CARIBOU Initial Assessment Guide

A Resource for Clinicians Working with Adolescents with Depression

camh | Cundill Centre for Child and Youth Depression

caribou by camh

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Acronyms and Abbreviations

ASAB ..... **A**ssigned **S**ex **A**t **B**irth

ASD ..... **A**utism **S**pectrum **D**isorder

ADHD ..... **A**ttention-**D**eficit-**H**yperactivity **D**isorder

CARIBOU ..... **C**are for **A**dolescents who **R**eceive **I**nformation '**B**out **OU**tcomes

CBT ..... ***C***ognitive-**B**ehavioural **T**herapy

NICE ..... **N**ational **I**nstitute for Health and **C**are **E**xcellence

NSSI ..... **N**on-**S**uicidal **S**elf-**I**njury

OCD ..... **O**bsessive-**C**ompulsive **D**isorder

PTSD ..... **P**ost-**T**raumatic **S**tress **D**isorder

Introduction

Purpose

This guide describes the initial assessment of what is a longer assessment process that continues throughout treatment. It is intended for clinicians who are working with adolescents with depression. In this guide we use the terms "adolescent" and "youth" interchangeably to refer to people aged 13 to 18, although many concepts in this guide will also apply more broadly to youth age 10 to 24.[1] This assessment involves one or two 90-minute meetings between the clinician, adolescent and, if the adolescent agrees, a primary caregiver (e.g., parent).

The **C**are for **A**dolescents who **R**eceive **I**nformation '**B**out **OU**tcomes (CARIBOU) pathway contains seven core components: assessment, psychoeducation, therapy options, caregiver support, medication options, measurement-based care "team reviews" and graduation. This guide provides instructions on how to perform the first component: assessment. The assessment is designed to help clinicians determine whether an adolescent presenting to care is appropriate for the CARIBOU pathway intervention. and how the intervention might be further personalized to meet the adolescent's treatment needs and wants, including risk management. The assessment is also used for clinicians and adolescents to co-create a formulation of the depressive symptoms and associated difficulties in functioning.

A formulation of the adolescent's concerns is part of the therapeutic process, and thus not just part of an assessment, but an aspect of treatment. Clinicians should already have some training in assessing the mental health needs of adolescents presenting to care. Relevant professions in Canada may include social workers, occupational therapists, registered nurses, registered therapists, and psychologists and doctors as well as their trainees. Newer clinicians (i.e., those with less than one year of experience), will need appropriate supervision, particularly on risk management.

In contrast to other CARIBOU tools, this document is not usually shared with the adolescent or caregiver; however, it can be shown to the adolescent if they request to see it.

Because youth may not reveal some information in the first few assessment meetings, **it is important to create space in later sessions to ask if there is anything they would like to add or clarify from previous sessions.**

Development

As with other CARIBOU materials, this guide integrates National Institute for Health and Care Excellence (NICE) guideline recommendations, clinician expertise, and the input of youth and caregivers. The relevant guideline recommendations were adapted from the *2019 NICE Guideline for Depression in Children and Young People*[2] and the *2022 NICE Guideline: Self-harm: Assessment, Management and Preventing Recurrence*[3] — earlier versions of both were appraised as high quality clinical practice guidelines.[4,5] Youth and caregiver partners — authors Jacquelin Relihan and Matthew Prebeg; along with caregiver KC (who wanted to be acknowledged with initials only) — then provided feedback on how to frame the questions. We then made further revisions with the support of psychologist/researcher, Dr. Amanda Uliazsek, and social worker/therapist, Remi Ziskind.

This guide also includes an assessment of risk, as depression is a risk factor for suicide. Questions in the guide content that relate to risk assessment are bolded in teal font for easy identification.
If the assessment takes two sessions, questions about suicide should be prioritized in the first session to give time to work on a safety plan.

Risk Assessment

Multiple factors have been linked to risk of suicide.[6,7] Longstanding risk factors outlined in the literature include:

- **Depression:** We hope to improve depressive symptoms through the CARIBOU pathway.
- **Sex/gender:** Boys are more likely to die by suicide than girls.
    - As research distinguishing assigned sex at birth (ASAB) and gender is relatively new, it is unclear whether sex or gender is the more prominent risk factor.
- **Age:** Older adolescents are more likely to die by suicide than younger adolescents.
- **Prior suicide attempts**
- **Prior non-suicidal self-injury (NSSI)**, such as cutting, burning or head-banging with no intent to die, with higher risk of future suicidal behaviour if:
    - There is a younger age of onset of NSSI.[8]
    - There is a history of NSSI on 20 or more separate occasions.[9]
    - NSSI has been used as a way to relieve distress or a sense of numbness (rather than communicating distress to others).[8]
- **Substance use:** Both chronic patterns and acute intoxication can increase risk.
- **Psychotic-like experiences:** Such as paranoia and hearing voices.
- **Few supports:** That is, social isolation.
- Having an **organized plan** to end their life.

More recent literature highlights the role of marginalization-related stress, particularly for youth who identify as LGBTQ+.[10, 11] Recent research also indicates that adolescents with autism spectrum disorders (ASDs) are at increased risk for suicide attempts.[12] These other risk factors should also be considered with respect to risk.

Protective factors may include:

- **Adolescent engagement** in treatment
- **Family engagement** in treatment
- A sense of **connection to community** or family
- A sense of **hope or purpose** (including, but not limited to, religious beliefs)
- **Limited access to means** for dying by suicide.

Suicide is the second most common cause of death in adolescents. It is important to assess and manage this risk. It is also important to acknowledge that risk of suicide cannot be predicted with precise accuracy; even the most sophisticated models are very poor at predicting suicide.[13] In fact, the NICE guidelines on managing self-harm recommends against using specific measurement tools (e.g., scales of suicidal ideation) for the purposes of determining "who should be offered treatment and who should be discharged."[14] However, measurement tools can be used to help structure risk assessments.

