



*National Institute for  
Health and Clinical Excellence*

**Quick reference guide**

Issue date: September 2005

## **Depression in children and young people**

Identification and management in primary,  
community and secondary care

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## Using this booklet

This quick reference guide is organised according to the different needs of children and young people with depression and their families or carers and the responses that are required from services.

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### Services

**Tier 1** Primary care services including GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services.

**Tier 2 CAMHS** Services provided by professionals relating to workers in primary care including clinical child psychologists, paediatricians with specialist training in mental health, educational psychologists, child and adolescent psychiatrists, child and adolescent psychotherapists, counsellors, community nurses/nurse specialists and family therapists.

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

**Tier 4 CAMHS** Tertiary-level services such as day units, highly specialised outpatient teams and inpatient units.

## About this information

In this guideline, the following terms are used to refer to specific age groups:

- children – people aged 5–11 years
- young people – people aged 12 to their 18th birthday.

### Patient-centred care

Treatment and care should take into account the child or young person's individual needs and preferences. Children and young people with depression should have the opportunity to make informed decisions about their care and treatment, but this depends on their age and capacity to make decisions. Where the patient is not old enough or does not have the capacity to make decisions, the Department of Health guidelines should be followed – *Reference guide to consent for examination or treatment* (2001) (available from [www.dh.gov.uk](http://www.dh.gov.uk)).

Unless specifically excluded by the child or young person, parent(s) or carer(s) should have the opportunity to be involved in decisions about

care and treatment and be provided with the information and support they need.

Good communication is essential. It should be supported by evidence-based information offered in a form that meets the needs of the individual. The treatment, care and information provided should be culturally appropriate and accessible to people with additional needs.

### Grading of recommendations

This quick reference guide summarises the recommendations in the NICE clinical guideline 'Depression in children and young people: identification and management in primary, community and secondary care'. The recommendations are based on the best available evidence and are graded **A**, **B**, **C** or good practice point **GPP**, depending on the type of evidence they are based on. For more information on the grading system, see the NICE guideline ([www.nice.org.uk/CG028NICEguideline](http://www.nice.org.uk/CG028NICEguideline)).

### This guidance is written in the following context

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or family or carer.

## Key priorities for implementation

### Assessment and coordination of care

- 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.

### Treatment considerations in all settings

- Psychological therapies used in the treatment of children and young people should be provided by therapists who are also trained child and adolescent mental healthcare professionals.
- 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.
- 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.

### Step 1: Detection and risk profiling

- 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.
- 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.

### Step 2: Recognition

- Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer-based instruments (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.

### Step 3: Mild depression

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

### Steps 4 and 5: Moderate to severe depression

- Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], interpersonal therapy or shorter-term family therapy; it is suggested that this should be of at least 3 months' duration).
- Antidepressant medication should not be offered 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.

## General principles of care across all settings

### Good information, informed consent and support

- Provide the child/young person and parent(s)/carer(s) with age-appropriate information at a suitable time. It should cover the nature, course and treatment of depression, and the likely side-effect profile of medication should this be offered. **GPP**
- Build a supportive and collaborative relationship with both the child/young person and family/carers. **GPP**
- Engage the child/young person and the parent(s)/carer(s) in treatment decisions so that they can give meaningful and properly informed consent before treatment starts. **GPP**
- Inform families and carers of self-help groups and support groups and encourage participation where appropriate. **GPP**

### Language and ethnic minorities

- Provide the following in the language of the patient and their family/carers where possible: **GPP**
  - written information (including information about medication and local services)
  - audiotaped material
  - psychological therapies.
- Seek professional interpreters for those whose preferred language is not English. **GPP**

## Assessment and treatment considerations across all settings

### Assessment

- Consider the following when assessing a child/young person with depression and record in the notes: **GPP**
  - potential comorbidities
  - social, educational and family context for the patient and family members
  - quality of patient’s relationships with family members, friends and peers.
- Assess with the young person their social network before treatment starts. In a written formulation identify factors that:
  - contributed to the development and maintenance of depression
  - impact in a positive or negative way on treatment efficacy. **B**
 Indicate ways to work in partnership with their social and professional network. **B**
- Always ask the child/young person and their parents/carers directly about the patient’s: **GPP**
  - alcohol and drug use
  - experience of being bullied
  - experience of being abused
  - self-harm
  - ideas about suicide
- Give young people the opportunity to discuss these issues initially in private. **GPP**
- Pay special attention to: **GPP**
  - confidentiality
  - young person’s consent (including Gillick competence)
  - parental consent
  - child protection
  - use of the Mental Health Act in young people
  - the Children Act.
- Ensure that cultural and ethnic variations in communication, family values and the place of the child/young person within the family influence the form of assessment. **GPP**

