Depression in children: identification and management of depression in children and young people in primary, community and secondary care

NICE guideline

First consultation, November 2004

If you wish to comment on the recommendations, please make your comments on the full version of the draft guideline.
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Key recommendations for implementation

Assessment and co-ordination of care

- When assessing a child/young person with depression, healthcare professionals should routinely consider, and record in the notes, the psychological and co-morbid factors, and the social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members, and with their friends and peers.

Treatment considerations in all settings

- Professionally trained therapists should provide the psychological treatment of clinically depressed young people wherever possible.

- Co-morbid diagnoses and social and educational problems should be assessed and treated, either in sequence or in parallel with the treatment for depression.

- Attention should be paid to the possible need for parents’ own psychiatric problems (particularly depression) to be treated in parallel, if the child is to improve.

Step 1: Detection and risk profiling

- Healthcare professionals in primary care, in schools and other relevant community settings, should be trained to detect depressive symptoms, and to assess children and young people who may be at risk of depression. Training should include the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, physical, sexual or emotional abuse, co-morbid disorders, and a history of parental depression; the natural history of single loss events; the importance of multiple risk factors; ethnic and cultural factors; and factors known to be associated with a high risk of depression and other
health problems, such as homelessness, refugee status and living in institutional settings.

- CAMHS tier 2/3 should work with healthcare professionals in primary care, schools and other relevant community settings, to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed.

**Step 2: Recognition**

- Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer based instruments (e.g. Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose.

**Step 3: Mild depression**

- Antidepressant medication should not be used for the initial treatment of children and young people with mild depression.

**Steps 4 & 5: Moderate or severe depression**

- Children and young people with moderate to severe depression should be offered, as a first line treatment, a specific, brief (up to 15 sessions, over at least 15 weeks) psychological intervention (individual cognitive behaviour therapy, interpersonal therapy or family therapy).

- Antidepressant medication should not be offered to children and young people with moderate to severe depression except in combination with a concurrent psychological treatment. If psychological treatment is declined, specific arrangements must be made for careful monitoring of adverse events.
The following guidance is evidence based. The grading scheme used for the recommendations (A, B, C), Good Practice Points (GPP) or NICE is described in Appendix A; a summary of the evidence on which the guidance is based is provided in the full guideline.

1 Guidance

This guideline makes recommendations for the identification and treatment of depression in children (5 to 11 years) and young people (12 to 18 years) in primary, community and secondary care. Depression is a broad and heterogeneous diagnostic grouping, central to which is depressed mood or loss of pleasure in most activities. Depressive symptoms are frequently accompanied by symptoms of anxiety, but may also occur on their own. ICD-10 uses an agreed list of 10 depressive symptoms, and divides the common form of major depressive episode into four groups: not depressed (fewer than four symptoms), mild depression (four symptoms), moderate depression (five to six symptoms), and severe depression (seven or more symptoms, with or without psychotic symptoms). Symptoms should be present for at least two weeks and every symptom should be present for most of the day.

For the purposes of this guideline, the treatment and management of depression has been divided into the following descriptions as defined by ICD-10:

- mild depression
- moderate and severe depression
- severe depression with psychotic symptoms.

However, it is doubtful whether the severity of the depressive illness can realistically be captured in a single symptom count. Clinicians will wish to consider family context and previous history, as well as the degree of associated impairment, in making this assessment (see Appendix E). Children and young people with a chronic sub-clinical version of depression that has persisted for over a year – known as dysthymia – should be treated as for mild depression in children: NICE guideline DRAFT (November 2004) Page 5 of 58
depression. We also make recommendations regarding the management of children and young people with recurrent depression.

The guideline draws on the best currently available evidence for the identification and management of depression. However, there are some significant limitations to the current evidence base, which have considerable implications for this guideline. These include the relatively small number of published studies of psychological treatments, concern about unpublished studies of pharmacological treatment, small, non-clinical, and sometimes unrepresentative samples with wide age ranges in the published pharmacological studies, a lack of consistency in reporting adverse effects, a dearth of studies comparing psychological with pharmacological treatments (with one recent exception) and very limited data on long-term outcomes.

However, the most significant limitation is with the concept of depression itself. The view of the Guideline Development Group is that it is too broad and heterogeneous a category, and has limited validity as a basis for effective treatment plans. A focus on symptoms alone is not sufficient because a wide range of biological, psychological and social factors have a significant impact on response to treatment and are not captured by the current diagnostic systems.

The guideline makes good practice points and evidence based recommendations for the psychological, physical and self-help interventions appropriate to each section. In addition, the first part of the guideline will make good practice points relevant to the care of all children and young people with depression.
1.1 Good practice points relevant to the care of all children and young people with depression

1.1.1 Providing good information, informed consent and support

Children and young people and their families need good information, given as part of a collaborative and supportive relationship with healthcare professionals, and to be able to give fully informed consent.

1.1.1.1 Healthcare professionals involved in the detection, assessment or treatment of children or young people with depression should ensure that the patient and their carers are provided with age-appropriate information on the nature, course and treatment of depression, including the likely side-effect profile of medication should this be offered. [GPP]

1.1.1.2 Healthcare professionals involved in the treatment of children/young people with depression should take time to build a supportive and collaborative relationship with both the patient and the family. [GPP]

1.1.1.3 Healthcare professionals should make all efforts necessary to engage the child/young person and their family in treatment decisions, taking full account of the patient and parental expectations, so that the patient and their carers can give meaningful and properly informed consent before treatment is initiated. [GPP]

1.1.2 Language and ethnic minorities

Information should be provided in a language that a patient can properly understand and interpreters engaged when needed. Psychological treatments are also best conducted in the patient’s first language. Healthcare professionals should be trained to understand the specific needs of depressed children from minority ethnic groups. Service users, including those from ethnic minority groups should be involved in planning services.
1.1.2.1 Where possible, all services should provide written information or audio taped material in the language of the patient and their family, and independent interpreters should be sought for those whose preferred language is not English. [GPP]

1.1.2.2 Consideration should be given to providing psychotherapies and information and medication and local services in the language of the patient and their family where the patient’s first language is not English. [GPP]

1.1.2.3 Healthcare professionals in primary, secondary and relevant community settings should be trained in cultural competence to aid in the diagnosis and treatment for minority ethnic groups. This training should take into consideration the impact of the patient’s and healthcare professional’s racial identity status on the patient’s depression. [GPP]

1.1.2.4 Depression services in both community and clinic settings should be developed and evaluated in collaboration with stakeholders including service users and their families, and members of minority ethnic groups. [GPP]

1.1.3 Assessment and co-ordination of care

The assessment of children and young people should be comprehensive and holistic, taking into account drug and alcohol use, the risks of self-harm and the use of self-help materials and methods. Parental depression may be an important factor and needs to be identified.

