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Depression in young people often goes undetected

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Dr Kate Stein
MRCPsych
NIHR Academic Clinical Fellow and Specialist Registrar in Child and Adolescent Psychiatry,
Department of Psychiatry,
University of Oxford,
Warneford Hospital,
Oxford, UK

Dr Mina Fazel
MRCPsych
NIHR Post Doctoral Research Fellow,
Department of Psychiatry,
University of Oxford, Warneford Hospital,
Oxford,
Consultant in Children's Psychological Medicine,
Oxford University Hospitals NHS Trust,
Oxford, UK

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AUTHORS
Dr Kate Stein
MRCPsych
NIHR Academic Clinical Fellow and Specialist Registrar in Child and Adolescent Psychiatry, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK

Dr Mina Fazel
MRCPsych
NIHR Post Doctoral Research Fellow, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, Consultant in Children's Psychological Medicine, Oxford University Hospitals NHS Trust, Oxford, UK

How do young people present with depression?

ALTHOUGH DEPRESSION CARRIES THE HIGHEST BURDEN OF ANY NON-COMMUNICABLE DISEASE[1] the prevalence, treatment and overall impact of adolescent depression has only more recently been appreciated.

Until the 1970s, it was believed that depressive disorders were uncommon among the young. Prepubertal children were thought to be incapable of experiencing depression, and depression in adolescents was simply seen as a normal feature of teenage emotional development.[2]

We now know that many young people suffer from clinical depression. In fact, major (unipolar) depression is one of the most common mental health disorders in children and adolescents, with an estimated one year prevalence of 4-5% in mid-late adolescence.[3]

What are the diagnostic criteria?

Despite its pervasiveness, a diagnosis of depression in young people is often missed. Depression is probably the single most important risk factor for teenage suicide, the second to third leading cause of death in this age group.[4]

We also know that depression in young people is a forerunner of adult depressive disorder which is strongly linked to poor physical health outcomes, lower income and increased unemployment.[5] Half of those with lifelong recurrent depression started to develop their symptoms before the age of 15 years.[6]

Opinion is divided on how depressed adolescents should be managed. The evidence highlights the importance of treating depression as early as possible, as the longer the course of untreated depression the worse the prognosis for that episode of depression and the higher the likelihood of recurrent, lifelong episodes.[7] NICE guidelines, published in March 2015, reflect the most up to date evidence in the management of children and adolescents with major depressive disorder.[8]

Which patients should be referred?

PRESENTATION

Depression in prepubertal children is much less common than in adolescents and this has been found consistently in the epidemiological literature. A large UK survey, for example, revealed that the risk of having a depressive disorder is eight fold greater in 11-15 year olds compared with 5-10 year olds.[9]

Family history is a well established risk factor and children born to depressed parents face three to four times increased rates of depression. Both »

Table 1

High-risk groups for depression (adapted from Thapar et al[16])

- Parent or sibling with depression
- Exposure to chronic adversity (e.g. bullying or history of abuse)
- Family discord (parental divorce/separation)
- Disruptive behaviour, decline in academic performance
- Learning problems
- Deliberate self-harm, suicide attempt
- Alcohol or substance misuse
- Living in institutional settings (looked after children)
- Recent migrant
- Multiple physical symptoms (recurrent abdominal pain, headaches)
- Chronic physical health problems, especially neurological or rheumatoid problems

genetic and environmental factors contribute to this risk so it always worth taking a family history.[10] In addition, gender is a major risk factor for depression in adolescence with girls being more vulnerable to this condition in a ratio of 2:1.[11] However, prepubertal depression has an equal sex ratio[12] and is thought to be more strongly related to family dysfunction.[13] Studies indicate that depression in females is also associated with periods of hormonal change – most notably, puberty, pregnancy and the menopause.[14]

Although low mood is the predominant feature, depression in children and adolescents can also present in a variety of other ways. For example, depressed children might have various unexplained physical symptoms, eating disorders, school refusal or substance misuse. This clinical heterogeneity potentially contributes to the difficulty GPs may have in recognising depression.[15] Table 1, above, illustrates some of the key risk factors in the development of depression.