**If comorbid diagnoses, developmental, social and educational problems exist:**

- Manage either in sequence or in parallel with the treatment for depression. **B**
- Work with schools or social services where appropriate. **B**

**If bullying is a factor:**

- Work with schools to prevent bullying and to develop effective anti-bullying strategies. **C**

**If patient presents acutely having self-harmed:**

- Follow the NICE self-harm guideline as it applies to children/young people. **GPP**
- Pay particular attention to guidance on consent and capacity in the NICE self-harm guideline **GPP**
- Follow this guideline for further management of the depression. **GPP**

**Consider parents’ mental health**

- Consider the possibility of parental depression and substance misuse (or other mental health problems and associated problems of living). **GPP**
- Obtain a family history to check for unipolar or bipolar depression in parents and grandparents in all children/young people with suspected mood disorder. **GPP**

**If a parent has a psychiatric problem (particularly depression):**

- Treat the child and parent in parallel if this will help the child’s progress. **B**

### Self-help

- Ask the child/young person and be prepared to give advice about self-help materials or other methods used or considered potentially helpful by the patient or their family/carers. **GPP**
- Only recommend self-help materials or strategies as part of a supported and planned package of care. **GPP**

### Exercise

- Offer advice about the benefits of regular exercise. **C**
- Encourage patients to consider a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. **C**