The goal of assessing risk is to identify risk factors (such as depression, lack of social support, substance use) that can be more easily changed to guide treatment planning, and to match the intensity of treatment and supervision to the level of assessed risk for suicide. Clinical judgment is key. While some people considered low risk can make serious attempts, most adolescents who think about suicide do not attempt it.[15] **In fact, the vast majority of adolescents considered to be high risk do not die by suicide. We very often see people get better; this message of hope needs to be conveyed to the youth and family.**

It is important to differentiate between chronic risk (e.g., youth with depression who endorse frequent thoughts about wishing to be dead over several years) versus acute risk (e.g., new onset suicidal thoughts in the context of a significant life stressor) as managing the risk in each case may be different. Sometimes both are present (i.e., the person presents with new or more concerning thoughts about suicide, although also has a history of chronic suicidal ideation).

If suicidal thoughts or behaviours are endorsed, we advise using the Columbia-Suicide Severity Rating Scale (C-SSRS) to describe the behaviours. The scale and training are freely available here: https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/.

Other aspects of safety also need to be considered, including risk of NSSI, risk of harm to others by aggression, risks related to substance use (including overdose), risk of neglect in managing important medical conditions, risk to minors, motor vehicle-related risks, high-risk sexual behaviours and perinatal risks (e.g., to fetal development or newborn infant).

Process Considerations

Take some time before the initial assessment to create a welcoming setting (whether in real life or virtual) where the privacy and needs of the youth will be respected. When asking questions, pay attention to the adolescent's tone of voice, posture, and eye contact. If the adolescent seems withdrawn, guarded or irritated, look for ways to make the space more welcoming to youth.[16] Express warmth and validate distress, while also maintaining the structure of the meeting. **Avoid word-for-word use of the scripts and questions; instead, personalize the words and tone to your own clinical style.**

You may notice that the question "why" is avoided in the assessment questions in favour of "what led to" (or some variation). There are several reasons for this:

- For more concrete thinkers, the question "why" is more abstract and more likely to lead to an answer of "I don't know."
- The question "why?" can have more judgment implied, potentially leading the adolescent to shut down.
- Asking "what led to" may help the adolescent see the connection between situations, thoughts, emotions and actions as a causal chain, which is important preparation for CBT.

How youth wish their caregiver to be involved can vary. More caregiver involvement leads to more treatment options. Therefore, caregivers should ideally be present for the majority of the assessment, even though the youth is the one providing most of the information. Every so often, the clinician can check with the caregiver on the information the youth is providing to see if they have observed things similarly "from the outside." Acknowledge from the outset that it is "normal" for the youth and caregiver to have different perspectives on a given situation and that both perspectives are important for the assessment. Remember that the caregiver is the expert in what it is like to care for an adolescent with depression. Where possible, integrate their expertise with your own clinical expertise and the adolescent's lived experience or expertise on their own life situation. For example, you could say, "I am going to ask you some questions and your parent some questions. When I am talking to your parent, you are free to disagree or add your perspective. You may see things differently, and that is common. Both perspectives are needed for me to understand the situation."

Clarify that the youth's perspective is prioritized as, ultimately, it is their needs that will be addressed in treatment.

A few common scenarios can arise when caregivers are invited to be involved in the assessment:

1. The caregiver may do most of the talking and list off all of the concerns they have with the adolescent's behaviour. A few ways to address this include:
    - As stated above, clarify before starting that the priority of the assessment is to address the adolescent's needs from the adolescent's perspective. State also that the adolescent is allowed to interrupt if the clinician and caregiver are talking, as this will give the adolescent some control over the assessment process.
    - Validate that the caregiver has good reason to be concerned about the adolescent, and for treatment to be successful, it is important for the adolescent to feel comfortable attending sessions. Clarify that the caregiver listing off concerns may be overwhelming for the adolescent and lead to disengagement.
2. The adolescent may decide to not have the caregiver in the room for a large portion (or any) of the assessment, which may make the caregiver feel "shut out." A few ways to address this include:
    - Validate the caregiver's concern about feeling "shut out." The caregiver may have been used to being highly involved in the adolescent's care when they were younger, but it is normal for adolescents to take on more independence as they get older.
    - Clarify the limits of confidentiality (see "Opening script" on the next page), and explain that with acute safety concerns, the caregiver may need to be notified.
    - Let the caregiver know that, throughout treatment, you will look for opportunities to promote more open communication between the adolescent and the caregiver and have the caregiver more involved in treatment.
    - Look for opportunities within your clinical team for another clinician to support the caregiver while you support the adolescent, so you can maintain the therapeutic relationship with the adolescent.

Assessment Questions

For the following sections of the assessment:

Black font refers to the clinician statements and questions to follow.

Purple italic font refers to further instructions for the clinician.

Teal bold font relates to safety assessment.

Opening Script

The next section of this guide describes what information and questions are to be asked of the adolescent (and, if applicable, the caregiver).

All assessments:
"Hello, I am (name). I am a (professional position) at this clinic. I use (they/she/he) pronouns.

The purpose of today's assessment is to get to know you and better understand your treatment needs. If you have seen a mental health professional before, you may have already answered these questions, but I need to hear for myself what has been going on.

This information is confidential, which means I cannot share the information with people outside the treatment team, unless you give me permission. There are a few exceptions: if I am worried about the immediate safety of yourself or someone else, I need to tell the appropriate people to make sure things are safe."

The clinician should be aware of local regulations around limits of confidentiality and expand on these as appropriate to this age group.

"This assessment is likely to take about 60–90 minutes. If at any point you need to take a break, let me know. Sometimes we set up a second appointment if we need to still clarify some of the information. It is often ideal to have a caregiver (e.g., parent) present for a portion of the assessment, as it helps me understand the situation from multiple perspectives. There may also be questions about things that have happened a while ago that you may not remember, but your caregiver does. It is your choice whether to have your caregiver here."

If caregiver is present for the assessment:
"I am going to ask you some questions and your [caregiver] some questions. When I am talking to your [caregiver], you are free to disagree, add something, or clarify your perspective. You may see things differently, and that is common. Both perspectives are needed for me to understand the situation.

