

# IMPACT

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Improving Mood with  
Psychoanalytic And Cognitive Therapies

## **BRIEF PSYCHOSOCIAL INTERVENTION (BPI) FOR ADOLESCENTS WITH MODERATE OR SEVERE DEPRESSION: A TREATMENT MANUAL**

**Version:** 2.1

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Improving Mood with  
Psychoanalytic And Cognitive Therapies



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### **Introduction**

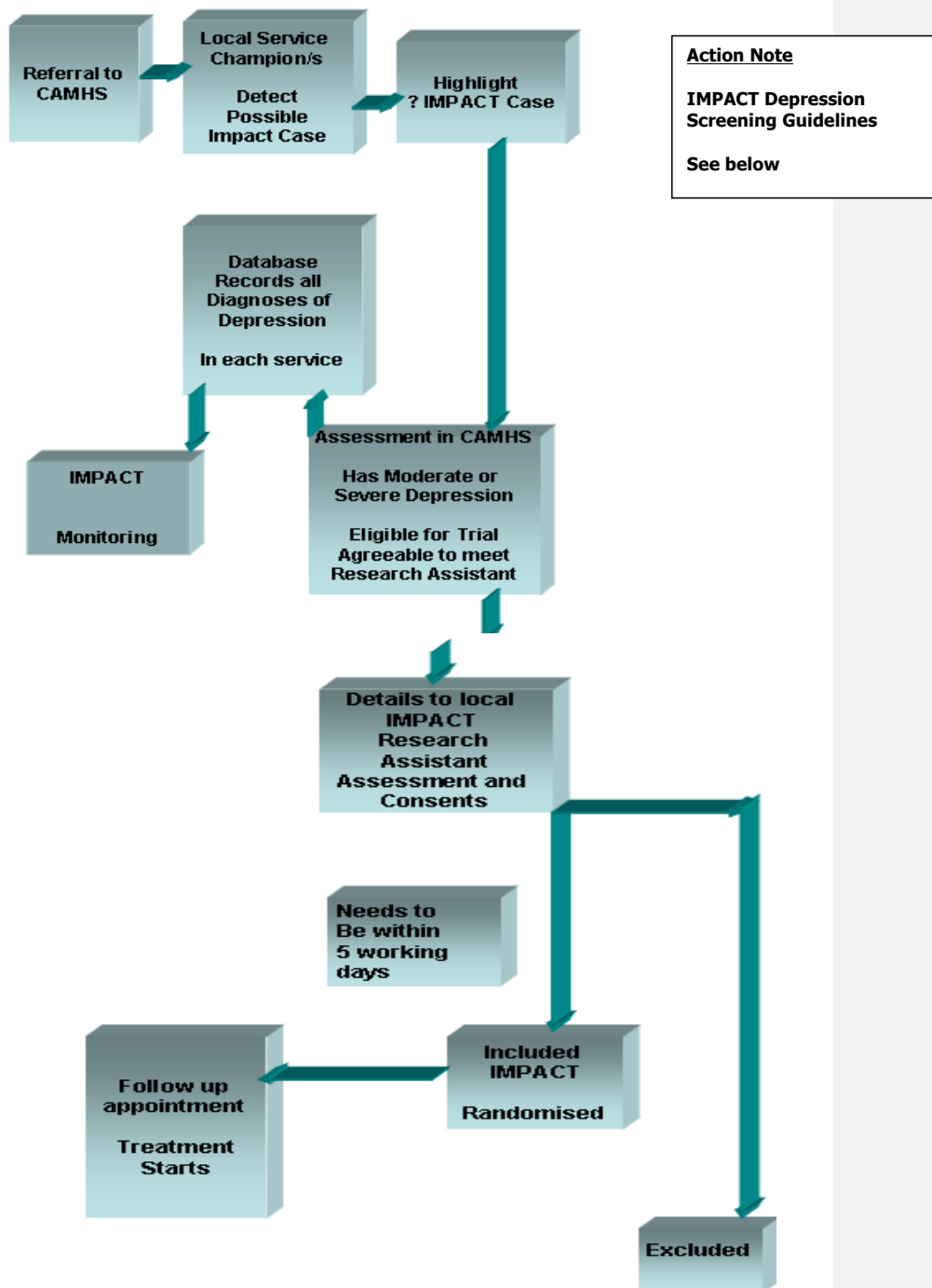
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Brief Psychosocial Intervention (BPI) for depression includes the full package of necessary care, assessment, formulation, case management, achieving engagement with the young person and their parents/carers, planning and delivery of treatment.

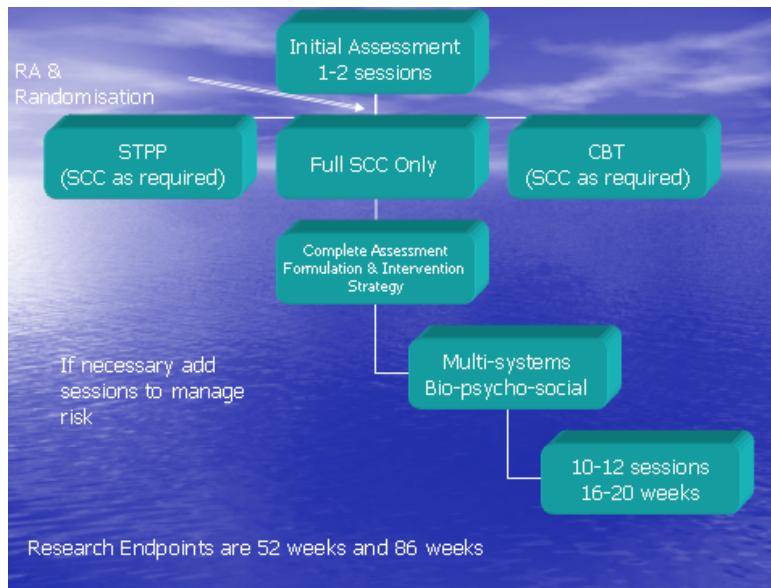
**Note** throughout where 'parent/s' is used alone this refers to parent/s or carer/s.

The test in IMPACT is whether Cognitive Behaviour Therapy (CBT) or Short Term Psychoanalytic Psychotherapy (STPP) is *superior to* Brief Psychosocial Intervention (BPI) *in preventing relapse in the long term (52 and 86 weeks after entry to the study)*. This is a, '**relapse prevention study**'. Elements of Brief Psychosocial Intervention will be available on an as required basis in either of the other two arms, in the BPI there must be no CBT or STPP for the depression treatment.

‘Depression Screening guidance’  
See below:

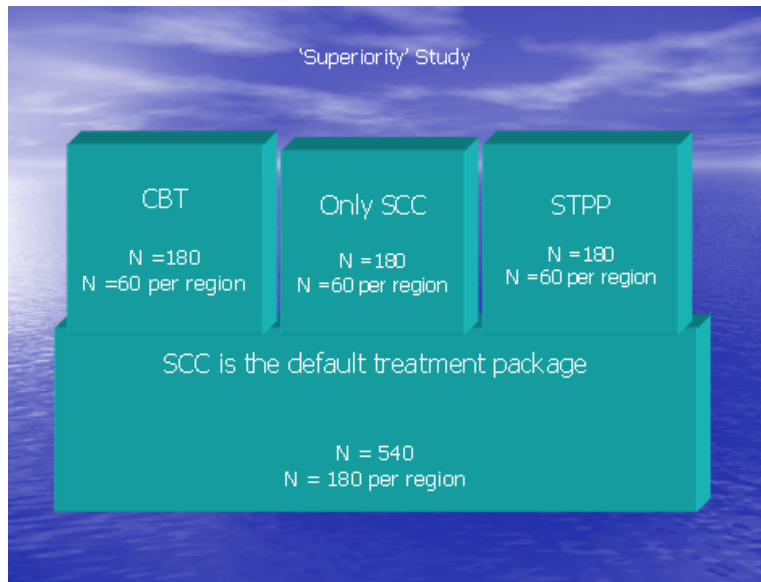


Therefore everyone will receive the assessment and an initial formulation element.



This will be followed by randomisation to one of the 3 arms (BPI, CBT,

STPP).



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## A depression screening tool to assist referral into the IMPACT Study

### -Summary of symptoms and their definitions for potential 'DSM' Depressive Disorder

**Action Note:** For further information please see the BPI Manual section called, "What makes assessments of children and adolescent who may have depression different?"

<b>Symptom</b>	<b>No</b>	<b>Possible</b>	<b>Definite</b>
<b>Low mood or irritability</b>	<b>0</b>	<b>1</b>	<b>2</b>
<b>Loss of interest or pleasure</b>	<b>0</b>	<b>1</b>	<b>2</b>
<b>If there is no</b> <ul style="list-style-type: none"> <li>❖ low mood/irritability or</li> <li>❖ loss of interest/pleasure</li> </ul> there is no need to ask the full set of further questions from the diagnosis of depression point of view			
Decreased or increased sleep	0	1	2
Decreased or increased appetite or weight	0	1	2
Fatigue	0	1	2
Poor concentration	0	1	2
Worthlessness	0	1	2
Agitation	0	1	2
Suicidal thoughts or plans	0	1	2



## Symptom Definition

### Rate as a 'symptom' if present for

- ❖ more than half the time or half the days
- ❖ over the last 2 weeks (or more)
- ❖ and associated with impairment

These are *persistence plus impairment criteria* to differentiate '*symptoms*' from more normative everyday experiences

-Refer to **IMPACT** if there is:

**EITHER depressed mood or irritability PLUS at least three further symptoms (total at least 4)**

***Action note:*** on rare occasions there will be loss of pleasure/interest/'anhedonia' without clear-cut depressed mood; in such cases, if there are 4 symptoms or more in total then still include and refer to **IMPACT**

***Action note:*** Return the rating sheet for every young person asked the mood and irritability, anhedonia/loss of interest-pleasure questions

## Symptom Probes

During review of problems/symptoms

The following is written so that the questions may be asked of the young person in this way.

### Depressed mood

How have you been feeling over the past few days – I mean have you felt at all low, depressed, or down in the dumps? Can you tell me more about that? What is it like? How much of the day do you feel like that? And over the past two weeks how many days?

**Irritability**

Do you get angry or irritated at little things, find things bug you, feel people are getting at you. Can you tell me more about that? What is it like? How much of the day do you feel like that? And over the past two weeks how many days?

**Loss of enjoyment or interest**

What sort of things do you usually enjoy? Has that changed? In what way? For example do you find yourself bored a lot of the time with things you used to like?

**If the answer is YES to one or both of these questions GO ON AND ASK THE FURTHER QUESTIONS**

**Sleep**

What has your sleep been like? Have you had any difficulties? What are they? What about getting off to sleep? Waking in the night? Waking up early? What time? Is this different from before? How long has it been like this?

**Appetite and/or weight**

What has your appetite been like? Has the amount you eat changed recently? Are you eating less? Or more? Can you tell me about that?  
Have you lost any weight? Do you know how much? Do your clothes still fit you? Or gained weight? Do you know how much?

**Loss of energy, fatigue**

How much energy have you had? Have you felt tired more than usual? How has that affected you? Have you had to take rests or stop doing things because you've feeling tired?

**Concentration**

What has your concentration been like? Can you keep your mind on things? Can you take things in? Or remember something you have just seen or read or heard? Do you have to read things more than once to understand? For example at school how are you managing in lessons? Or watching TV? Can you give me an example? Have people said you are not listening?

**Worthlessness or guilt**

How have you felt about yourself? Have been down on yourself? Or felt bad about yourself? Have you felt at all guilty about any things? What kind of things?

**Agitation**

Has it been hard to settle to things or keep still? Have you felt restless, had 'ants in your pants', picking at things such as your clothes or skin? Can you tell me about that? Have you found that your movements or thoughts are slowed down at all? In what way?

**Suicidal thoughts, plans or actions**

Have you been thinking about wishing you were not alive? Can you tell me about that? Have you thought of harming yourself? In what sort of ways? How often have you had those thoughts? Have you made any plans to harm yourself? Have you tried to harm your self?

**Impairment (a selection of probes)**

Over this time have you been going to school?

IF NO What is the reason? Has it been anything to do with what you have been telling me about (low mood, lack of interest...etc)? In what way?

IF YES How have you been managing with your lessons? Have you found the work harder? Have you had any problems getting the work done? In what ways? Have any teachers said anything?

Do you have a job? Have you been doing it? Have you found it harder to do? In what ways?

How much have you been seeing friends? Has that changed over this time? In what ways? Why is that?

And what about at home with your family? Has the way you have been feeling affected how you get on..with your parents.....with brothers or sisters?

### **How to proceed**

I would like to tell you we are taking part in research into different ways of helping young people with low mood ...(USE WORDS FROM THE YOUNG PERSON'S REPLY TO THE QUESTIONS). This is a big study and other clinics in North West England, East Anglia and North London are taking part. From what you have told me ....might be suitable for this study.

I can tell you a bit more about it, and then if it sounds like something you might be interested to join, I can ask one of the researchers (NAME) to meet you to tell you what it would involve.

CLINICIAN THEN PROVIDES BRIEF OUTLINE: see information sheets for clinicians in IMPACT.

## Brief Psychosocial Intervention in IMPACT 'BPI'

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This manual describes the components of BPI in IMPACT.

It is intended as a *guide* to practice not a session by session prescription. However we do expect across the treatment period that due consideration is given to all elements described herein and applied as appropriate to each case.

### Action Point

**Please note** the following important general points which are addressed as:

### Frequently Asked Questions:

1. *Does everyone have to be prescribed antidepressants in IMPACT?*

No, only on a clinical necessity basis, as guided in this BPI manual, see section and algorithm on use of antidepressants.

2. *Does everyone in each arm have equal access to antidepressants?*

Yes, that is the design and adherence to the BPI manual as the guide to practice in delivery of antidepressants will be measured

3. *How will adherence be measured?*

In part by audio-recording of every session and also by pen and paper measures. All clinics and clinicians taking part will be asked to consent to this integral element of the study. Random samples of treatments in each arm will be rated by the IMPACT study team. Feedback will not be offered or

provided to individual clinicians by the adherence raters. However adherence to treatment will be monitored by the BPI supervisors in day to day practice.

4. *Will elements of BPI be available to the participants in the CBT and STPP arms?*

Yes, on an as required basis.

5. *Does that mean that participants in the CBT or STPP arm must have an additional BPI clinician involved to deliver parts of the BPI package as required?*

Where a psychiatrist is required the answer is, yes, for example for re-evaluation questions relating to diagnosis, formulation, risks and case management that would in particular include questions about the need for medication. The Subsequent care path may indicate need for the psychiatrist to continue to be involved eg in initiation and on going medication management, case review and advise.

The BPI manual will guide this process.

The rest of any parts of the BPI required will be delivered by the CBT or STPP therapists.