1.1.3.1 When assessing a child/young person with depression, healthcare professionals should routinely consider, and record in the notes, the psychological and co-morbid factors, and the social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members, and with their friends and peers. [GPP]
1.1.3.2 In the assessment of children/young people with depression, healthcare professionals should always ask patients and their family directly about alcohol and drug use, self-harm and ideas about suicide. Young people may prefer to initially discuss these issues in private. [GPP]

1.1.3.3 In the assessment of children/young people with depression, healthcare professionals should always ask patients, and be prepared to give advice, about the use of self-help materials or methods used or considered by the patient or their family. This may include educational leaflets, help-lines, self-diagnosis tools, peer/social/family support groups, complimentary therapies or religious/spiritual groups. [GPP]

1.1.3.4 Health professionals should only recommend self-help materials or strategies as part of a supported and planned package of care. [GPP]

1.1.3.5 When a child or young person has been given the diagnosis of depression, consideration should be given to the possibility of parental depression (or other mental health problem) as this is often associated and, untreated, may have a negative impact on treatment offered to the child or young person. [GPP]

1.1.3.6 When monitoring the clinical progress of children and young people with depression, the self-report questionnaire, the Mood and Feelings Questionnaire (MFQ), should be considered as an adjunct to clinical judgment. [C]

1.1.4 The organisation and planning of services

Better links between CAMHS and Tier 1 and Tier 2 are needed to improve detection and availability of treatment. All healthcare professionals should monitor detection rates and record outcomes for local planning and local, regional and national comparison.
1.1.4.1 CAMHS services and PCTs should consider the introduction of a CAMHS link worker into each secondary school and secondary Pupil Referral Unit as part of tier 2 provision within the locality. [GPP]

1.1.4.2 CAMHS link workers should establish clear lines of communication between CAMHS and Tier 1/2, with named contact people in each Tier/service, and develop systems for the collaborative planning of services for depressed youth in Tiers 1 and 2. [GPP]

1.1.4.3 CAMHS Tier 1 professionals in conjunction with CAMHS Tier 2/3 professionals should routinely monitor the rates of detection, referral and treatment of children and young people with depression in local schools and primary care. This information should be used for planning services, and made available for local, regional and national comparison. [GPP]

1.1.4.4 All healthcare professionals should routinely use, and record in the notes, appropriate outcome measures for the assessment and treatment of depression in children and young people. This information should be used for planning services, and made available for local, regional and national comparison. [GPP]

1.1.5 Treatment considerations in all settings

Most treatment should be undertaken in outpatients or the community. Before starting treatment the social networks around the patient need to be clearly identified. If bullying is a factor, school and health professionals should jointly develop anti-bullying strategies. Psychological treatments should be provided by professionally trained therapists, who should aim to quickly develop a positive alliance with the patient and family. Co-morbid conditions will also need to be treated and therapy considered for parents with depression or other significant personal problem. Advice about exercise, sleep and nutrition should also be considered.
1.1.5.1 Most children and young people with depression should be treated on an outpatient or community basis. [C]

1.1.5.2 Before any treatment is commenced, healthcare professionals should describe in writing the social network around the child or young person. This should include identifying factors that may impact both positively and negatively on the efficacy of the treatments offered as well as on their compliance. [B]

1.1.5.3 When bullying is considered to be a factor in a child or young person’s depression, CAMHS and educational professionals should work collaboratively to prevent bullying and to develop effective anti-bullying strategies. [C]

1.1.5.4 Professionally trained therapists should provide the psychological treatment of clinically depressed young people wherever possible. [B]

1.1.5.5 Therapists should develop a joint treatment alliance with the family. If this proves difficult consideration should be given to providing the family with an alternative therapist. [C]

1.1.5.6 Co-morbid diagnoses and social and educational problems should be assessed and treated, either in sequence or in parallel with the treatment for depression. [B]

1.1.5.7 Attention should be paid to the possible need for parents’ own psychiatric problems (particularly depression) to be treated in parallel, if the child is to improve. [B]

1.1.5.8 Children and young people with depression should be advised of the benefits of regular exercise, and may consider following a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. [C]
1.1.5.9 Children and young people and with depression may benefit from advice on sleep hygiene and anxiety management. [C]

1.1.5.10 Children and young people with depression may benefit from advice about nutrition and the benefits of a balanced diet. [GPP]

1.2 Stepped care

The stepped-care model of depression draws attention to the different needs that depressed children/young people have – depending on the characteristics of their depression and their personal and social circumstances – and the responses that are required from services. It provides a framework in which to organise the provision of services supporting both patients and carers, and healthcare professionals in identifying and accessing the most effective interventions (see Figure 1).

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**Figure 1** The stepped care model
The guidance follows these five steps:

- detection and recognition of depression and risk profiling in primary care and community settings
- recognition of depression in children and young people referred to CAMH services
- managing recognised depression in primary care and community settings – mild depression
- managing recognised depression in tier 2/3 CAMHS – moderate to severe depression
- involvement of specialist mental health services – managing unresponsive and recurrent depression, and psychotic depression, including depression needing inpatient care.

Each step introduces additional interventions; the higher steps assume interventions in the previous step.

1.3 Step 1: Detection risk profiling and referral

Healthcare professionals working with children or young people in primary care, schools and in the community need training to assess the risk of depression, to provide emotional support and know when to refer, especially when a child or young person has experienced an undesirable life event. CAMHS tier 2/3 should work with Tier 1 professionals and help provide training in the recognition of depression.

