NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Depression in children and young people: identification and management

Draft for consultation, January 2019

This guideline covers identifying and managing depression in children and young people aged between 5 and 18 years. Based on the stepped care model, it aims to improve recognition and assessment and promote effective treatments for mild, moderate and severe depression.

Who is it for?

- Healthcare professionals
- Commissioners and providers
- Children and young people with depression, their families and carers

This guideline will update NICE guideline CG28 (published September 2005).

We have reviewed the evidence on psychological therapies for depression. You are invited to comment on the new and updated recommendations. These are marked as **[2019]**.

You are also invited to comment on recommendations that NICE proposes to delete from the 2005 guideline.

We have not reviewed the evidence for the recommendations shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See update information for a full explanation of what is being updated.

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the 2019 recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. Full details of the evidence and the committee's discussion on the 2019 recommendations are in the evidence reviews. Evidence for the 2005 recommendations is in the full version of the 2005 guideline.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Care of all children and young people with depression

Good information, informed consent and support

1.1.1 Children and young people and their families need good information, given as part of a collaborative and supportive relationship with healthcare professionals, and need to be able to give fully informed consent. **[2005]**

1.1.2 Healthcare professionals involved in the detection, assessment or treatment of children or young people with depression should ensure that information is provided to the patient and their parent(s) and carer(s) at an appropriate time. The information should be age appropriate and should cover the nature, course and treatment of depression, including the likely side effect profile of medication should this be offered. **[2005]**

1.1.3 Healthcare professionals involved in the treatment of children or young people with depression should take time to build a supportive and collaborative relationship with both the patient and the family or carers. **[2005]**

1.1.4 Healthcare professionals should make all efforts necessary to engage the child or young person and their parent(s) or carer(s) in treatment decisions, taking full account of patient and parental/carer expectations, so that the patient and their parent(s) or carer(s) can give meaningful and properly informed consent before treatment is initiated. **[2005]**

1.1.5 Families and carers should be informed of self-help groups and support groups and be encouraged to participate in such programmes where appropriate. **[2005]**

Language and black, Asian and minority ethnic groups

1.1.6 Where possible, all services should provide written information or audiotaped material in the language of the child or young person and their family or carer(s), and professional interpreters should be sought for those whose preferred language is not English. **[2005]**

1.1.7 Consideration should be given to providing psychological therapies and information about medication and local services in the language of the child or young person and their family or carers where the patient's and/or their family's or carer's first language is not English. If this is not possible, an interpreter should be sought. **[2005]**

1.1.8 Healthcare professionals in primary, secondary and relevant community settings should be trained in cultural competence to aid in the diagnosis and treatment of depression in children and young people from black, Asian and 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. **[2005]**

1.1.9 Healthcare professionals working with interpreters should be provided with joint training opportunities with those interpreters, to ensure that both healthcare professionals and interpreters understand the specific requirements of interpretation in a mental health setting. **[2005]**

1.1.10 The development and evaluation of services for children and young people with depression should be undertaken in collaboration with stakeholders involving patients and their families and carers, including members of black, Asian and minority ethnic groups. **[2005]**

Assessment and coordination of care

1.1.11 When assessing a child or young person with depression, healthcare professionals should routinely consider, and record in the patient's notes, potential comorbidities, 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. **[2005]**

1.1.12 In the assessment of a child or young person with depression, healthcare professionals should always ask the patient and their parent(s) or carer(s) directly about the child or young person's alcohol and drug use, any experience of being bullied or abused, self-harm and ideas about suicide. A young person should be offered the opportunity to discuss these issues initially in private. **[2005]**

1.1.13 If a child or young person with depression presents acutely having self-harmed, the immediate management should follow NICE's guideline on self-harm as this applies to children and young people, paying particular attention to the guidance on consent and capacity. Further management should then follow this depression guideline. **[2005]**

1.1.14 In the assessment of a child or young person with depression, healthcare professionals should always ask the patient, and be prepared to give advice, about self-help materials or other methods used or considered potentially helpful by the patient or their parent(s) or carer(s). This may include educational leaflets, helplines, self-diagnosis tools, peer, social and family support groups, complementary therapies, and faith groups. **[2005]**

1.1.15 Healthcare professionals should only recommend self-help materials or strategies as part of a supported and planned package of care. **[2005]**

1.1.16 For any child or young person with suspected mood disorder, a family history should be obtained to check for unipolar or bipolar depression in parents and grandparents. **[2005]**

1.1.17 When a child or young person has been diagnosed with depression, consideration should be given to the possibility of parental depression, parental substance misuse, or other mental health problems and associated problems of living, as these are often associated with depression in a child or young person and, if untreated, may have a negative impact on the success of treatment offered to the child or young person. **[2005]**

1.1.18 When the clinical progress of children and young people with depression is being monitored in secondary care, the self-report Mood and Feelings Questionnaire (MFQ) should be considered as an adjunct to clinical judgement. **[2005]**

1.1.19 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. **[2005]**

1.1.1.1 The form of assessment should take account of cultural and ethnic variations in communication, family values and the place of the child or young person within the family. **[2005]**

The organisation and planning of services[1]

1.1.20 Healthcare professionals specialising in depression in children and young people should work with local child and adolescent mental health services (CAMHS) to enhance specialist knowledge and skills regarding

[1] The terminology concerning tier 2 or 3 CAMHS is under revision and may change in the future in line with NHS England's Future in Mind policy.

depression in these existing services. This work should include providing training and help with guideline implementation. **[2005]**

1.1.21 CAMHS and local healthcare commissioning organisations should consider introducing a primary mental health worker (or CAMHS link worker) into each secondary school and secondary pupil referral unit as part of tier 2 provision within the locality. **[2005]**

1.1.22 Primary mental health workers (or CAMHS link workers) should establish clear lines of communication between CAMHS and tier 1 or 2, with named contact people in each tier or service, and develop systems for the collaborative planning of services for young people with depression in tiers 1 and 2. **[2005]**