6. *Can the therapist in any arm ask a colleague to assist in case review, case work and re-evaluation if necessary?*

Yes, as long as the all involved stick to the manuals and are not delivering any additional unique form of therapy so formal family systemic therapy is not allowed in the design, although informal family work is permitted. For example sessions for the parents with or without the patient and or siblings are allowed, these are integral to BPI. What is not permitted are formal 'family therapy team' type sessions.

7. *What if the clinician is concerned about the need to treat a major co-occurring disorder or problem, in addition to the depression?*

There are 4 components to consider in addressing this question

- ❖ First of all clinicians are reminded that the care packages in any one of the 3 arms are comprehensive and likely, on the basis of current evidence, to be effective in most of the common co-morbidities (anxiety, OCD, conduct disorder, PTSD/trauma, borderline states and emerging personality disorders and some early eating disorders).
- ❖ Secondly, everyday and appropriate specialist advice and guidance can be given for example regarding the nature of OCD and how to best deal with it in one of the 3 arms. Similarly for the other common co-morbidities, for example encouraging appropriate empathy and validation or understanding in Borderline presentations, or boundary management and self control and problem solving in Conduct disorder.
- ❖ Thirdly, the clinician is reminded of the value of taking phased approaches to treating complex and multi-problem presentations. Thus when the IMPACT treatment is completed in either 20, 24 or 30 weeks the case can be reviewed and if a further treatment package is necessary it can then follow on.
- ❖ Fourthly, if in the light of the above 3 points the clinician still has the view that a separate discrete treatment is necessary, this should be discussed with the IMPACT study trial committee- leads. If all agree this is indeed essential to treatment *at this point* the participant would be withdrawn from the treatment study at that time. The participant would still be followed up in the research arm of the study to allow full 'intention to treat' analysis to take place of all data.

8. *What happens to anyone who is withdrawn from the study?*

The data to that point will be used and they will be followed up in the research interviews, so long as they continue to consent to this, so their data can contribute to the planned intention to treat analysis.

9. *Will IMPACT see any type of depressed case?*

Yes, age 11-17yrs, providing they have met criteria for acceptance to NHS specialist CAMHS (Tier 2-3, moderate-severe depression cases = 5 or more symptoms, but refer cases with 4 symptoms to be more inclusive and not miss cases) and do not meet exclusion criteria:

Exclusion criteria.

- ❖ Generalised learning problems (clinical diagnosis) or a pervasive developmental disorder that results in an inability to complete the questionnaires, or both,
- ❖ pregnant, or currently having sexual relations without reliable contraception,
- ❖ currently taking another medication that may interact with an SSRI and unable to stop this medication [uncommon]
- ❖ current substance addiction, active substance abuse disorder (but occasional or recreational use of substances is not necessarily an exclusion)
- ❖ current significant and substantial anorexic type eating disorder

10. *Will IMPACT accept depressed cases already in a different treatment in specialist CAMHS?*

Yes, as long as they are still moderate to severely depressed and meet the criteria as per (9) above.

11. *What if the participant is crossing the age of 17 yrs?*

They can be accepted into IMPACT and their treatment completed within IMPACT as per the usual age and transition criteria in the CAMHS service. Thus if a treatment package of defined length as in IMPACT is deemed appropriate then it would be expected that case would remain in that CAMHS till the IMPACT treatment is completed (max of 30 weeks if randomised to STPP arm). Subsequently transition to adult services may be deemed necessary and should of course be considered and jointly planned for by the case-holders and the services well in advance.



*12. What happens if an older adolescent say age 16 or 17 doesn't wish their parents/carers to be involved in IMPACT/treatment?*

The usual issues around consent and confidentiality policies and procedures remain pertinent. Thus if the adolescent is deemed competent to consent and the clinician thinks it is safe and appropriate then the wish to have treatment without parental involvement may proceed. Of course this may change in the course of treatment if for example significant risks emerge or for medication is deemed necessary it is generally recommended another adult with parental or main carer responsibility is informed.

In addition in keeping with usual good practice it may be that in some cases involvement of the parent/s is deemed a core necessity of the treatment, for treatment to be effective. The formulation will guide this. Such issues need careful evaluation and negotiation with the young person, often requiring a judicious balance of needs, risks, and intended benefits. The clinician is advised to carefully record and seek appropriate supervision or consultation in arriving at these sometimes delicate clinical decisions.

So, bearing the foregoing in mind, if parent/s are indeed not informed or included, the young person may still participate in IMPACT. The GP must however always be informed.

*13. What happens at the end of the IMPACT study treatments?*

The participants will receive the usual care pathway that the service is able to offer.

*14. Will there be training in the manuals?*

Yes

*15. Who can deliver BPI?*

Eligibility and verification of Clinicians to Deliver BPI In IMPACT

- ❖ CAMHS professionals (Psychologists, Nurses, Occupational Therapists, Social Workers, Psychiatrists, Family therapists etc) could undertake BPI.
- ❖ They must have sufficient CAMHS specialist expertise, experience, and competence to undertake independent assessment and treatments of adolescents with moderate to severe depressive disorders and have done this for at least 6-12 months prior to BPI work.
- ❖ They must have received or are receiving specialist training and experience in child and adolescent mental health. This consists of at least 6-12 months prior supervised or independent work in a multidisciplinary CAMHS setting. This would normally be expected to have included working with both adolescents and families.
- ❖ The exceptions to this would 4<sup>th</sup> year level Specialist trainees (Specialist Registrars in Child and Adolescent Psychiatry) who could do BPI within their first 6 months as specialist trainees ST4 level provided their supervising consultant agrees. (Since they have provided this kind of work for at least 3 years already as junior psychiatrists CT1-3).
- ❖ Staff or associate specialists who have a minimum of 6 months previous experience in CAMHS as a specialty and the supervising consultant agrees they can deliver BPI.
- ❖ More junior trainees CT1-3 level and rotating unqualified trainees in psychology, nurse students, social work students and so forth would not be eligible to deliver BPI in IMPACT
- ❖ Senior year 5/6 trainees in Child psychotherapy who would meet the necessary criteria and whose supervising consultant child psychotherapist deems them competent for this task.
- ❖ It is recommended that supervision is available to all clinicians delivering BPI in IMPACT as part of good clinical governance.
- ❖ The intending BPI therapist must have attended the BPI training provided by the IMPACT team
- ❖ The intending BPI therapist must have read and have ready access to the BPI manual

- ❖ There will be a BPI registration form to track these criteria which all participating BPI clinicians will be required to complete for IMPACT to verify their eligibility (Appendix C).

*16. How many cases can any one therapist treat in the study*

Participating BPI clinicians should aim to each treat at least 3 cases and at the most around 10 cases in the whole study period. This is also true for therapists in each of the other 2 arms (CBT, STPP).

*17. What supervision is necessary for BPI?*

- ❖ BPI therapists should be supervised as is appropriate to their grade and experience,
- ❖ within the usual lines of supervision in their service,
- ❖ but see (18) below for eligibility of BPI supervisors
- ❖ The BPI therapist must in addition attend a specific BPI supervision group,
- ❖ usually on a 2-4 weekly basis,
- ❖ to be led by one of the Consultants in Child and Adolescent Psychiatry who is taking a lead role on BPI in that service.
- ❖ This local BPI lead will also need to meet all the requirements of the BPI therapists detailed above.

*18. Who can supervise BPI clinicians in IMPACT?*

Supervisor Eligibility & Verification in IMPACT

- ❖ Supervisors must meet criteria to be a BPI clinician themselves (Appendix D).
- ❖ And be an appropriate level of staff to provide supervision in the service

*19. Must all the 10-12 BPI sessions always be offered?*

No, this is a guide to practice. Clinical progress may dictate that fewer are required, or indeed more. If there is excellent progress and for example no medication is required then the clinician may as it were jump to maintenance and relapse prevention strategies and agree to provide fewer than the indicative 10-12 sessions. On the other hand if progress is slower and/or if medication is started it is more likely that 10-12 sessions will be required.

*20. Will the initial assessment and formulation be all that is needed-enough to guide all the treatments in all 3 arms?*

The initial assessment and formulation needs to be handled carefully, as always and is an ongoing process.

It is important that the following principals are considered by the assessing clinicians see table 1 below

**Key Principles For Safe and Effective Transition of Care From Assessment to Treatment In IMPACT II**

- ❖ No-one knows at the pre randomisation point which arm your case will be allocated to. So the formulation and the associated dialogue with the family and anyone else involved such as referrers should reflect this
- ❖ As in any handover of care between an intake or initial assessment and subsequent treatment phase the initial clinician *must take care to enable* the transition and not inadvertently undermine it
- ❖ For example it would be unhelpful to suggest treatment strategies that may not be applied eg CBT techniques or STPP techniques that the participant may end up not receiving due to randomisation
- ❖ 'Space' should be left for the appropriate development of the relevant understandings and evolving formulations that may follow initial assessment. This applies to any of the arms. 'Space' in the written (letters and notes) and interpersonal and intrapersonal sense. This depends on the good practice of the clinician in the assessment processes.

The broad outline of delivery of BPI is as follows;

### Initial Assessment

- ❖ Initial Assessment meeting (diagnosis/likely case of depression and agreement to be assessed by Researcher for IMPACT study inclusion-consents etc)
- ❖ Sufficient for purpose formulation of assessment and transition of care to treatment bearing in mind the '*Key Principals For Safe and Effective Transition of Care From Assessment to Treatment In IMPACT*' as in the previous table 1



### **Post randomisation**

- ❖ Ensure appropriate comprehensive assessment is in place
- ❖ Ensure appropriate comprehensive formulation is in place
- ❖ Must include risk assessment and risk management plan
- ❖ This must include risks to the self and others as well risks & vulnerabilities that relate to the rest of the patient's mental health
- ❖ And assessment of protective factors
- ❖ Develop comprehensive treatment plan including psycho-education about depression, a strategic approach to risk and protective factors identified and include mental and physical hygiene
- ❖ General support and encouragement-'re-moralisation'
- ❖ Appropriate psychosocial liaison for example with parents, family,

The clinician is directed to use their clinical discretion to decide in which session to apply which element though clearly comprehensive assessment and formulation belong early in engagement. They can be revisited in case reviews if there is

insufficient progress. This manual provides a detailed description of these elements of comprehensive case management.

### **Key points**

- ❖ *BPI requires a broad-based, expert, multimodal approach that addresses the relevant causal factors, as ascertained by the assessment.*
- ❖ *Family work, and medication, when necessary, should be used selectively in addition to BPI.*
- ❖ *Medication treatment should not be dissociated from the other aspects of BPI.*
- ❖ *When applying multimodal treatment, good liaison between the professionals involved is essential to maintain coherence in case management.*
- ❖ *Attention should be paid to both the internal and the external worlds of the Young persons, as well as the wider system: school, peers, neighbourhood, social care system, and, most of all, parents.*
- ❖ *Psycho-education of the young persons, their parents, and other responsible adults is a key element in treatment and relapse prevention.*
- ❖ *The basic clinical skills of listening and empathy are essential, especially when risk becomes an issue.*
- ❖ *Performing repeated risk assessments alone identify the risk but do not change it. Therapists should focus instead on understanding the dangers and on actions to modify risk.*
- ❖ *The depression should be placed within the "lived experience" of the Young persons and their families, with the particular developmental stage of Young persons and their families woven into this understanding.*

## Conceptual Framework of Case Management

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First the clinician should be motivated to formulate a unifying theme in the management of acute depressive episodes: the goal of activating. Activating the young person, their parents, carers, teachers and indeed if required, their friends, involves promoting reflection on what a) led to the depression and b) is required to find solutions. It is important to differentiate the use of the term, "activation" in this context from its use in describing one of the potential adverse effects of specific serotonin reuptake inhibitor (SSRIs) antidepressants. In this manual it is meant to describe a shifting of mental orientation in the young person and others, from a sense of helplessness and inertia, to one of action and solution. The clinician must be aware that such mindsets may evolve in both the individual with depression and *also* in those in contact with the Young person.

### ■ Case Management

To evolve and implement a rational management plan requires the clinician to understand the following components of case management and formulation:

- ❖ *Effective engagement with the young person and their parent(s) or carer(s).*
- ❖ *Diagnostic accuracy with respect to depression and any co-morbid conditions*
- ❖ *Understanding and knowledge of the impairments and consequences of symptoms; the "lived experience" including effects in other settings such as school or peer relationships*
- ❖ *Special care and accuracy in risk assessment*
- ❖ *Aetiological description: risk and protective factors*
- ❖ *A psycho-educative process that at all points aims to help "activate" the Young person, their carers and the social system around the Young person*
- ❖ *A management plan arising from the assessment together what is most likely to work in the given circumstances.*



These elements will be examined in turn as will the dynamic interactions that take place between them across time in clinical case management. While it can be helpful to think of assessment and treatment as separate components in a care pathway, in clinical reality elements of treatment can and should be part of assessment and assessment should and can continue during treatment.

Where the youngster, their family and teachers/social workers etc experience such a clinical engagement process they are more likely to feel understood, "held" and "contained". Such concepts are known to be fundamental to good clinical relationships and there is ample evidence that such therapeutic alliance is a key factor in any psychological treatment. However with depression especially, the sense of being understood may be pivotal.

#### ■ **Formulation of Cases**

##### ***What is Formulation?***

##### ***In BPI***

Fundamental to effective practice with depressive disorders is good case formulation. Intervention will follow from this formulation, which of course will be adapted in the light of information arising from subsequent work with the young person, leading to reformulation.

##### Action Note

A formulation covers the following areas:

- ❖ Summary of presentation
- ❖ Statement regarding diagnosis/diagnoses and differential diagnosis;
- ❖ Statement regarding risk;
- ❖ Statement of possible aetiology and of evidence of resilience and protective factors;
- ❖ A strategic decision about where and when to intervene
- ❖ Based on a dialogue of between the clinician and the Young person and their parent(s) or carer(s).

- ❖ It is crucial to understand what has helped as well as what makes things worse.

- **Elements of case formulation**

- Diagnostic Accuracy: severity, impairment, complexity & co-morbidity issues***

The treatment plan will depend on the severity and case complexity. Severity and complexity often co- occur but not necessarily.

ICD 10 proposes mild (4 symptoms), moderate (6 symptoms) or severe (8 or more symptoms) categories of depressive disorder with or without psychosis (ICD10).

DSM IV proposes mild, moderate and severe with and without psychosis; "mild major depression" (5 symptoms) still equates in ICD 10 to mild-to-moderate severity.

#### **ACTION POINT**

- ❖ 4 or 5 symptoms should trigger consideration of referral to the IMPACT study researcher;
- ❖ be over-inclusive, so if unsure, for example 3-4 symptoms better to refer than not

Symptom-by-symptom the clinician builds up a picture of the depression.

**Functional impairment** is also required for a diagnosis. *Severe* depression will usually be associated with complete cessation of ability to function in at least one sphere of life such as school, or with peers or family or personal psychological state (such as persistent suicidality or lack of self care such as eating or drinking). Here the CGAS score will likely be 40 or less.