DIAGNOSIS

The diagnostic features of depression in the paediatric population are broadly similar to that in the adult population. Table 2, right, lists the ICD-10 criteria.

Assessment of severity is important in developing an appropriate management plan.[17]

NICE guidelines state that GPs should be able to detect symptoms of depression, and to assess those children who may be at high risk. The importance of active listening and conversational techniques are highlighted in order to screen effectively for mood disorders. NICE also recommends that GPs consider the social, educational and family context of the patient and family members, including the quality of their interpersonal relationships.[8]

The key questions used for screening are from the PHQ-2 which asks about whether, in the past few weeks, the young person has experienced a lack of interest or pleasure in doing things, and if they have felt down, depressed or hopeless. If their response is no to both questions the screen is negative. If the young person responds yes to either question, then it is important to gather more information, see figure 1, opposite.

REFERRAL

GPs may find it difficult to know when to refer a patient to Child and Adolescent Mental Health Services (CAMHS). Figure 2, opposite, illustrates the four tiers of CAMHS. When a young person poses a high risk of self-harm or suicide or significant ongoing self-neglect (such as poor personal hygiene or significant reduction in eating) it is usually quite obvious that the patient needs a highly specialist (tier 4) service. By this point, the patient may have been under a tier 2 or 3 service and it is deemed that an intensity of assessment/treatment and/or level of supervision that is not available in lower tier services is required.

Recent changes to NHS England services include The Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT). This national programme works alongside existing CAMHS at tiers 2 and 3, to support the under-19 population in England. At present there are no plans to implement CYP IAPT in Scotland, Wales and N. Ireland. Currently, the programme is working with services that cover 68% of the 0-19 population in England. There is a target set in NHS England's 2015-16 business plan to reach 78% by March 2016, and a

Table 2

ICD-10 diagnostic criteria for major depression (adapted from ICD-10 Classification of Mental and Behavioural Disorders[17])

ICD-10 uses a list of ten key depressive symptoms for diagnostic criteria.

- Persistent sadness or low mood and/or
- Loss of interest or pleasure
- Fatigue or low energy

Patients must suffer from at least one of these symptoms most of the time for at least two weeks. If any of the above are present, ask about associated symptoms:

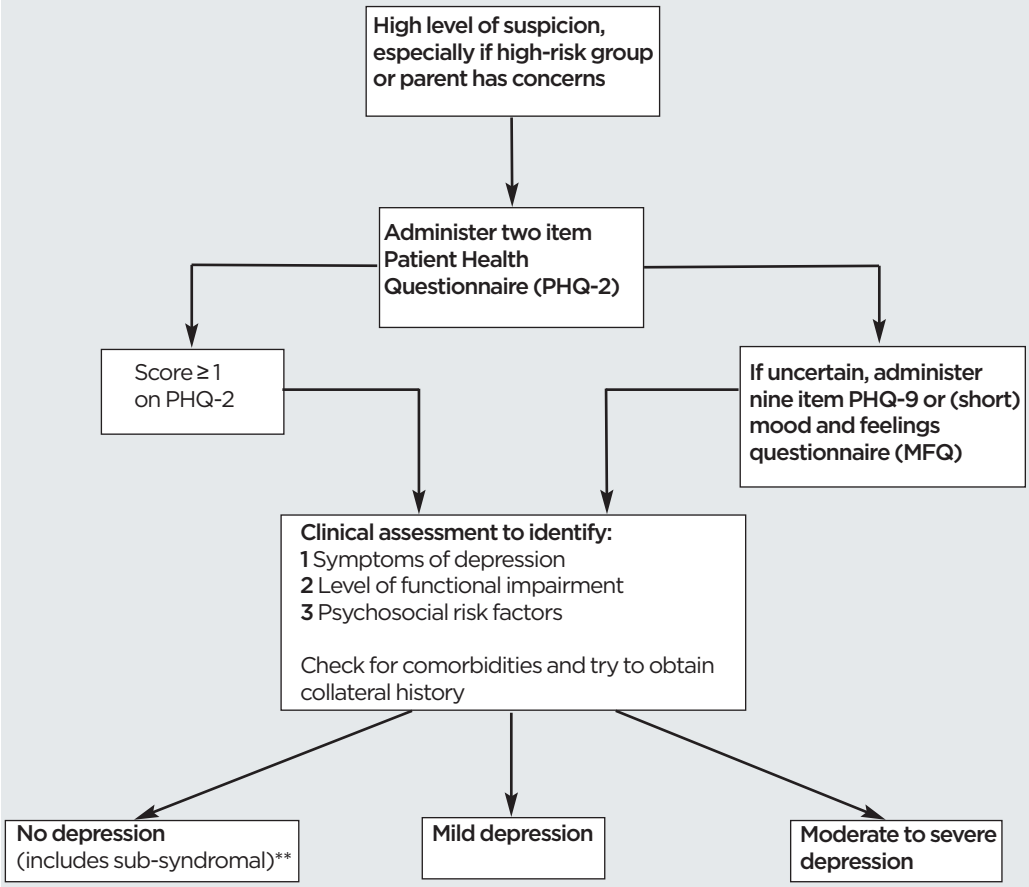
- Disturbed sleep
- Poor concentration or indecisiveness
- Low self-confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation or slowing of movements
- Guilt or self-blame

