The Matrix Evidence Tables
Children & Young People

The Scottish Government
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Evidence Tables – Children and Young People (Last updated 2015)
## Recommendations Key

<table>
<thead>
<tr>
<th>Matrix: Level of Evidence</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least one meta-analysis/systematic review with medium-large effect sizes; or more than one RCT of high quality and consistency, aimed at target population, showing medium-large effect sizes</td>
<td>A Highly Recommended</td>
</tr>
<tr>
<td>One RCT with medium-large effect size; or meta-analysis/systematic review or multiple RCTs showing small-moderate effect sizes, and demonstrating overall consistency of results</td>
<td>B Recommended</td>
</tr>
<tr>
<td>One RCT with small effect size and/or multiple non-RCT studies with small effect sizes. There may be inconsistency in findings across studies but a general trend towards a positive effect should be noted</td>
<td>C Limited/developing evidence to date, no indication against use</td>
</tr>
<tr>
<td>Findings with an effect size close to zero, or no systematic empirical evidence</td>
<td>/ No recommendation is possible at this time</td>
</tr>
<tr>
<td>Findings suggest a harmful effect is possible</td>
<td>NR A recommendation is made against using this intervention</td>
</tr>
</tbody>
</table>

## Methodology

The Matrix summarises the best available evidence for clinical practice in Child and Adolescent Mental Health. It is less rigorous than the National Institute for Care and Health Excellence (NICE) or the Scottish Intercollegiate Guideline Network (SIGN), but attempts to include all
research that is least susceptible to bias according to the Cochrane Collaborative, NICE and the Medical Research Council (MRC). Where possible, appraised evidence is limited to systematic reviews, meta-analyses, evidence based clinical practice guidelines, health technology assessments and randomised controlled trials (RCTs). Where not available, poorer quality evidence may be considered. Evidence summaries should be read with this in mind. Assessments of the overall evidence base for each area are considered within the framework of the MRC guidance for developing and evaluating complex interventions:

www.mrc.ac.uk/complexinterventionsguidance

Each chapter has been updated from the 2011 edition using a standardised search strategy (see figure 1). The search has been audited, and the revisions have been reviewed by academics and/or clinicians with expertise in the area.
Figure 1: Methodology

- Guideline (NICE, SIGN) since 2011
  - If Present Meta-analysis/Sys Review (inc. Cochrane) since guideline
    - If Present RCT since meta-analysis/sys review publication
  - If Absent Meta-analysis/Sys Review (inc. Cochrane) since 2011
    - If Present RCT since meta-analysis/sys review publication
    - If Absent RCT since guideline publication
    - If Absent RCT since 2011
Early Intervention, Infant Mental Health Risks & Disorders

Evidence of the long-term effects of very early experience and of the cost effectiveness of early intervention is growing. Early intervention is consequently a priority in several Scottish Government targets.

The National Scientific Council on the Developing Child\textsuperscript{26,27} clearly outlines the case for intervening before emotional or behavioural issues find expression as frank problems. In addition, its publications cogently argue that increased short-term expense can greatly reduce the potential financial costs incurred later down the line. For example, economic analyses suggest that the costs of early intervention may be paid back within 4 years, as the need for further services is reduced over the longer term\textsuperscript{29,31}. Translating this into a Scottish context, it is known that maintaining secure care for an adolescent costs more than £200,000 a year\textsuperscript{50}. This and other costs such as the long-term economic impact of untreated conduct disorder\textsuperscript{36}, far exceed the financial cost of implementing early interventions which can assist young children to grow into happy and healthy adults. While the most impressive evidence base for early interventions is found in interventions with slightly older children, infant mental health represents an increasingly promising area of preventive value.

The focus within the infant mental health field is primarily on the relationships that scaffold the infant’s development. NICE guidelines suggest that group based parent-training programmes focusing on promoting attachment and parenting skills should be available to all parents willing to access them\textsuperscript{25}. This relationship approach to assessment and treatment is a recent development and challenges remain in developing new methodologies to determine short and longer-term effects. Nonetheless, the evidence base for effective infant mental health interventions is emerging. This progress has been supported by an increase in research confirming the exceptional significance of the very earliest life experiences for future development. To date, there is limited evidence from UK studies, with the main body of evidence deriving from the US\textsuperscript{24}.

Interventions such as the Family Nurse Partnership\textsuperscript{28,29} aim to enhance parenting in order to prevent the associated long-term sequelae of infant exposure to unresponsive, coercive or intrusive parenting styles. A review of group based interventions reported mild significant effects in improving the emotional and behavioural adjustment of children under\textsuperscript{32}. Parenting programmes such as Triple P\textsuperscript{34} and the Incredible Years\textsuperscript{43},
both of which have been demonstrated to strengthen parent-child relationships from the pre-school period onwards, are now experimenting with extending their models downwards to the infant age group. Evidence for the effectiveness of these programmes in this context is limited at present, but a meta-analysis suggests benefits are limited to at-risk infants and that such interventions should be carefully targeted\(^1\). Further evidence for the Mellow Babies\(^32\) intervention is in development; independent randomised controlled trials are currently being carried out in Scotland and Northern Ireland to test Mellow Babies for mothers and fathers as well as Mellow Bumps (antenatal programme). Regarding specific components, those consistently associated with larger effects include increasing positive parent-child interactions, the importance of parenting consistency, and requiring parents to practise new skills with their children during parent training sessions\(^17\). Home visiting interventions achieve, across several trials, a very mild positive effect that may not translate into cost-effective practice.
### Early intervention, infant mental health & risk disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individual Interventions</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>2-4</td>
<td>High</td>
<td>Video Interactive Guidance</td>
<td>A 1,2,16,40,41,42</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Family Nurse Partnership (inc. home visiting)</td>
<td>B 28,30</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Attachment and Bio-behavioural Catch-up</td>
<td>B 3,8</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Watch Wait Wonder</td>
<td>B 6,7</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Group Interventions</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>2-4</td>
<td>High</td>
<td>Incredible Years</td>
<td>A 11,13,15</td>
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<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Circle of Security</td>
<td>C 4,21</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Interventions for maltreated infants</td>
<td></td>
</tr>
<tr>
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<td>Infant Parent Psychotherapy</td>
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<td></td>
<td></td>
<td>Interventions for very low birth weight/pre-term infants</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>2-4</td>
<td>High</td>
<td>Infant Behavioural Assessment and Intervention Programme</td>
<td>B 14,18,19,23</td>
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<td></td>
<td></td>
<td></td>
<td>Home visiting</td>
<td>B 11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interventions for very low birth weight/pre-term infants</td>
<td></td>
</tr>
<tr>
<td>Level of Severity</td>
<td>Service Tier</td>
<td>Intensity of Intervention</td>
<td>Type of Intervention</td>
<td>Recommendation</td>
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<tr>
<td>-------------------</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>infants</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>2/3</td>
<td>High</td>
<td>Home visiting with video interaction (inc. modelling, cognitive restructuring and infant massage)</td>
<td>B(^9,39)</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Mellow Babies</td>
<td>C(^31,32)</td>
</tr>
</tbody>
</table>
Children’s Attachment: Attachment in Children and Young People who are Adopted From Care, In Care or at High Risk of Going Into Care

