

Depression in children and young people: identification and management



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NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces CG28.

This guideline is the basis of QS48.

Overview

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

Who is it for?

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

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 parents and carers 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 parents or carers in treatment decisions, taking full account of patient and parental/carer expectations, so that the patient and their parents or carers 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 carers, 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 parents or carers 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 parents or carers. 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 Mental Capacity Act in young people
- the use of the Children Act. [2005, amended 2019]

1.1.20 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

1.1.21 Healthcare professionals specialising in depression in children and young people should work with local child and adolescent mental health services (CAMHS)^[1] to enhance specialist knowledge and skills regarding depression in these existing services. This work should include providing training and help with guideline implementation. [2005]

1.1.22 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^[1] provision within the locality. [2005]

1.1.23 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^[1]. [2005]

1.1.24 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]

- 1.1.25 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

- 1.1.26 Most children and young people with depression should be treated on an outpatient or community basis. [2005]
- 1.1.27 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]
- 1.1.28 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]
- 1.1.29 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]
- 1.1.30 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]

- 1.1.31 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]
- 1.1.32 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]
- 1.1.33 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]
- 1.1.34 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 3 sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. [2005]
- 1.1.35 A child or young person with depression should be offered advice about sleep hygiene and anxiety management. [2005]
- 1.1.36 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 parents or carers in identifying and accessing the most

effective interventions (see table 1).

Table 1 The stepped-care model

Focus	Action	Responsibility ¹
Detection	Risk profiling	Tier 1
Recognition	Identification in presenting children or young people	Tiers 2 to 4
Mild depression (including dysthymia)	<p>Watchful waiting</p> <p>Digital CBT, group CBT, group IPT or group NDST</p> <p>If shared decision making based on full assessment (including maturity and developmental level) indicates needs not met, individual CBT or attachment-based family therapy</p>	<p>Tier 1</p> <p>Tier 1 or 2</p>
Moderate to severe depression	<p>5- to 11-year-olds</p> <p>Family-based IPT, family therapy (family-focused treatment for childhood depression and systems integrative family therapy), psychodynamic psychotherapy, or individual CBT</p> <p>+/- fluoxetine</p> <hr/> <p>12- to 18-year-olds</p> <p>Individual CBT</p> <p>+/- fluoxetine</p> <p>If shared decision making based on full assessment (including maturity and developmental level) indicates needs not met, IPT-A, family therapy (attachment-based or systemic), brief psychosocial intervention or psychodynamic psychotherapy</p> <p>+/- fluoxetine</p>	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
Abbreviations: CBT, cognitive-behavioural therapy; IPT, interpersonal psychotherapy; IPT-A, IPT for adolescents; NDST, non-directive supportive therapy. ¹ June 2019 – terminology is under revision and may change in the future in line with NHS England's Future in Mind and the Care Quality Commission's report Are we listening . We have retained the tiers terminology and will revise this when we update the 2005 recommendations.		

The guidance follows these 5 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 Children and Young People's Mental Health Services (including CAMHS).
3. Managing recognised depression in primary care and community settings – mild depression.
4. Managing recognised depression in tier 2 or 3^[1] CAMHS – moderate to severe depression.
5. Managing recognised depression in tier 3 or 4^[1] 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

See also the recommendations on psychological and social issues in children and young people with

type 1 or type 2 diabetes in the NICE guideline on [diabetes \(type 1 and type 2\) in children and young people](#).

- 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 CAMHS tier 2 or 3^[1] 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 parents or carers 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 2 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^[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 1 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^[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^[1] 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^[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 2 or more other risk factors with no evidence of depression and/or self-harm
- exposure to a recent undesirable life event, where 1 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^[1] CAMHS:

- depression with 2 or more other risk factors for depression
- depression where 1 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^[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 parents or carers. [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^[1] 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^[1]. [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^[1] 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

For children and young people with learning disabilities, see the recommendations on psychological interventions in the NICE guideline on [mental health problems in people with learning disabilities](#).

- 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
 - the evidence for each age group (including the limited evidence for 5- to 11-year-olds)
 - how the therapies 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 family members or carers
 - their clinical and personal/social history and presentation
 - their maturity and developmental level
 - the context in which treatment is to be provided
 - comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities
 - patient and carer preferences and values (as appropriate). [2019]
- 1.5.6 For 5- to 11-year-olds with mild depression continuing after 2 weeks of watchful waiting, and without significant comorbid problems or active suicidal ideas or plans, consider the following options adapted to developmental level as needed:

- digital cognitive-behavioural therapy (CBT)
- group CBT
- group non-directive supportive therapy (NDST)
- group interpersonal psychotherapy (IPT).

