

Be vigilant for depression in children and adolescents

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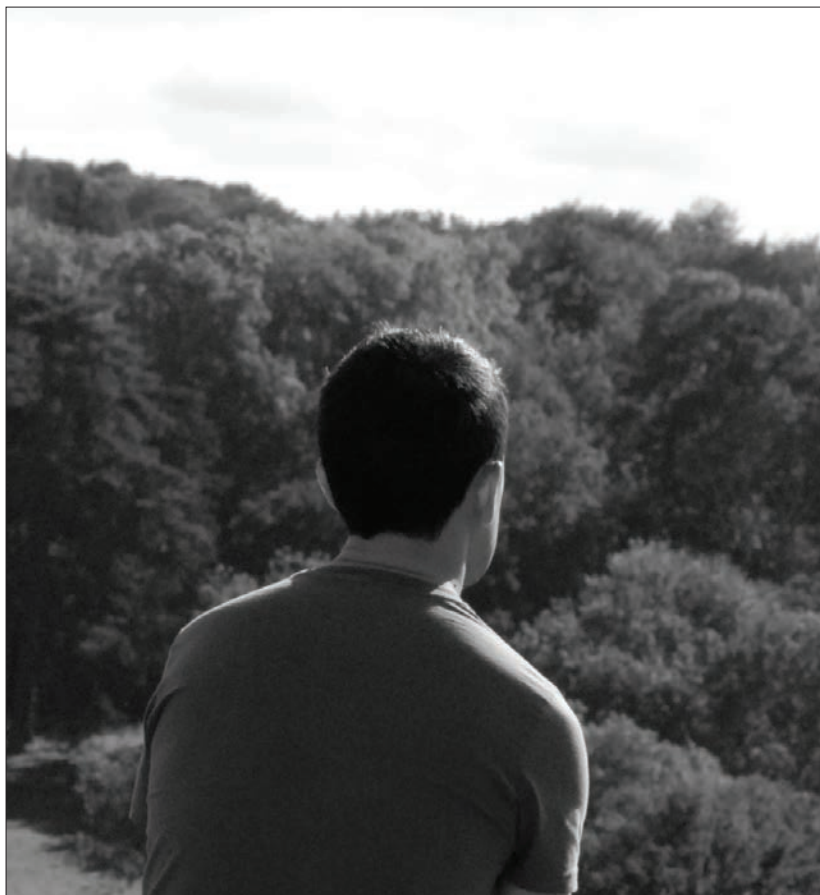
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How do children and adolescents present in primary care?

How should diagnostic assessment be carried out?

What are the management approaches?



ADOLESCENCE IS A HIGH-RISK PERIOD FOR THE DEVELOPMENT OF CLINICALLY SIGNIFICANT,

relatively common, mental health disorders such as depression.¹

The prevalence of depression is higher in adolescents (5.7%) than children (2.8%) and this has remained stable over time.² The female to male ratio for depression in adults is 2:1.³ This ratio is also seen in adolescents from the age of 12 years.⁴

In the UK, bipolar affective disorder is rarely diagnosed in individuals under the age of 18, especially in those under 13. It is more common in those who present with psychotic features, pharmacologically induced hypomania, psychomotor slowness or have a family history of bipolar disorder or psychosis.⁵

DIAGNOSTIC ASSESSMENT

Teasing out the difference between the normal mood variations of adolescence, sub-threshold syndromes and anxiety and depressive disorders is vital.

Depression can be conceptualised as a spectrum, with threshold cases meeting specific criteria as identified in the ICD⁵ and DSM⁶ classification schemes for psychiatric disorder, see table 1, p17. From these criteria it is clear that a child or adolescent may be clinically depressed without actually presenting with low mood.

It is important to ask about the presence or absence of particular symptoms: children and adolescents will rarely share this information spontaneously, even if their symptoms are severe. It is also useful to consider risk factors for depression (see box 1, right) during the assessment.

