NICE National Institute for Health and Care Excellence

NICE guideline

Depression in children and young people: identification and management

Clinical guideline

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Contents

This guideline is the basis of QS48.

This guideline should be read in conjunction with PH12.

Introduction

Recommendations on psychological therapies and antidepressants have been added to and updated in sections 1.5 and 1.6. The addendum contains details of the methods and evidence used to update these recommendations.

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

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

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

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

Safeguarding children

Remember that child maltreatment:

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

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

This section has been agreed with the Royal College of Paediatrics and Child Health.

Recommendations about medicines

The guideline will assume that prescribers will use a medicine's summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some medicines for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The patient (or those with authority to give consent on their behalf) should provide informed consent, which should be documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information. Where recommendations have been made for the use of medicines outside their licensed indications ('off-label use'), these medicines are marked with a footnote in the recommendations.

Patient-centred care

This guideline offers best practice advice on the care of children and young people with depression.

Patients and healthcare professionals have rights and responsibilities as set out in the NHS Constitution for England – all NICE guidance is written to reflect these. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If the patient is under 16, their family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Healthcare professionals should follow the Department of Health's advice on consent. If someone does not have capacity to make decisions, healthcare professionals should follow the code of practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards.

If a young person is moving between paediatric and adult services, care should be planned and managed according to the best practice guidance described in the Department of Health's Transition: getting it right for young people.

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with depression. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

Key priorities for implementation

The following recommendations were identified as priorities for implementation in the 2005 guideline and have not been changed in the 2015 update.

Assessment and coordination of care

- When assessing a child or young person with depression, healthcare professionals[1] 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]

Treatment considerations in all settings

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

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. [2005]

- Child and Adolescent Mental Health Services (CAMHS) tier 2 or 3 should work with health and social care professionals in primary care, schools and other relevant community settings to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed. [2005]

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. [2005]

Step 3: Mild depression

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

Steps 4 and 5: Moderate to severe depression

- Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. [new 2015]

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

[1] See appendix A for the glossary definition of healthcare professionals as used in this guideline.

1 Recommendations

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the **[2005]** recommendations. The guideline addendum gives details of the methods and the evidence used to develop the **[2015]** and **[new 2015]** recommendations.

> The wording used in the recommendations in this guideline (for example, words such as 'offer' and 'consider') denotes the certainty with which the recommendation is made (the strength of the recommendation). See about this guideline for details.

1.1 Care of all children and young people with depression

1.1.1 Good information, informed consent and support

1.1.1.1 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]**

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

1.1.1.3 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]**

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

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

1.1.2 Language and ethnic minorities

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

1.1.2.2 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]

1.1.2.3 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. 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]

1.1.2.4 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]

1.1.2.5 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 and minority ethnic groups. [2005]

1.1.3 Assessment and coordination of care

1.1.3.1 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]

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

1.1.3.3 If a child or young person with depression presents acutely having self-harmed, the immediate management should follow the NICE guideline Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care 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]

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

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

1.1.3.6 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]

1.1.3.7 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]

1.1.3.8 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]

1.1.3.9 In the assessment and treatment of depression in children and young people, special attention should be paid to the issues of:

- confidentiality
- the young person's consent (including Gillick competence)
- parental consent
- child protection
- the use of the Mental Health Act in young people
- the use of the Children Act. [2005]

1.1.3.10 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]

1.1.4 The organisation and planning of services

1.1.4.1 Healthcare professionals specialising in depression in children and young people should work with local CAMHS to enhance specialist knowledge and skills regarding depression in these existing services. This work should include providing training and help with guideline implementation. [2005]

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

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

1.1.4.4 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]

1.1.4.5 All healthcare and CAHMS 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]

1.1.5 Treatment considerations in all settings

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

1.1.5.2 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]

1.1.5.3 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]

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

1.1.5.5 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]

1.1.5.6 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]

1.1.5.7 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]

1.1.5.8 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]

1.1.5.9 A child or young person with depression should be offered advice on the benefits of regular exercise and encouraged to consider following a structured and supervised exercise programme of typically up to three sessions per week of moderate duration (45 minutes to 1 hour) for between 10 and 12 weeks. [2005]

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

1.1.5.11 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 that depressed children and young people have – depending on the characteristics of their depression and their personal and social circumstances – and the responses that are required from services. It provides a framework in which to organise the provision of services that support both healthcare

professionals and patients and their parent(s) or carer(s) in identifying and accessing the most effective interventions (see Table 1).

Table 1 The stepped-care model

Focus	Action	Responsibility
Detection	Risk profiling	Tier 1
Recognition	Identification in presenting children or young people	Tiers 2–4
Mild depression (including dysthymia)	Watchful waiting Non-directive supportive therapy/ group cognitive behavioural therapy/ guided self-help	Tier 1 Tier 1 or 2
Moderate to severe depression	Brief psychological therapy +/– fluoxetine	Tier 2 or 3
Depression unresponsive to treatment/recurrent depression/ psychotic depression	Intensive psychological therapy +/– fluoxetine, sertraline, citalopram, augmentation with an antipsychotic	Tier 3 or 4

The guidance follows these five steps.

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

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

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

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

5. Managing recognised depression in tier 3 or 4 CAMHS – unresponsive, recurrent and psychotic depression, including depression needing inpatient care.