Some questions are related to personal and private information. You are also allowed to pass on questions you don't want to answer. We will set aside some time for you to meet with me more privately should you feel more comfortable saying things without your caregiver/parent present."

Some adolescents may not want the assessment to involve a joint meeting with the caregiver but are fine to have the caregiver meet with the clinician without them to gather information. This is also reasonable. If the adolescent does not want the caregiver talking to the assessing clinician at all, see if there is another clinician that could meet with the caregiver separately to offer support, if requested. It is still important for the adolescent to be aware that this is happening.

All assessments:
Do you have any questions before we get started?

A Patient Identification (5–7 minutes)

The purpose of this section is to learn more about the adolescent and understand what they are like apart from the depressive symptoms.

Questions	Clinician Notes
1. What name do you go by? Are there certain situations where you use different names?	
2. How old are you?	
3. What pronouns do you use? Are there certain situations where you use different pronouns?	
4. How do you like to spend your time? *If not able to answer the above due to depression or other reasons:* How did you used to like to spend your time?	
Depending on clinician's knowledge up to this point: **5.** Do you live with other people? Who do you live with? How old are they? Who are other important people in your life I should know about (e.g., family members outside the home, grandparents, close friends, romantic partners, family friends, teachers)? Do your caregivers (e.g., parents) know you are doing this assessment? How much do you want them involved in your care? *If not:* What gets in the way of letting them know? Is there anything that could help make it easier for them to be involved? *If relevant:* Do you have contact with your biological parents? If so, how often?	*Describe caregiver arrangement, including names, ages, occupations. Describe siblings/step siblings/other people in the home. Describe if the child is a Crown ward of the Children's Aid Society or in a group home or kinship arrangement. Describe other significant people in the adolescent's life who may be involved in treatment.*

6. Are you currently enrolled at a school? Which one? Are you on track with your credits? What grade level are you working on? *If not:* What is the highest grade you have completed? Have you missed any school recently? *If yes:* How often did you get to school in the past two months? When was the last time you were regularly attending school? What gets in the way of going to school?	

B Reason for Assessment (2–3 minutes)

This section will help the clinician gain a broad understanding of the main concerns from the adolescent's and caregiver's perspective. It will also help structure the remainder of the assessment. Do not go into details yet. If the adolescent or caregiver starts going into details, orient them to the purpose of these questions and explain that details will come later.

Questions	Clinician Notes
1. What is your understanding of the reason you are seeing me today? How did you come to be referred to this clinic? Did someone refer you to this clinic? If so, who? *If has trouble answering:* Lots of young people come to this clinic because they are struggling with one or more of these four things: low mood, anxiety, anger or experiences they are having a hard time explaining. Which ones, if any, fit for you? *Can also add:* Some people also come to this clinic to talk about things like substance use, aggression, or self-harm. Do any of these fit for you? *Can also add:* Is anyone else concerned about your mental health? What do you know about their concerns? *If caregiver present:* What is your understanding of the reason [adolescent's name] is here today?	*Describe youth's own words. Describe referral source.*

C Past Treatment (5–15 minutes)

This information is important for treatment planning. Pay particular attention to how the adolescent has related to previous care providers (e.g., therapists), and use this information to guide how you might relate to them moving forward.

Questions	Clinician Notes
1. When was the first time you saw a professional for mental health or substance use reasons, like a counsellor, family doctor, psychologist or psychiatrist? *If no prior mental health service, skip to question 2.* How often did you see them? Over what period of time (e.g., once? over several weeks? months? years)? How old were you? Who did you see? What was happening at the time that led you to see that person? How was your experience with them? Was seeing them helpful? What did you find helpful or unhelpful? Who did you see next? How old were you? When was it? What led you to see them? How was your experience with them? Was seeing them helpful? What did you find helpful or unhelpful? *Continue by asking about sequential providers and obtaining the relevant details.* *If caregiver present, also ask their perspective on the above.*	*List previous service providers, approximate date/ages youth saw these providers, prompting events, quality of experience from youth's perspective and caregivers' perspectives.*
2. Are there any professionals you have been seeing regularly for your mental health in the past few months? *If no, skip to question 3.* *If yes:* In what way are they involved? Are they aware of your involvement with this clinic?	*Describe details of current providers, including name, organization, kind of intervention, how long they have known the provider, and whether they are aware of who referred them and why.*
3. What experiences have you had with talk therapy or counselling? *If none, skip to question 4.* *If yes:* With who? What were the reasons you went to therapy? Did you get along with your therapist(s)? What kind(s) of therapy have you had? Was it helpful? If yes, what was it that was helpful? If not, what got in the way? How long did each course of therapy last? Have you had cognitive-behavioural therapy (CBT)? Individual therapy? Group therapy? Family therapy?	*Describe therapy experiences:*

4. What experiences have you had with medications prescribed for mental health challenges (such as depression, anxiety, ADHD or anger)? *If no prior medications for mental health reasons, skip to question 5.* *If relevant:* Who prescribed (prescribes) these medications? If you can remember, which ones have you tried? Did you take them regularly? Did they work? Did the medications have physical side- effects? Or any mental or emotional side-effects? *If so:* Did side-effects make it so you could no longer take the medication? Is it okay for me to contact your pharmacy to get a list of your medications? Which pharmacy do you use?	*Describe experiences with medications:*
5. Have you ever used other types of treatment, like mental health apps (for stress, meditation, therapy etc.), natural remedies, peer support programs?	*Describe details of other mental health treatments:*
6. Have you ever needed to stay overnight in hospital for mental health reasons? What about residential care for mental health reasons? Or have you attended residential treatment programs for substance use? *If no, skip to question 7.* *If yes:* How many admissions have you had? When was the first? When was the last one? How long was the longest one? What events led up to the admission(s)? How helpful was each admission? What made them helpful or unhelpful? Where was each admission?	*Describe details of hospital admissions for mental health reasons:*
7. Has a psychologist, psychiatrist or family doctor ever made a mental health diagnosis? *If no, skip to question 8.* *If yes:* Which ones? When were these made? Do you agree with these diagnoses? What leads to you agree or disagree with them?	*Describe details of prior diagnoses:*
8. Are there (other) diagnoses you wonder if you might have? *If no, skip to question 9.* *If yes:* Which ones? What leads you to say this?	*Describe adolescent's perspective:*