The diagnosis of depression requires the presence of at least four⁵ or five⁶ symptoms that are present, most of the time, for most days for a minimum of

Box 1

Risk factors for depression

- Stress/pressure at home or school
- Relationship problems at home or school
- Bullying – face to face or online
- Money/housing worries
- Physical or mental illness in child
- Physical or mental illness in parent
- Young carer
- Abuse – emotional, physical, sexual
- Confusion about sexuality/gender
- Alcohol/drug problems
- Self-harm

Table 1

ICD-10 and DSM-V criteria for depression^{5,6}

Core	Biological	Cognitive
<ul style="list-style-type: none">● Depressed mood (sad, empty, irritable, hopeless, tearful)● Decreased interest or pleasure in all/most activities● Decreased energy or fatigue	<ul style="list-style-type: none">● Decreased energy or fatigue● Change in sleep (increased or decreased)● Change in weight (increased or decreased)● Observable psychomotor agitation/retardation	<ul style="list-style-type: none">● Guilt, worthlessness● Reduced concentration/thinking/decisiveness● Recurrent thoughts of death or suicide, may be associated with plans or attempts● Reduced self-esteem and self-confidence● Bleak and negative views about the future

Key: ICD and DSM ICD only DSM only

Symptoms

- Must have a minimum of 4 (ICD) or 5 (DSM)
- Are present for at least two weeks
- Are present most of the time during this period
- Cause significant distress and/or impairment of social/occupational/other functioning

two weeks. At least one of these must be a core symptom. These symptoms should be associated with significant distress and/or impairment of social or occupational functioning. Episodes of depression can be graded as mild, moderate, or severe depending on the number, type and intensity of symptoms.

The presentation of depression in adolescents can be similar to that in adults. Depression in primary school children may be very subtle and include mood fluctuations, increased irritability, tearfulness, frustration or temper tantrums. Somatic presentations such as abdominal pain or headaches are more common in younger children, who may struggle to express emotions verbally.⁷ Increased irritability, as a symptom of depression, is also common in this age group. This may be more marked in boys than girls. Delusions and suicide attempts are less common in children compared with adolescents.⁷

DIFFERENTIAL DIAGNOSIS

Table 2, right, highlights the most common medical and psychiatric conditions in children and adolescents. It is important to remember that the presence of one or more of these conditions does not necessarily exclude the possibility that the patient could have co-existing depression as well.

Coexisting conditions

Between 40 and 70% of children and adolescents presenting with a major depressive disorder, may also have other coexisting mental health conditions. These may include anxiety disorders, bipolar disorder, eating disorders, substance misuse and conduct disorder.⁸

Dysthymic disorder may increase the

risk of children and young people developing a major depressive disorder.⁸ Personality is, however, continuing to develop throughout adolescence and into mid to late adulthood.⁹

RISK ASSESSMENT

If you suspect that the patient may be depressed, it is essential to evaluate the degree to which they may be at risk. Risk has two key aspects: the likelihood of a potentially harmful incident occurring and the degree of potential harm. Risk is dynamic and can change quickly. Therefore, risk needs to be evaluated regularly.

The term risk assessment is somewhat

of a misnomer: a good risk assessment will also be therapeutic and lower the pre-existing level of risk. Risk assessments therefore represent a bridge between assessment and management.

The therapeutic relationship is important in improving health outcomes.¹⁰ Compassion, warmth, sensitivity and patience are common factors in clinical encounters that have been shown to be associated with better outcomes. These factors are particularly important during risk assessments to make them therapeutic and effective.

There are four main areas of risk: risk to self, to others, from others, to property. The most important risk to evaluate in children and adolescents with depression is the risk the patient poses to him/herself either from self-harm or suicide.

A good risk assessment will also include a safety plan, i.e. steps to reduce the level of risk e.g. informing parents, parents locking away medications or sharp objects, referral to child and adolescent mental health services (CAMHS) or A&E.

It is important to remember that asking about thoughts of suicide or self-harm does not lead to an increase in the likelihood of either occurring.¹¹

Self-harm and suicide

Self-harm is very common in children and adolescents¹² and rates are increasing.¹³ Self-harm may occur in a range of conditions - and on its own does not necessarily mean that the individual is clinically depressed. Frequent methods of self-harming include scratching, cutting, hitting/punching, head banging, taking less care (e.g. when crossing the road or going out alone late at night), placing >>

Table 2

Differential diagnosis of depression in children and adolescents

Normal

- Sadness
- Adolescent mood changes
- Grief/bereavement
- Premenstrual tension

Psychiatric illness

- Anxiety
- Eating disorder
- Substance misuse
- Bipolar affective disorder
- ADHD

Medical conditions

- Endocrine e.g. thyroid, diabetes
- Haematological e.g. anaemia, cancer
- Neurological e.g. headaches/chronic pain/epilepsy
- Infections/inflammatory: e.g. pneumonia, TB, HIV
- Side effects of medications e.g. methylphenidate, corticosteroids

oneself in vulnerable situations, overdoses with non-suicidal intent. Although the intention may 'only' be self-harm, individuals may unintentionally be at risk of fatal injury e.g. by cutting deeper than expected.