If these options would not meet the child's clinical needs or are unsuitable for their circumstances, consider the following adapted to developmental level as needed:

- attachment-based family therapy
- individual CBT. [2019]

1.5.7 For 12- to 18-year-olds with mild depression continuing after 2 weeks of watchful waiting, and without significant comorbid problems or active suicidal ideas or plans, offer a choice of the following psychological therapies for a limited period (approximately 2 to 3 months):

- digital CBT
- group CBT
- group NDST
- group IPT. [2019]

1.5.8 If the options in recommendation 1.5.7 would not meet the clinical needs of a 12- to 18-year-old with mild depression or are unsuitable for their circumstances, consider:

- attachment-based family therapy or
- individual CBT. [2019]

1.5.9 Provide psychological therapies in settings such as schools and colleges, primary care, social services and the voluntary sector. [2019]

1.5.10 If mild depression in a child or young person has not responded to psychological therapy after 2 to 3 months (recommendations 1.5.6 to 1.5.8 and [table 1](#)), refer the child or young person for review by a 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 (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

For children and young people with learning disabilities, see the recommendations on psychological interventions in the NICE guideline on [mental health problems in people with learning disabilities](#).

- 1.6.1 Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS 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
 - the evidence for each age group (including the limited evidence for 5- to 11-year-olds)
 - how the therapies could meet individual needs, preferences and values. [2019]
- 1.6.3 Base the choice of psychological therapy on:
- a full assessment of needs, including:
 - the circumstances of the child or young person and their family members or carers
 - their clinical and personal/social history and presentation
 - their maturity and developmental level
 - the context in which treatment is to be provided

- – comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities
- patient and carer preferences and values (as appropriate). [2019]

1.6.4 For 5- to 11-year-olds with moderate to severe depression, consider the following options adapted to developmental level as needed:

- family-based IPT
- family therapy (family-focused treatment for childhood depression and systems integrative family therapy)
- psychodynamic psychotherapy
- individual CBT. [2019]

1.6.5 For 12- to 18-year-olds with moderate to severe depression, offer individual CBT for at least 3 months. [2019]

1.6.6 If individual CBT would not meet the clinical needs of a 12- to 18-year-old with moderate to severe depression or is unsuitable for their circumstances, consider the following options:

- IPT-A (IPT for adolescents)
- family therapy (attachment-based or systemic)
- [brief psychosocial intervention](#)
- psychodynamic psychotherapy. [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

1.6.7 Consider combined therapy (fluoxetine^[2] 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 1.6.8 to 1.6.10. [2015]

- 1.6.8 If moderate to severe depression in a child or young person is unresponsive to psychological therapy after 4 to 6 treatment sessions, a multidisciplinary review should be carried out. [2005]
- 1.6.9 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]
- 1.6.10 Following multidisciplinary review, offer fluoxetine^[3] 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]
- 1.6.11 Following multidisciplinary review, cautiously consider fluoxetine^[4] 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

- 1.6.12 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 6 sessions, or the patient and/or their parents or carers 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 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]
- 1.6.13 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
- psychodynamic psychotherapy (approximately 30 weekly sessions). [2005]

How to use antidepressants in children and young people

- 1.6.14 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 parents or carers 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]
- 1.6.15 If an antidepressant is to be prescribed this should only be following assessment and diagnosis by a child and adolescent psychiatrist. [2005]
- 1.6.16 When an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine^[4] as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks. [2005]
- 1.6.17 If a child or young person is started on antidepressant medication, they (and their parents or carers, 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]

- 1.6.18 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 parents or carers 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]
- 1.6.19 When fluoxetine^[4] 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]
- 1.6.20 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 MFQ. [2005]
- 1.6.21 When a child or young person responds to treatment with fluoxetine^[4], 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]
- 1.6.22 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^[5]. [2005]
- 1.6.23 Sertraline or citalopram^[5] should only be used when the following criteria have been met^[6]:
- The child or young person and their parents or 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. 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).
- 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]

1.6.24 When a child or young person responds to treatment with citalopram or sertraline^[5], medication should be continued for at least 6 months after remission (defined as no symptoms and full functioning for at least 8 weeks). [2005]

1.6.25 When an antidepressant other than fluoxetine^[4] 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]

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

- 1.6.27 Tricyclic antidepressants should not be used for the treatment of depression in children and young people. [2005]
- 1.6.28 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]
- 1.6.29 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]
- 1.6.30 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]
- 1.6.31 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

- 1.6.32 For children and young people with psychotic depression, augmenting the current treatment plan with a second-generation antipsychotic medication^[7] should be considered, although the optimum dose and duration of treatment are unknown. [2005]
- 1.6.33 Children and young people prescribed a second-generation antipsychotic medication should be monitored carefully for side effects. [2005]

See also the recommendations on choice of antipsychotics and how to use them in the NICE guideline on [psychosis and schizophrenia in children and young people](#).

