Depression in children and adolescents: a commentary on the NICE guidance

Francesca Falzon Aquilina[1,*], Norma Verdolini[2], Mark Agius[3], Zoltan Rihmer[4,5]

[1] Department of Psychiatry, Mount Carmel Hospital, Attard, Malta

[2] Division of Psychiatry, Clinical Psychology and Psychiatric Rehabilitation, Department of Medicine, University of Perugia, Italy

[3] Clare College Cambridge, Department of Psychiatry, University of Cambridge, Cambridge, UK

[4] Department of Psychiatry and Psychotherapy, Kútvölgyi Clinical Center, Semmelweis University, Budapest, Hungary

[5] Laboratory of Suicide Prevention and Research, National Institute for Psychiatry and Addictology, Budapest, Hungary

***Corresponding author email: francesca.falzon-aquilina@gov.mt**

Abstract

The NICE guidelines for treatment of depression in children and adolescents are reviewed. Depression is not an uncommon presentation in children and adolescents. Treatment is a balance between risk and benefits, in particular with reference to use of medication. Treatment depends on very accurate diagnosis, as well as assessment of the possible psychosocial causes of depression. It is necessary to distinguish which causes can be altered by social intervention, which by psychological treatments and which require medication. If medication is necessary, choice of medication must be determined by the balance of evidence regarding its efficacy and adverse effects. Before committing to using medication, the possibility of bipolar disorder must be considered and eliminated. There is limited evidence for the efficacy of antidepressants in this age group and most antidepressants do not have a licence for use in children. Despite these problems, careful assessment and treatment can improve outcomes.

Keywords: depression, children, adolescents, SSRIs, risk profiling, CBT, interpersonal psychotherapy, family therapy

Introduction

Depression is not an uncommon presentation in children and adolescents. There is an estimated one-year incidence of 4 - 5% in mid-to-late adolescence (1).

There are important consequences of depression in adolescents. It is a major risk factor for suicide, which is a leading cause of death in this age group. More than half of adolescent suicide victims are reported to have had a depressive disorder at time of death. Depression causes serious social and educational impairments. Depression in adolescents is associated with an increased rate of smoking, substance misuse and obesity (2). All of these consequences of depression make its treatment in this age group an important concern.

The following statistics are taken from the Young Minds website (www.youngminds.org.uk): In the UK, 1 in 10 children and young people aged 5 -16 have a diagnosable mental health disorder - that is, around three children in every school class (3); in the UK, between 1 in 12 and 1 in 15 children and young people deliberately self-harm (4); in recent years, there has been a marked increase in the number of young people admitted to hospital because of self-harm. Over the last 10 years this figure has increased by 68% (5); more than half of all adults with mental health problems were diagnosed in childhood. However, less than half were treated appropriately at the time (6).

Nearly 80,000 children and young people suffer from severe depression. Over 8,000 children aged under 10 years of age have severe depression (3). It has been observed that the number of young people aged 15 - 16 diagnosed with depression nearly doubled between the 1980s and the 2000s (7). It is further observed that 0.9%, or nearly 80,000, children and young people in the UK are seriously depressed, 0.2%, or about 8,700, 5 - 10-year-olds are seriously depressed and 1.4%, or about 62,000, 11 - 16 year-olds are

seriously depressed.

Some general points can be made about mental health problems, including depression, in children and young people (8). Mental health problems in children and young people cause distress and can have wide-ranging effects, including having an impact on educational attainment and social relationships, as well as affecting life chances and physical health (9, 10). These mental health problems can be long-lasting. 50% of mental illness in adult life (including depression but excluding dementia) starts before age 15, and 75% has commenced by age 18 (11). In addition, there are well-identified increased physical health problems associated with mental health (12-15).

Psychosocial conditions are particularly important in this age group. There are strong links between mental health problems in children/young people and social disadvantage, so that those in the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes (3).