1.1.23 CAMHS and local healthcare commissioning organisations should routinely monitor the rates of detection, referral and treatment of children and young people, from all ethnic groups, with mental health problems, including those 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. **[2005]**

1.1.24 All healthcare and CAMHS professionals should routinely use, and record in the notes, appropriate outcome measures (such as those self-report measures used in screening for depression or generic outcome measures used by particular services, for example Health of the Nation Outcome Scale for Children and Adolescents [HoNOSCA] or Strengths and Difficulties Questionnaire [SDQ]), 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. **[2005]**

Treatment and considerations in all settings

1.1.25 Most children and young people with depression should be treated on an outpatient or community basis. **[2005]**

1.1.26 Before any treatment is started, healthcare professionals should assess, together with the young person, the social network around him or her. This should include a written formulation, identifying factors that may have contributed to the development and maintenance of depression, and that may impact both positively or negatively on the efficacy of the treatments offered. The formulation should also indicate ways that the healthcare professionals may work in partnership with the social and professional network of the young person. **[2005]**

1.1.27 When bullying is considered to be a factor in a child or young person's depression, CAMHS, primary care and educational professionals should work collaboratively to prevent bullying and to develop effective antibullying strategies. **[2005]**

1.1.28 Psychological therapies used in the treatment of children and young people with depression should be provided by therapists who are also trained in child and adolescent mental health. **[2005]**

1.1.29 Psychological therapies used in the treatment of children and young people with depression should be provided by healthcare professionals who have been trained to an appropriate level of competence in the specific modality of psychological therapy being offered. **[2005]**

1.1.30 Therapists should develop a treatment alliance with the family. If this proves difficult, consideration should be given to providing the family with an alternative therapist. **[2005]**

1.1.31 Comorbid diagnoses and developmental, social and educational problems should be assessed and managed, either in sequence or in parallel, with the treatment for depression. Where appropriate this should be done through consultation and alliance with a wider network of education and social care. **[2005]**

1.1.32 Attention should be paid to the possible need for parents' own psychiatric problems (particularly depression) to be treated in parallel, if the child or

young person's mental health is to improve. If such a need is identified, then a plan for obtaining such treatment should be made, bearing in mind the availability of adult mental health provision and other services. **[2005]**

1.1.33 A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to 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. **[2005]**

1.1.34 A child or young person with depression should be offered advice about sleep hygiene and anxiety management. **[2005]**

1.1.35 A child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet. **[2005]**

1.2 Stepped care

The stepped-care model of depression draws attention to the different needs of children and young people with depression – 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 that support both healthcare professionals and patients and their parent(s) or carer(s) in identifying and accessing the most effective interventions (see Table 1).

Table 1 The stepped-care model[2]

Focus	Action	Responsibility
Detection	Risk profiling	Tier 1
Recognition	Identification in presenting children or young people	Tiers 2–4
Mild depression (including dysthymia)	Watchful waiting Digital CBT or group therapy (CBT or IPT or mindfulness) If needs not met, individual CBT or family therapy	Tier 1 Tier 1 or 2
Moderate to severe depression	Individual CBT or family therapy +/– fluoxetine If needs not met, brief psychosocial intervention or psychodynamic psychotherapy or IPT plus parent sessions +/– fluoxetine	Tier 2 or 3
Depression unresponsive to treatment/recurrent depression/psychotic depression	Intensive psychological therapy +/– fluoxetine, sertraline, citalopram, augmentation with an antipsychotic	Tier 3 or 4
CBT, cognitive–behavioural therapy; IPT, interpersonal psychotherapy.		

The guidance follows these five steps.

1. Detection and recognition of depression and risk profiling in primary care and community settings.

2. Recognition of depression in children and young people referred to CAMHS.

[2] The terminology concerning tier 2 or 3 CAMHS is under revision and may change in the future in line with NHS England's Future in Mind policy.

3. Managing recognised depression in primary care and community settings – mild depression.

4. Managing recognised depression in tier 2 or 3 CAMHS – moderate to severe depression.

5. Managing recognised depression in tier 3 or 4 CAMHS – unresponsive, recurrent 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

Detection and risk profiling

1.3.1 Healthcare professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression, 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, comorbid disorders, including drug and alcohol use, 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. **[2005]**

1.3.2 Healthcare professionals in primary care, 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') that may be encountered in children and young people following recent undesirable events. **[2005]**

1.3.3 Healthcare professionals in primary care settings should be familiar with screening for mood disorders. They should have regular access to specialist supervision and consultation. **[2005]**

1.3.4 Healthcare professionals in primary care, schools and other relevant community settings who are providing support for a child or young person with situational dysphoria should consider ongoing social and environmental factors if the dysphoria becomes more persistent. **[2005]**

1.3.5 Child and adolescent mental health services (CAMHS) tier 2 or 3 should work with health and social care 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. **[2005]**

1.3.6 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 schools (particularly secondary schools), community paediatricians and GPs. **[2005]**

1.3.7 When a child or young person is exposed to a single recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience, healthcare professionals in primary care, schools and other relevant community settings should undertake an assessment of the risks of depression associated with the event and make contact with their parent(s) or carer(s) to help integrate parental/carer and professional responses. The risk profile should be recorded in the child or young person's records. **[2005]**

1.3.8 When a child or young person is exposed to a single recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience, in the absence of other risk factors for depression, healthcare professionals in primary care, schools and other

relevant community settings should offer support and the opportunity to talk over the event with the child or young person. **[2005]**

1.3.9 Following an undesirable event, a child or young person should not normally be referred for further assessment or treatment, as single events are unlikely to lead to a depressive illness. **[2005]**

1.3.10 A child or young person who has been exposed to a recent undesirable life event, such as bereavement, parental divorce or separation 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), 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. **[2005]**