### Sleep hygiene and anxiety management

- Offer advice about sleep hygiene and anxiety management. **C**

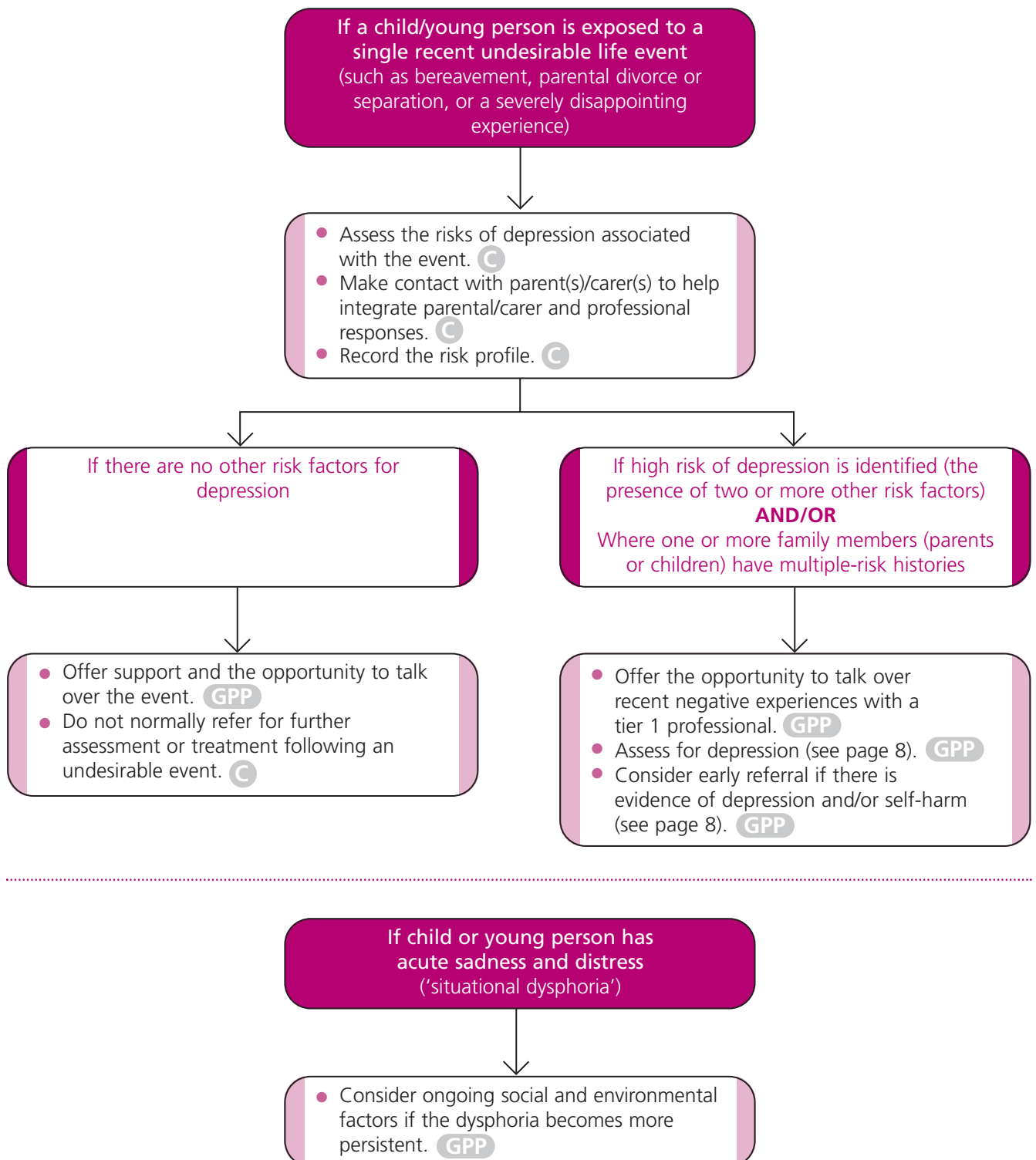
### Nutrition

- Offer advice about nutrition and the benefits of a balanced diet. **GPP**

### General treatment considerations

- Treat most children/young people on an outpatient or community basis. **C**
- Consider the Mood and Feelings Questionnaire (MFQ) as an adjunct to clinical judgement in secondary care. **C**

## Recognition, detection, risk profiling and referral in tier 1



## Referral criteria

### Management can remain at tier 1 if one or more of the following factors exist: **GPP**

- 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/young person
- mild depression without comorbidity.

### Refer to tier 2 or 3 CAMHS if one or more of the following factors exist: **GPP**

- 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 the child/young person's physical health
- active suicidal ideas or plans
- young person or parent(s)/carer(s) request referral.

### Refer to tier 4 CAMHS if one or more of the following factors exist: **GPP**

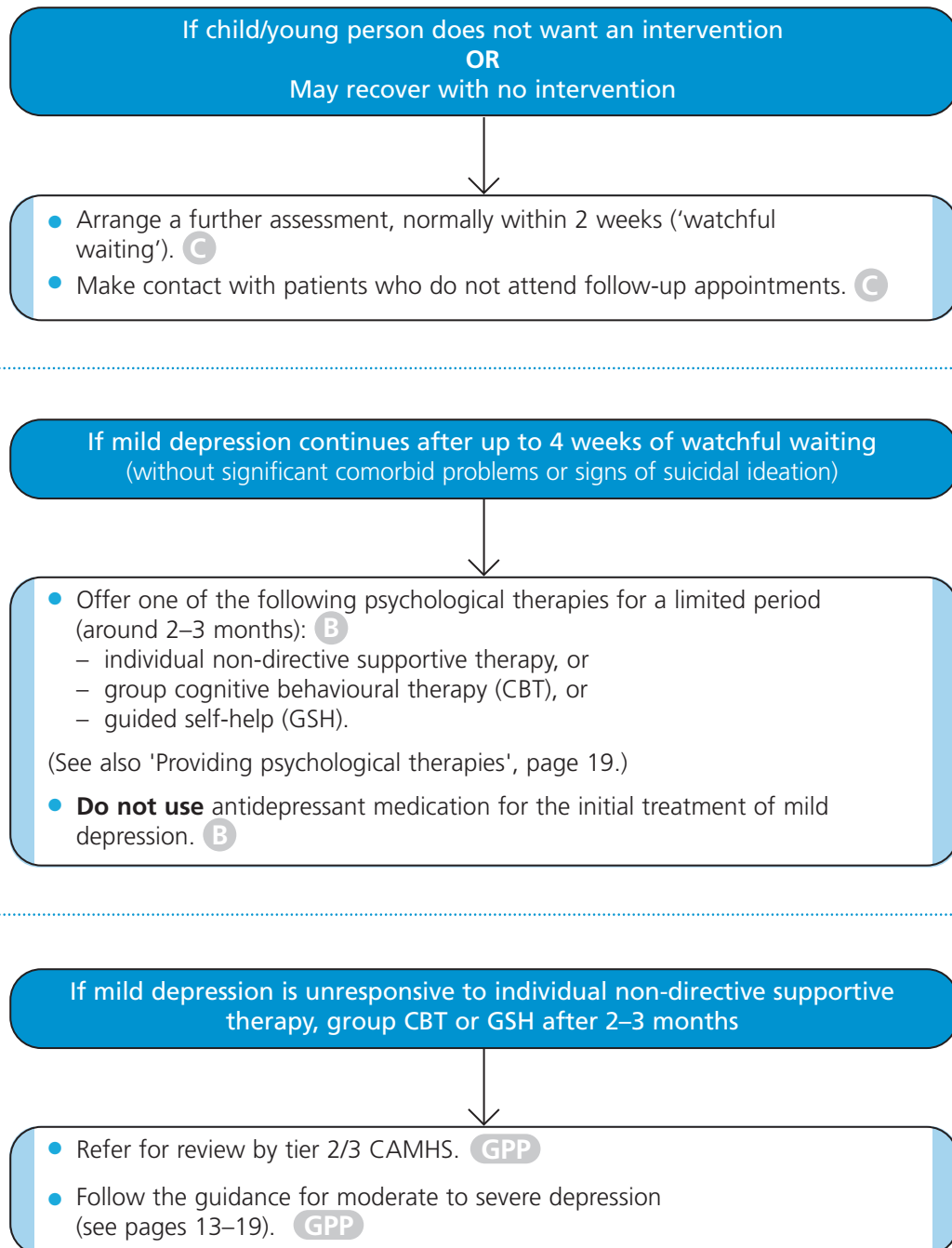
- high recurrent risk of acts of self-harm or suicide
- significant ongoing self-neglect (such as poor personal hygiene or significant reduction in eating that could be harmful to physical health)
- requirement for intensity of assessment/treatment and/or level of supervision that is not available in tier 2 or 3.

