# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## Health and social care directorate

## Quality standards and indicators

## Briefing paper

**Quality standard topic:** Depression in children and young people

**Output:** Prioritised quality improvement areas for development.

**Date of Quality Standards Advisory Committee meeting:** 8 January 2013

# Contents

# 1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for a NICE quality standard on depression in children and young people. It provides the Committee with a basis for discussion and prioritising quality improvement areas for developing quality statements and measures, which will be drafted for public consultation.

### Structure

This includes a brief overview of the topic followed by a summary of each of the suggested quality improvement areas followed with supporting information.

Where relevant, guideline recommendations selected from the key development source below are presented to aid the Committee when considering specific aspects for which statements and measures should be considered.

### Development source

Unless otherwise stated, the key development source referenced in this briefing paper as follows:

- Depression in children and young people. NICE clinical guideline 28 (2005).

The guideline was reviewed in 2011, and the decision made not to update at that time. Several ongoing clinical trials (publication dates unknown) were identified focusing on antidepressant treatment and efficacy of psychological therapies for depression in children and young people. The results of these trials may contribute towards the evidence base relating to management of depression in children and young people in the next update review (next review date: September 2013).

Where relevant, guideline recommendations from the key development source are presented alongside each of the suggested areas for quality improvement within the main body of the report.

# 2 Overview[1]

## 2.1 Focus of quality standard

The focus of this quality standard is the care of children and young people from the age of 5 up to the age of 18 years with depression.

## 2.2 Definition

Depression is a broad and heterogeneous diagnostic grouping, central to which is depressed mood or loss of pleasure in most activities. Depressive symptoms are frequently accompanied by symptoms of anxiety, but may also occur on their own.

The ICD-10 Classification of Mental and Behavioural Disorders (World Health Organization, 1992) uses an agreed list of 10 depressive symptoms, and divides the common form of major depressive episode into four groups:

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

Symptoms should be present for at least 2 weeks and every symptom should be present for most of the day.

## 2.3 Incidence and prevalence

In the national survey of child and adolescent mental health (2004)[2], 9.6% of 5–16 year olds (nearly 850,000) had a clinically diagnosed mental disorder; 3.7% with an emotional disorder including 0.9% of 5-16 year olds with depression (nearly 80,000).

Children and young people with depression were more likely than those with no emotional disorder to be girls (54% compared with 49%) and to be in the older age group, 11-16 years old (86% compared with 46%).

Children and young people with depression, when compared with those without an emotional disorder, were more than twice as likely to be living with a lone parent (37% versus 15%) and more likely to have parents who were on low incomes and had fewer educational qualifications. Moreover, 61% of children and young people with depression had a parent with a General Health Questionnaire (GHQ-12) score indicative of an emotional disorder, compared with 23% among other parents.

[1] Sections 2.1 and 2.2 are taken from NICE CG28 Depression in children and young people.
[2] Department of Health (2004) Mental health of children and young people in Great Britain.

## *2.4 Management*

Support is provided by four tiers of service following national frameworks in place since 1995 for the delivery of mental health services for children and young people (table one). These tiers provide a framework in which to organise the provision of services that supports people to identify and access the most effective interventions.

A stepped care model outlined in CG28 details the detection, recognition and management of depression in children and young people and prescribes responsibility for each tier (table two).

Children and young people at risk of or with recognised with depression do not automatically get referred to CAMHS services, and instead can be treated at Tier 1. This commonly includes milder cases of depression or those with fewer risk factors for depression.

See appendix 1 for key priority for implementation recommendations from CG 28.

**Tiers of service (Table one):**

| Tier | Service |
|---|---|
| 1 | Services including GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services.<br>*Universal services in the community (not mental health specialists).* |
| 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.<br>*Mental health professionals delivering CAMHS services in primary care or a community mental health setting.* |
| 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.<br>*Specialised mental health professionals delivering CAMHS services in a community mental health setting or specialist outpatient setting.* |
| 4 | CAMHS services at a tertiary-level such as day units, highly specialised outpatient teams and inpatient units.<br>*Specialised mental health professionals (same as Tier 3) delivering CAMHS services in a specialist setting.* |

**Stepped care model (Table two):**

| Step | Action | Responsible |
|---|---|---|
| 1 Detection | Risk profiling | Tier 1 |
| 2 Recognition | Identification in presenting children or young people | Tier 1 to 4 |
| 3 Management of mild depression | Watchful waiting<br>Non-directive supportive therapy / group CBT / guided self-help | Tier 1<br>Tier 1 or 2 |
| 4 Management of moderate to severe depression | Brief psychological therapy<br>+/- pharmacological therapy (fluoxetine) | Tier 2 or 3 |
| 5 Depression unresponsive to treatment / recurrent / psychotic depression | Intensive psychological therapy<br>+/- pharmacological therapy and augmentation with antipsychotic | Tier 3 or 4 |

## *2.5 National Outcome Frameworks*

The table below shows the indicators from the frameworks that the quality standard could contribute to:

| | | |
|---|---|---|
| NHS Outcomes Framework | Domain 4: Ensuring people have a positive experience of care. | 4.7 Improving children and young peoples experience of healthcare |

# 3 Summary of suggestions

## *3.1 Responses*

In total 15 stakeholders submitted suggestions for quality improvement as part of the 2-week engagement exercise (05/11/12 – 19/11/12). Suggestions were also provided by specialist committee members.

**Table 1 Summary of suggested quality improvement areas**

Stakeholders were asked to suggest up to 5 areas for quality improvement. These have been merged and summarised in the table below for further consideration by the Committee (incorporating stakeholder and specialist committee member suggestions). The full detail of the suggestions is provided in appendix 4 for information.

| Suggested area for improvement | Stakeholder |
|---|---|
| <u>Early recognition</u><br>• A number of risk factors have been suggested that could be used to better plan services and recognition strategies:<br>  • Sexuality<br>  • Social situation<br>  • Looked after children<br>  • Parental mental illness<br>  • Hard to reach groups<br>  • Co-existing medical conditions<br>  • Alcohol consumption<br>• Specialist Committee member reports limited capacity to provide school based screening and detection. | AFT<br>Break<br>BMA<br>ES<br>LGBTP<br>LGF<br>RDS<br>SCM<br>YM |
| <u>Assessment and diagnosis</u><br>• Stakeholders suggest that as recommended in CG28, children and young people should have a full assessment of biological, psychological and social factors.<br>• Stakeholders suggest that more training is needed in CAMHS on using scales and instruments to diagnose depressive conditions. | BPS<br>LGBTP<br>LGF<br>RDS |
| <u>Decision making</u><br>• Stakeholders suggest that if treatment is to be effective, service users should be involved in decision making. However this should account for age and capacity considerations. | RDS<br>YM |
| <u>Access to services</u><br>• Stakeholders suggest that timeliness of response from CAMHS and access to services providing NICE recommended psychological therapy should be improved.<br>• Multiple stakeholders report that IAPT services are not yet available nationally.<br>• Specialist Committee member reports large discrepancy across the country in the provision of psychological therapies. | ASCL<br>BACP<br>BMA<br>BPS<br>RCGP<br>SCM<br>YM |

| Suggested area for improvement | Stakeholder |
|---|---|
| Nutrition<br>• Stakeholder suggests children and young people with depression should be offered advice about nutrition. | RDS |
| Psychological therapies<br>• Two stakeholders call for changes to the range of psychological therapies recommended by the guideline. They quote evidence for the use of individual CBT, IPT and family therapy at all levels of depression irrespective of the 'tier' at which it is recognised. Stakeholders have submitted examples from IAPT services data suggesting the use of a wider range of therapies than recommended in CG28. | AFT<br>BPS |
| Anti-depressants<br>• Stakeholder suggests there is variation in under- and over-use and on newer evidence showing anti-depressants to be safer and more effective than originally found in CG28. However no evidence has been presented.<br>• Stakeholder suggests nurse prescribers may be better placed than psychiatrists to decide on anti-depressant usage.<br>• Specialist Committee member suggests anti-depressants are being prescribed more readily than recommended by NICE CG28, without adequate monitoring or adjunct psychological therapy. | BPS<br>RSM<br>SCM<br>SSS |
| Routine outcome measurement<br>• Stakeholder suggests that if services aim to offer effective treatment then routine outcome measurement should be used to monitor effectiveness of services. | BPS |
| Inappropriate admissions<br>• Stakeholder suggests that current measures of inappropriate admissions to adult wards could be extended to examine other locations that are inappropriate. | RCGP |
| Transition to adult services<br>• Specialist committee member reports the increased risks for young people transitioning to adult services. Eligibility criteria can differ, leading to young people falling into a 'black hole' upon turning 19 years old. | SCM |

**Table 2 Stakeholder details (abbreviations)**

The details of stakeholder organisations who submitted suggestions are provided in the table below.

| Abbreviation | Full name |
|---|---|
| AFT | Association for family therapy and systemic practice |
| ASCL | Association of school and college leaders |
| BACP | British association for counselling and psychotherapy |
| BMA | British Medical Association |
| BPS | British Psychological Society |
| Break | Break |
| ES | Epilepsy Society |

| | |
|---|---|
| LGBTP | National LBGT Partnership |
| LGF | The Lesbian and Gay Foundation |
| RCGP | Royal College of General Practitioners |
| RCN | Royal College of Nursing |
| RDS | Rotheram, Doncaster and S Humber NHS Trust |
| RSM | Royal Society of Medicine |
| SCM | Specialist Committee Member |
| SSS | South Staffordshire & Shropshire Healthcare NHS Foundation Trust |
| YM | Young Minds |

# 4 Suggested improvement area: Early recognition

## *4.1 Summary of suggestions*

Earlier recognition is linked to improved outcomes for children and young people with depression. A number of risk factors have been suggested that could be used to better plan services and recognition strategies:

- Sexuality
- Social situation
- Looked after children
- Parental mental illness
- Hard to reach groups
- Co-existing medical conditions
- Alcohol consumption.