1.3.11 When a child or young person is exposed to a recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience, and where one or more family members (parents or children) have multiple risk histories 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. **[2005]**

1.3.12 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 or 3 for rapid assessment. **[2005]**

Referral criteria

1.3.13 For children and young people, the following factors should be used by healthcare professionals as indications that management can remain at tier 1:

- exposure to a single 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, where one or more family members (parents or children) have multiple-risk histories for depression, providing that there is no evidence of depression and/or self-harm in the child or young person
- mild depression without comorbidity. **[2005]**

1.3.14 For children and young people, the following factors should be used by healthcare professionals as criteria for referral to tier 2 or 3 CAMHS:

- depression with two or more other risk factors for depression
- depression where one or more family members (parents or children) have multiple-risk histories for depression
- mild depression in those who have not responded to interventions in tier 1 after 2–3 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 1 month's duration that could be harmful to their physical health
- active suicidal ideas or plans
- referral requested by a young person or their parent(s) or carer(s). **[2005]**

1.3.15 For children and young people, the following factors should be used by healthcare professionals as criteria for referral to tier 4 services:

- high recurrent risk of acts of self-harm or suicide
- significant ongoing self-neglect (such as poor personal hygiene or significant reduction in eating that could be harmful to their physical health)

- requirement for intensity of assessment/treatment and/or level of supervision that is not available in tier 2 or 3. **[2005]**

1.4 Step 2: Recognition of depression in children and young people

1.4.1 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 as part of a general assessment procedure. **[2005]**

1.4.2 Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer-based instruments (such as Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose but will require modification for regular use in busy routine CAMHS settings. **[2005]**

1.4.3 Within tier 3 CAMHS, professionals who specialise in the treatment of depression should have been trained in interviewer-based assessment instruments (such as K-SADS and CAPA) and have skills in non-verbal assessments of mood in younger children. **[2005]**

1.5 Step 3: Managing mild depression

Watchful waiting

1.5.1 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’). **[2005]**

1.5.2 Healthcare professionals should make contact with children and young people with depression who do not attend follow-up appointments. **[2005]**

Treatments for mild depression

1.5.3 Antidepressant medication should not be used for the initial treatment of children and young people with mild depression. **[2005]**

1.5.4 Discuss the choice of psychological therapies with children and young people with mild depression and their family members or carers (as appropriate). Explain what the different therapies involve and how these could meet individual needs, preferences and values. **[2019]**

1.5.5 Base the choice of psychological therapy on:

- a full assessment of needs, including the circumstances of the child or young person and their carer(s), their clinical and personal/social history and presentation, their maturity and developmental level and the context in which treatment is to be provided
- patient and carer preferences and values (as appropriate). **[2019]**

1.5.6 Offer all children and young people with continuing mild depression (see recommendation 1.5.1), and without significant comorbid problems or active suicidal ideas or plans, a choice of the following psychological therapies for a limited period (approximately 2 to 3 months):

- digital CBT, **or**
- group therapy (CBT or interpersonal psychotherapy [IPT], **or** mindfulness). **[2019]**

1.5.7 If the options in recommendation 1.5.6 would not meet the child or young person's clinical needs, are unsuitable for their circumstances or are not available, offer the following:

- individual CBT, **or**
- family therapy. **[2019]**

1.5.8 Provide the therapies in settings such as primary care, schools, social services and the voluntary sector or in tier 2 child and adolescent mental health services (CAMHS)[3] **[2019]**

1.5.9 Refer to recommendations 1.1.28 and 1.1.29 for practitioner training and competency requirements. **[2019]**

1.5.10 If mild depression in a child or young person has not responded to psychological therapy after 2 to 3 months (see recommendations 1.5.6 and 1.5.7 and Table 1), refer the child or young person for review by a tier 2 or 3 CAMHS team. **[2019]**

1.5.11 Follow the recommendations on treating moderate to severe depression for children and young people who have continuing depression after 2 to 3 months of psychological therapy at tier 1 or 2 (see section 1.6 on moderate to severe depression). **[2019]**

To find out why the committee made the [2019] recommendations on treatments for mild depression and how they might affect practice, see rationale and impact.

1.6 Steps 4 and 5: Managing moderate to severe depression

Treatments for moderate to severe depression

1.6.1 Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS tier 2 or 3 team. **[2019]**

1.6.2 Discuss the choice of psychological therapies with children and young people with moderate to severe depression and their family members or carers (as appropriate). Explain what the different therapies involve and how these might meet individual needs, preferences and values. **[2019]**

1.6.3 Base the choice of psychological therapy on:

[3] The terminology concerning tier 2 or 3 CAMHS is under revision and may change in the future in line with NHS England's Future in Mind policy.

- a full assessment of needs, including the circumstances of the child or young person and their carer(s), their clinical and personal/social history and presentation, their maturity and developmental level and the context in which treatment is to be provided
- patient and carer preferences and values (as appropriate). **[2019]**

1.6.4 For children and young people with moderate to severe depression, offer a choice of the following psychological therapies for at least 3 months:

- individual CBT, **or**
- family therapy. **[2019]**

1.6.5 If the options in recommendation 1.6.4 would not meet the child or young person's clinical needs or are unsuitable for their circumstances, consider one of the following options:

- brief psychosocial intervention, **or**
- psychodynamic psychotherapy, **or**
- IPT plus parent sessions. **[2019]**

To find out why the committee made the [2019] recommendations on treatments for moderate to severe depression and how they might affect practice, see rationale and impact.