Inpatient care

- 1.6.34 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]
- 1.6.35 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]
- 1.6.36 When inpatient treatment is indicated, CAMHS professionals should involve the child or young person and their parents or carers in the admission and treatment process whenever possible. [2005]
- 1.6.37 Commissioners should ensure that inpatient treatment is available within reasonable travelling distance to enable the involvement of families and maintain social links. [2005]
- 1.6.38 Commissioners should ensure that inpatient services are able to admit a young person within an appropriate timescale, including immediate admission if necessary. [2005]
- 1.6.39 Inpatient services should have a range of interventions available including medication, individual and group psychological therapies and family support. [2005]
- 1.6.40 Inpatient facilities should be age appropriate and culturally enriching, with the capacity to provide appropriate educational and recreational activities. [2005]
- 1.6.41 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]
- 1.6.42 Tier 4^[1] 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 (ECT)

- 1.6.43 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]
- 1.6.44 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]
- 1.6.45 ECT is not recommended in the treatment of depression in children (5–11 years). [2005]

Discharge after a first episode

- 1.6.46 When a child or young person is in remission (fewer than 2 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 parents or carers 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]
- 1.6.47 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]
- 1.6.48 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

- 1.6.49 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 2 prior episodes, those who have high levels of

subsyndromal symptoms, or those who remain exposed to multiple-risk circumstances). [2005]

- 1.6.50 CAMHS specialists should teach recognition of illness features, early warning signs, and subthreshold disorders to tier 1^[4] professionals, children or young people with recurrent depression and their families and carers. Self-management techniques may help individuals to avoid and/or cope with trigger factors. [2005]
- 1.6.51 When a child or young person with recurrent depression is in remission (fewer than 2 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 parents or carers 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]
- 1.6.52 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*

See also the NICE guideline on [transition from children's to adults' services for young people using health or social care 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 mental health 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 NICE's [information for the public](#)) 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]

Terms used in this guideline

Tiers

June 2019 – The tiers terminology is under revision and may change in the future in line with NHS England's [Future in Mind](#) and the Care Quality Commission's report [Are we listening](#). We have retained the tiers terminology and will revise this when the 2005 recommendations are updated.

The Care Quality Commission's report 'Are we listening' referred to the whole system of care and support (tiers 1 to 4) as Children and Young People's Mental Health Services. These included counselling provided through schools or GP practices, youth services, voluntary sector advice and support, and universal healthcare services like health visitors, as well as CAMHS. They used CAMHS to refer to services offering specialist care in the community (tier 3) and inpatient care (tier 4).

Brief psychosocial intervention

This intervention is based on the brief psychosocial intervention (BPI) carried out in the IMPACT trial (Goodyer et al. 2017^[8]).

Core components of BPI include:

- psychoeducation about depression and action-oriented, goal-focused, interpersonal activities as therapeutic strategies
- building health habits
- planning and scheduling valued activities

- advice on maintaining and improving mental and physical hygiene including sleep, diet and exercise
- promoting engagement with and maintaining school work and peer relations, and diminishing solitariness.

BPI does not involve cognitive or reflective analytic techniques.

Digital CBT

Digital CBT is a form of CBT delivered using digital technology, such as a computer, tablet or phone. A variety of digital CBT programmes have been used for young people aged 12 to 18 years with mild depression. These include SPARX, Stressbusters and Grasp the Opportunity. Only Stressbusters has been tested in the UK. Some digital CBT interventions are supported by contact with a healthcare professional but in other cases there may be no additional support.

Common components of digital CBT programmes include: psychoeducation, relaxation, analysis of behaviour, behavioural activation, basic communication and interpersonal skills, emotional recognition, dealing with strong emotions, problem solving, cognitive restructuring (identifying thoughts, challenging unhelpful/negative thoughts), mindfulness and relapse prevention.

^[1] June 2019 – terminology is under revision and may change in the future in line with NHS England's [Future in Mind](#) and the Care Quality Commission's report [Are we listening](#). We have retained the tiers terminology and will revise this when we update the 2005 recommendations.