Specialist Committee member reports limited capacity to provide school based screening and detection.

## *4.2 Selected recommendations from development source*

Recommendations from the development source relating to the suggested improvement areas have been provisionally selected and are presented below to inform the Committee in their discussions.

**Detection and risk profiling**

NICE CG28 Recommendation 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.

NICE CG28 Recommendation 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.

## *4.3 Current UK practice*

The Department of Health commissioned an independent review in 2006, of national CAMHS progress[3]. The report concluded that professionals in universal services (including primary care and school nursing services) need a better understanding of their role in the promotion, prevention and early intervention in psychological well-being of children and young people.

A Royal College of Psychiatry peer review into the quality of community CAMHS[4] reported 84% of teams now provide training and advice to primary healthcare services.

A cross-sectional study of 258 UK school nurses in 2008[5], aimed to measure the attitudes of nurses towards mental heath work and the need for greater training. Nearly half of the respondents had not received any post-registration training in mental health, yet 93% agreed it was important to their job. Being better equipped to recognise depression was considered a key topic for development programmes.

[3] Department of Health (2006) Children and young people in mind: the final report of the National CAMHS Review

[4] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6. Self-reported assessment of 67 CAMHS teams and peer-reviewed assessment of 32 teams.

[5] Haddad (2010) School nurses' involvement, attitudes and training needs for mental health work. Journal of Advanced Nursing.

# 5 Suggested improvement area: Assessment and diagnosis

## *5.1 Summary of suggestions*

Stakeholders suggest that as recommended in CG28, children and young people should have a comprehensive assessment of biological, psychological and social factors. Only through this full assessment can the causes and factors related to depression be fully understood.

Stakeholders also suggest that more training is needed in CAMHS on using scales and instruments to diagnose depressive conditions.

## *5.2 Selected recommendations from development source*

**Assessment**

NICE CG28 Recommendation 1.1.3.1 (KPI)

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.

NICE CG28 Recommendation 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.

**Diagnosis**

NICE CG28 Recommendation 1.4.1

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

NICE CG28 Recommendation 1.4.2 (KPI)

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.

NICE CG28 Recommendation 1.4.3

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.

## *5.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

A Royal College of Psychiatry peer review into the quality of community CAMHS[6] reported 92% of services ensure that assessments include consideration of the young person's family and community needs and context and that they show, the young person's abilities and strengths as well as their difficulties. Only 37% of case notes, across the network, show that assessments evidence whether there are concerns about alcohol or drug usage. Only 63% of services ensure that all assessments relating to the young person's ability to consent are recorded in their notes.

[6] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.

# 6 Suggested improvement area: Decision making

## *6.1 Summary of suggestions*

Stakeholders suggest that if treatment is to be effective, service users, their family and carers should be involved in decision making and treatment decisions. However this should account for age and capacity considerations.

## *6.2 Selected recommendations from development source*

NICE CG28 Recommendation 1.1.1.3

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.

## *6.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

A Royal College of Psychiatry peer review into the quality of community CAMHS[7] reported 100% of services actively sought the views of parents and carers during assessments. However, only 63% of teams are ensuring that young people have written plans for intervention and 32% of services do not give young people and their parents copies of any written plans for intervention or allow ready access to them. Only in 54% of services are young people and their parents/carers provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention. Only 61% of services gain consent sought for each proposed treatment or intervention, and documented this in health records.

[7] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.

# 7 Suggested improvement area: Access to services

## *7.1 Summary of suggestions*

Stakeholders suggest that timeliness of response from CAMHS and access to services providing NICE recommended psychological therapies should be improved.

Multiple stakeholders report that IAPT services for children and young people are not yet available nationally.

Specialist Committee member reports large discrepancy across the country in the provision of psychological therapies.

## *7.2 Selected recommendations from development source*

**Access to CAMHS**

NICE CG28 Recommendation 1.1.4.2

CAMHS and primary care trusts (PCTs) should consider introducing a primary mental health worker (or CAMHS link worker) (see glossary) into each secondary school and secondary pupil referral unit as part of tier 2 provision within the locality.

NICE CG28 Recommendation 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.

NICE CG28 Recommendation 1.1.4.4

CAMHS and PCTs 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.

NICE CG28 Recommendation 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.

NICE CG28 Recommendation 1.1.4.4

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).

NICE CG28 Recommendation 1.1.4.4

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.

**Access to psychological services**

NICE CG28 Recommendation 1.1.5.4 (KPI)

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.

## 7.3 Current UK practice

### Access to CAMHS

A Department of Health review of national CAMHS progress (2006)[8] reported some specific improvements in local CAMHS provision between 2005 and 2007. This included some decreases in waiting lists size, waiting times, an increase in 24/07 support and an increase in alternatives to inpatient care in Tier 4. However it concluded that children and young people are still waiting too long to access services. The review found barriers remain preventing people from working together to deliver care. Schools, social care and primary healthcare reported insufficient access to CAMHS specialists.

Young Minds *Children and Young People Manifesto for Change* highlights the importance of accessing CAMHS easily. The manifesto uses an example of Joe, 18, waiting 12 weeks to access CAMHS, which was then located in a distant part of London.

A Royal College of Psychiatry peer review into the quality of community CAMHS[9] reported 33% of CAMHS services don't have documented, up-to-date procedures and response times agreed with other agencies for specialist referrals. However for those offered an appointment, 85% of services are able to provide easy and prompt contact. Average waiting time for assessment was reported as 11 days (range 1 to 98 days), with average waiting time for treatment (from point of referral) reported as 13 days (range 1 to 52 days).

The Wales Audit Office however, reported in 2009[10] that waiting times for specialist CAMHS services varied between 19 weeks and 41 weeks.

### Access to psychological therapies

Stakeholders have highlighted reports outlining historical under-provision of service and evidence based therapies for children and young people with mental health problems. Mind highlighted in 2005[11], that staffing levels in CAMHS were approximately 33% of that recommended by the National Service Framework. One report by the Mental Health Policy Group of the London School of Economics[12] claims that in 2010, 78% of GPs in an ad hoc survey were rarely able to access specialist psychological therapy within two months.

[8] Department of Health (2006) Children and young people in mind: the final report of the National CAMHS Review
[9] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.
[10] Wales Audit Office (2009) Services for children and young people with emotional and mental health needs
[11] Mind (2005) We need to talk: getting the right therapy at the right time.
[12] London School of Economics (2012) How mental illness loses out in the NHS.

More recent data is highlighted by stakeholders available in the resources from the Children's and Young People's project in the Improving Access to Psychological Therapies programme (CYP IAPT) www.iapt.nhs.uk/cyp-iapt/.

In 2011, the existing adult IAPT programme added a new project working to support children and young people to access evidence based treatments and approaches. Different to the adult programme, CYP IAPT is not creating new standalone services. It works with existing CAMHS services to focus on extending training and embedding evidence based practice.

In 2012-13 there will be five Learning Collaboratives covering multiple CAMHS partnerships, which will be funded to provide the training programme:

| Learning Collaborative | CAMHS Partnerships | |
|---|---|---|
| Oxford and Reading | Ox and Bucks<br>Wilts, Bath and NE<br>Somerset<br>Gloucestershire<br>Swindon | Bournemouth, Dorset and Poole<br>Berkshire<br>Kensington and Chelsea<br>Bedfordshire<br>Luton |
| London and South East | Lambeth & Southwark<br>Hertfordshire<br>Sussex<br>Westminster<br>Haringey<br>Cambridge<br>Wandsworth<br>Greenwich | Waltham Forest<br>Tower Hamlets<br>Hackney<br>Islington<br>Camden<br>Bromley<br>Croydon<br>Richmond |
| Salford | Derby<br>Manchester and Salford<br>Pennine North<br>Pennine South | Barnsley<br>Central Lancashire<br>North Lancashire<br>Bolton |
| North East, Yorkshire and Humber | Tees<br>County Durham<br>North Yorkshire | Darlington<br>Rotherham<br>Doncaster<br>North Lincolnshire |
| South West | Devon<br>Plymouth | Torbay |

By the end of 2013, services covering 34% of the population aged 0–19 years will have been through the CYP IAPT service transformation process[13].

[13] Department of Health (2012) IAPT three year report: the first million patients.

# 8 Suggested improvement area: Nutrition

## *8.1 Summary of suggestions*

Stakeholder suggests children and young people with depression should be offered advice about nutrition. The supporting evidence presented is the Report of an Inquiry held by the Associate Parliamentary Food and health Forum (2008). This report claimed a strong negative correlation between prevalence of depression and the amount of fish consumed.

## *8.2 Selected recommendations from development source*

NICE CG28 Recommendation 1.1.5.10

A child or young person with depression should be offered advice about nutrition and the benefits of a balanced diet.