1.3.1 Detection and risk profiling

1.3.1.1 Healthcare professionals in primary care, in schools and other relevant community settings, should be trained to detect depressive symptoms, and to assess children and young people who may be at risk of depression. Training should include the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, physical, sexual or emotional abuse, co-morbid disorders, and a history of parental depression; the natural history of single loss events; the importance of multiple risk factors;
ethnic and cultural factors; and factors known to be associated with a high risk of depression and other health problems, such as homelessness, refugee status and living in institutional settings. [C]

1.3.1.2 Healthcare professionals in primary care, in schools and other relevant community settings, should be trained in communications skills such as ‘active listening’ and ‘conversational technique’, so that they can deal confidently with the acute sadness and distress (‘situational dysphoria’) encountered in children and young people following recent adverse events. [GPP]

1.3.1.3 CAMHS tier 2/3 should work with healthcare professionals in primary care, schools and other relevant community settings, to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed. [GPP]

1.3.1.4 In the provision of training by CAMHS professionals for healthcare professionals in primary care, schools and relevant community settings, priority should be given to the training of pastoral support staff in secondary schools, community paediatricians, and GPs. [GPP]

1.3.1.5 When a child or young person is exposed to a single recent undesirable life event, such as bereavement, divorce or a severely disappointing experience, healthcare professionals in primary care, schools or other relevant community settings should undertake an assessment of the risks associated with depression. The risk profile should be recorded in the child/young person’s records. [C]

1.3.1.6 When a child or young person is exposed to a single recent undesirable life event, such as bereavement, divorce or a severely disappointing experience, in the absence of other risk factors for depression, healthcare professionals in primary care, schools or other relevant community settings should offer support and the
opportunity to talk over the event with the child or young person. [GPP]

1.3.1.7 Following an uncomplicated undesirable event, children and young people should not normally be referred for further assessment or treatment, as single events are unlikely to lead to a depressive illness. [C]

1.3.1.8 When a child or young person is exposed to a recent undesirable life event, such as bereavement, divorce or a severely disappointing experience, and is identified to be at high risk of depression (the presence of two or more other risk factors for depression), they should be offered the opportunity to talk over their recent negative experiences with a professional in Tier 1 and assessed for depression. Early referral should be considered if there is evidence of depression and/or self-harm. [GPP]

1.3.1.9 When a child or young person is exposed to a recent undesirable life event, such as bereavement, divorce or a severely disappointing experience, in the context of multiple-risk histories for depression in one or more family members (parents or children), they should be offered the opportunity to talk-over their recent negative experiences with a professional in Tier 1 and assessed for depression. Early referral should be considered if there is evidence of depression and/or self-harm. [GPP]

1.3.1.10 If children and young people who have previously recovered from moderate or severe depression begin to show signs of a recurrence of depression, healthcare professionals in primary care, schools or other relevant community settings should refer them to CAMHS tier 2/3 services for rapid assessment. [GPP]
1.3.2 Referral criteria

1.3.2.1 For children and young people, the following factors should be used by healthcare professionals as referral criteria for tier 1 services:

- Exposure to a single uncomplicated undesirable event in the absence of other risk factors for depression
- Exposure to a recent undesirable life event in the presence of two or more other risk factors with no evidence of depression and/or self-harm
- Exposure to a recent undesirable life event in the context of multiple-risk histories for depression in one or more family members (parents or children) providing that there is no evidence of depression and/or self-harm
- Uncomplicated mild depression. [GPP]

1.3.2.2 For children and young people, the following factors should be used by healthcare professionals as referral criteria for CAMHS:

- Depression with two or more other risks for depression
- Depression with multiple risk histories in another family member (parent or siblings)
- Mild depression in those who have not responded to interventions in tier 1 after 2 to 3 months
- Moderate or severe depression (including psychotic 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 the physical health of the child/young person.
1.3.2.3 For children and young people, the following factors should be used by healthcare professionals as referral criteria for tier 4 services:

- High recurrent risk of acts of self-harm or suicide
- Significant ongoing self-neglect (e.g. poor personal hygiene or significant reduction in eating that could be harmful to the physical health of the child/young person)
- Intensity of assessment/treatment and/or level of supervision that is not available in tiers 2/3. [GPP]

1.4 Step 2: Recognition

CAMHS professionals need to improve their ability to recognise depression

1.4.1.1 Children and young people of 11 years or older referred to CAMHS without a diagnosis of depression, should be routinely screened with a self-report questionnaire for depression (of which the Mood and Feelings Questionnaire [MFQ] is currently the best) as part of a general assessment procedure. [B]

1.4.1.2 Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer based instruments (e.g. Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose. [C]

1.4.1.3 Tier 3 CAMHS staff specialising in the treatment of depression should have been trained in interview-based assessment instruments (e.g. K-SADS and CAPA). [GPP]
1.5 Step 3: Mild depression

Some children and young people diagnosed with mild depression may not need or want a specific intervention, but they need to be monitored and followed up, especially if they miss appointments.

1.5.1 Watchful waiting

1.5.1.1 For children and young people with diagnosed mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting'). [C]

1.5.1.2 Healthcare professionals should make contact with children and young people with depression who do not attend follow-up appointments. [C]

1.5.2 Treatments for mild depression

After up to 4 weeks of watchful waiting, those children/young people with continuing mild depression should be offered a course of non-directive supportive therapy, group CBT or guided self-help in the first instance. If this is ineffective within 2 to 3 months, refer for assessment by Tier 2/3 CAMHS team. Antidepressants should not be used in the initial treatment of mild depression.

1.5.2.1 Following a period of up to 4 weeks of watchful waiting, all children and young people with continuing mild depression and without significant co-morbid problems or signs of suicidal ideation, should be offered individual non-directive supportive therapy, group cognitive behaviour therapy or guided self-help for a time-limited period (approximately 2 to 3 months). This could be provided by appropriately trained staff in primary care, schools, social services and the voluntary sector as well as in tier 2 CAMHS. [B]
1.5.2.2 Children and young people with mild depression who do not respond after 2 to 3 months to non-directive supportive therapy, group CBT or guided self-help should be referred for review by a tier 2/3 CAMHS team. [GPP]

1.5.2.3 Antidepressant medication should not be used for the initial treatment of children and young people with mild depression. [B]

1.5.2.4 The further treatment of children and young people with persisting mild depression unresponsive to treatment at Tier1/2 should follow the guidance for moderate to severe depression. [GPP]

1.6 Steps 4& 5: Moderate or severe depression

There is very little research evidence on the effectiveness of treatments for the younger child (5 to 11 years) with moderate to severe depression. In particular, there is little evidence for the effectiveness of antidepressants in children, which should, therefore, only be used very cautiously in this age group. In other respects, the recommended treatments for children are based upon the evidence for effectiveness in young people (12 to 18 years).

In children and young people psychological treatments are the first line treatments.

1.6.1 Treatment for moderate to severe depression

All children and young people with moderate depression, or persisting mild depression, should be assessed by CAMHS tier 2/3 professionals and offered a specific psychological therapy as a first line treatment.

1.6.1.1 Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS tier 2/3 team. [B]

1.6.1.2 Children and young people with moderate to severe depression should be offered, as a first line treatment, a specific, brief (up to 15 sessions, over at least 15 weeks) psychological intervention
(individual cognitive behaviour therapy, interpersonal therapy or family therapy). [B]

1.6.2 Combined treatments for moderate to severe depression

If a specific psychological treatment doesn’t work within 4 to 6 sessions, then review and consider alternative or additional psychological treatment for co-existing problems. Consider combining psychological treatment with fluoxetine (cautiously in the younger children). If combined treatment is not effective within a further 6 sessions, review and consider more intensive psychological treatment.