## Recognition in tiers 2–4

If a child/young person aged 11 years or older is referred to CAMHS without a diagnosis of depression

- Routinely screen with a self-report questionnaire for depression (the Mood and Feelings Questionnaire [MFQ] is the best) as part of general assessment. **B**

## Management of mild depression – tiers 1/2



## Management of moderate to severe (including psychotic) depression – tiers 2–4

### For moderate to severe depression

- Carry out a review in CAMHS tier 2 or 3. **B**
  - Offer one of the following specific psychological therapies (for at least 3 months) as a first-line treatment: **B**
    - individual CBT, or
    - interpersonal therapy, or
    - shorter-term family therapy.
- (See also 'Providing psychological therapies', page 19.)

### If depression is unresponsive to psychological therapy after 4–6 sessions

#### Review

- Carry out a multidisciplinary review. **GPP**

#### After multidisciplinary review

- **Consider alternative or additional psychological therapies**
  - If the child/young person's depression is not responding to psychological therapy as a result of other co-existing factors such as comorbid conditions, persisting psychosocial risk factors (e.g. family discord) or parental mental ill-health, consider: **C**
    - alternative or perhaps additional psychological therapy for the parent or other family members
    - alternative psychological therapy for the patient.
- **Offer/consider medication**
  - For young people aged 12–18 years offer fluoxetine<sup>1</sup> in addition to psychological therapy. **B**
  - For children aged 5–11 years **cautiously** consider the addition of fluoxetine<sup>1</sup> (evidence for its effectiveness in this age group is not established). **C**

(See 'Using antidepressants in children and young people', pages 17–18.)

<sup>1</sup> Fluoxetine does not have a UK Marketing Authorisation for use in children and adolescents under the age of 18 at the date of publication (September 2005). Check the Summary of Product Characteristics for current licensed indications. Unlicensed medicines can be legally prescribed where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion (Royal College of Paediatrics and Child Health, 2000; see also the NICE version of this guideline).

If depression is unresponsive to combined treatment with a specific psychological therapy and fluoxetine after a further 6 sessions  
**OR**  
 Patient or parent(s)/carer(s) have declined offer of fluoxetine

**Multidisciplinary review**

- Make a full needs and risk assessment: **GPP**
  - review the diagnosis
  - examine the possibility of comorbid diagnoses
  - reassess the possible individual, family and social causes of depression
  - consider whether there has been a fair trial of treatment
  - assess for further psychological therapy for the patient and/or additional help for the family.