Combined treatments for moderate to severe depression

1.6.6 Consider combined therapy (fluoxetine[4] and psychological therapy) for initial treatment of moderate to severe depression in young people (12–18 years), as an alternative to psychological therapy followed by combined therapy and to recommendations 1.6.7 and 1.6.9. **[2015]**

[4] At the time of consultation (January 2019), fluoxetine did not have UK marketing authorisation for initial combination use (fluoxetine with psychological therapy) in children and young people who have not previously had a trial of psychological therapy on its own. For combined antidepressant treatment and psychological therapy as an initial treatment, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

1.6.7 If moderate to severe depression in a child or young person is unresponsive to psychological therapy after four to six treatment sessions, a multidisciplinary review should be carried out. **[2005]**

1.6.8 Following multidisciplinary review, if the child or young person's depression is not responding to psychological therapy as a result of other coexisting factors such as the presence of comorbid conditions, persisting psychosocial risk factors such as family discord, or the presence of parental mental ill-health, alternative or perhaps additional psychological therapy for the parent or other family members, or alternative psychological therapy for the patient, should be considered. **[2005]**

1.6.9 Following multidisciplinary review, offer fluoxetine[5] if moderate to severe depression in a young person (12–18 years) is unresponsive to a specific psychological therapy after 4 to 6 sessions. **[2015]**

1.6.10 Following multidisciplinary review, cautiously consider fluoxetine[6] if moderate to severe depression in a child (5–11 years) is unresponsive to a specific psychological therapy after 4 to 6 sessions, although the evidence for fluoxetine's effectiveness in this age group is not established. **[2015]**

Depression unresponsive to combined treatment

1.6.11 If moderate to severe depression in a child or young person is unresponsive to combined treatment with a specific psychological therapy and fluoxetine after a further six sessions, or the patient and/or their parent(s) or carer(s) 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 comorbid diagnoses, reassessment of the possible individual, family and

[5] At the time of consultation (January 2019), fluoxetine was the only antidepressant with UK marketing authorisation for use in this indication for children and young people aged 8 to 18.
[6] At the time of consultation (January 2019), fluoxetine did not have a UK marketing authorisation for use in children under the age of 8 years. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

social causes of depression, consideration of whether there has been a fair trial of treatment, and assessment for further psychological therapy for the patient and/or additional help for the family. **[2005]**

1.6.12 Following multidisciplinary review, the following should be considered:

- an alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term family therapy, of at least 3 months' duration), or
- systemic family therapy (at least 15 fortnightly sessions), or
- individual child psychotherapy (approximately 30 weekly sessions). **[2005]**

How to use antidepressants in children and young people

1.6.13 Do not offer antidepressant medication to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact with the child or young person and their parent(s) or carer(s) for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis, and recorded in the notes. In the event that psychological therapies are declined, medication may still be given, but as the young person will not be reviewed at psychological therapy sessions, the prescribing doctor should closely monitor the child or young person's progress on a regular basis and focus particularly on emergent adverse drug reactions. **[2015]**

1.6.14 If an antidepressant is to be prescribed this should only be following assessment and diagnosis by a child and adolescent psychiatrist. **[2005]**

1.6.15 When an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine[6] as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks. **[2005]**

1.6.16 If a child or young person is started on antidepressant medication, they (and their parent(s) or carer(s) as appropriate) 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 or young person's and parents' or carers' needs that covers the issues described above and includes the latest patient information advice from the relevant regulatory authority. **[2005]**

1.6.17 A child or young person prescribed an antidepressant should be closely monitored for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment, by the prescribing doctor and the healthcare professional delivering the psychological therapy. Unless it is felt that medication needs to be started immediately, symptoms that might be subsequently interpreted as side effects should be monitored for 7 days before prescribing. Once medication is started the patient and their parent(s) or carer(s) should be informed that if there is any sign of new symptoms of these kinds, urgent contact should be made with the prescribing doctor. **[2005]**

1.6.18 When fluoxetine[6] is prescribed for a child or young person with depression, the starting dose should be 10 mg daily. This can be increased to 20 mg daily after 1 week if clinically necessary, although lower doses should be considered in children of lower body weight. There is little evidence regarding the effectiveness of doses higher than 20 mg daily. However, higher doses may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority. **[2005]**

1.6.19 When an antidepressant is prescribed in the treatment of a child or young person with depression and a self-report rating scale is used as an adjunct to clinical judgement, this should be a recognised scale such as the Mood and Feelings Questionnaire (MFQ). **[2005]**

1.6.20 When a child or young person responds to treatment with fluoxetine[6], medication should be continued for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks); in other words, for 6 months after this 8-week period. **[2005]**

1.6.21 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[7]. **[2005]**

1.6.22 Sertraline or citalopram should only be used when the following criteria have been met[7].

- The child or young person and their parent(s) or carer(s) have been fully involved in discussions about the likely benefits and risks of the new treatment and have been provided with appropriate written information. This information should cover 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; it should also include the latest patient information advice from the relevant regulatory authority.
- The child or young person's depression is sufficiently severe and/or causing sufficiently serious symptoms (such as 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 therapy (in other words that all efforts have been made to ensure adherence to the recommended treatment regimen).

[7] At the time of consultation (January 2019), citalopram and sertraline are not licensed for use in children and young people under 18 for this indication. See the individual summary of product characteristics for further information. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

- There has been a reassessment of the likely causes of the depression and of treatment resistance (for example other diagnoses such as bipolar disorder or substance misuse).
- There has been advice from a senior child and adolescent psychiatrist – usually a consultant.
- The child or young person and/or someone with parental responsibility for the child or young person (or the young person alone, if over 16 or deemed competent) has signed an appropriate and valid consent form. **[2005]**

1.6.23 When a child or young person responds to treatment with citalopram or sertraline[7], medication should be continued for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks). **[2005]**

1.6.24 When an antidepressant other than fluoxetine[6] is prescribed for a child or young person with depression, the starting dose should be half the daily starting dose for adults. This can be gradually increased to the daily dose for adults over the next 2 to 4 weeks if clinically necessary, although lower doses should be considered in children with lower body weight. There is little evidence regarding the effectiveness of the upper daily doses for adults in children and young people, but these may be considered in older children of higher body weight and/or when, in severe illness, an early clinical response is considered a priority. **[2005]**