### Action Point

See the CGAS (Children's Global Assessment Scale, Schaffer et al) scale for information on levels of impairment

Severity of depression, including presence or absence of psychosis, has prognostic significance. The level of severity of depression at presentation may well be a key predictor of resistance to treatment (5, 6, 7, 8).

### Case severity

Indexed by pulling together

- ❖ The seriousness of functional impairment,
- ❖ The number of symptoms
- ❖ Number of coexisting disorders/problems complicating presentation,
- ❖ The length of time the disorder was present prior to treatment (8, 9, 10).
- ❖ The presence of psychosis may indicate increased risk of onset of bipolar disorder later in (6).
- ❖ Both severe depression and presence of psychosis (in particular, nihilistic and or command hallucinations) will increase the risk of serious self-harm and perhaps in some cases harm to others.

### Clinical Action note

- ❖ Thus severe depression, in particular if accompanied by psychotic symptoms, increases the urgency of initiation of potent intervention (consider medication early, see section on medication).

However while severity and associated impairment arising from the depression are important, so too is *complexity*.

Clinical practice and research findings tell us that certain co-occurring problems or disorders can complicate assessment, and subsequent treatment.

One example of a complication of depression, psychosis, was discussed above.

While severity of depression at presentation is one probable predictor of persistence, there is also some evidence that co-occurring hopelessness, major family conflict (11), OCD, anxiety, attention deficit hyperactivity disorder (ADHD), conduct disorder, and persistent suicidal plans and behaviours predict either persistence or more difficult to treat presentations (6, 9,10).

In addition clinical experience suggests that current abuse and hidden or undisclosed previous abuse may complicate treatment and predict more difficult to treat cases (6).

Similarly parental mental disorder and unsupportive versus supportive families will have an important impact on how treatment is delivered and probably on the chances of success in treatment.

Peer relationships and exposure to stresses and adversity in the broader psychosocial environment of the child or adolescent also have a bearing; a close confiding relationship with a good friend may act as a protective factor while exposure to risk of loss or trauma in relationships are risk factors. (12)

### Action Point

- ❖ *The Young person and their parents/carers will benefit from discussion about the severity, impairment, complexity and their interplay with the symptoms/disorder itself.*
- ❖ *The clinician must ask, is complexity amplifying the depression or vice versa?*

### Intervention Strategy is based on

- ❖ The likely benefit accruing from either decreasing the exposure to a risk factor (including the disorder itself which may indicate need for medication) or increasing resilience and or amplifying protective factors; this will include particular attention to severity of the disorder, the presence of suicide ideation or indeed risk to others and psychosis
- ❖ The likelihood of the proposed intervention achieving this
- ❖ The likelihood of the relevant parties engaging usefully in the proposed intervention
- ❖ Which should therefore be linked to Young person and carer choice
- ❖ As illustrated by informed consent, with feedback to the Young person and their parents/carers of the formulation.

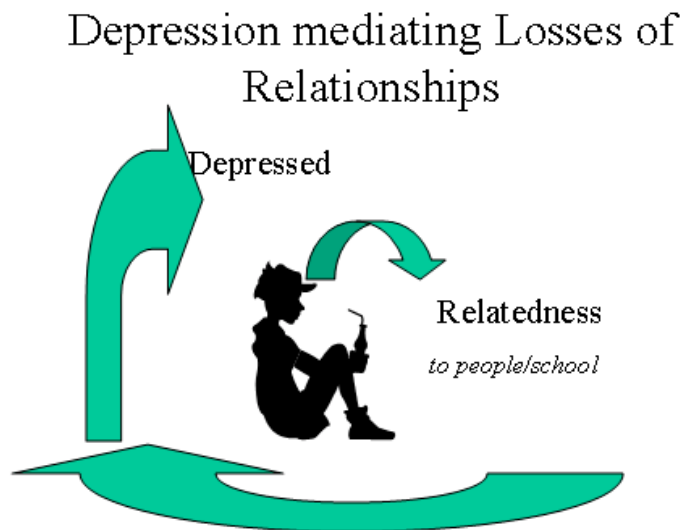
- ❖ There should be a view regarding prognosis or what might be hoped for,
- ❖ And a plan for when to fully review the formulation and management plan arising.
- ❖ This should include potential failure paths as well success paths.

■ **What makes assessments of children and adolescent who may have depression different?**

- ❖ There are differences in use of language, that reflect different, less mature levels of thinking, less capacity to self reflect and verbalise thoughts and feelings
- ❖ So for example, loss of interest expressed may get express as "always bored"
- ❖ Loss of energy and anhedonia, as loss of friendships, isolation and or impairments in family relationships, 'they don't like me anymore' ... 'I cant be bothered with them'
- ❖ Loss of concentration, as school academic decline, 'don't like school anymore, school is ...!'
- ❖ Depression and irritability as impaired relationships in the family, 'they just get on my nerves, always on my case, I wish they would just leave me alone'
- ❖ Self harm as an expression of hopelessness, negative self worth and perhaps suicidal ideation, 'I just do it don't know why, just comes on ...'

The point is that all these statements, in quote marks, could very easily be interpreted as ordinary adolescent behaviours, or indeed evidence of a behavioural problem. It is not until the practitioner is alerted to the underlying symptom, which will require careful interviewing and direct questioning, that the depressive constellation becomes apparent.

The young person so often has no idea they are depressed, nor do their parents; or else they feel they are not going to be 'taken seriously' so they enter the meeting in an oppositional mind set that can be misinterpreted.



***The hallmarks of depression in children and adolescents***

- ❖ Withdrawal
- ❖ Lowered mood tone
- ❖ Negativity
- ❖ Drop off in school work
- ❖ Change in peer group to more morbidly preoccupied group or more deviant group
- ❖ Increased isolation from friends
- ❖ Increased isolation from family
- ❖ Increased confrontations with family or friends or school
- ❖ Changes in appetite and weight
- ❖ Sleep dysregulation not just early morning waking
- ❖ Loss of confidence or self esteem
- ❖ Anxiety and avoidant behaviour like school refusal
- ❖ Morbid world outlook

- ❖ Self harming ideas and or behaviour
- ❖ Loss of usual get up and go, lethargy

***Some myths regarding depression in children and adolescents***

- ❖ Myth of ordinary low mood of adolescence; not universally true
- ❖ Myth of growing out of problems-impling no need to listen or make changes; not helpful
- ❖ Myth of all adolescents want to isolate themselves from their families; not true
- ❖ Myth of all families having major, repeated and persistent conflicts with adolescents; not true

***Some risks in diagnosis of depression in children and adolescents***

- ❖ Risk of pathologising normality, normal grief and upset
- ❖ Risk of paralyzing adaptive systems in the family or school or peers with a *diagnosis* of depression

***Avoiding these risks in practice***

- ❖ Ensure comprehensive assessment with good diagnostic skills
- ❖ Aim to enhance protective and help orientated behavioral strategies
- ❖ Aim for an 'activated' Young person and family
- ❖ Not a passive and de-skilled family waiting for us 'to do it all' to or for them
- ❖ BUT the clinician must know *what it is that* needs doing
- ❖ AND we must not encourage those parts of current behaviour that contribute to the problem

***Diagnosis of depression in children and adolescents***

**Using DSM IV :**

- ❖ 4 or more symptoms (see below)

*Severity assessment (ICD 10 severity criteria)*

- ❖ Where 4 symptoms = mild depression, 5/6 = moderate depression and 7/8 = severe depression



*Persistence and pervasiveness criteria*

- ❖ Present for the same 2 week period
- ❖ Each symptom must occur on most days and for the majority of the day

*Impairment and qualitative change criteria*

- ❖ Each represents a change from previous function and results in impairment

*Core Symptoms*

- ❖ One symptom must be either Depressed Mood OR Loss of Interest/pleasure (anhedonia)

*Exclusions*

- ❖ Not clearly due to a medical condition,
- ❖ Each symptom must occur on most days and for the majority of the day

**Action Note:** *Criteria For Inclusion in IMPACT : at Least Moderate Severity (4-5 or more symptoms)*

***Symptoms of depression in children and adolescents***

- ❖ Depressed mood, can be irritable mood
- ❖ Decreased interest/pleasure
- ❖ Fatigue or loss of energy
- ❖ Unreasonable self blame or excessive guilt, feeling worthless
- ❖ Decreased concentration or ability to think, indecisiveness or vacillation
- ❖ Psychomotor agitation or retardation (subjective or objectively)
- ❖ Insomnia or hypersomnia
- ❖ Marked appetite change with significant weight loss or gain, or failure to gain expected weight
- ❖ Recurrent thoughts of death, recurrent suicidal ideation, or any suicidal behaviour

***Plus in psychotic depression, either of the following:***

- ❖ Delusions or hallucinations, other than those typical of schizophrenia; so for example delusions and or hallucinations with depressive, guilty, hypochondriacal, nihilistic, self denigratory or persecutory content.
- ❖ Depressive stupor

## Risk assessment and management

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### ■ Risk to self

Depression is a major risk factor for non-suicidal deliberate self-harm and completed suicide. In *some* cases risk for self harm and completed suicide increases as the severity of depressive disorder escalates. Clearly in such cases the pursuit of the effective treatment of the depression diminishes the potential risk from self-harm. However there are, in the authors' experience, a number of cases that present where the level of suicidality or self-harm is greater than the severity of the depression. A typical example would be where unhappy, distressing family circumstances are driving the self-harming thoughts and behaviour much more than the level of depression is. In such presentations treatment should address the unhappiness in family relations, e.g. through work with the family which may include helping the adolescent to a new understanding of the family, their strengths and in all likelihood their limitations. In these cases, with ongoing interpersonal difficulties, continued self-harm may become perceived as evidence of treatment of depression failure. This incorrect assumption may lead to a vicious negative cycle with unhelpful in-Young person admissions focussed on the adolescent or second and third line medications being used in the presence of mild or even minimal symptoms when the solution lies in addressing the actual psychosocial driver of the self-harm.

### **Guidance on managing Self Harm and Suicidality**

Usual local safety procedures should be in place, including risk assessment and appropriate monitoring; this may mean more frequent contacts, the IMPACT study is pragmatic in this sense, so as much contact as is necessary should be provided. However it is advised that these are not just repeated risk assessment as that doesn't help the Young person cope with their self harm or suicidality. We recommend a combination of advice to Young person and family on managing risk; information sharing, providing trusting relationship and place to be understood and looking for solutions to crises/problems that lead to suicidality and self harm including 'chain analysis' described below. The emergent risks should be placed within the overarching framework of the formulation to help the clinician contextualise the risk and appropriately share such understandings with the young person and their parents and carers as part of the case management package.

■ **Assessing risk to self**

Because depression is a major risk factor for completed suicide and non-suicidal deliberate self-harm, often severity-related, assessing and managing this risk is essential. A summary of the factors associated with completed suicide is given here for reference. A general comment would be to note that the more detached and isolated, hopeless and entrapped the young person appears to be the higher the risk is likely to be. A further comment is that while risk is often allocated in a categorical manner, the clinical experience of risk is dimensional and often quickly fluctuating. A copy of the assessment schedule for self harm from one of the NHS Trusts taking part is attached here for reference and guidance. (see appendix 1)

***Common Characteristics of Completed Suicide Cases***

- ❖ Broken homes (separated parents or parents dying)
- ❖ Family psychiatric history or suicidal behaviour
- ❖ Psychiatric disorder or behaviour problem, especially depression and abuse/trauma related phenomena like PTSD
- ❖ Substance misuse
- ❖ Previous self harm
- ❖ Behaviour Disorder

***Factors Indicating Risk of Suicide in DSH Cases***

- ❖ Older teenage male
- ❖ Violent DSH method
- ❖ Multiple episodes of DSH
- ❖ Apathy
- ❖ Hopelessness & Insomnia
- ❖ Substance misuse
- ❖ Previous psychiatric hospital admission
- ❖ Behaviour Disorder

In our experience, there are cases where the level of suicidality or self-harm is greater than and inconsistent with the level of severity of the depression — for example, where unhappy, distressing family circumstances are driving the self-

harming thoughts and behaviour. Continued self-harm may be perceived as evidence of failure of treatment of the depression. This assumption, when incorrect, can lead to a vicious cycle of unhelpful admissions or use of complex medication regimes in the presence of mild or even minimal depressive symptoms. In such cases treatment should address the family relationships, e.g. through work with the family.

**Remember** it is important to differentiate self-harm aimed at unpleasant affect relief from self-harm aimed at ending life or endangering life. It is also important to understand where self harm is aimed at making other people change their behaviour or change something relating to the young person's life, so called 'instrumental self harm', from self harm being driven by a depressive disorder in itself

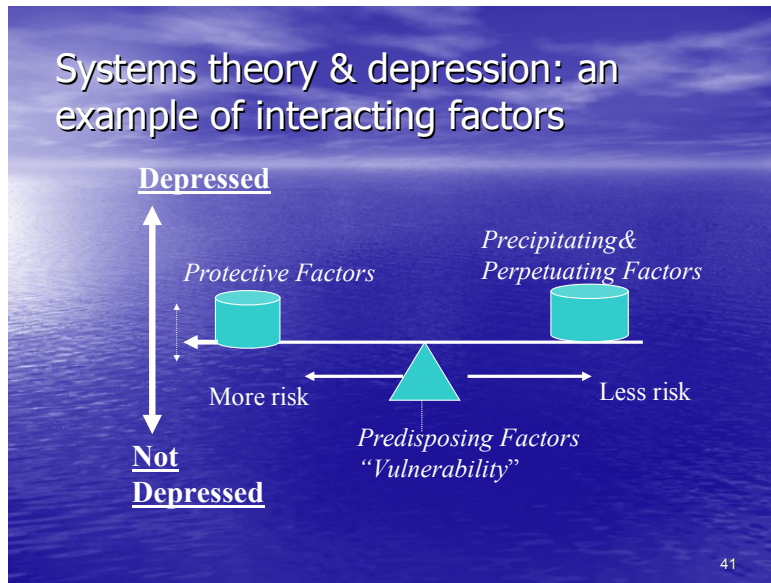
■ **Risk of violence to others by depressed young people**

It is relevant to note the very rare but occasional circumstance of a depressed young person posing a risk to others. Clinicians should be aware of their duty to disclose this risk and assist in the management of such a risk in the public interest. Assessors should be aware of such possibilities and seek appropriate expert forensic advice if presented with such a case. Such cases and their management are beyond the scope this manual but are deserving of specialist forensic examination and assessment as they may pose particular risks and management problems.

**Risk and protective factors: aetiological description**

It is important to assess for aetiological factors in an episode of depression. Treatment needs to be focussed on ameliorating these, whenever possible.