1.6.2.1 If a child or young person with moderate to severe depression is unresponsive to psychological treatment after 4 to 6 treatment sessions (of the 15 session treatment), a multidisciplinary review should be carried out. [GPP]

1.6.2.2 If the patient’s depression is not responding to treatment as a result of other co-existing factors such as the presence of co-morbid conditions, persisting psychosocial risk factors such as family discord, or the presence of parental mental ill-health, additional or alternative psychological treatment for the patient, a parent or the family, should be considered. [C]

1.6.2.3 Following multidisciplinary review, if a young person (12 to 18 years) with moderate to severe depression is unresponsive to a specific psychological treatment after 4 to 6 sessions (of the 15 session treatment), fluoxetine should be offered. [B]

1.6.2.4 Following multidisciplinary review, if a child (5 to 11 years) with moderate to severe depression is unresponsive to a specific psychological treatment after 4 to 6 sessions (of the 15 session treatment), the addition of fluoxetine may be cautiously considered, although the evidence for its effectiveness in this age group is not established. [C]
1.6.3 Depression unresponsive to combined treatment

1.6.3.1 If the child or young person with moderate to severe depression is unresponsive to combined treatment with a specific psychological treatment and fluoxetine after a further 6 sessions, or the patient and/or their family have declined the offer of fluoxetine, the multidisciplinary team should make a full needs and risk assessment. This should include a review of the diagnosis, examination of the possibility of co-morbid diagnoses, reassessment of the causes of depression, whether there has been a fair trial of treatment and assessment for further more intensive psychological treatment for the patient and/or additional help for the family. [GPP]

1.6.3.2 Following multidisciplinary review, more intensive psychological treatments such as individual child psychotherapy (30 weekly sessions) or systemic family therapy (15 fortnightly sessions) should be considered where first line psychological treatments with fluoxetine have been tried and failed, or where the child/young person or their families have expressed a preference not to use fluoxetine. [B]

1.6.4 How to use antidepressants in children and young people

All antidepressants have significant risks when given to children and young people with depression and, with the exception of fluoxetine, there is little evidence that they are effective in this context. Although fluoxetine can cause significant adverse reactions, fluoxetine is safer when combined with psychological treatments. The following guidance outlines how fluoxetine should be used, and suggests possible alternatives in the event that fluoxetine is ineffective or not tolerated because of side effects.

1.6.4.1 Antidepressant medication should not be offered to children and young people with moderate to severe depression except in combination with a concurrent psychological treatment. If
psychological treatment is declined, specific arrangements must be made for careful monitoring of adverse events. [B]

1.6.4.2 If an antidepressant is to be prescribed it should only be following assessment and diagnosis by a child and adolescent psychiatrist. [C]

1.6.4.3 When an antidepressant is prescribed to children and young people with moderate to severe depression, it should be fluoxetine as this is the only antidepressant where clinical trial evidence shows that benefits outweigh risks. [A]

1.6.4.4 Children and young people started on antidepressant medication should be informed about the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible side effects, and the need to take the medication as prescribed. Discussion of these issues should be supplemented by written information appropriate to the child/young person’s and family’s needs. This should include a copy of the advice from the Committee on Safety of Medicines. [GPP]

1.6.4.5 Children and young people prescribed antidepressants should be monitored for agitation, suicidal ideation and self-harm by the prescribing doctor and the professional delivering the psychological intervention. Patients and their families should be informed that if there is any sign of new symptoms of these kinds, urgent contact should be made with the prescribing doctor. [GPP]

1.6.4.6 When an antidepressant is prescribed in the treatment of children and young people with depression, as an adjunct to clinical judgment a patient’s progress may be monitored using a recognised self-report rating scale for depression such as the Mood and Feelings Questionnaire. [GPP]
1.6.4.7 Where children/young people respond to treatment with fluoxetine, medication should be continued for at least 6 months post recovery (no symptoms and full functioning for at least 8 weeks). [C]

1.6.4.8 If treatment with fluoxetine is unsuccessful or is not tolerated because of side effects, consideration should be given to the use of another antidepressant. In this case sertraline or citalopram are the recommended second line treatments. [A]

1.6.4.9 Sertraline and citalopram should only be used when the following criteria have been met:

- The child/young person and their carers have been fully involved in discussions about the likely benefits and risks of the new treatment and have been provided with appropriate written information including the advice from the Committee on Safety of Medicines

- The child/young person's depression is sufficiently severe and/or causing sufficiently serious symptoms (e.g. weight loss or suicidal behaviour) to justify a trial of another antidepressant

- There is clear evidence that there has been a fair trial of the combination of fluoxetine and a psychological intervention (i.e. that all efforts have been made to ensure adherence to the recommended treatment regime)

- There has been a reassessment of the likely causes of the depression and of treatment resistance (e.g. other diagnoses such as bipolar disorder, substance abuse etc.)

- There has been a review by a senior child and adolescent psychiatrist – usually a consultant

- The child/young person and/or someone with parental responsibility for the child and young person (or the young person alone, if over 16 or deemed competent) has signed an appropriate and valid consent form. [C]
1.6.4.10 Where children/young people respond to treatment with citalopram or sertraline, medication should be continued for at least 6 months post recovery (no symptoms and full functioning for at least 8 weeks). [C]

1.6.4.11 Paroxetine and venlafaxine should not be used for the treatment of depression in children and young people. [A]

1.6.4.12 Where antidepressant medication is to be discontinued, the drug should be phased out over a period of 6 to 12 weeks with the exact timing being titrated against response. [C]

1.6.4.13 As with all other medications, consideration should be given to possible drug interactions when prescribing medication for depression in children and young people. This should include possible interactions with complementary and alternative medicines as well as with alcohol and 'recreational' drugs. [GPP]

1.6.5 The treatment of psychotic depression

1.6.5.1 For children/young people with psychotic depression, augmenting the current treatment plan with antipsychotic medication should be considered, although the optimum dose and duration of treatment are unknown. [C]

1.6.5.2 Children/young people prescribed antipsychotic medication should be monitored carefully for side effects. [C]

1.6.6 Inpatient care

Inpatient treatment for children and young people with depression should only be considered when the patient is at significant risk of harm to self, and/or needs intensive treatment or supervision not available elsewhere. The following guidance outlines the use of inpatient facilities.
1.6.6.1 Inpatient treatment should be considered for children and young people who present with a high risk of suicide, serious self-harm, self-neglect, and/or when the intensity of treatment (or supervision) needed is not available elsewhere, or when intensive assessment is indicated. [C]