The scope of this chapter is limited to children and young people (aged 0–18 years) who are adopted, looked after children, and children at high risk of being taken into care.

Of the 67,000 children and young people in care in the UK in 2012, 75% were in foster care, 4% were placed for adoption, 5% were in placements with their parents, 9% were in secure units, children’s homes and hostels, and 1% were in a residential school. Two-thirds had been subject to a single placement in the preceding year, 22% had 2 placements and 11% had 3 or more. In Scotland, during 2013, 16,248 children, accounting for 2% of children in Scotland, were looked after by local authorities or on the child protection register. Of these, 57% lived with relatives (of which 31% living at home), 32% placed with foster carers, 2% with prospective adopters, 0.5% at secure units, 5% in residential care homes and 3% at residential schools. Looked after children are considered to be at greater risk than the general population of developing attachment difficulties, as a result of repeated changes of primary caregiver and separation. It is estimated that only 10% are securely attached to their biological parents.

Therapeutic interventions target insecure or disorganised attachment or aim at the prevention of insecure or disorganised attachment through focus on key components of attachment: sensitivity, warmth and consistency. It is important to note that interventions that are based on attachment theory (e.g. Attachment and Bio-behavioural Catch-up – ABC) are included, even if the study did not measure changes in attachment status per se. As the child’s attachment status is not likely to change during the course of an intervention, due to the limited time scope of the latter, various studies measure behavioural or emotional difficulties rather than attachment style per se. Overall, research on the effectiveness of attachment-based interventions for looked-after or adopted children is limited in both quantity and quality, limiting conclusive recommendations. Various additional interventions were identified (e.g. narrative therapy, theraplay, animal assisted therapy), however the evidence base has not yet been developed to recommendation standards. Therefore, these interventions were not included. A Cochrane review on Cognitive...
Behavioural or Behavioural training interventions for foster carers concludes that to date, it is difficult to offer practice guidelines due to the lack of evidence and therefore the need for further research is emphasised. The identified studies show that such interventions appear to have very little effect on child psychological functioning, interpersonal functioning and behavioural problems. Parenting interventions employing video interactive guidance (VIG or VIPP) currently have the best evidence base with young children. Dyadic Developmental Psychotherapy in a single small non-randomised trial showed significant improvements across all measures. Further evidence is needed to support this popular intervention.

Finally, caution should be exercised regarding interventions that include physical techniques (for example holding therapy) that have resulted in a number of deaths in the past. Interventions that include coercion, “re-birthing techniques” and holding therapy should not be used.
# Children’s Attachment

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td><strong>Children at Risk</strong></td>
<td></td>
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</tr>
<tr>
<td>Prevention</td>
<td>3</td>
<td>High</td>
<td>Video-Interactive Guidance</td>
<td>B(^{19}) /</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Child-Parent Psychotherapy (CPP)</td>
<td>B(^{11,34})  /</td>
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<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Attachment and Bio-behavioural Catch-up</td>
<td>B(^{13,14,15,23,25,32}) /</td>
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<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Circle of Security</td>
<td>C(^{34}) /</td>
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<tr>
<td><strong>Fostered children</strong></td>
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</tr>
<tr>
<td>Subclinical/mild</td>
<td>2</td>
<td>Low</td>
<td>CBT based programmes (e.g. Fostering Change)</td>
<td>C(^{8,28}) /</td>
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<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Multidimensional Treatment Foster Care Program- Preschool</td>
<td>C(^{16,17,18}) /</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Parenting programmes (e.g. Incredible Years)</td>
<td>C(^{9}) /</td>
</tr>
<tr>
<td><strong>Moderate/Severe</strong></td>
<td>2</td>
<td>Low</td>
<td>Group Parenting CBT based interventions</td>
<td>C(^{35}) / C(^{35})</td>
</tr>
<tr>
<td>Level of Severity</td>
<td>Service Tier</td>
<td>Intensity of Intervention</td>
<td>Type of Intervention</td>
<td>Recommendation</td>
</tr>
<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Children at Risk</td>
<td></td>
<td></td>
<td></td>
<td>Child</td>
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<td>Adopted Children</td>
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<td>Adolescent</td>
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<td>Parent training interventions using video feedback</td>
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</tr>
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<td></td>
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<td>/</td>
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<tr>
<td>Mild/ Subclinical</td>
<td>3</td>
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<td>Child Parent Relationship Therapy (CPRT)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>/</td>
</tr>
<tr>
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<td>High</td>
<td>Parent–Child Interaction Therapy (PCIT)</td>
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<td>3</td>
<td>High</td>
<td>Fostering Attachments</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>/</td>
</tr>
<tr>
<td>Moderate/ Severe</td>
<td>3</td>
<td>High</td>
<td>Treatment Foster Care</td>
<td>C26</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>C26</td>
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</table>
Autism Spectrum Disorders