Parental mental illness is associated with increased rates of mental health problems in children and young people. It is estimated that one-third to two-thirds of children and young people, whose parents have a mental health problem, have mental health problems themselves (16-18).

Mental health problems in children and young people are associated with costs estimated at between £11,030 and £59,130 annually per child (19). In the UK, these costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family. However, there are clinically proven and cost-effective interventions.

Detection and risk profiling

It is important that healthcare professionals in primary care, including GPs, health visitors and social workers, as well as teachers, youth workers, clergy and others should be trained to detect the signs and symptoms of depression, and to assess children and young people who may be at risk of depression (20). Such 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, drug and alcohol use, and history of parental depression, the natural history of single-loss events, such as divorce or bereavement, and 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. Primary care staff need to be aware of how to refer patients to appropriate services. All services need to work together in a joined-up fashion.

Diagnosis of depression in children and young persons

Depression is a broad diagnosis which can include different symptoms in different people. Key signs of depression are depressed mood or loss of pleasure in most activities. Depressive symptoms are frequently accompanied by symptoms of anxiety, but they may also occur without any significant apparent anxiety. For a diagnosis of depression, symptoms should be present for at least two weeks and each symptom should be present for most of the day.

The International Classification of Diseases (ICD-10) uses an agreed list of 10 depressive symptoms: persistent sadness or low mood, loss of interest and pleasure, fatigue or low energy, disturbed sleep, poor concentration, low self-confidence, poor or increased appetite, suicidal thoughts or acts, guilt or self-blame, and agitation or slowing of movement. The ICD-10 divides diagnosis of depression into four categories:

- not depressed (fewer than four symptoms)
- mild depression (four symptoms)
- moderate depression (five or six symptoms)
- severe depression (seven or more symptoms, with or without psychotic symptoms)

However, there is debate whether the distinction between mild and moderate depression can be made on symptom count alone.

For any child or young person with a suspected mood disorder, a family history should be obtained to check for unipolar or bipolar depression in parents, siblings, grandparents and other close relatives. (20). This is very important, because if the patient has bipolar disorder, or occult bipolar disorder, the treatment may need to be different. The use of SSRIs as described in this article is only appropriate in unipolar depression.

The family context, previous history and the degree of associated impairment are all important in helping the assessment of depression. It is also important to assess how the child or young person functions in different settings, such as at school, with peers and with family, as well as asking about specific symptoms of depression (20).

NICE recommends that training opportunities should be made available to improve the accuracy with which child and adolescent mental health services (CAMHS) professionals diagnose depressive conditions. Furthermore, NICE recommends that the existing interviewer-based instruments (such as Kiddie-SADS [K-SADS] and the Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose, but it acknowledges that such instruments will need modification if they are to be regularly used in busy routine CAMHS settings. Alternatively, NICE recommends the use of the self-report Mood and Feelings Questionnaire (MFQ) as an adjunct to clinical judgement (20).

General considerations in assessment and diagnosis

It is important when considering depression in children and young people to consider safeguarding issues. Child maltreatment is common and can present anywhere, including in emergency departments, in primary care and on home visits. Abuse can be a contributory factor or even the cause of the symptoms or signs of depression in children. Child abuse may present as, and coexist with, depression (20).

When assessing a child or young person with depression, healthcare professionals should routinely consider, and record in the patient's notes, potential comorbidities. They should also consider the social, educational and family context of the patient and family members. Healthcare professionals should consider the quality of interpersonal relationships between the patient, other family members, their friends and their peers.

Comorbid conditions, as well as developmental, social and educational problems, need to be assessed and managed, in sequence or in parallel with the treatment of depression. It is appropriate that this should be managed through consultation and alliance with the patient’s wider network, including both education and social care (20).