^[2] At the time of publication (June 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.

^[3] At the time of publication (June 2019), fluoxetine was the only antidepressant with UK marketing authorisation for use in this indication for children and young people aged 8 to 18 years.

^[4] At the time of publication (June 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.

^[5] At the time of publication (June 2019), citalopram was not licensed for use in children and young people under 18 and sertraline was not licensed for 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.

^[6] The Medicines and Healthcare products Regulatory Agency has published advice on [QT prolongation with citalopram and escitalopram](#) (2011).

^[7] At the time of publication (June 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 second-generation 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.

^[8] 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.

Recommendations for research

Key recommendations for research

1 Psychological therapies for children aged 5 to 11 years with mild or moderate to severe depression

What is the clinical and cost effectiveness, post-treatment and at longer-term follow-up, of psychological therapies in children aged 5 to 11 years with mild or moderate to severe depression? [2019]

To find out why the committee made the research recommendation for children aged 5 to 11 years, see the rationale for [treatments for mild depression](#) or [moderate to severe depression](#).

2 Digital cognitive-behavioural therapy

What is the clinical and cost effectiveness, post-treatment and at longer-term follow-up, of supported digital cognitive-behavioural therapy (CBT) compared with unsupported digital CBT in young people aged 12 to 18 years with mild depression, and what are the key components of the interventions that influence effectiveness? [2019]

To find out why the committee made the research recommendation on digital CBT, see the [rationale](#).

3 Family therapy, interpersonal psychotherapy for adolescents and psychodynamic psychotherapy

What is the clinical and cost effectiveness, post-treatment and at longer-term follow-up, of family therapy, psychodynamic psychotherapy and interpersonal psychotherapy for adolescents (IPT-A) compared with each other and with individual CBT 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 family therapy, IPT-A and psychodynamic psychotherapy, see the [rationale](#).

4 Brief psychosocial intervention delivered by non-psychiatrists and in other settings

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 mild or moderate to severe depression? [2019]

To find out why the committee made the research recommendation on brief psychosocial intervention delivered by non-psychiatrists, see the [rationale](#).

5 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 children aged 5 to 11 years and young people aged 12 to 18 years with mild or moderate to severe depression? [2019]

To find out why the committee made the research recommendation on behavioural activation, see the rationale for [treatments for mild depression](#) or [moderate to severe depression](#).

Other recommendations for research

Group mindfulness

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

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]

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

Making choices about treatments

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 shared 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 discussion should also cover the evidence for the different treatments and make it clear that there is limited evidence for effective treatments for 5- to 11-year-olds.

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 only think about clinical needs, but also take into account the child or young person's personal/social history, the current environment, the setting where the treatment will be provided and individual preferences and values. In addition, certain therapies may not be suitable or may need to be adapted for use with children generally or those with comorbidities, neurodevelopmental disorders, learning disabilities or different communication needs (due to language or sensory impairment). To ensure that these factors are part of the decision-making process, the committee included them in the full assessment of needs.

Psychological therapies for 5- to 11-year-olds with mild depression

The evidence for psychological therapies for 5- to 11-year-olds was confined to group cognitive-behavioural therapy (CBT), and although depression symptoms were reduced at the end of treatment compared with waiting list/no treatment, this was not maintained in the longer term. There were no data for other outcomes such as functional status or remission. As a result, the

committee decided to recommend the same interventions that were effective in 12- to 18-year-olds for this age group, but adapted for their age and developmental level.

Because of the limited evidence for effective treatments for 5- to 11-year-olds with mild depression, the committee made a research recommendation to try to stimulate research in this area.

Psychological therapies for 12- to 18-year-olds with mild depression

Analysis of the evidence for 12- to 18-year-olds with mild depression showed that digital CBT (also known as online CBT or computer CBT), group therapies (group CBT, group interpersonal psychotherapy [IPT] and group non-directive supportive therapy [NDST]), individual CBT and family therapy reduced depression symptoms or improved functional status by the end of treatment and up to 6 months later compared with a waiting list control or no treatment. In some cases, such as digital CBT, these positive effects persisted for longer than 6 months, but information on long-term effects was not always available. Digital CBT was also better than other psychological therapies at reducing depression symptoms longer term.

The committee agreed to base recommendations for psychological therapies on clinical effectiveness and cost. The average costs estimated for digital CBT and group therapy (CBT, IPT and NDST) were lower than those for individual CBT and family therapy. Taking the magnitude of effect, the estimated cost and the size of the evidence base into account, the committee agreed that a choice of digital CBT, group IPT, group NDST or group CBT should be offered first.