9. Have you ever been diagnosed by a medical doctor or psychologist with ADHD? Or a learning disorder? Or autism spectrum disorder? Have any of these been suspected by yourself, your caregivers, teachers or other adults?	*Describe diagnoses (or suspicions of diagnoses) of neurodevelopmental disorders:*
10. Do you have a family doctor and/or pediatrician? *If no:* Do you know how to go about finding one? *This is an important part of the treatment plan below. If they do have a primary care provider:* Has the family doctor or pediatrician been involved in your mental health care? In what ways?	*Name of primary care provider and involvement*:
If caregiver present, ask the caregiver: **11.** What is your understanding of the mental health services so far? Are there diagnoses that have been made that have not yet been discussed in the assessment? Is there anything that [adolescent] has missed?	*Describe caregiver's perspective of service use:*

D Course of Symptoms and Stressors (5–15 minutes)

This section is key to the formulation; that is, the time course of symptoms (e.g., how long symptoms have lasted, when they were at their most severe, whether there were intervals when no symptoms were present and if symptoms were episodic or continuous), how symptoms relate to life events, perpetuating factors and protective factors. Remember that formulation can be collaborative: the adolescent is the expert in their experience; you are the expert in mental health concepts. The caregiver, if present, is the expert in what it is like to care for an adolescent with depression. The formulation can orient the adolescent (and the caregiver) to their experience and, as such, this process can be therapeutic.

Questions	Clinician Notes
1. Which of your symptoms (e.g., anxiety, anger, sadness) came first? Were there any stressors that you think might have brought on those symptoms at the time? What were the symptoms like at the time for you? Could other people tell you were struggling? Was there a key time in your life when the type or intensity of your symptoms changed? **Were there stressors that led to this change?** Are your symptoms something you are hoping to reduce? Is there anything in particular you think is getting in the way of your symptoms improving?	*Describe the timeline of symptoms and behaviours and how they relate to events in the adolescent's life. Consider the role of marginalization-related stress, if relevant (e.g., related to being LGBTQ; related to race, culture, or a combination of these or other identities). Is being marginalized affecting their ability to feel authentic in interactions with others? Consider the role of traumatic events. Describe the extent to which improvement in symptoms or behaviours is part of the adolescent's treatment goals.*

1. continued: *If relevant:* When did [self-harm, aggression, substance use] start? When did it start happening regularly? What did it do for you then? How often have you done this in the past three months? What does it do for you now? Is it something you want to stop or reduce?	
2. What made you seek support now? What are your biggest (e.g., top three) stressors now?	*Describe most current stressors:*
3. How do you cope with the symptoms? Which coping strategies are helpful for you? Which are unhelpful for you? What supports or strengths do you have right now that might be helping you get through this time? *If caregiver present, ask the caregiver:* What is your understanding of the timeline of depressive symtoms? What have you noticed about [adolescent's] coping, strengths and supports?	*Describe current coping strategies, strengths and supports:*

E Depressive Symptoms (7–10 minutes)

These symptoms are unique to depression and unlikely to be attributable to another psychiatric condition (apart from severe substance use). Their presence makes it more likely that depression is a key component of the presentation. Again, having the adolescent put these experiences into words can be therapeutic. Adolescents will have varying levels of comfort discussing their depressive symptoms with the caregiver present. ***Follow the adolescent's lead regarding caregiver involvement.*** *Some adolescents may be disclosing the thoughts and behaviours to their caregiver for the first time. Don't assume that it is best to wait until the adolescent is alone to ask these questions.*

Questions	Clinician Notes
1. Over the past two weeks or more, do you think you have been depressed (i.e., had low mood or felt persistently sad) more than half of the time? For how long has the depressed mood been present for more than half of the time? What percent of the time would you guess you have been depressed in the past two weeks (e.g., more than three quarters of the time or less)? When was the last time you felt happy for over a week? Would you say the depression is a small problem, a medium one or a big one? How much does it impact your day-to-day life? Do you get tearful easily? Do you get overwhelmed with sadness easily?	*Describe recent pattern of depressed mood:*

2. Are you able to enjoy activities (e.g., sports, art, music, games)? Are you able to enjoy being with friends or family? *If not:* When did you notice that you had stopped enjoying things?	*Describe pattern of anhedonia (inability to experience pleasure):*
3. Describe your energy levels. Do you find that it takes you extra effort to get through important activities, like getting out of bed, bathing, eating, getting to work or school?	*Describe the adolescent's energy levels:*
4. Do you have a lot of negative thoughts about yourself? Do they have a specific theme to them – or can they be about anything? Do you tend to blame yourself for things that go wrong that you can't control? Do you have positive thoughts about yourself? Do you feel as though you are able to contribute something positive to your relationships with friends or family?	*Describe negative and positive thought patterns:*
5. Do you feel connected to your friends or family (e.g., you feel understood by them, can go to them for help or enjoy being with them)? Are there things you are looking forward to in your life right now? What is meaningful for you in your life right now? What gives you a sense of hope? Do you know what you would like to be doing in two to three years?	*Describe extent of sense of connectedness, purpose, hope, meaning and future-orientation:*
6. *If the caregiver is present, this is where you might ask the youth if they would like to discuss this more privately or continue with the caregiver present.* **Some people with depression struggle with thoughts about suicide or wanting to die. Have you ever struggled with thoughts of suicide — or wishing you were no longer around? How old were you when these thoughts first started? Were there events in your life that first led to these thoughts? Were there events in your life that led to the thoughts getting worse? Has it ever gotten to the point where you developed a plan?** *If so:* **When did you make a plan? Have you recently made a plan? What was the plan?** *If onset started more than one year ago:* **Do thoughts of suicide always seem to be there? Have thoughts been there for many years? Or are they new?**	*Describe suicidal ideation, if this exists, and its intensity (e.g., if there is a developed plan):*