■ **Formulation standard setting: A summary of components of case formulation**



A formulation covers the following areas:

- ❖ a summary of presentation;
- ❖ a statement regarding diagnosis and differential diagnosis; or a OR state symptoms and signs and possible diagnosis if you are not in a position to make diagnosis
- ❖ a statement regarding risk;
- ❖ a statement of possible aetiology (risk factors) and of evidence of resilience and protective factors;
- ❖ a strategic decision about where and when to intervene
- ❖ based on a dialogue between the clinician, the patient and their parents or carers.
- ❖ Consider what is/are the hoped for outcome/s? Who hopes for what?
- ❖ It is crucial to understand what has helped as well as what makes things worse

These standards will be used to inform the adherence ratings for BPI

<b>A summary of presentation</b>	No summary	Summary but no longitudinal element or context description	Summary with longitudinal and context description
Scoring	0	1	2
<b>Diagnosis and Differential diagnosis Or mapping type main problem type and possible alternatives</b>	No diagnostic of problem type statement	Diagnosis or problem type statement No differential diagnosis of alternative problem types statement	Full statement Diagnosis/problem type and differential
Scoring	0	1	2
<b>Risk statement</b> ❖ Risk to self ❖ Risk to others ❖ Risk from others (child protection)	No statement	One or two areas covered but not all 3	All 3 areas covered in statement
<b>Statement of</b> ❖ possible aetiology (risk factors) ❖ and of evidence of resilience/protective factors	None stated	Partial statement	Full statement (all 4 Ps considered) ❖ Predisposing ❖ Precipitating ❖ Perpetuating ❖ Protective
Scoring	0	1	2
<b>Strategic decision about where and when to intervene</b>	No statement	Incomplete statement	Full statement points considered ❖ Where in the case to intervene ❖ In which way ❖ When ❖ By whom ❖ With what review process
Scoring	0	1	2
<b>All based on a dialogue between the clinician, the patient and their parents or carers</b>	No evidence of dialogue from formulation	Some evidence	Clear statement ❖ of dialogue and ❖ agreements reached
Scoring	0	1	2
<b>Consider what is/are the hoped for outcome/s? Who hopes for what?</b>	None noted	Clinician or parent-child/young persons hopes noted but not all	❖ Note of all relevant parties hoped for outcomes
Scoring	0	1	2
<b>It is crucial to understand</b> ❖ what has helped ❖ as well as what makes things worse	No protective factor/s noted No risk factor/s noted	Either protective or risk factors noted but not both	Note of ❖ Protective factor/s And ❖ Risk factor/s

Table x Some of the risk factors for depression and methods to address them in BPI

	<b>Consequences</b>	<b>Treatment</b>	<b>Modality of Delivery</b>
<b>Parental Conflict</b>	<ul style="list-style-type: none"> <li>❖ Low self esteem</li> <li>❖ Splitting between parents: all good or all bad</li> <li>❖ Divided loyalties-leading to rumination</li> <li>❖ Lack of support from parent/s to child</li> </ul>	<ul style="list-style-type: none"> <li>❖ Psycho-education of Young person, parents and other involved adults</li> <li>❖ Parental conflict resolution by mediation or couples work</li> <li>❖ Activate all by alerting to consequences for child</li> <li>❖ Opportunities for validation to child from each parent</li> </ul>	<ul style="list-style-type: none"> <li>❖ Family work</li> </ul>
<b>Bullying</b>	<ul style="list-style-type: none"> <li>❖ Fear and Low self worth</li> <li>❖ Rumination on fear if not dealt with</li> <li>❖ Can sometimes resonate with other maltreatment e.g. in the family</li> </ul>	<ul style="list-style-type: none"> <li>❖ Activate all concerned to action</li> <li>❖ Ask parents to be involved in liaison with school to address bullying</li> <li>❖ Address issues in the family if bullying at school is mirrored by bullying at home</li> </ul>	<ul style="list-style-type: none"> <li>❖ School liaison with parents</li> <li>❖ Family consultation</li> <li>❖ Individual work regarding coping and trauma processing but not CBT or BPP in BPI</li> </ul>
<b>Disappointment and Loss event E.g. Friendship breakdown</b>	<ul style="list-style-type: none"> <li>❖ Grief and bereavement response</li> <li>❖ Loss of intimacy</li> <li>❖ Helplessness/hopelessness</li> <li>❖ Identification with the loss and withdrawal from current life opportunities</li> <li>❖ Loss of self worth/guilt</li> </ul>	<ul style="list-style-type: none"> <li>❖ Psycho-education re grief process all concerned</li> <li>❖ Enable expression of loss and linked feelings</li> <li>❖ Encourage actions to restart working through of loss and complete this</li> <li>❖ Emphasise importance of living in the present to self worth and current function</li> </ul>	<ul style="list-style-type: none"> <li>❖ Same as above</li> </ul>
<b>Family History of Depressive disorder</b>	<ul style="list-style-type: none"> <li>❖ Elevated chances of developing depression usually following precipitating events</li> <li>❖ Possibly familial cultural style of relating and thinking linked to effects on development of parent being depressed</li> </ul>	<ul style="list-style-type: none"> <li>❖ Psycho-education about this tendency</li> <li>❖ Place epidemiology and increased risk in context</li> <li>❖ Advise re managing this liability relapse prevention/emotional hygiene, early help seeking if symptoms develop</li> </ul>	<ul style="list-style-type: none"> <li>❖ BPI</li> <li>❖ Treatment of depression in family members</li> <li>❖ Plus family consultations</li> <li>❖ Medication perhaps more likely to be needed (6)</li> </ul>

<b>High levels of temperamental traits of neuroticism or emotionality</b>	<ul style="list-style-type: none"> <li>❖ Same as above</li> </ul>	<ul style="list-style-type: none"> <li>❖ Same as above, enhance self awareness and strategies to manage-emotional hygiene</li> </ul>	<ul style="list-style-type: none"> <li>❖ BPI</li> <li>❖ Plus family consultations</li> <li>Medication perhaps more likely to be needed</li> </ul>
<b>Substance Misuse Drugs and Alcohol</b>	<ul style="list-style-type: none"> <li>❖ Direct chemical effects on mood</li> <li>❖ In vulnerable individuals may act as precipitant factor</li> <li>❖ Loss of usual relationships</li> <li>❖ Induction to crime and dishonesty</li> <li>❖ Increased risk taking behaviours with associated risks of adversity and loss which comprise risk for depression</li> </ul>	<ul style="list-style-type: none"> <li>❖ Psycho-education re drugs and alcohol and depression</li> <li>❖ Consider involvement of substance misuse service</li> <li>❖ Beware risk of substance-medication interactions and advise accordingly</li> </ul>	<ul style="list-style-type: none"> <li>❖ Same as above</li> </ul>
<b>Maltreatment or very traumatic event e.g. sexual assault</b>	<ul style="list-style-type: none"> <li>❖ Guilt, confusion, loss of trust, anger and aggression often against the self</li> <li>❖ Repeated self harm</li> <li>❖ Repeated risk taking behaviours</li> </ul>	<ul style="list-style-type: none"> <li>❖ Safety actions as necessary e.g. involve social services-protective agencies</li> <li>❖ Assist in processing of trauma and helping change self perception</li> <li>❖ Help Young person develop appropriate trust in others</li> <li>❖ Help Young person become active in making current relationships right and not remaining a victim by repeating the trauma</li> </ul>	<ul style="list-style-type: none"> <li>❖ Bringing together post trauma work and safety work with managing the depression</li> <li>❖ Will require multi-system liaison</li> </ul>
<b>Ruminating Cognitive Style</b>  <b>This may operate as a predisposing or perpetuating risk factor</b>	<ul style="list-style-type: none"> <li>❖ Tendency to stick with the negative</li> <li>❖ Failure to resolve problems</li> <li>❖ Conflict avoidance</li> <li>❖ Loss of self worth as a consequence of the above</li> </ul>	<ul style="list-style-type: none"> <li>❖ Psycho-education of Young person, parents and other involved adults</li> <li>❖ Assist problem solving, and conflict resolution</li> <li>❖ Activate Young person and their close others</li> </ul>	<ul style="list-style-type: none"> <li>❖ BPI</li> <li>❖ Plus family consultations</li> <li>❖ Medication can help with breaking ruminatory cycles</li> </ul>

In addition, by helping all involved to understand the consequences of these risk factors, we can provide explanations to the young person and to other people important in their social world. This is an aspect of *psycho-education* and links with relapse protection and heightening awareness for the future.



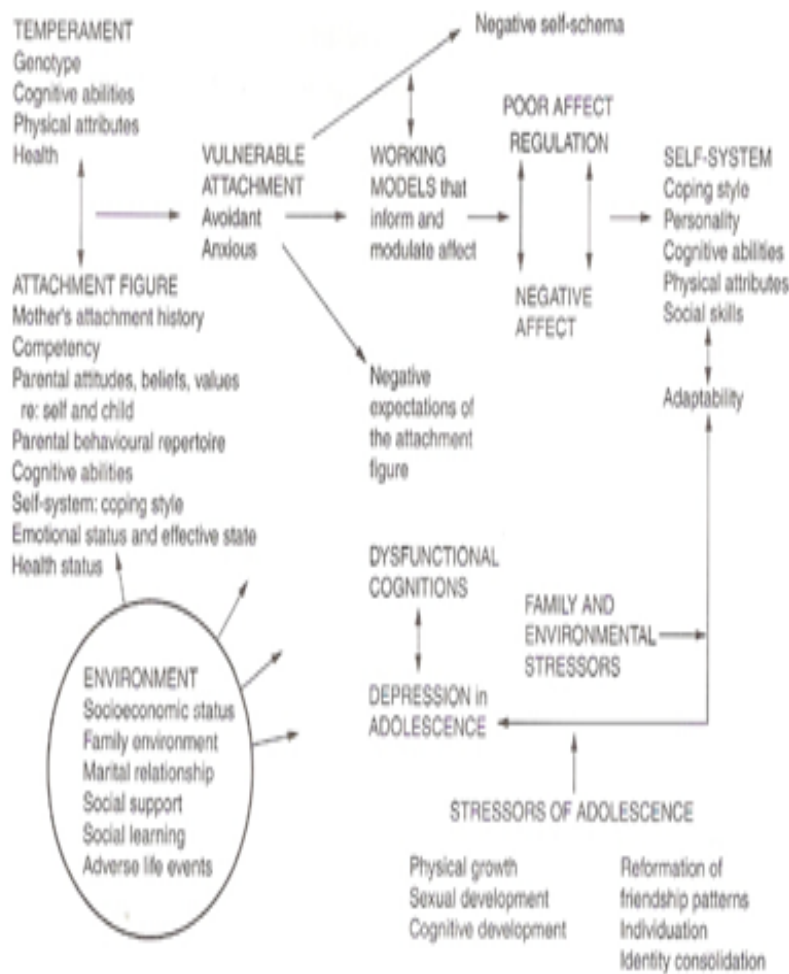


Figure 3.1. Factors affecting vulnerability to depression in adolescence.

Illustration: From 'The Depressed Child' CUP Ed: I.M. Goodyer, 2001

Another way of conceptualising risk and protective factors is using the kind of grid illustrated below

This provides a useful mnemonic as well '4Ps and 3Ps'

**Risk and Protective Factors: a grid to assist developing the formulation**

<b>Risk and Protective Factors</b>	<b>Physical Domain</b>	<b>Psychological Domain</b>	<b>Psychosocial Domain</b>
<b>Predisposing risk factors</b>	Family genetic history	Negative self esteem	Parental marital problems
<b>Precipitating risk factors</b>	Physical illness	Overly responsible	Parental separation
<b>Perpetuating risk factors</b>	Temperament	Guilt Impaired problem solving	Parental access disputes
<b>Protective or Resilience factors</b>	Usually enjoys participation in sport	Can see alternative view points	Has secure attachment to one parent and a good friend

■ **Developmental Considerations**

Individual tailoring of treatment for the case we see before us is a pivotal element in good clinical engagement; allied with appropriate communication and clinical skills, this will hopefully leave the Young person feeling listened to and understood. The clinician must adjust case management according to the emotional, cognitive, social and physical development of the Young person and the life-cycle of the family they are working with. *We should take special care not to try to fit the Young person to the treatment; we should adjust our therapeutic engagement according to the Young person's current developmental situation.* From the

adolescent's perspective we need to understand how the current level of development will impact on presentation and interactions between people and how it may affect how they are able to utilise specific treatments. The family life cycle stage must also be taken into account.

For example, in adolescents there is an increasing drive and need for independence, for a sense of themselves as evolving young adults; for the younger child the need to feel safe and secure. In both cases the experience of illness, in this case depression, can easily have a regressive effect, on the Young person and/or the family as a whole. The task of the clinician is to help counteract these regressive tendencies. The young person and family can be helped to cope, through engagement and treatment that helps the Young person and family back to a healthier developmental trajectory; whilst at the same time recognising and acknowledging that the increased proximity seeking behaviours may be natural in adversity. Sometimes self-harm is a proxy for such proximity seeking. Such subtle emotional fluxes or movements in the interpersonal relational patterns need to be validated on the one hand and often then gradually challenged in case management. For example one might wish to say something that contains some of the following elements "it is natural to want to be at home more, or to be seeking interactions more, even when these don't always work out, at times of illness, and this is also true with depression. It is sad for you all when you end up arguing and feeling more isolated. Depression can lead to adolescents wanting comfort and parents want to give it but this can all get rather messed up when people are more irritable and angry. At the same time, as an adolescent, you want more privacy and independence and you as parents want to provide that, but these problems seem to be getting in the way. We do see this with many families in your sort of situation." This then leads onto developing plans for addressing these problems. Parents need to be supported to achieve a balance between facilitating autonomy but also providing the necessary support. There is evidence that families ability to maintain emotional attachments and provide support and acceptance is more likely in adolescents who are emotionally competent, rather than in those who are depressed, thus clinicians need to be aware of the difficulties families may face in responding appropriately the depressed young person's needs.

Adolescents experience strong emotional states, greater than in adults. Although adolescents' capabilities are maturing, the increased complexity of social demands may overwhelm their competencies. Adolescents are very focused on social

standing and acceptance and thus particularly vulnerable to social rejection or loss of status, and consequent feelings of shame. Engagement in romantic relationships is associated with increased depressive symptoms and breakups are predictive of depression and suicidality. Girls are more driven by these 'affiliative' social needs and are therefore more likely to experience disappointment if rejected. There also evidence that although friendships are important for reducing feelings of loneliness, co-rumination with friends, particularly for girls, may contribute to the emergence or maintenance of depressive symptoms. Therefore any treatment program needs to be aware of the social context of the depressed young person, and the vulnerability of adolescents to the effects of their peer group (for a review of adolescent depression and emotional development see Allen and Sheeber).

## **Engaging youth and parents**

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### ■ **Confidentiality and trust**

The chance to develop trust and help the young person through this new *trusting* relationship is delicate and easily lost. This is pivotal for the whole therapeutic relationship and in particular for the management of risk. The clinician is less likely to be told of risk related thoughts or behaviours if there insufficient trust or engagement. Trust is hard to earn yet easily broken for example by injudicious breaks in confidentiality.

With adolescents in particular it is advisable to be clear from the outset what can be kept confidential and what cannot, and explicitly state that we need to tell appropriate adults if they tell us something that makes us concerned about their safety. Explicit confidentiality statements in age appropriate language can be helpful for example, stating what the policy and practice of staff or therapists is regarding confidentiality.