Each step introduces additional interventions; the higher steps assume interventions in the previous step. **[2005]**

1.3 Step 1: Detection, risk profiling and referral

1.3.1 Detection and risk profiling

1.3.1.1 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]

1.3.1.2 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]

1.3.1.3 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]

1.3.1.4 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]

1.3.1.5 Child and Adolescent Mental Health Services (CAMHS) tier 2 or 3 should work with health and social care professionals in primary care, schools and other relevant community settings to provide training and develop ethnically and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed. [2005]

1.3.1.6 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]

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

1.3.1.8 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]

1.3.1.9 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]

1.3.1.10 A child or young person who has been exposed to a recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience and is identified to be at high risk of depression (the presence of two or more other risk factors for depression), should be offered the opportunity to talk over their recent negative experiences with a professional in tier 1 and assessed for depression. Early referral should be considered if there is evidence of depression and/or self-harm. [2005]

1.3.1.11 When a child or young person is exposed to a recent undesirable life event, such as bereavement, parental divorce or separation or a severely disappointing experience, and where one or more family members (parents or children) have multiple-risk histories for depression, they should be offered the opportunity to talk over their recent negative experiences with a professional in tier 1 and

assessed for depression. Early referral should be considered if there is evidence of depression and/or self-harm. [2005]

1.3.1.12 If children and young people who have previously recovered from moderate or severe depression begin to show signs of a recurrence of depression, healthcare professionals in primary care, schools or other relevant community settings should refer them to CAMHS tier 2 or 3 for rapid assessment. [2005]

1.3.2 Referral criteria

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

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

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

- depression with two or more other risk factors for depression
- depression where one or more family members (parents or children) have multiple-risk histories for depression
- mild depression in those who have not responded to interventions in tier 1 after 2–3 months
- moderate or severe depression (including psychotic depression)
- signs of a recurrence of depression in those who have recovered from previous moderate or severe depression

- unexplained self-neglect of at least 1 month's duration that could be harmful to their physical health
- active suicidal ideas or plans
- referral requested by a young person or their parent(s) or carer(s). **[2005]**

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

- high recurrent risk of acts of self-harm or suicide
- significant ongoing self-neglect (such as poor personal hygiene or significant reduction in eating that could be harmful to their physical health)
- requirement for intensity of assessment/treatment and/or level of supervision that is not available in tier 2 or 3. **[2005]**

1.4 Step 2: Recognition

1.4.1.1 Children and young people of 11 years or older referred to CAMHS without a diagnosis of depression should be routinely screened with a self-report questionnaire for depression (of which the Mood and Feelings Questionnaire [MFQ] is currently the best) as part of a general assessment procedure. **[2005]**

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

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

1.5 Step 3: Mild depression

1.5.1 Watchful waiting

1.5.1.1 For children and young people with diagnosed mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting'). **[2005]**

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

1.5.2 Interventions for mild depression

1.5.2.1 Discuss the choice of psychological therapies with children and young people and their family members or carers (as appropriate). Explain that there is no good-quality evidence that one type of psychological therapy is better than the others. **[new 2015]**

1.5.2.2 Following a period of up to 4 weeks of watchful waiting, offer all children and young people with continuing mild depression and without significant comorbid problems or signs of suicidal ideation individual non-directive supportive therapy, group cognitive behavioural therapy (CBT) or guided self-help for a limited period (approximately 2 to 3 months). This could be provided by appropriately trained professionals in primary care, schools, social services and the voluntary sector or in tier 2 Child and Adolescent Mental Health Services (CAMHS). **[2015]**

1.5.2.3 Children and young people with mild depression who do not respond after 2 to 3 months to non-directive supportive therapy, group CBT or guided self-help should be referred for review by a tier 2 or 3 CAMHS team. **[2005]**

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

1.5.2.5 The further treatment of children and young people with persisting mild depression unresponsive to treatment at tier 1 or 2 should follow the guidance for moderate to severe depression (see section 1.6 below). **[2005]**

1.6 Steps 4 and 5: Moderate to severe depression

1.6.1 Treatments for moderate to severe depression

See recommendation 1.5.2.1 on discussions to have with children and young people and their family members or carers (as appropriate) before starting psychological therapies.

1.6.1.1 Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS tier 2 or 3 team. **[2005]**

1.6.1.2 Offer children and young people with moderate to severe depression a specific psychological therapy (individual CBT, interpersonal therapy, family therapy, or psychodynamic psychotherapy) that runs for at least 3 months. **[new 2015]**

1.6.2 Combined treatments for moderate to severe depression

1.6.2.1 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 1.6.2.2–1.6.2.4. **[new 2015]**

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

1.6.2.3 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]**

1.6.2.4 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]**

1.6.2.5 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]

1.6.3 Depression unresponsive to combined treatment

1.6.3.1 If moderate to severe depression in a child or young person is unresponsive to combined treatment with a specific psychological therapy and fluoxetine after a further six sessions, or the patient and/or their parent(s) or carer(s) have declined the offer of fluoxetine, the multidisciplinary team should make a full needs and risk assessment. This should include a review of the diagnosis, examination of the possibility of comorbid diagnoses, reassessment of the possible individual, family and 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]

1.6.3.2 Following multidisciplinary review, the following should be considered:

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

1.6.4 How to use antidepressants in children and young people

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

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

1.6.4.3 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]

1.6.4.4 If a child or young person is started on antidepressant medication, they (and their parent(s) or carer(s) as appropriate) should be informed about the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible side effects, and the need to take the medication as prescribed. Discussion of these issues should be supplemented by written information appropriate to the child or young person's and parents' or carers' needs that covers the issues described above and includes the latest patient information advice from the relevant regulatory authority. [2005]

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

1.6.4.6 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]

1.6.4.7 When an antidepressant is prescribed in the treatment of a child or young person with depression and a self-report rating scale is used as an adjunct to

clinical judgement, this should be a recognised scale such as the Mood and Feelings Questionnaire (MFQ). [2005]

1.6.4.8 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]

1.6.4.9 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]