The term, autism spectrum disorders, (ASD) is used to describe the complex neurodevelopmental disorders of childhood autism, atypical autism, Asperger’s syndrome and pervasive developmental disorder included in ICD-10. ASD may occur in association with any level of general intellectual/learning ability and manifestations range from subtle problems of understanding and impaired social function to severe disabilities.

Previously published figures suggest a median ASD prevalence rate of 62 per 10,000 globally with prevalence rates ranging from as low as 30 to as high as 116 per 10,000 individuals\textsuperscript{9}. The wide range of prevalence rates may be in part attributable to differences in methodological considerations, such as diagnostic concept, service ability and clinician awareness. UK prevalence figures indicate the overall ASD prevalence rate of between 70.3 per 10,000 in pre-school children\textsuperscript{25,21} and 116.1/10,000 in 9-10 year olds with approximately half having an IQ >701. A more recent UK based study examining ASD prevalence using the Special Educational Needs (SEN) register and parent surveying methods of children aged 5-92. The prevalence estimates generated from the SEN register and diagnosis survey were 94 per 10,000 and 99 per 10,000 respectively. The ratio of known:unknown cases was 3:2 and taken together they estimated the total prevalence to be 157 per 10,000, including previously undiagnosed cases.

The SIGN guideline focused on clinical interventions for children and young people with ASD, but emphasised their entitlement to additional support if needed to benefit from their education, and to have positive wider life experiences. The current NICE (2013) autism guidelines aimed at children and young people recommend interventions geared towards life skills and social communication as well as parent/carer mediated interventions\textsuperscript{22}. It has been recognised that parents, educationalists, health professionals, social workers and the voluntary sector may use individualised interventions to optimise a child’s functioning, either by promoting development of skills, or by adapting the environment to compensate when skills are not present. Further, interventions incorporating the school environment are now becoming more prevalent, and research suggests accommodating schools into child and adolescent interventions may be efficacious\textsuperscript{15,31}.
SIGN recommends that other common difficulties including mental health problems (particularly anxiety and attention deficit disorders common to childhood, and depression which tends to emerge later in childhood), sleep disorders and other neurodevelopmental problems such as tics, should not be assumed to be part of ASD but should be appropriately assessed and managed with reference to other clinical guidelines as relevant. Although approaches to intervention are described here within a categorical system, it is important to note that a variety of aims may be represented within each category. The benefits of an intervention must be considered in light of its aim, for example, different approaches to parent training may aim to improve aspects of parental wellbeing, while others focus on developing parent-child interactions or achieving improvements in the child’s own condition. Specifically, the current NICE guidelines recommend group or individual CBT for diagnoses of autism and anxiety to alleviate relevant symptoms\(^{25}\). Further, technology-based and drama-based music-based interventions are emerging as possibly effective treatment options; however more evidence is still required providing consistent, positive results\(^{5,10,12}\).
## Autism Spectrum Disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild-Severe</td>
<td>2</td>
<td>Low</td>
<td>School-based Behavioural interventions</td>
<td>A&lt;sup&gt;6,13&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Peer Mediation for school-aged youth</td>
<td>A&lt;sup&gt;22,38,43,48&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>2/3</td>
<td>Low/High</td>
<td>Social communication and interaction interventions</td>
<td>A&lt;sup&gt;17,18,20,22,23,32,37,42,46&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low/High</td>
<td>Behavioural interventions (including ABA) for specific behaviours e.g. self injury, sleep to reduce symptom frequency and severity and to increase development of adaptive skills e.g. social skills, daily living skills, life skills.</td>
<td>A&lt;sup&gt;6,13,14,18,19,22,27,44&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Modified Individual- or Group-based CBT for autism and anxiety</td>
<td>A&lt;sup&gt;22,29,41,45&lt;/sup&gt;</td>
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<td>2-4</td>
<td>High</td>
<td>Sensory Integration Therapy</td>
<td>A&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>2-4</td>
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<tr>
<td></td>
<td>2/3</td>
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<td>Communication supports</td>
<td>B&lt;sup&gt;9,34,47&lt;/sup&gt;</td>
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<td>2-4</td>
<td>Low/High</td>
<td>Parent or Carer mediated intervention</td>
<td>B&lt;sup&gt;3,7,11,16,20,22,24,30,33,35,36,44&lt;/sup&gt;</td>
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<td></td>
<td>2/3</td>
<td>Low</td>
<td>Parent education</td>
<td>B&lt;sup&gt;39,40&lt;/sup&gt;</td>
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<tr>
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<td>2/3</td>
<td>Low/High</td>
<td>Music Therapy</td>
<td>B&lt;sup&gt;10&lt;/sup&gt;</td>
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<tr>
<td>Level of Severity</td>
<td>Service Tier</td>
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<td>Type of Intervention</td>
<td>Recommendation</td>
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</tr>
<tr>
<td>2-4</td>
<td>High</td>
<td>Mindfulness-based approaches</td>
<td></td>
<td>C^{15,31}</td>
</tr>
</tbody>
</table>
Disruptive Behaviour and Conduct Disorders

Both of these vary widely in their presentation with high levels of co-morbidity. It is therefore vital that interventions target a broad population of individuals. This needs to include those who fall within the clinical range of diagnosis, as well as those who do not, but whose behaviours place them at serious risk for later maladjustment.