## *8.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

# 9 Suggested improvement area: Psychological therapies

## *9.1 Summary of suggestions*

Stakeholders called for changes to the range of psychological therapies recommended by the guideline. They quote primary evidence sources, published since the review decision for CG28, on the use of individual cognitive behavioural therapy, interpersonal therapy and family therapy at all levels of depression irrespective of the 'tier' at which it is recognised.

## *9.2 Selected recommendations from development source*

A review decision was made in 2011 that the guideline would not be updated. No new published evidence on effectiveness of psychological treatments was presented.

NICE CG28 Recommendation 1.5.2.1

Following a period of up to 4 weeks of watchful waiting, all children and young people with continuing mild depression and without significant comorbid problems or signs of suicidal ideation should be offered individual non-directive supportive therapy, group 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 CAMHS.

NICE CG28 Recommendation 1.6.1.2 (KPI)

Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], interpersonal therapy or shorter-term family therapy); it is suggested that this should be of at least 3 months' duration.

## *9.3 Current UK practice*

Stakeholders have highlighted the resources available from the Children's and Young People's project in the Improving Access to Psychological Therapies programme (CYP IAPT) www.iapt.nhs.uk/cyp-iapt/.

Year One of the programme (2011-12) delivered training in cognitive behavioural therapy and parenting for 3-10 year olds.

Year Two of the programme (2012-13) will also deliver training in Systemic Family Therapy and Interpersonal therapy.

# 10 Suggested improvement area: Anti-depressants

## *10.1 Summary of suggestions*

Stakeholder suggests there is variation in under- and over-use of anti-depressants and newer primary evidence showing anti-depressants to be safer and more effective than originally found in CG28.

Stakeholder suggests nurse prescribers may be better placed than psychiatrists to decide on anti-depressant usage.

Specialist Committee member suggests anti-depressants are being prescribed more readily than recommended by NICE CG28, without adequate monitoring or adjunct psychological therapy.

## *10.2 Selected recommendations from development source*

A review decision was made in 2011 that the guideline would not be updated. No new published evidence on effectiveness of pharmacological treatment was presented.

NICE CG28 Recommendation 1.5.2.3 (KPI)

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

NICE CG28 Recommendation 1.6.2.3

Following multidisciplinary review, if moderate to severe depression in a young person (12–18 years) is unresponsive to a specific psychological therapy after four to six sessions, fluoxetine should be offered.

NICE CG28 Recommendation 1.6.2.4

Following multidisciplinary review, if moderate to severe depression in a child (5–11 years) is unresponsive to a specific psychological therapy after four to six sessions, the addition of fluoxetine should be cautiously considered, although the evidence for its effectiveness in this age group is not established.

NICE CG28 Recommendation 1.6.4.1 (KPI)

Antidepressant medication should not be offered to a child or young person with moderate to severe depression except in combination with a concurrent psychological therapy. Specific arrangements must be made for careful monitoring of adverse drug reactions, as well as for reviewing mental state and general progress; for example, weekly contact with the child or young person and their parent(s) or

carer(s) for the first 4 weeks of treatment. The precise frequency will need to be decided on an individual basis, and recorded in the notes. In the event that psychological therapies are declined, medication may still be given, but as the young person will not be reviewed at psychological therapy sessions, the prescribing doctor should closely monitor the child or young person's progress on a regular basis and focus particularly on emergent adverse drug reactions.

NICE CG28 Recommendation 1.6.4.3

When an antidepressant is prescribed to a child or young person with moderate to severe depression, it should be fluoxetine as this is the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks.

## *10.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

# 11 Suggested improvement area: Routine outcome measurement

## *11.1 Summary of suggestions*

Stakeholder suggests that if services aim to offer effective treatment then routine outcome measurement should be used to monitor effectiveness of services.

## *11.2 Selected recommendations from development source*

NICE CG28 Recommendation 1.1.4.5

All healthcare 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.

## *11.3 Current UK practice*

A Department of Health review of national CAMHS progress (2006)[14] highlighted about half of CAMHS are undertaking routine outcome measurement, though not necessarily throughout the service.

Stakeholders highlight the IAPT services minimum dataset for use with children and young people receiving psychological therapies. This dataset uses a series of validated measures to help practitioners monitor the progress and effectiveness of treatment and support. It is hoped that this dataset will be rolled out similarly to the adult dataset that collects first and last outcome scores.

A Royal College of Psychiatry peer review into the quality of community CAMHS[15] reported 88% of services measure progress towards the goals of the young person and their parents/carers and that these are agreed in the care plan and monitored at regular intervals. However 25% of services feed back information from outcome measurement to staff, service-users and commissioners, and use it to inform individual plans for intervention, service evaluation and development.

[14] Department of Health (2006) Children and young people in mind: the final report of the National CAMHS Review
[15] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.

# 12 Suggested improvement area: Inappropriate admissions

## *12.1 Summary of suggestions*

Stakeholder suggests that current measures of inappropriate admissions to adult wards could be extended to examine other locations that are inappropriate.

## *12.2 Selected recommendations from development source*

NICE CG28 Recommendation 1.1.5.1

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

## *12.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

A Department of Health review of national CAMHS progress (2006)[16] highlighted the high cost of inpatient placements ranging from £1377 to £4800 per week. They reported that a number of areas found it difficult to access or provide beds in an emergency. This leads to a number of consequences including admittance to inappropriate adult or paediatric wards, or insufficient funds to meet needs in the community.

The Care Quality Commission published a guidance note in 2012[17] explaining the legal duties on providers in regards to children and young people being admitted to adult mental health wards. National policy has stated since 1999 that children and young people should only be placed on adult mental health wards under exceptional circumstances. However the legal duty under the Mental Health Act 1983 does not meant that no child or adolescent may be admitted to an adult mental health ward. It may be that particular security or specialist needs of a patient make placement on an adult ward the most appropriate arrangement.

National data collected by the Department of Health[18] report the number of occupied bed days of CAMHS patients on adult psychiatric wards (All England, all diagnoses):

[16] Department of Health (2006) Children and young people in mind: the final report of the National CAMHS Review
[17] Care Quality Commission (2012) The admission of children and adolescents to adult mental health wards and the duty to provide age-appropriate services
[18] Department of Health (2011) CAMHS integrated performance measures

| Quarter | Bed days for patients under 16 on adult psychiatric wards | Bed days for patients 16 to 17, on adult psychiatric wards. |
|---|---|---|
| Q4 2010/11 | 3 | 707 |
| Q3 2010/11 | 2 | 1623 |
| Q2 2010/11 | 2 | 1418 |
| Q1 2010/11 | 0 | 1458 |

# 13 Suggested improvement area: Transition to adult services

## *13.1 Summary of suggestions*

Specialist committee member reports the increased risks for young people transitioning to adult services. Eligibility criteria can differ, leading to young people falling into a 'black hole' upon turning 19 years old.

## *13.2 Selected recommendations from development source*

NICE CG28 Recommendation 1.7.1

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.

## *13.3 Current UK practice*

No published reports relating to current practice were highlighted by stakeholders for this quality improvement area; this area is based on stakeholder's knowledge and experience.

A Royal College of Psychiatry peer review into the quality of community CAMHS[19] reported on leaving the service, 98% of services' staff tell young people and parents/carers how they can receive further advice if needed. When young people leave the service, their key worker or equivalent takes responsibility for planning this in 98% of services. However, where young people are referred to adult services, only 12% are provided with a transition pack which includes information about what will happen. Only 49% of services ensure that on leaving the service, there are agreements with other agencies for young people to re-access the service if needed, without following the initial referral pathway.

The National Mental health Development Unit has reported[20] considerable variation in where CAMHS ends and AMHS begins. In some places the end point for CAMHS is 18 years of age, whilst in others it is 16, in others it is 16 if out of school, and 18 if in education. In many Early Intervention services, provision spans a wider age range, for example from 14 to 35. The vast majority (84%) of parents of children aged 14-17 receiving support, reported that their child requires ongoing mental health support.

[19] Royal College of Psychiatry (2011) Quality Network for Community CAMHS, cycle 6.
[20] National Mental Health Development Unit (2011) Planning mental health services for young adults – improving transition: A resource for health and social care commissioners

Most of these parents and parents of 18-21 year olds requiring ongoing mental health support said that there was no plan in place to determine what support their child would receive when they got too old for support from CAMHS (70%). Almost all parents (92%) worried about what mental health support their child would get when they turned 18.

## Appendix 1 Key priorities for implementation recommendations (CG28)

### Assessment and coordination of care

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

### Treatment considerations in all settings

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

- Comorbid diagnoses and developmental, social and educational problems should be assessed and managed, either in sequence or in parallel, with the treatment for depression. Where appropriate this should be done through consultation and alliance with a wider network of education and social care.

- Attention should be paid to the possible need for parents' own psychiatric problems (particularly depression) to be treated in parallel, if the child or young person's mental health is to improve. If such a need is identified, then a plan for obtaining such treatment should be made, bearing in mind the availability of adult mental health provision and other services.

### Step 1: Detection and risk profiling

- Healthcare professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression, and to assess children and young people who may be at risk of depression. Training should include the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, physical, sexual or emotional abuse, comorbid disorders, including drug and alcohol use, and a history of parental depression; the natural history of single loss events; the importance of multiple risk factors; ethnic and cultural factors; and factors known to be associated with a high risk of depression and other health problems, such as homelessness, refugee status and living in institutional settings.