The following extract is one an example of what the clinician might say on meeting an adolescent, parent(s) or carer(s):

***“Before we start I would like to tell you what kind of things we can discuss and keep confidential if that is your wish. Often we find it best if we can be as open as possible with your family, with your agreement, but there are sometimes things young people like to keep private or are worried about telling people about. Now if you tell us things that would leave us concerned about your personal safety or that of someone else we cannot just keep that confidential between you and me. I would encourage you with my support to tell the other adult(s) who would need to know such as your parent(s) or a social worker etc. If you did not wish to do so I could do it for you with you present. If you did not want me to tell anyone, then I may well still have to tell (an) appropriate adult(s) as I am required to do so to help keep you safe. This way you know what will happen if you tell me such things. So you can decide if, and when, you may wish to do so.”***

This sort of message sets the scene for treatment; for example what to do if the adolescent discloses in the course of initial engagement or subsequent treatment, abuse or a high risk plan to seriously harm or kill themselves, or indeed harm others. The adolescent who has already lost trust in others in the course of developing his or her presenting problems (e.g. following abuse), who then loses trust in the person they seek help from, may be at greater risk, or pose greater risk to others, than prior to the clinical intervention.

■ **Interviewing the family or the individual in the early phases**

Careful planning and evaluation of how to conduct the interviews is important as it can set the tone for the interaction and the treatment to follow.

It pays to take a little time to discuss

- ❖ options of who is seen
- ❖ in what combination
- ❖ when and by whom
- ❖ with what sort of information sharing

There are reasons in favour of individual as well as family interviewing, and the ideal situation is to make both an option in case management. Joint interviews can help Young persons remember, especially the younger ones. They can be useful for opening up previously blocked communication between parents and children, can lead to parents describing their concern and bewilderment at what has happened, and help young persons start feeling more positive toward their parents again. Young persons describing their mental state and their experiences in front of the parents can lead them to understand better what their child is going through. Tears are not unusual at this point and can be the beginning of an effective treatment.

However, clinicians also need to be vigilant for parents indicating their own needs so that they can be addressed at the appropriate time and without compromising the adolescent's own engagement. Not all parents may behave in a helpful way in treatment, and clinicians need to be aware of occasions when they may need to be more directive with parents in the session and the subsequent planning of further sessions. For example, if parents interrupt frequently, make intrusive disclosures, express hopelessness, infantilise or are overly critical, then this may adversely affect the therapeutic alliance with the young person. It is also important to remember that an alliance with parents is vital in order to engage, support and empower them in promoting the young person's engagement with treatment - the 'parents as partners' principle (Chick, 2009). It can be all too easy for clinicians to over-identify with a depressed young person, at the expense of a therapeutic alliance with the parent, but generally this is not a helpful position. Thus the clinician needs to carefully negotiate sessions in order to effectively engage both the adolescent and family in order to maximise therapeutic benefit.

Many adolescents prefer to be seen alone because they want to say things to the therapist that they are afraid to say in front of the parents and want to feel independent. Sometimes there are so many conflicts with the parents that at the beginning it is better to see parents and child separately. They will argue during the initial interview and the child or parents may refuse to come back as a consequence.

■ **The “lived experience of depression”**

It is not sufficient in specialist care just to know the symptoms of depression. To really understand depressed Young persons, clinicians must link the impairments associated with the particular symptoms for that individual. For example, one Young person finds his schoolwork deteriorating owing to loss of concentration; another finds her sports performance diminished by loss of motivation and energy. In each case the effect is amplified through a negative feedback loop. Clinicians need to understand this, use these losses as targets for rehabilitation, and convey to the Young person that they understand and together the clinician and Young person can do something about it. From the Young person’s perspective, he may have been criticised by his teacher for not completing his schoolwork or she may be disparaged by her sports coach.

■ **Chain analysis**

Chain analysis can be useful in managing self-harm in young people and is equally applicable to other aspects of the depressive presentation. Chain analysis consists of naming elements in a chain of events and seeing them link together. This is a powerful method of capturing some of the three-dimensional aspects of the Young person’s lived experience. For example, Young persons are asked to relay an episode of self-harm. Often the answer is they just “felt bad” and found cutting themselves, overdosing, or risk taking with no obvious reason. Working through the events of the preceding period—minutes, hours, or days—the therapist can identify salient happenings. The salience can be highlighted by either the Young person or the therapist. Once salient points are identified, they are noted on a piece of paper. Eventually, a sort of map of the chains of events (with associated emotions) emerges. A copy of the map is offered to the Young person for own reference and reflection; if agreed, it can be shared with important others.

This process is a form of psycho-education and helps develop the emotional literacy of Young persons. Solutions may be identified by examining triggers and factors that reinforce the process.

### **Treatment planning**

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Most cases of child or adolescent depression can be safely and effectively treated on an out-patient person basis. However this will be contingent on having access as necessary to the range of skills and knowledge necessary and the possibility for some high risk cases of intensive and frequent review in periods of crisis.

While admitting a young person to an in-patient unit can seem like a safe alternative, and is sometimes clearly necessary, there are also risks to be considered with admission. Admission may lead to a reduced sense of self-responsibility and in-Young persons may learn or amplify maladaptive coping strategies, such as self-harm, from each other. Nevertheless there are times when admission is the favoured option. These would include: when the depression is severe and not responding to out-Young person treatment; when it is not possible to safely enough manage the level of risk associated with the depression despite best efforts in out Young person services; when there is diagnostic doubt and there is a need for more intensive observation and examination than is possible in out Young persons settings; when aspects of the home environment seem to play a major role but can't be clarified in the out Young person setting.

Day-patient care offers a half way house between residential in-patient care and out-patient care, and can be useful where it seems particularly important for the young person to be at home or in their community in the evenings and weekends; where admission on residential basis is not acceptable to the young person or their family; where a brief admission on day-patient basis can be used for more intensive assessment or as an introduction and prelude to admission.



- ❖ Most cases can be treated on *an* out patient basis
- ❖ Admission to an in-patient unit also has risks
- ❖ **Admission** is favoured
  - in severe depression not responding to out patient treatment;
  - when risk cannot be safely managed;
  - deteriorating physical health not eating/drinking
  - high risk psychotic depression
  - when further examination is required;
  - and when the home setting plays a major part
- ❖ Day-patient care can be used as a prelude to admission or when admission is unacceptable to the young person/family
- ❖ Informing the school, with consent, may help
- ❖ Psycho-education is an important part of the treatment for the young person and family, including the symptoms of depression, what seems to make them better/worse, the clinician's expectations and information about medication if applicable
- ❖ In severe cases where the young person and or parent make choices that are against the best interests or safety of the young person, compulsory admission under the mental health act or consultation with social workers regarding child protection issues may be deemed necessary

#### ■ **Psycho-education**

Psycho-educating the young person and their parents can and should be integral to the treatment. Each interaction is an opportunity to help Young persons and parents learn about themselves, the disorder, and how they can become experts in helping themselves recover and remain well. This includes describing the symptoms and how they affect the individual Young person, discussing with the family what seems to

make them better, what makes them worse, how commonly depression occurs in the community, typical time course of treatment, and what may happen if untreated. An indication should be given of what the clinician expects will occur. False optimism is not helpful, but clinicians need to look for opportunities to instil hope. Sometimes it is helpful to remember the importance of *harm minimisation* and not to seek a full “cure” at any cost (e.g., where circumstances indicate it is unrealistic). Toward the end of a successful treatment, there should be discussion regarding risks in the medium and longer term (e.g., risk of recurrence), what to do to prevent recurrences, and the importance of acting early. When medication is used, appropriate information and psycho-education regarding the medication should be part of the care.

#### ■ **Schools**

Letting teaching staff know—after obtaining Young persons’ and parents’ consent—what the young person is going through can relieve Young persons’ anxieties. The message conveyed depends on the severity of the depression. In milder cases, the advice may be to become aware the youth is more vulnerable, may have lapses in concentration or be more irritable, but should be able to manage school with support. In moderate to severe cases, school and family need to be helped to strike a balance between supporting attendance and schoolwork with lower achievement or, in more severe cases, partial or no attendance with reduced teachers’ and parents’ expectations. This needs reviewing as treatment proceeds and impairment changes. Bullying may either be a precursor or arise following the onset of depression. If so, activation of the parental and school systems to invoke effective anti-bullying measures is necessary.

■ **Factors likely to enhance treatment adherence**

***Consent and confidentiality***

- ❖ Careful attention to these issues
- ❖ Sometimes helpful to see adolescent on their own, at first or indeed for some elements or treatment, if they ask to be seen without parents' knowledge, but need to bear in mind balance of risks and need to share information as necessary with responsible adult(s)
- ❖ Ensuring the young person is offered as the default position the possibility of being interviewed separately from the family/parents as well as together.

***Treatment specifics***

- ❖ All the above with the understanding that defaults from appointments can represent the Young person's way of saying it is not working and considering review and reformulation
- ❖ Working with resistance to change, using appropriate strategies including motivational enhancement
- ❖ Remaining alert to opportunities to encourage and enable Young person and family choice in the process in ways that empower towards well-being

### ***Clinician related***

- ❖ Relationship quality with the Young person
- ❖ Therapeutic alliance with both young person and parent
- ❖ Expertise (knowledge, skills and attitude) of the clinician transmitted in ways that enhance the therapeutic alliance
- ❖ Clear framework for sessions with rationale, e.g. joint or individual sessions
- ❖ Allowing individual time for both adolescents and parents
- ❖ Young person and/or parents simply liking the clinician
- ❖ Availability and flexibility to meet needs in crisis and to meet needs in terms of appointment times and appointment setting
- ❖ Skilled handling of situations which threaten alliance with adolescent, eg. parental criticism, conflict, parental interruptions, parental needs, intrusive parental disclosures
- ❖ Counter-therapeutic therapist behaviours, e.g. negative beliefs about parents, failing to acknowledge emotions, misunderstanding, criticizing, too much eliciting of information (Chick, 2009; Karver et al 2008)

### ***The setting***

- ❖ Young person and family friendly settings
- ❖ For selected young people and families a setting in the community rather than necessarily in a central clinic may help
- ❖ A setting the family can get to reasonably easily or be supported to get to if it is far or difficult

### ***Pre-assessment processes***

- ❖ The attitude (positive, encouraging of the family/young person) of the referring agent to the clinic as transmitted to the Young person and family/school etc
- ❖ A realistic setting of expectations by the referring agent  
Continued links and availability of the primary care professional(s) e.g., General practitioner or teacher or social worker to help Young person and family through the process and treatment

### ***Administrative***

- ❖ Consider utility of, where appropriate, copying correspondence, assessments etc. to the young person and family so they can feel fully involved in the treatment planning and delivery
- ❖ Keeping appointments and to appointment times where possible seeing the young person and family in a timely manner

■ **Negotiating Treatment Goals & Dealing with Young person or Parent Refusals of Treatments**

The clinician will form a view about the best treatment package they can offer. The young person's views and those of their parents should be integral to the clinician's thinking. Sometimes the young person will have a view about what they do and don't want which is not what the clinician considers the ideal treatment package, for example requesting medication early in treatment and not wanting any talking therapy.

Except in the most extreme circumstances the task is to respect but also explain the likely risks and benefits of each approach using current best evidence. In the case of this study they may not be eligible if they are unwilling to be randomised to any one of the 3 arms. Subsequently during reviews these issues can be revisited and re examined; people do change their minds, including us the clinicians.

In the most severe cases, for example in psychotic depression or severe determined suicidality, the Young person's choices may be so against their own best interests and safety that the use of some form of compulsory admission for assessment and sometimes treatment is needed using statutory mental health act powers.

Similarly refusal of parents to allow or enable effective psychiatric care can amount to a child protection issue; the clinician is then advised to consult with a social worker and consider the statutory child protection legislative framework.

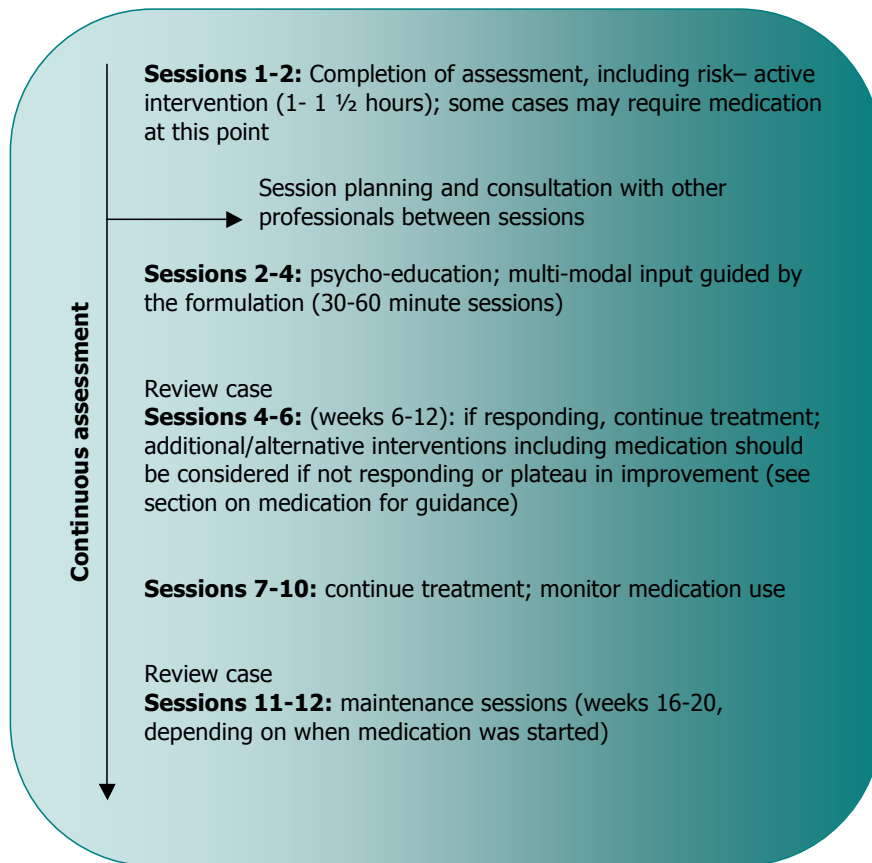
## Organisation of Sessions

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The typical pattern of treatment will be spread across twelve sessions over 20 weeks. This of course starts with assessment. Assessment sessions will typically take around 1 to 1 ½ hours, and may take 1-2 sessions. Elements of active intervention should be weaved

into every step of the assessment process. Next is the early psycho-education phase, followed by multi-modal input, as guided by the formulation. It will be necessary to start medication for some carefully selected Young persons at the assessment phase. For others medication will be considered after 4 to 6 sessions have passed without adequate progress. (See section on medication for details). Session frequency will depend on severity, risk and the family's ability and willingness to attend regular sessions. Ideally this should be weekly at first, decreasing in frequency as the depression improves. In IMPACT the BPI phase of treatment will conclude at 20 weeks. Once in early recovery consider maintenance sessions for a further 6 to 12 months after onset of recovery. The setting in which this maintenance work occurs may be negotiated e.g., starting in the specialist setting and in some cases care then being transferred to the non specialist or primary care setting. (6,19)

Session length will likely be 30 to 60 minutes; longer sessions are more likely to be needed when family interviewing is necessary. Planning and booking sessions in advance can help the engagement process and provide a sense of hope and being helped for the Young person and family, this in itself can diminish risk and help manage and contain crises.