1.6.4.10 Sertraline or citalopram should only be used when the following criteria have been met[5].

- The child or young person and their parent(s) or carer(s) have been fully involved in discussions about the likely benefits and risks of the new treatment and have been provided with appropriate written information. This information should cover the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible side effects, and the need to take the medication as prescribed; it should also include the latest patient information advice from the relevant regulatory authority.
- The child or young person's depression is sufficiently severe and/or causing sufficiently serious symptoms (such as weight loss or suicidal behaviour) to justify a trial of another antidepressant.
- There is clear evidence that there has been a fair trial of the combination of fluoxetine and a psychological therapy (in other words that all efforts have been made to ensure adherence to the recommended treatment regimen).
- 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 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]

1.6.4.11 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]

1.6.4.12 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]

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

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

1.6.4.15 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]

1.6.4.16 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]

1.6.4.17 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]

1.6.4.18 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]

1.6.5 The treatment of psychotic depression

1.6.5.1 For children and young people with psychotic depression, augmenting the current treatment plan with an atypical antipsychotic medication[6] should be considered, although the optimum dose and duration of treatment are unknown. [2005]

1.6.5.2 Children and young people prescribed an atypical antipsychotic medication should be monitored carefully for side effects. [2005]

1.6.6 Inpatient care

1.6.6.1 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]

1.6.6.2 When considering admission for a child or young person with depression, the benefits of inpatient treatment need to be balanced against potential detrimental effects, for example loss of family and community support. [2005]

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

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

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

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

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

1.6.6.8 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]

1.6.6.9 Tier 4 CAMHS professionals involved in assessing children or young people for possible inpatient admission should be specifically trained in issues of consent and capacity, the use of current mental health legislation and the use of childcare laws, as they apply to this group of patients. [2005]

1.6.7 Electroconvulsive therapy

1.6.7.1 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]

1.6.7.2 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]

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

1.6.8 Discharge after a first episode

1.6.8.1 When a child or young person is in remission (less than two symptoms and full functioning for at least 8 weeks) they should be reviewed regularly for 12 months by an experienced CAMHS professional. The exact frequency of contact should be agreed between the CAMHS professional and the child or

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

1.6.8.2 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]

1.6.8.3 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]

1.6.9 Recurrent depression and relapse prevention

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

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

1.6.9.3 When a child or young person with recurrent depression is in remission (less than two symptoms and full functioning for at least 8 weeks) they should be reviewed regularly for 24 months by an experienced CAMHS professional. The exact frequency of contact should be agreed between the CAMHS professional and the child or young person and/or the parent(s) or carer(s) and recorded in the notes. At the end of this period, if remission is maintained, the young person can be discharged to primary care. [2005]

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

1.7 Transfer to adult services

1.7.1.1 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]

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

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

1.7.1.4 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]

[2] At the time of publication (March 2015), fluoxetine did not have UK marketing authorisation for use in young people (aged 12–18), without a previous trial of psychological therapy that was ineffective. 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 (March 2015), fluoxetine was the only antidepressant with UK marketing authorisation for use for children and young people aged 8 to 18 years.

[4] At the time of publication (March 2015), 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 (March 2015), sertraline and citalopram did not have a UK marketing authorisation for use in young people under the age of 18 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.

[6] At the time of publication (March 2015), risperidone did not have a UK marketing authorisation for use in young people under the age of 18 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.

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2 Research recommendations

In 2005, the Guideline Development Group made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future. The recommendations labelled **[2015]** were reviewed during the 2015 update by the standing committee, who decided to keep them in the guideline.

As part of the 2015 update, the Standing Committee made an additional research recommendation on the combination of psychological therapy and antidepressants. This can be found in the addendum.

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

2.2 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]**

Additional research

2.3 An appropriately blinded, randomised controlled trial should be conducted to assess the efficacy (including measures of family and social functioning as well as depression) and the cost effectiveness of another self-help intervention compared with computerised CBT and treatment as usual in a sample of children and young people treated in primary care who have been diagnosed

with depression. The trial should be powered to examine the effect of treatment in children and young people separately and involve a follow-up of 12 to 18 months (but no less than 6 months). [2015]

2.4 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]

2.5 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]

3 Other information

3.1 Scope and how this guideline was developed

The scope for the 2005 guideline covers the recommendations labelled **[2005]**. The recommendations labelled **[2015]** or **[new 2015]** have been produced during the update.

How this guideline was developed

The 2005 guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

NICE's Clinical Guidelines Update Programme updated this guideline in 2015. This guideline was updated using a Standing Committee of healthcare professionals, methodologists and lay members from a range of disciplines and localities, as well as topic experts.

The methods and processes for developing NICE clinical guidelines can be found here.

3.2 Related NICE guidance

Details are correct at the time of publication (March 2015). Further information is available on the NICE website.

Published

General

- Medicines adherence (2009) NICE guideline CG76

Condition-specific

- Self-harm: longer-term management (2011) NICE guideline CG133
- Generalised anxiety disorder and panic disorder (2011) NICE guideline CG113
- Social and emotional wellbeing in secondary education (2009) NICE guideline PH20
- Depression in adults with a chronic physical health problem (2009) NICE guideline CG91
- Depression in adults (2009) NICE guideline CG90

- Computerised cognitive behaviour therapy for depression and anxiety (2006) NICE technology appraisal guidance 97
- Post-traumatic stress disorder (PTSD) (2005) NICE guideline CG26
- Self-harm: short-term management (2004) NICE guideline CG16
- Eating disorders (2004) NICE guideline CG9

Under development

NICE is developing the following guidance (details available from the NICE website):

- Transition from children's to adult services. NICE guideline. Publication expected February 2016
- Transition between inpatient mental health settings and community and care home settings. NICE guideline. Publication expected August 2016
- Child abuse and neglect. NICE guideline. Publication date to be confirmed
- Social and emotional wellbeing in primary and secondary education. Public Health Guidance update. Publication date to be confirmed

3.3 Standing Committee

Members of Standing Committee B and the topic experts for the 2015 update are listed on the NICE website.