- Child and Adolescent Mental Health Services (CAMHS) tier 2 or 3 should work with health and social care professionals in primary care, schools and other relevant community settings to provide training and develop ethnically

and culturally sensitive systems for detecting, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed.

**Step 2: Recognition**

- Training opportunities should be made available to improve the accuracy of CAMHS professionals in diagnosing depressive conditions. The existing interviewer-based instruments (such as Kiddie-Sads [K-SADS] and Child and Adolescent Psychiatric Assessment [CAPA]) could be used for this purpose but will require modification for regular use in busy routine CAMHS settings.

**Step 3: Mild depression**

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

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

- Children and young people with moderate to severe depression should be offered, as a first-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], interpersonal therapy or shorter-term family therapy; it is suggested that this should be of at least 3 months' duration).

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

## Appendix 2 Suggestions from stakeholder engagement exercise

| Organisation name | Key area for quality improvement | Why is this important? | Why is this a key area for quality improvement? | Supporting information |
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| Specialist committee member | All psychological treatments evidenced in the NICE guidance for treatment of childhood depression should be available in all areas covered by the guideline | There needs to be equality of access to effective treatments and not a post code lottery. | There is a large discrepancy across the country of the availability of some treatments for childhood depression. This means some children and adolescents are not getting the treatment they need. | In the IMPACT study currently underway which is a RCT looking at two treatments in the NICE guidance CBT and Short Term psychoanalytic psychotherapy, some areas had no qualified practitioners to undertake this treatment. The research funded some short term posts to provide treatment under research protocol which will soon end. Many areas of the country have no child and adolescent psychotherapists in their whole region. |
| Specialist committee member | Drug prescription should be limited to those medications validated in the guideline and should be under the supervision of child and adolescent psychiatrists. Adverse drug reactions need careful monitoring | There maybe a ease of prescription of anti depressant medication without adequate monitoring of adverse side effects and with no psychological therapies as these are harder to come by in some parts of the country. | GPs and other continue to prescribe anti depressant medication as first line treatment often without adjunct psychological therapies as determined in the guideline which require referral to CAMHS Also some of the drugs prescribed have no licence for children and have no evidence base for effectiveness in children. | We need to look at prescribing patterns for GPs and perhaps an audit how many times this in is conjunction with psychological therapies. Royal college data or PCT prescribing patterns. ? |

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| Specialist committee member | There needs to be effective screening and training of people in contact with children and adolescents in all settings to recognise symptoms of emerging depression | There is limited capacity in schools to provide school based screening and detection as well as interventions for treatment of mild to moderate depression with the demise of funding for school based CAMHS services. | Early identification of childhood depression is crucial to prevent later difficulties that can effect the whole life cycle. Schools are now limited in what they can provide within the current cuts in funding. Also there have been massive cuts in youth services who were in contact with young people before. Services in Vol sector also need to be targeted . | Information on availability of Tier 2 services for schools. Anecdotally there appears to be a diminution of services to schools as well as in Tier 3 CAMHS services. Also youth services have been drastically cut. |
| Specialist committee member | There should be smooth transition to adult mental health services where needed. | The thresholds for adult mental health services are very different from CAMHS services. It is sometimes difficult to find help for young people post 18 who are not taken on by AMH | Adolescents can fall into a black hole at this age and with difficulties in finding employment or funding tertiary education there can be a severe increased risk of depression and suicidality. Children leaving the care system are especially at risk | Referral rates from CAMHS to AMH who are accepted. The number of specialist services who take on post 18 adolescents. |
| Specialist committee member | Attention should be paid to the mental health needs of parents whose children are depressed and help offered to them | The mental health needs of parents have a strong impact on the mental states of children and so treating children alone will not address the systemic issues in the family. It is difficult to find help for these parents for the same reason above about thresholds of AMH services | We know that there is a strong association between the mental health of parents and the risks this poses to their children. | Cases in Impact where the parents were also engaged and offered help seemed to do better than those where the parents would not engage in their own work |
| Royal Society of Medicine | Treatment for depression | There is trial evidence for use of antidepressant medicine – more recent than NICE – the combination of CBT and SSRI appears safer and more efficacious | Practice varies greatly around the country, with some professionals overusing and some under- using medication | - |

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| Break | Early recognition | The earlier depression is detected – the less entrenched the negative thinking and view of self is, hence gives better outcomes in treatment. | Raising knowledge in parents, schools and other networks around children and young people. Training professionals to detect how depression may manifest in younger children, perhaps more so through behaviour than spoken words. | - |
| Break | Early intervention | Better outcomes and may halt the progression of depression | More therapists required in CAHMS teams – including therapists for much younger children- play therapists for example. | - |
| Break | Looked after children | By the very nature of being in care have suffered loss and grief and hence very susceptible to depression. | Better outcomes. | Why are not all looked after children offered an assessment from CAHMS anyway to assess possible needs earlier on. |
| AFT, the Association for Family Therapy and Systemic Practice | Key area for quality improvement 1 Systemic approaches to assessment and intervention available at all tiers | There is good evidence that appropriate and effective systemic family therapy with the child or young person with mild or moderate to severe depression and their family and/or networks of care can<br>• prevent difficulties embedding and escalating further<br>• improve practitioner recognition and response to safeguarding issues and risk factors including family violence and parental mental health difficulties<br>• Minimise risk of pathologising child or young person experiencing difficulties in their family life and important relationships<br>• Mobilise relational strengths and resources, helping parents and others make useful changes to minimise risk of relapse | Systemic services for vulnerable children and young people and their families/networks of care are being developed within and across tiers, including primary care, and in multi-disciplinary teams within and across social, education and health services in some areas of the UK.<br><br>There is strong and growing evidence of systemic therapies' effectiveness in supporting C+YP and families, and the professionals who work with them. However, provision remains patchy. In many areas of the UK, availability of systemic services for families is seriously limited, with children's depression worsening and/or families having to reach crisis point before they can access the skilled supports they need. | C+YP IAPT Phase 2 recognises the importance of systemic family therapy in CAMHS, and of systemic training for IAPT practitioners. AFT questions why only Phase 1 IAPT resources are currently listed for consideration.<br><br>Carr, A. (2009a) The effectiveness of family therapy and systemic interventions for child-focused problems. Journal of Family Therapy, 31: 3–45.<br><br>Kaslow, N. J., Broth, M. R., Smith, C. O. and Collins, M. H. (2012), Family-Based Interventions for Child and Adolescent Disorders. Journal of Marital and Family Therapy, 38: 82–100 |

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| | | • Support the child/young person's recovery<br><br>NB: systemic family therapy and approaches do not require practitioners to work with family group only, and often includes meetings with the child or young person on their own | The current NICE guideline includes family therapy among the recommended treatments at T3 and T4. Provision of family therapy earlier in the development of a young person's difficulties will increase possibilities of earlier recovery and reduce risk of relapse.<br><br>Unless specifically excluded or contra-indicated, family and carers should be included in the child or young person's treatment and care wherever possible, and not simply 'involved in decisions about treatment and care' (p4 NICE Guideline: quick reference guide). Systemic family inclusive approaches to care should be important elements of treatment at all tiers. Systemic family therapy should be considered for all 'levels' of depression in children and young people, whether moderate to severe or mild. | |
| AFT, the Association for Family Therapy and Systemic Practice | Key area for quality improvement 2<br>Improved workforce trainings in systemic practice skills and understandings | Improved practitioner trainings in systemic practice skills and understandings will support children, young people and families – and the practitioners themselves.<br><br>Without systemic trainings, skills and understandings in engaging with families, and supporting the child/young person and family members in talking about difficult issues in their lives, relational and | Basic systemic skills and understandings are not yet included in core competencies for all practitioners working with children and young people.<br><br>Without robust structures of training, and supervision and consultation with more highly trained practitioners, staff can find themselves in roles they are neither trained nor qualified to perform. | A Systemic Psychological Therapies Competences Framework has been developed with the UCL Centre for Outcomes Research and Effectiveness (CORE).<br><br>AFT accredits and maintains standards of systemic trainings in the UK (see www.aft.org.uk/training . AFT representatives are part of the team developing the systemic curriculum for workforce trainings in CYP IAPT Phase |

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| | | contextual factors impacting on a child or young person's mental health (including violence, abuse and parental mental health difficulties) may remain hidden.<br><br>All practitioners working with children and young people experiencing or at risk of developing depression should be supported by at least basic trainings in systemic skills and understandings to support them in more effectively assessing child and family, and in knowing when a referral to more specialist services from fully qualified family therapists (aka family and systemic psychotherapists) may best serve a child or young person's needs.<br><br>NB: The current guidance refers to 'shorter term family therapy' and longer term 'systemic family therapy'. Yet the term 'systemic' applies to family therapy of any duration. It should be led by fully qualified and accredited Family Therapists (aka Family and Systemic Psychotherapists), who have the training and experience to work with families with complex and serious needs, and to provide supervision and consultation to practitioners with lower levels of training. | | 2.<br><br>The importance of high level systemic family working in assessing risk and responding effectively to the needs of vulnerable children and families was highlighted in The Munro Review of Child Protection (2011)<br>Increasing recognition of the need to incorporate interpersonal relationships in diagnosis:<br>Wamboldt, M. Z., Beach, S. R. H., Kaslow, N. J., Heyman, R. E., First, M. B., & Reiss, D. (2010). Describing relationship patterns in DSM-V: A preliminary proposal. In T. Millon, R. F. Krueger & E. Simonsen (Eds.), Contemporary directions in psychopathology: Scientific foundations of the DSM-V and ICD-11 (pp. 565–576). New York: Guilford.<br><br>Large scale studies of US managed care find that family therapy is more effective, and more cost-effective but only when the family therapists are properly trained:<br><br>Crane, D.R., Christenson, J.D., Dobbs, S.M., Schaalje, G.B., Moore, A.M., Chiang, F.F., Ballard, J. & Marshall, E.S. (2012) Costs of treating depression with individual versus family therapy. Available on early view, Journal of Marital and Family Therapy. |