Time needs to be set aside by the clinician to write to, phone and/or visit other professionals involved, so that the kind of liaison and psycho-education detailed in the earlier section can be provided. More time should be allowed in the more complex cases.

There will need to be case progress reviews, bringing forward recovery and ensuring that cases don't stagnate.

#### ■ **Family Conflict: Family Consultation**

Indications for family work include high levels of family conflict not resolving early in the assessment process, severe misunderstandings about the youth's presentation, and family adversities (e.g., bereavements or chronic illness). Concerns regarding abuse or neglect need addressing also through the appropriate social care

agencies and statutory processes. Parents who suffer from depression or other conditions should also be referred for treatment in their own right.

Some families, or members of the family, find it hard to come and some adolescents will refuse to part of a family meeting. If a family session/s is indicated, the clinician needs to discuss its advantages with the parents and young person. We recommend a flexible approach when necessary, engaging those adults and family members who are willing.

■ **Parent consultation during individual sessions**

Where possible, regular feedback, discussion and problem solving with the parent(s) should be maintained, even when it is not felt that family sessions are necessary. This becomes ever more crucial as levels of case complexity, severity and risk rise.

### **Use of Medication**

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Here the clinician is guided further to some key issues in the deployment of medication as part of the whole care package in acute episodes of depression.

■ **Who is medication indicated for?**

In moderate (5/6 symptoms) to severe (7/8 and above symptoms) depression, if there is no progress or minimal progress with Brief Psychosocial Intervention or one of the specific psychological treatment arms CBT/BPP, after around 6-12 weeks, then antidepressant medication should be considered. If medication is not being added there needs to be a clear rationale, for example a change is likely to occur through new direction in the non-medication interventions.

If there is an actual deterioration during Brief Psychosocial Intervention or the active psychological treatment then the addition of medication should be considered. The evidence suggests the specific serotonin reuptake-inhibitor (SSRI), fluoxetine should be the first choice. If after an adequate trial of fluoxetine there is no response, alternative medications should be considered. In the UK the suggested second line treatments are sertraline or citalopram (19).

If the improvement plateaus at a clinically significant level after an initial improvement, this would be a further indication that a trial of medication should be considered.

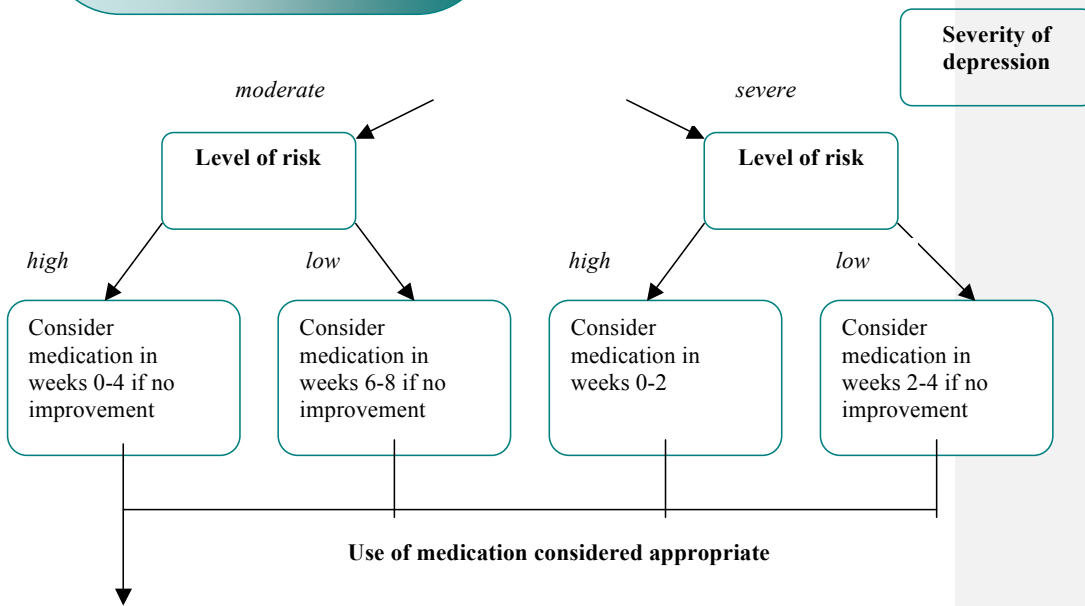


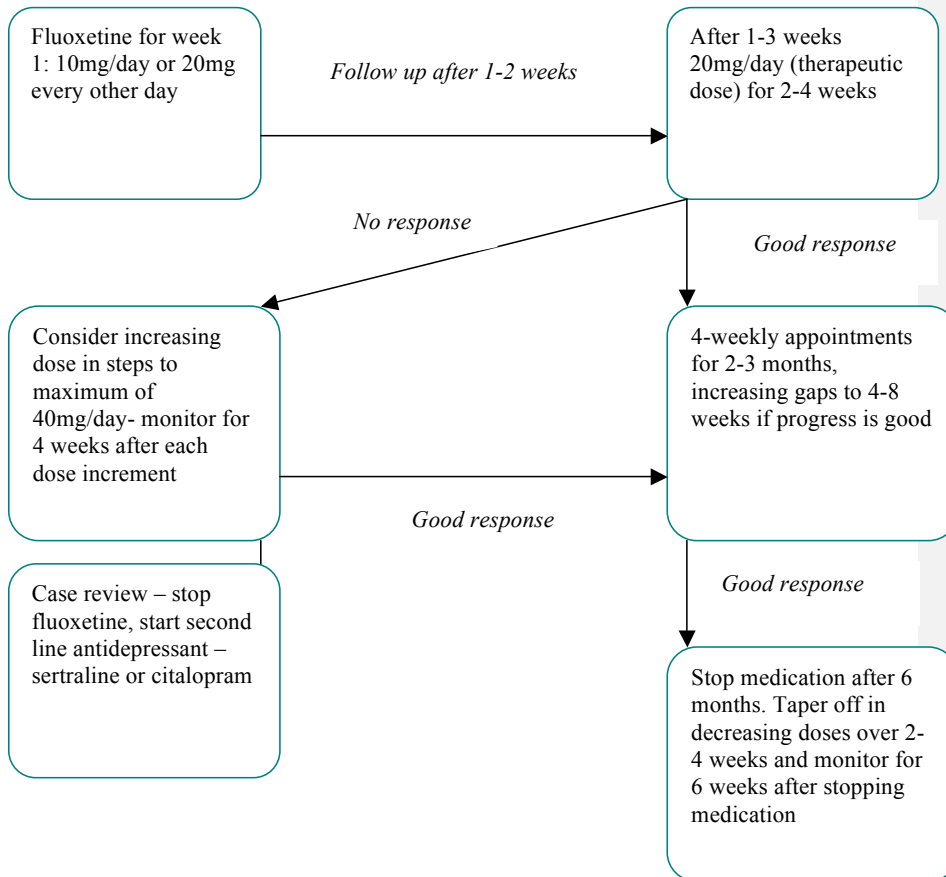
■ **Cases where medication should be considered from the outset**

**Early administration of medication**

- ❖ *High severity and high risk of self-harm, particularly self-harm aimed at ending life*
- ❖ *Cases with risk-laden psychotic symptoms*
- ❖ *Inability to engage effectively in talking treatment due to depression itself*
- ❖ *Certain personal circumstances*

In all cases, medication should always be used in concert with active specialised psychosocial intervention (BPI), or in the case of those cases in the specific therapy arms alongside either the CBT or BPP.





Cases which at presentation have a very severe disorder and associated high risk of serious self harm should be offered medication within the first one to two weeks of assessment/engagement. Beware of prescribing in a crisis, such as in the first hours after an episode of self-harm; where possible, always see the Young person for a second time before starting medication. This is because the therapeutic content of the initial assessment, or indeed the family's response to the crisis, can lead to an improvement in symptoms. In helping the Young person and their family to decide on the best treatment it is also important to inform them that there is a rare, but significant, risk that antidepressants may worsen suicidality and self-harm ideation in the short-term (23).

*Remember* it is important to differentiate self-harm aimed at unpleasant affect relief from self-harm aimed at ending life or endangering life. It is also important to understand where self harm is aimed at making other people change

their behaviour or change something relating to the Young person's life, from self harm being driven by a depressive disorder in itself.

Cases presenting with risk-laden psychotic thinking, such as nihilistic delusions and command hallucinations, should be considered for urgent-early prescription of medication, in this case antidepressants plus an anti-psychotic such as risperidone. Again the clinician must carefully go through the risks and benefits of atypical anti-psychotics, both short and long term. There must be particular mention of the risks of extra-pyramidal side effects and metabolic effects such as weight gain and risk of diabetes, and possible cardiac effects, and the need for blood and ECG monitoring.

In some cases personal circumstances, such as looming major exams, mean the rapid and effective amelioration of some or many symptoms of depression may have a major effect on the developmental trajectory. In such circumstances, medication should be considered earlier, of course weighing up the potential benefits and risks with the Young person and their family.

■ **Policy on the initiation and prescription of antidepressants**

The current risk-benefit analysis suggests that for young people the potential benefits outweigh the risk for fluoxetine (6, 19)

The recent controversy highlights the importance of the judicious use of these medications. The response of the UK NICE (National Institute of Clinical Excellence) committee was to recommend a policy (9) of only specialist practitioners initiating antidepressants in children and adolescents. General Practitioners may prescribe (repeat prescriptions) after specialist recommendation and in consultation with the specialist.

■ **Psycho-education when prescribing medication in the acute episode**

***Symbolism and cultural context of prescription***

The very act of prescribing is a powerful symbolic moment, the handing over of, "the cure", of the thing that will make things better. This can leave the person waiting for the effect to happen, waiting in a passive way, which is likely not to help. The clinician is guided to help the Young person take active steps to help themselves and be helped.

In some cultures such medications or "potions" still have very close associations in people's thinking to the arts of the traditional healers, for better or

worse. In many western cultures the well-known placebo effect in young people may be linked to meaning stimulated by the symbolism of prescription and taking of medication. The advice is to be aware of these beliefs and ideas. In addition, some beliefs or cultural contexts may make adherence or compliance a problem.

In many cultures with extended family hierarchy, the head of the family must agree for the prescription to be effective and complied with. It is important to be aware of this and engage in dialogue with the appropriate decision maker/head person in that young person's social network, not just their parent(s).

### ***Placing medication in the context of the whole care package***

The task is to set the advice on the prescription in the context of the case formulation in such a way as to maintain the overarching message of activation (increasing personal and familial efficacy in the face of adversity. The medication is not *the* answer, it is part of the solution; the Young person must not be encouraged into a passive and helpless position. The Young person and their family need to be empowered. This is further achieved by remembering to attend to the full range of interventions and strategies detailed herein together with a process of effective information sharing about the medication.

The clinician must avoid falling into the trap of failing to provide the rest of the Specialist BPI for Depression when medication is used. The clinician is advised to avoid either explicitly or implicitly saying "here take these pills, it's all chemical imbalances and it will all get better, nothing else matters much, next Young person please".

#### **■ Risks and benefits of antidepressants**

Openly speaking about the risks as well as the benefits empowers and enables real choice for the Young person and their carers/parents. The clinician should impart information about the more common side effects, such as tiredness, headache or nausea which may occur in around 1 in 10 to 1 in 20 cases; and the less common but potentially more serious side effects such as discontinuation syndrome after medication cessation, serotonin syndrome, blood dyscrasias/increased bleeding diathesis, potential interactions with other medication or surgical complications (surgeons should be told of medication due to potential of increased risk of bleeding) and the short term reported increased suicidal ideation or behaviours thought to

occur in around 1-3 in 100 cases. It is helpful to put this data in some context by stating that the depression itself carries risk of serious self-harm without an effective treatment. It should be noted by the clinician, and as appropriate, discussed with the adolescent and their carers, that the NNT (number needed to treat, after allowing for the substantial 40% placebo response rate) for Fluoxetine is 6, so many Young persons can benefit before statistically one will arise whose ideas of self harm may have increased following medication.

Finally in this respect it is worth highlighting that in being carefully selective in only offering medication to cases who really need it, and then monitoring closely, we weigh the balance in favour of the potential benefit.

The chances of side effects are greatest early in treatment and often wear off after a few weeks, and Young persons should be reassured of this before starting medication. The chances of side-effects are reduced by starting medication at half dose for the first 1 week or so.

The Young person and their parents/carers must be clear that if they have any concerns who they can contact and how for advice, particularly bearing in mind concerns regarding any changes in suicide-related thinking or serotonin syndrome.

Alcohol consumption is not advised. In moderation it is often not dangerous. However its effects are likely to be amplified when also taking SSRI antidepressants. In addition, alcohol may worsen depressed mood and reduce inhibitions, increasing the risk of harming the self or others.

At some point the young person will need to come off the medication. It is hoped that Specialist BPI will have enhanced old coping strategies and/or developed new coping strategies in case of future mood problems.

### ***Mechanism of action***

The young person and their parents/carers and important others such as teachers need to understand some the properties of the medication. A brief discussion on the psychopharmacology of SSRIs can be helpful, stating that the medication probably boosts the brain's serotonin system, which can lead to improved depressive symptoms.

#### ■ **Time-course & prescribing pattern, changing doses**

As stated earlier, a lower dose of 10mg/day (or 20mg alternate days) is usually given for up to and around 1 week, before an increase to the usual therapeutic dose of 20mg/day. The clinician should explain the expectation would be for a response

within 2-4 weeks of establishment on a stable therapeutic dose. It is not uncommon to find the parents and or the treating clinician notice the onset of change and effects before the young person does. If there is no response then there will be a case review and consideration be given to increasing dose in steps to the maximum (fluoxetine 40 mg) with a monitoring period of around 4 weeks after each dose increment. Young persons should be reviewed regularly, in particular they should be seen 1-2 weeks after dose increases, to monitor for and address side-effects. Case reformulation and review is essential to ensure other factors that may impinge on progress are attended to. If, after such adjustments of dose, there is still no progress, further case review should decide whether it is time to stop the fluoxetine and switch to the second line antidepressant, usually either sertraline or citalopram.

Once stable and with no major problems, 4 weekly appointments for 2-3 months, followed by increasing gaps to 4-8 weeks if progressing well. Medication is usually stopped after 6 months of recovery. For very severe first episodes, early recurrence post-discharge or those with recurrent disorder, medication should be continued for 1-2 years. Medication should be tapered off in decreasing doses over 2-4 weeks, to reduce the chance of discontinuation symptoms. Young persons should be monitored for at least 6 weeks after stopping medication, to ensure there is not recurrence.