Oppositional problems occur in 2.6-15.6 % of non-clinical samples\(^1^2\). The 2013 NICE Guideline estimated the prevalence of conduct disorders in children between the ages of 5 and 10 years to be 7% for boys and 3% for girls, and in older children (11-16 years of age), the prevalence of diagnosed conduct disorders is slightly higher, at 8% for boys and 5% for girls\(^2^2\).

Early onset conduct disorders represent the main reason for referral to CAMHS\(^2^4\). Untreated, prognosis is poor, reinforcing the importance of early effective treatment and preventive approaches. This is especially so as the most powerful early interventions alter the maladaptive developmental trajectory of ODD/CD which so readily escalates into academic problems, school exclusion, substance abuse, delinquency and violence, and ultimately into a range of high cost psychiatric disturbances including antisocial personality disorders in adulthood\(^1^9,^3^4\). Early intervention is also important as the literature suggests that early starter aggressive tendencies in children may crystallise around age eight and thereafter become less amenable to change\(^3\).

Conduct disorders have a significant and detrimental impact on the quality of life of both the child and their family or carer(s). Caught early enough, they are however very treatable\(^2^3\), with significant gains benefiting not only individual children, but also improving maternal mental health and representing significant cost savings for the taxpayer\(^1^5,^2^7,^3^5\).

Social learning theory-based group-based parenting is the treatment of choice for young children\(^2^1,^3^7,^2^2\). With increasing age, multi-modal approaches, especially those incorporating cognitive problem-solving and social skills training become progressively required, such as multi-systemic therapy\(^3^4\). By adolescence complex, multi-faceted and far more expensive interventions are required\(^2^9,^4\).
### Disruptive Behaviour and Conduct Disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3-6 years</td>
</tr>
<tr>
<td>Mild</td>
<td>2/3</td>
<td>Low</td>
<td>Group or individual Social Learning Theory-based Parent, Guardian or Foster Carer Management training</td>
<td>A&lt;sup&gt;5,9,11,14,16,20,22,30,32&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>2/3</td>
<td>High</td>
<td>Group or individual Social Learning Theory-based Parent Management Training</td>
<td>B&lt;sup&gt;5,9,11,14,20,22,30,32&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Problem Solving Skills Treatment (PSST) (more effective when integrated with Parent Training Programme)</td>
<td>B&lt;sup&gt;33&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Anger Coping Therapy</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>/</td>
</tr>
<tr>
<td>Severe</td>
<td>3/4</td>
<td>High</td>
<td>Multi-Systemic Therapy</td>
<td>A&lt;sup&gt;31&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Social Learning Theory-based Parent Management Training</td>
<td>A&lt;sup&gt;5,9,11,14,16,20,22,30,32&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Functional-Family Therapy</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Multi-Systemic Therapy</td>
<td>A&lt;sup&gt;31&lt;/sup&gt;</td>
</tr>
<tr>
<td>Level of Severity</td>
<td>Service Tier</td>
<td>Intensity of Intervention</td>
<td>Type of Intervention</td>
<td>Recommendation</td>
</tr>
<tr>
<td>-------------------</td>
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<td>-----------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Therapeutic Foster Care</td>
<td>/</td>
<td>C&lt;sup&gt;6,7,8,10&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Social Learning Theory-based multimodal intervention</td>
<td>/</td>
<td>A&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Child focused group Social and Cognitive Problem Solving Programs</td>
<td>/</td>
<td>B&lt;sup&gt;34&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Psychodynamic Psychotherapy</td>
<td>/</td>
<td>B&lt;sup&gt;36&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Webster-Stratton, 1998<sup>30</sup>.
Anxiety Disorders (inc. Panic Disorder)

Anxiety disorders represent a group of diagnoses including generalized anxiety disorder, panic disorder, separation anxiety, obsessive-compulsive disorder (OCD), phobias, post-traumatic stress disorder (PTSD), social anxiety and panic disorder.

As such, anxiety disorders are among the most common presentations in children and adolescents with prevalence estimated at 12% per year, and cross-sectional surveys using structured assessment techniques have found prevalence to range between 4 and 16% at any one point in time. Over the course of childhood approximately 10-11% of all children and young people experience anxiety disorders.

Anxiety disorders in children and young people, while common, are very likely to be under-recognised and under-treated. In a sample of 8 to 17 year olds, 72% of those with an anxiety disorder that was causing impairment did not receive any treatment, and in this respect fair worse than children with behavioural problems or those with depression. Amongst those who are recognised, cognitive behavioural therapy (CBT) is the treatment of choice, with an approximately 50-60% success rate. This relatively modest success rate has led researchers to focus on both the mode of delivery and relevant mediating factors in treatment success. In particular, group and individual treatment delivery to children only, parents only, and to both have been compared, with inconsistent findings. Some studies have found that, where parental anxiety is present, family CBT (FCBT) is more effective than individual CBT. An RCT of parenting group-based treatment for anxiety in young children (9 years and under) demonstrated good results for both children's anxiety and parental and family functioning. Additionally, 2 RCTs support parent training followed by parent-delivered CBT, with therapist support (by telephone) in school aged children with anxiety. One suggestion is that where parental involvement is used as an additive to child-oriented interventions, care should be taken to avoid over-complicating key messages. Finally, recent studies indicate that the addition of booster sessions in CBT is beneficial in sustaining treatment effects.

Panic disorders

Panic disorder with/without agoraphobia is considered to be a rare condition before puberty. Some argue that the reason for this trend is that children might not have the cognitive capacity to experience catastrophic attributions of dying, losing control, or going crazy when experiencing
bodily symptoms of panic, therefore do not meet the criteria of a diagnosis\textsuperscript{50}.