When assessing a child or young person with depression, healthcare professionals should always ask the patient, and their parents or carers, directly about the child or young person's alcohol and drug use, as well as any experience of being bullied or abused. Asking about self-harm and ideas about suicide is also mandatory. The young person should be offered the opportunity to discuss these issues initially in private. If a child or young person with depression presents acutely having self-harmed, then the self-harm must be treated (20). When assessing a child or young person with depression, healthcare professionals should always ask the patient what self-help materials they have accessed.

It is also important to pay attention to the possible psychiatric needs of the parents (particularly in regard to depression), and to ask about associated problems of living so that they can be treated in parallel, in order to achieve improvement in the mental health of the child or young person. If such a need is identified, then a plan for obtaining treatment should be made in collaboration with adult mental health provision and other services. In addition, consideration should be given to the possibility of parental substance misuse and accompanying problems of living, as these are often associated with depression in the child or young person and, if untreated, may have a negative impact on the success of their treatment (20).

The form of assessment should take account of cultural and ethnic variations in communication, family values and the place of the child or young person within the family. Regarding issues of ethnicity, the UK is a multicultural nation with many different ethnic minorities. Information, including written information, needs to be available in languages which patients can understand. Psychological therapies also need

to be offered in appropriate languages; healthcare professionals need to be culturally competent and know how depression may be expressed in different cultures; interpreters should be available as needed; services should be developed with the input of all appropriate stakeholders (20).

When assessing and treating depression in children and young people, special attention should be paid to issues of confidentiality, the young person's consent, parental consent, child protection, the use of the Mental Health Act in young people and the use of the Children Act. The social network around the young person must be properly assessed by the healthcare professionals before treatment is started. This should include a written formulation, identifying factors that may have contributed to the development and maintenance of depression, and an assessment of how these factors may impact, positively or negatively, on the efficacy of the treatments offered. This formulation should indicate the ways that the healthcare professionals may work in partnership with the social and professional network of the young person (20).

Evidence-based treatments for depression

General considerations in treatment

It is important that children, young people and their families are given good information, received as part of a collaborative and supportive relationship with healthcare professionals, so that they may give fully informed consent. Healthcare professionals involved in the treatment of children or young people with depression should aim to build a supportive and collaborative relationship with both the patient and their family or carers. Information should be provided to the patient, their parents and carers at appropriate times. This information must be attuned to the age and maturity of the child. The information will typically cover the nature, course and treatment of depression, as well an explanation of possible adverse effects of any medication (20).

Healthcare professionals should endeavour to engage the child or young person and their parents or carers in treatment decisions, taking full account of patient and parental expectations, so that they are able to give meaningful and properly informed consent to treatment. Families and carers need to be informed about self-help groups and support groups. They should be encouraged to participate in such programmes where appropriate (20).

When assessing a child or young person with depression, healthcare professionals should always, before giving advice, ask the patient about self-help materials or other methods which may be used or considered potentially helpful by the patient, their parents or carers. This may include making available educational leaflets and referrals to helplines, self-diagnosis tools, peer, social, and family support groups and religious and spiritual groups. Healthcare professionals should only recommend self-help materials or strategies as part of a supported and planned package of care (19). Because some complementary therapies may be counterproductive, healthcare professionals should also enquire about their use (20).

Comorbid diagnoses, as well as developmental, social and educational problems need to be assessed and managed, in sequence or in parallel with the treatment for depression. When appropriate this will involve consultation and co-working with schools and social care. When bullying is found to be a factor in a child or young person's depression, CAMHS, primary care and educational professionals should work collaboratively to prevent any further bullying and to ensure that effective anti-bullying strategies are being implemented (20).

NICE recommends that a child or young person with depression should be offered advice on the benefits of regular exercise. The young person should be 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. It is recommended that a child or young person with depression should be offered advice about sleep hygiene and anxiety management. NICE further recommends that a child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet (20).

Most children and young people who suffer from depression are treated on an outpatient or community basis. NICE divides its recommendations into stages according to whether the depression is mild, moderate or severe (20).