There are many reasons for self-harm – communicating distress, relief, self-punishment, a desire to 'feel' if numb, conversion of emotional to physical pain which may be experienced as more real or manageable.^{12,14} The associated level of risk may depend on several factors: the method of self-harming, the degree of physical harm/damage caused, e.g. depth and location of cuts, frequency, duration, intention (relief of distress, or self-punishment).

Suicide is relatively rare in children and adolescents. Rates of completed suicide are approximately 4.8 deaths per 100,000 in the 10-19 year age group and are higher in males than females.¹⁵ A recent study found that the incidence of suicide in adolescent boys is more than twice that among adolescent girls, whereas self-harm is much more common in girls than boys.¹⁶ The most dangerous acts associated with suicidal thoughts, are an intention to jump (from buildings/in front of cars/trains); hanging/asphyxiation, and shooting. The risk of suicide is significantly increased in those who self-harm.¹²

All individuals who have taken overdoses should be referred to A&E. This includes those who may have taken relatively small amounts of drugs e.g. six paracetamol tablets. This helps to convey a message that all overdoses are dangerous, it is protective in case of under-reporting and it should enable access to a review by CAMHS.

NICE guidelines for self-harm recommend that all young people who present to A&E with self-harm or following an overdose should be admitted to a paediatric ward overnight.¹⁷ This facilitates a CAMHS review, and increases the likelihood that it will be useful. The patient may feel more rested and able to talk the next day. Hospitals may also routinely make a social services referral following presentations of self-harm. This is because self-harm may signal a range of wider difficulties or distress.

Intent and protective factors

When considering the risks associated with self-harm and suicide it is important to differentiate between thoughts, intent and plans. Thoughts represent the lowest level of risk; intent, intermediate; and plans/completed acts, the highest. For example, thoughts of suicide are a

symptom of depression. The associated risks may be low if the individual also says that they have no intention of acting on them, and have not made any plans to do so, they would not commit suicide because they would be concerned about the effect on their family and friends and/or for religious reasons. Thoughts of suicide, associated with a stated lack of intent and no associated significant recent previous attempts or plans, is not an emergency and these individuals do not need to be referred to A&E.

The nature of intent and any recent acts is also important to consider. The relationship between intent and acts in relation to risk is not always straightforward. For example, self-harm that is associated with superficial scratches (completed act), is a lower risk than an intention to self-harm by severing an artery (act not yet taken place, although appears likely).

Protective factors reduce the level of

risk and should always be explored. These may be effective coping strategies, hope, good relationships with family/friends, positive future plans.

Key questions for risk assessment of self-harm and suicide are listed in box 2, below.

Key questions following an overdose are listed in box 3, below.

CONFIDENTIALITY AND SAFETY PLANS

If you conclude that a child or adolescent is at significant risk then a parent or other responsible adult should be informed. Breaching confidentiality in this situation is justified if you cannot get consent for information sharing. Relatively minor levels of self-harm e.g. superficial cutting, may not necessarily need to be shared with parents in the short term, if it can be used to build a therapeutic alliance that may lead to engagement with a plan for treatment e.g. referral to CAMHS.

Box 2

Key questions for risk assessment of self-harm and suicide

- 1 Do you ever have any thoughts about harming yourself or ending your life?
- 2 IF YES: Have you done anything to act on these thoughts?
- 3 IF NO: Do you have any intention of acting on these thoughts?
- 4 IF YES: Have you made any plans about how you will do it?
- 5 IF YES: Are there any good things in your life that might make you think twice about doing this?
- 6 Have you found any ways of coping with these difficult thoughts so far? These may be helpful e.g. distraction through listening to music, talking to friends, or unhelpful e.g. alcohol/drugs, self-harm, running away)