However, the committee recognised that digital CBT is not well defined and the evidence for effectiveness came from studies using a variety of different programmes. In addition, digital CBT can be delivered with support (from a healthcare professional) or as an unsupported intervention. It is unclear whether unsupported or supported digital CBT is more effective and which programmes would be most effective for use in the UK. As a result, the committee made a research recommendation to inform future guidance.

Individual CBT and family therapy were among the more expensive options. Individual CBT had a smaller effect on depression symptoms than digital CBT or group therapy (CBT, IPT or NDST). Individual CBT had a meaningful effect on functional status; this outcome was only reported in a study that recruited young people with depression and a comorbidity. Family therapy showed meaningful effects on depression symptoms, but these results were based on a single study.

The committee acknowledged that digital CBT, group CBT, group IPT and group NDST may not be

suitable for everyone and that individual CBT or family therapy could be considered in these situations. They specified attachment-based family therapy in the recommendation because that was the type of family therapy used in the study.

The committee agreed not to make a recommendation for individual NDST or guided self-help because:

- Individual NDST was not more effective at reducing depression symptoms at the end of treatment or at 6 months' follow-up than control and there was no evidence for functional status or remission.
- Although guided self-help reduced depression symptoms at the end of treatment compared with a waiting list control/no treatment, this was not sustained at later time points. In addition, guided self-help was no more effective at reducing depression symptoms at the end of treatment, and was either less effective or no more effective at later time points, than the recommended group therapies (group CBT, group IPT, group NDST), digital CBT, individual CBT or family therapy.

The committee made a research recommendation aimed at investigating the effectiveness of behavioural activation compared with other psychological therapies. They agreed that behavioural activation may meet the needs of some children and young people with depression that are not already covered by the other recommended psychological therapies. In particular, it might suit children and young people who struggle with the concepts of CBT, and children and young people with learning disabilities or neurodevelopmental disorders. The only evidence for behavioural activation came from a single small study (60 participants) that found no difference between behavioural activation and usual care, but this may have been because of the small study size.

The committee also made a research recommendation for group mindfulness, because, although it was more effective at reducing depression symptoms post treatment and at 6 months' follow-up than a waiting list control/no treatment, there was no evidence for other key outcomes such as functional status or later time points, and the evidence came from a single small study.

How the recommendations might affect practice

The recommendation for digital CBT or group therapy (CBT, IPT or NDST) 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. Individual NDST and guided self-help are no longer recommended and the net resource impact of this change is therefore unclear.

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](#)

Treatments for moderate to severe depression

Recommendations [1.6.1](#) to [1.6.6](#)

Why the committee made the recommendations

Making choices about treatments

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

Psychological therapies for 5- to 11-year-olds with moderate to severe depression

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. The committee agreed that the child or young person and their family or carers should be made aware of this when making decisions about treatments.

In the analysis of evidence for 5- to 11-year-olds with moderate to severe depression, family-based IPT and family therapy were more effective at reducing depression symptoms at the end of treatment than psychodynamic psychotherapy; but psychodynamic psychotherapy was better than family therapy at maintaining remission 6 months later. However, the evidence base was small (3 studies) and none included a control intervention. In other studies that included a control, no interventions were better than the control at reducing depression symptoms after treatment or at later time points.

Despite the limited evidence for 5- to 11-year-olds, the committee agreed that treatment was important for these young children. They agreed to recommend the treatments (family therapy, family-based IPT and psychodynamic psychotherapy) for which there was some evidence. They specified the types of family therapy used in the studies (family-focused treatment for childhood depression and systems integrative family therapy). They also included individual CBT in the recommendation because it was the most effective treatment for 12- to 18-year-olds with

moderate to severe depression and they agreed that more mature children might benefit from this intervention.

Because of the limited evidence for effective treatments for 5- to 11-year-olds with depression, the committee made a research recommendation to inform future guidance.

Psychological therapies for 12- to 18-year-olds with moderate to severe depression

In an analysis of a large body of evidence for 12- to 18-year-olds with moderate to severe depression, individual CBT was better at reducing depression symptoms and improving functional status, quality of life and suicidal ideas compared with waiting list/no treatment, or usual care. It also increased remission at the end of treatment compared with attention control and other therapies (such as family therapy). Based on the size of these effects, the number of outcomes showing improvement and the size of the evidence base, the committee agreed to recommend individual CBT as the first-line treatment for young people with moderate to severe depression.