Mild depression

Antidepressant medication should not be used for the initial treatment of children and young people with mild depression. Children and young people who are diagnosed with mild depression and who do not want an intervention, or who, in the opinion of the healthcare professional, may recover with no intervention, should be offered a further assessment, normally within two weeks. This has been referred to as 'watchful waiting'. If the child does not return for this follow-up appointment, the healthcare professionals should contact them to offer a further appointment (20). After a period of watchful waiting for up to four weeks, children and young people with continuing mild depression, and without significant comorbidities or signs of suicidal ideation, should be offered individual non-directive supportive therapy, group cognitive behavioural therapy (CBT), or guided self-help for a limited period of approximately two to three months. This can be provided by appropriately trained professionals in primary care, schools, social services and the voluntary sector or in CAMH services. The choice of psychological therapies should be discussed with the child or young person and their family members or carers, and it should be explained that there is no good-quality evidence that one type of psychological therapy is superior (20). Those children and young people with mild depression who do not respond after two to three months of non-directive supportive therapy, group CBT, or guided self-help should be referred for review to CAMHS (20-27).

Psychological therapies used in the treatment of children and young people with depression should be provided by therapists who are competent in its delivery; they should be trained child and adolescent mental healthcare professionals (20). Therapists should develop a treatment alliance with the family. If this proves to be difficult, consideration should be given to providing the family with an alternative therapist.

Moderate-to-severe depression

In moderate-to-severe depression, it is clear from the evidence base that treatment should always, where possible, be in the form of psychological interventions, combined, where necessary, with medication. This combination is recommended by NICE (20).

Psychological interventions

There are effective treatments for depression in children and young people. CBT for depression has been shown to be effective in both individual and group settings; it is most likely to be helpful in the acute phase of the disorder and in individuals who are motivated. It appears that using CBT principles in general case management (such as careful monitoring of problems and lifestyle and providing practical suggestions about sleep, hygiene and diet) achieves good results. Interpersonal psychotherapy and family therapy are also effective, while attachment-based family therapy has been shown to be helpful for patients with severe suicidal ideation (28). NICE recommends that children and young people with moderate-to-severe depression should be offered a specific psychological therapy (individual CBT, interpersonal therapy, family therapy or psychodynamic psychotherapy) that runs for at least three months (20, 21-27, 29).

Again, the choice of psychological therapies should be discussed with the child or young person and their family members or carers; it should be explained that there is no good-quality evidence to indicate that one type of psychological therapy is better than the others (20).

If a child or young person with moderate-to-severe depression is unresponsive to psychological therapy after four to six treatment sessions, a multidisciplinary review should be held (20). If the depression is not responding to psychological therapy because 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, risk factors which can be altered should be addressed, alternative or perhaps additional psychological therapy for the parent or other family members, and alternative psychological therapy for the patient, should be considered.

Psychosocial interventions

Apart from specific psychological interventions, there is evidence supporting the use of adjunctive psychosocial treatments, which may speed up response to treatment and decrease the risk of suicide (28).

Medication

Medication, in the form of selective serotonin reuptake inhibitors (SSRIs), especially fluoxetine, are effective in the treatment of unipolar depression, and maintenance doses may be able to reduce the likelihood of recurrence. However, there has been a major controversy about their use because it was suggested that some SSRIs might increase the risk of suicide in this population (2). The decision regarding whether to use antidepressants in a specific case of depression is a matter of weighing up risks against benefits. A recent study from Hungary (30) showed that treatment with lithium and antidepressants reduced the risk of suicide in young patients under 20 years of age. The difficulty of balancing risk versus benefit are clear (31, 32). It may, however, be necessary to use SSRI medication in order to reduce the risk of suicide among depressed young patients.

To balance risks versus benefits, it is important that patients are assessed meticulously. Other diagnoses, such as bipolar disorder, which tends to develop initially as recurrent depression, followed by episodes of hypomania or mania (33-35) and possibly mixed states, should be excluded (36). Also, other possible co-morbidities must be identified and managed appropriately. Alcohol and drug misuse and family factors need to be identified, ensuring that all alterable causes of depression are addressed (20).