Estimates of panic disorder in adolescence vary between 0.5\% and 3.3\% with the disorder being more common among girls\textsuperscript{14,15,20,35}. It is reported that up to 90\% of children and adolescents with Panic disorder have comorbid anxiety and/or depressive disorders\textsuperscript{48}. Panic disorder is considered to emerge in adolescence and continue to increase in the transition to adulthood, while for most cases the age of onset is likely to fall between 15 and 19 years\textsuperscript{15}.

Cognitive behavioural therapy appears to be the most effective treatment for panic disorder in adults\textsuperscript{48}. PCT (Panic Control Treatment) is a cognitive behavioural therapy for panic disorder that has been found effective in adults\textsuperscript{3} adapted PCT for use with adolescents (PCT-A)\textsuperscript{28}. The treatment consists of 11 sessions of individual CBT, including: psychoeducation, breathing retraining, cognitive restructuring, interoceptive exposure and hypotheses testing. Psychoeducation and cognitive restructuring were found to lead to sudden treatment improvements in a study examining effective components of treatment\textsuperscript{44}, however the results are preliminary. Recently, an intensive treatment version of PCT-A has been developed, which consists of 6 sessions of delivery\textsuperscript{1}. Research in panic disorders in childhood and adolescence is scarce. To date, there is one small scale randomised controlled trial examining the effectiveness of PCT-A in adolescence, which reported positive outcomes\textsuperscript{54}. Additionally, another study examined a case series, which found improvements in anxiety sensitivity, trait anxiety, fear, and depression\textsuperscript{52}. PCT-A appears to be a promising treatment, however the evidence base is still limited.

For the 2014 update, studies containing data exclusively on panic disorder were documented separately within the anxiety disorders matrix. Social anxiety (social phobia) is considered in a separate matrix. Studies examining these disorders as part of a variety of anxiety disorders (GAD, SAD, SP) were included. Studies including OCD or PTSD are addressed in separate matrices.
## Anxiety Disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child</td>
</tr>
<tr>
<td>Mild</td>
<td>1/2</td>
<td>Low</td>
<td>School-based prevention and early intervention programmes (e.g. FRIENDS for Life)</td>
<td>A&lt;sup&gt;6,8,13,17,21,22,23,37,39,41,45,50,56,61&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>Low</td>
<td>Bibliotherapy based on CBT principles</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>Low</td>
<td>Computerised CBT</td>
<td>C&lt;sup&gt;42&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3/4</td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy without Parental/Family Involvement</td>
<td>A&lt;sup&gt;2,7,8,21,24,30,32,33,38,55,56,63&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy with Parental/Family Involvement</td>
<td>A&lt;sup&gt;5,8,21,30,33&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Group Cognitive Behavioural Therapy without Parental/Family Involvement</td>
<td>A&lt;sup&gt;21,29,30,31,36,55&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Group Cognitive Behavioural Therapy with Parental/Family Involvement</td>
<td>A&lt;sup&gt;4,21,30,31,43,57,58&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Booster Sessions in CBT</td>
<td>A&lt;sup&gt;26&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>CBT based parenting programme</td>
<td>A&lt;sup&gt;12,51&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Attention Bias Modification</td>
<td>B&lt;sup&gt;40&lt;/sup&gt;</td>
</tr>
<tr>
<td>Level</td>
<td>Treatment Description</td>
<td>Evidence</td>
<td>Rating</td>
<td></td>
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<tr>
<td>-------</td>
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<td></td>
</tr>
<tr>
<td>3/4 High</td>
<td>Clinician-assisted Computerised CBT</td>
<td>B$^{34,37}$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/4 Low</td>
<td>Computerised CBT for parents of preschool children, with therapist (online &amp; telephone) support</td>
<td>C$^16$</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>3/4 High</td>
<td>From Timid to Tiger parenting intervention for preschool children</td>
<td>C$^10$</td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>3/4 High</td>
<td>Panic Control Treatment (PCT-A) for panic disorder</td>
<td>/</td>
<td>C$^5,16,18$</td>
<td></td>
</tr>
</tbody>
</table>

* Extrapolated from adult populations.
Anxiety Disorders: Obsessive Compulsive Disorder

Estimates of prevalence vary from 0.25% to 4%\textsuperscript{9,4,5,16}, with peak onset in the early school years (when boys present more frequently) and again in early adolescence (when girls are more likely to present)\textsuperscript{5}.

OCD is both under-recognised and under-treated\textsuperscript{5} with clear clinical evidence that it is often associated with significant disruption and impairment in family, social and academic life and can have adverse impacts on psychosocial development\textsuperscript{15}. Cognitive Behavioural therapy (CBT) is strongly supported by literature as the first-line therapy choice for both children and adolescents diagnosed with Obsessive Compulsive Disorder. In pilot studies, Internet and webcam based CBT programmes have shown effectiveness in child and adolescent populations. However, these treatment options require further evaluation to establish an evidence-base\textsuperscript{3, 7, 19}.
# Obsessive Compulsive Disorder

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>3</td>
<td>Moderate</td>
<td>Therapist-guided Behavioural Therapy, self-help CBT, or therapist-guided CBT</td>
<td>B 7, 13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>B 7, 13</td>
</tr>
<tr>
<td>Moderate-Severe</td>
<td>3/4</td>
<td>High</td>
<td>Behavioural Therapy or CBT in combination with medication (SSRI specifically) (better than medication alone)</td>
<td>A 1, 2, 4, 11, 13, 14</td>
</tr>
<tr>
<td>(CY-BOCS &gt;1611)</td>
<td></td>
<td></td>
<td>12-20 sessions therapist-guided CBT incorporating Exposure and Response Prevention (ERP). Augmented with:</td>
<td>A 1, 2, 7, 9, 10, 12, 14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychoeducation and Anxiety Management</td>
<td>A 1, 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive Therapy</td>
<td>A 1, 2, 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Family Sessions</td>
<td>A 1, 2, 10, 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Family-based or -enhanced CBT</td>
<td>A 7, 8, 18</td>
</tr>
</tbody>
</table>
Anxiety Disorders: Social Anxiety Disorder/Social Phobia

Estimates of Social Anxiety Disorder or Social Phobia prevalence range from 0.5% to 4% of adolescents\(^8, 9, 15, 27\).