However, the committee recognised that individual CBT might not be suitable or meet the needs of all young people with moderate to severe depression and so they agreed that other therapies (IPT-A [IPT for adolescents], family therapy, brief psychosocial intervention [BPI] and psychodynamic psychotherapy) could be considered as second-line options because there was some evidence supporting them, but this was less certain.

IPT-A and family therapy both increased functional status and depression symptoms at the end of treatment compared with waiting list/no treatment, or usual care (4 studies each). Family therapy was also better at inducing remission at the end of treatment than attention control.

The IMPACT trial could not detect a difference between BPI, psychodynamic psychotherapy and individual CBT over a range of outcomes and follow-up times for 12- to 18-year-olds with moderate to severe depression. The committee agreed that BPI could be considered as an option when individual CBT is unsuitable. But they acknowledged that further research would be helpful to determine the effectiveness of BPI when delivered by a wider range of less senior practitioners and in other settings such as primary care.

Psychodynamic psychotherapy increased remission at the end of treatment compared with attention control or family therapy and relaxation. However, there was no evidence for functional status and psychodynamic psychotherapy was not more effective than control at relieving depression symptoms or improving quality of life post treatment. The data for this analysis came from the IMPACT trial^[6], which found no detectable differences between the effectiveness of

psychodynamic psychotherapy and individual CBT across a range of outcomes and follow-up times. However, a second trial of this intervention was identified with participants that spanned both age groups. It was included in the analysis for 5- to 11-year-olds. The committee decided not to recommend psychodynamic psychotherapy as a first-line option because it was no better than control at reducing depression symptoms at the end of treatment and there were only 2 studies including this intervention.

The committee recognised that there were fewer studies of family therapy, IPT-A and psychodynamic psychotherapy than for individual CBT, and the existing studies either lacked data for later follow-up times or did not cover the full range of outcomes of interest. The committee wanted more evidence to support their use in young people with moderate to severe depression and they therefore made a research recommendation to look at the relative effectiveness of these interventions compared with each other and individual CBT.

The committee agreed that behavioural activation may meet the specific needs of some children and young people with depression. In particular, it might suit those who might struggle with the concepts of CBT and children and young people with learning disabilities or neurodevelopmental disorders. They made a research recommendation to inform future practice.

How the recommendations might affect practice

Individual CBT, family therapy, psychodynamic psychotherapy and IPT-A are already in widespread use and, as a result, the recommendations are unlikely to change resource use. Brief psychosocial intervention is not commonly delivered in current practice. Although this represents a change in practice, it is a lower intensity intervention than other individual therapies and may therefore reduce overall 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 to 11 years) and young people (12 to 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 unlikely that the severity of depression can be understood in a single symptom count or visit. A child or young person may present initially with psychosomatic symptoms, and may need to be seen on more than one occasion with parents/carers and without, if appropriate, in order to gain trust. Therefore, beyond single symptom count, family context, previous history, and the degree of associated impairment are all important in helping to assess the severity of 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.

Children and young people's mental health services are NHS priorities for care quality and outcomes improvement within the [NHS Long Term Plan](#). As part of the plan, services will be expanded and will receive more funding. This includes the expansion of community-based mental health services to meet the needs of more children and young people and the improvement of mental health support for children and young people in school and colleges.

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

You can see everything NICE says on depression in children and young people in our interactive flowchart on [depression in children and young people](#).

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

For full details of the evidence and the guideline committee's discussions, see the [evidence review](#). You can also find information about [how the guideline was developed](#), including details of the committee.

NICE has produced [tools and resources](#) to help you put this guideline into practice. For general help and advice on putting NICE guidelines into practice, see [resources to help you put guidance into practice](#).

Update information

June 2019: We have reviewed the evidence and made new recommendations on psychological therapies for children and young people with depression. These recommendations are marked [2019].

We have also made 1 change without an evidence review:

- the Mental Capacity Act has been added to the considerations when assessing and treating depression in young people.

This recommendation is marked [2005, amended 2019].

Recommendations marked [2005] or [2015] last had an evidence review in 2005 or 2015. In some cases, minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

September 2017: Recommendation 1.1.29 was updated to clarify the training needed for therapists. Recommendation 1.4.1 was updated to delete reference to a preferred questionnaire as this is no longer relevant.

March 2015: We reviewed the evidence and made new recommendations for combination therapy for children and young people with depression. These recommendations are marked [2015].

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Accreditation