1.6.25 Paroxetine and venlafaxine should not be used for the treatment of depression in children and young people. **[2005]**

1.6.26 Tricyclic antidepressants should not be used for the treatment of depression in children and young people. **[2005]**

1.6.27 Where antidepressant medication is to be discontinued, the drug should be phased out over a period of 6 to 12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms. **[2005]**

1.6.28 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. **[2005]**

1.6.29 Although there is some evidence that St John's wort may be of some benefit in adults with mild to moderate depression, this cannot be assumed for children or young people, for whom there are no trials upon which to make a clinical decision. Moreover, it has an unknown side-effect profile and is known to interact with a number of other drugs, including contraceptives. Therefore St John's wort should not be prescribed for the treatment of depression in children and young people. **[2005]**

1.6.30 A child or young person with depression who is taking St John's wort as an over-the-counter preparation should be informed of the risks and advised to discontinue treatment while being monitored for recurrence of depression and assessed for alternative treatments in accordance with this guideline. **[2005]**

The treatment of psychotic depression

See also the NICE guideline on psychosis and schizophrenia in children and young people.

1.6.31 For children and young people with psychotic depression, augmenting the current treatment plan with a second-generation antipsychotic medication[8] should be considered, although the optimum dose and duration of treatment are unknown. **[2005]**

[8] At the time of consultation (January 2019), none of the second-generation antipsychotics were licensed for use in this indication for children and young people under 18. Licensed indications for the atypical antipsychotics vary and clinicians should refer to the individual summary of product characteristics for licensing information. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

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1.6.32 Children and young people prescribed a second-generation antipsychotic medication should be monitored carefully for side effects. **[2005]**

Inpatient care

1.6.33 Inpatient treatment should be considered for children and young people who present with a high risk of suicide, high risk of serious self-harm or high risk of self-neglect, and/or when the intensity of treatment (or supervision) needed is not available elsewhere, or when intensive assessment is indicated. **[2005]**

1.6.34 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. **[2005]**

1.6.35 When inpatient treatment is indicated, CAMHS professionals should involve the child or young person and their parent(s) or carer(s) in the admission and treatment process whenever possible. **[2005]**

1.6.36 Commissioners and strategic health authorities should ensure that inpatient treatment is available within reasonable travelling distance to enable the involvement of families and maintain social links. **[2005]**

1.6.37 Commissioners and strategic health authorities should ensure that inpatient services are able to admit a young person within an appropriate timescale, including immediate admission if necessary. **[2005]**

1.6.38 Inpatient services should have a range of interventions available including medication, individual and group psychological therapies and family support. **[2005]**

1.6.39 Inpatient facilities should be age appropriate and culturally enriching, with the capacity to provide appropriate educational and recreational activities. **[2005]**

1.6.40 Planning for aftercare arrangements should take place before admission or as early as possible after admission and should be based on the Care Programme Approach. **[2005]**

1.6.41 Tier 4 CAMHS professionals 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 childcare laws, as they apply to this group of patients. **[2005]**

Electroconvulsive therapy

1.6.42 ECT should only be considered for young people with very severe depression and either life-threatening symptoms (such as suicidal behaviour) or intractable and severe symptoms that have not responded to other treatments. **[2005]**

1.6.43 ECT should be used extremely rarely in 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. **[2005]**

1.6.44 ECT is not recommended in the treatment of depression in children (5–11 years). **[2005]**

Discharge after a first episode

1.6.45 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 the child or young person and/or the parent(s) or carer(s) and recorded in the notes. At the end of this period, if remission is maintained, the young person can be discharged to primary care. **[2005]**

1.6.46 CAMHS should keep primary care professionals up to date about progress and the need for monitoring of the child or young person in primary care. CAMHS should also inform relevant primary care

professionals within 2 weeks of a patient being discharged and should provide advice about whom to contact in the event of a recurrence of depressive symptoms. **[2005]**

1.6.47 Children and young people who have been successfully treated and discharged but then re-referred should be seen as soon as possible rather than placed on a routine waiting list. **[2005]**

Recurrent depression and relapse prevention

1.6.48 Specific follow-up psychological therapy sessions to reduce the likelihood of, or at least detect, a recurrence of depression should be considered for children and young people who are at a high risk of relapse (for example individuals who have already experienced two prior episodes, those who have high levels of subsyndromal symptoms, or those who remain exposed to multiple-risk circumstances). **[2005]**

1.6.49 CAMHS specialists should teach recognition of illness features, early warning signs, and subthreshold disorders to tier 1 professionals, children or young people with recurrent depression and their families and carer(s). Self-management techniques may help individuals to avoid and/or cope with trigger factors. **[2005]**

1.6.50 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 the child or young person and/or the parent(s) or carer(s) and recorded in the notes. At the end of this period, if remission is maintained, the young person can be discharged to primary care. **[2005]**

1.6.51 Children and young people with recurrent depression who have been successfully treated and discharged but then re-referred should be seen as a matter of urgency. **[2005]**

1.7 Transfer to adult services

1.7.1 The CAMHS team currently providing treatment and care for a young person aged 17 who is recovering from a first episode of depression should normally continue to provide treatment until discharge is considered appropriate in accordance with this guideline, even when the person turns 18 years of age. **[2005]**

1.7.2 The CAMHS team currently providing treatment and care for a young person aged 17–18 who either has ongoing symptoms from a first episode that are not resolving or has, or is recovering from, a second or subsequent episode of depression should normally arrange for a transfer to adult services, informed by the Care Programme Approach. **[2005]**

1.7.3 A young person aged 17–18 with a history of recurrent depression who is being considered for discharge from CAMHS should be provided with comprehensive information about the treatment of depression in adults (including the NICE 'Information for the public' version for adult depression) and information about local services and support groups suitable for young adults with depression. **[2005]**

1.7.4 A young person aged 17–18 who has successfully recovered from a first episode of depression and is discharged from CAMHS should not normally be referred on to adult services, unless they are considered to be at high risk of relapse (for example, if they are living in multiple-risk circumstances). **[2005]**

Recommendations for research

The 2005 guideline committee made the following recommendations for research (marked [2005]). The guideline committee's full set of research recommendations is detailed in the full guideline. The recommendations labelled [2015] were reviewed during the 2015 update by the standing committee, who decided to keep them in the guideline. As part of the 2015 update, the standing committee made an additional research recommendation on the combination of psychological therapy and

antidepressants. Details for this research recommendation can be found in the addendum.