It is associated with an increased risk for depression and suicide and will impact adversely on outcomes for people with comorbid mental health problems such as bipolar disorder and eating disorders\(^27\). There is an overlap between social anxiety and school refusing behaviour, although proper assessment has found that this relationship is not as strong as originally thought\(^16\) with social anxiety appearing more often as a consequence of non-attendance at school.

Cognitive behavioural therapy (CBT) has the best evidence-base with success rates consistently found in approximately 50% of cases. Of particular significance for young people with social anxiety disorder, early intervention is paramount with chronicity quickly becoming established, significantly reducing the likelihood of a positive outcome. Therefore, early intervention should be prioritised, and in all cases, responsible adults should be alerted to the importance of maintaining social contact through activities of daily living.
### Social anxiety disorder/social phobia

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>1/2</td>
<td>Low</td>
<td>Skills for Social and Academic Success (SASS) (Group CBT with social skills elements)</td>
<td>Child A, B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>Low</td>
<td>FRIENDS prevention and early intervention programme</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>2/3</td>
<td>Low</td>
<td>Computer-Assisted CBT (7+)</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Supported Self-Guided CBT (15+ who have the cognitive and emotional capacity to undertake a treatment developed for adults)</td>
<td>/</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Group Cognitive Behavioural Therapy (CGBT) with or without Parental/Family Involvement (7+)*</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Social Effectiveness Training for Children and Adolescents (SET– C) **</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy with/without Parental/Family Involvement (7+)*</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Social Skills Training (SST) ***</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
<td>C</td>
</tr>
</tbody>
</table>
### Evidence Tables – Children and Young People (Last updated 2015)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>1 - 4</td>
<td>High</td>
<td>Short-Term Psychodynamic Psychotherapy (15+ who have the cognitive and emotional capacity to undertake a treatment developed for adults)</td>
<td>/</td>
</tr>
</tbody>
</table>

| Mild/Moderate/Severe | 1 - 4        | Interventions NOT recommended: | Do not routinely offer pharmacological interventions Do not routinely offer mindfulness-based interventions, or supportive therapy to treat social anxiety disorder. | NR²⁴ | NR²⁴ |

*Both individual CBT and GCBT may include psycho-education and skills training for parents, particularly of young children, to promote and reinforce the child’s exposure to feared or avoided social situations and development of skills.*²³

** Including social skills training, peer generalisation sessions and individualised in vivo exposure.

*** An integrated cognitive behavioural group intervention consisting of social skills training, graded exposure and cognitive restructuring.
Anxiety Disorders: Specific Phobia

Specific phobia is one of the earlier anxiety disorders to appear developmentally, and includes all phobias specified to a single phenomenon, and excludes social phobia which typically presents as more generalised.

The developmentally normal appearance of specific fears at certain stages in childhood provides information about the typical onset of specific phobia, with animal and environmental (natural disasters, weather etc.) phobias most often triggered during toddlerhood (2-3 years) and other specific phobias during primary school years\textsuperscript{1}. Animal and environmental phobias are the most common subtypes of specific phobia in children\textsuperscript{33}. Prevalence is estimated at 2.3-9.2\%\textsuperscript{12,33}. Comorbidity is high, with almost half (47.2\%) experiencing an additional anxiety disorder, a third with depression (36.1\%) and a third (33.3\%) with somatoform disorders. Comorbid substance use disorders are less commonly seen (8.3\%)\textsuperscript{8}. Specific phobias have been found in 17-42\% of children with a primary anxiety disorder diagnosis. Among children seeking treatment for anxiety disorders, specific phobias appear in 42-75\% of cases\textsuperscript{15,31,35,38}.

Treatment for phobias in children and young people is more likely to be successful in children under 11 years old\textsuperscript{10,23}. The involvement of parents appears to confer a mild non-significant benefit in the short-term\textsuperscript{4,11} with one study finding a significant benefit appearing at three-year follow-up\textsuperscript{5}.

One Session Treatment (OST)\textsuperscript{32}, an intervention consisting of participant modelling and systematic in vivo desensitisation is the most evidence-based effective treatment. OST is a variation of cognitive behavioural therapy, with the difference of massed instead of spaced exposure\textsuperscript{29}. Two trials investigating the added benefit of EMDR to OST found no improvement in outcomes. Spaced over massed exposure might be preferable, in that One Session Treatment (OST), an intervention consisting of participant modelling and systematic in vivo desensitisation is the most evidence-based effective treatment.

For the purposes of this classification, research on OST has been categorised under Participant Modelling, rather than under Systematic Desensitisation or CBT.
### Specific Phobia

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>2/3</td>
<td>High</td>
<td>Behavioural: Participant Modelling (including OST)</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2,6,17,18,26,28,29,30,31,36,37,43</td>
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<td></td>
<td></td>
<td>Behavioural: Reinforced Practice</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>6,16,20,22,27,28</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Systematic Desensitisation (in vivo desensitisation more effective for younger children)</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,7,14,19,20,23,28,39,40,41,42</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5,9,17,21,28,34,38,40</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Emotive Imagery (pairing frightening situations with an exciting story involving a hero-figure)</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,13,37</td>
</tr>
</tbody>
</table>
Attention Deficit Hyperactivity Disorder (ADHD)

ADHD and hyperkinetic disorder (HKD) are commonly diagnosed behavioural disorders in children and young people and are associated with myriad poor outcomes.