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| AFT, the Association for Family Therapy and Systemic Practice | Key area for quality improvement 3 Improved recognition in adult MH services of children + young people experiencing or at risk of developing depression | Parental mental illness is a recognised risk factor for depression in children and young people | Most Adult Mental Health workers are not adequately trained to recognise the impact of parental mental health problems on children and young people, or the complex difficulties that may fuel them. Some workers receive training to recognise 'children at risk' but depression or other 'lower level' difficulties which may develop into embedded, chronic problems.<br><br>There is clear and urgent need for family-sensitive provision and trainings within the AMH system, inclusive of and responsive to the needs of family members of all ages. | Cooklin, A (2006), 'Children of Parents with Mental Illness', Chap 12 in Children in Family Contexts, Second edition: Perspectives on Treatment, Combrinck-Graham, L (Ed). The Guilford Press.<br><br>Child and adolescent depression is common especially when parents are depressed: Lieb, R., Isensee, B., Hofler, M., Pfister, H., & Wittchen, H. U. (2002). Parental major depression and the risk of depression and other mental disorders in offspring. Archives of General Psychiatry, 59, 365–374.<br><br>Garber, J., Clarke, G. N., Weersing, V. R., Beardslee, W. R., Brent, D. A., Gladstone, T. R. G., et al. (2009). Prevention of depression in at-risk adolescents. Journal of the American Medical Association, 301 (21), 2215–2224. |

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| AFT, the Association for Family Therapy and Systemic Practice | Key area for quality improvement 4 Development of outreach services | There is strong and growing evidence that mental health and social work outreach teams, including and supported by professionals with high-level systemic training, are successfully engaging with children, young people and families unable or unlikely to attend mainstream clinic based services.<br><br>Many vulnerable children and young people experiencing or at risk of developing depression will not be supported by their parents and carers in attending clinic appointments. Outreach services that can meet with children and families in their own homes or at other venues of their choice (such as schools) are essential if they are to receive the supports they need. | Some areas have developed outreach services of excellence, but provision is limited and patchy. | Aggett P. et al (2011) 'Seeking Permission: an interviewing stance for finding connection with hard to reach families' Journal of Family Therapy http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1467-6427/earlyview<br><br>The Reclaiming Social Work model This social work model is transferrable to health and multi agency, multi disciplinary teams. In RSW, small outreach teams of appropriately skilled staff engage and work with family members<br>Goodman S and Trowler I (2012) Social Work Reclaimed Jessica Kingsley<br><br>Systemic Multi-Family Therapy groups in schools are proving effective in supporting children and families experiencing emotional, behavioural and social problems http://marlborough.thedigitalacademy.com/asset/286/Marlborough%20Model%20Brochure.pdf).<br><br>This model is currently being evaluated http://www.uel-ftsrc.org/ongoing_research.htm |

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| National LGB&T (lesbian, gay, bisexual and trans) Partnership, and the Lesbian and Gay Foundation | Key area for quality improvement 1<br><br>Implementation of sexual orientation and gender identity monitoring of all patients across all NHS services | Monitoring of patients' protected characteristics, including sexual orientation and gender identity, should be included in the quality standard as a recommendation for service providers. Many protected characteristics are related to increased incidence of depression and poorer clinical outcomes, yet sexual orientation and gender identity are not routinely monitoring in NHS services, particularly for children and young people. | Monitoring will generate data to help services better understand and cater for the specific needs of lesbian, gay, bisexual and trans (LGB&T) children and young people. These communities are more likely to experience depression and other mental health issues than their heterosexual peers. Knowledge of a patient's sexual orientation and gender identity would allow healthcare providers to better plan and deliver specific care to LGB&T patients.<br><br>There is evidence that some healthcare professionals are unaware of the higher incidence of mental health issue in LGB&T people; implementation of monitoring alongside appropriate training would increase awareness of these issues among service providers. | Evidence relating to LGB&T experiences of depression and mental health issues, and provision of mental health services to LGB&T people:<br><br>Mitchell, M., Sexual Orientation Research Review. Equality & Human Rights Commission, 2008 http://www.equalityhumanrights.com/uploaded_files/sexual_orientation_research_review.pdf<br><br>Hutchison C., Live to Tell: Finding of a study of suicidal thoughts, feelings and behaviours amongst young gay and bisexual men in Edinburgh. GMH, 2003 http://gmh.org.uk/about/research_files/Live%20to%20Tell-%20Young%20GB%20Men%20and%20Suicide%20%28GMH%20%26%20LGBT%20Youth%20Scotland,%20Nov%202003%29.pdf<br><br>Ryan, C., Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults. Pediatrics Journal, 2009 http://pediatrics.aappublications.org/content/123/1/346.full.html |

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| National LGB&T (lesbian, gay, bisexual and trans) Partnership, and the Lesbian and Gay Foundation | Key area for quality improvement 2<br><br>Recognition of increased risk factors for depression for young LGB&T people | Evidence shows that young LGB&T people are at increased risk of depression due to a number of depression risk factors such homophobia, discrimination and bullying, internalised homophobia and issues related to coming out. | Clinicians and service providers working with LGB&T young people need to be aware of the increased risk factors for depression among these groups and having the skills and knowledge to address these issues appropriately. | Warner, J. et al. Rates and predictors of mental illness in gay men, lesbians and bisexual men and women. British Journal of Psychiatry, 2004. http://bjp.rcpsych.org/content/185/6/479.full?sid=79efee5c-d077-4fdf-bd77-dc2f84bb62d6 |
| National LGB&T (lesbian, gay, bisexual and trans) Partnership, and the Lesbian and Gay Foundation | Key area for quality improvement 3<br><br>Better management to deal with young LGB&T people's depression | There is a need for better management to deal with young LGB&T people's depression, e.g. support from voluntary groups, peer support as alternative therapies and the need for safe environments. | A lack of recognition of the increased risk factors for depression among young LGB&T people can result in a lack of appropriate service provision. For example, research shows that sexual orientation or gender identity was implicated directly or indirectly in the causes of someone becoming homeless. Many homeless LGBT young people reported negative experiences of homelessness services (local authorities did not recognise their vulnerability or they felt unsafe in temporary accommodation) and they felt safer sleeping rough. There is a need for specialist services (such as specialist accommodation for LGB&T youth and a need to make current mainstream service safer for LGBT people, which would include the monitoring of sexuality and gender identity of clients. | Cull, M. Out On My Own. Brighton University, 2006 http://webarchive.nationalarchives.gov.uk/20120919132719/www.communities.gov.uk/documents/housing/pdf/outonmyown.pdf |

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| National LGB&T (lesbian, gay, bisexual and trans) Partnership, and the Lesbian and Gay Foundation | Key area for quality improvement 4<br><br>Protocol for providing cross sex hormone medication to gender variant adolescents | 1% of the adult population experiences some degree of gender variance. Many of them are aware of this variance in childhood but rarely reveal this to others, even within their families. However, the number of people seeking treatment for gender variance is now growing rapidly, with an annual growth among adults at 21% and 34% among children and adolescents.<br><br>Healthcare professionals in general practice, as well as in paediatric services, need to be aware of and trained to respond to this growing need among gender variant young people. Early intervention is critical to achieving successful outcomes. This is especially necessary in early puberty, when the development of secondary sex characteristics that are in conflict with the innate gender identity gives rise to intense stress. 23% of the young people aged 12 and over referred to the sole treatment centre for England and Wales for this patient group had engaged in self harm/overdose. In recognition of this requirement for early intervention, that treatment centre began in 2011 to offer medication to suspend puberty at an early stage for carefully selected | Among transgender adults, suicidality is a major risk, with 34% having made at least one attempt to kill themselves. Appropriate intervention in adolescence will reduce that risk | Trans prevalence, incidence and growth: GIRES prevalence study, 2009 http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUKreport.pdf and update 2011 http://www.gires.org.uk/Prevalence2011.pdf<br><br>Self-harm/overdose in adolescents: Di Ceglie, D. Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics. International Journal of Transgenderism 6 (1). http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no01_01.htm<br><br>Suicide risk in transgender adults: Whittle, S. Equalities Review: Transgender and Transsexual People's Experiences of Inequality and Discrimination. Press For Change, 2007. http://www.pfc.org.uk/pdf/EngenderedPenalties.pdf<br><br>Administration of cross-sex hormones: Spack, N.P., Children and Adolescents With Gender Identity Disorder Referred to a Pediatric Medical Center. Pediatrics, 2012. http://pediatrics.aappublications.org/content/early/2012/02/15/peds.2011-0907.full.pdf |