To deliver Specialist BPI, further appointments may be necessary. It can be advantageous, particularly from the Young person and family's point of view, if medication and the psychosocial care can be delivered by the same person. This is not always possible and where that is the case, close effective communication is essential between the prescribing clinician and the provider of the broader BPI, or indeed the specific therapy practitioner if the Young person is receiving either CBT or STPP.

### ***Time of day to be taken***

Fluoxetine may be used once a day and the time of day administered is not thought to make any difference due to the long half-life. Nevertheless some Young persons find morning doses suit them better, and cause less sleep disturbance.

There is some suggestion in the literature that the half-life of sertraline and citalopram is shorter in young people than adults, and if so this may lead to withdrawal type effects on once daily doses. If that is thought to be a problem twice daily divided doses should help (6).

■ **Nature of the effects of medication: with reference to the lived experience of depression**

The medication is not a sedative or a tranquilliser; so there is not instant effect on symptoms such as anxiety, fearfulness, irritability or sleep disturbance. However it can and often does have positive effects on some or all these symptoms in time.

Elevation of mood is the effect most young people and their parents will be thinking is the role of antidepressants, and it is a core symptom that antidepressants can impact on. Paradoxically, the clinician needs to monitor mood elevation and ensure that hypo-manic mood is not precipitated as those young people with a strong family history of bipolar disorder or those with a presentation of psychotic depression may be more likely to switch to manic or hypo-manic state. In such cases, "starting low and going slow" with dose increments together with very close monitoring is required.

Antidepressants can improve sleep that is disturbed by a depressive disorder. Sleep tends to improve as the depression recedes, but SSRIs can also cause sleep disturbances. These can be transitory or persistent. If troublesome then sometimes switching dosing times helps, or decreasing dose or ultimately if necessary switching medication.

*Young persons and their families should be advised not to stop the antidepressants without advice.*

■ **Young person and parent/carers preferences; what about requests for only medication or no medication in the care package?**

Clearly by entering the trial there will have been a robust process of informed consent, which will include clarification that they may be allocated to any one of the three treatment arms at random and that medication will be offered as necessary in any one of the three arms. A teenager may want medication and not talking treatment; informed consent is the crucial concept in such circumstances. This means an informed discussion with all concerned of the risks and benefits using current best evidence. Such a young person, if they maintain this view, would not be appropriate for this study.

Therefore the clinician should ascertain these thoughts in the course of assessment and treatment planning, and be prepared to discuss the pros and cons of such an approach. In our experience, when such an open and informative/psycho-educative discussion occurs some adolescents will change their view and some will still

conclude they prefer medication alone. In some cases this is based on a misperception of what psychotherapy may have to offer, following previous perhaps less specialised therapy or counselling experienced as ineffective. In those cases that still only want the medication, they would not be suitable for the IMPACT study as they may get randomised to a specific therapy arm such as CBT or STPP.

■ **Medium to longer term perspective in treatment including use of medication**

The clinician is advised to consider that, as we know around 20% or so of cases will be unresponsive to treatment, in the short to medium term. The problem is we do not know at the outset which cases will respond and which will not, though it is likely the risk factors identified earlier for persistence give some indication, this is an area requiring the further research and data we hope will emerge from this study (IMPACT).

### **Physical and Mental Health Hygiene; Exercise, sleep and diet**

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■ **Exercise**

There is good evidence that exercise is an antidepressant for milder episodes in adults, the same is probably true in adolescents and perhaps children (19). Sensitivity is necessary; for example in the early treatment of a retarded melancholic adolescent it may simply be asking too much. Effects will probably include: help with distraction from negative thoughts and rumination; increased opportunity for social interaction and achievement; and decreasing stress. It will also counteract obesity, a risk in itself for depression and lowered self-esteem, and is clearly beneficial from a general health point of view.

■ **Other Activities**

Encouragement of involvement in other activities that are of the young persons choosing is helpful. The opportunity for increased socialisation and for positive feedback from interpersonal experiences and or small or bigger achievement should be supported. However in all cases a balance needs to be struck so the young person feels this encouragement as a support not a criticism. It needs some times to be achieved in small steps across time.



■ **Sleep**

Sleep problems can be integral to depression or indeed precede it especially in adolescents. At any event poor sleep exacerbates irritability, loss of energy and concentration problems. Advice on basic sleep hygiene is the first step, often to be linked with advice on exercise and diet. Diet is relevant with respect to potentially stimulating food and drinks, and the time they are taken in relation to bedtimes. Help in getting to sleep with relaxation exercises can be helpful. It is crucial to be aware and let the Young person and family know that shifts in waking up times can easily disturb the circadian rhythms.

■ **Diet**

While the current evidence on effects of diet is rather limited there are indications that unhealthy diets can have negative effects on mood, sleep patterns and concentration (19, 24). Certainly some food and drinks are known for mood related effects such as alcohol, caffeine, and cacao/chocolate. Overall healthy diet should be part of any management plan with particular emphasis where there is evidence of very poor diet or poor knowledge in this regard.

Some young people will either comfort eat or indeed lose their appetite when depressed. It can be helpful to offer support and advise in either regard as part of general mental and physical hygiene, in particular putting on weight can lead to lowering of self esteem and mood so worsening depression. Advice here can help counter these trends.

■ **Street drugs and alcohol**

Clinicians need to be aware of the possibility that young people with depression may be using illicit substances or alcohol as a coping strategy, or, alternatively, depression may have arisen as a consequence of drug or alcohol dependency. It is essential that clinicians enquire about this as part of the initial assessment. Young people may not always admit to drug and alcohol use, and therefore if there is minimal progress in treatment, this possibility needs to be considered as a reason for the maintenance of depressive symptoms and further enquiries should be made. Drug and alcohol use is not necessarily a contra-indication to participating in the study; however, if there is evidence at the initial assessment that depression arose secondary to drug or alcohol use and there is a high level of dependency requiring a

detoxification program with specialist services, then the young person would not be suitable for the trial.

If there the adolescent admits to drug or alcohol use, the clinician needs to assess the extent of the problem and provide psychoeducation. This should include the harmful effects of these substances, including physical risks, physical and psychological dependency, and the use of substances as inappropriate coping strategies. Reasons for drug and alcohol use should be explored and strategies for stopping developed. Referral to a specialist drug and alcohol youth service may need to be considered if there is regular use. A risk assessment should be completed, particularly regarding any increased risk of suicidality or aggression whilst intoxicated, and whether the young person places themselves at risk in this situation. If this is the case, then further liaison with carers and possibly social care may be necessary to address safety issues. If there is no increased risk to the adolescent as a result of drug and alcohol use and the young person does not wish carers to be informed, then further discussion will need to take place with the adolescent and supervisors regarding the appropriateness of maintaining confidentiality.

■ **Hope and expectation**

It is important to kindle hope but it is not helpful to set up expectations that will not be met, as the ensuing disappointment may be considered an iatrogenic adverse effect of treatment. Iatrogenic effects are of course also possible from the various medications themselves, and indeed talking treatments, and we are monitoring these as part of this study.

The clinician is advised to also consider the importance, in very treatment resistant cases, of harm minimisation and harm reduction as well as 'full cure'.

## Outcomes

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The current study aims to address medium to longer term outcomes questions in depression amongst adolescents. Current data however suggests that among Young persons with MDD referred to specialist clinics, 20% are likely to respond to the first 2 to 4 weeks of assessment and early intervention (early BPI for depression) (1). A further 50% to 60% of the remainder is likely to respond over the next 12 to 28 weeks to a combination of SCC and medication. Data regarding longer term outcome are sparse. Most longer term studies have found a group of treatment-resistant Young persons comprising about 20% of cases by 12 months (7, 8). The evidence to date indicates that our treatments are bringing forward the onset of recovery when compared with naturalistic outcomes without active care. Studies of untreated samples suggest the median length of an episode is around 7 to 8 months (8) However, there is a subgroup of youth who will have disorders that may last years if untreated, perhaps around 20% (7, 8).

Factors thought to be associated with worse outcome include: increased severity of depression at presentation, greater impairment at presentation, persisting family discord, family history of depression, abuse or neglect, hopelessness at presentation/lack of faith in professionals being able to help (often indexed by suicidality).

## Ending treatment

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### Tailing off medication and Relapse Prevention

Medication should be continued for 6 months following onset of recovery. If there has been a recent previous episode or other complicating features then medication may need to be continued for longer, up to 12-18 months post onset of recovery (See NICE guidelines)

When tailing medication off this should take place gradually over a minimum of 2-4 weeks, in some cases up to 8 weeks and the young person should be monitored for at least another 6 weeks after that.

During BPI the formulation will have led to an aetiological description for the Young person being treated and this should guide the advice regarding relapse prevention. The clinician should highlight as treatment ends the particular pathway/s into depression and how to avoid them in the future. In addition the clinician should highlight the early warning signs of relapse and what to do in the way of self help or professional help seeking. The importance of maintaining those factors identified as protective or helpful in treatment will be highlighted.

**Appendix A**

**A sample Comprehensive Self Harm Assessment Schedule**

*Cambridge and Peterborough NHS Foundation Trust.*

**SELF HARM ASSESSMENT SCHEDULE.**

<b>Name</b> - .....	<b>Date of birth</b> - .....
<b>Address</b> - .....	<b>Date of S/H</b> - .....
.....	<b>Date of risk assessment</b> - .....
.....	<b>GP</b> - .....
<b>Post code</b> .....	<b>School</b> -.....
<b>Who has parental responsibility?</b> -.....	
<ul style="list-style-type: none"> <li>■ <b>Child physically fit to be assessed? Yes / No</b></li> <li>■ <b>Who present at assessment? –</b></li>   <li>■ <b>Where assessed?</b></li> </ul> <p><b>Boundaries on confidentiality?</b> – permission to contact other agencies? Boundaries re child protection made clear?</p>	
<b>Other agencies/professionals involved already -</b>	
<ul style="list-style-type: none"> <li>■ <b>Self harm in combination with other risk behaviour?</b></li> </ul> <p>Consumption of alcohol / drugs?</p> <p>Other risk-taking behaviours?</p>	

**Name:**

**DOB:**

■ **Understanding the self harm–**

Detailed account of the 48 hours preceding the self harm – separate out immediate precipitants from ongoing problems. Note issues of conflict & loss. Increased risk = violence, legal/disciplinary, drugs, alcohol, hopelessness, impulsivity

■

Confirmation of events from medical notes? Yes / No

Confirmation of events from carers Yes / No

Please detail any discrepancies.

Name:	DOB:
<p>■ <b>Impulsive or planned? –</b> How long been thinking of self harm?</p> <p>Timing - Alone or someone present or with easy access?</p> <p>Nature of precautions to prevent or ensure discovery?</p> <p>Any 'notes' left? Paper, text, email.</p> <p>Other impulsive actions?</p> <p>Anticipated outcome? –</p> <p>Awareness of others who have self harmed and the outcome for them? -</p>	
<p><b><i>Circumstances surrounding the self harm –</i></b></p> <p>Degree of suicidal intent and other reasons for the self harm?</p> <p>Actions after the self harm? who was the self harm revealed to?</p> <p>Thoughts about the self harm now? Regrets? Any continued wish to die?</p> <p>Plans to repeat? How safe do you feel? Can you trust yourself not to do it again?</p>	

<b>Name:</b>	<b>DOB:</b>
<b><i>O/D only</i></b> What taken? –  Quantity taken? –  All available taken / selectively taken? –  How many tablets thought would cause death/serious harm? –	
<b>■ Past deliberate self harm ?</b> Any previous o/d or self harm?  Any previous thoughts of o/d or self harm?	
<b>■ Clarification of current difficulties</b> Nature of problems – physical, psychological, relationships, duration, recent changes  Other problems – acute or chronic	



<b>Name:</b>	<b>DOB:</b>
<ul style="list-style-type: none"><li>■ <b>Mental state –</b> Any evidence of mental illness? Description of behaviour, mood, cognitive state, disturbance of sleep or appetite, clear abnormal symptoms e.g. auditory hallucinations. Increased risk is associated with psychiatric illness – psychosis, depression, eating disorder, substance misuse.</li></ul>	
<ul style="list-style-type: none"><li>■ <b>Family and personal history</b> Simple genogram can help. Psychiatric illness or addiction in family, separated family, contact issues, many changes, losses, in care, homelessness, running away</li></ul>	

<b>Name:</b>	<b>DOB:</b>										
<p>■</p> <p>■ <b>Coping resources and support systems</b>                  Family, friends, social agencies, GP ?</p> <p>Previous ways of coping?</p> <p>Attitude of the individual and family towards further help?</p> <p>List of current problems – formulated preferably with the Young person and in their own words.                  Consider – parents, school, boy/girlfriend, social isolation, siblings, physical and psychiatric                  problems – self &amp; family, sexual problems, relationships with peers, alcohol, drug/substance                  misuse, legal &amp; financial issues, disciplinary crisis...</p>											
<p><b><u>PATHOS screening questionnaire O/D only</u></b>                  Assessment of risk?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;">1. Have you had <b>P</b>roblems for longer than one month ?</td> <td style="width: 20%; text-align: right;">YES/NO</td> </tr> <tr> <td>2. Were you <b>A</b>lone in the house when you overdosed ?</td> <td style="text-align: right;">YES/NO</td> </tr> <tr> <td>3. Did you plan the overdose for longer than <b>T</b>hree hours ?</td> <td style="text-align: right;">YES/NO</td> </tr> <tr> <td>4. Are you feeling <b>H</b>Opeless about the future ? that things won't get much better?</td> <td style="text-align: right;">YES/NO</td> </tr> <tr> <td>5. Were you feeling <b>S</b>ad for most of the time before the overdose ?</td> <td style="text-align: right;">YES/NO</td> </tr> </table> <p>(A score of 1 is given for each 'yes' answer for the questions. The total score for the questions correlates well with depression, hopelessness, long premeditation time and high suicidal intent. The higher the score, the more the overdose is 'of concern')</p> <p style="text-align: right;"><b>SCORE - _____.</b></p>		1. Have you had <b>P</b> roblems for longer than one month ?	YES/NO	2. Were you <b>A</b> lone in the house when you overdosed ?	YES/NO	3. Did you plan the overdose for longer than <b>T</b> hree hours ?	YES/NO	4. Are you feeling <b>H</b> Opeless about the future ? that things won't get much better?	YES/NO	5. Were you feeling <b>S</b> ad for most of the time before the overdose ?	YES/NO
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2. Were you <b>A</b> lone in the house when you overdosed ?	YES/NO										
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5. Were you feeling <b>S</b> ad for most of the time before the overdose ?	YES/NO										

<b>Name:</b>	<b>DOB:</b>						
<p><b><u>Establishing what further help is required.</u></b>                  What is wanted and what is the young person prepared to accept?</p>          Who else should be involved?							
<p>■ <b>Care plan following assessment -</b></p>          <table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Follow up from CAMHS</td> <td style="width: 40%;">YES/NO</td> </tr> <tr> <td>Follow up from other agency</td> <td>YES/NO</td> </tr> <tr> <td>Which agency to be referred/follow up?</td> <td></td> </tr> </table>          Signed.....Clinician		Follow up from CAMHS	YES/NO	Follow up from other agency	YES/NO	Which agency to be referred/follow up?	
Follow up from CAMHS	YES/NO						
Follow up from other agency	YES/NO						
Which agency to be referred/follow up?							
Original Schedule by P. Harper. Northampton from work by K Hawton et al. Adapted by Kettering C.A.F.S. in March 2004. Adapted for Peterborough Cedars 10/06 IH							

## **Appendix B**

### **A Guide to Supervision & Practice of BPI in IMPACT**

A Vignette & Checklist of Key Touchstones of BPI

Vignette

Referral information

J is a 14 year old boy who presented following an overdose of paracetamol. He has been having difficulty in school and complains that the teacher is giving him a hard time, and he is getting in to trouble. At home his parents say they just can't talk to him, he goes to his room and shuts himself away. He says that he is bored with school and his parents don't take him seriously. He has a new group of friends and sees them but his parents are worried about their influence on him. He was previously referred to the service age 7 with angry outbursts at home and concerns about his self esteem, and communication with peers. He has a history of asthma and mild cerebral palsy with weakness in his legs. His mother has a history of depression and has had several admissions to the local psychiatric hospital one at least following self harm.