NICE recommends that antidepressants should be administered with care by a child and adolescent psychiatrist and reserved for moderate-to-severe depression. In this group, the only first-line treatment is fluoxetine. This is because fluoxetine is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks (20, 37-43). If an antidepressant is to be prescribed, this should only be following assessment and diagnosis by a child and adolescent psychiatrist (20). When a child or young person is started on antidepressant medication, the child, parents and carers must be informed about the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible adverse effects and the need to take the medication as prescribed. Such a discussion should be supplemented with written up-to-date information (20) about these issues. Fluoxetine should be offered following multidisciplinary review, if moderate-to-severe depression in a young person aged 12 - 18 years is unresponsive to a specific psychological therapy after four to six sessions (38-40, 42, 43). When the NICE guidelines were published in March 2015, fluoxetine was the only antidepressant approved in the UK for use in children and young people aged 8 - 18 years. Following multidisciplinary review, in a child aged 5 - 11 years whose moderate-to-severe depression is unresponsive to a specific psychological therapy after four to six sessions, one may consider the cautious use of fluoxetine, although the evidence for the effectiveness of fluoxetine in this age group is not established. When the NICE guidelines were published fluoxetine did not have a licence for use in the UK in children under the age of 8 years. Antidepressant medication should only be offered to a child or young person with moderate-to-severe depression in combination with concurrent psychological therapy (20).

In all patients, arrangements must be made for careful monitoring of adverse drug reactions, as well as reviewing mental state and general progress; there should be weekly contact with the child or young person and their parents or carers for the first four weeks of treatment. The frequency of contact should be decided on an individual basis and recorded in the notes. Usually, the therapist giving the psychological treatment and the doctor work together to monitor the patient; however, if psychological therapies are declined, medication may still be given and, since the young person will not be reviewed at psychological therapy sessions, the prescribing doctor must closely monitor the child or young person's progress regularly, and focus particularly on emergent adverse drug reactions (20). Any child or young person who is prescribed an antidepressant should be monitored closely by the prescribing doctor and the healthcare professional delivering the psychological therapy for the appearance of suicidal behaviour, self-harm or hostility, particularly at the beginning of treatment (20, 38, 40, 41). Once medication has been started, the patient and their parents or carers should be advised that, if there are any new symptoms such as these, urgent contact should be made with the prescribing doctor. In order to be able to distinguish between adverse effects of medication and the symptoms of the disorder, it is recommended that, unless medication needs to be started immediately, symptoms that might be subsequently interpreted as side effects should be monitored for seven days before prescribing (20), so as to establish the patient's usual pattern of symptoms.

When fluoxetine is prescribed for a child or young person with depression, the starting dose should be 10 mg daily. After one week, the dose can be increased to 20 mg daily if clinically necessary, although lower

doses should be considered in children of lower body weight. There is insufficient evidence regarding the effectiveness of doses above 20 mg a day, but higher doses may be considered in older children of higher body weight or when, because the illness is severe, an early clinical response is considered to be a priority. When a child or young person responds to treatment with fluoxetine, the medication should be continued for at least six months after remission, defined as no symptoms and full functioning for at least eight weeks; in other words, for six months after an eight-week remission (20).

NICE recommends that when a child or young person is prescribed an antidepressant, a self-report rating scale should be used as an adjunct to clinical judgement; the guidelines recommend the Mood and Feelings Questionnaire (MFQ). Where antidepressant medication is to be discontinued at the end of treatment, the medication should be phased out over 6 to 12 weeks, with the exact dose being titrated against the level of discontinuation/withdrawal symptoms (20).