As part of the 2019 update, the guideline committee made the following research recommendations (marked [2019]) on psychological interventions for children aged 5 to 11 years or for young people aged 12 to 18 years. Full details can be found in the evidence review.

Key recommendations for research

1 Group CBT for children aged 5 to 11 years with moderate to severe depression

What is the clinical and cost effectiveness, post treatment and at longer-term follow-up, of group cognitive–behavioural therapy (CBT) compared with other psychological therapies or a control in children aged 5 to 11 years with moderate to severe depression? **[2019]**

To find out why the committee made the research recommendation on group CBT for children aged 5 to 11 years with moderate to severe depression, see the rationale.

2 Brief psychosocial intervention delivered by practitioners other than psychiatrists and in other settings, including primary care

What is the clinical and cost effectiveness, post treatment and at longer-term follow-up, of a brief psychosocial intervention as reported by the IMPACT trial, but delivered by practitioners other than psychiatrists and in other settings, including primary care, to young people aged 12 to 18 years with moderate to severe depression? **[2019]**

To find out why the committee made the research recommendation on brief psychosocial intervention delivered by non-consultant psychiatrists, see the rationale.

3 Sequences of psychological interventions

What are the most effective sequences of psychological interventions for children and young people with mild or moderate to severe depression who do not benefit from an initial psychological intervention? **[2019]**

To find out why the committee made the research recommendation on sequences of psychological interventions, see the rationale.

4 Behavioural activation

What is the clinical and cost effectiveness, post treatment and at longer-term follow-up, of behavioural activation compared with other psychological therapies in young people aged 12 to 18 years with moderate to severe depression? **[2019]**

To find out why the committee made the research recommendation on behavioural activation, see the rationale.

5 IPT in combination with parent sessions

What is the clinical and cost effectiveness, post treatment and at longer-term follow-up, of interpersonal psychotherapy (IPT) with parent sessions compared with individual IPT without parent sessions or other psychological therapies in young people aged 12 to 18 years with moderate to severe depression? **[2019]**

To find out why the committee made the research recommendation on behavioural activation, see the rationale.

Other recommendations for research

Individual CBT, systemic family therapy and child psychodynamic psychotherapy

An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of family and social functioning as well as depression) and the cost effectiveness of individual CBT, systemic family therapy and child psychodynamic psychotherapy compared with each other and treatment as usual in a broadly based sample of children and young people diagnosed with moderate to severe depression (using minimal exclusion criteria). The trial should be

powered to examine the effect of treatment in children and young people separately and involve a follow‑up of 12 to 18 months (but no less than 6 months). **[2015]**

Combination therapy (fluoxetine and psychological therapy)

An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of family and social functioning as well as depression) and the cost effectiveness of fluoxetine, psychological therapy, the combination of fluoxetine and psychological therapy compared with each other and placebo in a broadly based sample of children and young people diagnosed with moderate to severe depression (using minimal exclusion criteria).The trial should be powered to examine the effect of treatment in children and young people separately and involve a follow up of 12 to 18 months (but no less than 6 months). **[2015]**

Guided self-help and computer CBT

An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of family and social functioning as well as depression) and the cost effectiveness of another self‑help intervention compared with computer CBT and treatment as usual in a sample of children and young people treated in primary care who have been diagnosed with depression. The trial should be powered to examine the effect of treatment in children and young people separately and involve a follow‑up of 12 to 18 months (but no less than 6 months). **[2015]**

Care pathway experience

A qualitative study should be conducted that examines the experiences in the care pathway of children and young people and their families (and perhaps professionals) in order to inform decisions about what the most appropriate care pathway should be. **[2005]**

Computer technology to assess mood and feelings

An appropriately designed study should be conducted to compare validated screening instruments for the detection of depression in children and young people. An emphasis should be placed on examining those that use computer technology and more child‑friendly methods of assessing current mood and feelings, and take

into account cultural and ethnic variations in communication, family values and the place of the child or young person within the family. **[2005]**

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Treatments for mild depression

Recommendations 1.5.4 to 1.5.11

Why the committee made the recommendations

To ensure that children and young people with depression and their families or carers (as appropriate) receive the best possible care and can take part in decision-making, the committee recommended that healthcare professionals explain the treatment options, what these are like in practice and how different psychological therapies might best suit individual clinical needs, preferences and values.

The committee recognised that some children and young people have difficulties accessing treatment because of lack of transport (particularly in rural areas), chaotic family lives, being in a young offender's institute or being in care. They agreed that the healthcare professional should not just think about clinical needs, but should take into account the child or young person's personal/social history, the current environment, the setting where the treatment will be provided as well as individual preferences and values.

Evidence for children aged 5 to 11 years was limited so the committee decided to make recommendations for all children and young people based on the evidence for 12- to 18-year-olds with mild depression. They agreed that the younger children would be directed to treatments that fitted their needs, and included consideration of developmental level and maturity in the recommendation for the choice of treatment to ensure that these issues were taken into account during the decision making process.

Analysis of the evidence showed that digital CBT (also known as online CBT or computer CBT), group therapies (group CBT, group interpersonal psychotherapy [IPT] and group mindfulness), individual CBT and family therapy reduced depression symptoms or improved functional status by the end of treatment compared with a waiting list control or no treatment. In some cases, these effects were also seen 6 months later, but information on long-term effects was not always available.