For the composition of the previous Guideline Development Group, see the full guideline.

3.4 Clinical Guidelines Update Team

Philip Alderson
Clinical Adviser

Emma Banks
Co-ordinator

Elizabeth Barrett
Information Scientist

Paul Crosland
Health Economist

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Kathryn Hopkins
Technical Analyst

Susannah Moon
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Charlotte Purves
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3.5 NICE project team

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James Hall
Editor

Mark Baker
Guideline Lead

Judith Thornton
Technical Lead

Jennifer Wells
Guideline Coordinator

3.6 Declarations of interests

The following members of the Standing Committee made declarations of interest under the new NICE policy (2014). All other members of the Committee stated that they had no interests to declare.

Committee member	Interest declared	Type of interest	Decision taken
Susan Bewley	Self-employed academic and obstetric expert	Personal financial interest	Declare and participate
Susan Bewley	100 hour per annum teaching contract with Kings College London	Personal financial interest	Declare and participate

Susan Bewley	In the last 12 months received income or fees for: • Research projects as a principal or co-investigator or giving expert advice (presently these include projects on major postpartum haemorrhage, the organisation of maternity care, gestation time for abortion) • Academic supervision (PhD on implementation of external cephalic version, chair of 35/39 TSC on the timing of induction) • Teaching (BSc law and ethics tutor at KCL, occasional fees for lectures on obstetrics) • Medico-legal reports (approx. 2/year) and Medical Defence Union cases committee and council • External reviews for NHS organisations related to my obstetric expertise (serious incident and maternal mortality investigations, RCOG review) • Chairing NICE GDG • Expert advice to NHS Quest (development of a maternity 'safety thermometer') • Royalties from edited books • Advice to Marie Stopes International about obstetric standards	Personal financial interest	Declare and participate

Susan Bewley	Expenses paid to attend conferences to lecture on obstetric topics. In the last year this included speaking to a Human Rights conference at the Hague, the Royal Society of Edinburgh, and the International Society of Psychosomatic Obstetrics and Gynaecology, and attending the British Maternal Fetal Medicine Society conference. Received a community grant to attend the British HIV Association conference	Personal financial interest	Declare and participate
Susan Bewley	Joint intellectual property rights in a new neonatal resuscitation trolley, but these were negotiated to be handed over to Liverpool University and Inditherm. In return, the inventors have negotiated that a fee generated on the sale of each trolley will be given to charity	Non-personal financial interest	Declare and participate
Susan Bewley	Expressed views in publications about obstetric matters, largely based on evidence	Personal non-financial interest	Declare and participate
Susan Bewley	A trustee and committee member of Healthwatch (a charity devoted to evidence and "for treatments that work") and a trustee of Sophia (a charity devoted to women with HIV and the UK arm of the Global Coalition for Women and AIDS)	Personal non-financial interest	Declare and participate
Susan Bewley	Member of the following editorial boards: Medical Law Review, International Journal of Childbirth, JASS (Journal Article Summary Service); Member of the London Clinical Senate; Member of the Mayor's Office for Policing and Crime Violence Against Women and Girls Panel; Member All-Parliamentary Party Group on Maternity; Trustee of Maternity Action (a charity which aims to end inequality and improve the health and well-being of pregnant women, partners and young children), one of seven members of the Women's Health and Equality Consortium which is a Strategic Partner of the Department of Health	Personal non-financial interest	Declare and participate

Susan Bewley	Expert advice to Salamander Trust (funded by WHO to perform a global community consultation of women living with HIV to inform Sexual and Reproductive Health and Human Rights guideline update)	Personal financial interest	Declare and participate
Susan Bewley	Expenses paid to attend and present at 'Changing Motherhood' and 'Assisted reproduction that harms' conferences	Personal financial interest	Declare and participate
Gita Bhutani	Chair of Psychological Professions Network North West	Personal non-financial interest	Declare and participate
Gita Bhutani	Member of British Psychological Society; Division of Clinical Psychology; Faculty of Leadership and Management Committee Member	Personal non-financial interest	Declare and participate
Gita Bhutani	Project lead on BPS Division of Clinical Psychology project on 'Comprehensively representing the complexity of psychological services'	Personal non-financial interest	Declare and participate
Gita Bhutani	Analytical support in partnership with Liverpool University on Liverpool Health Partners project on Patient Quality and Safert	Personal non-financial interest	Declare and participate
Simon Corbett	Network Service Adviser for the British Cardiovascular Society. This role incorporates the regional specialty adviser role for the Royal College of Physicians	Personal non-financial interest	Declare and participate
Simon Corbett	Acting Director for Clinical Effectiveness for employer (University Hospital Southampton NHS Foundation Trust). Part of this role involves the dissemination and implementation of NICE guidance in the Trust	Personal non-financial interest	Declare and participate
John Graham	Director of National Collaborating Centre for Cancer – this post is funded through a contract with NICE to produce NICE's clinical guidelines	Non-personal financial interest	Declare and participate

