# Depressed Mood

## Definition / Supporting Information

Depression is a mental health diagnosis defined by feelings of sadness, despair and discouragement. Low mood can range from mild ("the blues") to severe (major depressive disorder).

One in 10 children in the UK aged 5–16 years suffer from a diagnosable mental illness; of these children, almost 10% have depression. Depression is 7 times more common in older children (11–16 years) and in girls [NHS Digital].

Recovery from depression varies – 10% of children recover within 3 months of onset; 40% within a year; 20% within 2 years and 30% do not recover after 2 years [NICE clinical guideline CG28].

According to The International Classification of Diseases, 10th revision (ICD-10) [WHO 1992], key symptoms for depression include:

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

Depression can be as such categorised as:

- Mild (eg, at least 2 of the 3 key symptoms, then an additional symptom(s) (to give a total of at least 4) from the following):
  - Loss of confidence / self esteem
  - Excessive or inappropriate guilt
  - Recurrent thoughts of death / suicide
  - Diminished ability to think
  - Change in psycho-motor activity
  - Sleep disturbance
  - Change in appetite
- Moderate (eg, as above but a total of at least 6 symptoms required)
- Severe (eg, as above but a total of at least 8 symptoms required)

## Essential History

Ask about:

- Key symptoms of depression (as above)
- Social, educational and family context (eg, quality of interpersonal relationships)
- Potential comorbidities (eg, alcohol misuse, drug misuse)

- Associated symptoms of depression, including:
  - Anhedonia (loss of enjoyment of usual activity)
  - Hopelessness
  - Reduced energy / motivation
  - Low mood
  - Anger
  - Irritability
  - Early morning waking / sleep abnormaltities
  - Pessimistic / guilty thoughts (negative cognitions)
  - Loss of libido
  - Amenorrhea
  - Reduced / increased appetite
  - Weight loss / gain
- Somatic complaints
  - Acute or chronic medical conditions or pain syndromes
    - Gastrointestinal symptoms
    - Headaches
    - Chest pain
- Low self-esteem
- Impaired academic progress
  - Learning disability
  - Bullying
  - Lack of positive peer relationships
- Physical illness (see differential diagnosis section)
- Family history
  - Including parents' physical and mental health
  - Family dynamics
- Significant events
  - Bereavement
  - Loss
  - War
- Prescribed drug history
  - Steroids
  - Beta-blockers
  - Attention-deficit hyperactivity disorder (ADHD) medications
- Developmental history, especially screening for differential diagnoses of either autism spectrum disorders (ASD) or ADHD

Offer the young person an opportunity to consult independently from their parents / carers for part of the consultation, explain confidentiality and its limits, and seek consent to share information as required.

## ‘Red Flag’ Symptoms and Signs

Ask about:

- Active suicidal ideas / plans
- Significant and persistent self-neglect (eg, poor personal hygiene)
- Safeguarding concerns

Be aware that there is a 50% increased risk of mortality in people who suffer with depression.

## Differential Diagnosis / Conditions

- Learning problems or disabilities
- Exposure to adverse childhood experiences
  - Natural disaster
  - Neglect
  - Parental divorce or separation
  - Death of a parent or sibling
  - Parental substance use
  - Physical, emotional, or sexual abuse
  - Separation from a parent
  - Trauma
  - Violence
- Higher risk of developing emotional difficulties
  - Adjustment disorder
  - Post-traumatic stress disorder (PTSD)
- Other mood disorders
  - Anxiety
  - Obsessive-compulsive disorder (OCD)
  - Depression (co-morbid with anxiety)
- Loss / life events
  - Separation or divorce of parents
  - Relocation
  - Change of school
  - Deployment of a parent in military service
  - Break-up with a girlfriend or boyfriend
  - Remarriage of parent
  - Parental poor physical and mental health
- Physical illness and medication side-effects
  - Medical issues mimicking or provoking symptoms of depression
    - Endocrine disease (eg, hypothyroidism)
    - Lupus

        - Chronic fatigue syndrome
        - Diabetes
        - Anaemia
        - Other metabolic diseases (eg, Morbus Wilson)
    - Depression is more likely in children with chronic medical conditions
    - Medications commonly used in adolescence associated with depression
        - Acne preparations, e.g. isotretinoin
        - Corticosteroids
        - Oral contraceptives
- Substance misuse may result in:
    - Self-medication with alcohol, nicotine, or other drugs
        - Manifestation of depression / deteriorating school performance
- Conduct or oppositional disorders may result in:
    - Manifestation of depressive symptoms
    - Higher risk for suicide
- Psychosis
    - Delusions
    - Paranoia
    - Hallucinations
    - Unusual interactions
- Bipolar disorder
    - Varying low mood (depression) or high mood (mania)
        - May cycle over weeks or months (cyclothymia)
- Pervasive developmental disorders (eg, ASD)