The core symptoms of ADHD and HKD have a significant impact on the child’s development, including social, emotional and cognitive functioning and they are responsible for considerable morbidity and dysfunction for the child or young person, their peer group and their family. The secondary effects of ADHD and HKD can be extremely damaging. Affected children are often exposed to years of negative feedback about their behaviour and suffer educational and social disadvantage. It is estimated that up to two thirds of children affected by hyperactivity disorders continue to have problems into adulthood” (p.1)\(^{17}\).

Prevalence rates for ADHD vary across epidemiological studies and in different countries. Much of this variation is attributable to differences in diagnostic criteria\(^{1,22}\) and not necessarily to geographical differences. The point prevalence of the more severe form HKD is widely accepted as approximately 1.5% within the UK’s school-aged population (4-16) with attention deficit hyperactivity disorder having an estimated prevalence rate of at least 5% for the same population group. However, a national study by NHS-QIS\(^{15}\) found significant under recognition of the disorder, approximately 0.6% of Scottish school children had a diagnosis of ADHD/HKD.

Recent research supports NICE and SIGN guidelines recommending parent behavioural training, child behavioural treatment and school interventions. The majority of evidence suggests that parent behavioural training (PBT) is an effective and well-established treatment\(^{2,4,6,9,11,18}\). However, clarity is still needed regarding the mechanisms of change, for whom treatments work and how outcomes can be enhanced\(^{6}\). An earlier Cochrane Review found that evidence for PBT was limited and hence could not be used as basis for guidelines of treatment of ADHD in clinics or schools\(^{23}\). The SIGN guideline (2009) states that for children aged less than 12 years, behavioural parent training reduces comorbid conduct and internalising problems but does not confer additional benefit to medication or ‘routine care’ on core ADHD symptoms. Recent evidence continues to support the above finding\(^{4}\).
A self-help intervention, the New Forest Parent Training programme for ADHD (NFPP) found significant improvements in parent-reported child ADHD symptoms and parental competence. School interventions are effective and in some cases implemented along with behavioural training and PBT. Behavioural treatment is a well-established treatment. A Cochrane Review reports that there is little evidence to support or refute social skills training for adolescents with ADHD. In another meta-analysis, social skills training was classified as a non-effective treatment. Cognitive training has not been considered effective. However, in a recent meta-analysis, cognitive training was found to be effective, but the need for more blinded evidence is highlighted. Thus, cognitive training is considered an experimental treatment. Computerised CBT provided mixed results, indicating a need for further blinded studies; thus no recommendation can yet be made. The NICE quality statement (2013) recommends that parents or carers of children with symptoms of attention deficit hyperactivity disorder (ADHD) who meet the NICE eligibility criteria are offered a referral to a parent training programme. Children and young people with moderate attention deficit hyperactivity disorder (ADHD) are offered a referral to a psychological group treatment programme. A combination of medication and behavioural treatments are recommended for school aged children and young people with ADHD/HKD and comorbid symptoms of ODD and/or aggressive behaviour, and/or significant anxiety.
### Attention Deficit Hyperactivity Disorder (ADHD)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school Children</td>
<td></td>
<td></td>
<td>Behavioural parent training. This should be delivered by trained facilitators.</td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate/Severe</td>
<td>2-4</td>
<td>High</td>
<td>Behavioural parent training. This should be delivered by trained facilitators.</td>
<td>A2,3,4,6,9,10,18,23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Behavioural approaches at home (parent training programmes) and at school should be considered in the first instance for school-aged children</td>
<td>Recommended best practice A3,4,6,7,8,9,18,23</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Individualised school intervention programme including behavioural and educational interventions.</td>
<td>A5,6,8,19</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3/4</td>
<td>High</td>
<td>Combination of medication and behavioural treatments</td>
<td>A4,11,16</td>
</tr>
</tbody>
</table>

Evidence Tables – Children and Young People (Last updated 2015)
Bipolar disorder

There are very few studies of bipolar disorders in children and adolescence. Two studies identified the incidence of bipolar disorder for children and young people as being 0.2 and 0.3\%\(^8,16\). The onset may occur following the initiation of antidepressant medication for a depressive illness\(^4\). The age of onset can be between 8 to 19 years with a mean onset age of 15.9 years\(^6\), with 20\% having their first episode during adolescence\(^1\).

Both sexes are affected equally\(^1\). Comorbid disorders with bipolar disorder are not uncommon\(^10\). ADHD and Conduct Disorder are frequently seen in young people with Bipolar Disorder\(^5\). Substance abuse has also been noted\(^3,5\).

Individual CBT or IPT have been deemed the primary psychological therapies for young people with bipolar disorder\(^19\). However, certain family therapies and alternative individual therapies have also shown efficacy and are recommended if primary therapies are deemed ineffective after a 4-6 week period.

### Bipolar Disorder

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child to Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td>3/4</td>
<td>High</td>
<td>CBT</td>
<td>A(^9, 13, 19)</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Psychoeducation &amp; relapse prevention</td>
<td>B(^9, 13)</td>
</tr>
<tr>
<td></td>
<td>Tier 3/4</td>
<td>High</td>
<td>Family intervention</td>
<td>B(^7, 9, 13, 15, 18, 19)</td>
</tr>
<tr>
<td></td>
<td>Tier 3/4</td>
<td>High</td>
<td>Interpersonal Therapy</td>
<td>B(^13, 19)</td>
</tr>
<tr>
<td></td>
<td>Tier 3/4</td>
<td>High</td>
<td>Mindfulness-Based Cognitive Therapy</td>
<td>C(^17)</td>
</tr>
</tbody>
</table>

* Participants include adolescent and child populations.
Body Dysmorphic Disorder

It is thought that 0.5–1.8% of the population have Body Dysmorphic Disorder (BDD)\(^3,11\), but studies with adolescents have estimated the prevalence to be as high as 2.2%\(^9\). BDD has a typical onset during early adolescence and subclinical BDD may onset in late childhood\(^2,17\) and often demonstrates a chronic course\(^16\).