John Graham	Principal investigator for ongoing clinical trials in prostate cancer: 1) With Custirsen funded by OncoGenex Technologies Inc and Teva Pharmaceutical Industries Ltd 2) Orteronel Affinity Trial funded by Millenium Pharmaceuticals Inc 3) Principal investigator for a study of radium-223 in prostate cancer that is funded by Bayer Pharmaceuticals	Non-personal financial interest	Declare and participate
John Graham	Principal investigator for 8 ongoing clinical trials in breast and prostate cancer run via the National Cancer Research Network (not pharmaceutical industry funded)	Non-personal financial interest	Declare and participate
John Graham	Member of the trial management groups for 2 prostate cancer trials: RT01 and CHHIP. Both are closed to recruitment but continuing to report trial results	Personal non-financial interest	Declare and participate
John Graham	Consultancy work for NICE International on a project with the Philippines Department of Health to produce clinical guidelines on breast cancer. Travel expenses paid	Personal non-financial interest	Declare and participate
John Graham	Council member of the South-West England Clinical Senate	Personal non-financial non specific	Declare and participate
Peter Hoskin	Investigator in research studies sponsored by various companies with payment for expenses to NHS Trust and department which fund research staff. Recent studies have been on behalf of Millenium, Astellas, Ipsen and Amgen	Non-personal financial interest	Declare and participate
Peter Hoskin	Fellow of the Royal College of Radiologists and member of Faculty Board, Specialist Training Board and Chair of Exam Board	Personal non-financial interest	Declare and participate

Peter Hoskin	Consultant to the IAEA; Undertake by invitation lectures and working group meetings for which expenses may be paid	Personal financial interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on alpharadin by Astellas	Non-personal financial interest	Declare and participate
Peter Hoskin	Department reimbursed for studies on MDV 3100 by Medivation. and Astellas	Non-personal financial interest	Declare and participate
Peter Hoskin	Department receives grants from Astellas for trials in prostate cancer	Non-personal financial interest	Declare and participate
Peter Hoskin	Department receives grants from Bayer for trials in prostate cancer	Non-personal financial interest	Declare and participate
Peter Hoskin	Department received grants from Millennium for trials in prostate cancer	Non-personal financial interest	Declare and participate
Peter Hoskin	Trustee for funding research within the unit/ department. Funded by Donations/Legacies. No Non-Hodgkin's lymphoma research has been funded in the last 12 months	Personal non-financial interest	Declare and participate
Peter Hoskin	Chair Steering Group for National Cancer Intelligence Network (NCIN)	Personal non-financial interest	Declare and participate
Peter Hoskin	Member of the faculty board of the Royal College of Radiologists	Personal non-financial interest	Declare and participate
Peter Hoskin	Member of the specialist training committee for the Royal College of Radiologists	Personal non-financial interest	Declare and participate

Peter Hoskin	Editorial board member for the Journal of Contemporary Brachytherapy	Personal non-financial interest	Declare and participate
Peter Hoskin	Member of the East of England senate	Personal non-financial interest	Declare and participate
Peter Hoskin	Member of the NICE standing committee for rapid updates / and non-Hodgkin's lymphoma GDG	Personal non-financial interest	Declare and participate
Roberta James	Programme Lead at Scottish Intercollegiate Guidelines Network (SIGN)	Personal financial interest	Declare and participate
Roberta James	Member of Guideline Implementability Research and Application network (GIRAnet)	Personal non-financial interest	Declare and participate
Roberta James	Expert group member of Project on a Framework for Rating Evidence in Public Health (PRECEPT)	Personal non-financial interest	Declare and participate
Asma Khalil	Member of the National Clinical Reference Group for Fetal Medicine	Personal non-financial	Declare and participate
Asma Khalil	Co-chair of the "Improving Outcomes" working group, South West London Maternity Network	Personal non-financial	Declare and participate
Asma Khalil	Associate Editor for the journal Biomedical Central Pregnancy and Childbirth	Personal non-financial	Declare and participate
Asma Khalil	Member of the Maternal and Fetal Medicine National Clinical Study Group	Personal non-financial	Declare and participate
Asma Khalil	Assistant Convenor for the MRCOG Part1 course, RCOG	Personal non-financial	Declare and participate

Asma Khalil	Principal Investigator at St George's Hospital for several NIHR funded studies, e.g. Non-invasive Prenatal Testing	Personal non-financial	Declare and participate
Asma Khalil	Chief Investigator for Cardiovascular changes in Pregnancy (CVP) study and Quantitative fetal fibronectin, Cervical length and ActimPartus® for the prediction of Preterm birth in Symptomatic women (QFCAPS)	Personal non-financial	Declare and participate
Asma Khalil	Collaboration with commercial companies, such as USCOM®, Roche Diagnostics®, Alere Diagnostics® and proact medical Ltd® (research equipment and/or consumables)	Personal non-financial	Declare and participate
Asma Khalil	Reviewer for the National Maternal Near-miss Surveillance Programme (UKNes)	Personal non-financial	Declare and participate
Manoj Mistry	Public member of Pennine Care NHS FT in the capacity as a carer	Personal non-financial interest	Declare and participate
Manoj Mistry	PPI representative for the Health Research Authority (London)	Personal non-financial interest	Declare and participate
Manoj Mistry	PPI representative for the Health Quality Improvement Partnership (London)	Personal non-financial interest	Declare and participate
Manoj Mistry	PPI representative for the Primary Care Research in Manchester Engagement Resource group at the University of Manchester	Personal non-financial interest	Declare and participate
Manoj Mistry	Carer representative on NICE Guideline Development Group: 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'	Personal non-financial interest	Declare and participate
Manoj Mistry	Appointed Lay representative for the MSc (Clinical Bioinformatics) at the University of Manchester	Personal non-financial interest	Declare and participate