1.6.6.2 When considering admission for a child or young person with depression, the benefits of inpatient treatment need to be balanced against potential detrimental effects, for example loss of family and community support. [C]

1.6.6.3 When inpatient treatment is indicated, professionals need to involve the child or young person and their family in the admission and treatment process whenever possible. [B]

1.6.6.4 Commissioners and strategic health authorities should ensure that inpatient treatment should be available within reasonable traveling distance to enable the involvement of families and maintain social links. [B]

1.6.6.5 Inpatient services need to have a range of treatments available including medication, individual and group psychological interventions and family support. [C]

1.6.6.6 Inpatient facilities should be age-appropriate with the capacity to provide appropriate educational and related activities. [C]

1.6.6.7 Planning for after care arrangements should take place prior to admission or as early as possible during an admission and should be based on the Care Programme Approach. [GPP]

1.6.6.8 Those professionals (tier 4 CAMHS staff) involved in assessing children or young people for possible inpatient admission should be specifically trained in issues of consent and capacity, the use of current mental health legislation, and the use of Child Care Laws, as they apply to this group of patients. [GPP]
1.6.7 Electroconvulsive therapy (ECT)

ECT should be reserved for life threatening depressions unresponsive to other treatments in young people. If it is used, ECT should be used in accordance with NICE guidance. ECT is not recommended for children (5 to 11 years)

1.6.7.1 Electroconvulsive therapy (ECT) may be considered for young people with either life-threatening symptoms (e.g. suicidal behaviour) or intractable symptoms unresponsive to other treatments. [C]

1.6.7.2 Electroconvulsive therapy should be used extremely rarely with young people and only after careful assessment by a practitioner experienced in its use and only in a specialist environment in accordance with NICE recommendations. [C]

1.6.7.3 ECT should not be used in the treatment of depression in children (5 to 11 years). [C]

1.6.8 Discharge after a first episode

After full recovery, children and young people who have been depressed should be followed up for a year. After discharge, those re-referred should be seen quickly and should not be placed on a routine waiting list.

1.6.8.1 When a child or young person is in remission (less than two symptoms and full functioning for at least 8 weeks) they should be reviewed regularly for 12 months by an experienced CAMHS professional. The exact frequency of contact should be agreed between the CAMHS professional and service user and/or carer and recorded in the notes. At the end of this period if recovery is maintained the young person can be discharged to primary care. [C]

1.6.8.2 Children and young people who have been successfully treated, discharged but re-referred should be seen as soon as possible rather than placed on a routine waiting list. [GPP]
1.6.9 Recurrent depression and relapse prevention

Those at high risk of relapse, including those with recurrent depression, may benefit from an extended period of psychological treatment, practical help to self-monitor symptoms of relapse, should be followed up for at least 2 years after recovery, and be seen urgently if they are re-referred.

1.6.9.1 In children and young people who are at a high risk of relapse (e.g. individuals who have already experienced two prior episodes, individuals who have high levels of subsyndromal symptoms, or those who remain exposed to multiple risk circumstances), it may be of benefit to offer specific follow-up psychological treatment sessions to reduce the likelihood of, or at least detect, a relapse of depressed state. [B]

1.6.9.2 CAMHS specialists should teach recognition of illness signatures and other early warning signs to other professionals, the children/young person with recurrent depression and their families. Self-management techniques may help individuals to avoid and/or cope with trigger factors. [GPP]

1.6.9.3 When a child or young person with recurrent depression is in remission (less than two symptoms and full functioning for at least 8 weeks) they should be reviewed regularly for 24 months by an experienced CAMHS professional. The exact frequency of contact should be agreed between the CAMHS professional and service user and/or carer and recorded in the notes. At the end of this period if recovery is maintained the young person can be discharged to primary care. [C]

1.6.9.4 Children and young people with recurrent depression who have been successfully treated, discharged but re-referred should be seen as a matter of urgency. [GPP]
2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation; it is available from http://www.nice.org.uk/page.aspx?o=87925

This guideline is relevant to children and young people aged 5 – 18 years with depression, and to all healthcare professionals involved in the help, treatment and care of children and young people with depression and their carers. These include:

- professional groups (including general practitioners, psychiatrists, clinical psychologists, psychotherapists, mental health, community psychiatric and practice nurses, secondary care professionals, occupational therapists and physicians) who share in the treatment and care of people with a diagnosis of depression
- professionals in other health and non-health sectors who may have direct contact with, or are involved in the provision of health and other public services for, children and young people diagnosed with depression; this may include staff from schools and other educational settings, paediatric and community child health, social services, the voluntary sector and youth offending and criminal justice teams
- those with responsibility for planning services for children and young people with depression and their carers – including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address:

- children 4 years of age and under and adults 19 years of age and over
- bipolar disorder
• how learning disabilities and challenging behaviour moderate the effect of various interventions
• the specific management of patients with other physical or psychiatric conditions (co-morbidities).

3 Implementation in the NHS

3.1 In general
Local health communities should review their existing practice in the treatment and management of depression against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1, the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the National Service Framework for Children, which is available for England from www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation/fs/en, and for Wales from www.wales.nhs.uk/sites/home.cfm?orgid=441.

3.2 Audit
Suggested audit criteria are listed in Appendix D. These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Key research recommendations
The Guideline Development Group identified the following key research recommendations to address gaps in the evidence base:

[To be included in second consultation draft]
5 Other versions of this guideline

*Full guideline*

The National Institute for Clinical Excellence commissioned the development of this guidance from the National Collaborating Centre for Mental Health. The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline *Depression in Children: the identification and management of depression in children and young people in primary, community and secondary care* will be published by the National Collaborating Centre for Mental Health; it will be available from its website ([URL to be added]), from the NICE website (www.nice.org.uk) and on the website of the National Electronic Library for Health (www.nelh.nhs.uk).

The members of the Guideline Development Group are listed in Appendix B. Information about the independent Guideline Review Panel is given in Appendix C.

The booklet *The Guideline Development Process – An Overview for Stakeholders, the Public and the NHS* has more information about the Institute’s guideline development process. It is available from the Institute’s website and copies can also be ordered by telephoning 0870 1555 455 (quote reference N0472).

*Information for the public*

A version of this guideline for children and young people with depression, their advocates and carers, and for the public is available from the NICE website (www.nice.org.uk/CGxxxpublicinfo) or from the NHS Response Line (0870 1555 455; quote reference number N0xxx for an English version and N0xxx for an English and Welsh version). This is a good starting point for explaining to patients the kind of care they can expect.
Quick reference guide

A quick reference guide for healthcare professionals is also available from the NICE website (www.nice.org.uk/CGxxxquickrefguide) or from the NHS Response Line (0870 1555 455; quote reference number N0xxx).