Box 3

Key questions following an overdose

- 1 What have you taken? (tablets, quantity, strength)
- 2 When?
- 3 Have you taken anything else? (e.g. tablets or liquids, watch for staggered overdoses)
- 4 Was it planned or did you do it without thinking? (impulsive, lower risk)
- 5 Where were you when you took it? (at home with other people, lower risk)
- 6 What was your intention when you took the tablets? (sleep, suicide, unclear)
- 7 Did you tell anyone about it afterwards? (seeking help, lower risk)
- 8 Do you have any regrets about it? (mistake, low risk; didn't work, high risk)
- 9 Do you have any thoughts of doing something like this again? (persistent intent, high risk)

PATHOS questionnaire¹⁸

- P** - Have you had **P**roblems for longer than one month?
A - Were you **A**lone in the house at the time?
T - Did you plan the overdose for longer than **T**hree hours?
HO - Are you feeling **H**Opeless about the future?
S - Were you feeling **S**ad for most of the time before the overdose?

Responses to each question are scored 0 or 1

If the score is 2 or more the individual is considered to be high risk

key points

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The prevalence of depression is higher in adolescents (5.7%)

than in children (2.8%) and this has remained stable over time. The 2:1 female to male ratio of depression in adults becomes evident in adolescents from the age of 12 years. In the UK, bipolar affective disorder is rarely diagnosed in those under the age of 18, especially in those under 13. It is more common in those who present with psychotic features, psychomotor slowness or pharmacologically induced hypomania, and in those with a family history of bipolar disorder or psychosis.

The symptoms of depression in adolescents are similar

to those in adults. However, depression in children of primary school age may be very subtle and symptoms include mood fluctuations, tearfulness, frustration or temper tantrums. Somatic presentations, such as abdominal pain or headaches, are more common in younger children, who may struggle to express emotions verbally. Increased irritability is also a common symptom of depression in this age group particularly among boys. Delusions and suicide attempts are less common in children than in adolescents.

If depression is suspected, it is essential to evaluate the degree of risk. Risk has two key aspects: the likelihood of a potentially harmful incident occurring and the degree of potential harm. Risk can change quickly and therefore needs to be evaluated regularly. The term risk assessment is somewhat of a misnomer: a good risk assessment is also therapeutic and will lower the pre-existing level of risk. The most important risk to evaluate is the risk an individual poses to him/herself either from self-harm or suicide. A good risk assessment will include a safety plan i.e. steps to reduce the level of risk such as informing parents, parents locking away medications or sharp objects or referral to CAMHS/A&E.

Suicide is relatively rare in children and adolescents.

Rates of completed suicide are approximately 4.8 deaths per 100,000 in the 10-19 year-old population and are higher in males than females. The most dangerous acts associated with suicidal thoughts are jumping (from buildings or in front of cars/trains), hanging/asphyxiation and shooting. All those who have taken overdoses should be referred to A&E even if they have only taken small amounts of drugs e.g. six paracetamol tablets. This helps to convey a message that all overdoses are dangerous, is protective in case of under-reporting and should enable access to a review by CAMHS.

Depression should be treated in CAMHS unless the

episode is mild and of less than three months' duration. Watchful waiting is recommended as initial treatment for mild depression with a review of the patient's mental state within two weeks. Antidepressants should not be prescribed for mild depression. For those with moderate to severe depression NICE recommends that CAMHS should only prescribe antidepressants in combination with psychological treatments.

Safety plans that involve parents can significantly help to reduce levels of risk. Parents may be able to reduce access to potentially harmful objects and be able to provide comfort and support.

Where relationships with parents are not caring or supportive, and the child is at significant risk, then consideration should be given to informing an alternative responsible adult and/or social services.

In emergency situations, a child or adolescent should not be expected to go to A&E alone. An adult from the practice should wait with them, until a responsible adult can come to collect them.

MANAGEMENT

GPs have a key role in recognition of depression, early referral and risk assessment. This includes:¹⁹

- Referral to CAMHS or to A&E in an emergency (e.g. overdose or strong and imminent suicidal intent)
- Risk assessment for suspected/known cases
- Treatment of any self-harm if indicated e.g. suturing deep cuts, prescribing antibiotics if wounds become infected
- Shared care arrangements with CAMHS where GPs are continuing to prescribe and monitor the response to medications that have been initiated by specialists

GPs would generally be expected to play a very limited role in all other aspects of the management of depression in children and adolescents.

The NICE guideline on depression in children and adolescents¹⁹ provides guidance about the roles of primary care, when to refer and treatment options available.

