**National Institute for Health and Care Excellence**

Depression in children and young people

**Quality Standard Consultation Comments Table**

| ID | Stakeholder | Statement No | Comments | Responses |
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| 1 | Association for Family Therapy and Systemic Practice (AFT) | General | This response is submitted by AFT, the Association for Family Therapy and Systemic Practice (www.aft.org.uk). AFT is committed to supporting developments in practice, research, training and delivery of high quality therapeutic services for children, young people and their families and other caring groups. It is the UK's leading organisation for professionals working systemically with individuals, couples, families and other networks of care across the lifespan. AFT's membership is multi-disciplinary and includes Family and Systemic Psychotherapists (aka family therapists), clinical psychologists, psychiatrists, GPs, nurses, social workers, teachers, occupational therapists, health visitors and others committed to developing their systemic practice skills and understandings. | Thank you for your comment. Noted. |
| 2 | Association for Family Therapy and Systemic Practice (AFT) | General | We strongly question the appropriateness and validity of attempting to measure each quality statement as a simple proportion. While for some this may be appropriate (e.g. the proportion of young people at high levels of suicidal risk seen within 24 hours), for other statements that require a more subjective judgment such a figure simply provides a spurious sense of accuracy. There are other ways of quantifying that are more appropriate for such statements (e.g. Likert scales) | Thank you for your comment. The Committee noted there are complexities in the measurability of aspects of care which involve a subjective nature. However, where relevant the Committee have outlined in the supporting text for each quality statements the importance of these factors. |
| 3 | Association for Family Therapy and Systemic Practice (AFT) | General | We generally welcome the main aims of this quality guidance and the clear aim of it being presented in a relatively simple descriptive terms. However, there re a number of instances where the desire for clarity leads to oversimplification, creating the risk that they could be implemented in a mechanistic way that does not take due account of the complexity of the problem. | Thank you for your comment. Noted. |
| 4 | Association of Child Psychotherapists (ACP) | General | The ACP would like to make reference to Parent Work: Whether one's understanding of depression is biologically | Thank you for your comment. The introductory section of the quality standard state that |

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| | | | based or psychological, or both, the fact is that depression is most often not confined to only one family member, and the young person's experience of depression is best helped and managed by the parents if their own emotional capacities for noticing, thinking about, tolerating, and managing their young person's depression is well supported and enhanced through the provision of support to parents, alongside therapeutic work with the depressed young person. | "Depression is most often not confined to only 1 family member. Parental depression is a strong risk factor for the child or young person's depression, and the child or young person's experience of depression is best helped by their parents or carers. Parents and carers have an important role to play in supporting the child or young person with depression and should be engaged at all stages of assessment, diagnosis and treatment." |
| 5 | Association of School and College Leaders | General | The Association of School and College Leaders (ASCL) represents over 17,000 heads, principals, deputies, vice-principals, assistant heads, business managers and other senior staff of maintained and independent schools and colleges throughout the UK. ASCL has members in more than 90 per cent of secondary schools and colleges of all types, responsible for the education of more than four million young people. This places the association in a unique position to consider this issue from the viewpoint of the leaders of secondary schools and colleges. | Thank you for your comment. Noted. |
| 6 | Association of School and College Leaders | General | ASCL welcomes this quality standard. School leaders often report problems in obtaining suitable diagnosis and treatment for young people in their care who are or may be depressed. | Thank you for your comment. |
| 7 | British Medical Association | General | Whilst we agree with the sentiments behind the consultation, we would question whether there are the resources in place to meet them. The measures are dependent on the availability and quality of Child and Adolescent Mental Health Services (CAMHS), and in many places these are inadequate. | Thank you for your comment. NICE quality standards are intended to demonstrate what high quality care looks like for a particular topic based on the best available evidence. A supporting document has been published alongside the standard reviewing the potential cost impact and implications for commissioners and service providers, however, the configuration of services will be determined locally. Supporting documents are available from www.nice.org.uk. We hope this will help to address your concerns. |
| 8 | British Psychological Society | General | The Society is encouraged by the aim to develop quality standards for depression in children and young people. We hugely support the endeavor to ensure that services for | Thank you for your comment. |

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| | | | children, young people and their families are of the highest, most appropriate and evidence-based standard. While we have some concerns and additional recommendations as outlined below, overall we agree with all of the high priority areas identified. | |
| 9 | Critical Psychiatry Network | General | We value the emphasis on outcome and understand the wish for this to be measured. However, many of the standards do not acknowledge variability of clinical presentation (such as background context, level of family support, co-morbidity and so on) that make application of a simplistic formulaic protocol that emphasises only one aspect of the presenting problem (symptoms of depression) dangerous, particularly as it is also fails to acknowledge the 'real world' of services that clinicians practice in. Standards need to recognise, support, and facilitate clinicians being able to practice with the uncertainties and multi-dimensionality of the clinical problems they face. This more flexible approach will encourage an openness to co-constructing with patients meaningful interventions in a manner that these rigid standards will stifle, and to allowing local services to set priorities and systems that make sense in relation to their local circumstances (from staffing levels to the nature of the local communities they serve). The key to moving services forward is to have on-going evaluation of outcomes, so that outcome data is used to revise where necessary the model of intervention being used with an individual patient and family as well as being used at a meta-level to reflect on outcomes at the service level (for example whether in the service getting a particular intervention – CBT, family therapy, medication, groups etc. – results in improved outcomes or not, and in how many sessions, as a way of reflecting on what may and may not be effective at the service level and how these can be changed).<br>Existing evidence finds that carefully designed diagnostic pathway based child and adolescent mental health services significantly increase costs without any improvement in outcomes for children and young people with mental health problems (Bickman et al, 1995; 1997; 2000). Ignoring this evidence in times of austerity with CAMH services already | Thank you for your comment. NICE quality standards are intended to demonstrate what high quality care looks like for a particular topic based on the best available evidence. The Committee identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards development process, and prioritised the areas of care they felt were most important for patients. The Committee prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the committee who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care. It remains important that other evidence-based guideline recommendations continue to be implemented.<br><br>The QSAC consider equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. |

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| | | | suffering significant and large cuts in their staff numbers, seems positively reckless.<br>Finally these standards take no consideration of issues of culture. Depression is constructed around particular Western notions of self and individuality. There ought to be some reference to working with models that are meaningful to children and families who have other systems of belief and practice and in particular sensitivity to dealing with 'culture conflict' issues without just trying to resolve these by encouraging rejection of parental culture and values (which is what may well happen if adopting a Westernised model of depression is being encouraged in areas with high numbers of ethnic minority families). As it stands therefore these standards appear to us as institutionally racist.<br><br>References<br><br>Bickman, L., Guthrie, P. R., & Foster, E. M. (1995). Evaluating managed mental health services: The Fort Bragg experiment. New York: Plenum.<br>Bickman, L., Lambert, E. W., Andrade, A. R., & Penaloza, R. (2000). The Fort Bragg continuum of care for children and adolescents: mental health outcomes over five years. Journal of Consulting and Clinical Psychology, 68, 710-716.<br>Bickman, L., Summerfelt, W. T., Firth, J., & Douglas, S. (1997). The Stark County evaluation project: Baseline results of a randomized experiment. In D. Northrup & C. Nixon (Eds.), Evaluating mental health services: how do programs for children “work” in the real world? (pp. 231-259). Newbury Park, CA: Sage Publications.<br>Lambert, M. (2010) Yes, it is time for clinicians to routinely monitor treatment outcome. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A Hubble (Eds.), The Heart and Soul of Change (2nd edition; pp. 239–266). Washington, DC: American Psychological Association.<br>Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. In J. C. Norcross (Ed.), Psychotherapy Relationships that Work (2nd edition; pp. 37–69). New York: Oxford | |

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| | | | University Press.<br>Miller, S., Wampold, B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: a meta-analysis. Psychotherapy Research, 18, 5-14.<br>Regier, D., Narrow, W., Clarke, D., Kraemer, H., Kuramoto, S., Kuhl, E., Kupfer, D. (2013) DSM-5 field trials in the United States and Canada, Part II: Test-Retest Reliability of Selected Categorical Diagnoses. American Journal of Psychiatry 2013, 170, 59–70.<br>Timimi, S. (2004) Rethinking childhood depression. British Medical Journal, 329, 1394-1396.<br>Timimi, S., Tetley, D., Burgoine, W., Walker, G. (2013) Outcome Orientated Child and Adolescent Mental Health Services (OO-CAMHS): A whole service model. Clinical Child Psychology and Psychiatry 18, 169-184.<br>Whitaker R. (2010). Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America. Broadway Paperbacks: New York. | |
| 10 | Department of Health | General | This all looks very sensible, and in line with our understanding of good practice in terms of suicide and self-harm.<br><br>Our only query relates to the definition of "High risk of self-harm or suicide", which we think leaves quite a lot of room for local interpretation. As well as the issues identified in the draft as raising suicide risk (history of/current self-harm, active suicidal plans and mental health problems), there are other factors associated with increased suicide risk: behavioural disorders, substance misuse, experienced family breakdown, abuse, neglect or mental health problems or suicide in the family.<br><br>Risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person. Children and young people in the youth justice system share many of the same risk factors as adults in the criminal justice system. Looked after children and care leavers are between four and five times more likely to self-harm in adulthood. | Thank you for your comment was taken into account by the QSAC when producing the final version of the quality standard. An updated definition of 'high risk of suicide' has now been included in the final quality standard within the definitions section for quality statement 4 and 5 taken from NICE clinical guideline 28. |

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| | | | We think that these additional risks could be reflected better in the definition". | |
| 11 | National LGB&T Partnership | General | The National LGB&T Partnership is pleased to see that sexual orientation is acknowledged as a risk factor for depression in children and young people in the topic briefing paper under Suggested improvement area: Early recognition. However, we are concerned that gender identity has not been recognised as a risk factor also. Evidence submitted by the National LGB&T Partnership in response to the topic engagement exercise showed that young lesbian, gay, bisexual and trans people in general experience higher incidence of depression, self-harm and suicide, compared to heterosexual and cis-gendered youth, and that this may be even higher for trans young people specifically. | Thank you for your comment. The Committee identified the areas of care they felt were most relevant to developing the standard, within the framework of the quality standards development process. The quality standards are based on recommendations from the source guidance (NICE CG28). The QSAC do however consider equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. |
| 12 | National LGB&T Partnership | General | Implementation of sexual orientation and gender identity monitoring of all patients across all NHS services. Monitoring of patients' protected characteristics, including sexual orientation and gender identity, should be included in the quality standard as a recommendation for service providers, as sexual orientation and gender identity are not routinely monitoring in NHS services, particularly for children and young people. Monitoring will generate data to help services better understand and cater for the specific needs of LGB&T children and young people. These groups are more likely to experience depression, self-harm and suicide than their heterosexual and cis-gendered peers. Knowledge of a patient's sexual orientation and gender identity would allow healthcare providers to better plan and deliver specific care to LGB&T patients. | Thank you for your comment. The Committee identified areas of care they felt were most important for patients, based on the development sources listed. The Committee prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>All suggestions for additional statements were discussed by the committee who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 13 | Public Health England | General | There is no reference to the role of carers in the guidance.<br><br>Carers have a critical part to play in supporting the individual as well as requiring support themselves (e.g. understanding diagnosis, potential risks and protective factors, management | Thank you for your comment. The introductory sections of the quality statement outline that parents and carers have an important role to play in supporting the child or young person with depression and should be engaged at all stages |