Manoj Mistry	Appointed 'Lay Educational Visitor' with the Health and Care Professions Council. (London)	Personal non-financial interest	Declare and participate
Manoj Mistry	Appointed Lay representative at the Clinical Research Facility (collaboration between Central Manchester University Hospital NHS FT/ University of Manchester)	Personal non-financial interest	Declare and participate
Manoj Mistry	Public Representative Interviewer at the Medical School, Lancaster University	Personal non-financial interest	Declare and participate
Manoj Mistry	Public Member of NUHS 'Research for Patient Benefit Programme Committee' (North West region)	Personal non-financial interest	Declare and participate
Amaka Offiah	Provision of expert advice to Her Majesty's Courts in cases of suspected child abuse	Personal financial interest	Declare and participate
Amaka Offiah	Recipient of honoraria and expenses for lectures and guidelines development from BioMarin	Personal financial interest	Declare and participate
Amaka Offiah	Chairperson Skeletal Dysplasia Group for Teaching and Research	Personal non-financial interest	Declare and participate
Amaka Offiah	Chairperson Child Abuse Taskforce of the European Society of Pediatric Radiology	Personal non-financial interest	Declare and participate
Amaka Offiah	Member Joint RCR/RCPCH NAI Working Party for Guideline Update - Imaging in Suspected Non-Accidental Injury	Personal non-financial interest	Declare and participate
Amaka Offiah	Member of the Royal College of Radiology Academic Committee	Personal non-financial interest	Declare and participate

Amaka Offiah	Committee member of the International Consortium for Vertebral Anomalies and Scoliosis	Personal non-financial interest	Declare and participate
Amaka Offiah	Member of South Yorkshire (Sheffield) Research Ethics Committee	Personal non-financial interest	Declare and participate
Amaka Offiah	Medical Academic Staff Committee Representative of the Yorkshire Regional Council of the BMA	Personal non-financial interest	Declare and participate
Amaka Offiah	Partner Governor of the Sheffield Children's NHS Foundation Trust (representing the University of Sheffield)	Personal non-financial interest	Declare and participate
Amaka Offiah	Editorial Committee Member of the journal Paediatric Radiology	Personal non-financial interest	Declare and participate
Amaka Offiah	Recipient of research funding from NIHR, ARUK, The Sheffield Children's Charity, Skeletal Dysplasia Group for Teaching and Research	Non-personal financial interest	Declare and participate
Amaka Offiah	Member of the Sheffield Children's Hospital Research and Innovations Committee	Personal non-financial	Declare and participate
Mark Rodgers	Associate editor of the journal Systematic Reviews that publishes research on health and social care	Personal non-financial non-specific interest	Declare and participate
Mark Rodgers	Research fellow in health services research; has provided independent academic reviews of clinical effectiveness and diagnostic accuracy evidence for funders including NIHR and NICE	Non-personal non-financial non-specific interest	Declare and participate
Mark Rodgers	Employee of the Centre for Reviews and Dissemination (University of York) which provides Evidence Review Group (ERG) reports and Technology Assessment Reports (TARs) as part of the NICE technology appraisals process	Non-personal financial non-specific	Declare and participate

Nicholas Steel	Currently finishing work as the principal investigator on a National Institute of Health Research (NIHR) funded project on: 'Are NICE clinical guidelines for primary care based on evidence from primary care?'	Non-personal financial interest	Declare and participate
Nicholas Steel	National Institute for Health Research (NIHR) Health Services & Delivery Research Programme Healthcare Delivery Research Panel member	Personal non-financial interest	Declare and participate
Nicholas Steel	NIHR Regional Advisory Committee for the Research for Patient Benefit Programme East of England region	Personal non-financial interest	Declare and participate
Nicholas Steel	Norfolk & Suffolk Primary & Community Care Research Steering Group	Personal non-financial interest	Declare and participate
Nicholas Steel	Advisory Committee on Clinical Excellence Awards (ACCEA) East of England	Personal non-financial interest	Declare and participate
Nicholas Steel	'Implementation Science' Editorial Board member	Personal non-financial interest	Declare and participate
Nicholas Steel	'Quality in Primary Care' Editorial Board member	Personal non-financial interest	Declare and participate
Nicholas Steel	Faculty of Public Health Part A MFPH Examiner	Personal non-financial interest	Declare and participate
Nicholas Steel	Faculty of Public Health Part A MFPH Development Committee	Personal non-financial interest	Declare and participate
Nicholas Steel	Honorary Public Health Academic Consultant, Public Health England	Personal non-financial interest	Declare and participate

Nicholas Steel	Publication in press: Steel N, Abdelhamid A, Stokes T, Edwards H, Fleetcroft R, Howe A, Qureshi N. Publications cited in national clinical guidelines for primary care were of uncertain relevance: literature review. In Press Journal of Clinical Epidemiology	Personal non-financial interest	Declare and participate
Sietse Wieringa	At the Centre for Primary care & Public Health at Barts & The London School of Medicine & Dentistry/Queen Mary University I am working on a literature review of 'mindlines' (related to communities of practice) and a qualitative study of a large group of GPs on a virtual social network sharing medical knowledge. I was funded for this via an NIHR In practice fellowship	Personal financial interest	Declare and participate
Sietse Wieringa	I co-own a small social enterprise called ZorgIdee that develops ideas to help GPs to collaborate. There are no current funders	Personal financial interest	Declare and participate
Sietse Wieringa	Board member of the Platform of Medical Leadership in the Netherlands, via which I am involved in a mixed methods study for the development of a medical leadership competency framework. The study group receives funds from KNMG (Royal Dutch College of Medicine) and SBOH which receives its funds from the Dutch Ministry of Health	Non-personal financial interest	Declare and participate
Sietse Wieringa	Member of Generation Next, a think tank and network of young GPs. It's indirectly funded by the Ministry of Health	Personal non-financial interest	Declare and participate
Sietse Wieringa	Member of NHG (Dutch GP Society), which produces guidelines and I worked for this organisation in the past	Personal non-financial interest	Declare and participate
Topic-specific member	**Interest declared**	**Type of interest**	**Decision**
Peter Fonagy	None	N/A	No action