7. **Have you ever made a suicide attempt (i.e., an act of self-harm with an intention to die)?** *If yes to suicide attempts:* **Has this occurred more than once? How many times? When was the first attempt? When was the most recent one? Have you told other people about them? Are there stressors that led to the attempt(s)? Did the attempt(s) result in seeing a mental health professional? How did you attempt? Was it something planned or impulsive? Was there anyone around when the attempt happened?** **Have you ever developed a safety plan if you are having these thoughts? What is the safety plan? Who have you shared it with?**	*Describe details of prior suicide attempts. Prior attempt indicates higher risk. Be mindful of how "extreme" the attempt is, which may indicate risk level.*
8. **Do you ever end up physically harming yourself without wanting to die? In what ways have you harmed yourself without any suicidal intent (e.g., cutting, burning, banging your head, overdosing on medications)? How old were you when you first self-harmed without intending to die? When was the most recent time? How often have you self-harmed without intending to die in the past three months? What did or does it do for you? Is it something you want to decrease? If so, for what reason do you want to reduce or stop? Do any of your friends self-harm? Do you ever watch online videos of people who self-harm?**	*Note that NSSI is a risk factor for suicide. Younger age of onset, more than five days on which NSSI took place, and using NSSI to regulate emotions (including numbness, guilt, anxiety, sadness) are all indicators of increased risk. Describe each of these factors. Pay particular attention to how youth respond when or if you list off methods of NSSI. Some youth may find it overwhelming; at the same time, it is important to actively ask about the method they have used, as important information, like the fact that they have been head-banging or injuring themselves in a different way, is often revealed.*
9. *If the caregiver is present, ask the caregiver their understanding of the adolescent's depressive symptoms.*	

F Further Questions About Depressive Symptoms (7–10 minutes)

These symptoms are not specific to depression and can indicate the presence of other mental health symptoms, depending on the context.

Questions	Clinician Notes
1. Do you find you can get irritated or angry easily – where you don't like being around people much at all? What types of events tend to set off your anger? Do you struggle with explosive episodes of anger; for example, where you are yelling at people, throwing things, slamming doors or punching walls? When did this start? How often has this happened in the past two to three months? Are you able to do anything to make yourself feel less angry or irritated and be calmer when you get this way?	*Describe patterns of irritability and/or anger:*
2. What is your sleep pattern like? What time do you normally wake up? What time do you normally go to sleep? Do you have trouble falling asleep? *If there is insomnia or hypersomnia:* What are you doing before you to go to bed? Do you have a bedtime routine? What is your sleep environment like? What are you doing between the time you try to go to sleep and when you fall asleep? Once you are asleep, are you able to stay asleep? Do you wake up too early? Are you able to wake up the next morning when you would like to? Do you sleep in the day? Do you feel rested the next day? Are you taking any medications that might affect your sleep?	*Describe sleep patterns and factors that may improve your sleep or make it worse:*
3. What are your eating patterns like? Do you enjoy food? Do you have an appetite? Do you regularly eat impulsively and consume more than you would like? Has your weight recently changed dramatically? Are you on any medications that affect your weight? How healthy is your diet? What leads you to say that? Do you have much control over what food you have available to eat?	*Describe eating patterns, appetite, and weight changes. Note that disordered eating (restricting, purging) is described in more detail later in section H7, but clinicians can ask about it now for the flow of the interview if they wish.*
4. Describe your ability to concentrate. Are you able to focus on schoolwork (if applicable)? Are you able to read a book that you would like to read? Are you able to follow the plot in a TV show? Are you able to pay attention to conversations or activities that interest you? Has your difficulty with concentration been going on for years? Or is it recent?	*Describe the impact of depression on concentration. For adolescents with ADHD or ASD, look for changes in concentration that happen when the adolescent is depressed.*

4. continued: Are there things that help you better concentrate or make it more difficult to concentrate? *If the adolescent works or is in school:* What is your concentration like at your job or in class? Are you able to focus on your assigned tasks?	

G Functional Impact of Depression (3–5 minutes)

Function refers to the ability to relate to peers and family members, engage in activities and perform expected tasks at school or work. It can also refer to the ability to carry out personal life goals.

Questions	Clinician Notes
1. To what extent does depression get in the way of your life? Does it cause difficulties with peer or family relationships? Your ability to engage in enjoyable activities? Your ability to engage in school or work? Does it affect your ability to organize your belongings? Does it affect your ability to pay attention to your hygiene? Does it interfere with any other goals in your life? Do other people in your life know you struggle with depression? How do they respond when you show signs of depression? Would you say that depression interferes with your life a little, a medium amount or a lot?	*Describe effects of depression on functioning:*

H Other Psychological Conditions (5–7 minutes)

Answers to these questions will help explain how other groups of symptoms may or may not be interacting with depressive symptoms.

Questions	Clinician Notes
1. Do you struggle with anxiety? Throughout the past six months or more, do you think you have felt anxious more than half of the time? Do you worry about a lot of different things? Or are there specific things your anxiety is focused on? Do social situations make you anxious? Would you say that anxiety is a small problem, medium problem or big problem for you? How much does anxiety impact your day-to-day life?	*Anxiety is not an exclusion from the CARIBOU pathway. If anxiety is more severe than depression, more focused treatment on anxiety instead of CARIBOU may be considered.*

