DEPRESSION AND LOW MOOD IN YOUNG PEOPLE: TOWARDS BEST PRACTICE

The recent NICE quality standards for managing depression in children and young people included a call for GPs to have a more pivotal role in setting affected patients on the care pathway. Here, Jane Roberts, RCGP Clinical Champion for Youth Mental Health, looks at the issues.

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Mental health problems in children and young people (CYP) are common and concerning. A major national survey was last conducted in 2004 and reported one in 10 5-16 year olds has a diagnosable mental health disorder.[1] For older teenagers the rates are higher again, with around 15% reporting psychological problems which impact on daily life.[2] Emotional disorders such as depression and anxiety are among the most common problems, with the other most frequently occurring conditions listed as conduct disorders, attention deficit disorders and autistic spectrum disorders. It is always important to note that, in contrast to adult psychopathology, co-morbidity of mental health disorders for children and young people is the norm rather than the exception.

While boys are over-represented among diagnoses of conduct disorders (see *BJFM* Vol.1 Issue 2), post-pubertal girls and young women are much more likely to present with "internalising" or emotional disorders. The mechanisms explaining this widespread phenomenon are not fully understood. They are likely to be multifactorial and include the recently accepted belief that the hormonal changes arising in puberty sensitise the brain to the harmful effects of stress at a time when exposure to stressors also rises.[3] Societal expectations and limited opportunities for young women also play a role.

One in three children and young people in the UK live in poverty.[4] All of the common mental health disorders in children and young people are more often experienced by those living in low income families, with three-fold increases in the poorest families, compared to those growing up in more affluent homes. Linked to this observation is the high association between parental and child mental ill-health, with an estimated 50-75% of affected children and adolescents having a parent experiencing mental health difficulties themselves.

There is controversy regarding trends in the prevalence of emotional disorders in childhood and adolescence, but agreement that rates of self-harm – a behavioural response indicating emotional distress which is associated (although not exclusively) with young people with low mood – have increased sharply over the past decade. This is evidenced by rates of hospital admission and calls to help lines.[5] Bullying, which we know can lead to young people experiencing low mood and other psychological sequelae, has also increased both in terms of absolute numbers and in multiple forms, including face to face and in cyberspace.

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Identification of depression in CYP

Detecting and diagnosing depression in the younger population is challenging. Firstly, young people (using the WHO definition of adolescents as being 10-19 year olds) rarely present with psychosocial problems. Kramer and Garralda report that only 2% of psychological problems are the primary presentation.[6] They are much more likely to present with unexplained physical symptoms, anxiety related symptoms or behavioural problems. Secondly, low mood in adolescence, which may indicate a depressive disorder, presents with a more fluctuating pattern in younger patients, with irritability often more pronounced than flattened affect and greater mood lability. This is manifest by a picture of marked variation in this group, with teenagers often able to maintain good levels of function in some areas of their life, e.g. on the sports field, but with a co-existing decline in other areas, such as academic performance or social relationships.[7] This contrasts with adult presentations, which typically have greater uniformity, making the diagnosis in younger patients more complicated.

Thirdly, co-morbidity of psychological problems in adolescence also challenges clinicians. Where a young person is exhibiting "oppositional" – e.g. atypically negative or defiant – behaviour suggestive of conduct disorder, or has a known neuro-developmental problem or is using drugs, it can be taxing to consider co-existing low mood and possible depression. Finally, depression in under 19 year olds, as with older age groups, exists along a spectrum from dysthymia (low mood not meeting the diagnostic criteria for a "depressive disorder") to full blown severe depression, and its manifestation may move along the axis at different time points.