[Note: these details will apply when the guideline is published.]

6 Related NICE guidance


NICE is in the process of developing the following guidance:

- Depression: management of depression in primary and secondary care. Clinical Guideline 23. (Publication to be confirmed.)
- Anxiety: management of generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults in primary, secondary and community care. Clinical Guideline 22. (Publication to be confirmed.)

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7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.
Appendix A: Grading scheme

All evidence was classified according to an accepted hierarchy of evidence that was originally adapted from the US Agency for Healthcare Policy and Research Classification (see Table 1). Recommendations were then graded A to C on the basis of the level of associated evidence or noted as a GPP or NICE recommendation (see Table 1) – this grading scheme is based on a scheme formulated by the Clinical Outcomes Group of the NHS Executive (1996).

Table 1 Hierarchy of evidence and recommendation grading scheme

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of evidence</th>
<th>Grade</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials</td>
<td>A</td>
<td>At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation.</td>
</tr>
<tr>
<td>IIa</td>
<td>Evidence obtained from at least one well-designed controlled study without randomisation</td>
<td>B</td>
<td>Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence.</td>
</tr>
<tr>
<td>IIb</td>
<td>Evidence obtained from at least one other well-designed quasi-experimental study</td>
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<tr>
<td>III</td>
<td>Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case studies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from expert committee reports or opinions and/or clinical experiences of respected authorities</td>
<td>C</td>
<td>Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GPP</td>
<td>Recommended good practice based on the clinical experience of the GDG.</td>
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<td></td>
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<td>NICE</td>
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</tbody>
</table>

Appendix B: The Guideline Development Group

Professor Peter Fonagy
Freud Memorial Professor of Psychoanalysis
Chief Executive, The Anna Freud Centre
Chair, Guideline Development Group

Dr Tim Kendall
Co-Director, The National Collaborating Centre for Mental Health
Deputy Director, Royal College of Psychiatrists’ Research Unit
Medical Director and Consultant Psychiatrist, Sheffield Care Trust
Facilitator, Guideline Development Group

Mr Peter Attwood
Social Worker and Family Therapist
Section Manager, Lewisham CAMHS, South London & Maudsley NHS Trust

Mr Peter Blackman
Chief Executive Officer, The Afiya Trust
Service User Representative

Ms Ellen Boddington
Research Assistant, The National Collaborating Centre for Mental Health

Dr Dick Churchill
GP & Senior Lecturer in Primary Care, University of Nottingham

Ms Michelle Clark
Project Manager (From February 03 – August 03)

Dr Andrew Cotgrove
Clinical Director & Consultant in Adolescent Psychiatry, Pine Lodge Young People’s Centre, Chester

Professor David Cottrell
Professor of Child and Adolescent Psychiatry, University of Leeds

Ms Charlotte Dodds
Depression Support Group Co-Facilitator, Self-help Services, Big Life Company
Mother/Carer of Depressed Child
Professor Ian Goodyer
Professor of Child & Adolescent Psychiatry, University of Cambridge

Mr Ricky Emanuel
Consultant Child and Adolescent Psychotherapist, Royal Free Hospital, London
Clinical Lead, Camden Child and Adolescent Mental Health Service

Dr Peter Fuggle
Consultant Clinical Psychologist
Chair, Faculty for Children and Young People, Division of Clinical Psychology, British Psychological Society
CAMHS Services Manager, Islington Primary Care Trust

The Late Professor Richard Harrington
Professor of Child and Adolescent Psychiatry, Royal Manchester Children’s Hospital

Ms Alison Hunter
Project Manager (November 03 – July 04), The National Collaborating Centre for Mental Health

Mr Christopher Jones
Health Economist, The National Collaborating Centre for Mental Health

Ms Rebecca King
Project Manager (September 03 – November 03 & July 04 to date), The National Collaborating Centre for Mental Health

Mrs Sharon Leighton
Nurse Consultant in Child & Adolescent Mental Health, South Staffordshire Healthcare NHS Trust

Ms Catherine Lowenhoff
Nurse Consultant, North Essex Mental Health Partnership NHS Trust

Ms Amelia Mustapha
Fundraising, Marketing and Communications Manager, Depression Alliance

Service user representative

Dr Mary Target
Psychoanalyst and Clinical Psychologist
Reader in Psychoanalysis, University College London
Professional Director, The Anna Freud Centre, London

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Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, health professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

**Member**

Dr Chaand Nagpaul  
GP, Stanmore

Mr John Seddon  
Patient Representative

Professor Kenneth Wilson  
Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust

Dr Paul Rowlands  
Consultant Psychiatrist, Derbyshire Mental Health Services Mental Health Care Trust

Dr Roger Paxton  
R&D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust
Appendix D: Audit criteria

Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- Children and young people with depression are involved in their care
- Treatment options are appropriately offered and provided for children and young people with depression

People who could be included in an audit

A single audit could include all children and young people with depression. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- a sample of children or young people from particular populations in primary care

Measures that could be used as a basis for an audit

Please see tables overleaf.
### Assessment and co-ordination of care

When assessing a child/young person with depression, healthcare professionals should routinely consider, and record in the notes, the psychological and co-morbid factors, and the social, educational and family context for the patient and family members, including the quality of interpersonal relationships, both between the patient and other family members, and with their friends and peers.

#### Clinical notes include information concerning
- life events
- associated psychological factors
- co-morbid conditions
- family context
- school context
- social context
- family relationships
- peer relationships

#### Case note audit of a random selection of children/young people with depression

Review of service protocols for the management of depression
<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment considerations in all settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionally trained therapists should provide the psychological treatment of clinically depressed young people wherever possible.</td>
<td>Services should agree minimum training criteria for staff engaging in psychological treatment Staff delivering psychological treatments should meet agreed minimum criteria</td>
<td>Review of service policies Survey of staff qualifications and CPD experience</td>
</tr>
<tr>
<td>Co-morbid diagnoses and social and educational problems should be assessed and treated, either in sequence or in parallel with the treatment for depression.</td>
<td>Clinical notes include information concerning • co-morbid conditions • social difficulties • educational problems</td>
<td>Case note audit of a random selection of children/young people with depression Review of service protocols for the management of depression</td>
</tr>
<tr>
<td>STANDARDS</td>
<td>CRITERIA</td>
<td>AUDIT METHODS</td>
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<tr>
<td>Where problems in these areas are identified in case notes, evidence should exist that discussion has taken place about intervention for identified problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention should be paid to the possible need for parents' own psychiatric problems (particularly depression) to be treated in parallel, if the child is to improve.</td>
<td>Clinical notes should record information concerning the assessment of parental mental health Where clinical notes indicate that parental mental health is of concern there should be a record of a discussion about referral to appropriate treatment services</td>
<td>Case note audit of a random selection of children/young people with depression</td>
</tr>
</tbody>
</table>
### Step 1 Detection and risk profiling