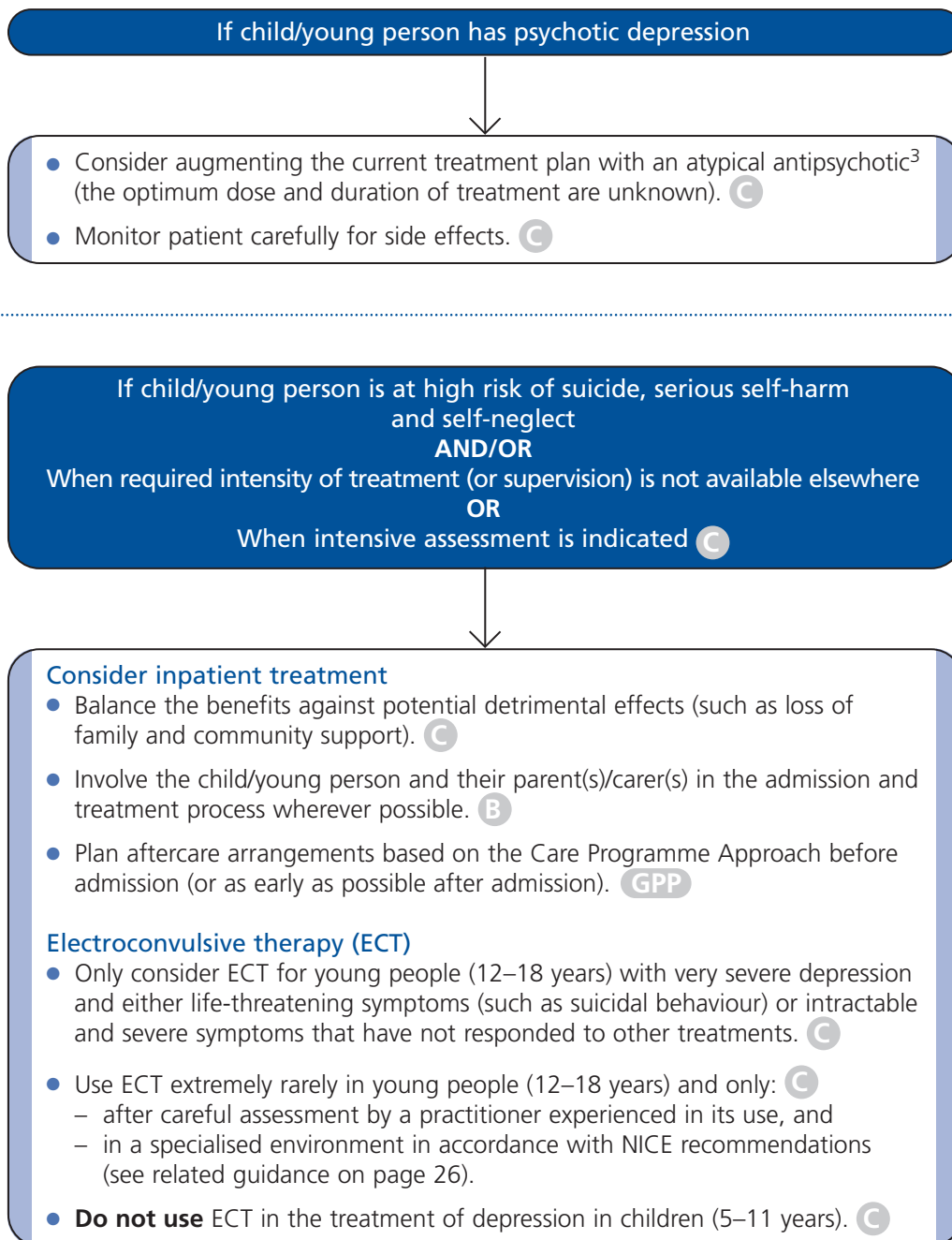
**Psychological therapy**

- Following multidisciplinary review, consider: **B**
  - an alternative psychological therapy which has not been tried (individual CBT, interpersonal therapy or shorter-term family therapy for at least 3 months), or
  - systemic family therapy (at least 15 fortnightly sessions), or
  - individual child psychotherapy (approximately 30 weekly sessions).

If treatment with fluoxetine is unsuccessful  
**OR**  
 Fluoxetine is not tolerated due to side effects

- Consider the use of another antidepressant (sertraline or citalopram<sup>2</sup> are the recommended second-line treatments). **B**  
 (See 'Special considerations for using sertraline and citalopram', page 19.)

<sup>2</sup> Sertraline and citalopram do not have a UK Marketing Authorisation for use in depression in children and adolescents under the age of 18 years at the date of publication (September 2005). Check the Summary of Product Characteristics of each drug for current licensed indications. Unlicensed medicines can be legally prescribed where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion (Royal College of Paediatrics and Child Health, 2000; see also the NICE version of this guideline).



<sup>3</sup> There are no atypical antipsychotic drugs with a UK Marketing Authorisation for depression in children at the date of publication (September 2005). Check the Summary of Product Characteristics of individual drugs for current licensed indications. Unlicensed medicines can be legally prescribed where there are no suitable alternatives and where the use is justified by a responsible body of professional opinion (Royal College of Paediatrics and Child Health, 2000; see also the NICE version of this guideline).

## Remission and relapse

When child or young person is in remission after a first episode (less than two symptoms and full functioning for at least 8 weeks)

- Review regularly for 12 months. **C**
- Agree exact frequency of contact with the patient and/or the parent(s)/carer(s) and record in the notes. **C**
- If remission is maintained for 12 months, discharge to primary care. **C**
- Keep primary care professionals up to date about progress and the need to monitor the patient in primary care. **GPP**
- Inform relevant primary care professionals within 2 weeks of discharge and provide advice about whom to contact if depressive symptoms recur. **GPP**
- See patients who have been successfully treated and discharged but then re-referred as soon as possible (do not put them on a routine waiting list). **GPP**

When child/young person has high risk of relapse or recurrence (such as those who:

- have experienced two prior episodes
- have high levels of subsyndromal symptoms
- remain exposed to multiple-risk circumstances)