Referral

The following cases should be referred to CAMHS¹⁹

- Active suicidal ideas or plans
- Referral requested by patient, parents or carers
- Diagnosis of moderate/severe depression or mild depression that has not responded to treatment in primary care
- Unexplained self-neglect of at least one month's duration that could be harmful to physical health

NICE stepped care model of treatment

Treatment of depression varies depending on the severity of the symptoms. Depression should be treated in CAMHS unless the episode is mild and of less than three months'

duration. For mild depression, NICE recommends initial management should be watchful waiting, followed by a review of mental state after two weeks.¹⁹ If there is no response, then individual non-directive supportive therapy, guided self-help or group CBT should be offered. These could be provided by appropriately trained professionals in primary care, schools, social services, the voluntary sector or Tier 2 CAMHS. In their absence a referral to Tier 3 CAMHS would be appropriate.

NICE recommends Tier 3/4 CAMHS should treat moderate to severe depression, and mild depression unresponsive to treatment and/or of more than three months' duration. The following treatments are recommended for moderate to severe depression: individual CBT, family therapy, interpersonal therapy or psychodynamic psychotherapy. These may be started initially alone, or in combination with fluoxetine.

Prescribing antidepressants

NICE recommends that antidepressants should not be initiated in general practice for children and adolescents with depression or anxiety without advice from CAMHS. We would also advise that propranolol is not prescribed for anxiety. Although propranolol can relieve some troublesome anxiety symptoms, it is much less effective in helping with the associated underlying thoughts and emotions than antidepressants prescribed for anxiety.

NICE also recommends that CAMHS should only prescribe antidepressants in combination with psychological treatments,¹⁹ although a meta-analysis²⁰ has questioned this. Antidepressants should not be prescribed for mild depression.

Fluoxetine is the first-line medication recommended by NICE.¹⁹ In the most recent large meta-analysis, fluoxetine was the only antidepressant shown to be more effective than placebo in children and adolescents.²¹ Second-line medications include sertraline and citalopram.¹⁹ Paroxetine, venlafaxine and tricyclic antidepressants are not recommended for the treatment of depression in this age group. These medications are associated with higher risks of suicide and are more dangerous in overdose.¹⁹

On initiation of the antidepressant, CAMHS should undertake a regular review of monitoring for any adverse effects, and response to the medication, and a mental state examination should be undertaken weekly for the first four

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weeks.¹⁹ This time period is key, as 40% of suicide attempts occur within this timeframe.²²

Monitoring and stopping antidepressants

CAMHS may commonly discharge young people on antidepressants after psychological treatment is finished and they are doing well. If they do, CAMHS should also provide guidance for GPs regarding monitoring of antidepressants and how and when to stop prescribing.

Antidepressants should usually only be stopped after a patient is symptom free for six months after a first episode of depression, or two years if there have been several episodes. This is to reduce the risk of relapse.

The dose of antidepressants should be reduced gradually. Suddenly stopping antidepressants can lead to discontinuation symptoms.²³

OUTCOMES AND PROGNOSIS

Outcome is dependent on the age of onset. Adolescent depression is associated with a 60-90% remission rate within one year, with 50-70% of young adolescents suffering a relapse within five years.^{24,25} Both childhood and adolescent onset depression are likely to recur with a 40% probability of recurrence at two years and 70% by five years.²⁶

Shorter duration of illness is associated with a better prognosis. Female gender and parental separation or divorce are associated with a worse prognosis.¹ In females, first episode depression is associated with lower levels of impairment and suicide attempts.⁴ There is no difference in number of suicide attempts in males with a first episode or recurrent episodes of depression.⁴

A long duration of illness is a predictor for continuation of the illness into adulthood.¹ Unlike adolescent-onset depression, childhood depression does not necessarily lead to depression in adulthood.²⁷

Competing interests: None

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Useful information

Royal College of Psychiatrists

www.rcpsych.ac.uk

Information leaflets for patients and their families on depression and the management options. There is also a useful link that outlines who's who in CAMHS

www.rcpsych.ac.uk/healthadvice/parentsandyoungpeople/parentscarers/whoswhoincamhs.aspx

Safe spot

A free downloadable app for children and young people to help improve their coping skills

<http://safespot.org.uk>

Moodkit

An app which includes a mood tracker as well as CBT-based techniques to help with managing depressive symptoms www.thriveport.com/products/moodkit

Young Minds

<https://youngminds.org.uk>

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