Healthcare professionals in primary care, in schools and other relevant community settings, should be trained to detect depressive symptoms, and to assess children and young people who may be at risk of depression. Training should include the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, physical, sexual or emotional abuse, co-morbid disorders, and a history of parental depression; the natural history of single loss events; the importance of multiple risk factors; ethnic and cultural factors; and factors known to be associated with high a

<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detection of depressive</td>
<td>Services should have training programmes for Tier 1 staff that address:</td>
<td>Review of service polices</td>
</tr>
<tr>
<td>symptoms</td>
<td>Detection of depressive symptoms</td>
<td>Review of service training records</td>
</tr>
<tr>
<td>Assessment of risk factors for</td>
<td>Assessment of risk factors for depression</td>
<td>Survey of Tier 1 staff perceptions of</td>
</tr>
<tr>
<td>depression</td>
<td>Culturally sensitive systems for detecting and supporting children/young</td>
<td>a) availability of training</td>
</tr>
<tr>
<td></td>
<td>people with depression</td>
<td>b) quality of training</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>risk of depression and other health problems, such as homelessness, refugee status and living in institutional settings.</td>
<td>See above</td>
<td>See above</td>
</tr>
<tr>
<td>CAMHS tier 2/3 should work with healthcare professionals in primary care, schools and other relevant community settings, to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed.</td>
<td>See above</td>
<td>See above</td>
</tr>
</tbody>
</table>

**Step 2 Recognition**

<table>
<thead>
<tr>
<th>Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing</th>
<th>Services should have training programmes for CAMHS staff across all tiers that address the</th>
<th>Review of service polices</th>
</tr>
</thead>
</table>

depressive conditions. The existing interviewer based instruments (e.g. Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose.

detection and diagnosis of depression in children/young people

Review of service training records
Survey of CAMHS staff perceptions of
a) availability of training
b) quality of training
Review of teaching methods used

**Step 3 Mild depression**

Antidepressant medication should not be used for the initial treatment of children and young people with mild depression.

Children/young people presenting with mild depression should not be prescribed antidepressant medication as a first line treatment

Children/young people prescribed antidepressants in primary care, child health or CAMHS could be identified using pharmacy records. Those identified could be surveyed to establish that other psychological treatments had been offered before the antidepressant was
### Steps 4 & 5 Moderate or severe depression

Children and young people with moderate to severe depression should be offered, as a first line treatment, a specific, brief (up to 15 sessions, over at least 15 weeks) psychological intervention (individual cognitive behaviour therapy, interpersonal therapy or family therapy).

<table>
<thead>
<tr>
<th>STANDARDS</th>
<th>CRITERIA</th>
<th>AUDIT METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychological treatments should be offered before medication</td>
<td>Review of service protocols for treatment of depression</td>
</tr>
<tr>
<td></td>
<td>Psychological treatments should be:</td>
<td>Review of service protocols for delivering psychological treatments</td>
</tr>
<tr>
<td></td>
<td>Time limited</td>
<td>Structured review of case notes of a random representative sample of children/young people with depression</td>
</tr>
<tr>
<td></td>
<td>Structured</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cognitive Behavioural therapy, Family therapy or Interpersonal therapy</td>
<td></td>
</tr>
<tr>
<td>STANDARDS</td>
<td>CRITERIA</td>
<td>AUDIT METHODS</td>
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</tr>
<tr>
<td>Antidepressant medication should not be offered to children and young people with moderate to severe depression except in combination with a concurrent psychological treatment. If psychological treatment is declined, specific arrangements must be made for careful monitoring of adverse events.</td>
<td>Children on antidepressant medication should have been offered psychological treatment. Where children/young people have been offered medication, systems must be in place for regular monitoring of side effects. Where children/young people are not receiving psychological treatment, regular meetings must be held (at least monthly in the first three months of treatment) to monitor side effects. Children/young people and their carers must have been informed of the risks as well as benefits of</td>
<td>Structured review of case notes of a random representative sample of children/young people with depression. Survey of users/carers to establish whether information about risks/ side effects has been provided.</td>
</tr>
<tr>
<td>STANDARDS</td>
<td>CRITERIA</td>
<td>AUDIT METHODS</td>
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<tr>
<td></td>
<td>antidepressant medication</td>
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</table>
Appendix E: Assessing the severity of depression in primary care

Key symptoms:

- persistent sadness or low (irritable) mood; and/or
- loss of interests or pleasure
- fatigue or low energy

At least one of these, most days, most of the time for at least 2 weeks.

If any of above present, ask about associated symptoms:

- poor or increased 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.

Then ask about past, family history, associated disability and availability of social support

1. Factors that favour general advice and watchful waiting:

- four or fewer of the above symptoms
- no past or family history
- social support available
- symptoms intermittent, or less than 2 weeks duration
- not actively suicidal
- little associated disability.

1 Whilst this is a well-documented feature it is not currently listed in ICD 10 diagnostic criteria.
2. Factors that favour more active treatment in primary care:
   - five or more symptoms
   - past history or family history of depression
   - low social support
   - suicidal thoughts
   - associated social disability.

3. Factors that favour referral to mental health professionals:
   - poor or incomplete response to two interventions
   - recurrent episode within one year of last one
   - patient or relatives request referral
   - self-neglect.

4. Factors that favour urgent referral to a psychiatrist:
   - actively suicidal ideas or plans
   - psychotic symptoms
   - severe agitation accompanying severe (7 or more) symptoms
   - severe self-neglect.

ICD-10 definitions
Mild depression: four symptoms
Moderate depression: five or six symptoms
Severe depression: seven or more symptoms, with or without psychotic features
Appendix F: Glossary

**Adherence:** The behaviour of taking medicine according to treatment dosage and schedule as intended by the prescriber. In this guideline, the term adherence is used in preference to the term compliance, but is not synonymous with concordance, which has a number of different uses/meanings.

**Adverse events:** Any undesirable experience that results in any of the following outcomes: death, a life-threatening experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect.

**Bipolar disorder:** This condition is also known as manic depression. It is an illness that affects mood, causing a person to switch between feeling very low (depression) and very high (mania).

