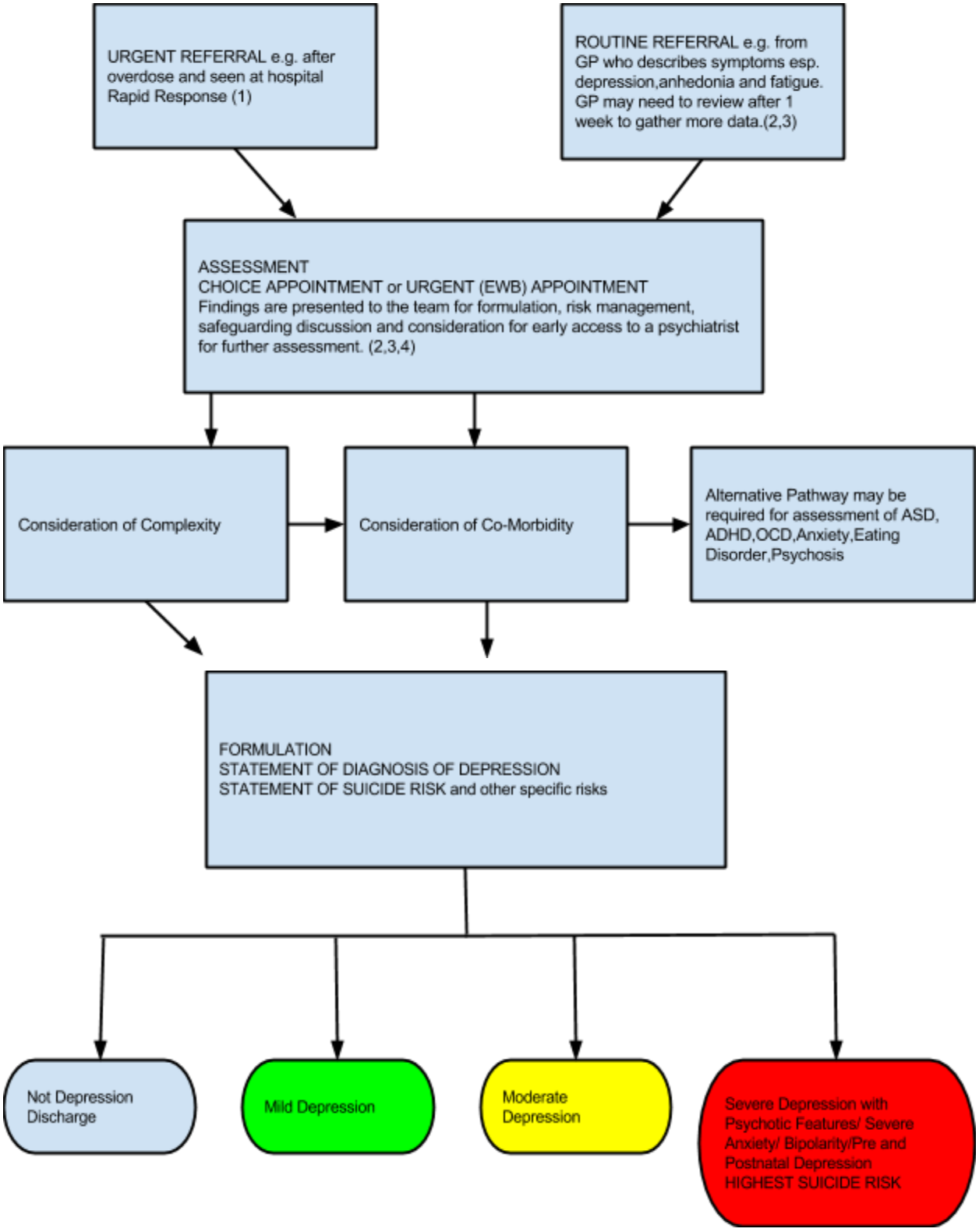
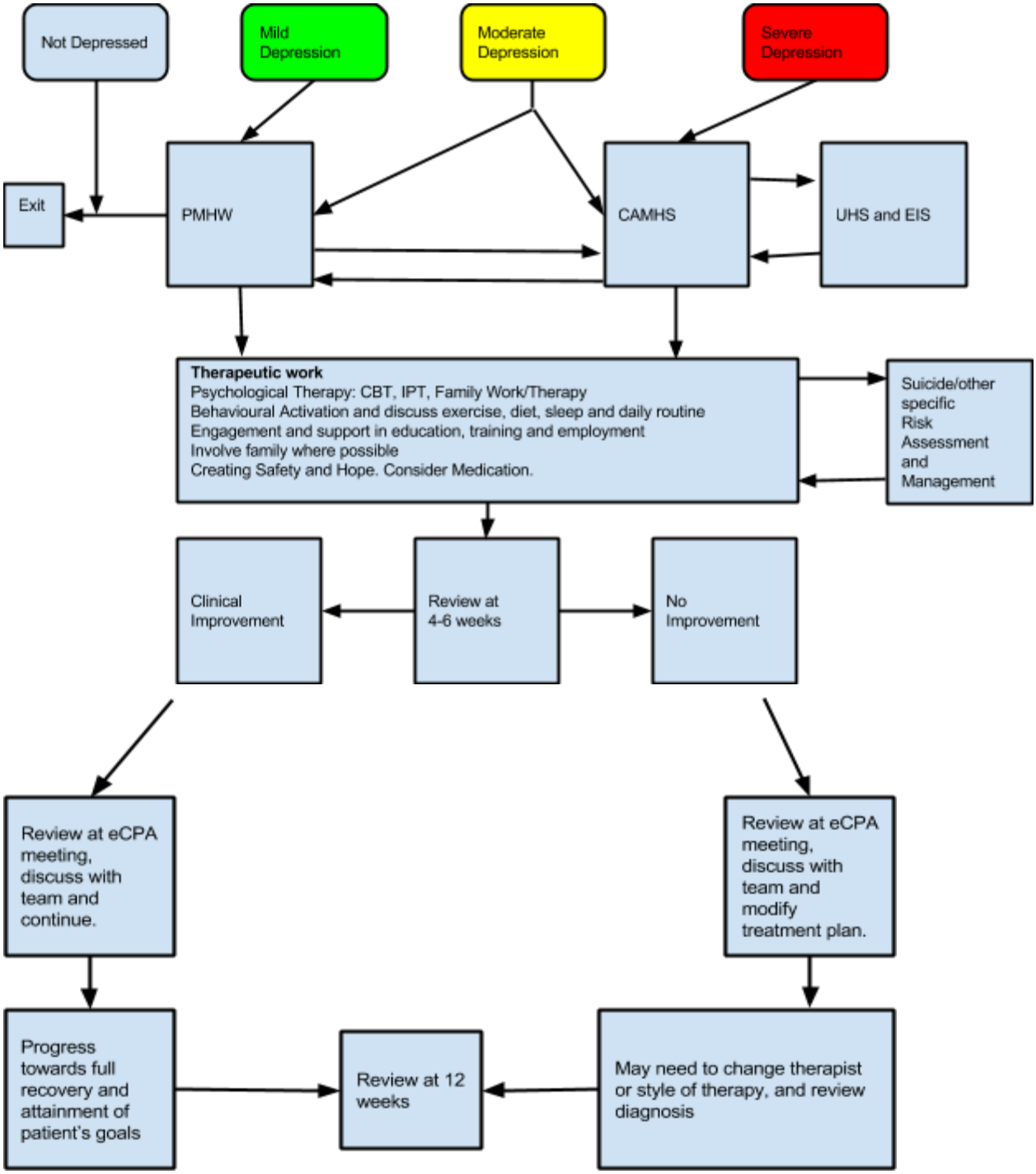
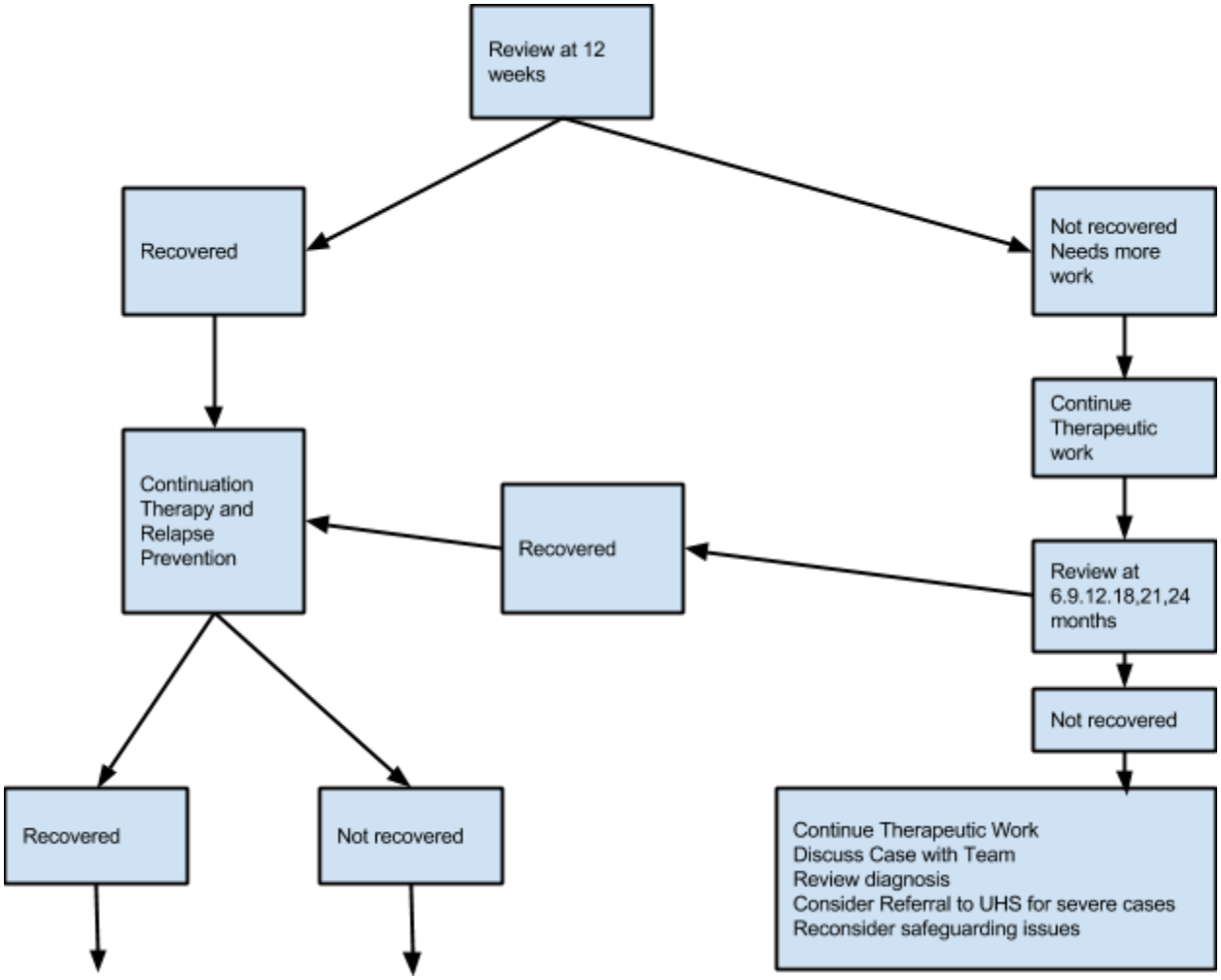
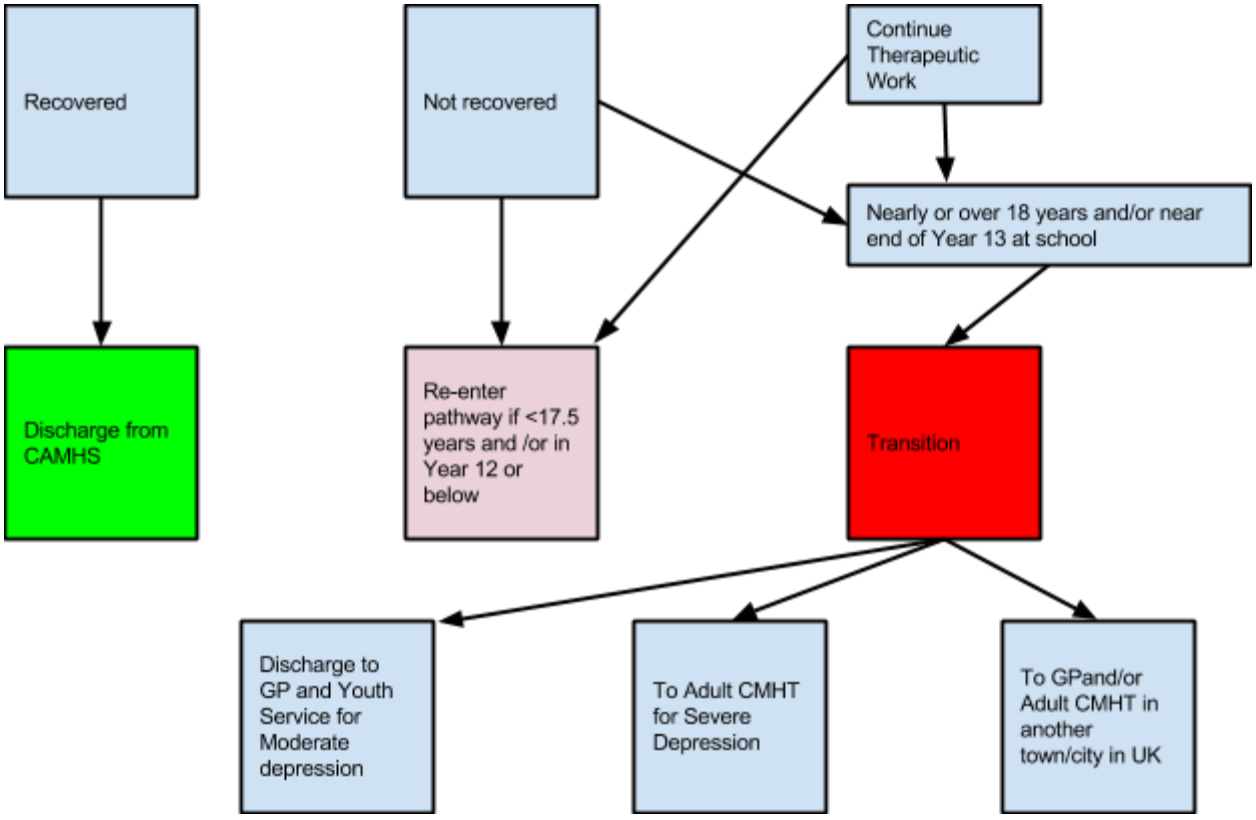

URGENT REFERRAL e.g. after overdose and seen at hospital Rapid Response (1)
ROUTINE REFERRAL e.g. from GP who describes symptoms esp. depression,anhedonia and fatigue. GP may need to review after 1 week to gather more data.(2,3)
ASSESSMENT
CHOICE APPOINTMENT or URGENT (EWB) APPOINTMENT
Findings are presented to the team for formulation, risk management, safeguarding discussion and consideration for early access to a psychiatrist for further assessment. (2,3,4)
Consideration of Complexity
Consideration of Co-Morbidity
Alternative Pathway may be required for assessment of ASD, ADHD,OCD,Anxiety,Eating Disorder,Psychosis
FORMULATION
STATEMENT OF DIAGNOSIS OF DEPRESSION
STATEMENT OF SUICIDE RISK and other specific risks
Not Depression Discharge
Mild Depression
Moderate Depression
Severe Depression with Psychotic Features/ Severe Anxiety/ Bipolarity/Pre and Postnatal Depression
HIGHEST SUICIDE RISK


Not Depressed
Mild Depression
Moderate Depression
Severe Depression
Exit
PMHW
CAMHS
UHS and EIS
Therapeutic work
Psychological Therapy: CBT, IPT, Family Work/Therapy
Behavioural Activation and discuss exercise, diet, sleep and daily routine
Engagement and support in education, training and employment
Involve family where possible
Creating Safety and Hope. Consider Medication.