Lynn Henderson	Registration with the Nursing and Midwifery Council (Registered Nurse - Learning Disabilities)	Personal non-financial	Declare and participate
Lynn Henderson	Graduate Membership of the British Psychological Society; Division of Clinical Psychology	Personal non-financial	Declare and participate
Lynn Henderson	Membership of the British Association of Behavioural and Cognitive Psychotherapies	Personal non-financial	Declare and participate
Peta Mees	None		No action
Maria Moldavsky	None		No action
Anna Wilson	None		No action

Appendix A: Glossary

Active listening A way of listening that focuses entirely on what the other person is saying and confirms understanding of both the content of the message and the emotions and feelings underlying the message to ensure that understanding is accurate.

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

Adverse drug reaction Any undesirable experience that results from the administration of a pharmacologically active agent.

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

CAMHS Child and Adolescent Mental Health Service(s).

CAMHS link worker See **Primary mental health worker**

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

Child An individual aged 5–11 years.

Child and Adolescent Psychiatric Assessment (CAPA) An interviewer-based diagnostic interview with versions for use with children and their parent(s).

Cognitive behavioural therapy (CBT) A range of behavioural and cognitive behavioural therapies, in part derived from the cognitive behavioural model of affective disorders, in which the patient works collaboratively with a therapist using a shared formulation to achieve specific treatment goals. These may include recognising the impact of behavioural and/or thinking patterns on feeling states and encouraging alternative cognitive and/or behavioural coping skills to reduce the severity of target symptoms and problems.

Conversational technique This term is used in the guideline to emphasise the importance of a two-way communication. A collaboration between patient and healthcare professional aims to ensure that the patient feels able to express their feelings in the healthcare setting safe in the knowledge that their healthcare professional will listen.

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

Depression unresponsive to treatment Depression that has failed to respond to two or more antidepressants taken at an adequate dose for an adequate duration given sequentially.

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

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

Effectiveness The extent to which a specific intervention, when used under ordinary circumstances, does what it is intended to do. Clinical trials that assess effectiveness are sometimes called management trials.

Efficacy The extent to which an intervention produces a beneficial result under ideal conditions. Clinical trials that assess efficacy are sometimes called explanatory trials and are restricted to participants who fully cooperate. The randomised controlled trial is the accepted 'gold standard' for evaluating the efficacy of an intervention.

Electroconvulsive therapy (ECT) A therapeutic procedure in which an electric current is briefly applied to the brain to produce a seizure. This is used for treatment of severe depression symptoms or to ease depression that isn't responding well to other forms of treatment. It is sometimes called convulsive therapy, electroshock therapy or shock therapy.

Family therapy Family therapy sessions based on systemic, cognitive behavioural or psychoanalytic principles, which may include psychoeducational, problem-solving and crisis management work, and might involve specific interventions with a depressed child or young person.

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

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

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

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

Healthcare professionals A generic term used in this guideline to coverall health professionals such as GPs, psychologists, psychotherapists, psychiatrists, paediatricians, school doctors, nurses (including school and community based), health visitors, counsellors, art therapists, music therapists, drama therapists and family therapists who work with children and young people and whose work may involve considering the young person's additional psychological needs.

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

Meta-analysis The use of statistical techniques in a systematic review to integrate the results of several independent studies.

Mild depression Four depressive symptoms as defined by the ICD-10.

Moderate depression Five or six depressive symptoms as defined by the ICD-10.

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

Multidisciplinary review A comprehensive review of the child or young person's situation that involves professionals additional to the therapist(s) delivering treatment. This review should consider a range of sources of information including evidence of functioning at home, school and other relevant settings and should take account of the wishes of the child or young person and their parent(s) or carer(s).

Multidisciplinary team For the purposes of this guideline this term refers to professionals who are involved in the care of a child or young person working in partnership across all tiers. Members of the team are likely to include healthcare professionals (including CAMHS professionals, GPs, health visitors and school nurses), teachers, social services and voluntary agencies.

Non-directive supportive therapy (NDST) This therapy involves the planned delivery of direct individual contact time with an empathic, concerned and skilled non-specialist CAMHS professional to offer emotional support and non-directive problem solving as appropriate and to review the child or young person's state (for example, depressive symptoms, school attendance, suicidality, recent social activities) in order to assess whether specialist help is needed.

Primary mental health worker (PMHW) Sometimes also called 'CAMHS link worker'. This role was described in *NHS Health Advisory Service*, *Together We Stand* (London: NHS Health Advisory Service, 1995) and was recommended as a way of improving the relationship, communication and collaboration between specialist mental health services (CAMHS) and the wider network of services working with children, such as schools, youth and community services, primary care, etc. Primary mental health workers tend to operate in tiers 1 and 2. In some parts of the UK, including Scotland, this has led to the establishment of PMHW posts. In other areas the role has been developed, but delivered in a variety of ways. In some cases, workers are employed specifically to deliver primary mental health work, whilst in others, this work is achieved through an extension of pre-existing professional roles.

Psychoanalytic/psychodynamic child psychotherapy Psychodynamic interventions are defined as psychological therapies derived from a psychodynamic/psychoanalytic model, and where:

1. Therapist and patient explore and gain insight into conflicts and problem behaviours, modes of thought and relating and how these are represented in current situations and relationships including the therapy relationship (for example, transference and counter-transference).