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| | | adolescents. However, that treatment centre's protocol does not allow cross-sex hormones before age 16. This includes oestrogen for gender variant young people with male phenotype. This medication caps their growth and prevents their reaching a height that is greater than the typical range for women, which may be a life-long disadvantage. Setting an arbitrary age does not take account of individual's psychological and physical readiness, which may be before age 16. | | |
| Association of School and College Leaders | Timeliness of response when young people are referred for psychiatric assessment and help. | Young people may lose significant parts of their education whilst waiting. Their condition may worsen while waiting. They may self-harm or in extreme cases commit suicide. | CAMHS overloaded case loads making for long waits. | ASCL members, who run secondary schools and tertiary colleges across the UK, report that waiting times can be long on some occasions and consistently long in some locations. This is the single factor that is most often mentioned when we ask them about mental health services for young people. |
| British Psychological Society | Key area for quality improvement 1: All children and young people have access to evidence based interventions from qualified practitioners as early as possible following identification of depressive symptoms regardless | The NICE guidelines indicate the importance of children and young people being offered evidence-based treatment in Tier 1 and 2 once the period of 'watchful waiting' is over. Over the past few years there is a growing and clear evidence base supporting Cognitive Behaviour Therapy (CBT), Interpersonal Therapy (IPT) and Family Therapy as all effective in the treatment of depression in | CBT has repeatedly been found to be effective in the treatment of depression in children and young people (e.g. Compton et al., 2004; Harrington et al., 1998). IPT has also been found to be effective (e.g. Santor & Kusumakar, 2001). In terms of early intervention there is some evidence that IPT is even useful in a preventative level within school with young people whose depressive symptoms are sub threshold (Young, Mufson & Davis, 2006). Family | Compton, S.N., March, J.S, Brent, D., Albano, A.M., Weersing, V.R., and Curry, J. (2004). Cognitive behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: an evidence based medicine review. Journal of American Academy of Child Adolescent Psychiatry, 43, 930-959. Harrington, R., Campbell, F., Shoebridge, P., and Whittaker, J. (1998). Meta- analysis of CBT for depression in adolescents. |

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| | of the arena in which the need has been identified. | children and young people. As a result of the evidence base these are also the treatments that are being offered through Improving Access to Psychological Therapies Child and Adolescent Mental Health Services. | Therapy has also been seen to have an evidence based therapeutic role in treatment of depression in children and young people (e.g. Larner, 2009) | Journal of American Academy of Child Adolescent Psychiatry, 37, 1005-1007. Santor, D.A. and Kusumakar, V. (2001). Open Trial of Interpersonal Therapy in Adolescents With Moderate to Severe Major Depression: Effectiveness of Novice IPT Therapists Journal of the American Academy of Child & Adolescent Psychiatry, 40(2), 236-240. Young, J. F., Mufson, L. and Davies, M. (2006), Efficacy of Interpersonal Psychotherapy-Adolescent Skills Training: an indicated preventive intervention for depression. Journal of Child Psychology and Psychiatry, 47,1254–1262. An example of a summary of effective psychosocial intervention- David-Ferdon, C. and Kaslow, N. J. (2008). Evidence-Based Psychosocial Treatments for Child and Adolescent Depression Journal of Clinical Child & Adolescent Psychology, 37(1) 62-104. Larner, G. (2009), Integrating family therapy in adolescent depression: an ethical stance. Journal of Family Therapy, 31: 213–232. |

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| British Psychological Society | Key area for quality improvement 2: All children and young people have access to evidence-based interventions within Tiers 3 and 4 as outlined in the NICE guidelines to include: CBT, IPT and Family Therapy. | The NICE guidelines indicate the importance of children and young people being offered evidence based treatment in Tier 3 and 4. Over the past few years there is a growing and clear evidence base supporting CBT, IPT and Family Therapy as all effective in the treatment of depression in children and young people. As well as there being a role for some psychopharmacological interventions for adolescents. There is evidence of a need to sometimes offer a combination of evidence based treatments for those with moderate and severe depression. As a result of the evidence base these are also the treatments that are being offered through IAPT-CAMHS. | Evidence for these treatments as listed above and the need for these to be offered in combination for moderate to severe depression has also been well demonstrated (e.g. Larner, 2009; for a good summary of the evidence base also see the American Academy of Child and Adolescent Psychiatry Practice parameters, 2007) There is also evidence regarding barriers to implementation, for example Hetrick, Simmons, Thompson and Parker (2011) examined potential barriers to the use of evidence-based guidelines (the NICE guidelines) for youth depression in a tertiary specialist mental health service, as part of an initiative to implement evidence based practice within the service. The found that barriers existed at (i) the individual clinician level; (ii) the clinical level in terms of the presentation of young people; and (iii) the service level. The key individual clinician level barrier was a stated belief that the guidelines were not relevant to the young people presenting to the service, with little evidence to guide practice. Similarly, the main barrier related to the clinical presentation was the severity and complexity, often making the delivery of interventions like cognitive behavioural therapy difficult. At the service level, a lack of integration with primary and secondary level care meant sequencing interventions according to guideline recommendations was difficult. | Larner, G. (2009), Integrating family therapy in adolescent depression: an ethical stance. Journal of Family Therapy, 31, 213–232. ACTION, AACAP OFFICIAL. "Practice parameter for the assessment and treatment of children and adolescents with depressive disorders." J. Am. Acad. Child Adolesc. Psychiatry, 46,11. Hetrick, S.E., Simmons, M., Thompson, A., and Parker, A.G. (2011). What are specialist mental health clinician attitudes to guideline recommendations for the treatment of depression in young people? Australian and New Zealand Journal of Psychiatry, 45(11), 993-1001. |

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| | | | The authors concluded that there is a need for greater investment in models of care that ensure integration between existing primary and secondary care and enhanced specialist early intervention mental health services for young people, something which in our clinical experience is the case in many services in the UK. | |
| British Psychological Society | Key area for quality improvement 3: All children and young people who have been identified as having a need have early access to high quality assessments and formulation. Which include information regarding the system around | Based on high quality evidence the NICE guidelines state: 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 and negatively on | In order to fully understand how an individual child or young person has come to experience symptoms of depression it is important to examine the organisation of their biological, psychological and social systems as they have developed (Cicchetti and Toth, 1998). It is rarely the case that one individual risk factor alone has led a young person to develop such symptoms. A comprehensive psychological formulation considering all | Cicchetti, D., & Toth, S. L. (1998). The development of depression in children and adolescents. American Psychologist, 53(2), 221. ACTION, AACAP OFFICIAL. "Practice parameter for the assessment and treatment of children and adolescents with depressive disorders." (2007). J. Am. Acad. Child Adolesc. Psychiatry 46.11. http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters |

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| | the child: including family, social network, school. That this assessment precedes and informs the treatment plan. | 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. (1.1.5.2) | areas of the child/young person's life allows better planning in terms of appropriate treatment. For example: as the American Academy of Child and Adolescent Psychiatry Practice Parameters state: "An assessment of the key relationships in the patient's social network is a critical component to the implementation of one type of psychotherapy for adolescent depression for which there is evidence of efficacy, namely, interpersonal psychotherapy (IPT; Mufson et al., 2004). Involvement in deviant peer groups may lead to antisocial behavior, generating more stressful life events and increasing the likelihood of depression (Fergusson et al., 2003)." | Mufson, L., Dorta, K.P., Wickramaratne, P., Nomura, Y., Olfson, M., and Weissman, M.M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. Arch Gen Psychiatry, 61, 577-584. Fergusson, D.M., Wanner, B., Vitaro, F., Horwood, L.J., and Swain-Campbell, N. (2003). Deviant peer affiliations and depression: confounding or causation. J Abnorm Child Psychol, 31, 605-618. |
| British Psychological Society | Key area for quality improvement 4: Screening and monitoring as standard within all services to objectively evaluate change and ensure that interventions are effective and appropriate. | NICE guidelines state that: All healthcare 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 | It is important that if services are aiming to offer evidence based treatment that they use outcome measures to inform and monitor this. There is evidence that, not only are standardised measures not always used by staff within CAMHS, but that there is active concern about their use and the lack of training of junior staff in interpretation of the results of such measures. Consideration needs to be given to how unskilled some junior practitioners feel when they start working in CAMHS and appropriate support and supervision offered (Martin, Fishman, Baxter & Ford, 2011). The first article published by the CAMHS Outcomes Research Consortium | Department of Health (2008) Children and young people in mind: the final report of the National CAMHS Review http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090399 Martin, Fishman, Baxter & Ford (2011) Practitioners' attitudes towards the use of standardized diagnostic assessment in routine practice: A qualitative study in two Child and Adolescent Mental Health Services, Clin Child Psychol Psychiatry, 16: 407-420, Wolpert, M., Ford, T., Trustam, E., Law, D., Deighton, J., Flannery, H., & Fugard, R. J. (2012). Patient-reported outcomes in child and adolescent mental health services |