Suicide/other specific Risk Assessment and Management
Clinical Improvement
Review at 4-6 weeks
No Improvement
Review at eCPA meeting, discuss with team and continue.
Review at eCPA meeting, discuss with team and modify treatment plan.
Progress towards full recovery and attainment of patient's goals
Review at 12 weeks
May need to change therapist or style of therapy, and review diagnosis


Review at 12 weeks
Recovered
Not recovered Needs more work
Continue Therapeutic work
Continuation Therapy and Relapse Prevention
Recovered
Review at 6.9.12.18,21,24 months
Not recovered
Recovered
Not recovered
Continue Therapeutic Work
Discuss Case with Team
Review diagnosis
Consider Referral to UHS for severe cases
Reconsider safeguarding issues


Recovered
Not recovered
Continue Therapeutic Work
Nearly or over 18 years and/or near end of Year 13 at school
Discharge from CAMHS
Re-enter pathway if <17.5 years and /or in Year 12 or below
Transition
Discharge to GP and Youth Service for Moderate depression
To Adult CMHT for Severe Depression
To GPand/or Adult CMHT in another town/city in UK

Node	Information	
Urgent Referral	From rapid response call to CAMHS, to see as an emergency in hospital. Use of rapid response proforma (1)	Top
Routine Referral	From GP, Paediatrician, CHOICE, Tier 2 PMHW, discussion with CAMHS GP to focus on DSM IV symptoms from proforma (2), explaining symptoms and timing and could administer Mood and Feelings Questionnaire MFQ (3). Referrer can call the CAMHS duty mobile for advice. GP, Midwife or Family Nurse should refer suspected cases of Pre and Post Natal Depression in Teenage Girls.	Top
Assessment	In multi-professional context (Specialist Partnership) with EWB team discussion and use of risk assessment material (4) and eCPA documentation (5) and any other rating scales or measures below. Need to assess parental mental illness e.g. depression, bipolar disorder, personality disorder. Consideration of involvement of parents in assessment and support (6)NICE 2013.	Top
Assessment	Use of semi-structured interview (2). Eliciting DSM-IV, DSM-V criteria for depression. Suicide, homicide risk assessment (4). Abuse/neglect/exploitation or violence. Use of other rating scales (SDQ, RCADS, BDI,CGAS,CGI,QID-SR16, Young's Mania Rating Scale).	Top
Assessment	Feedback of assessment within two weeks to the MDT, describing context, explanations, formulation and considering whether a psychiatrist should be involved who may then assess and feedback to the next team meeting.	Top
Consideration of Complexity	Include effect of neglect and abuse that would merit involvement with CAF, Social Service, CPS. In other instances Youth Service, Anti-bullying Counsellor, Bereavement counsellor Life Centre. See (7) Kelvin 2011.	Top
Consideration of Co-morbidity	Other diagnoses e.g. OCD, Anxiety Disorders, Psychosis, Substance Misuse/Dependence esp, wrt Alcohol and Cannabis; refer to CRI WSYPSMS Consider physical health especially if emaciated, implying need to rule out eating disorder and diabetes melitus, thyroid disease. Will need to discuss this with psychiatrist.In our practice we have seen organic mood disorder in the context of epilepsy, iron deficiency anaemai and post roaccutance use.	Top
Alternative Pathways	OCD, Psychosis, ADHD, ASD, Physical Health issues requiring referral to GP and /or paediatrician.	Top
Formulation and Statement of Diagnosis and Statement of Suicide Risk and other specific risks.	Putting all the information together through assessments and team discussion. The other specific risks are homicide risk, risk of sexual exploitation especially in teenage girls engaged in truancy or NEET. There will also be consideration of risk of other violent or non-violent offending behaviours. Sometimes the child may have a learning disability or an autistic spectrum disorder and the consideration of risk may involve more data from schools and social services. The multi-disciplinary team/ EWB will decide the level of severity with the psychiatrist.	Top
Not Depression Discharge	Few symptoms without intensity to cause impairment of function at school and in relationships. Alternative explanations could be sought or linked to social or domestic events. There may be some anxiety linked with particular events which are normal.	Top
Mild Depression	This is subsyndromal depression and would not meet threshold for moderate or severe depression in ICD 10/11 or DSM V. Primary Mental Health Workers. School Nurses or School counsellors should be able to help within the school or tier 2 setting. These cases could be dealt with throughout the tier 2.	Top
Moderate Depression	These cases usually seen in CAMHS and allocated to partnership appointments with low priority for CBT,IPT,Family Therapy. Group therapy and on line materials and free apps can be used here.	Top
