Authors' reply: Professor Chaturvedi raises the possibility that our systematic review of the length of the duration of untreated psychosis in LAMI countries was confounded by a definition of treatment that was based on presentation to psychiatric services and did not account for presentations to traditional healers.

We acknowledge that a minority of the studies included in our review were based on population-based surveys of psychosis and that most of the studies did not include patients who only presented to traditional healers or did not receive any psychiatric treatment.

However, poor outcome in schizophrenia is known to be associated with delay in commencing treatment with antipsychotic medication, whereas little is known about the effects of a delay in non-pharmacological treatment. Furthermore, in a literature review (submitted for publication: details available on request) we confirmed the findings of Marshall *et al*[1] that the adverse effects of delaying antipsychotic treatment are similar in high-income and LAMI countries. Hence, we believe that non-psychiatric treatment for psychosis is best thought of as a potential cause of prolonged duration of untreated psychosis, rather than a confounding factor in the definition of duration of untreated psychosis.

Psychoses with acute onset and short duration that might remit without treatment may be more common in LAMI countries.[2,3] Patients with a short-lived psychosis might not always present to psychiatric services in LAMI countries, although in high-income countries acute psychosis is associated with a shorter duration of untreated psychosis. We do not know whether the exclusion of patients with a potentially short duration of untreated psychosis and those who only present to traditional healers would increase or decrease the mean period of non-treatment. In our review, population-based studies tended to report much longer mean periods of non-treatment than studies based on presentation to psychiatric services, although it is also possible that the lower mean duration of untreated psychosis found in upper-middle income countries was due to more individuals with an acute onset presenting for treatment early in their illness.

We agree that the pathways to care through non-psychiatric treatments warrant further investigation, but these studies should be conducted as part of an effort to reduce the unacceptably long duration of untreated psychosis in many LAMI countries.

1 Marshall M, Lewis S, Lockwood A, Drake R, Jones P, Croudace T. Association between duration of untreated psychosis and outcome in cohorts of first episode patients. *Arch Gen Psychiatry* 2005; **62**: 975–83.

2 Susser E, Wanderling J. Epidemiology of nonaffective acute remitting psychosis vs schizophrenia. Sex and sociocultural setting. *Arch Gen Psychiatry* 1994; **51**: 294–301.

3 Mojtabai R, Susser E, Varma V. Duration of remitting psychoses with acute onset. Implications for ICD–10. *Br J Psychiatry* 2000; **176**: 576–80.

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To prescribe or not to prescribe?

Despite the possible heterogeneity among some of the studies included in Tsapakis *et al*'s study,[1] the results, if accepted by the psychiatric fraternity, could lead to further reduction in the use of antidepressants in the child and adolescent population. The use of antidepressants in this group has already decreased by 33% since the Committee on Safety of Medicine's (CSM's) warning against the use of most antidepressants in children and adolescents.[2] Although the National Institute for Health and Clinical Excellence guidelines on the treatment of depression among children and adolescents states that medication should only be used in conjunction with psychological interventions,[3] the provision of psychological therapies remain thin on the ground in most parts of the country, which means that medication is often the only option available to clinicians for treatment of severe depression.

Although purely pharmacological treatment would be the least desirable option in depression and research evidence on the efficacy of antidepressants for those with depression in all age groups is either mixed or at best shaky, depending on which side of the debate one is on,[4] most clinicians would agree that many patients with significant depression do improve on antidepressants. Although it is too early to judge whether reduction in antidepressant prescribing resulting from the CSM warning has resulted in an increase in depressive morbidity among children and adolescents in the UK, disturbing evidence is already emerging from the USA, Canada and The Netherlands[5] on an increase in completed suicide among children and adolescents, which seems to coincide with the reduction in antidepressant prescribing following warnings by regulatory agencies. In a retrospective study done in Canada, a significant reduction in antidepressant prescribing, accompanied by a statistically significant increase in suicide among children and adolescents (relative risk=1.25, 95% CI 1.08–1.44; annual rate per 1000=0.04 before and 0.15 after the warning) was noted in the 2 years following issuance of the warning.[6]

Given the well-established link between depression and suicide, one can only conclude that clinicians may be undertreating depression in children and adolescents since the emergence of concerns in relation to antidepressants. I feel clinicians should use their own clinical judgement and take into account local resources before making decisions on the course of treatment in juvenile depression. This would help one maintain the right balance between evidence-based practice and what's best for individual patients, especially in an area of practice where research evidence is often ambiguous and contradictory.

1 Tsapakis EM, Soldani F, Tondo L, Baldessarini RJ. Efficacy of antidepressants in juvenile depression: meta-analysis. *Br J Psychiatry* 2008; **193**: 10–7.

2 Kurian BT, Ray WA, Arbogast PD, Fuchs DC, Dudley JA, Cooper WO. Effect of regulatory warnings on antidepressant prescribing in children and adolescents. *Arch Pediatr Adolesc Med* 2007; **161**: 690–6.

3 National Collaborating Centre for Mental Health. *Depression in Children and Young People*. British Psychological Society & Royal College of Psychiatrists, 2005.

4 Moncrieff J, Kirsch I. Efficacy of antidepressants in adults. *BMJ* 2005; **331**: 155–7.

5 Yan J. Canada sees troubling trend in antidepressant prescribing. *Psychiatr News* 2008; **43**: 14 .

6 Katz LY, Kozyrskyj AL, Prior HJ, Enns MW, Cox BJ, Sareen J. Effect of regulatory warnings on antidepressant prescription rates, use of health services and outcomes among children, adolescents and young adults. *CMAJ* 2008; **178**: 1005–11.

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Authors' reply: We agree with Menon that, in clinical practice, many juvenile patients with depression almost certainly are underdiagnosed, reluctant to accept treatment, undertreated or leave treatment prematurely, and that competent clinical help, especially other than the use of antidepressants, for such patients and their