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| | | made available for local, regional and national comparison (1.1.4.5) | (CORC) (Wolpert et al., 2012) states that there is increasing emphasis on use of patient-reported outcome measures (PROMs) in mental health but little research on the best approach, especially where there are multiple perspectives. The CORC data outcomes were collected from CAMHS across the UK. These comprised idiographic measures (goal-based outcomes) and standardized measures (practitioner-rated Children's Global Assessment Scale; child- and parent-rated Strengths and Difficulties Questionnaire). There was reliable positive change from the beginning of treatment to later follow-up according to all informants. Standardized clinician function report was correlated with standardized child difficulty report ($r = -0.26$), standardized parent report ($r = -0.28$) and idiographic joint client-determined goals ($r = 0.38$) in the expected directions. These results suggest that routine outcome monitoring is feasible, and suggest the possibility of using jointly agreed idiographic measures alongside particular perspectives on outcome as part of a PROMs approach. The National CAMHS Review in 2008 also stated- "About half of CAMHS are undertaking routine outcome measurement, though not necessarily throughout the service, supported by the work of the CAMHS Outcome Research Consortium. This data is included in the CAMHS mapping. | (CAMHS): Use of idiographic and standardized measures. Journal of Mental Health, 21(2), 165-173. Also see- Margison, F. R., Mcgrath, G. R. A. E. M. E., Barkham, M., Clark, J. M., Audin, K., Connell, J., and Evans, C. (2000). Measurement and psychotherapy Evidence-based practice and practice-based evidence. The British Journal of Psychiatry, 177(2), 123-130. |

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| | | | Many educational psychology and behaviour support services also do this, but data is not collated nationally. In our practice visits, four of the nine areas said that they would welcome a better understanding and guidance about outcome indicators, and four out of nine said that they had concerns about the costs and capacity required to move towards an outcomes-focused system." (Section 8.34) | |
| British Psychological Society | Key are for quality improvement 5 Family/Systemic involvement with interventions is offered whenever possible to ensure long-term efficacy of any therapeutic changes. To include (if there is a need) parents' own mental health problems (particularly depression) being treated in parallel. If parental treatment is offered by a different service than that working with the child or young person services must work closely and collaboratively. | There is clear evidence that therapeutic interventions and specifically CBT for depression, in children and young people are more effective when the family are involved (Clark, Beck and Alford, 1999). Additionally, regarding parental mental health specifically, there is strong evidence linking parental mental health problems to the development of depression in children and young people (Restifo and Bogels, 2009). The NICE current guidelines recommend both family/systemic involvement in treatment and that parents' own psychiatric problems are to be treated in parallel if necessary (1.1.5.8). | There is strong evidence that family factors play a role in the development, maintenance and course of youth depression. However, to date, few clinical trials of psychological therapies for youth depression employ family therapy interventions or target the known family risk factors. Restifo and Bogels (2009) indicated that there is strong evidence supporting a relationship between family factors at multiple system levels and depressive symptoms or disorders. They also state that a comparison of the identified family risk factors and psychotherapy trials for youth depression indicated that few RCT's target family factors; among those that do, only a few of the family risk factors are targeted (Restifo and Bogels, 2009). Children of depressed parents are at elevated risk for depression (Tully et al. 2008). Treatment trials of maternal depression (Weissman et al. 2006; Foster et al. 2008) also | Clark, D. A., & Beck, A. T. with Alford, BA (1999). Scientific foundations of cognitive theory and therapy of depression. New York, NY: John Wiley & Sons. Restifo, K., and Bögels, S. (2009). Family processes in the development of youth depression: translating the evidence to treatment. Clin Psychol Review, 29(4), 294-316. Tully, E.C., Iacono, W.G., McGue, M. (2008). An adoption study of parental depression as an environmental liability for adolescent depression and childhood disruptive disorder. American Journal of Psychiatry, 165, 1148–1154. Weissman, M.M., Pilowsky, D.J., Wickramaratne, P.J., Talati, A., Wisniewski, S.R., Fava, M., Hughes, C.W., Garber, J., Malloy, E., King, C.A., Cerda, G., Sood, A.B., Alpert, J.E., Trivedi, M.H., and Rush, A.J. (2006). Remissions in maternal depression and child psychopathology: a STAR*D-child report. Journal of the American Medical Association, 295, |

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| | | | suggest direct environmental effects of maternal depression on children's psychopathology. Robson and Gingell (2012) additionally found that when mental health problems affect children and parents within the same family there is a need for close professional collaboration between the respective psychiatric teams. However, there is no nationally established precedence for this, and the area has not been investigated within the published literature. In their retrospective case note study only 14.2% of the cases identified as having parental mental health problems present contained evidence of ongoing professional liaison between child and adult mental health teams. The authors stated that: inadequate liaison between child and adult services is a problem within the UK mental health system and detrimental to patient care. Recent national interest in establishing a more integrated family-focused service is encouraging, but will take time to implement and will not replace the need for separate specialist services. Efficient clinical collaboration must be developed at local levels to create a more comprehensive management strategy for children and parents with concurrent mental health problems. | 1389–1398. Foster CE, Webster MC, Weissman MM, Pilowsky DJ, Wickramaratne PJ, Talati A, Rush AJ, Hughes CW, Garber J, Mally E, Cerda G, Kornstein SG, Alpert JE, Wisniewski SR, Trivedi MH, Fava M, King CA (2008). Remission of maternal depression: relations to family functioning and youth internalizing and externalizing symptoms. Journal of Clinical Child and Adolescent Mental Health. 37(4), 714-24 Robson, J. and Gingell, K. (2012), Improving care for families where children and parents have concurrent mental health problems. Child and Adolescent Mental Health, 17, 166–172. |
| Royal College of General | Children and young people not | this includes bullying, gender based, or sexual violence of all | | This point is taken from this year's Children's Outcomes forum report (p31- |

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| Practitioners | experiencing stigma or discrimination | kinds. | | 35 particularly with the chart showing planned data sources). |
| Royal College of General Practitioners | Time taken to appropriate treatment | this includes waits to see professionals, even if the NICE guidelines are followed; at the moment many GPs prescribe outside the NICE recommendations because the wait for psychological interventions or CAMHS, alcohol, drug or exercise referral schemes is too long. | | This point is taken from this year's Children's Outcomes forum report (p31-35 particularly with the chart showing planned data sources). |
| Royal College of General Practitioners | Appropriate environment | measures are already made of admissions to adult wards but could be extended to other inappropriate places in A&E or even in children's wards | | This point is taken from this year's Children's Outcomes forum report (p31-35 particularly with the chart showing planned data sources). |
| Royal College of General Practitioners | Experience of services | GPs and CAMHS and the response to complaints. Questionnaires of young people's experience were recommended in the forum report. (This applies particularly to attitudes to self harm which have also been highlighted in the NICE self harm guidance) | | This point is taken from this year's Children's Outcomes forum report (p31-35 particularly with the chart showing planned data sources). |
| Rotherham Doncaster and South Humber NHS Foundation Trust | Key area for quality improvement 1 | Person centred care:<br>Children and young people with depression should have the opportunity to make informed decisions about their care and treatment, but this does depend on their age and capacity to make decisions. | Good communication is essential.<br><br>Making informed decisions<br><br>Promoting choice | CG 28 Depression in children and young people - Identification and management in primary, community and secondary care 2005<br><br>CQC Essential Standards of Quality and Safety (2010)<br>Outcome1, (b)<br>Outcome 2, (a) |

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| Rotherham Doncaster and South Humber NHS Foundation Trust | Key area for quality improvement 2 | 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. | Professionally trained therapists are more likely to be successful than other paraprofessionals because of a positive treatment alliance with depressed young people. | Depression in children and young people: identification and management in primary, community and secondary care<br>National Collaborating Centre for Mental Health (2012) |
| Rotherham Doncaster and South Humber NHS Foundation Trust | Key area for quality improvement 3 | 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. | Evidenced based practice<br>use of validated interviewer- based instruments | CQC Depression in children and young people: identification and management in primary, community and secondary care<br>National Collaborating Centre for Mental Health (2012)<br><br>Essential Standards of Quality and Safety (2010)<br>Outcome 14 (b) |
| Rotherham Doncaster and South Humber NHS Foundation Trust | Key area for quality improvement 4 | Children and young people with moderate to severe depression should be offered, as a<br>First-line treatment, a specific psychological therapy (individual cognitive behavioural therapy [CBT], interpersonal therapy or shorter-term family therapy. | Evidenced based practice<br>use of validated interviewer- based instruments | CG 28 Depression in children and young people - Identification and management in primary, community and secondary care 2005<br><br>CQC Essential Standards of Quality and Safety (2010)<br>Outcome 14 (b) |
| Rotherham Doncaster and South Humber NHS Foundation Trust | Key area for quality improvement 5 | A child or young person with depression should be offered advice on nutrition and the benefits of a balanced diet. | Nutrition is usually taken to be important for physical health, but mental health – brain health in its widest sense – must be considered as equally important. (ref see supporting evidence) | The Links Between Diet and Behaviour The influence of nutrition on mental health. Report of an inquiry held by the Associate Parliamentary Food and Health Forum (2008) January |

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| YoungMinds | Key area for quality improvement 1 Children and young people with depression should have easy access to psychological therapies that is relevant to the severity of their condition | Psychological therapies are highlighted as a priority area in the NICE childhood depression guideline. | Whilst the children and young people's Improving Access to Psychological Therapies (IAPT) programme will help young people within the 5 learning collaboratives, it hasn't been rolled out nationally. Therefore access at the moment is variable.<br><br>Data on outcomes will routinely be collected as part of the children and young people's IAPT programme. So there will be data available to measure quality improvements. | See the children and young people's IAPT programme for more information - http://www.iapt.nhs.uk/cyp-iapt/ |
| YoungMinds | Key area for quality improvement 2 Pastoral support staff in schools (particularly secondary schools), community paediatricians, GPs and School nurses should receive training to identify children and young people with depression. | Children and young people with mental health problems such as depression are likely to come to the attention of school and primary care staff in the first instance but they are not always able to diagnose the problem or know how to refer children and young people for treatment. Therefore it is essential that they receive training in how to identify young people who are and becoming depressed.<br><br>Training for school and primary care staff is included in the NICE childhood depression guideline.<br><br>The School Nursing Develop programme states that school nurses are in a good position to identify mental health issues and | | The British Youth Council was invited by the Department of Health to consult with secondary school age young people on their views of school nurses. Mental health was identified by young people as one of the priority areas for school nurses. http://www.byc.org.uk/media/75447/byc_school_nurse_report_web.pdf<br><br>We know from the young people we work with that many have had bad experiences when they went to their GP about mental health issues. The Very Important Kids group at YoungMinds states that 'sometimes they (GPs) are dismissive and we don't feel listened to. (21 year-old Alison's doctor told her he couldn't help her and suggested she call the Samaritans.) We want all GPs to have better training in mental health and |