He was assessed in the A & E department and thought to be depressed. On assessment he is thought to be moderate- severely depressed, not currently suicidal but feels he may become suicidal again if someone 'gets on my case again'

Potential formulation (*with omissions to stimulate reflection*)

J is a 14 and was found to be moderate-severely depressed, with associated lowered frustration tolerance and deliberate self harm. His frustrations are likely to have arisen in the context of his depression which impairs his concentration at school, where he used to have much better relationships with his teachers. His depression had an onset around 9 months ago, and seems likely to have been precipitated by his increasing awareness of the difficulties his impaired coordination cause him from his cerebral palsy. He feels a bit of a failure and can't compete as he would like to in football and sports. He has now developed increasingly negative interactions with his teachers and is gravitating to a more disruptive peer group, both of which may serve to maintain his current difficulties to some degree. Similarly the deterioration in the relationships with his parents. He is a little evasive about current plans to self harm, he hints there may have been previous episodes. Risk of repeat self harm is raised, but no current plans or current self harm occurring. He does take alcohol when with friends and this could increase risk of an impulsive or unplanned episode.

He has protective factors in his continued good relationship with his brother and best friend, his wish for things to be different in school and grudgingly admitted but also at home. His parents are evidently concerned and engaged in wanting to 'sort things out', but are a bit unsure how. J wants to be 'taken seriously', he feels nobody understands.

## **Key elements in delivery of BPI**

### **A Checklist for Supervision and Supervisees**

#### **Engagement and the culture of the treatment: activation and problem solving**

1. Has the BPI clinician engaged the patient and parents collaboratively?
2. Has there been appropriate empathy, warmth, understanding and depression specific expertise shared with the patient and parent/s?
3. Has there been a culture in the engagement and ongoing treatment of balanced optimism, activation, problem solving, listening and support?
4. Has there been actual problem solving together?
5. Has there been an eliciting of what are the main concerns for the patient and his parents?

#### **Diagnostic accuracy**

6. Has the BPI clinician ensured diagnosis is accurate, and severity appropriately assessed?
7. Is there a missed or co occurring comorbid disorder such as Aspergers syndrome, OCD, anxiety or conduct disorder, emerging personality disorder?

#### **Account taken of risk and protective factors**

8. Has the assessment and formulation taken account of and understood the impact of his mothers depression on him?
9. Has the assessment allowed understanding of any other risk and or protective factors?

#### **Formulation and information sharing**

10. Has the treating clinician discussed the formulation with the family?
11. Has consideration been given to the order in which information is shared, to the lad on his own or together with the parents and or brother?
12. Has the patient been interviewed on his own?
13. Has there been clarity in discussions about consent and confidentiality boundaries and limitations?

#### **Assessment of and attention to safeguarding & risk to the self or others**

14. Has the assessment checked re safeguarding and history of maltreatment?
15. Has the therapist established if there is any risk to the self or others?
16. Has a safety plan been developed and who has it been agreed with?

#### **Consent and confidentiality**

17. Has the therapist addressed these issues appropriately?

### **Treatment planning**

18. Has the therapist discussed the treatment plan?
19. Has the therapist discussed any appropriate options, acceptability, for where and when the patient will be seen
20. Has consideration been given to who should be involved apart from the patient?

### **Psycho-education, risk and safety planning, mental and physical hygiene**

21. Has there been psycho-education regarding: depression, self harm, family history of depression and how these all relate specifically in Js case?
22. Has a safety plan been discussed in case of further crises, who to call, what to look out for in J, what might help, what might make him worse eg alcohol, high expressed emotion, losses and failures in daily life
23. Has there been advice and discussion about what tends to help and what can make mood, and wellbeing worse such as sleep patterns, exercise and diet?

### **Parent support and family work**

24. Has consideration been given to the parents having time to discuss their concerns about the effects of mums illness on the family ?
25. Have the parents been helped to understand how Js depression is negatively impacting on their relationships in the household?

### **School and other agency liaison**

26. Has J's school progress been sufficiently understood? In particular are there other data school has that could impact on his presentation and treatment
27. So has liaison with the school been considered and agreed,
28. In particular has school been helped to understand the assessment and how it might be impacting on J's school experience?

### **Medication**

29. Has the usefulness and role of antidepressant medication been considered and discussed?
30. Has there been a rationale discussed with the family for when it might be used ?
31. If medication is discussed has there been a discussion of the
  - ❖ Potential risks and benefits
  - ❖ Course of treatment
  - ❖ Types of dose regimes likely
  - ❖ Monitoring and safety requirements
  - ❖ Time of day and other daily administration of medication issues
  - ❖ Potential interactions eg with alcohol
32. Has the outcome of this discussion been recorded on file?
33. If medication is being considered has written information on the medication been provided to the patient and the family?
34. If medication is being considered has a baseline pre treatment checklist of potential side effects been taken

**Alcohol and drugs**

- 35. If alcohol is an issue has there been psycho-education regarding the alcohol
- 36. Has consideration been given to impact of drugs if an issue?

**Maintaining engagement and communication in the systems: family, primary health, school, etc**

- 37. Have the parents/carers, primary health , school etc been regularly as far is possible and agreed updated on progress and made part of the continued treatment delivery process?

**Personalising the formulation to J and his depression**

- 38. As understanding of J develops has the BPI clinician continued to pay attention, as guided by the formulation, to the interactions between Js symptoms, his interaction with others, and the impact on others in his school, peer and family life?
- 39. Has the BPI clinician provided advise about mental hygiene and depression, as guided by the particular formulation?

**Maintenance of recovery and relapse prevention**

- 40. As improvement occurs and recovery becomes evident has there been a discussion about J specific relapse prevention, things to look out for, steps to take to remain well and what relapse paths might look like?

**Maintenance of general psychological therapy skills across the care pathway**

- 41. Has the therapist maintained engagement, collaboration, empathy and understanding and an activation focus in delivery of care?

**Notes**

*Please refer to the BPI manual for details  
This checklist forms the basis for adherence and competence monitoring of BPI*

**Appendix C**

Brief Psychosocial Intervention (BPI)  
Registration Form

**IMPACT**

Improving Mood with  
Psychoanalytic And Cognitive Therapies

Name of the BPI therapist:

Clinic Location:

**Please tick all boxes that apply to you**

I am qualified in at least one mental health speciality

I have sufficient specialist expertise, experience and competence to undertake independent assessment and treatment of adolescents with moderate and severe depressive disorders and have done this at least 6-12 months prior to BPI work

I have received/ I am receiving specialist training and experience in child and adolescent mental health. This consists of at least 6-12 months prior supervised or independent work in a multidisciplinary CAHMS setting

I am a 4<sup>th</sup> year Specialist Trainee/Registrar in Child and Adolescent Psychiatry or final year Child Psychotherapy Trainee

I am a staff/associate specialist who has a minimum of 6 months previous experience in CAMHS as a speciality and the supervising consultant agrees I can deliver BPI

Date of IMPACT BPI training attended:

I have read and understood the IMPACT BPI Manual

I have access to the IMPACT BPI manual on site

I confirm that I take part in the supervision that addresses the requirements of delivering the manual.

Signature

Date



**Appendix D**

**IMPACT**

Improving Mood with  
Psychoanalytic And Cognitive Therapies

Brief Psychosocial Intervention (BPI)  
Registration Form

BPI Supervisors verification

Name of the BPI therapist:

Clinic Location:

**Please tick all boxes that apply to you**

I meet the criteria for being a 'BPI therapist'

Date of IMPACT BPI training attended:

Please state in the space provided below how you qualify to be a supervisor in your service?

I have read and understood the IMPACT BPI Manual

I have access to the IMPACT BPI manual on site

I confirm that I take part in the supervision that addresses the requirements of delivering the manual.

Signature

Date

## References

1. **American Academy of Child and Adolescent Psychiatry (2007).** Practice Parameter For The Assessment and Treatment of Children and Adolescents with Depressive Disorders. [www.aacap.org](http://www.aacap.org)
2. **Goodyer I, Dubicka B, Wilkinson P, Kelvin R, Roberts C, Byford S, Breen S, Ford C, Barrett B, Leech A, Rothwell J, White L, Harrington R (2007)** Selective serotonin reuptake inhibitors (SSRIs) and routine specialist care with and without cognitive behaviour therapy in adolescents with major depression: randomised controlled trial. *British Medical Journal* 335: 142-146
3. **Byford S, Barrett B, Roberts C, Wilkinson P, Dubicka B, Kelvin R, White L, Ford C, Breen S, Goodyer I (2007)** Cost-effectiveness of selective serotonin reuptake inhibitors and routine specialist care with and without cognitive-behavioural therapy in adolescents with major depression. *British Journal of Psychiatry* **191**: pp 521-527
4. **Goodyer IM, Herbert J, Secher SM, Pearson J (1997a)**, Short-Term Outcome of Major Depression: I. Comorbidity and Severity at Presentation as Predictors of Persistent Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 36: 179-187
5. **American Academy of Child and Adolescent Psychiatry (2007).** Practice Parameter For The Assessment and Treatment of Children and Adolescents with Depressive Disorders. [www.aacap.org](http://www.aacap.org)
6. **Dunn V, Goodyer IM (2006)**, Longitudinal investigation into childhood- and adolescence-onset depression: psychiatric outcome in early adulthood. *British Journal of Psychiatry* **188**: 216-22
8. **Harrington, R.C., & Dubicka, B. (2001).** Natural history of mood disorders in children and adolescents. In I.Goodyer (Ed.), *The Depressed Child and Adolescent* (2<sup>nd</sup> Ed., pp. 311-343). Cambridge: Cambridge University Press.

9. **Goodyer IM, Herbert J, Secher SM, Pearson J (1997a)**, Short-Term Outcome of Major Depression: I. Comorbidity and Severity at Presentation as Predictors of Persistent Disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 36: 179-187
10. **Curry J, Rohde P, Simons A, Silva S, Vitiello B, Kratochvil C, Reinecke M, Feeny N, Wells K, Pathak S, Weller E, Rosenberg D, Kennard B, Robins M, Ginsburg G, March J (2006)**. Predictors and moderators of acute outcome in the Treatment for Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry* 45: 1427-39
11. **Brent DA, Kolko DJ, Birmaher B, Baugher M, Bridge J, Roth C, et al.(1998)**. Predictors of treatment efficacy in a clinical trial of three psychosocial treatments for adolescent depression. *J Am Acad Child Adolesc Psychiatry*;37(9):906-14.
12. **Goodyer, I.M. (2001)**. Life events: their nature and effects. In *The Depressed Child and Adolescent*, 2<sup>nd</sup> Edition, Ed. Goodyer, I.M. pp 204-232. Cambridge Monographs. Cambridge University Press.
14. **Burleson Davis, W., Birmaher, B., Melham, N.A., Axelson, D.A., Michaels, S.M. & Brent, D.A. (2006)** Criterion Validity of the Mood and Feelings Questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of Child Psychology and Psychiatry* 47:9 pp 927-934
15. **Shaffer, D., Gould, M. S., Brasic, J., et al (1983)** A children's global assessment scale (C-GAS). *Archives of General Psychiatry*, 40, 1228 –1231
16. **Schorre BE, Vandvik IH. Global assessment of psychosocial functioning in child and adolescent psychiatry (2004)**. A review of three uni-dimensional scales (CGAS, GAF, GAPD). *Eur Child Adolesc Psychiatry*;13(5):273-86.
17. **Dyrborg J, Larsen FW, Nielsen S, Byman J, Nielsen BB, Gautre-Delay, F., (2000)**. The Children's Global Assessment Scale (CGAS) and Global Assessment of Psychosocial Disability (GAPD) in clinical practice--substance and reliability as judged by intraclass correlations. *Eur Child Adolesc Psychiatry*;9(3):195-201.

18. **Cooper, P. J., & Goodyer, I. M. (1993).** A community study of depression in adolescent girls: I. estimates of symptom and syndrome prevalence. *British Journal of Psychiatry*, **163**, 367-74.
19. **NICE Guideline (2004)** Depression in children and Young People; identification and management in primary, community and secondary care. National Institute for Health and Clinical Excellence, London. Published by The British Psychological Society and The Royal College of Psychiatrists, London, UK. Website: [www.nice.org.uk](http://www.nice.org.uk)
21. **Mufson, L., Dorta, K.P., Wickmaratne, P., Nomura, Y., et al (2004).** A randomised effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry*, 61 (6), 577-584.
23. **Dubicka B, Hadley S, Roberts C (2006).** Suicidal behaviour in youths with depression treated with new-generation antidepressants: meta-analysis. *Br J Psychiatry*;189:393-8
24. **Gesch, C.B., Hammond, S.M., Hampson, S.E., Eves, A., Crowder, M.J. (2002)** Influence of supplementary vitamins, minerals and essential fatty acids on the antisocial behaviour of young adult prisoners. Randomised, placebo-controlled trial *British Journal of Psychiatry*, 181, 22-8.
25. **Wilkinson, P.O., & Goodyer, I. M., (2008).** The effects of cognitive-behavioural therapy on mood-related ruminative response style in depressed adolescents *Child and Adolescent Psychiatry and Mental Health*, 2:3
26. **Chick, Greg (2009).** **Qualitative analysis of medication management in the ADAPT study: the HOMEPAGE model.** MSc dissertation University of Manchester.
27. **Karver (2008) if you want to include this reference I'll chase it u with Greg.** Adolescent emotional development and the emergence of depressive disorders. Edited by Nicholas B. Allen and Lisa B. Sheeber, Cambridge University Press.