Severe Depression	These case will involve CAMHS tier 3 and occasionally input for the Urgent Help Service Tier 4. Cases of severe depression will be complicated by psychotic symptoms, higher suicide risk, anxiety, bipolar symptoms, more complex social dynamics esp. if the parents have a mental illness or alcohol or substance dependence. Occasionally a teenage girl will have depression	Top

	after abortion or during pregnancy or post natal depression which we should consider urgently in the context of her network which will include obstetrics, family nurse and often social services.Post natal depression is the number one cause of maternal death in the UK.	
PMHW	Take on cases thought to be of mild depression for therapeutic work. Some of these cases and cases thought to be adjustment reactions or not depression or mood symptoms that are subsyndromal can be discharged out of this care pathway and seen by school counsellor, PMHW, school nurse or other service in tier 2. Most of these cases will be younger children of primary school age. Occasionally children at transition to secondary school who do not have cognitive skills to deal with suicidal thoughts and depressive thoughts and have a difficult transition, especially if they also have an ASD may be prone to suicide attempts. This could happen even in the context of an assessment which concluded mild depression. Usually PMHW take on cases of mild/moderate depression without suicidal thoughts or recent DSH or suicidal acts	Top
CAMHS	The cases of moderate and severe depression are discussed in regular weekly EWB and Bring Back meetings where cases are allocated for Therapeutic Work and/or Care Co-ordinator and/or Psychiatric Assessment.	Top
Urgent Help Service UHS Early Intervention Service EIS	At the weekly meetings we can decide if severe cases needed more intensive input over a short period of time to develop engagement and manage imminent suicide risk in order to create safety and hope for young people. The UHS work closely with CAMHS and the in-patient services and there will be occasions usually after serious suicide attempts when a young person may be at high suicide risk and may require a Mental Health Act assessment. The result of this may be informal or formal admission to hospital. The work of UHS is vital in developing engagement with a young person and their family and network. EIS work closely with CAMHS in supporting assessments for severely depressed teenagers (over age of 14 years) who describe voice hearing and other psychotic/non-psychotic phenomena. EIS liaise with CAMHS on a weekly basis and can offer valuable clinical insight and advice on whether or not a young person should be commenced on anti-psychotic medication, given that the potential side-effects of weight gain and metabolic syndrome will be troublesome to teenage girls and boys.	Top
Therapeutic Work	CAMHS need to offer Psychological Therapy for at least three months in the following modalities : Cognitive Behaviour Therapy CBT, Interpersonal Psychotherapy IPT and short term Family Therapy/Work. In addition to this young people need ongoing assessment and management of suicide risk and other specific risks. There should also be engagement with a young person in promoting behavioural activation and activity scheduling. These processes can be done in conjunction with schools and the youth service in the area. Family involvement in supporting young people with depression is important to recognise and is possible in most, but not all, cases.	Top
Therapeutic Work	Academic references NICE 2005 (8), NICE 2013 (6), ADAPT 2007 (9), ADAPT 2011 (10), TORDIA 2008 (11), TORDIA 2011 (12), TASA 2009 (13) , TADS 2007 (14).	Top
Partnership Sessions	Psychological Therapy. Offer one of CBT, IPT, shorter term FT for 3 months. 20-30% of severe cases of depression will remit after 2-3 appointments (ADAPT 2007,2011) and Goodyer 2007 (15). The first six weeks of work are crucial in developing engagement. About 70% well engaged at 6 weeks will go on to make recovery by 6 months (TORDIA 2011). We cannot afford to leave depressed adolescents on ‘waiting lists’ at all.	Top
Review at 4-6 weeks	Review within 4-6 weeks with MDT, if not sooner. Offer 4-6 sessions and document CPA review plan. Get a sense of progress in the first 4 weeks. Members of UHS and EIS can also be present to discuss cases and offer more support where required.	Top
Progress	Especially according to mental health outcome e.g. SDQ, BDI, MFQ, other rating scales and qualitative feedback form patients and relatives.Is the young person able to set achievable goals each day and show responsibility and motivation in being to follow through and give feedback about their progress?	Top