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| | | | of behaviours etc. at home, family support etc.). The standards should be clearer about the requirements to engage carers at all stages, clearly maintaining patient confidentiality and safeguarding, and to provide them with information and other services as necessary.<br><br>It would be valuable for NICE to consult with carers/parents if they have not done so already | of assessment, diagnosis and treatment. |
| 14 | Public Health England | General | PHE supports the other standards. | Thank you for your comment. |
| 15 | Public Health England | General | 1. Whilst acknowledging that the guidance is focusing on improving quality standards for provision of services it would be helpful to see some reference to the mental health objectives from the cross Government strategy 'No Health without Mental Health' which relate to the promotion of better wellbeing and good mental health for children & young people and families. This could be applied across all the quality standards under consideration.<br><br>2. One of the commitments resulting from the strategy is to produce peer-reviews evidence of what works which will be published in September by DH / PHE.<br><br>3. As part of this work, evidence for interventions on improving mental health & wellbeing for children & young people and families is included in a section on Starting well and the importance of place and community in Healthy places , Healthy communities.<br><br>4. From this there is good evidence that investing in promoting the mental health & wellbeing of parents and children, notably in the pre-school years, can avoid health & social problems throughout life<br><br>5. The range of interventions include:<br>o Supporting parenting & family life -<br>o Supporting school readiness<br>o Supporting & promoting mental health & wellbeing in | Thank you for your comment. The Evidence sources section of the quality standard lists policy documents considered most relevant to the scope of the quality standard. This section highlights the importance of considering the quality standard alongside the listed policy documents, making sure standards stay relevant i.e. regarding forthcoming DH/PHE peer reviews and the MH dashboard. The Department of Health (2012) No health without mental health: implementation framework is listed amongst these relevant policy documents. |

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| | | | schools –<br>- with a focus on points of transition, whole school approaches on social & emotional learning programmes<br>- work on resilience and life skills programmes<br>o promotion of mentally healthy environments and the importance of social capital and asset based approaches<br><br>6. Furthermore a Mental Health Dashboard is under development by DH in partnership with organisations including PHE, which is bringing together relevant measures from a wide range of sources to build a concise picture of mental health outcomes as a whole. This will include a measure for Children & young people's experience of mental health services, patient outcomes following Child and Adolescent Mental Health Services, self-harm amongst others. | |
| 16 | Rotherham Doncaster and South Humber NHS Foundation Trust | General | In general there is an issue regarding generic 'clinicians' being described. It is important that we identify the relevant professional groups with the necessary training – in particular on a specialised pathway as described. This is particularly important in high risk cases and where there is a question regarding diagnosis and appropriate treatment which cannot be carried out entirely by rating scales (the guidelines give this impression) | Thank you for your comment. Where appropriate the relevant healthcare providers have been stipulated in the quality standard but it is expected the QS would be used in the context of relevant legislation and governance. |
| 17 | Rotherham Doncaster and South Humber NHS Foundation Trust | General | I am concerned that we have not considered the possible negative effect of repeat questionnaires to patients, in that it may interrupt the therapeutic process. Regular reassessment is important but is it necessary or helpful at every appointment? | Thank you for your comment. Quality statement 5 no longer requires clinicians to record outcomes at each appointment. The committee agreed to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |
| 18 | Royal College of General Practitioners | General | I accept that the standards are just that but these seem particularly unrealistic in Primary Care. We have no incentives for Kiddie SADS and I had to look up what the questions are – they are ones I ask. | Thank you for your comment. Noted. |
| 19 | Royal College of General Practitioners | General | NHS Outcome Framework compliance – the standards do not only improving patient experience!<br>How about preventing people from dying prematurely (1) | Thank you for your comment. Statements are mapped to relevant areas of the NHS Outcomes Framework at the indicator and improvement area |

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| | | | (through adequate self-harm and suicide prevention)<br>Also improving the recovery (3) through assessing progress by a tool at each visit.<br>4c, the friends and family test needs particular mention! The point is well made in NICE guidance that parents are very often depressed too or have their own mental health difficulties so a mention of this in one of the standards would improve them. | level (rather than at the level of the overarching domain heading). For domain 1 – depression is not included in the technical specifications as a cause considered amenable to health care which is why this domain was not mapped to the quality standard. There are also no overarching indicators or improvement areas in domain 3 of the NHS outcomes framework relevant to the statements in this quality standard (as defined by the technical specifications). |
| 20 | Royal College of Nursing | General | The Royal College of Nursing welcomes proposals to develop this quality standard. It is timely. | Thank you for your comment. |
| 21 | Royal College of Paediatrics and Child Health | General | Something about joint care with primary care should be mentioned. | The introductory paragraphs of the quality standard include a section on Coordinated services which outline that services should be commissioned from and coordinated across all relevant agencies encompassing the whole care pathway for depression in children and young people. |
| 22 | The Lesbian & Gay Foundation | General | The Lesbian & Gay Foundation is pleased to see that sexual orientation is acknowledged as a risk factor for depression in children and young people in the topic briefing paper under Suggested improvement area: Early recognition. However, we are concerned that gender identity has not been recognised as a risk factor also. Evidence submitted by The Lesbian & Gay Foundation in response to the topic engagement exercise showed that young lesbian, gay, bisexual and trans people in general experience higher incidence of depression, self-harm and suicide, compared to heterosexual and cis-gendered youth, and that this may be even higher for trans young people specifically. | Thank you for your comment. The Committee identified the areas of care they felt were most relevant to developing the standard, within the framework of the quality standards development process. The quality standards are based on recommendations from the source guidance (NICE CG28). The QSAC do however consider equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. |
| 23 | The Lesbian & Gay Foundation | General | Implementation of sexual orientation and gender identity monitoring of all patients across all NHS services. Monitoring of patients' protected characteristics, including sexual orientation and gender identity, should be included in the quality standard as a recommendation for service providers, as sexual orientation and gender identity are not routinely | Thank you for your comment. The Committee identified areas of care they felt were most important for patients, based on the development sources listed. The Committee prioritised areas of care where practice is variable, or where implementation could have a significant impact on |

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| | | | monitoring in NHS services, particularly for children and young people. Monitoring will generate data to help services better understand and cater for the specific needs of LGB&T children and young people. These groups are more likely to experience depression, self-harm and suicide than their heterosexual and cis-gendered peers. Knowledge of a patient's sexual orientation and gender identity would allow healthcare providers to better plan and deliver specific care to LGB&T patients. | patient care and improved outcomes, and where there is potential to generate measurable indicators.<br><br>All suggestions for additional statements were discussed by the committee who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. It remains important that other evidence-based guideline recommendations continue to be implemented. |
| 24 | Association of School and College Leaders | Question 1 | Yes | Thank you for your comment. |
| 25 | NHS England | Question 1 | NHS England is delighted to see that depression in children and young people is under consideration for a quality standard. However, bearing in mind the NICE guidelines on depression are due to be reviewed this September, we recommend that the quality standard, which we note is based on the previous NICE guidelines, is delayed to take into account any recommendations following the review. If this is not possible, we recommend that the authors of the quality standards take account of the work underway in CAMHS through the CYP IAPT and CAMHS PbR projects.<br><br>The standard quite rightly emphasises the need for a whole system approach to commissioning and provision, but at present key elements of the standard around waiting times relate only to severe depression and self-harm. Children and young people with mild or moderate depression need to have their needs met in a timely fashion and these needs may be met by services operating in the NHS, schools, in the community, by counsellors and therapists. Omitting a waiting time for other than severe depression could send a message to commissioner and providers that early intervention and prevention of deterioration are not a priority. We recommend that, if waiting times are included in the standard, that waiting times include mild and moderate depression. Draft quality | Thank you for your comment. We are unfortunately unable to delay publication of this quality standard on the basis of an upcoming review of the underpinning clinical guideline. The quality standard will formally be reviewed after five years, however if the underpinning guideline is updated following the imminent planned review we would consider whether there had been any significant changes in the evidence base requiring an earlier review and would ensure that the quality standard remained accurate.<br><br>The data sources section for quality statement 5 in the final QS - monitoring progress, now references the CYP IAPT stating that routine outcome monitoring is being specified as part of The Children and Young People's IAPT project. |

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| | | | standard 6 contains guidance relating to all levels of depression but we have concerns about how this data is collated across all CAMHS, including those in the voluntary sector who do not commonly use ICD10.<br><br>The standards do not currently fully reflect the CYP-IAPT work and other policy directives on involving children, young people and their families around decision making with respect to mental health issues.<br><br>Draft Standard 2 states that CYP should be given information about the treatment options, but there is nothing setting standards for how their choices or preferences would be attended to or taken into account: so some standard(s) around active engagement of service users in their own care would be welcome. There is nothing in the standard about who can refer, what constitutes referral or self-referral. For example, a young person may tell a schools counsellor that they are very unhappy and contemplating harming themselves. If the local specialist CAMHS is required by its service specification to only accept referrals from a GP, the referral itself will take considerable time.<br><br>Draft quality statement 5 talks about monitoring outcomes. However there is nothing in the standard about monitoring is feedback to the child or young person or used in supervision. Given this the emphasis in NHS policy on personalisation of care and outcomes that have a meaning for the child or young person, it would seem appropriate that there were also some standard set around<br>• monitoring the process of therapy and/or levels of satisfaction with the treatment: i.e., how service users are experiencing the intervention, and whether it feels appropriate and helpful for them.<br>• Feedback to service users/families<br>• Use of the outcome monitoring in supervision<br><br>CYP IAPT records symptoms, goals and the experience of | |

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| | | | undergoing therapy at each session. There are further measures at the end of therapy or at review. We are already receiving data regarding children and young people in CAMHS with a diagnosis of depression.<br><br>NHS England recommends that agreement on these standards is postponed until after the NICE Guidelines have been revised, and recommends that colleagues working on CYP IAPT and CAMHS PbR assist to ensure that the standards reflect the use of quality measures rather than their collection alone | |
| 26 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | Question 1 | Overall we felt the draft standards reflect key areas for quality improvement. However, greater clarification and guidance is required about criteria for identifying the most 'at risk' young people. | Thank you for your comment. An updated definition of 'high risk of suicide' has now been included in the final quality standard within the definitions section for quality statement 4 and 5 taken from NICE clinical guideline 28. |
| 27 | Sheffield Clinical Commissioning Group | Question 1 | Broadly agree, but I think every opportunity should be taken to flag up working towards empowerment and recovery, with a focus on early intervention, so that young people can learn skills to improve their wellbeing over time, develop a sense of self-worth and reduce the frequency and severity of episodes. C+YP IAPT session by session monitoring lends itself to empowering people to see the progress they are making, but this isn't always mentioned | Thank you for your comment. Noted.<br><br>The data sources section for quality statement 5 in the final QS - monitoring progress, now references the CYP IAPT stating that routine outcome monitoring is being specified as part of The Children and Young People's IAPT project. |
| 28 | The Judith Trust | Question 1 | The Judith Trust is concerned that depression in young people with learning disabilities be addressed as a distinct quality standard statement.<br><br>Our research has indicated that young people with learning disabilities, particularly girls and those from BME communities, are at a greater risk of experiencing depression than the over population of young people. Additionally, the research showed that there are difficulties in early identification and appropriate intervention with this group.<br><br>We have addressed these needs in relation to the individual | Thank you for your comment. Learning disabilities was an additional area suggested by stakeholders which the Committee discussed, however the committee agreed this was not a key quality area in itself for quality improvement. The QSAC did however considered equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. People with learning disabilities are also highlighted as a specific group for consideration in quality statement 2. We hope this helps to address your concerns. |