## Investigations

To be undertaken by non-mental health practitioners (eg, General Practitioner with Special Interest (GPSI), Universal Services, General or Community Paediatric Team(s)):

- Thorough medical history (see essential history)
- Assess level of risk
    - Check for ideas, plans, attempts at self-harm
    - Methods used
    - Suicidal plans
    - Suicide notes written
    - Final acts put in place
        - Giving personal possessions away
    - Evidence of self-neglect
        - Stopped bathing / shaving

- Baseline blood tests to rule out comorbid medical issues (if supported by history, family history of thyroid dysfunction)
  - Full blood count (FBC)
  - Thyroid function
  - Vitamin D levels
- Questionnaires can be useful to establish
  - Severity of symptoms of depression
  - Impact of symptoms of depression on functioning
  - Presence of comorbid anxiety

To be undertaken by mental health practitioners (eg, Child and Adolescent Mental Health Services (CAMHS)) if not already done:

- Assessment questionnaires to establish the severity of depression [NICE clinical guideline CG28]
  - Revised Children's Anxiety and Depression Scale (RCADS)
  - Hospital Anxiety and Depression Scale (HADS)
  - Children's Global Assessment Scale (CGAS)
  - Beck Depression Inventory (BDI)
  - Mood and Feelings Questionnaire (MFQ)
  - Kiddie-Sads (K-SADS)
  - Child and Adolescent Psychiatric Assessment (CAPA)
- Formulation of child's presentation to include risk and resilience factors

## Treatment Approach

To be undertaken by non-mental health practitioners (eg, General Practitioner with Special Interest (GPSI), General or Community Paediatric Team(s)):

- Watchful waiting
  - Arrange further assessment within 2 weeks if the professional opinion is that recovery with minimal intervention is likely
  - If follow-up not attended, further contact with the patient should be made
- Self-help / psychoeducation
  - Only as part of a supported package of care [NICE clinical guideline CG28, recommendation 1.1.3.5], including usage of:
    - Complementary / alternative therapies
    - Contact with voluntary organisations
    - Educational leaflets
    - Exercise
    - Healthy diet
    - Helpline / support websites

        - Mentoring
        - Peer support groups
        - Self-diagnosis tools
        - Sleep / relaxation
        - Social networks
        - Talking to family and friends
- Develop a supportive therapeutic alliance
    - Work collaboratively with the child and family
- Address comorbidities
    - Drug / alcohol misuse
    - Anxiety
- Where bullying is evident, close liaison with education staff is essential
- Advice on sleep hygiene
    - Regular bedtime
    - Avoid caffeine
    - Avoid drugs / alcohol
    - Use calming oils
    - Take a warm bath
    - Avoid using electronic devices before bedtime
        - Computers
        - Tablets
        - Phones
        - Television
- Reinforce strengths of the child and family and their support groups
    - Good relationships with at least one parent or important adult
    - Prosocial peers
    - Concerned or caring family
    - Help-seeking
    - Connection to positive organisations
    - Support for education
    - Clear, consistent discipline
    - High standard of living
    - Range of sport / leisure activities
    - Experiences of success / achievement
    - Good communication skills
    - Absence of any of the above risk factors
- Assess need to address parental mental, physical health or social difficulties in parallel
- Refer parents for assessment and treatment as necessary
    - Basic safety techniques

  - Ensure medication locked away
- Monitor change through patient-reported outcome measures (eg, MFQ)

To be undertaken by mental health practitioners (eg, CAMHS) if not already done:

- Psychological therapy (by trained therapists)
  - If no comorbid conditions / suicidal ideation
- Monitor progress using questionnaire (eg, MFQ) and outcome measures
- Refer to Specialist CAMHS if no response after 2–3 months
- For moderate to severe depression consider:
  - Individual cognitive behavioural therapy (CBT) or
  - Psychodynamic psychotherapy
    - These therapies should run for at least 3 months
- Antidepressant medication (fluoxetine) can be used in individuals aged 12–18 years alongside psychological therapy
- Antidepressants should be initiated by a child psychiatrist or experienced paediatrican with a special interest in mental health
- Whenever any medication is prescribed, information must be given on:
  - Side-effects
  - Delay before therapeutic effects become noticeable
  - Time taken for maximal therapeutic effect
  - Expected duration of treatment
  - Risk of suicidal ideation associated with antidepressants
- Printed information should complement discussions
- As above, therapy progress should be monitored using the MFQ
- Paroxetine, venlafaxine and tricyclic antidepressants should not be used in individuals under 18 years