No progress	Poor engagement, clinical deterioration,more self harm (NSSI), more suicidal behaviours and other risky behaviours that are likely to be life threatening and and occasionally with intent to manipulate health professionals, teachers and police. A young person may actually be too depressed to be motivated enough to engage in therapeutic work and lifestyle improvement.	Top
Joint Assessment with Psychiatrist	Cases can be discussed with a psychiatrists at the EWB meeting where some will be allocated for an assessment by a psychiatrist. This assessment may take the form of a joint assessment with another team member or a meeting to decide whether or not to start medicine sooner (1-12 weeks) or later, after the 3 month review (NICE 2005).	Top
Consideration of Pharmacotherapy	Usually the psychiatrist will prescribe either fluoxetine or sertaline. The patient and family will need explanations of the rationale for prescribing and data regarding the effects and side-effects of medication. Written information or website citations regarding medication can be given. (16,17). Ideally the medication should be monitored every week i.e. very closely in the first 6 weeks. (NICE 2005).Sometimes a psychiatrist may prescribe another anti-depressant or continue citalopram that had been started by a GP, prior to referral to CAMHS. The Trust has produced guidelines on the use of anti-depressant medication (18). A psychiatrist may suggest a prescription of Melatonin or related compound in some instances. It is possible for a psychiatrist to augment anti-depressant medication with antipsychotic medication or consider a diagnosis of bipolar affective disorder. These instances are unusual, and a psychiatrist may discuss these issues with other medical colleagues and consider referring the case to EIS for further assessment and opinion. Antipsychotic drugs and mood stabilising drugs have metabolic side effects e.g. weight gain that are unacceptable for young people, especially young teenage women/girls.There is likely to be a separate pathway for bipolar affective disorder and it is very unusual for a child psychiatrist in our practice to prescribe Lithium or other mood stabilising drugs. We are grateful that GPs will usually continue to prescribe medication after it has been initiated by a Psychiatrist. Shared Care arrangement (19)	Top
Review at 12 weeks	This review is an opportunity to review progress with the young person and their family. If there has been recovery with no evidence of depressive symptoms, the young person can be considered for relapse prevention and continuation therapy. If the there is no recovery then there need to be a discussion to understand where the difficulties have been and to find a new strategy or explore new areas, which might involve a change of therapist, a switch of therapy to family therapy, art therapy or individual psychodynamic psychotherapy. These therapies are precious resources and careful discussion needs to happen in the team prior to allocation for the young person. This is usually considered from 12,24,36,52 weeks of treatment.	Top
Suicide Risk and Self Harm	Decision making at reviews is complicated by the issues of complexity especially if the young person is involved in excessive deliberate self-harm and/or multiple suicide attempts e.g. through overdoses and frequent presentation to A+E with suicidal thoughts or behaviours. These cases may have a history of recovery from Emotional, Physical and Sexual Abuse and it may be very difficult for them to access any help, even from counsellors for trauma/sexual abuse. We have to do what we can to save lives in the short term and make use of a young person's support network to facilitate recovery. In more complex cases the UHS have a vital role in life saving work and helping a young person to stay safe, build hope and engage in a recovery plan.	Top
Teenage Girls	Some girls presenting with depression have suffered abuse and at risk in the community to sexual exploitation and may be very difficult to engage in therapy. More collaborative work can be done with schools and social services in these cases. Also some therapists in CAMHS may be able to develop good therapeutic relationships with them that create safety.	Top
Pregnancy and Post Partum	Identifying these cases is a priority. Many experience depression in the later part of pregnancy and have contact with their GP and the family nurse. We do have a role in assessing and supporting these cases. Usually these mothers	Top

	would prefer to have anti-depressant medication rather than breastfeed after 3 months. Work can be done jointly with the family nurse and discussions around maternal support from the family, maternal nutrition and sleep are crucial. The UHS have offered life saving specialist in-patient admission for at least one case.	