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| | | | points raised in the consultation paper below. | |
| 29 | The Royal College of Psychiatrists | Question 1 | Broadly speaking yes | Thank you for your comment. |
| 30 | British Psychological Society | Question 1 | 1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every school class. Nearly 80,000 children and young people suffer from severe depression. Over 8,000 children aged under 10 years old suffer from severe depression (Green et al., 2005).<br>Significantly fewer statistics are available for children and young people with mild or moderate depression. While it is accepted that milder forms and consequent effects of depression may not demand imperative access to services, the short and long term effects cannot be deferred or ignored. Nor should the positive effects of brief intervention in this group of young people be ignored as from both a individual but also public health and cost perspective (e.g. Weisz et al., 1997).<br>The paucity in available statistics may be related to the difficulties in defining and diagnosing depression in children in young people. Given developmental considerations, in addition to accepted and well-documented aetiologies of depression, there may be a need for a conceptual shift to include maturational depression, which may be manifested in different ways at different ages and stages of development through to old age.<br>In support of this, Jacob (2009) proposed that “There is a need to focus more on the context of depression (stress, coping and support) and to reduce the medicalisation of distress”. Jacob (2009) went on to propose a<br>“typological perspective where three types of nonorganic depression can be recognised:<br>chronic depression as a result of poor coping strategies and personality traits<br>acute depression secondary to severe stress in people with good premorbid adjustment<br>depression arising de novo in people with good coping skills.”<br>He concluded, “Current categorisation systems, based on | Thank you for your comment. Noted. |

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| | | | description rather than aetiology, have served the psychiatric community well but it is time to acknowledge the roles of stress and poor coping in producing depressive disorders. There is a need for more pragmatic approaches that move beyond major depression."<br>Accordingly, it is proposed that the Draft while a valuable endeavor and a positive start, currently does not sufficiently address the key areas for quality improvement in meeting the needs of children and young people who suffer mild and potentially even moderate depression.<br>Green H, McGinnity A, Meltzer H et al. (2005) Mental health of children and young people in Great Britain 2004 London: Palgrave<br>Jacob KS (2009) Major depression: revisiting the concept and diagnosis Advances in Psychiatric Treatment 2009, 15: 279-285<br>Weisz, J. R., Thurber, C. A., Sweeney, L., Proffitt, V. D., & LeGagnoux, G. L. (1997). Brief treatment of mild-to-moderate child depression using primary and secondary control enhancement training. Journal of consulting and clinical psychology, 65(4), 703. | |
| 31 | British Medical Association | Question 2 | Whilst we would agree that, where structures and systems in place, it would be possible to gather the data required for the outcome measures of the quality standard, we do not believe that there are resources available to create these systems and structures. | Thank you for your comment. Noted. |
| 32 | British Psychological Society | Question 2 | The Society believes that given the current wording of the quality standards, and given the correct structures and systems it would be possible for collection of the data proposed. We would however suggest the need for additional considerations within the quality standards which may subsequently make data collection more comprehensive (although still possible). | Thank you for your comment. Noted. |
| 33 | NHS England | Question 2 | The CAMHS Minimum data set has been mandated as of April 2013, but as yet we have no information about how successfully or fully the MDS, including diagnostic codes are input. However it is important to note that many of the | Thank you for your comment. Noted.<br><br>Statements are mapped to relevant areas of the NHS Outcomes Framework at the indicator and |

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| | | | standards (3,4 & 6) rely on ICD-10 codes to identify severity of diagnosis. This may cause a problem for services within CAMHS operating within the voluntary sector or local authority sector that do not use ICD10. The use of ICD 10 is a long standing difficult issue, as many voluntary sector services and counselling services view this as an essentially medical model.<br><br>CYP IAPT has created a dataset and prescribes the use of particular assessment tools and outcome symptom measures. These measures have been chosen following consideration of available measures, and is based on clinical validity, ease of use for practitioner, child, young person or parent and cost the the NHS or voluntary sector. The measures we select have to be free to use or so commonly used by services that there is no financial extra burden. We have consulted twice with the CAMHS community nationally.<br><br>The CYP IAPT approved assessment and measurement methodology is being used to support the development of CAMHS Payment By Results Clusters.<br><br>CAMHS operate across the NHS, voluntary sector and local authority in a web of services which include prevention, early intervention and treatment. The use of ICD10 is controversial in some areas, and can be a barrier to services working together. The CYP IAPT approach has been to define 'problem' areas which still map to ICD 10), so services which use ICD10 and those that don't can both use the same database and symptom trackers. Some of the measures listed in the guidelines (eg KSADs, CAPA) are not those used within the CYP IAPT as measures used at assessment, in session or at review . Please see http://www.iapt.nhs.uk/cyp-iapt/routine-outcome-monitoring-as-part-of-iapt/<br>For full details<br><br>NHS England strongly recommends that any measures proposed for the quality standard aligns to the CYP IAPT and PbR programmes. We recommend further discussion with | improvement area level (rather than at the level of the overarching domain heading). For domain 2 the technical specifications for overarching indicator 2 (Improved health-related quality of life for people with long-term condition) and improvement area 2.1 (Proportion of people feeling supported to manage their condition) state that these indicators only measure people over the age of 18 years and therefore would not include the population included in this quality standard.<br><br>The data sources section in the final QS for quality statement 5, monitoring progress, now references routine outcome monitoring as part of The Children and Young People's IAPT project. |

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| | | | both programmes prior to determining the measures agreed.<br>Additional General Points<br><br>We note that on page two the link is made between the NHS Outcomes Framework and improvement area in Domain 4, improving children and young people's experience of care. NHS England would like this to be extended to include links to Domains 2 and 3. Depression can be a long term, life long condition, and early appropriate treatment is vital to ensure that children or young people have the best chance of recovery. | |
| 34 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | Question 2 | Existing systems would struggle to provide accurate data to evidence the proposed quality measures. Investment in systems that are more sensitive to the collation of this specific data on a routine basis would be needed. Goal based outcomes identified at the start of treatment alongside more sensitive outcomes measures could evidence improvements and maintenance of quality standards. | Thank you for your comment. Examples of existing national data collection which may be relevant, in part at least, to the quality measure are referenced where appropriate. It is expected that local data sources and audits where appropriate will be considered in order to measure the quality statements in full. |
| 35 | Sheffield Clinical Commissioning Group | Question 2 | Providing clinicians do the necessary recording, and with the adoption in many places of C+YP IAPT, it should be possible to collect data but will take time for all services to be able to comply fully | Thank you for your comment. |
| 36 | The Royal College of Psychiatrists | Question 2 | This is always difficult even when it seems simple. The standards would present some challenges unless data is collected through specific audits. However, they would be fairly easy to identify from a family/ service recipients point of view, except for standard 6.<br><br>Standards 3, 4, 5 are the most likely to be measureable in a routine way, since outcome measurement is much more routine and for IAPT sites, session by session monitoring is a normative expectation. For 3 and 4, waiting time information is collected by all services. The difficulty will be matching the specific conditions outlined in the framework with the specific waits. For instance distinguishing between 3 and 4 themselves would require data about diagnosis, diagnostic severity, risk and risk level, and risk types stratified by self-harm and suicide. Further, what is meant by a CAMHS professional? | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard.<br><br>The committee discussed stakeholder comments in relation to quality statement 3 and 4 and agreed to include 'suspected' severe depression in the statement as they felt this was correct population for this statement as this group of people may not have received a confirmed diagnosis.<br><br>The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The committee also |

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| | | | Presumably this means a specialist health CAMHS (tier 3) professional of any discipline.<br><br>There is a problem with knowing if someone is severely depressed and at high risk before an assessment has been completed. The referral information may lead to suspicion that this is the case, but this may not necessarily be so. The standard should ideally reflect this aspect of the patient journey by saying that, where severe depression and high risk to the self is suspected, then the young person should be seen in 24 hours<br><br>Finally the wait time of 10 days (assuming this means 10 calendar days since these are easier to measure) is at odds with national time frames – Emergency, urgent and routine. So again there is a risk that there is a further expectation for a new data field to be added to existing system. Using time frames in line with national terms would probably be better.<br><br>Standard 6 is the most complex to measure since it involves multiple intervention types at varying time frames for varying individuals. This would be very difficult to evaluate even with a specific audit. Given the complexity of measurement, leaving this standard out, would probably be wise. | agreed that self-harm should be removed from the statement as there is a self-harm quality standard in development and this would cause overlap.<br><br>The committee discussed stakeholder comments in relation to quality statement 6. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. The Committee therefore agreed to remove this statement from the final standard.<br><br>The data sources section for quality statement 5 in the final quality standard - monitoring progress, now references the CYP IAPT stating that routine outcome monitoring is being specified as part of The Children and Young People's IAPT project. |
| 37 | Association for Family Therapy and Systemic Practice (AFT) | QS1 | We agree with the general aim of ensuring that the assessment of depression is should not rely solely on the subjective judgement of the clinician. However, the wording of the quality statement could be understood as meaning that a validated measure will always be stronger than clinical judgement. There are several problems with this.<br><br>First, validated measures have been developed principally in research contexts where the strength of the measure is determined at a group rather than individual level. There is good evidence that at a group level validated measures perform better than individual clinical judgements. However, this does not always translate well in to the clinical context where a judgement needs to be made about an individual. At | Thank you for your comment. The committee agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |

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| | | | an individual level there will be many situations where a validated measure provides a misleading answer (e.g. a child/young person may deny symptoms; the measure has not been evaluated with the specific cultural/ethnic group to which the family young person belongs etc).<br><br>This leads to the second point. Validated assessment measures are typically used at a particular point in time. In a research context this is not a problem, as the lack of validity at an individual level simply becomes part of "measurement error". In the clinical context where decisions concerning an individual are paramount this is addressed differently, e.g. assessments are made over a period of time, multiple informants are used etc.<br><br>The third, point is a pragmatic one. The strongest validated measures (e.g. K-SADS, CAPA) are highly time consuming and as the guidance rightly points out would need modification for busy clinical settings. This means that in practice the measures that are likely to be used are going to be much less robust and all the problems highlighted above are likely to be magnified. Thus a service, wishing to comply with this guidance but without the resources to use measures such as K-SADS or CAPA, could meet the guidance by using a well-validated self report questionnaire such as MFQ which is not designed to provide a diagnosis and use such questionnaires to override the clinical diagnosis. For this reason we would recommend modifying the wording of the quality statement in the following way:<br><br>The diagnosis of depression in children and young people should not rely solely on clinical judgment and should include the use of validated diagnostic tools. Where clinical judgment is used to override the results of a validated measure, clinicians should give clear reasons why this is appropriate. | |
| 38 | Association for Family Therapy and Systemic Practice (AFT) | QS1 | Replace all instances of "to confirm a diagnosis" with "Clinical judgment and validated diagnostic tools are both an integral part of the diagnostic process. Where clinical judgment is used | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The |

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| | | | to override the results of a validated measure a (brief) reason for this should be given. | committee also agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 39 | Association of Child Psychotherapists (ACP | QS1 | The ACP welcomes the commitment to the greater identification of depression in young people, given the evidence of relatively low-levels of detection, especially among adolescent boys. The ACP would like to indicate that the quality standards will be highly dependant on the level of training among professionals. The ACP would also like to draw attention to the pervasiveness of co-morbidity among depressed young people and how much more complex this makes diagnosis. | Thank you for your comment. Noted. |
| 40 | British Association of Behavioural and Cognitive Psychotherapies | QS1 | Using a gold standard “validated diagnostic tool” would not be feasible in a CAMHS because of the time it would take up to administer a full structured interview by a health professional with specialist training. Time taken up at assessment can mean delay in access to treatment such as talking therapy. It might be more efficient and client centred to carry out a clinical interview to assess for depression in order validate a young person’s experience of distress and refer for appropriate treatment in a timely manner to ensure the best opportunity for positive engagement in treatment. There is more chance of a young person’s feelings of depression being understood and assessed in context of talking therapy than during an assessment process using a questionnaire/assessment tool. In view of scarcity of resources, further development of pragmatic, cost effective methods of screening for depression in non specialist contexts would be necessary in order to support this quality statement. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee also agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |

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| | | | Research tells us that early detection and robust treatment of adolescent depression is vital in order to reduce symptoms and impairment, however, diagnostic tools sensitive enough to capture features of mild depression or depression masked by other issues such as physical symptoms, poor school attendance, substance misuse, behaviour problems & eating distress are not widely available and front line clinicians would require training to identify risk factors to indicate referral onto specialist services. | |
| 41 | British Medical Association | QS1 | It is not clear whether GPs will have to confirm diagnoses of depression in children and young people with a validated diagnostic tool. We are concerned that, were GPs to have to use such a tool, the lack of resources available in CAMHS would lead to them limiting referrals to those which reached a certain score. This is particularly a problem as GPs are more likely to refer children or young people who clearly have a problem, but for whom the diagnosis is unclear, such as those with behavioural issues in whom depression may be part of the underlying pathology. | Thank you for your comment. The Committee agreed that for a proportion of children and young people with suspected depression the first point of contact may be with GPs in primary care. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement.<br><br>The committee also agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 42 | British Psychological Society | QS1 | One of the strongest risk factors for child depression is parental depression, and this is in large part mediated by the effects of depression on parenting. Therefore, when assessing child depression, assessment should also be made of parental mental state and parenting. Relevant references include:<br>Beardslee et al. Children of affectively ill parents: a review of the past 10 years. J Am Acad Child Adolesc Psychiatry. 1998; 37: 1134-1141.<br>Weissman et al. (2005) Families at high and low risk for | Thank you for your comment. The Committee prioritised the areas of care they felt were most important for patients, based on the development sources listed. All suggestions for additional statements were discussed by the Committee who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The introductory sections of the |

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| | | | depression: a 3-generation study. Arch Gen Psychiatry. 62: 29-36.<br>Murray et al. (2011) Maternal postnatal depression and the development of depression n offspring up to 16 years of age. J Am Acad Child Adolesc Psychiatry ; 50: 460-470<br>Lovejoy et al. (2000) Maternal depression and parenting behavior a meta-analytic review. Clinical Psychology Review, 20: 561–592. | quality statement outline that parental depression is a strong risk factor for the child or young person's depression, and the child or young person's experience of depression is best helped by their parents or carers. |
| 43 | Critical Psychiatry Network | QS1 | Where's the evidence that using structured instruments improves diagnosis? We think you're confusing the potential value of screening instruments by calling them validated diagnostic tools. We believe it's wrong to give the impression that the diagnosis of depression is other than a clinical diagnosis. Recent field-work, for DSM 5, including use of screening instruments showed shockingly low kappa reliability figures for childhood Major Depression (Regier et al.), as have most studies examining reliability of psychiatric diagnoses like depression. Given the remaining major question marks about the validity and utility of a diagnosis of childhood depression (Timimi, 2004), giving the impression that diagnosing depression is part of a validated and objective process (using 'tools') is simply not an evidence based position. In addition, there is no evidence, to the best of our knowledge, that using structured instruments to aid diagnosis improves outcomes. Routine outcome monitoring and measuring is better done without defining them by diagnostic groups (Timimi, et al., 2013), and there is ample evidence that diagnosis has an insignificant impact on outcomes in the treatment of childhood mental disorders (e.g. Miller et al., 2008). Can depression really be separated from other childhood emotional and behavioural problems? Is this a sensible strategy anyway given the high rate of co-morbidity, which could mean a focus on one aspect of the presenting problem relegating others to being of lesser importance (unless we wish to embark on the ludicrous strategy of running several NICE guideline recommendations simultaneously for a given patient) and leading to the opposite of the type of holistic care CAMHS clinicians are striving for. Perhaps this could instead be a standard encouraging the | Thank you for your comment. The committee discussed this statement alongside stakeholder comments and agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |

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| | | | recognition and assessment of the whole psychosocial picture when a child/young person presents with unhappiness and distress. | |
| 44 | National LGB&T Partnership | QS1 | The National LGB&T Partnership approves these draft quality standards. However, we recommend Early Recognition is included specifically in quality statement 1, as this is a key issue for in the diagnosis of depression among children and young people, particularly for LGB&T youth. | Thank you for your comment. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement. |
| 45 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | QS1 | Children and young people with depression have the diagnosis confirmed through the use of validated diagnostic tools.<br><br>Whilst diagnostic tools may contribute to a child / young person's assessment of mental health needs, this should take place as part of a comprehensive CAMHS assessment in which a child's mental health needs are understood in the wider context of that child's functioning and their family's and care systems. These systemic assessments should inform appropriate treatment or interventions including specialist interventions relating to the treatment of depression. | Thank you for your comment. The committee discussed this statement alongside stakeholder comments and agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 46 | Oxleas Nhs Partnership Trust | QS1 | There is support for the use of diagnostic tools for Children and YP. There is some uncertainty around the statement 'health care and CAMHS professionals' i.e. that making a diagnosis would need to take into account clinical interview plus tool. What other H/C professionals are expected to diagnose and at what stage of the patient journey? | Thank you for your comment. The Committee considered that for a proportion of children and young people with suspected depression the first point of contact may be with GPs in primary care. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement.<br><br>The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee |

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| | | | | agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 47 | Public Health England | QS1 | The draft statement is: Children and young people (CYP) with depression have the diagnosis confirmed through the use of validated diagnostic tools.<br><br>This appears to leave a gap between presentation of potentially depressive symptoms and diagnosis. We support the use of validated diagnostic tools; the concern is how services should manage the screening/assessment of potentially depressed children and young people (CYP). | Thank you for your comment. The Committee considered that for a proportion of children and young people with suspected depression the first point of contact may be with GPs in primary care. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement.<br><br>The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 48 | Royal College of Nursing | QS1 | There is support for the use of diagnostic tools for Children and Young People. There is some uncertainty around the statement 'healthcare and CAMHS professionals' i.e. that making a diagnosis would need to take into account clinical interview plus tool. What other health care professionals are expected to diagnose and at what stage of the patient journey? | Thank you for your comment. The Committee considered that for a proportion of children and young people with suspected depression the first point of contact may be with GPs in primary care. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement.<br><br>The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined |

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| | | | | clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 49 | The Judith Trust | QS1 | Diagnostic tools must be validated for use with those with learning disabilities, across the spectrum of need, and adapted as appropriate | Thank you for your comment. The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 50 | The Lesbian & Gay Foundation | QS1 | The Lesbian & Gay Foundation approves these draft quality standards. However, we recommend Early Recognition is included specifically in quality statement 1, as this is a key issue for in the diagnosis of depression among children and young people, particularly for LGB&T youth. | Thank you for your comment. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement. |
| 51 | The Royal College of Psychiatrists | QS1 | For Standard 1, the word "confirmed" should be replaced by the word, "supported". This is because there is a very strong clinical and academic consensus that measures supplement clinical decision making and not the other way around. | Thank you for your comment. The Committee noted that there would be definitional issues associated with measuring "supported". |
| 52 | University of Reading | QS1 | This comment reflects the joint opinion of Prof Lynne Murray (University of Reading) and Prof Alan Stein (University of Oxford): One of the strongest risk factors for child depression is parental depression, and this is in large part mediated by the effects of depression on parenting. Therefore, when assessing child depression, assessment should also be made of parental mental state and parenting. Relevant references include: Beardslee et al. Children of affectively ill parents: a review of | Thank you for your comment. The Committee prioritised the areas of care they felt were most important for patients, based on the development sources listed. All suggestions for additional statements were discussed by the Committee who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing |

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| | | | the past 10 years. J Am Acad Child Adolesc Psychiatry. 1998; 37:1134-1141.<br>Weissman et al. Families at high and low risk for depression: a 3-generation study. Arch Gen Psychiatry. 2005;62:29-36.<br>Murray et al. Maternal postnatal depression and the development of depression n offspring up to 16 years of age. J Am Acad Child Adolesc Psychiatry 2011; 50: 460-470<br>Lovejoy et al. Maternal depression and parenting behavior a meta-analytic review. Clinical Psychology Review, 2000; 20: 561–592. | statements. The introductory sections of the quality statement outline that parental depression is a strong risk factor for the child or young person's depression, and the child or young person's experience of depression is best helped by their parents or carers. |
| 53 | NHS England | Question 3 | For draft quality statement 1: The measure for this statement will not capture those children and young people for whom a diagnosis of depression has been discounted without the use of a diagnostic tool. Is this statement still appropriate?<br><br>Will the use of a different assessment and measurement tool such as RCADs or SDQ used by CYP IAPT and CAMH PbR be included?<br><br>The challenge here will be for those children and young people for whom watchful waiting is appropriate may not reach the threshold of ICD 10, and work with them may not be recorded fully | Thank you for your comment. The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 54 | Sheffield Clinical Commissioning Group | Question 3 | Difficult to answer this as a generalist, but as they discuss needing to modify the screening tools, I wonder if they remain valid. Whilst this approach may be appropriate for the majority, many people with co-morbidities don't always present mood disorder in a straight-forward way. Clinical experience is needed in these cases. And as they recognise, if mood disorder isn't suspected, the tool may not be used, and depression missed. So it may be better for this to be "most cases" rather than "all cases"? | Thank you for your comment. The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 55 | The Judith Trust | Question 3 | Young people with learning disabilities are likely to be | Thank you for your comment. Learning disabilities |

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| | | | disproportionately represented within the group of those for whom a diagnosis of depression has been discounted without the use of a diagnostic tool; diagnostic over-shadowing in this group is well documented.<br><br>There is a need for greater awareness of the potential early indicators of depression in young people with learning disabilities, amongst health, social care and education professionals. | was an additional area suggested by stakeholders which the Committee discussed, however the committee agreed this was not a key quality area in itself for quality improvement. The QSAC did however considered equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard and people with learning disabilities are highlighted as a specific group for consideration in quality statement 2. We hope this helps to address your concerns. |
| 56 | The Royal College of Psychiatrists | Question 3 | This is correct, but not that important, if practice is viewed systemically. Or to put it another way, it is important to focus on the important things to measure. Trying to measure everything is usually impossible and often counter-productive. | Thank you for your comment. |
| 57 | Royal College of Paediatrics and Child Health | Question 3 | It might make more sense to say that a screening tool should be used when suspected – one of the main issues is lack of recognition after all. | Thank you for your comment. The committee discussed this statement and the stakeholder comments but agreed that whilst tools were used to validate a diagnosis it is unlikely they would be used to diagnose depression. The committee agreed that this statement undermined clinical judgement which was appropriate when supported by diagnostic tools and recorded according to ICD-10 codes. The committee agreed the statement should be progressed but should not specifically stipulate the use of validated diagnostic tool and should allow clinical judgement to be the first line diagnostic tool. |
| 58 | Association for Family Therapy and Systemic Practice (AFT) | QS2 | We very much agree that children and young people should be consulted on which way they wish to address their troubles. However, many clinicians (and indeed researchers) have questioned the over-reliance on diagnostic categories and the risk of pathologizing the young person by simply locating depression in them as individuals. It is important that age appropriate accounts of depression include the psychosocial and relational context in which feelings and emotions occur. | Thank you for your comment. The Committee agreed it was important that the child or young person understood the information they were given however recognised that this was very hard to measure. The committee felt that 'engagement' of the child or young person was important and agreed that the rationale should be amended to state that information about their diagnosis and treatment options should be understood so that |