A stepped-care model is advocated by the National Institute for Health and Care Excellence (NICE) [NICE clinical guideline CG28, recommendation 1.2]:

- Provides a framework to organise the provision of services which support healthcare professionals and patients, and their parent(s) or carer(s), in identifying / accessing the most effective interventions
- In primary care and community settings the guidance follows 5 steps (note that guidance is adapted to the level of severity):
  - Detection
  - Recognition
  - Development of treatment plan
  - Implementation of treatment plan
  - Resolution / cure

## When to Refer

Refer (urgently) to child mental health specialist if:

- Above treatment is not successful after 2–3 months
- Child talks of active suicidal ideation
- Child / family request referral onto CAMHS
- Multiple risk factors are present
- Moderate or severe depression
- Recurrence of depression [NICE clinical guideline CG28, recommendation 1.3.2.2]

Escalate care to Specialist CAMHS if:

- Clear suicidal intent with a plan (eg, suicide note written)
  - Final acts
    - Dangerous methods cited (eg, hanging)
  - Making of / intent to make a will
  - Use of vehicles
  - Jumping from heights
  - Use of weapons
  - Avoidance of being found
- Expressing hopelessness for the future
- Significant self-neglect
- School attendance has stopped / dropped significantly
- Child is significantly isolated
  - Spending long periods alone in room

## ‘Safety Netting’ Advice

- Refer urgently to specialist practitioners (eg, Local Authority / Social Care Team(s)) for safeguarding concerns
  - Follow local safeguarding protocols (local children’s safeguarding boards)
- Advise parents / carers to seek urgent medical review if worried about child’s safety / safety of other children
- Seek professional advice from GP, the emergency department and / or social care
  - Furthermore, advice from CAMHS should be sought, if known to this service
- Clear risk assessment, formulation and management plans should be completed at the earliest opportunity
  - These plans should be reviewed as needed, at a minimum every 3 months
  - These plans should be shared with everybody involved in the child’s care to minimise risk
- In the assessment and treatment of depression in children and young people, special attention should be paid to the issues of:
  - Confidentiality

- The young person's consent (including Gillick competence)
- Parental consent
- Child protection
- The use of the Mental Health Act in young people
- The use of the Children Act 2004 [GOV UK]

# Patient / Carer Information

**Please note: whilst these resources have been developed to a high standard they may not be specific to children.*

- Prevention of young suicide (Web page), Papyrus
- Child & Adolescent Mental Health (Web page), Young Minds
- Mental Health Medication (Web page), Headmeds
- Depression in children and teenagers (Web page), the NHS website
- Charlie Waller Memorial Trust (Web page)
- The Sleep Council (Web page)
- FRANK (Web page)
- Self-Harm Support (Web page), Harmless

# Resources

## National Clinical Guidance

Depression in children and young people: identification and management (Web page), NICE clinical guideline CG28, National Institute for Health and Care Excellence

Self-harm in over 8's: short term management and prevention of recurrence (Web page), NICE clinical guideline CG16, National institute for Health and Care Excellence

## Suggested Resources

**Please note: these resources include links to external websites. These resources may not have national accreditation and therefore PCO UK cannot guarantee the accuracy of the content.*

The mental health of children and young people in England (Web page), Public Health England

Young Minds (Web page)

Depression (Web page), Moodjuice self-help guide

Mood and Feelings questionnaire (Web page), Child Outcomes Research Consortium (CORC)

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**Content Editor:** Dr Monica Shaha

**Clinical Expert Reviewers:** Dr Doug Simkiss, Dr Nicola Herberholz, Dr Boglarka Fischer and Dr Munib Haroon

**GP Reviewer:** Dr Richard Pratt

**Nurse Reviewer:** Mrs Doreen Crawford

**Health Visitor Reviewer:** Mrs Julie Carter-Lindsay

**Paediatric Trainee Reviewer:** Dr Sian Copley

**Paediatric Specialty Groups:** Paediatric Mental Health Association, British Association of Community Child Health

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