2. This leads to patients being given an opportunity to explore through play, drawing, talking and behaviour, feelings and conscious and unconscious conflicts, originating in the past or in learnt

behaviour. The technical focus is on interpreting and working through conflicts and recurrent problematic areas of behaviour and relating as they manifest in the treatment situation.

3. Therapy is non-directive and recipients are not taught specific skills (such as thought monitoring, re-evaluating, or problem solving).

Psychological therapies A group of treatment methods that involve psychosocial rather than physical intervention. They include cognitive behavioural therapy, family therapy, systemic family therapy, non-directive supportive therapy, psychodynamic psychotherapy, group psychotherapy, counselling, art therapy, interpersonal psychotherapy, guided self-help and any other form of treatment that aims to be helpful through the communication of thoughts and feelings in the presence of a therapist, who works with the material using a systematic framework for understanding and responding to it.

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

Randomisation A method used to generate a random allocation sequence, such as using tables of random numbers or computer-generated random sequences. The method of randomisation should be distinguished from concealment of allocation, because if the latter is inadequate, selection bias may occur despite the use of randomisation. For instance, a list of random numbers may be used to randomise participants, but if the list were open to the individuals responsible for recruiting and allocating participants, those individuals could influence the allocation process, either knowingly or unknowingly.

Randomised controlled trial (RCT) (also termed **randomised clinical trial**) An experiment in which investigators randomly allocate eligible people into groups to receive or not to receive one or more interventions that are being compared. The results are assessed by comparing outcomes in the different groups. Through randomisation, the groups should be similar in all aspects apart from the treatment they receive during the study.

Recurrent depression The development of a depressive disorder in a person who has previously suffered from depression.

Relapse The reappearance of disease signs and symptoms after apparent remission. The definitions of relapse used in the review in the guideline were those adopted by the individual studies and varied between studies.

Remission Diminution or disappearance of symptoms.

Risk profiling A structured assessment and analysis of those factors in a child or young person's environment and history that are known to increase the risk of depression.

Screening Screening is defined by the Guideline Development Group as a simple test performed on a large number of people to identify those who have depression.

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

Severe depression Seven or more depressive symptoms as defined by the ICD-10.

Sleep hygiene Behavioural practices that promote continuous and effective sleep.

Stepped care A considered, organised, coordinated approach to screening, assessment, treatment and onward referral by an individual practitioner, team or care provider organisation, within the parameters of defined protocols or pathways. These approaches may or may not be provided within the context of a fixed budget (for example, the Health Maintenance Organisation [HMO] in the USA). Local healthcare commissioning organisations are required to develop protocols for the treatment of depression in primary care within the National Service Framework for Mental Health.

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

Subsyndromal depression (subthreshold depression) Depressive symptoms that fail to meet the criteria for major depressive disorder. This type of depression is not covered by this guideline.

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

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.

Tricyclic antidepressants (TCAs) The original class of antidepressants used to treat depression by increasing levels of the neurotransmitters serotonin and noradrenaline.

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

Young person An individual aged between 12 and 18.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions.

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

This guideline was developed by the National Collaborating Centre for Mental Health, which is based at the Royal College of Psychiatrists. The Collaborating Centre worked with a Guideline Development Group, comprising healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, which reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in the guidelines manual.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Update information

Recommendations on psychological therapies and antidepressants have been added to and updated in sections 1.5 and 1.6.

Recommendations are marked as **[new 2015]**, **[2015]** or **[2005]**:

- **[new 2015]** indicates that the evidence has been reviewed and the recommendation has been added or updated
- **[2015]** if the evidence has been reviewed but no change has been made to the recommendation
- **[2005]** if the evidence has not been reviewed since the original guideline.

Strength of recommendations

Some recommendations can be made with more certainty than others. The Guideline Development Group makes a recommendation based on the trade-off between the benefits and harms of an intervention, taking into account the quality of the underpinning evidence. For some interventions, the Guideline Development Group is confident that, given the information it has looked at, most patients would choose the intervention. The wording used in the recommendations in this guideline denotes the certainty with which the recommendation is made (the strength of the recommendation).

For all recommendations, NICE expects that there is discussion with the patient about the risks and benefits of the interventions, and their values and preferences. This discussion aims to help them to reach a fully informed decision (see also patient-centred care).

Interventions that must (or must not) be used

We usually use 'must' or 'must not' only if there is a legal duty to apply the recommendation. Occasionally we use 'must' (or 'must not') if the consequences of not following the recommendation could be extremely serious or potentially life threatening.

Interventions that should (or should not) be used – a 'strong' recommendation

We use 'offer' (and similar words such as 'refer' or 'advise') when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, 'Do not offer…') when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use 'consider' when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient's values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Recommendation wording in guideline updates

NICE began using this approach to denote the strength of recommendations in guidelines that started development after publication of the 2009 version of 'The guidelines manual' (January

2009). This does not apply to any recommendations ending [2005] or [2015] (see 'Update information' box below for details about how recommendations are labelled). In particular, for recommendations labelled [2005] or [2015], the word 'consider' may not necessarily be used to denote the strength of the recommendation.

Other versions of this guideline

The full guideline, depression in children and young people: identification and management in primary, community and secondary care, contains details of the methods and evidence used to develop the guideline. It is published by the National Collaborating Centre for Mental Health.

The recommendations from this guideline have been incorporated into a NICE pathway.

We have produced information for the public about this guideline.

Implementation

Implementation tools and resources to help you put the guideline into practice are also available.

Your responsibility

This guidance represents the view of NICE, 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. However, the guidance does not 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 guardian or carer, and informed by the summaries of product characteristics of any drugs.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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