For all of the above reasons, compounded by the often limited exposure in undergraduate medical education and CPD to adolescent mental health, GPs often feel anxious and uncertain about their competence in this area.[8]

According to the WHO's ICD-10, a depressed individual usually suffers from depressed mood, loss of interest and enjoyment and reduced energy. However, adolescents are more likely to display irritability than flattened affect

TABLE 1. COMMON SYMPTOMS OF DEPRESSION IN CHILDREN AND YOUNG PEOPLE ARE:

Depressed mood
Loss of interest and enjoyment
Increased tiredness and diminished activity
Reduced concentration and attention
Reduced self esteem and self confidence
Ideas of guilt and unworthiness
Bleak and pessimistic views of the future
Ideas or acts of self harm or suicide
Disturbed sleep
Irritability

The role of the GP

Recent exposure to psychological stress is the key event in new presentations or first onset of a depressive episode in adolescence. Recognising who might be most vulnerable to being adversely affected by a traumatic event, such as serious family influence or divorce, is an important role for GPs, given their access to family history and contemporaneous problems.
The greatest risk appears to be where children and young people are exposed to a combination of:

- Chronic marital difficulties
- Parental (predominantly maternal) low mood or depression
- Recent life events
- Two or more lifetime losses, such as bereavement or marital breakdown[1]

High risk groups for common mental health problems in childhood and adolescence includes those who:

- are "in care"
- are seeking asylum or refuge
- have a learning disability
- suffer with long term physical illnesses or conditions
- have a history of offending behaviour
- live in "a troubled family" (https://www.gov.uk/government/policies/helping-troubled-families-turn-their-lives-around: The Troubled Families Programme)

Points to consider during the consultation

It is important to bear in mind that the young person will most likely present with another problem, for example a skin condition or musculo-skeletal disorder.[7] In the course of addressing the presenting problem, an awareness of other family members' health narratives and psychosocial issues may alert the GP to a higher index of suspicion. For this reason, it will be helpful to gently probe with questions, asked thoughtfully and sensitively, which address mood and mental health.

Above all, creating an atmosphere of trust is essential and requires a discussion of confidentiality, including the caveat that if a GP suspects a young person's safety is compromised in any way they will need to talk to the local safeguarding lead and or social services, ideally with the teenager's permission. If the young person feels they cannot give their permission but they are considered to be at risk of harm, then the GP should explain that they have a professional duty to talk with social services and that they will continue to keep the young person informed about the process.

It is important to establish a background of what is happening at home and at school for the young person. Using a respectful and compassionate tone, consider asking questions based around the following topics (while recognising that unless there is a high index of suspicion, it may well be worth pacing the consultation and not aiming to cover all the ground in the first consultation):

- Who do they live with? Any recent changes?
- Are they regularly attending school, in training or employment?
- Do they have a supportive peer group? Positive social relationships?
- Are they being bullied? Do they have a history of being bullied?

- How do they sleep? Dietary patterns?
- Do they feel "stressed"? How do they deal with this?
- Do they feel low and/or hopeless about their future?
- Are they self-harming? Cutting? Any history of overdose?
- Do they feel anxious at times? (Here it might be helpful to ask the GAD 2 screening questions – see box below)
- Do they smoke? Drink? Use drugs?
- Are there co-existing physical health problems (which may need further attention)

GAD 2 SCREENING QUESTIONS

Over the past 2 weeks how often have you been bothered by:

1. Feeling nervous, anxious or on edge?
Not at all (0);
several days (1);
more than half of the days (2);
nearly every day (3)

2. Being unable to stop or control worrying?
Not at all (0);
several days (1);
more than half of the days (2);
nearly every day (3)

Scoring >3 suggests anxiety or panic disorder and needs a GAD 7 questionnaire

Empathic questioning regarding daily functioning and clinical judgement remains the mainstay for deciding whether a young person might be experiencing a persisting low mood, since the best strategy for clinical assessment by generalists has yet to be determined.[3] While a number of validated screening tools are used by our colleagues in the Child and Adolescent Mental Health Service (CAMHS), including the useful Strengths and Difficulties Questionnaire (www.sdqinfo.com), these are not diagnostic tools for depression and are not routinely carried out in general practice.

Current Guidelines

NICE guidelines (www.nice.org.uk/nicemedia/live/10970/29856/29856.pdf) offer a five step plan for the diagnosis and treatment of depression in children and young people.