NOTE: These symptoms should be present for a month or more, and every symptom should be present for most of every day.
The number of symptoms then defines the severity of the depression:

Fewer than four symptoms — Not depressed
Four symptoms — Mild depression
Five to six symptoms — Moderate depression
Seven or more symptoms ± psychotic symptoms — Severe depression

Figure 1

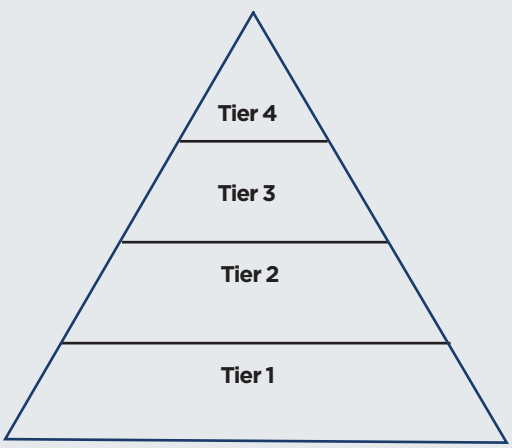
Screening for depression in children and adolescents in primary care (adapted from Thapar et al[16])



** Sub-syndromal depression = high score on questionnaires but below the threshold at clinical assessment for a diagnosis of depression

Figure 2

Child and Adolescent Mental Health Services (CAMHS)



CAMHS tiers

Tier 1 Non-specialist primary care workers such as school nurses or health visitors working with common childhood problems, e.g. sleeping/feeding difficulties

Tier 2 Mental health professionals specialising in child development; assessment and treatment in primary care (e.g. family work, counselling for mild depression, *CYP IAPT)

Tier 3 Specialist multidisciplinary CAMHS teams. More complex problems than tier 2 (e.g. management of moderate-severe depression, *CYP IAPT, assessment of autism, treating hyperactivity, early onset psychosis)

Tier 4 Highly specialised day and inpatient units, for CAMHS patients with more severe mental health problems

*CYP IAPT = The Children and Young People's Improving Access to Psychological Therapies Programme

Table 3

Criteria for referral to CAMHS tier 2 or 3 services for depression[8]

- Mild depression in those who have not responded to interventions after 2–3 months
- Moderate or severe depression (including psychotic depression)
- Depression with two or more other risk factors for depression
- Depression where one or more family members (parents or children) have multiple risk histories for depression
- Signs of a recurrence of depression in those who have recovered from previous moderate or severe depression
- Unexplained self-neglect of at least one month's duration that could be harmful to their physical health
- Active suicidal ideas or plans
- Referral requested by a young person or their parent(s) or carer(s)

commitment in the mandate to roll out to 100% of the 0-19 population in England by 2018.[18]

