington R. Systematic review of efficacy of cognitive behaviour therapies in childhood and young person depressive disorders. *BMJ* 1998; **316**(7144): 1559–1563.
- Haavet OR, Sirpal MK, Haugen W, Christensen KS. Diagnosis of depressed young people in primary health care — a validation of HSCL-10. *Fam Pract* 2011; **28**(2): 233–237.
- Kramer T, Iliffe S, Miller L, et al. Depression in adolescents: collaboration to overcome barriers in primary care. *BMJ* 2010; **340**: c908.
- Harrington R, Whittaker J, Shoebridge P. Psychological treatment of depression in children and adolescents. *Br J Psychiatry* 1998; **173**: 291–298.
- Hazell P, O'Connell D, Heathcote D, et al. Efficacy of tricyclic drugs in treating child and adolescent depression: a meta-analysis. *BMJ* 1995; **310**(6984): 897–901.
- Moore GC, Benbasat I. Development of an instrument to measure the perception of adopting an information technology innovation. *Information Systems Research* 1991; **2**: 172–191.
- Rogers EM. *Diffusion of innovation*. 5th edn. New York, NY: Free Press, 2003.
- Gledhill J, Kramer T, Iliffe S, Garralda ME. Training general practitioners in the identification and management of young person depression within the consultation: a feasibility study. *J Adolesc* 2003; **26**(2): 245–250.
- Kramer T, Iliffe S, Gledhill J, Garralda E. Recognising and responding to adolescent depression in general practice: developing and implementing the Therapeutic Identification of Depression in Young People (TIDY) programme. *Clin Child Psychol Psychiatry* 2012; in press.
- Gilbody S, Whitty P, Grimshaw J, Thomas R. Educational and organizational interventions to improve the management of depression in primary care. A systematic review. *JAMA* 2003; **289**(23): 3145–3151.
- BMJ. *BMJ Primary Care Team of the Year Award 2010*. <http://groupawards.bmj.com/primary-care-team-of-the-year-2010> [accessed 8 Feb 2012].
- Britten N. Qualitative interviews in medical research. *BMJ* 1995; **311**(6999): 251–253.
- Addison RB. Grounded hermeneutic research. In: Crabtree BF, Miller WL. *Doing qualitative research*. London: Sage, 1992: 110–124.
- Murphy E, Dingwall R, Greatbach D, et al. Qualitative research methods in health technology assessment: a review of the literature. *Health Technol Assess* 1998; **2**(16): iii–ix, 1–274.
- Andre M, Borgquist L, Foldevi M, Molstad S. Asking for 'rules of thumb': a way to discover tacit knowledge in general practice. *Fam Pract* 2002; **19**(6): 617–622.
- Deveugele M, Derese A, De Bacquer D, et al. Consultation in general practice: a standard operating procedure? *Patient Educ Couns* 2004; **54**(2): 227–233.
- Burnard P. Qualitative data analysis: using a word processor to categorise qualitative data in social science research. *Soc Sci Health* 1998; **4**: 55–61.
- Guba E, Lincoln Y. *Effective evaluation: improving the usefulness of evaluation results through responsive and naturalistic approaches*. San Francisco: Jossey-Bass, 1981.
- Zuckerbrodt RS, Maxon L, Pagar D, et al. Adolescent depression screening in primary care: feasibility and acceptability. *Paediatrics* 2007; **119**(1): 101–108.
- Sanci LA, Coffey CMM, Veit FCM, et al. Evaluation of the effectiveness of an educational intervention for general practitioners in adolescent health care: randomised controlled trial. *BMJ* 2000; **320**(7229): 224–230.
- Bernard P, Garralda E, Hughes T, Tylee A. Evaluation of a teaching package in adolescent psychiatry for general practitioner registrars. *Educ Gen Pract* 1999; **10**: 21–28.
- Zuckerbrodt RA, Jensen PS. Improving recognition of adolescent depression in primary care. *Arch Pediatr Adolesc Med* 2006; **160**(7): 694–704.
- Cockburn K, Bernard P. Child and young person mental health within primary care: a study of general practitioners' perceptions. *Child Adolesc Ment Health* 2004; **9**: 21–24.
- Bower P, Byford S, Barber J, et al. Meta-analysis of data on costs from trials of counselling in primary care: using individual data to overcome sample size limitations in economic analysis. *BMJ* 2003; **326**(7401): 1247–1250.
- Kari J, Donovan C, Li J, Taylor B. Adolescents' attitudes to general practice in north London. *Br J Gen Pract* 1997; **47**(415): 109–110.
- Churchill R, Allen J, Denman S, et al. Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *Br J Gen Pract* 2000; **50**(461): 953–957.
- Jacobson L, Richardson G, Parry-Langdon N, Donovan C. How do teenagers and primary healthcare providers view each other? An overview of key themes. *Br J Gen Pract* 2001; **51**(471): 811–816.
- Jacobson L, Churchill R, Donovan C, et al; Adolescent Working Party, RCGP. Tackling teenage turmoil: primary care recognition and management of mental ill health during adolescence. *Fam Pract* 2002; **19**(4): 401–409.
- Greenhalgh T, Hurwitz B. Narrative based medicine: why study narrative? *BMJ* 1999; **318**(7175): 48–50.
- Farrand P, Perry J, Lee C, Parker M. Adolescents' preference towards self-help: implications for service development. *Prim Care Commun Psychiatry* 2006; **11**(2): 73–79.
- [No authors listed]. 'I don't know': the three most important words in education: paradigms in learning [editorial]. *BMJ* 1999; **318**: 02.
- May C, Gask L, Atkinson T, et al. Resisting and promoting new technologies in clinical practice: the case of telepsychiatry. *Soc Sci Med* 2001; **52**(12): 1889–1901.
- Eddy DM. Quality assurance and care. In: Ellis R (ed.). *Professional and quality assurance in the caring professions*. London: Croom Helm/Chapman Hall, 1988: 43–57.
- Frankenberg R. 'Your time or mine': temporal contradictions of biomedical practice. In: Frankenberg R. *Time, health and medicine*. London: Sage, 1992: 10–11.
- Pritchard P. Doctors, patients and time. In: Frankenberg R (ed.). *Time, health and medicine*. London: Sage, 1992: 78.
- Asarnow JR, Jaycox LH, Duan N, et al. Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: a randomised controlled trial. *JAMA* 2005; **293**(3): 311–319.
- Medical Research Council. *A framework for development and evaluation of RCTs for complex interventions to improve health*. London: Medical Research Council, 2000.