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| | | | Childhood depression is a response to many features of life but particularly to family and peer circumstances that must be part of any explanations of the problems and any vision of any treatment. | they can participate in shared decision-making. The Committee also agreed that it is not only the age of the child or young person that can affect understanding. The Committee agreed that information should also be appropriate to the developmental level, emotional maturity and cognitive capacity of the child or young person, taking into account any learning disabilities, sight or hearing problems or delays in language development. This has now been stipulated in the rationale section for this quality statement. |
| 59 | Association for Family Therapy and Systemic Practice (AFT) | QS2 | This is an example of a statement where assessing the measure as a simple proportion is misleading given the qualitative nature of the statement. Defining an appropriate criterion for the numerator raises more questions than it answers. We would question the validity of trying to reduce this quality statement to such a simplistic quantitative measure. Defining the measure in quantitative terms requires a more nuanced judgement that would be inappropriate to define in purely categorical terms | Thank you for your comment. The Committee agreed it was important that the child or young person understood the information they were given however recognised that this was very hard to measure. The committee felt that 'engagement' of the child or young person was important and agreed that the rationale should be amended to state that information about their diagnosis and treatment options should be understood so that they can participate in shared decision-making. The Committee also agreed that it is not only the age of the child or young person that can affect understanding. The Committee agreed that information should also be appropriate to the developmental level, emotional maturity and cognitive capacity of the child or young person, taking into account any learning disabilities, sight or hearing problems or delays in language development. This has now been stipulated in the rationale section for this quality statement. |
| 60 | British Association for Counselling and Psychotherapy | QS2 | BACP agrees that children and young people with depression should be given information appropriate to their age about diagnosis and their treatment options. In addition, BACP would suggest that children and young people are given information about the degree of choice or at least their preferences are attended to. Currently, Draft Standard 2 is | Thank you for your comment which was discussed by the Committee. The Committee agreed it was important that the child or young person understood the information they were given however recognised that this was very hard to measure. The committee felt that 'engagement' |

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| | | | about what children and young people are told, but given the current emphasis in NHS policy on participation, choice and consultation, it seems that the standard should go some way beyond this to ensuring that there is some active engagement by the service user, and that clinicians are expected to attend to and engage with this. The key point here is about having some standard that good quality care involves the participation of service users, and not simply something that is done to them. For instance, in CYP-IAPT there is a significant focus on user participation, but this does not seem to be reflected here. BACP would suggest that it would be beneficial if the standard could be developed in this way. | of the child or young person was important and agreed that the rationale should be amended to state that information about their diagnosis and treatment options should be understood so that they can participate in shared decision-making. The Committee also agreed that it is not only the age of the child or young person that can affect understanding. The Committee agreed that information should also be appropriate to the developmental level, emotional maturity and cognitive capacity of the child or young person, taking into account any learning disabilities, sight or hearing problems or delays in language development. |
| 61 | British Association of Behavioural and Cognitive Psychotherapies | QS2 | Age appropriate information about the experience of depression and options for treatments should be provided to children, young people and carers. Web resources may also prove to be useful and accounts written by young people for young people. | Thank you for your comment. The Equality and diversity considerations for this statement state that information should be accessible in a variety of formats, for example, web-based resources and written information, and that it should be tailored to the person's needs. |
| 62 | Critical Psychiatry Network | QS2 | Surely there needs to be something about the quality of information, not just whether 'appropriate' (whatever that means) information is given. There is a grave danger in setting out treatment in a 'medical model' fashion as if 'depression' is a discrete entity with the same meaning for anyone presenting with as an unhappy young person. There is no value neutral 'knowledge' out there about 'depression' and any information presented in a medicalised format is contributing to dangerous 'medicalisation'. There is much evidence that medicalization of mental health difficulties can lead to increasing rates of chronic illness (e.g. whitaker, 2010). We would much rather be giving out leaflets to parents primarily (as they will be the main decision makers for most of the young people CAMHS see) that emphasises a recovery philosophy rather than the linear 'diagnosis – treatment options'. A recovery philosophy will emphasise the strengths and resources of people, be predicated on hope and optimistic messages about the future | Thank you for your comment. The rationale section supporting quality statement 2 outlines factors that need to be considered to ensure information is appropriate, this includes age, developmental level, emotional maturity and cognitive capacity of the child or young person, taking into account any learning disabilities, sight or hearing problems or delays in language development.<br><br>The Committee also agreed that the role of parents, family members and carers should be highlighted in the introduction of the quality standard. |

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| | | | and be clear about the evidence finding therapeutic equivalence for treatment models and therefore finding the most helpful approach is a collaborative effort between the practitioner and the family and dependent on a thorough understanding of the overall context the problem is presenting in. | |
| 63 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | QS2 | Children and young people with depression are given information appropriate to their age about the diagnosis and their treatment.<br><br>We would endorse this as an important standard for all children & their families, and where appropriate their care systems. Age appropriate verbal and written formulations which provide a child or young person with an understanding of their depression, including factors affecting this and appropriate interventions to support them and their care. | Thank you for your comment. |
| 64 | Oxleas Nhs Partnership Trust | QS2 | Fully supported | Thank you for your comment. |
| 65 | Public Health England | QS2 | The statement currently reads: 'children and young people with depression are given information appropriate to their age about the diagnosis and their treatment options…'<br><br>The way young people access information and are given information is important alongside the content of information. NICE has an opportunity for this to be conveyed in the quality standards.<br><br>It would add value if a line similar to the following is included: Consideration should be given to conveying the information in a way that responds to the expressed needs of the child/young person. | Thank you for your comment. The committee discussed this statement and the stakeholder comments and agreed that this is an important statement and should be progressed. They agreed it was important that the child or young person understood the information they were given however recognised that this was very hard to measure. The committee felt that 'engagement' of the child or young person was important and agreed that the rationale should be amended to include that information should be understood and that it is not only the age of the child or young person that can affect understanding. The rationale now stipulates that, in addition to age, information should be appropriate to the developmental level, emotional maturity and cognitive capacity of the child or young person, taking into account any learning disabilities, sight or hearing problems or delays in language |

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| | | | | development. |
| 66 | Royal College of Nursing | QS2 | We fully support this statement. | Thank you for your comment. |
| 67 | The Judith Trust | QS2 | Specific resources should be developed to ensure that this information can be appropriately transmitted to young people with learning disabilities. If this is done on an ad hoc basis locally, it is likely that this information will not be given in an appropriate format or in a timely manner.<br>The NDTi is currently compiling a bank of resources for Adult Mental Health Services, as part of phase 2 of Reasonably Adjusted; this model would be beneficial for CAMHS. | Thank you for your comment. Noted. |
| 68 | British Association of Behavioural and Cognitive Psychotherapies | QS3 | Prior to CAMHS referral, who is qualified to decide that the client has severe depression and is at risk? The rationale for standard 1 is that diagnosing depression is complicated, so to make this standard 3 feasible it will be necessary to have workers outside of CAMHS (e.g. tier 1) who can assess and diagnosis. This quality standard could be improved by changing the wording to “suspected severe depression” and “considered to be at high risk”, to enable non CAMHS workers to feel equipped to make referrals that will be assessed within the time frame. Alternatively, a cut-off score on a standardised screening measure administered by the referrer could be used to invoke this quality standard. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed to include ‘suspected’ depression in the statement as they felt this was correct population for this statement as this group of people may not have received a confirmed diagnosis. |
| 69 | British Medical Association | QS3 (and 4) | We are concerned that although there are specified time limits for access to assessment by CAMHS, there are no time limits specified for access to treatments. Access to appropriate treatment is important, and should be time limited to ensure that children and young people are not made to wait weeks or months following assessment for referral for treatment. CAMHS is the only access point for many relevant therapies, as commissioned services tend to be limited to adults (18-65 year olds). | Thank you for your comment. Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. Suggestions for additional areas of care were considered by the QSAC. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression and at high risk of suicide by CAMHS following referral. As waiting times for treatment is an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 70 | British Medical Association | QS3 (and 4) | We are concerned that the introduction of time limits for assessment for depression should not cause responses for | Thank you for your comment. Noted. |

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| | | | other conditions to be 'downgraded'. | |
| 71 | Critical Psychiatry Network | QS3 | Such a blanket statement is open to widely differing interpretations. What is 'severe' after all? In addition, assessment of risk of suicide and self-harm needs to be the responsibility of all healthcare professionals, not just CAMHS. Timely response by CAMHS for crisis cases is required, but a blanket figure of 24 hours is not helpful, particularly if this is based on self-harm, for several reasons. Sometimes the crisis is such that 24 hours is too long, so putting this 'magical' figure may inadvertently delay more urgent responses, due to a false re-assurance from having a 'target' time (and we all now should understand the dangers to healthcare of setting targets such as this). For other cases, 24 hours may be unnecessary as some forms of self harm are more behaviourally motivated than a suicide risk and do not need such urgent responses. In reality such targets will probably be rendered meaningless by services interpreting severity and the degree of urgency by how quickly they can end up responding (i.e. if they can respond within 24 hours it will be classed as 'urgent/severe', if not it will be categorised as non-urgent/severe). We should all be very careful about the 'games' such targets create and not absolve institutions such as NICE from a responsibility to understand these real life scenarios that this is likely to encourage. | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement. |
| 72 | Oxleas Nhs Partnership Trust | QS3 | There is some confusion here – 'YP with severe depression and a high risk of SH or suicide'. This seems to suggest that a diagnosis will need to be made by professionals outside of CAMHS? There are already protocols for access to camhs where a YP has presented with high risk of suicide and or self harm with 24hrs. | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement as this group of people may not have received a confirmed diagnosis. |
| 73 | Public Health England | QS3 | CYP with severe depression and a high risk of self-harm or suicide are assessed by CAMHS professionals within 24 hours of referral.<br><br>Whilst clinical consensus recommends this time frame, the | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that 24 hours should be the maximum amount of time for those at a high risk |

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| | | | standard would benefit from reiterating the requirement that all children and young people presenting in this context are provided with a place of safety and appropriate care immediately as appropriate to their needs, and that the assessment will be carried out within 24 hours. This would remove any ambiguity around keeping the individual safe from harm. | of suicide and not a target to aim for and this has been stipulated in the final quality statement.<br><br>The rationale supporting this statement also now states that a safe place should be provided for the child or young person until the assessment is carried out to help prevent injury or worsening of symptoms. |
| 74 | Royal College of Nursing | QS3 | There is some confusion here – 'Children and Young People (CYP) with severe depression and a high risk of self harm or suicide'... This seems to suggest that a diagnosis will need to be made by professionals outside of CAMHS? There are already protocols for access to CAMHS where a CYP has presented with high risk of suicide and or self harm with 24hrs. | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed to include 'suspected' depression in the statement as they felt this was correct population for this statement as this group of people may not have received a confirmed diagnosis. |
| 75 | Royal College of Paediatrics and Child Health | QS3 | We have some concern that there is no mention of a safe, monitored place such as admission to hospital in the meantime. The clinician cannot just send them away with an appointment for next afternoon. | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard.<br>The rationale supporting this statement also now states that a safe place should be provided for the child or young person until the assessment is carried out to help prevent injury or worsening of symptoms. |
| 76 | Sheffield Children's NHS Foundation Trust | QS3 | Assessment within 24 hours of referral to CAMHS is an acceptable time frame for children and young people with severe depression and a high risk of self-harm or suicide to be assessed, however not all areas have a CAMHS 24 hour on call service which when present would facilitate this standard being met as young people could be seen by the on call service. Even if seen by the on call service within 24 hours this does not determine the time frame in which young people will then be followed up by a CAMHS team following this initial contact. This may require some services to change the time frame of their current arrangements in which they are able to respond and see urgent cases. | Thank you for your comment. NICE quality standards are intended to demonstrate what high quality care looks like for a particular topic based on the best available evidence. A supporting document has been published alongside the standard reviewing the potential cost impact and implications for commissioners and service providers, however, the configuration of services will be determined locally. Supporting documents are available from www.nice.org.uk. We hope this will help to address your concerns. |
| 77 | The Judith Trust | QS3 | Outcome measures must be validated for use with those with | Thank you for your comment. Noted. |