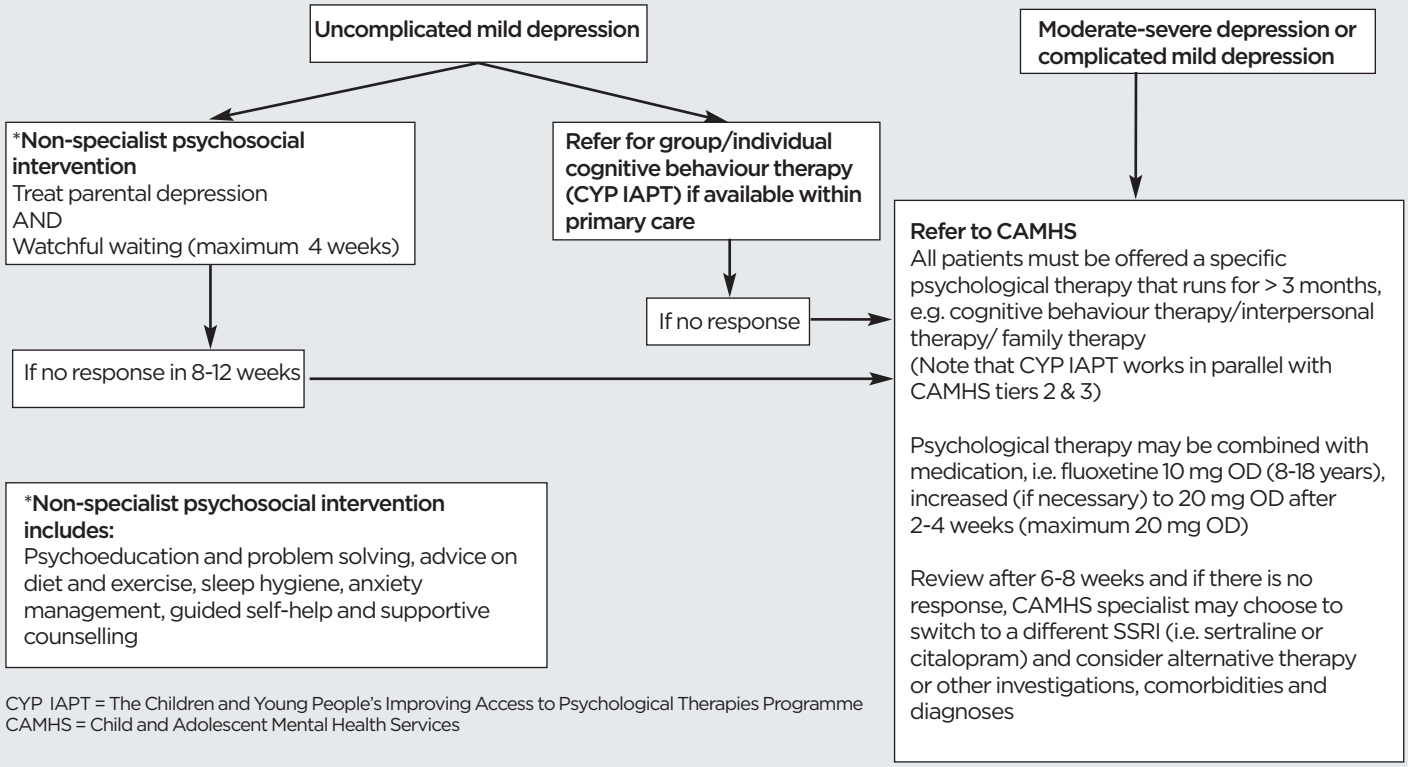
The situations in which GPs should always refer to CAMHS are listed in table 3, above.