- **Step 1** is detection and risk profiling. NICE calls for healthcare professionals in primary care and schools to be trained to detect the symptoms of depression.
- **Step 2** calls for improvements in the training of child and adolescent mental health workers.
- **Step 3** addresses mild depression and states that antidepressants should not be used in the treatment of mild depression.
- **Steps 4 and 5** address moderate and severe depression. The guidance states that such children and young people should be offered, as a first line treatment, a specific psychological therapy, such as cognitive behavioural therapy (CBT), interpersonal therapy, or shorter term family therapy. Antidepressant medication should only be offered in combination with concurrent psychological therapy. Fluoxetine is the first line drug that can be prescribed, almost always by a child psychiatrist. High levels of monitoring for side effects and monitoring of the child's or young person's mental state is essential.
- Shared care prescribing may follow, with the GP offering interim follow-up care while the young person remains on medication.

Occasionally a physical illness may precipitate a low mood, and rarely it is useful to consider ordering blood tests (e.g. full blood count, thyroid function, blood sugar).

Recent exposure to psychological stress is the key event in new presentations or first onset of a depressive episode in adolescence

Red flags

For any young person presenting with depression, the greatest risk is of suicide. Although the numbers in absolute (practice level) terms are small, suicide is globally the second cause of death in 10-24 year olds,[9] and at an individual level the impact is devastating.

It is also important not to miss children and young people who:

- are being seriously bullied (enduring, recurrent, high level, multi-source)
- are being neglected through absent, inadequate parenting or who are being abused, including through sexual exploitation
- show escalating patterns of self harm (typically cutting or self-poisoning).

Concerns that a young person is subject to any of the above requires an immediate referral to Social Services Direct and/or urgent referral to CAMHS, depending on the nature of the presentation.

Do not hesitate to seek advice from your local safeguarding lead, and from your CAMHS team (often the primary mental health worker as the front line practitioner; or you can request to speak to the duty psychiatrist).

Management and follow- up

The NICE stepped care plan advocates that mild depression is treated in primary care by generalists. There is no prescriptive algorithm for how this is offered, but rather an approach based on sound clinical judgement which will typically include:

- offering tailored advice around sleep hygiene
- understanding the importance of aiming for a healthy diet and being physically active
- promoting positive strategies for dealing with stress such as dancing, music, seeing friends, art, writing, reading, cinema
- minimising risky behaviour, e.g. offering smoking cessation support and advice on using contraception if sexually active
- arranging regular follow-up.

Addressing parental mental health needs is also important and may be essential if the young person is to be helped. This will also help reduce recurrence of depression, rates of which are as high as 70% for young adults.

Always arrange to review young people and ask their permission to contact them, ideally by mobile phone if they miss an appointment. This can often happen through mere forgetfulness but may possibly indicate a worsening mood and social withdrawal.

Future directions

New research is looking at targeted interventions, such as cognitive behavioural therapy for young people who are considered to be most at risk: those who are the offspring of parents with depression, adolescents with sub-threshold symptoms of depression, and those who have had a previous episode of depression. School-based programmes are also being trialled to evaluate their possible role in community screening and early identification of depression.[10] However, the evidence of benefit for universal screening is inconclusive at present.

Final word

The recently published NICE Quality Standard (2013) for depression in CYP (see *BJFM* Vol. 1 Issue 3) specifies that primary care healthcare professionals should be trained in detection and assessment of young people aged under 19 years at risk of depression, with adequate educational support. The QS declares that CAMHS professionals should provide such training, including use of screening tools, and provide adequate supervision and consultation. How this is to be translated into everyday practice remains to be seen, given that many CAMHS teams are faced with budgetary cuts. On the other hand, GPs need increased educational support if we are to address the burden of need experienced by young people in the UK today.

KEY POINTS

1. Mental health problems in CYP are common, with 1 in 10 reported to have a diagnosable psychiatric disorder
2. Young people from lower income families are at particularly high risk of mental health disorders
3. The incidence of self-harm and bullying are both showing an increase
4. Unexplained physical conditions, anxiety-related symptoms or behavioural problems are more common symptoms of depression than psychological problems in this group
5. Functionality in different facets of life is far more variable among younger people compared to adults
6. Domestic difficulties and/or parental low mood or depression are key warning signs
7. Creating an atmosphere of trust is essential to good practice
8. Evidence of self-harm, serious bullying, neglect and abuse should be seen as red flags

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