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| | | | learning disabilities, across the spectrum of need, and adapted as appropriate | |
| 78 | Association of Child Psychotherapists (ACP | Question 4 (& 5) | It should be noted that while there are tight time limits for "assessment", there seems no guidance about waiting times for treatment. The ACP feels this is a major issue. Initial impressions from the on-going IMPACT Study suggests that cases that waited longer than they should have done, due to a lack of resources, were harder to engage/hold in therapy. Although we welcome the setting of targets for initial assessment, the process of assessment is not always therapeutic in itself, and so we would support guidance on waiting times for treatment, especially in cases of more severe depression. | Thank you for your comment. Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. Suggestions for additional areas of care were considered by the QSAC. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression and at high risk of suicide by CAMHS following referral. As waiting times for treatment is an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 79 | Association of School and College Leaders | Question 4 | Yes | Thank you for your comment. |
| 80 | National LGB&T Partnership | Question 4 | The quality statement could be rephrased to make clear that assessment within 24 hours of referral to CAMHS should be the maximum time limit, rather than the target. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee also agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement. |
| 81 | NHS England | Question 4 | For draft quality statement 3: Is assessment within 24 hours of referral to CAMHS an acceptable time frame for children and young people with severe depression and a high risk of self-harm or suicide?<br><br>Our first imperative must always to be to ensure the child or young person is safe and in extremis this may require intervention in under 24 hours. Where this is the case, the care offered should still be Age Appropriate. Assessment within 24 hours accords with previous targets under previous systems. There is no definition in the quality standard of who can make the referral – in CYP IAPT the project is encouraging self referral. Should the details in the quality standard explore | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee also agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement.<br><br>Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring |

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| | | | the issues regarding who can make the referral? What is classed as a waiting time and what is classed as a CAMHS referral is subject to local variation and needs to be clear and unambiguous | timely assessment of children and young people with suspected severe depression and at high risk of suicide by CAMHS following referral. As the issue of how the referral occurs is an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 82 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | Question 4 | Children and young people referred to CAMHS with severe depression and a high risk of self-harm or suicides are assessed by CAMHS professionals within 24 hours of referral.<br><br>Assessment within 24 hours was considered appropriate for young people with severe depression alongside current self harming behaviour or active suicidal plans. These are the young people that we would consider to be very high risk as indicated by: A history of self harm or suicidal thoughts / plans, or co-morbid mental health problems.<br><br>More guidance needed about the criteria for identifying the most 'at risk' young people. It would be unrealistic to expect CAMHS to provide assessment within 24 hours for all children / young people referred, where increased risk has been raised relating to presentations of low mood & self harm behaviour.<br><br>There needs to be recognition of the fact that mood disturbance and self-harm behaviour can be affected by social care or environmental stresses, not relating directly to mental illness. In these circumstances a urgent CAMHS assessment is not always the most appropriate intervention. Recognition that a multiagency response may be more appropriate where increased risk as been identified. | Thank you for your comment. Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression and at high risk of suicide by CAMHS following referral. As the quality and detail of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 83 | Sheffield Clinical Commissioning Group | Question 4 | I think 24 hours is a long time for parents/carers to cope with a suicidal child or young person. My experience looking after young people high risk of self harming is that they can be at risk to the point of needing restraint (worse case scenario) and some may be bigger and stronger than their parents. For all cases, this situation is likely to cause severe stress for all concerned and I think 4 hours should be the aim, with 12 hours | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement. The |

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| | | | the measurable target ideally. I recognise that resources may make this challenging, but 24 hours might mean no sleep for a parent, with increase in risk. | rationale supporting this statement also now states that a safe place should be provided for the child or young person until the assessment is carried out to help prevent injury or worsening of symptoms. |
| 84 | The Lesbian & Gay Foundation | Question 4 | The quality statement could be rephrased to make clear that assessment within 24 hours of referral to CAMHS should be the maximum time limit, rather than the target. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee also agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement. |
| 85 | The Royal College of Psychiatrists | Question 4 | The standard says “are seen” in 24 hours. This does depend on family logistics as well as service response. The standard is quite a stretch but worthy of aspiring to achieve. | Thank you for your comment. |
| 86 | British Psychological Society | Question 4 | Children are well into the latter stages of upper primary school before they truly understand the abstract concept of time. Therefore, any time lapse between being promised and receiving help, especially for those children who are suffer any level of depression, with the associated fear, isolation and withdrawal must be as short as possible.<br>It is unclear from the guidance under what circumstances CAMHS can wait 24 hours. The Society suggests that a safe timeframe very much depends on the level of assessment the child or young person has received prior to the referral. For example: if the young person was seen by a qualified mental health professional in A&E and fully assessed before being discharged and referred to CAMHS the seeing the young person within 24 hours- which in reality might mean the following day- might be acceptable since someone qualified had assessed the risk and deemed that the young person and/or their family could keep them safe for this period. However, if for example a school nurse (who would be much less qualified in assessing risk of self harm and sucidiality) was referring to CAMHS then it would clearly be more concerning if that child or young person was not assessed by a mental health professional until the next day. | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that 24 hours should be the maximum amount of time for those at a high risk of suicide and not a target to aim for and this has been stipulated in the final quality statement. The rationale supporting this statement also now states that a safe place should be provided for the child or young person until the assessment is carried out to help prevent injury or worsening of symptoms.<br><br>Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression and at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment is an |

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| | | | The Society suggests that children and young people need to be assessed immediately by a qualified mental health professional when they have expressed or demonstrated a risk to themselves. If this has been completed then it would be acceptable for CAMHS then to follow up within 24 hours providing the professional referring and the family was in agreement with this plan.<br>We would also suggest that parents are fundamental in the tasks of keeping children and young people safe and that their views (where possible and appropriate) should be sought at all stages. | additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 87 | British Association of Behavioural and Cognitive Psychotherapies | QS4 | As with standard 3, this standard relies on severe depression being diagnosed before being assessed by CAMHS, and diagnosing depression (as stated in the rationale for standard 1) is complex. This quality standard could be improved by changing the wording to “suspected severe depression” and “considered to be at high risk”, to enable non CAMHS workers to feel equipped to make referrals that will be assessed within the time frame. Alternatively, a cut-off score on a standardised screening measure administered by the referrer could be used to invoke this quality standard. Education and training in risk factor identification is important and ensuring that CAMHS have comprehensive and up to date information in order to assess risk and make judgement, perhaps risk assessment checklist could be developed aligned with this standard. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed to include ‘suspected’ depression in the final statement as they felt this was correct population for this statement as this group of people may not have received a confirmed diagnosis.<br><br>Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. All suggestions for additional statements were discussed by Committee. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 88 | British Medical Association | QS4 (and 3) | We are concerned that although there are specified time limits for access to assessment by CAMHS, there are no time limits specified for access to treatments. Access to appropriate | Thank you for your comment. Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most |

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| | | | treatment is important, and should be time limited to ensure that children and young people are not made to wait weeks or months following assessment for referral for treatment. CAMHS is the only access point for many relevant therapies, as commissioned services tend to be limited to adults (18-65 year olds). | important for patients. All suggestions for additional statements were discussed by Committee. For this quality statement the QSAC agreed that the key quality aspect should focus on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As access to treatment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 89 | British Medical Association | QS4 (and 3) | We are concerned that the introduction of time limits for assessment for depression should not cause responses for other conditions to be 'downgraded'. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. |
| 90 | Critical Psychiatry Network | QS4 | Same problem as statement 3. This is just 'magical' thinking at its worst. We know of no evidence that finds that 10 days is the cut off for outcomes, managing risk or anything else clinically meaningful. Why not 24 hours, 3 days, one week, one month? This target mentality has all the dangers that accrue when we encourage centralised bureaucracies to create artificial and clinically meaningless targets to persecute staff and services (and therefore ultimately patients) with. More severe cases should be prioritised by CAMHS, something they all generally do. How prioritisation happens involves much more multi-dimensional thinking, which includes, presenting problem, severity, social circumstances and history. How a service manages the variety of priorities for demands when there is a lack of resources coupled with the importance of providing equity in access to services, means that the nuts of bolts of prioritisation should be established locally, service by service. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The final quality statement states that children and young people with suspected severe depression but not at high risk of suicide are assessed by CAMHS professionals within a *maximum* of 2 weeks of referral. This does not preclude local prioritisation of assessments for more urgent cases sooner. |
| 91 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | QS4 | Is assessment within 10 days of referral to CAMHS an acceptable time frame for children and young people with severe depression but not at high risk of self-harm or suicide?<br><br>We acknowledge that whilst assessment within 10 days would | Thank you for your comments which were taken into account by the QSAC when producing the final version of the quality standard.<br><br>The committee discussed consultation comments |

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| | | | be an ideal quality standard, it would be unrealistic given the current competing demands on services.<br><br>Assessing the level of need is also highly dependent on the quality of information within referrals made to CAMHS, which is extremely variable.<br><br>There is inherent in the draft standards, the assumption that symptoms or indicators of severe depression will be recognised by all referrers and reflected in the detail and quality of information provided by referrers.<br><br>We would therefore recommend that quality standards may reflect systems which are put in place by specialist services in order to screen referrals with referrers where concern and increased risk is raised at the point of referral. We would also recommend that systems are put in place where referrals can be expedited where there are increased concerns re depression and the need for earlier assessment indicated. | relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The committee also agreed that self-harm should be removed from the statement as there is a self-harm quality standard in development and this would cause overlap.<br><br>Quality statements are restricted to one concept. The Committee prioritised the areas of care they felt were most important for patients. All suggestions for additional statements were discussed by Committee. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 92 | Oxleas Nhs Partnership Trust | QS4 | Again some confusion that this assumes a diagnosis has been made of severe depression by referrers, who tend to be GPs as well as school nurses, SENC's etc. where we would not necessarily expect assessment of the level of depression to have been accurately assessed. There is a potential for overwhelming assessment slots in specialist camhs with less urgent cases. | Thank you for your comment. Quality statements are restricted to one concept. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 93 | Rotherham Doncaster and South Humber NHS Foundation Trust | QS4 | I think 10 days is too tight a time scale and would necessitate a category between urgent and routine in our service. 21 Days/ 3 weeks would be better. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed consultation comments relating to the |

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| | | | | timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. |
| 94 | Royal College of Nursing | QS4 | Again some confusion that this assumes a diagnosis has been made of severe depression by referrers, who tend to be GPs as well as school nurses, SENCOs etc. where we would not necessarily expect assessment of the level of depression to have been accurately assessed. There is a potential for overwhelming assessment slots in specialist CAMHS with less urgent cases. | Thank you for your comment. Quality statements are restricted to one concept. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 95 | Royal College of Paediatrics and Child Health | QS4 | This is only appropriate if the patient is assessed as severe, not at risk of suicide etc. by someone trained to do so, otherwise those with severe depression should be seen within 24 hours, because of the risk of unrecognised, unreported suicidality. The individual should also be given a 24 hour contact number if suicidal ideation or attempted self-harm appear. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The committee also agreed that self-harm should be removed from the statement as there is a self-harm quality standard in development and this would cause overlap. |
| 96 | Sheffield Children's NHS Foundation Trust | QS4 | Assessment within 10 days of referral to CAMHS is an acceptable time frame for children and young people with severe depression but not at high risk of self-harm or suicide to be assessed but again this may require some services to change the time frame of their current arrangements in which they are able to respond to such cases. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard.<br><br>The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The committee also agreed that self-harm should be removed from the statement as there is a self-harm quality standard in development and this would cause overlap |
| 97 | Tees Esk and Wear Valley NHS Trust | QS4 | • I feel standard 4 should read "Children and young people referred to CAMHS, with severe depression but not at risk of | Thank you for your comment. The committee discussed consultation comments relating to the |