2. Do you ever have obsessive thoughts about the same thing over and over, but it's not something you want to be thinking about? *Optional:* Some people with obsessive-compulsive disorder can have unwanted thoughts about taboo topics, like sex and violence, that causes them a lot of distress. Does this ever happen to you? Do you have to engage in rituals to reduce anxiety (e.g., counting, washing, checking)?	*Obsessive-Compulsive Disorder (OCD) is not an exclusion from the pathway. If OCD is more severe than depression, you may consider more focused treatment on OCD instead of CARIBOU. Unwanted thoughts about sex and violence that are very different from the person's sense of identity can be a relatively common symptom of OCD and highly distressing. If these are endorsed, further assessment is recommended.*
3. Do you get nightmares? Do you get vivid memories of stressful or traumatic events that get in the way of your life?	*These questions screen for Post-Traumatic Stress Disorder (PTSD). PTSD is not an exclusion from the pathway. If PTSD is more severe than depression, you may want to consider more focused treatment for the PTSD instead of CARIBOU. Note that trauma can contribute to many types of mental health difficulties that are not PTSD, including depression.*
4. Have you had the opposite of depression, where you have high energy for several days at a time, want to do lots of things and feel really happy? How long did this up phase last? Do other people notice this change? If a stranger saw you during this time, do you think they would say your mood was excessively happy or energetic?	*Youth with bipolar I and II are excluded from the pathway. Many youth will endorse brief periods of high mood and energy. To consider the possibility of mania or hypomania, symptoms should clearly be persistent for more than four days, and be evident to others (e.g., caregivers) that this is a dramatic change from how they usually are, and not related to substance use.*

5. Many young people with depression have experiences that are hard to explain, such as auditory hallucinations. Do you ever hear voices? *If yes:* What are they like? How often do you experience them? Do they bother you?	*Youth with schizophrenia are excluded from the pathway. Youth with depression often hear transient voices (lasting seconds to minutes) but are aware that these voices are a product of their mind rather than from an external source. Some voices may also be related to a prior traumatic event, in keeping with themes of nighttime PTSD. Hearing voices in the absence of persistent paranoid beliefs and/or disorganized thinking would not be considered psychotic symptoms and thus would not be an exclusion.*
6. Do you worry about people wanting to harm you?	*Youth with detailed and unwavering conviction of being persecuted, lasting for days or weeks should be excluded and referred to a psychosis clinic (or hospital if urgent). Mild ideas of persecution are not an exclusion.*
7. Would you say you have a complicated relationship with food? Do you worry a lot about your body image? Do you end up restricting food because of this worry? How many meals do you eat a day? Do you binge eat? How often? Do you ever force yourself to throw up? How often? Do you take laxatives? How often? Do you overexercise due to concerns about your body image? How often?	*People with whom you suspect severe eating disorders (e.g., whose eating disorder has a daily impact on their quality of life and/or has medical consequences) are excluded from CARIBOU. Many youth will restrict food to some extent. Severe anorexia nervosa often presents with persistent skipping of meals (i.e., full days without taking in food) and very low body weight. Severe bulimia nervosa often presents with binging and purging multiple times a week. If unclear, advise the young person to have an appointment with a primary care physician to assess the extent of medical consequences.*

I Medical History (3–5 minutes)

Note the relationship between depressive symptoms and medical conditions. Each can make the other worse.

Questions	Clinician Notes
1. Do you have any challenges with your physical health, such as asthma, diabetes, thyroid problems, seizures, or head injuries (including concussions)? Do you have any other neurological conditions? What surgeries have you had?	
2. What medications do you currently take? What is the reason for taking each medication?	
3. Do you have any allergies?	

J Substance Use History (3–10 minutes)

Substance use can precede mood symptoms and make them worse, or the substance use may start after mood symptoms to regulate emotions. Clarifying the temporal relationship to mood symptoms can help with formulation. Substance use combined with at least one of the following is consistent with a severe substance use disorder and likely warrants more targeted treatment than what CARIBOU can provide:

- *A loss of control over use*
- *Functional impairment*
- *Physical or psychological harm and*
- *Physiological evidence of dependence.*

Consider more targeted treatment for substance use disorders outside of the CARIBOU pathway if there is:

- *Daily cannabis use starting within hours of waking up, and used throughout the day (so being constantly intoxicated, rather than just limited to nighttime)*
- *Binge alcohol use or non-prescribed benzodiazepine use at least three times a week*
- *Cocaine or methamphetamine, non-prescribed opiates, or other illicit drug use at least twice a month.*

Questions	Clinician Notes
1. Do you use any nicotine products, including cigarettes, vapes (e.g., JUULs, STLTH pods, e-cigs) or chewing tobacco? Which ones? How much? Have you ever tried to reduce or stop?	*Popular brand name nicotine products are likely to change over time. It is helpful to keep up to date on what brands are common and how these are dosed (e.g., milligrams of nicotine in a standard vaping cartridge).*
2. Do you drink alcohol? In the past two to three months, how often have you drunk alcohol? When do you typically drink (e.g., what time of day, which days of the week)? What kinds (e.g., wine, beer or hard alcohol)? On a given drinking day, how much do you drink? What does it do for you? Do you or your caregivers feel like you have lost control of your drinking? Has drinking caused problems for you? Is it something you want to stop or reduce? Do you drink alone or with certain people? How do you obtain the alcohol?	*If getting intoxicated 3 times a week, consider focussing treatment on alcohol use.*
3. Do you use weed (cannabis/ marijuana)? In the past two to three months, how often have you used weed? When do you typically use (e.g., what time of day, which days of the week)? How many grams do you use in a day, on the days you do use? Do you use a bong, joints, edibles, concentrates? Do you know what percentage of THC is in the cannabis you are using? What does it do for you? Do you or your caregivers feel like you have lost control of your cannabis use? Has using weed caused problems for you? Is it something you want to stop or reduce? Do you use it alone or with certain people? How do you obtain it?	
4. Have you used other substances in the past two to three months? Which ones? How often? Do you or your caregivers feel like you have lost control of your drug use? Has using drugs caused problems for you? Is it something you want to stop or reduce? Do you use the other substances when you are alone or with certain people?	

K Family and Psychosocial Context

These questions may both provide information about genetic risk as well as information on how mental health symptoms in other family members may affect relationships with the youth.