The committee agreed to base recommendations for psychological therapies on effectiveness, availability and cost. They envisaged that digital CBT would be more readily available than individual CBT, which might have long waiting lists. The average costs estimated for digital CBT and group therapy (CBT, IPT and mindfulness) were lower than those for individual CBT and family therapy. Therefore the committee agreed that a choice of digital CBT or group therapy (group CBT, group IPT or group mindfulness) should be offered first. They acknowledged that these options may not be suitable for everyone and that individual CBT or family therapy could be offered in these situations.

The committee agreed not to recommend non-directive supportive therapy (NDST) or guided self-help because:

- NDST was no more effective at reducing depression symptoms at the end of treatment than control and was less effective than group or digital CBT, group mindfulness, group IPT or family therapy at 6 months follow-up.

- Although guided self-help reduced depression symptoms at the end of treatment compared with waiting list control/no treatment, this was not sustained at 6 months follow-up. In addition, guided self-help was no more effective at reducing depression symptoms at the end of treatment, and less effective at 6 months follow-up, than the recommended group therapies (group CBT, group mindfulness, group IPT), digital CBT, individual CBT or family therapy.

The committee included a recommendation that provided information about some of the places that psychological therapies could be conducted, but the list is not meant to be exhaustive. They also included a link to other recommendations in the

guideline to ensure that the people administering these therapies were trained and competent.

The committee agreed that it was appropriate to refer children or young people who have continuing depression after 2 to 3 months of therapy to child and adolescent mental health services (CAMHS)[1] and to treat them based on the recommendations for moderate to severe depression. There was no new evidence to warrant changes to these recommendations, which were based on the 2015 guideline.

How the recommendations might affect practice

The recommendation for digital CBT or group therapy (CBT or IPT or mindfulness) for children and young people with mild depression is not likely to result in increased resource use. It may even result in lower resource use if these interventions reduce the need for intensive individual therapies. It is unclear how often digital CBT is used in current practice and therefore what the extent of the change could be. Individual NDST and guided self-help are no longer recommended. The net resource impact of the change in recommendation is unclear.

Return to recommendations

Treatments for moderate to severe depression

Recommendations 1.6.1 to 1.6.5

Why the committee made the recommendations

There was some evidence for psychological therapies for children aged 5 to 11 years with moderate to severe depression, but this included very few interventions. In the analysis of the evidence, none of the therapies were more effective than waiting list/no treatment for reducing depression symptoms at the end of treatment. However the committee agreed that treatment was important for these young children, so they made recommendations for this group based on the evidence for young people aged 12 to 18 years. In addition, the committee made a research recommendation for children aged 5 to 11 years with moderate to severe depression to try to provide more evidence about the effectiveness of group CBT and other psychological therapies. Information from trials of these therapies could be used to help make

specific recommendations for 5- to 11-year-olds in the future. The committee chose to focus on group CBT in the research recommendation because although it was no better at reducing depression symptoms than waiting list/no treatment, it was better than some of the other therapies and the only trial looking at this intervention was very small (with 21 participants).

As for mild depression, the committee agreed that children and young people and their families or carers should be empowered to take part in decision-making. Healthcare professional should also think about a number of key factors, including history, individual circumstances and the developmental level and maturity of the individual.

The committee made a recommendation to ensure that children and young people with moderate to severe depression are reviewed by specialist tier 2 or 3 child and adolescent mental health services (CAMHS)[1], where they can receive treatment suitable for this severity of depression.

In an analysis of a large body of evidence, individual CBT or family therapy were effective at improving functional status and reducing depression symptoms at the end of treatment compared with a waiting list control/no treatment. Individual CBT improved quality of life and reduced suicidal ideas at the end of treatment compared with control. It was also more effective at inducing remission at end of treatment than family therapy, NDST or relaxation. The committee agreed that individual CBT or family therapy should be the first psychological therapy offered.

Analysis of the evidence showed that IPT plus parent sessions increased functional status compared with individual CBT, NDST, relaxation, group CBT, individual IPT, group IPT and behavioural activation. However, because there was no effect on depression symptoms at the end of treatment and the results were based on a single study, the committee decided that IPT plus parent sessions could only be considered if individual CBT or family therapy are not suitable. They also included a research recommendation for IPT plus parent sessions compared to other psychological therapies to provide additional information to strengthen this recommendation.

IPT (without parent sessions) was not recommended because the evidence showed that although it increased functional status at the end of treatment compared to waiting list/no treatment or usual care, it did not have a corresponding effect on depression symptoms at this time point. In addition, it was less effective than IPT plus parent sessions at improving functional status at the end of treatment.

The analysis of the evidence showed that psychodynamic psychotherapy increased remission at the end of treatment compared with attention control or family therapy and relaxation. In addition, it was as effective as individual CBT across a range of outcomes and follow-up times. However, only 1 study included psychodynamic psychotherapy. The committee agreed that psychodynamic psychotherapy may be the most appropriate intervention in some cases and could be considered for some young people with depression.

The IMPACT trial[9] reported similar results for a brief psychosocial intervention (BPI), psychodynamic psychotherapy and individual CBT over a range of outcomes and follow-up times. The committee agreed that BPI could be considered as an alternative treatment when individual CBT or family therapy are unsuitable. But they acknowledged that further research would be helpful to determine the effectiveness of BPI when delivered by practitioners other than psychiatrists and in other settings such as primary care.

The committee also made a research recommendation to investigate the effectiveness of behavioural activation because this therapy may meet the specific needs of some children and young people with moderate to severe depression that are not already covered by the other recommended psychological therapies and the only evidence for this intervention came from a single small RCT that did not detect a difference between behavioural activation and usual care.