NICE recommends that GPs should routinely consider, and record in the patient's notes, potential comorbidities when assessing a child or young person with depression. This is essential because two thirds of adolescents with depression are thought to have at least one comorbid psychiatric disorder, most commonly the range of anxiety disorders, disruptive behavioural disorders and substance misuse problems.[19] Around 20% of adolescents with depression, for example, meet diagnostic criteria for generalised anxiety disorder.[20] Furthermore, comorbidity is more prevalent in adolescents with severe depression, and predicts poor response to treatment and worse functional outcomes.[21]

With regard to differential diagnosis, there are four main diagnoses to consider. Adjustment disorder and dysthymic disorder are characterised by prominent depressive symptoms. Adjustment disorder usually arises after a single, isolated negative event and is short lived (arises within three months of the stressor onset and generally persists for less than six months). Dysthymic disorder describes a pattern of chronic depressive symptoms that »

Figure 3

Management of depression in children and adolescents [8,16]



CYP IAPT = The Children and Young People's Improving Access to Psychological Therapies Programme
CAMHS = Child and Adolescent Mental Health Services

are present most days for at least a year. The symptoms tend to be low level but not reaching the threshold for a clinical diagnosis of depression. If these patients do, however, later develop a depressive illness, they can be particularly difficult to treat.

The other two diagnoses to rule out are bipolar affective disorder and schizophrenia, although these are much less common in children and adolescents than major depression. It is therefore important to ask about previous periods of overactivity, elated mood or disinhibited behaviour. If this behaviour lasted for four or more days, referral for a specialist mental health assessment should be considered.[22] Similarly for schizophrenia, GPs should be routinely screening for psychotic features and refer appropriately.

MANAGEMENT

Recent changes to NICE guidelines have focused on the important area of psychological therapies. They recommend that GPs discuss choices of psychological therapies with the patient and family. They need to explain that at present, there is not sufficient evidence to choose one type of psychological therapy over the others.[8] As mentioned, CYP IAPT works alongside tiers 2 and 3 in CAMHS and this programme offers easier access to psychological intervention. A pathway for the management of depression in young people is shown in figure 3, above. For children and young people with moderate to severe depression, referral to tier 2 or 3 CAMHS care is recommended. New NICE guidelines state that once referred, all these patients should be offered a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least three months.[8]

Fluoxetine is the only SSRI antidepressant currently licensed for use in the UK for those under 18 although the evidence base is limited. It is important for the decision to start medication to be made in secondary and not primary care as the balance of risks and benefits needs to be carefully considered. If a specialist CAMHS doctor decides that medication is appropriate, it is recommended that this should be accompanied by concurrent psychological therapy.

In terms of monitoring, specific arrangements must be made to look out for adverse drug reactions, and the GP and specialist can liaise about the frequency of contact.[8]

SUPPORTING PATIENTS AND FAMILIES

GPs should be vigilant for any parental psychiatric problems, in particular untreated depression, if the child or young person's mental health is to improve.[8] It is crucial that the child's symptoms are monitored in the context of the full family environment, paying careful attention to key interpersonal relationships. Having a clear idea of what services are available from CAMHS, as well as what community support can be offered is important.

It is also worth GPs keeping an eye on patients with sub-syndromal depression, in which young people have high levels of symptoms but do not meet the threshold for a clinical diagnosis. There is robust evidence that these individuals are at a much higher risk of developing a depressive disorder in the future.[23] GPs may consider targeting these young people with low-risk intervention strategies and lifestyle changes.

Some of the more common side

key points

SELECTED BY

Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Until the 1970s, it was believed that depressive disorders were uncommon among the young. It is now known that many young people suffer from clinical depression. Major (unipolar) depression is one of the most common mental health disorders in children and adolescents, with an estimated one year prevalence of 4-5% in mid-late adolescence.

Depression is probably the single most important risk factor for teenage suicide, the second to third leading cause of death in this age group and a forerunner of adult depressive disorder. Half of those with lifelong recurrent depression started to develop their symptoms before the age of 15 years.

Family history is a well established risk factor and children born to depressed parents face three to four times increased rates of depression. Both genetic and environmental factors contribute to this risk. Adolescent girls are more vulnerable to depression in a ratio of 2:1. However, prepubertal depression has an equal sex ratio and is thought to be more strongly related to family dysfunction.