Questions	Clinician Notes
1. Where were you born?	
2. Have you had any major moves in your life? Were any of them challenging? Have you moved frequently? Are you anticipating any big changes in your life (like going to a new school)?	
3. Does anyone in your family struggle with depression? What about any other mental health conditions, like anxiety, bipolar disorder, schizophrenia or suicide attempts? A tic disorder? ADHD? Autism? Intellectual disability? Learning difficulties? Speech problems?	
4. Does anyone in your family use substances? Who in your family? Did you ever live with anyone who used too much alcohol or too many drugs? Does anyone in your family struggle with any addictions?	
5. How do you get along with each family member? Have there been any change in these relationships in the last two to three months? If so, how so?	
6. Do you have favourite subjects at school? Are there ones you struggle with?	
7. Has child protective services (i.e., the Children's Aid Society) ever been involved with your family?	

8. Have you ever been charged with anything? Has anyone in your household gone to prison? Have the police ever had to come to your home?	
9. Have you ever been subjected to bullying? In what ways (e.g., physical, someone spreading rumours about you or excluding you, cyberbullying)?	
10. How would you describe your involvement with social media? What about Internet use and/or video games? In what ways have social media and Internet use been helpful or harmful to your life?	
11. Have there been any important losses in your life (e.g., the death of a loved one, breakup of an important relationship, separation from a parent)?	
12. Have there been any other major events in your life that might be contributing to low mood or stress?	
13. If you are comfortable sharing, how would you describe your sexual orientation? *Take into account apparent comfort of the young person when or if asking questions related to sexuality, particularly if there is a caregiver in the room. Remind the adolescent that they are free to go into as much or as little detail as they are comfortable with when answering.*	
14. If you are comfortable sharing, how would you describe your gender identity?	
15. Are you sexually active? Do you ever engage in impulsive or risky sex? Do you have concerns about sexual experiences you have had?	

16. *If applicable:* Is there any chance that you might be pregnant? What leads you to say that?	*If yes, obtain details (e.g., last menstrual period, use of contraception, use of home pregnancy tests). Advise youth to see primary care physician for further assessment.*
17. Would you consider yourself a spiritual person? How would you describe your religious beliefs?	
18. Have cultural factors affected your experience of your symptoms? What about race and/or ethnicity? What about peer pressure?	

L Developmental History (5 minutes)

The questions suggested here can be used to help with formulation. Within the broader context, they may help draw your attention to developmental concerns that may require further assessment. If the caregiver is available for these questions, it is recommended to direct these questions to them, as they are much more likely to provide reliable information.

Questions	Clinician Notes
1. Were there any complications during the mother's pregnancy or during the birth? Was the mother exposed to any substances or medications during pregnancy? Was [the adolescent] hospitalized after birth? For how long?	
2. Was [the adolescent] in hospital at all during the first year of life?	

3. To the best of your recollection, was [the adolescent] able to walk unsupported by 12 months of age?	*It is common for infants to have not begun walking by 12 months. This information is only relevant if there have been other difficulties with motor functioning later in life.*
4. Were there any concerns that [the adolescent's] speech was delayed when they were two or three years old? To the best of your recollection, was [the adolescent] talking spontaneously in three-word phrases by 36 months?	
5. Did a pediatrician, GP or preschool teacher raise any concerns about development (e.g., prominent and persistent difficulty with regulating emotions or problems with attention, impulsivity, behaviour or social interactions) either before or during preschool, kindergarten (JK, SK) or Grade 1?	

M Adverse Childhood Experiences (5–10 minutes)

These next questions about adverse childhood experiences (ACEs) can create strong emotions for some people. Explain that if the adolescent finds certain questions too overwhelming, they can tell you this, and you will move on to other questions. However, these questions are important to ask as these kinds of adverse experiences in childhood are associated with both harmful mental and physical health outcomes. Early intervention, if possible, may improve these outcomes.

A family member going to prison and an adult living in the home with significant substance use are also ACEs but will have already been addressed in questions-K4 and K8. If the adolescent answers yes to any of the following questions, it is important to follow up with an open invitation to describe the experience in their own words as they are comfortable (e.g., "To the extent that you are comfortable, tell me more.") It is important to avoid further yes or no questions as this may influence the answers. You may want to reiterate the limits of confidentiality before asking about possible abuse, neglect or experiences of trauma.

Questions	Clinician Notes
1. Throughout your life, did you feel supported, loved and cared for by adults in your house?	

2. Have you ever experienced a time when you didn't have enough to eat or clothes to wear?	
3. Were your parents or other caregivers ever separated or divorced?	
4. Were you ever emotionally abused? For example, did any adult or other person in your household repeatedly put you down, insult you or make you feel afraid for your safety?	
5. Were you ever physically abused?	
6. Were any adults in your household ever physically abused by another adult in the household?	
7. Were you ever sexually abused or sexually assaulted?	

N Strengths and Resilence

These questions are important for identifying protective factors that can be drawn on during treatment. Look for ways the youth might be coping, but do not label these examples of strength or resilience (e.g., physical activity, hobbies) as coping.

Questions	Clinician Notes
1. **We are going to change gears now, looking at things that might be going well in your life to see if we can build on these. What are your strengths? What comes easily to you? What are you proud of? What do others say are your strengths?**	
2. **Can you describe a time in your life when you overcame difficult challenges? Are there strategies you already use to help in the face of stress (e.g., listening to music or exercise)?**	
3. **What is one thing you like about yourself?**	

O Preparing for Treatment Planning

Questions	Clinician Notes
1. How do you understand the cause of your symptoms (including vulnerability and recent stressors)? What things are making your symptoms stick around? What is making things better? Do you think your mental health difficulties are mild, medium or severe?	*This is more of a discussion, than a question. It is building a formulation together.*
2. Do you have specific treatment goals in mind?	*Consider using the Goal-Based Outcome measure to help the adolescent set personalized goals and track their progress toward these goals throughout treatment.*[17]
3. What are your thoughts about doing psychotherapy? What about group therapy?	
4. Is medication something you want to explore as an option at this point?	*If symptoms and functional impairment are mild, discourage use of medication.*
5. What do you hope to gain from this program? Do you have any questions or concerns about your treatment with our clinic?	
6. From the beginning of treatment, it is important to start thinking about what supports you will need after you finish treatment with us. Are there any supports you think you would need when treatment is complete? Do you have access to a family doctor or school guidance counsellor should we need to follow up with them and help transfer care back to them once they finish treatment with the clinic?	