Improvement / Recovery	Evidenced from the young person's report and feedback and the outcomes of various rating scales. The presence of residual features of depression predicts relapse after 6 months.	Top
No improvement / Not recovered	Evidenced from worsening depression and rating scale measure e.g. MFQ and evidence of more self harm and suicidal ideation and behaviours.	Top
Specific Partnership	**CBT 10-12 Sessions** *(link to BRENT 1997) 19* **IPT 12-16 Sessions** *(link to MUFSON 2004) 20* **Brief PP 10-12 Sessions** *(link to 'Reserved for YP whose emotional response to therapeutic encounters is likely to lead to the failure of CBT or IPT')* Input to address functional deficit, if needed.	Top
Reviews should be convened every 3 months up to two years if necessary	This should be done every three months, where difficulties should be considered and alternative explanations for the presentation considered where necessary.	Top
Improvement	No information for this point	Top
No Improvement	Consider augmenting or changing medication. Specialist psychotherapy	Top
Specialist Psychotherapy	Child psychotherapy, systemic family therapy **Child Psychotherapy 30 Sessions** *(link to TROWELL et. al 2007, (21) GOODYER et al 2011, MIDGLEY et al 2013) (22,23)* **FT 15 Sessions** *(link to WILKINSON et al 2010) (24)*	Top
Improvement	No information for this point	Top
No Improvement	No information for this point	Top
Discharge	This is negotiated with the young person and their family. If there is a subsequent relapse then the young person can be referred back into the service and seen promptly within a week as a long term service user.	Top
		Top
Continue Reviews	Consideration to be given at this point to transition. Continue with reviews for 6 months and feedback from patient e.g outcome measures and rating scale such as SDQ	Top
End of Therapy Assessment	Assessment of residual symptoms, which predict relapse. If there is no evidence of residual symptoms of depression then the young person can be considered for discharge.	Top
Stop Medication	Gradual process over weeks/months at the discretion of the psychiatrist in consultation with the young person. The psychiatrist could also set up a review or organise surveillance for the young person after 3 months from the point of cessation of medication.	Top
Continuation of Therapy	For example, Mindfulness groups & Youth Service involvement. Research from, USA 2011(25), highlights the value of Continuation Therapy in the form of extra sessions of CBT or group work to help the young person consolidated their recovery. Mindfulness Groups for young people. e.g. which run in Brighton are believed to be beneficial for young people.	Top
Review at 3-6 Months	Following end of all therapy and MDT discussion. Include SDQ and outcome measures	Top
Improvement	No information for this point	Top
No Improvement at <18yrs	No information for this point	Top

No Improvement at 18yrs	Some of these case will have severe symptoms of depression with recurrent suicide attempts and emotional intensity. The diagnosis of personality disorder can be viewed as controversial by many in CAMHS but may have a role in providing clarity to the care plan and in facilitating handover to the adult service. However the diagnosis of personality disorder is stigmatising and may actually be harmful to a young person and possibly lead to their greater dependency on mental health service for the answer/solution.	Top
Transition	The transition protocol (26) could be followed. More severe cases will have a care coordinator who would be a position to facilitate the transfer of care.	Top
Re-enter Pathway	No information for this point	Top
Discharge to GP and Youth Service	No information for this point	Top
Transition of Severe Cases to Local Adult Services	No information for this point	Top
Transition to GP and WAMHS in another town/ city	Most young people in our service leave to go to University where some planning for transition has to begin in the August after they get their A Level results and confirmation of University place.	Top