- Consider specific follow-up psychological therapy to reduce or detect recurrence. **B**
  - Teach tier 1 professionals, the patient, family and carer(s) recognition of:
    - illness features
    - early warning signs
    - subthreshold disorders.
- Self-management techniques may help individuals to avoid and/or cope with trigger factors. **GPP**

When child or young person is in remission after recurrent depression (less than two symptoms and full functioning for at least 8 weeks)

- Review regularly for 24 months. **C**
- Agree the exact frequency of contact with the patient and/or the parent(s)/carer(s) and record in the notes. **C**
- If remission is maintained for 24 months, discharge to primary care. **C**
- See patients with recurrent depression who have been successfully treated and discharged but then re-referred as a matter of urgency. **GPP**

## Using antidepressants in children and young people

- Do not offer antidepressant medication except in combination with a concurrent psychological therapy. **B**
- If psychological therapies are declined, medication may still be given, but monitor regularly and focus on adverse drug reactions. **B**
- Only prescribe following assessment and diagnosis by a child and adolescent psychiatrist. **C**
- Fluoxetine should be prescribed as this is the only antidepressant for which trials show that benefits outweigh the risks. **A**
- Consider the use of another antidepressant (sertraline or citalopram are the recommended second-line treatments). **B** (See 'Special considerations for using sertraline and citalopram', page 19.)

### Do not use:

- paroxetine and venlafaxine **A**
- tricyclic antidepressants **C**
- St John's wort. **C**

### If patient is taking St John's wort (over the counter)

- Inform of the risks: **C**
  - there are no trials in children and young people upon which to make a clinical decision
  - unknown side-effect profile
  - known drug interactions, including contraceptives.
- Advise discontinuation of St John's wort. **C**
  - Monitor for recurrence of depression.
  - Assess for alternative treatments in accordance with this guideline.

### Provide information

- Inform patients and their parent(s)/carer(s) about the: **GPP**
  - rationale for drug treatment
  - delay in onset of effect
  - time course of treatment
  - possible side effects
  - need to take the medication as prescribed.
- Supplement discussion with written information appropriate to the needs of the patient and parent(s)/carer(s), including the latest patient information advice from the relevant regulatory authority. **GPP**

## Dose

- Fluoxetine
  - The starting dose should be 10 mg daily, increased if necessary to 20 mg daily after 1 week. Consider lower doses for children of lower body weight.
  - There is little evidence regarding the effectiveness of doses of fluoxetine higher than 20 mg daily, but 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. **GPP**
- Antidepressants other than fluoxetine
  - The starting dose should be half the daily starting dose for adults, increased if necessary to the daily adult dose gradually over 2 to 4 weeks. Consider lower doses in children of lower body weight.
  - There is little evidence regarding the effectiveness of upper daily adult doses 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. **GPP**

## Monitoring

- Unless medication needs to be started immediately, monitor symptoms that might be subsequently interpreted as side effects for 7 days before prescribing. Inform patients and their parent(s)/carer(s) that if there is any sign of new symptoms of these kinds, they should make urgent contact with the prescribing doctor. **GPP**
- Arrange to carefully monitor adverse drug reactions (for example, weekly for the first 4 weeks of treatment) and record in the notes. **B**
- Ensure patients are monitored for suicidal behaviour, self-harm or hostility by the prescribing doctor and the professional delivering the psychological therapy, particularly at the beginning of treatment. **GPP**
- If one is needed, use a recognised self-report rating scale such as the Mood and Feelings Questionnaire (MFQ). **GPP**

## Interactions

- Consider possible interactions with: **GPP**
  - other drugs (including recreational)
  - alcohol
  - complementary and alternative medicines.

## Length of treatment

- After remission (no symptoms and full functioning for at least 8 weeks) continue medication for at least 6 months (after the 8-week period). **C**

## Discontinuing medication

- Phase out antidepressant medication over 6–12 weeks with the exact dose being titrated against the level of discontinuation/withdrawal symptoms. **C**

### Special considerations for using sertraline and citalopram

#### Only use when the following criteria have been met: **C**

- The patient and parent(s)/carer(s) have been fully involved in discussions about the benefits and risks.
- The patient and parent(s)/carer(s) have been provided with appropriate written information covering:
  - rationale for drug treatment
  - delay in onset of effect
  - time course of treatment
  - possible side effects
  - need to take medication as prescribed
  - the latest patient information advice from the relevant regulatory authority.
- The depression is sufficiently severe and/or causing sufficiently serious symptoms (e.g. weight loss or suicidal behaviour) to justify trial of another antidepressant.
- There is clear evidence of a fair trial of fluoxetine with 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 abuse).
- There has been advice from a senior child and adolescent psychiatrist (usually a consultant).
- The child/young person and/or someone with parental responsibility (or the young person alone, if over 16 or deemed competent) has signed an appropriate and valid consent form.