P Priority Next Steps

The following are not questions you ask the adolescent and/or caregiver, rather a way to organize the treatment plan. These are arranged in order of priority to ensure safety first.

Questions	Clinician Notes
1. Safety *This may include immediate safety planning, following up with CARIBOU safety modules, consulting with a senior clinician, providing advice to go to the emergency room, and/or ongoing monitoring.*	
2. Medical *If medical conditions may be contributing to their mental health symptoms, encourage the young person to set up an appointment with their primary care doctor. If they do not have a doctor, discuss strategies to find one (e.g., by using the Ontario government website at: www.ontario.ca/page/find-family-doctor-or-nurse-practitioner).*	
3. Mood *Once you have addressed any safety issues and medical conditions, you can then give the adolescent and/or caregiver the link to the orientation video, www.youtube.com/watch?v=Zx211NEOyxI, which describes the pathway. Note that more details will be provided during the Mood Foundations information session.* *If the Mood and Feelings Questionnaire (MFQ) has not been done recently, please administer the MFQ to get a baseline score.*	
4. Other Conditions *While many components of the CARIBOU pathway can address other potential mental health symptoms, you could judiciously consider other resources in their community or through the clinic to address suspected conditions like anxiety or substance use. However, it is important not to overwhelm the young person with too much information.*	
5. Graduation *Start anticipating what might be needed to support the young person after graduation from the pathway.*	

Formulation

Formulation refers to the process of coming to an understanding about how the young person came to present with the depressive symptoms and difficulties with functioning, what is perpetuating the condition and what has prevented things from being more severe than they are. When developing the formulation, it is important to consider:

- Biological factors (e.g., genetics, temperament, substance use, medical conditions)
- Psychological factors (e.g., coping styles, thought processes, relationship patterns, sense of identity)
- Social factors (e.g., economic stressors, family relationships, social expectations).

It is equally important to discuss how each of these factors interact with each other.

Formulation serves multiple functions:

- It can help guide treatment planning and orient the young person (and caregiver) to the rationale for this treatment. For this reason, it is important to use theoretical frameworks that fit with the anticipated treatments (e.g., CBT or brief psychosocial intervention).
- It can help orient the young person (and caregiver) to their experience. Done skillfully, this process can reduce anxiety and shame about their situation. It can also validate their experience, which is therapeutic.
- When done skillfully, it helps build rapport with the young person and makes them feel understood.

A formulation is a conversation between the clinician, the young person and, in some situations, the caregiver. Each person provides important expertise from a different perspective. Using plain language, present the formulation as a theory. Invite the young person (and caregiver) to clarify or disagree and build on the theory. The formulation may also change over time. While suggested wording and steps are provided below, having your own style will likely come across as more genuine and empathic. A formulation doesn't need to happen all in one session: it can be discussed over time and in multiple sessions. When charting or delivering a formulation, it is important to use non-judgmental language.

Here are steps in the formulation:

1. Start with a brief focused statement of the presenting concern.

- "You have come to this clinic concerned about depressive symptoms that have been there since you broke up with your girlfriend six months ago."

2. Describe contributing factors leading to vulnerability to depression. Examples include:

- Genetic contributions, temperament, perinatal factors
- Neurodevelopmental factors (e.g., learning disorders, ADHD and ASD symptoms)
- Interaction of major life events with developmental stages: comment if developmental tasks (e.g., learning socialization skills, developing a sense of identity, gaining a sense of achievement) are interrupted.

3 Use the adolescent's history and description of recent stressors to identify recurrent themes. These may include some of the following:

- Relationship patterns (e.g., how the adolescent learned what to expect from others and get interpersonal needs met)
- Sense of self (e.g., coherence [do they feel like they are the same person in different situations?] valued [do they have a positive perception of themselves, and feel that others view them positively]? efficacious [does the person feel like they can solve problems]?)
- Loss (e.g., grief, loss of friendships, loss of status)
- Current maladaptive coping skills that may have once been adaptive
- Certain behaviours and ideas that may have been reinforced by previous experiences
- Cognitive distortions, assumptions or core beliefs
- Family, social, culture and spiritual context.

4 Explain how past adverse events can make someone vulnerable to depression.

- Using the themes identified in step #3, note how recent stressors led to depression.

5 Describe reasons why someone might be stuck in this pattern of depressive symptoms. Common perpetuating factors may include:

- Maladaptive coping strategies (e.g., avoidance, substance use)
- Limited economic resources
- Ongoing invalidating environments.

6 Describe protective factors or strengths that the adolescent can build on or use for treatment. Common examples include:

- Resourcefulness
- Existing peer, family or extended family support
- Seeking treatment
- Motivation
- Assertiveness
- Problem-solving skills
- Openness to new experiences.

7 Describe how your formulation relates to the treatment. You could address the following questions:

- How does the above formulation fit into what the pathway offers?
- Which components might the young person (and caregiver) particularly benefit from?
- How can we use the formulation to facilitate effective treatment?
- Are there anticipated barriers to the pathway being effective for this young person?

Treatment Plan

Communicate clearly about the treatment plan. You can use the following materials to help describe the CARIBOU pathway and its components:

- Orientation video (www.youtube.com/watch?v=Zx211NEOyxI)
- Mood Foundations videos (www.youtube.com/watch?v=6xONySz9XLk and www.youtube.com/watch?v=qMnQFTy3t30)
- Medication handout (https://www.camh.ca/-/media/files/medication-for-youth-resource-pdf.pdf).

Be sure to present the treatment plan as flexible over time: in the CARIBOU pathway, the treatment plan is assessed at each team review and decisions are made around whether to change treatment. Principles of shared decision-making need to be included in treatment planning:

1 Identify treatment decision(s) that need to be made. This might including starting, intensifying, switching, adding, tapering or stopping various treatment options.

2 Elicit adolescent and caregiver values about this decision.

3 Discuss potential benefits and risks of the decision in light of these values.

4 Make a decision.

5 Follow up to see if the treatment plan worked.

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