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| | | provide early support to prevent problems escalating. | | in talking to young people about their problems'. http://www.youngminds.org.uk/for_children_young_people/youngminds_manifesto<br><br>In a recent NCB report young people said that they would be reluctant to seek help for depression from a GP for fear that their emotional problems would not being taken seriously. They also surveyed GPs and found that 58 per cent lacked confidence in diagnosing depression in young people and children. http://www.gponline.com/News/article/932919/GPs-seek-support-diagnosing-depression-young-people/ |
| YoungMinds | Key area for quality improvement 3<br><br>Children and young people with depression should have the opportunity to make informed decisions about their care and treatment. | In line with Government policy of No Decision About Me Without Me, children and young people where possible, should be given the opportunity to be involved in decisions about their own care.<br><br>To enable this, young people need to be given sufficient information in an age appropriate format to help them reach informed decisions. | | - |

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| British Association for Counselling and Psychotherapy | Non-directive therapy being made available | Non-Directive Supportive Therapy (NDST) is a NICE recommended intervention for mild depression in children and young people.<br><br>Completing a full-roll out of NDST would help provide wider patient choice.<br><br>The We Need to Talk coalition's report We Need to Talk: getting the right therapy at the right time (2010) found that people who had a choice of therapies were three times more likely to be happy with their treatment than those who wanted choice but did not get it. | NDST involves the child or young person receiving individual contact time with an empathic and skilled non-specialist CAMHS professional to offer emotional support and non-directive problem solving, as well as assessing whether further specialist help is required.<br><br>NICE Guidelines recommend that children and young people with continuing mild depression should be offered access to a course of non-directive supportive therapy and that this should be offered by appropriately trained professionals in tier 1 and tier 2 – including primary care, schools, social services and the voluntary sector.<br><br>School-based counselling is a professional activity, delivered by qualified practitioners in schools. Counsellors offer distressed children and young people an opportunity to discuss their difficulties within a relationship of agreed confidentiality.<br><br>Evidence shows that school-based counselling is associated with improvements around family issues, bereavement, eating disorders, bullying and relationships as well as other emotional, behavioural and social difficulties.<br><br>Early and easy access to counselling in | NICE Guideline for Depression in Children and Young People (Clinical Guideline 28) (2005) http://www.nice.org.uk/nicemedia/live/10970/29856/29856.pdf<br><br>Evaluation of the Welsh School-based Counselling Strategy: Final Report (2011) – Welsh Government http://wales.gov.uk/docs/caecd/research/111118EvalWelshSchoolCounsellingStrategyFinalReporten.pdf<br><br>We Need to Talk: Getting the right therapy at the right time (2010) – We Need to Talk Coalition http://www.mind.org.uk/assets/0001/0027/Mind_We_need_to_talk_Report.pdf |

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| | | | schools may prevent mental health problems form developing or becoming more serious, as well as enabling young people to access more specialist services if required. | |
| Royal College of Nursing | No comments | No comments | No comments | No comments |
| Epilepsy Society | Support of children and young people with epilepsy and co-morbid depression | There is a high prevalence of co-morbid depression in people with epilepsy, and studies indicate that depression in children and young people with epilepsy is more common that in the general population. This is therefore a significant population of people at risk. Identification of depression, independent of epilepsy, is important for its diagnosis and treatment to ameliorate the symptoms and to reduce the risk of diagnostic overshadowing from the epilepsy. | Early identification and consideration of treatment options of depression can enhance the quality of life and, potentially epilepsy symptoms, in children and young people, which may beneficial effects into adulthood. Treatment of co-morbid depression needs to be compatible with treatment for epilepsy. | Reilly et al; Depression & Anxiety in childhood epilepsy: A review. Seizure 2011;20;598-597 (see http://www.ncbi.nlm.nih.gov/pubmed/21741277 ) |
| South Staffordshire & Shropshire Healthcare NHS Foundation Trust. | That patients need to see a psychiatrist before commencing anti-depressant medication – that should change to 'patients need to see an independent prescriber in Tier Three CAMHS before commencing anti-depressant | Independent nurse prescribers in CAMHS are experienced CAMHS Nurse Specialists, often with a diagnostic remit. We are seeing an increased number of patients (particularly in the 14 to 18 age range) who meet the diagnostic criteria for clinical depression, have been low in mood for 18 months and who have either had prior intervention without impact, or who are too low to make effective use of | Because a lot of the point about nurse prescribing is swifter access to medicines. The National Prescribing Centre highlights in its' guides for commissioners that independent nurse prescribers are a central part of designing and commissioning services in patients' best interests.The Department of Health (2010), in their evaluation of nurse and pharmacist independent prescribing in England, found that nurse and pharmacist | The evidence is nurse prescribing enhances services and patient satisfaction, as in Brooks et al, 2001, Courtenay, 2008, and Savage & Moore, 2004. Carey & Stenner (2011) support this and found nurse prescribing as having important implications for maximising resources and improving patient care.In 2010 the British Medical Association publicly supported non medical prescribing, accepting it as an important principle in future |

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| | medication' | cognitive input and would need their mood raising first to place them to make use of other intervention. That cohort should not have to wait longer for treatment and independent nurse prescribers should be able to initiate treatment: they are prescribing in their specialist field from a limited formulary, and would not prescribe unless it is needed. Courtenay (2007) reflected evidence of quicker access to medicines for patients through nurse prescribing, with Jones, K, (2009) concurring and adding that this better used staffs' skills. The scope and range of non medical prescribing allows commissioners an appropriate range of options to improve patient choice and streamline services (Fittock, 2010). In July 2000 the Department of Health's NHS Plan outlined the extension of nurses' prescribing roles as a key element of radical reform of the NHS over the next ten years (Lomas, 2009). The Scottish Government (2009) found widespread and varied benefits to public health through nurse prescribing, with no compromising of patient safety.The research concluded that nurse prescribing would be of even greater benefit if rolled out even further, if best practice could be | prescribing to be safe and clinically appropriate. Patient satisfaction was high and non-medical prescribers were viewed positively by other healthcare professionals. Imagine then the potential for service improvement, and benefit to patients if organisations conspired to determinedly and coherently harness the planned development of non medical prescribing for progressive service re-design, and safe access to treatment. If, at Governmental level, there is a recognition of benefit through non medical prescribing to patients, service design, health outcomes, and the identification of non medical prescribing as contributing to the achievement of commissioning objectives, non medical prescribing programmes must be a central part of strategic planning for modern health services. Wix (2007) revealed mental health service users as satisfied with nurse prescribing; 85% citing improved service, and 95% enjoying improved access to and involvement in services and treatment. | development and delivery of health care (Stuttle, 2010).<br>An increasing number of referrals are being made by medics external to CAMHS who are specifically requesting either pharmacological treatment, or assessment with a view to pharmacological treatment. There is a recognition by GP's that independent nurse prescribers in CAMHS are better placed than they are to assess patients and consider whether medication is appropriate – and if so, which medication. |

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| | | more readily exchanged and communication and support networks further facilitated. An example perhaps of the NHS developing around nurse prescribing. Confirming patient benefits, Wix (2007) revealed mental health service users as satisfied with nurse prescribing; 85% citing improved service, and 95% enjoying improved access to and involvement in services and treatment. Anecdotally the advice from Camhs consultants (geographically dispersed nationally) that their experience is that nurse prescribers make better prescribing decisions than trainee doctors at any level, since their experience of the field in which they work is usually significantly beyond that of a trainee medic. | | |
| British Medical Association | Access to services | We welcome the opportunity to contribute to NICE's topic engagement exercise on the new quality standard in depression in children and young people. However, we are disappointed that the topic overview refers only to government-produced papers which present an artificially positive image of the quality of care for children and young people suffering from depression. | | • The Young Minds Manifesto;<br>• The 2005 ONS report, *Mental Health of Children and Young People in Great Britain, 2004*, which concludes that only 25% of young people are able to access the services they require;<br>• The June 2012 commentary on mental health services from the Mental Health Policy Group of LSE's Centre for Economic |

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| | | We would like to broaden the exercise and recommend the following be considered as evidence: | | Performance, which notes that only 6% of GPs are usually able to get access to mental health services for their child patients whilst 78 are rarely able to. |
| British Medical Association | Alcohol consumption | We would also suggest that the correlation between alcohol consumption and depression in children and young people should be considered as a key area for improvement. Alcohol consumption impacts negatively on mental health and the NICE Clinical guideline 115 Alcohol-use disorders (Feb 2011) gives no licensed drug treatment for use in patients aged between ten and seventeen, hindering treatment. | - | - |