Low mood is the predominant feature and depressed children might also have various unexplained physical symptoms, eating disorders, school refusal or substance misuse. Two thirds of adolescents with depression are thought to have at least one comorbid psychiatric disorder, most commonly the range of anxiety disorders, disruptive behavioural disorders and substance misuse problems.

NICE highlights the importance of active listening and conversational techniques in order to screen for mood disorders effectively. The key questions used for screening are from the PHQ-2 which asks about whether, in the past few weeks, the young person has experienced a lack of interest or pleasure in doing things, and if they have felt down, depressed or hopeless.

When a young person poses a high risk of self-harm or suicide or significant ongoing self-neglect it is usually quite obvious that they need a highly specialist service – CAMHS tier 4. For children and young people with moderate to severe depression, referral to tier 2 or 3 CAMHS care is recommended. The new NICE guidelines state that once referred, all these patients should be offered a specific psychological therapy.

Fluoxetine is the only SSRI antidepressant currently licensed for use in the UK for those under 18 although the evidence base is limited. It is important that the decision to start medication is made in secondary and not primary care as the balance of risks and benefits needs to be carefully considered.

Table 4

Common side effects of fluoxetine

- Headache
- Dizziness
- Nausea, vomiting or diarrhoea
- Dry mouth
- Difficulty sleeping
- Tiredness, sleepiness, weakness, or difficulty thinking clearly
- Feeling nervous, excitable, irritable, or restlessness

effects of fluoxetine, often most prominent in the first fortnight of treatment are listed in table 4, above. Rarely, fluoxetine may cause increased thoughts of self-harm and hostility or high fever, excessive sweating and confusion. GPs should remind their patients to seek medical help immediately in these situations.[24]

CONCLUSION

Despite the fact that major depressive disorder is relatively common in adolescents, it often goes undetected. As we develop our understanding of the causes of depression in terms of cognitive processes, emotional regulation and coping strategies, we can tailor more effective treatments to the individual. For example, particular treatments might be better suited to certain clusters of symptoms or at a specific stage of the disease.

The GP plays a vital role in the identification and treatment of depressive symptoms in young people and the NHS now provides much better access to psychological services for these individuals.

The recent NICE guidelines have focused on a fully comprehensive biopsychosocial model, with a renewed focus on psychological interventions for major depression in young people.

There are new models of care being introduced to improve the access of young people to these much needed psychological therapies. As well as CYP IAPT, described above, there has been a surge in interest regarding early intervention services, for example in schools.[25]

Furthermore, many new and innovative psychological therapies are being developed with a focus on treating depression, for example, mindfulness based cognitive therapy, which has been associated with enduring positive outcomes in depressed adults.[26] It is hoped that a stronger evidence base for these treatments will develop in the next few years.

Finally, research into resilience has the potential to help us identify targets for prevention of depression. Studies suggest that intelligence, good interpersonal relationships, as well as potentially modifiable factors such as emotional regulation and adaptive coping styles, can be effective at buffering young people against life's adversities.[27]

By the time the adolescents of today become adults, it has been predicted that depression will carry an ever greater burden of global disease. Given that half of those with lifelong recurrent depression start to develop their symptoms before the age of 15 years,[6] investing in early interventions to treat depression effectively will have positive implications for a young person at such an important stage in their social, educational and personal development.

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Useful information

For patients

Young Minds
www.youngminds.org.uk/for_children_young_people/whats_worrying_you/depression

Depression Alliance
www.depressionalliance.org/

Mind
www.mind.org.uk/information-support/types-of-mental-health-problems/depression

NHS Choices
www.nhs.uk/conditions/stress-anxiety-depression/pages/children-depressed-signs.aspx

Rethink Mental Illness
www.rethink.org/diagnosis-treatment/conditions/depression

Royal College of Psychiatrists
www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/youngpeople/depressioninyoungpeople.aspx

SANE
www.sane.org.uk/resources/mental_health_conditions/depression/

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