The committee made a recommendation to stimulate research into the most effective sequences of treatment for children and young people with mild or moderate to severe depression with no response to an initial psychological therapy. They did this

[9] Goodyer IM, Reynolds S, Barrett B, et al. (2017) Cognitive-behavioural therapy and short-term psychoanalytic psychotherapy versus brief psychosocial intervention in adolescents with unipolar major depression (IMPACT): a multicentre, pragmatic, observer-blind, randomised controlled trial. Health technology assessment 21(12), 1-94.

because some children and young people have no response to an initial psychological therapy and there was no evidence available to determine which psychological therapy would be most likely to be effective as a second-line treatment in these cases.

How the recommendations might affect practice

The recommendations are likely to result in an increased use of individual CBT and family therapy and a decrease in other individual therapies. Brief psychosocial intervention is not commonly delivered in current practice. While this represents a change in practice, it is a lower intensity intervention than other individual therapies and may therefore reduce resource use.

Full details of the evidence and the committee's discussion are in evidence review A: Psychological interventions for the treatment of depression.

Return to recommendations

Context

This guideline covers the identification and treatment of depression in children (5–11 years) and young people (12–18 years) in primary, community and secondary care. Depression is a broad diagnosis that can include different symptoms in different people. However, depressed mood or loss of pleasure in most activities, are key signs of depression. Depressive symptoms are frequently accompanied by symptoms of anxiety, but may also occur on their own. The International Statistical Classification of Diseases (ICD-10) uses an agreed list of 10 depressive symptoms, and divides depression into 4 categories: not depressed (fewer than 4 symptoms), mild depression (4 symptoms), moderate depression (5 to 6 symptoms), and severe depression (7 or more symptoms, with or without psychotic symptoms). For a diagnosis of depression, symptoms should be present for at least 2 weeks and every symptom should be present for most of the day.

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

- mild depression

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

However, it is not clear whether the severity of depression can be understood in a single symptom count. Family context, previous history, and the degree of associated impairment are all important in helping to assess depression. Because of this, it is important to assess how the child or young person functions in different settings (for example, at school, with peers and with family), as well as asking about specific symptoms of depression.

Safeguarding children

Remember that child maltreatment:

- is common
- can present anywhere, such as emergency departments and primary care or on home visits.

Be aware of or suspect abuse as a contributory factor to or cause of the symptoms or signs of depression in children. Abuse may also coexist with depression. See the NICE guideline on child maltreatment for clinical features that may be associated with maltreatment.

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see our web page on depression.

Update information

We have reviewed the evidence on psychological therapy for children and young people with depression.

Recommendations are marked **[2019]** if the evidence has been reviewed.

Recommendations that have been deleted or changed

We propose to delete some recommendations from the 2005 guideline. Table 2 sets out these recommendations and includes details of replacement recommendations. If there is no replacement recommendation, an explanation for the proposed deletion is given.

In recommendations shaded in grey and ending **2005**, we have not reviewed the evidence. In some cases minor changes have been made – for example, to update links, or bring the language and style up to date – without changing the intent of the recommendation. Minor changes are listed in table 3.

See also the previous NICE guideline and supporting documents.

1 Table 2 Recommendations that have been deleted

Recommendation in 2015 guideline	Comment
Discuss the choice of psychological therapies with children and young people and their family members or carers (as appropriate). Explain that there is no good-quality evidence that one type of psychological therapy is better than the others. (1.5.2.1)	This recommendation has been replaced following a review of the evidence carried out for the current update. Replaced by: Discuss the choice of psychological therapies with children and young people with mild depression and their family members or carers (as appropriate). Explain what the different therapies involve and how these could meet individual needs, preferences and values. (1.5.4)
Following a period of up to 4 weeks of watchful waiting, offer all children and young people with continuing mild depression and without significant comorbid problems or signs of suicidal ideation individual non-directive supportive therapy, group cognitive behavioural therapy (CBT) or guided self-help for a limited period (approximately 2 to 3 months). This could be provided by appropriately trained professionals in primary care, schools, social services and the voluntary sector or in tier 2 Child and Adolescent Mental Health Services (CAMHS). (1.5.2.2)	This recommendation has been replaced following a review of the evidence carried out for the current update. It has been replaced by recommendations 1.5.6 to 1.5.9 on mild depression.
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 or 3 CAMHS team. (1.5.2.3)	This recommendation has been replaced following a review of the evidence carried out for the current update. Replaced by: If mild depression in a child or young person has not responded to psychological therapy after 2 to 3 months (see recommendations 1.5.6 and 1.5.7 and Table 1), refer the child or young person for review by a tier 2 or 3 CAMHS team. (1.5.10)
The further treatment of children and young people with persisting mild depression unresponsive to treatment at tier 1 or 2 should follow the guidance for moderate to severe depression (see section 1.6 below). (1.5.2.5)	This recommendation has been replaced following a review of the evidence carried out for the current update. Replaced by: Follow the recommendations on treating moderate to severe depression for children and young people who have continuing depression after 2 to 3 months of psychological therapy at tier 1 or 2 (see section 1.6 on moderate to severe depression). (1.5.11)

Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. (1.6.1.2)	This recommendation has been replaced following a review of the evidence carried out for the current update. Replaced by recommendations 1.6.2 to 1.6.5.

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2 **Table 3 Minor changes to recommendation wording (no change to intent)**

Recommendation numbers in current guideline	Comment
1.1.8 and 1.1.10	Changed black and minority ethnic groups to black, Asian and minority ethnic groups
1.1.13	Updated the wording around the cross-reference
1.1.14	Changed religious and spiritual groups to faith groups
1.3.5	Changed to lower case first letters for child and adolescent mental health services
1.6.6	Updated the recommendation numbers in the cross-reference
1.6.22	Changed abuse to misuse
1.6.31	Changed atypical antipsychotic to second-generation antipsychotic
1.6.32	Changed atypical antipsychotic to second-generation antipsychotic

3

4 **[September 2017]:** Recommendation 1.1.28 was updated to clarify the training
5 needed for therapists. Recommendation 1.4.1 was updated to delete reference to a
6 preferred questionnaire as this is no longer relevant.

8