#### Length of treatment

- After remission (no symptoms and full functioning for at least 8 weeks) continue medication for at least 6 months (after the 8-week period). **C**

### Providing psychological therapies

- Ensure psychological therapies are provided by:
  - therapists who are also trained child and adolescent mental healthcare professionals **B**
  - healthcare professionals who have been trained to an appropriate level of competence in the therapy being offered. **C**
- Develop a joint treatment alliance with the family. If this proves difficult consider providing the family with an alternative therapist. **C**

## Transfer to adult services from CAMHS

Young person aged 17 years recovering from first episode of depression

- Continue to provide treatment and care until discharge is appropriate in accordance with this guideline, even when the person turns 18 years of age. **GPP**

Young person aged 17–18 years who either

- has ongoing symptoms from a first episode that are not resolving
- or
- is recovering from a second or subsequent episode

- Arrange for a transfer to adult services, informed by the Care Programme Approach. **GPP**

Young person aged 17–18 years with a history of recurrent depression being considered for discharge from CAMHS

- Provide patient with information about: **GPP**
- treatment in adults (including the NICE information for the public about adult depression)
  - suitable local services and support groups.

Young person aged 17–18 years who has recovered from a first episode of depression and is discharged from CAMHS

- Do not refer on to adult services, unless high risk of relapse exists (e.g. if patient is living in multiple-risk circumstances). **GPP**

## Organisation and planning of services

### CAMHS and PCTs should: **GPP**

- 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
- routinely monitor detection, referral and treatment rates of children/young people with mental health problems from all ethnic groups in local schools and primary care
- use information about these rates to plan services, and make it available for local, regional and national comparison.

### Primary mental health workers (or CAMHS link workers) should: **GPP**

- establish clear lines of communication between CAMHS and tiers 1 and 2, with named contact people in each tier/service
- develop systems for the collaborative planning of services for young people with depression in tiers 1 and 2.

### All healthcare professionals should: **GPP**

- routinely use, and record in the notes, appropriate outcome measures (e.g. HoNOSCA or SDQ), for assessing and treating depression in children/young people
- use this information from outcome measures to plan services, and make it available for local, regional and national comparison.

### Commissioners and strategic health authorities should ensure that:

- inpatient treatment is available within reasonable travelling distance to enable family involvement and maintain social links **B**
- inpatient admission occurs within an appropriate time scale **GPP**
- immediate inpatient admission can be offered if necessary **GPP**
- inpatient services have a range of interventions available including:
  - medication
  - individual and group psychological therapies
  - family support **C**
- inpatient facilities are age appropriate and culturally enriching and can provide suitable educational and recreational activities. **C**

## Training and development

Managers of services need to ensure that training and development for healthcare professionals who are involved in the detection, recognition, assessment and treatment of children and young people with depression is available in the areas below. In particular, healthcare professionals specialising in depression in children and young people should work with local CAMHS to enhance specialist knowledge and skills. This work should include providing training and help with guideline implementation. **GPP**

### Detection and risk profiling – tier 1

Healthcare professionals in primary care, schools and other relevant community settings should be trained in:

- detection of depressive symptoms and assessment of children/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
    - history of parental depression
  - the natural history of single loss events
  - the importance of multiple risk factors
  - ethnic and cultural factors
  - factors known to be associated with a high risk of depression and other health problems such as:
    - homelessness
    - refugee status
    - living in institutional settings **C**
- developing ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of depression **GPP**
- communications skills such as ‘active listening’ and ‘conversational technique’. **GPP**

In the provision of training by CAMHS professionals, give priority to the training of pastoral support staff in schools (particularly secondary schools), community paediatricians and GPs. **GPP**

Healthcare professionals in primary care should be familiar with:

- screening for mood disorders. They should have regular access to specialist supervision and consultation. **GPP**

### Recognition – tiers 2–4

Tier 2–4 CAMHS professionals should be trained in:

- improving accuracy in diagnosing depressive conditions. Interviewer-based instruments (such as K-SADS and CAPA) could be used but will require modification for regular use in busy routine CAMHS settings. **C**

Tier 3 CAMHS professionals who specialise in the treatment of depression should be trained in:

- interviewer-based assessment instruments (such as K-SADS and CAPA) and have skills in non-verbal assessments of mood in younger children. **GPP**

### Inpatient care – tier 4

Tier 4 CAMHS professionals involved in assessing children/young people for possible inpatient admission should be specifically trained in:

- issues of consent and capacity
- use of current mental health legislation
- use of childcare laws

as they apply to this group of patients. **GPP**

### Language and ethnic minorities – all tiers

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 and minority ethnic groups. (Training should consider the impact of the patient's and healthcare professional's racial identity status on the patient's depression.) **GPP**

Healthcare professionals working with interpreters should be provided with joint training opportunities to:

- ensure that both understand the specific requirements within a mental health setting. **GPP**

Stakeholders (involving patients and their families and carers, including members of black and minority ethnic groups) should be involved in:

- development and evaluation of services. **GPP**

## Implementation

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

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

Information on the cost impact of this guideline in England is available on the NICE website and includes a template that local communities can use ([www.nice.org.uk/CG028costtemplate](http://www.nice.org.uk/CG028costtemplate)).