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| | | | self-harm or suicide are assessed by appropriately trained CAMHS professionals within 5 working days of referral"<br>• The draft standard states within 10 days of referral and for someone with severe depression, the clinical picture may change quickly and 10 days | timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and be changed to two weeks. The committee also agreed that self-harm should be removed from the statement as there is a self-harm quality standard in development and this would cause overlap. |
| 98 | Association of Child Psychotherapists (ACP | Question 5 (& 4) | It should be noted that while there are tight time limits for "assessment", there seems no guidance about waiting times for treatment. The ACP feels this is a major issue. Initial impressions from the on-going IMPACT Study suggests that cases that waited longer than they should have done, due to a lack of resources, were harder to engage/hold in therapy. Although we welcome the setting of targets for initial assessment, the process of assessment is not always therapeutic in itself, and so we would support guidance on waiting times for treatment, especially in cases of more severe depression. | Thank you for your comment. Quality statements are restricted to one concept. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As waiting times for treatment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 99 | Association of School and College Leaders | Question 5 | Yes. In an ideal world this timescale would be shorter, but given the pressures on the service this seems reasonable. It is a much shorter time than that sometimes reported by ASCL members, and so would represent a marked improvement if followed. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks. |
| 100 | National LGB&T Partnership | Question 5 | The quality statement could be rephrased to make clear that assessment within 10 days of referral to CAMHS should be the maximum time limit, rather than the target. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks. |
| 101 | NHS England | Question 5 | For draft quality statement 4: Is assessment within 10 days of referral to CAMHS an acceptable time frame for children and young people with severe depression but not at high risk of self-harm or suicide? Should this standard also include waiting times for mild/moderate depression? | Thank you for your comment. |
| 102 | Sheffield Clinical Commissioning Group | Question 5 | We are currently arranging our services in Sheffield to include MAST teams (and other areas may have partnership | Thank you for your comment. The committee discussed consultation comments relating to the |

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| | | | approaches), it may not be necessary for a CAMHS worker to physically assess a young person within 10 days if there is no risk. It may be that liaison should be within 10 days and assessment be within 10 days if needed, but if appropriate support and input is in place, then CAMHS assessment could be planned around that and may be after a longer period of time. This might allow a quicker response than 24 hours where there is identified risk. | timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks. |
| 103 | The Lesbian & Gay Foundation | Question 5 | The quality statement could be rephrased to make clear that assessment within 10 days of referral to CAMHS should be the maximum time limit, rather than the target. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks. |
| 104 | The Royal College of Psychiatrists | Question 5 | Yes. With the caveats as outlined above question 5 should read 'treatment for depression', not 'treated for depression'. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks. |
| 105 | British Psychological Society | Question 5 | As stated above, it is unclear from the guidance under what circumstances CAMHS can wait 24 hours. The Society suggests that a safe timeframe very much depends on the level of assessment the child or young person has received prior to the referral. For example: if the young person was seen by a qualified mental health professional in A&E and fully assessed before being discharged and referred to CAMHS the seeing the young person within 24 hours- which in reality might mean the following day- might be acceptable since someone qualified had assessed the risk and deemed that the young person and/or their family could keep them safe for this period. However, if for example a school nurse (who would be much less qualified in assessing risk of self harm and suicidiality) was referring to CAMHS then it would clearly be more concerning if<br>that child or young person was not assessed by a mental health professional until the next day. | Thank you for your comment. The committee discussed consultation comments relating to the timeframe of 10 days. The committee felt that this should be aligned with cancer services and other services and has now been amended to two weeks.<br><br>Quality statements are restricted to one concept. For this quality statement the QSAC agreed that the key quality aspect and focus should be on ensuring timely assessment of children and young people with suspected severe depression but not at high risk of suicide by CAMHS following referral. As the quality of the pre-referral assessment would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |

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| | | | It should be noted that ten days is a relatively long time in the life of a child, especially when cognitive development in dealing with the abstract concept of time is taken into account.<br>Secondly, the role of the negative influences of social media cannot be minimised and may result in impulsive action to self harm, even to the ultimate taking of one's own life.<br>In conclusion, while we recognise the complexity of the need to balance realistic expectations of services with high quality for children and young people within these, for children and young people suffering from depression 10 days may be considered too long for a lapse between diagnosis and treatment. | |
| 106 | Association for Family Therapy and Systemic Practice (AFT) | QS5 | This statement confuses several issues.<br><br>1. The routine use of validated outcome measures<br>2. Ongoing assessment of progress as part of the treatment process<br>3. The assessment of progress on a session-by-session basis and the empirical evidence as to whether session by session evaluation improves outcomes of treatment<br><br>1. There is a clear rationale for requiring treatment outcomes to be assessed routinely and for such outcomes to be made using validated measures (this is part of good audit practice to ensure that we know how effective our treatments are)<br><br>2. Assessing ongoing progress on a regular basis addresses a different set of issues. These can relate to improving knowledge of how and when change occurs (i.e. research question) or ensuring that therapy is adjusted to specific needs of individual patients and how feedback from patients is used to modify interventions. The quality statement should be clearly related to the latter and a case can be made that using validated measures at such regular review sessions has its place. However, the important issue here is not the use of validated measures but the ongoing use of feedback about how treatment is progressing. If the emphasis is on the use of validated measures rather than on the feedback process there is a risk that quality standards will be driven by the frequency | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that this statement was important and should be progressed but agreed to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment.<br><br>The committee also agreed that the quality statement should allow greater flexibility in the choice of tools for monitoring health outcomes and has been now amended so this does not specifically stipulate the use of a validated outcome measure. |

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| | | | of the use of measures rather than by their actual use in therapeutic practice<br><br>3. Session-by-session assessment raises additional issues. Measures that can be used in such a way have to be of necessity brief. They may be derived from longer, validated measures but they are unlikely to have the same robust psychometric properties, The rationale for using assessment of progress at every session is not based on the robustness of the psychometric properties of the measures used but more on the impact of the use of such assessments on the interactive process between therapist and young person, changes in the power balance, giving the young person a different kind of voice etc. If this process is reduced to simply "dishing out questionnaires" it completely misses the point. The use of the term "validated" in this context is unhelpful because it may encourage inappropriate use of longer measures in session-by-session feedback (a better term than measure?).<br><br>An additional point that needs to be made here is that at present there is lack of convincing empirical evidence about the value of session-by-session feedback on outcome with children and adolescents. There are a number of studies in adults, with somewhat are equivocal findings which on balance show beneficial effects of routine session-by-session monitoring. With children and adolescents, however, the evidence at present is lacking and caution is needed in implementing a standard that extrapolates from adults to children | |
| 107 | Association of Child Psychotherapists (ACP) | QS5 | Within this statement is a specification that a validated outcome measure should be used at every appointment - the ACP feels this seems to go beyond what even Children and Young People's IAPT is recommending i.e. that there should be regular and routine on-going outcome monitoring - not necessarily every meeting.<br>With regards to the section "Children and young people receiving treatment for depression answer a set of standard questions at each appointment to check that the treatment is | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that the quality statement should allow greater flexibility in the choice of tools used to monitor health outcomes and this now no longer stipulates that this needs to be a validated outcome measure. |

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| | | | working" - the ACP understands the pressure in the current climate for session by session outcome monitoring. However the ACP supports the idea of monitoring the progress of psychological interventions, but feels that the idea of asking "standard questions" repeatedly to adolescents may not always be well received by these young clients and that the very nature of their therapeutic treatment, involving highly charged emotional issues, may not fit in with this approach to ascertain how much progess is being made. A degree of flexibility in how this quality statement is worded could be of great clinical value. | The data sources section also now cross-references the CYP IAPT stating that routine outcome monitoring is being specified as part of The Children and Young People's IAPT project.<br><br>The committee also agreed that to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |
| 108 | British Association for Counselling and Psychotherapy | QS5 | In relation to draft quality statement 5 on the monitoring of outcomes, BACP would suggest that given the participation agenda, and also the emphasis in NHS policy on the personalisation of care, there should also be some expectation of monitoring the process of therapy and how the service users are experiencing the intervention, and whether it feels right for them. This could be through a process measure such as the CSRS (part of the PCOMS family of measures for children), or through some other form of quasi-independent evaluation. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that the quality statement should allow greater flexibility in the choice of tools used to monitor health outcomes and this now no longer stipulates that this needs to be a validated outcome measure. The "Definitions of terms used in this quality statement" section for this quality statement outlines methods that could be used to monitor health outcomes and indicates that this may include self-report measures or generic outcome measures. |
| 109 | British Association of Behavioural and Cognitive Psychotherapies | QS5 | In addition to monitoring using outcome measures e.g. SDQ or Honosca, research from CORC informs us that young people get better faster when they monitor their own progress in treatment via client centred outcome measures that might be subjective e.g. goal oriented and idiosyncratic, such self-monitoring methods seem to have high face validity and might motivate young people in therapy. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that the quality statement should allow greater flexibility in the choice of tools used to monitor health outcomes and this now no longer stipulates that this needs to be a validated outcome measure. |
| 110 | British Medical Association | QS5 | We would question this statement, as these tools can become obstructive to good consulting and lead to the doctor simply filling in the questionnaire without actively listening to the patient's response. Given the time limits of consultations in general practice, we would prefer doctors to be asked to spend their time talking, and particularly listening, to the patient, | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that the quality statement should allow greater flexibility in the choice of tools used to monitor health outcomes and this now no longer |

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| | | | rather than using closed lists of questions. | stipulates that this needs to be a validated outcome measure. |
| 111 | Critical Psychiatry Network | QS5 | We agree that routine outcome monitoring session by session (and this should be the case for all CAMHS patients) can be beneficial. We do not think symptom based tools should be used, as what is a meaningful outcome varies by person and family. More generic outcome measures are just as valid and reliable and have the added example of easier feasibility for a CAMHS service, rather than having to use different tools for different diagnoses (and god knows how we then manage the norm of co-morbidity without burgeoning paperwork). It is important that the purpose of using outcomes is made clear. For examples, outcomes should be graphed and this graph discussed with patients and a change made to the therapeutic approach if no improvement is indicated after several sessions (as evidence finds the more sessions that occur with no evidence of improvement, the less likely that episode of care will result in an improvement). Lack of improvement is more likely to be as a result of alliance variables or extra-therapeutic factors and therefore following a lack of improvement, the possibility of changing therapist (rather than just adding a new treatment) should be contemplated. The guidance should be therefore more specific about how outcome data will be used with patients to involve patients and families in the decision making process session by session and to tailor treatments to their preferences. There is little point in using outcome ratings unless it forms part of the discussions that clinicians have with patients to allow them to adjust treatment model based on whether what is being offered is connecting with what is meaningful for them and helping them achieve meaningful (to them) change. There is plenty of evidence that that type of active use of feedback does improve outcomes (e.g. Lambert, 2010; Lambert and Shimokawa, 2011). | Thank you for your comment. The committee agreed that this statement was important and should be progressed but agreed to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment.<br><br>The committee also agreed that the quality statement should allow greater flexibility in the choice of tools for monitoring health outcomes and has been now amended so this does not specifically stipulate the use of a validated outcome measure.<br><br>Quality statements are restricted to one concept. For this quality statement the QSAC agreed that the key quality aspect should focus on ensuring outcomes are recorded. It is anticipated that the information gathered would be used by healthcare professional to inform future care however since the use of outcomes data to tailor treatments to children and young people's preferences would be an additional concept, and this was not prioritised by the QSAC, this is not covered by this quality statement. |
| 112 | National LGB&T Partnership | QS5 | This should include recommendation to monitor sexual orientation and gender identity monitoring of young people assessing these services; please see general comment above re. implementation of sexual orientation and gender identity | Thank you for your comment. The Committee identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards |

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| | | | monitoring of all patients across all NHS services. | development process. The quality standards are based on recommendations from the source guidance (NICE CG28). The QSAC do however consider equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. |
| 113 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | QS5 | Children and young people receiving treatment for depression have their progress monitored at each appointment using a validated outcome measure.<br><br>We support the recommendation for session by session monitoring of therapeutic progress however consideration needs to be given to the measure used. Completion time and sensitivity to session by session change would be important factors. For example, the Definitions section lists the Strengths and Difficulties Questionnaire as an example outcome measure. This takes a time to complete and could therefore impact on client engagement if it needed to be completed at every session.<br><br>We do not believe the SDQ has the sensitivity to track session by session change. Problem-oriented questions as found in the SDQ, can have limited meaning at the extremes of the 5-18 years age range and also when applied to developmentally vulnerable children e.g. children with ASD or LD.<br>It would be better to measure general factors such as distress level, impact on functioning, hope, improvement, therapeutic relationship etc. Goal based outcomes agreed at the start of treatment could also be considered as a measure of change. | Thank you for your comment which was taken into account by the QSAC when producing the final version of the quality standard. The committee agreed that the quality statement should allow greater flexibility in the choice of tools used to monitor health outcomes and has been now amended so this does not specifically stipulate the use of a validated outcome measure. |
| 114 | Oxleas Nhs Partnership Trust | QS5 | Fully supported | Thank you for your comment. The committee agreed that this statement was important and should be progressed but agreed to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |

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| 115 | Rotherham Doncaster and South Humber NHS Foundation Trust | QS5 | I think it is important that we don't overload patients and the service with questionnaires. It is important to tie this rating scale in with CIAPt. The scale I find best is the CDI. | Thank you for your comment. The committee agreed that this statement was important and should be progressed but agreed to amend the statement so that outcomes are recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment.<br><br>The data sources section for quality statement 5 in the final QS, now references the CYP IAPT stating that routine outcome monitoring is being specified as part of The Children and Young People's IAPT project. |
| 116 | Royal College of Nursing | QS5 | We fully support this statement. | Thank you for your comment. The committee agreed that this statement was important and should be progressed but agreed to amended recording of outcomes at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |
| 117 | Royal College of Paediatrics and Child Health | QS5 | This is not needed at each and every appointment. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and agreed that whilst it was important to record health outcomes, it was not appropriate at every appointment. They agreed with stakeholders that this could have a negative impact on the treatment. The committee therefore agreed that this statement should be progressed but should be amended to show that an outcome should be recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |
| 118 | The Lesbian & Gay Foundation | QS5 | This should include recommendation to monitor sexual orientation and gender identity monitoring of young people assessing these services; please see general comment above re. implementation of sexual orientation and gender identity | Thank you for your comment. The Committee identified the development sources they felt were most relevant to developing the standard, within the framework of the quality standards |

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| | | | monitoring of all patients across all NHS services. | development process. The quality standards are based on recommendations from the source guidance (NICE CG28). The QSAC do however consider equality issues throughout development of the quality standard and a section on 'Diversity, equality and language' can be found in the final quality standard. |
| 119 | The Royal College of Psychiatrists | QS5 | There is concern that Standard 5 might not be appropriate if someone is severely depressed since there may be slow progress and the young person may not be in a fit state to complete monitoring. An alternate and more broadly achievable standard may be to say that outcomes are routinely monitored, either at each session or at 6 month intervals. This should be achievable across the board so is realistic | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and agreed that whilst it was important to record health outcomes, it was not appropriate at every appointment. They agreed with stakeholders that this could have a negative impact on the treatment. The committee therefore agreed that this statement should be progressed but should be amended to show that an outcome should be recorded at the beginning and end of treatment and at transition across steps in the treatment pathway, rather than each appointment. |
| 120 | Association for Family Therapy and Systemic Practice (AFT) | QS6 | The way in which different therapeutic approaches are defined here vary considerably from purely descriptive to more conceptual. The definition of family therapy offered here is devoid of any conceptual account and we would therefore suggest the following definition.<br><br>Family Therapy draws on an understanding that individual problems occur in the context of significant relationships (and family relationships in particular), which are both affected by individual problems and sometimes can also become part of what maintains individual problems. Family Therapy works with people in close relationship to help each other by enabling them to express and explore difficult thoughts and emotions safely, to understand each other's experiences and views, appreciate each other's needs, build on family strengths and make useful changes in their relationships and their lives. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |

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| | | | Family therapy interventions draw on a range of conceptual ideas including systemic, narrative, cognitive-behavioural, and psychodynamic. | |
| 121 | Association of Child Psychotherapists (ACP) | QS6 | When describing the range of therapies that should be available, there is no reference to section 1.6.3 of the guidance (NICE clinical guideline 28) which refers to depression unresponsive to combined treatment. In that section, 1.6.3.2 "Following multidisciplinary review, the following should be considered: an alternative psychological therapy which has not been tried previously (individual CBT, interpersonal therapy or shorter-term therapy, of at least three months' duration), or systemic family therapy (at least 15 fortnightly sessions), or individual child psychotherapy (approximately 30 weekly sessions)." Without this section being referred to, there is no reference to psychodynamic child therapy as a recommended treatment within the quality standards at all - and therefore no expectation that services should make this form of treatment available. Given that this is part of the treatment recommendations for moderate/severe depression - and that there is a major NIHR study (the IMPACT Study) now taking place to investigate this recommendation further - the ACP feels that a strong case needs to be made that this element of the NICE guidance is not 'dropped' from the quality assurance document.<br>With regards to the section "Children and young people with depression are offered a talking therapy that best suits them" and the "full range" - the ACP feels that IMPACT experience has heightened awareness that the necessary therapeutic alliance involves very careful attention to what works for whom. The ACP feels that both CBT and STPP therapists have had cases they feel sure would have been better seen in each other's modalities, and that it is therefore important to hold in mind the principle that evidence based practice is decision-making based on the judicious combination of: a) the best available evidence; b) the client's preferences; and c) the clinical judgement of the practitioner. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. The committee discussed the focus of the statement at length and noted the advice that the evidence in this area had changed and had not been incorporated into the guideline. They therefore agreed to remove this statement from the final standard as they felt the utility was lost. |
| 122 | British Association of | QS6 | This quality standard is complicated in England: The GP may | Thank you for your comment, which was taken |

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| | Behavioural and Cognitive Psychotherapies | | be the referrer, the commissioner and also the treatment provider. Many children and young people with only mild depression who have been prescribed anti-depressants have usually been prescribed them by their GP. More access to appropriate therapy services is required. Models where young people can “drop-in” are viewed by young people as less stigmatising. Cultural and economic factors may also impede access to treatment. Treatment works best when it’s individualised and severity can be defined by symptoms of depression but also by complexity of the individual’s symptoms and presence of other risk factors in their environment. | into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 123 | Critical Psychiatry Network | QS6 | We are sceptical about your assessment of the evidence for treatment but welcome attempts to measure the proportion of patients that receive different therapies. The standard should also include recording of outcome and length of treatment that can be analysed by intervention received. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. The committee discussed the focus of the statement at length and noted the advice that the evidence in this area had changed and had not been incorporated into the guideline. They therefore agreed to remove this statement from the final standard as they felt the utility was lost. |
| 124 | Nottinghamshire Healthcare NHS Trust – Specialist Child & Adolescent Mental Health Services (CAMHS) | QS6 | Children and young people with depression receive psychological and pharmacological therapy appropriate to the severity of depression<br><br>In principal, yes. In practice there is typically a waiting list for psychological therapy and (in the most severe cases of depression) it could be considered unethical to withhold an available treatment (medication) while a young person waits to start psychological therapy. | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 125 | Oxleas Nhs Partnership Trust | QS6 | Agree in principle with the statement however feel that training would be requirement to professionals in health and education to provide skilled and safe watchful waiting, guided self help etc | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and |

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| | | | There is concern that schools who have taken academy status no longer employ counsellors in some areas and hence there is a potential for children with mild symptoms to be missed. | as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 126 | Public Health England | QS6 | The draft standard is currently worded to imply that children and young people with depression receive both psychological and pharmacological therapy appropriate to the severity of depression. The rationale then qualifies the fact that some CYP may not want or need a specific intervention.<br><br>The standard needs to be rephrased in a way which includes reference to taking into consideration the views/desires of what CYP or their carers might want as well as what is deemed to be clinically appropriate. Something along lines of the choice of therapy takes into consideration the expressed views of child/young person and their carers. | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 127 | Royal College of General Practitioners | QS6 | So often depression includes a social and family element – a multi-disciplinary approach is needed in primary as well as secondary care – not just psychological and pharmacological! It often is a component of other disorders, physical or mental, so these need addressing as well. Multi-disciplinary approach is mentioned in other QS – why not this one? | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 128 | Royal College of Nursing | QS6 | Agree in principle with the statement however feel that training would be requirement to professionals in health and education to provide skilled and safe watchful waiting, guided self help etc. There is concern that schools who have taken academy status no longer employ counsellors in some areas and hence there is a potential for children with mild symptoms to be missed. | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. |
| 129 | Sheffield Clinical Commissioning Group | QS6 | I also think statement 6 could read better. Whilst it is intended to ensure that the correct treatment based on evidence is used, I think it should actually say something like "interventions appropriate to the level of depression, but taking account of the evidence where it exists and the young person's preference and situation". | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. The committee discussed the focus of the |

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| | | | | statement at length and noted the advice that the evidence in this area had changed and had not been incorporated into the guideline. They therefore agreed to remove this statement from the final standard as they felt the utility was lost. |
| 130 | University of Reading | QS6 | This comment reflects the joint opinion of Prof Lynne Murray (University of Reading) and Prof Alan Stein (University of Oxford): Given the associations above, and some evidence that treatment of parental depression influences child psychopathology, treatment for child depression should be able to accommodate treatment of parental depression. A relevant reference is:<br>Gunlicks and Weissman. Change in child psychopathology with improvement in parental depression: a systematic review. J Am Acad Child Adolesc Psychiatry. 2008; 47: 379-389 | Thank you for your comment. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. Quality statement 6 has now been removed from the final quality standard. The introductory sections of the quality statement outline that parental depression is a strong risk factor for the child or young person's depression, and the child or young person's experience of depression is best helped by their parents or carers. |
| 131 | The Judith Trust | QS6 | There is a need for more research into the effectiveness of psychological therapies with young people with learning disabilities, and how these can be adapted to improve their efficacy. | Thank you for your comment, which was taken into account by the QSAC when producing the final version of the quality standard. The committee discussed this statement and the comments from stakeholders. They agreed that whilst this is an important area the statement was too general and as such would not improve quality. The committee discussed the focus of the statement at length and noted the advice that the evidence in this area had changed and had not been incorporated into the guideline. They therefore agreed to remove this statement from the final standard as they felt the utility was lost. |