When planning the prescription of antidepressants in children and young people, it is important to consider the possibility of drug interactions. These can include interactions with other prescribed medications, illicit 'recreational' drugs and complementary medications. Regarding complementary medications, although there is some evidence that St John's Wort may be of benefit in adults with mild-to-moderate depression, there are no trials with children or young people and it is not recommended in this group. It also interacts 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. A child or young person with depression who is already taking St John's Wort should be informed of the risks and advised to discontinue treatment while being monitored for recurrence of depression; they should, instead, be assessed for the more appropriate treatments already described (20).

Patients resistant to combined psychological and fluoxetine treatment

After a further six sessions of psychological treatment, if moderate-to-severe depression in a child or young person is unresponsive to combined treatment with a specific psychological therapy and fluoxetine, or if the offer of fluoxetine has been declined by the patient, parents or carers, then the multidisciplinary team should make a full needs and risk assessment (20). Such an assessment will include a reassessment of the diagnosis, consideration of the possibility of comorbid diagnoses, reassessment of possible individual, family and social causes of depression, assessment of whether there has been a fair trial of treatment, and assessment for further psychological therapy for the patient as well as any additional help for the family (20).

Patients resistant to combined psychological and fluoxetine treatment - psychological treatments

If a case of moderate-to-severe depression is unresponsive to combined treatment with a specific psychological therapy and fluoxetine, the following further psychological treatment protocols may be offered at multidisciplinary review:

1. an alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term family therapy, of at least three months duration)
2. systemic family therapy (at least 15 fortnightly sessions)
3. individual child psychotherapy (approximately 30 weekly sessions) (20)

Patients resistant to combined psychological and fluoxetine treatment - other medication options

If treatment with fluoxetine is unsuccessful or is not tolerated because of adverse effects, then consideration might be given to the use of another antidepressant, such as the second-line treatments of sertraline or citalopram (20). However, as of March 2015, when the NICE guidelines were published, neither sertraline nor citalopram had a UK licence for use in young people under the age of 18 years. Furthermore, the analysis by Cipriani et al. (37) called into question the efficacy of these drugs for depression in young people. A decision to use sertraline or citalopram as a second-line treatment for depression in young persons should only be made if the following clinical criteria are met:

- the depression is sufficiently severe and/or causing 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, and 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 (20)

Because sertraline and citalopram are not licensed for use in children and young persons in the UK, they should only be used after the child or young person and their parents or carers have been fully involved in discussions about the likely benefits and risks of the new treatment, and have been provided with appropriate written information, which should include the rationale for the drug treatment, the delay in onset of effect, the time course of treatment, the possible adverse effects and the need to take the medication as prescribed, as well as information from the regulatory authorities. Furthermore, the child or young person if competent and over 16, or whoever has parental responsibility if the child is under 16, should sign an appropriate and valid consent form. If a child or young person responds to treatment with citalopram or sertraline, medication should be continued for at least six months after remission (defined as no symptoms and full functioning for at least eight weeks) (20). If an antidepressant other than fluoxetine 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 two to four weeks if clinically necessary. However, lower doses should be considered in children with lower body weight. There is insufficient evidence for the effectiveness of higher doses in children and young people, although these may be considered in older children of greater body weight or when, because of severe illness, it is urgent to achieve an early clinical response (20).

Other antidepressants

NICE recommends that paroxetine and venlafaxine, and tricyclic antidepressants, should not be used for the treatment of depression in children and young people (20, 37, 41-45).

Psychotic depression

If a child or young person has psychotic depression, the augmentation of the current treatment with an atypical antipsychotic, such as risperidone, should be considered; however the optimum dose and duration of treatment are unknown. Children and young people who are prescribed an atypical antipsychotic medication should be monitored carefully for adverse effects (20).