Detailed implementation advice and a slide set are also available on the NICE website.

The Healthcare Commission considers implementation of clinical guidelines to be a developmental standard. The implementation of this guideline will build on the National Service Frameworks for Children in England and Wales and should form part of the service development plans for each local health community in England and Wales.

The National Service Framework for Children is available for England from [www.dh.gov.uk](http://www.dh.gov.uk) and for Wales from [www.wales.nhs.uk](http://www.wales.nhs.uk)

Suggested audit criteria based on the key priorities for implementation are listed in Appendix D of the NICE guideline, and can be used to audit practice locally.

## Further information

### Quick reference guide

This quick reference guide to the Institute's guideline on depression in children contains the key priorities for implementation, summaries of the guidance, and notes on implementation. It has been distributed to healthcare professionals in England (see [www.nice.org.uk/CG028distributionlist](http://www.nice.org.uk/CG028distributionlist)).

It is available from

[www.nice.org.uk/CG028quickrefguide](http://www.nice.org.uk/CG028quickrefguide)

For printed copies, phone the NHS Response Line on 0870 1555 455 and quote reference number N0910.

### NICE guideline

The NICE guideline, *Depression in children and young people: identification and management in primary, community and secondary care*, is available from

[www.nice.org.uk/CG028NICEguideline](http://www.nice.org.uk/CG028NICEguideline)

The NICE guideline contains the following sections: Patient-centred care; Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Key research recommendations; 5 Other versions of this guideline; 6 Related NICE guidance; 7 Review date. It also gives details of the grading scheme for the evidence and recommendations, the Guideline Development Group and the Guideline Review Panel and technical detail on the criteria for audit.

### Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline. It is published by the National Collaborating Centre for Mental Health. It is available from its website ([www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)), the website of the National Library for Health ([www.nlh.nhs.uk](http://www.nlh.nhs.uk)), and [www.nice.org.uk/CG028fullguideline](http://www.nice.org.uk/CG028fullguideline)

### Information for the public

NICE has produced a version of this guidance for children and young people with depression, their families and carers, and the public, which is available from [www.nice.org.uk/CG028publicinfo](http://www.nice.org.uk/CG028publicinfo)

For printed copies, phone the NHS Response Line on 0870 1555 455 and quote reference number N0911.

### Related guidance

NICE has issued the following related clinical guidelines.

- *Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. NICE Clinical Guideline No. 9 (2004). Available from [www.nice.org.uk/CG009](http://www.nice.org.uk/CG009)
- *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. NICE Clinical Guideline No. 16 (2004). Available from [www.nice.org.uk/CG016](http://www.nice.org.uk/CG016)
- *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. NICE Clinical Guideline No. 22 (2004). Available from [www.nice.org.uk/CG022](http://www.nice.org.uk/CG022)

- *Depression: management of depression in primary and secondary care*. NICE Clinical Guideline No. 23 (2004). Available from [www.nice.org/CG023](http://www.nice.org/CG023)
- *Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care*. NICE Clinical Guideline No. 26 (2005). Available from [www.nice.org/CG026](http://www.nice.org/CG026)

NICE has also issued the following related technology appraisal guidance.

- *Guidance on the use of computerised cognitive behavioural therapy for anxiety and depression*. NICE Technology Appraisal No. 51 (2002 – note that at the time of publication, NICE is reviewing this Appraisal). Available from [www.nice.org.uk/TA051](http://www.nice.org.uk/TA051)
- *Guidance on the use of electroconvulsive therapy*. NICE Technology Appraisal No. 59 (2003). Available from [www.nice.org.uk/TA059](http://www.nice.org.uk/TA059) (Note: in this guidance, caution is recommended when considering electroconvulsive therapy for children and young people.)

Printed copies of the quick reference guides can be ordered from the NHS Response Line on 0870 1555 455 by quoting the following reference numbers: N0406 (eating disorders), N0625 (self-harm), N0763 (anxiety), N0766 (depression), N0848 (PTSD), N0157 (computerised cognitive behavioural therapy) and N0206 (electroconvulsive therapy).

For information about NICE guidance that has been issued or is in development, see the website ([www.nice.org.uk](http://www.nice.org.uk)).

### Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin before this if significant evidence that affects the guideline recommendations is identified. The updated guideline will be available within 2 years of the start of the review process.



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