**Care Programme Approach:** Introduced in 1991, this approach was designed to ensure that different community services are coordinated and work together towards a particular person’s care. This approach requires that professionals from the health authority and local authority get together to arrange care, and applies to all patients accepted for care by the specialist mental health services.

**Child:** an individual aged 5 to 11 years old

**Cognitive behavioural therapy (CBT):** Discrete, time-limited, structured psychological interventions, derived from the cognitive-behavioural model of affective disorders in which the patient: (1) works collaboratively with a therapist to identify the types and effects of thoughts, beliefs and interpretations on current symptoms, feelings states and/or problem areas; (2) develops skills to identify, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms/problems; and (3) learns a repertoire of coping skills appropriate to the target thoughts, beliefs and/or problem areas.
Committee on Safety of Medicines (CSM): The CSM is one of the independent advisory committees established under the Medicines Act (Section 4) which advises the UK Licensing Authority (Government Health Ministers) on the quality, efficacy and safety of medicines in order to ensure that appropriate public health standards are met and maintained.

Depression (major depressive disorder): The guideline uses the ICD-10 definition in which ‘an individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness after only slight effort is common. Other symptoms are: (a) reduced concentration and attention; (b) reduced self-esteem and self-confidence; (c) ideas of guilt and unworthiness (even in a mild type of episode); (d) bleak and pessimistic views of the future; (e) ideas or acts of self-harm or suicide; (f) disturbed sleep; (g) diminished appetite.’

Depression unresponsive to treatment: A term used to describe depression that has failed to respond to two or more antidepressants at an adequate dose for an adequate duration given sequentially.

Dysphoria: An emotional state characterised by malaise, anxiety, depression or unease.

Dysthymia: A chronic depression of mood which does not currently fulfil the criteria for recurrent depressive disorder, mild or moderate severity, in terms of either severity or duration of individual episodes. There are variable phases of mild depression and comparative normality. Despite tiredness, feeling down and not enjoying much, people with dysthymia are usually able to cope with every day life.

Electroconvulsive therapy (ECT): A therapeutic procedure in which an electric current is briefly applied to the brain to produce a seizure. This is used for treatment of severe depression symptoms or to ease depression that isn’t responding well to other forms of treatment. Sometimes called convulsive therapy, electroshock therapy or shock therapy.
Family therapy: Family sessions with a treatment function based on systemic, cognitive behavioural or psychoanalytic principles, which may include psychoeducational, problem-solving and crisis management work and specific interventions with the identified patient.


Guided self-help (GSH): A self-administered intervention designed to treat depression, which makes use of a range of books or a self-help manual that is based on an evidence-based intervention and is designed specifically for the purpose.

Guideline development group (GDG): The group of academic experts, clinicians and service user representatives responsible for developing the guideline.

Guideline implementation: Any intervention designed to support the implementation of guideline recommendations

Guideline recommendation: A systematically developed statement that is derived from the best available research evidence, using predetermined and systematic methods to identify and evaluate evidence relating to the specific condition in question.

Interpersonal psychotherapy: A discrete, time-limited, structured psychological intervention, derived from the interpersonal model of affective disorders that focuses on interpersonal issues and where: (1) therapist and patient work collaboratively to identify the effects of key problematic areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effects on current symptoms, feelings states and/or problems; (2) they seek to reduce symptoms by learning to cope with or resolve these interpersonal problem areas.

Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS): An interviewer led procedure for diagnostic assessment of depression including
the severity of current episode designed to be used by trained individuals with some clinical experience for use with participants aged 6 to 17 years.

**Mild depression:** The guideline uses the ICD-10 definition of 4-6 depressive symptoms.

**Moderate depression:** The guideline uses the ICD-10 definition of 7-9 depressive symptoms.

**Mood and Feelings Questionnaire for Children (MFQ -C):** A self-report measure used to screen for depression.

**Psychosis:** a condition in which an individual isn't in contact with reality. This can include: sensing things that aren't really there (hallucinations); having beliefs that aren't based on reality (delusions); problems in thinking clearly; and not realising that there is anything wrong with themselves (called 'lack of insight').

**Racial identity status:** An individual’s perception of himself or herself as belonging to a racial group; also the beliefs, morals and attitudes that one shares with a particular racial group in contrast with other groups. It has been suggested that racial identity is integral to personality and is a key dynamic factor in psychotherapeutic dyads.

**Recurrent depression:** the development of a depressive disorder in a person who has previously suffered from depression.

**Risk profiling:** A structured assessment and analysis of those factors in the child/young person’s environment and history that are known to increase the risk of depression.

**Screening:** Screening is defined by the guideline development group as a simple test performed on a large number of people to identify those who have depression.
Selective serotonin reuptake inhibitors (SSRIs): A class of antidepressant medications that increase the level of serotonin in the brain, a neurotransmitter believed to influence mood.

Self-help: Any activity or lifestyle choice that an individual makes in the belief that it will confer therapeutic benefit.

Sleep hygiene: Behavioural practices that promote continuous and effective sleep.

Stepped-care model: A sequence of treatment options to offer simpler and less expensive interventions first and more complex and expensive interventions if the patient has not benefited, based on locally-agreed protocols.

Stepped care: A considered, organised, co-ordinated approach to screening, assessment, treatment and onward referral by an individual practitioner, team or care provider organisation, within the parameters of defined protocols or pathways. These approaches may or may not be provided within the context of a fixed budget (for example, the Health Maintenance Organisation (HMO) in the USA). Primary Care Trusts are required to develop protocols for the treatment of depression in primary care within the National Service Framework for Mental Health. Screening as a separate activity will be covered in its own right.

Sub-syndromal depression (sub-threshold depression): Depression symptoms which fail to meet criteria for major depressive disorder. This is not covered by this guideline.

Suicidal ideation: Thoughts about suicide or of taking action to end one’s own life.

Tier 1 CAMHS: Primary care services including GP’s, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services.
Tier 2 CAMHS: Services provided by professionals relating to workers in primary care including clinical child psychologists, paediatricians, educational psychologists, child and adolescent psychiatrists, child and adolescent psychotherapists, community nurses/nurse specialists and family therapists.

Tier 3 CAMHS: Specialised services for more severe, complex or persistent disorders including child and adolescent psychiatrists, clinical child psychologists, nurses (community or in-patient), child psychotherapists, occupational therapists, speech and language therapists, art, music and drama therapists, family therapists.

Tier 4 CAMHS: Tertiary level services such as day units, highly specialised outpatient teams and in-patient units.

Watchful waiting: an intervention in which no active treatment is offered to the person with depression if in the opinion of the health professional the person may recover without a specific intervention. All such patients should be offered a follow up appointment.

Young person: an individual aged 12 to 18 years old.