Inpatient treatment

Only a small number of young persons with depression require inpatient treatment. Inpatient treatment should be considered for those who present with a high risk of suicide, high risk of serious self-harm or high risk of self-neglect, and when the intensity of treatment or supervision needed is not available elsewhere, or when intensive assessment is indicated (20). For these patients, it is very important that inpatient services are available within reasonable travelling distance to enable the involvement of families and to maintain social links. The benefits of inpatient treatment need to be balanced against potential detrimental effects, such as loss of family and community support. Furthermore, when inpatient treatment is indicated, CAMHS professionals should involve the child or young person and their parents or carers in the admission and treatment process whenever possible. The inpatient facility should be age appropriate and culturally enriching, with the capacity to provide appropriate educational and recreational activities. The inpatient services should have a range of interventions available, including medication, individual and group psychological therapies, and family support (20).

Planning for aftercare arrangements after a period of inpatient treatment should take place before admission, or as early as possible after admission, and should be based on the Care Programme Approach (20).

The use of ECT in children is very unusual. ECT should only be considered for young people with very severe depression and life-threatening symptoms, including suicidal behaviour or intractable self-harm, or severe symptoms that have not responded to other treatments. ECT should only be used in

young people after careful assessment by a practitioner experienced in its use and only in a specialist environment in accordance with NICE recommendations. ECT is not recommended in the treatment of depression in children aged 5 - 11 years (20).

Discharge after a first episode

When a child or young person is in remission, as defined by less than two symptoms and full functioning for at least eight 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, the child or young person and his or her parents or carers, and recorded in the notes. After this time, if remission is maintained, the young person can be discharged to primary care (20).

While in the inpatient unit, CAMHS should keep primary care professionals up to date about progress and the need for monitoring of the child or young person. Primary care should also be informed within two weeks of a patient being discharged and CAMHS should provide advice to primary care as well as to the patient/carers about whom to contact in the event of a recurrence of depressive symptoms. If children and young people have been successfully treated and discharged but then require re-referral, they should be seen as soon as possible rather than placed on a routine waiting list (20).

Recurrent depression and relapse prevention

Specific follow-up psychological therapy sessions to reduce the likelihood of, or at least detect, a recurrence of depression need to be considered for children and young people who are at a high risk of relapse. These include individuals who have already experienced two prior episodes of depression, those who have high levels of sub-syndromal symptoms, and those who remain exposed to multiple-risk circumstances. CAMHS specialists should teach primary care professionals, the child or young person with recurrent depression and their families/carers about recognition of illness features, early warning signs, and sub-threshold disorders (20). Self-management techniques can help individuals to avoid and/or cope with trigger factors. When a child or young person who has recurrent depression is in remission, with less than two symptoms and full functioning for at least eight weeks, they should be reviewed regularly for 24 months by an experienced CAMHS professional (20). The exact frequency of contact should be agreed between the CAMHS professional, the child or young person and the parents or carers and recorded in the notes. If remission is maintained, at the end of this period, the young person can be discharged to primary care. If children and young people with recurrent depression have been successfully treated and discharged but then it becomes necessary for them to be re-referred, they should be seen as a matter of urgency (20).

Transition to adult services

For patients who have ongoing treatment needs, transition at an appropriate age to adult services becomes an important issue. Transition between CAMHS and adult services needs to be seamless, so that patients continue receiving appropriate services. A CAMHS team which is 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, even when the person reaches the age of 18. A CAMHS team which is currently providing treatment and care for a young person aged 17 - 18, who either has ongoing symptoms from a first episode which are not resolving, or is recovering from a second or subsequent episode of depression, should normally arrange for transition to adult services, informed by the Care Programme Approach (20). 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 as well as information about local services and support groups suitable for young adults with depression. A young person aged 17 - 18 who has successfully recovered from a first episode of depression and has been 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 (20).

Conclusion

The NICE guidelines for treating depression in children and adolescents represent a well-balanced clinical approach in a difficult-to-treat group of patients. The aim is to optimise benefits and to reduce risks. This can be achieved by giving meticulous attention to proper monitoring of the patient and by presenting the patient with a balanced combination of psychological and pharmacological interventions.

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