Many adults and adolescents will seek cosmetic treatment or surgery to address body image concerns. Symptoms tend to be the same or worse following the procedure, and sometimes new appearance concerns emerge\(^13,15\). Surgery and other cosmetic treatments should not be offered to young people\(^13,17\).

Individuals with BDD have high rates of comorbid problems such as eating disorders\(^4\), and social phobia\(^18\). Children and adolescents with BDD usually have moderate to high functional impairments\(^11,14\). In particular, social functioning is markedly impaired. BDD shares many clinical features of social phobia, but both the fear and avoidance of social interactions are directly linked to anxiety over others’ perception and negative evaluations of the perceived bodily ‘defect’ or ‘deformity’ the individual is preoccupied with\(^6,18\). Academic functioning can also be impaired and some adolescents may even drop out of secondary school due to BDD symptoms\(^1\).

Suicidal ideation is also commonly observed in children and adolescents with BDD\(^1,14\). Further, 21-44% of youth in these studies reported having attempted suicide. The evidence-base for interventions in this area is limited, but CBT with an Exposure Response Prevention (ERP) component is currently the best supported approach. CBT combined with ERP and psycho-education, adapted to be developmentally appropriate, should therefore be offered as first-line treatment\(^11\), should involve parents or carers, and address the family’s role in not accommodating BDD symptoms (e.g., not providing reassurance)\(^5,17\). If CBT is not effective, the addition of an SSRI to ongoing psychological treatment should be offered with careful monitoring, particularly at beginning of treatment (ages 8-18)\(^11\). Manualised versions specific to BDD are available (e.g. CBT-BDD)\(^21\), within which there are optional modules available to address specific individual concerns such as surgery seeking\(^21\).
### Body Dysmorphic Disorder

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>CBT-BDD + ERP</td>
<td>B^{11,17}</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>CBT + SSRI</td>
<td>B^{11,17}</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Stepped-care model including assessment of young people seeking cosmetic or dermatological procedures</td>
<td>C^{11,13}</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Behaviour Therapy (ERP only)</td>
<td>/</td>
</tr>
</tbody>
</table>

* Indicates evidence from adult studies and adult recommendations.
**Chronic Fatigue Syndrome**

The prevalence of Chronic Fatigue Syndrome (CFS, or Myalgic Encephalopathy-ME) among children has been estimated to be 0.06%\(^3\), and among adolescents the estimates range between 0.4% and 2.4%\(^4\),\(^9\),\(^32\). The differing prevalence rates can be attributed to whether or not the diagnostic definition required 3 or 6 months of fatigue\(^14\).

CFS has marked consequences on children and young people as a result of the disorder's potentially impairing effects on emotional, intellectual and physical development\(^15\),\(^33\). One particular problem is its association with high rates of school absenteeism\(^30\). It is estimated that approximately 1% of children in secondary school miss 1 school day per week as a result of CFS\(^8\). CBT has the strongest evidence-base, with many CBT interventions include graded increases in activity\(^34\).

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>Adolescent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild/Moderate</td>
<td>2</td>
<td>Low</td>
<td>Psycho-education</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Internet-CBT</td>
<td>/</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Family-Focused CBT</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>CBT</td>
<td>C(^26)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>CBT + Biofeedback</td>
<td>/</td>
</tr>
<tr>
<td>Severe</td>
<td>4</td>
<td>High</td>
<td>Multidisciplinary Inpatient Rehabilitation Program</td>
<td>/</td>
</tr>
</tbody>
</table>

* Recommendations for adults
Eating Disorders

Eating Disorders represents group of disorders characterised by over-evaluation of body shape and size and attempts to control food intake. They include Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder and Atypical Eating Disorders.

Prevalence estimates in Scotland are difficult to calculate given the likely numbers who do not seek medical help. Worldwide estimates range from 0.1% and 1%\(^{27}\) with an average reported rate of around 0.3%\(^ {40}\). Epidemiological studies typically find a marked gender difference in prevalence although this is shrinking\(^ {40}\).

Historically, in adolescents and young adults around 5–10% of cases have occurred in males\(^ {7}\). In children between 19–30% of cases have been in boys\(^ {10,28,33,39,42}\). Whilst the median age of onset is 12.3 years\(^ {27}\), prevalence increases with age. Whilst socio-economic class is implicated, more recent evidence suggests that this may be a mild effect, with confounding variables of culture and family factors that have not been adequately accounted for in earlier research\(^ {27}\).

Over the long-term recovery is seen in 50-80% of young people, although there are high levels of emerging long-term other mental illness, and 10-20% will have a poor outcome\(^ {27}\). Mortality rates for AN range from 2.16% to 8.3%, and increases with length of follow-up. The risk to physical health in the short and long-term has meant that randomised controlled trials of interventions are not perceived as safe to conduct. The result is a paucity of good quality research to guide best practice\(^ {27}\). The NICE (2004) Guidelines\(^ {58}\) identify this as a priority for future research.

Anorexia Nervosa

NHS QIS guidelines\(^ {60}\) recommend individualised care and treatment based on individual needs and not on arbitrary targets for weight gain or number of sessions of therapy. The Junior Marsipan report\(^ {61}\) outlines best practice based guidelines for management of children and young people with eating disorders including risk management, location of care, and management across sectors.
There is increasing evidence for family-based treatment (FBT) (manualised treatments, including the Maudsley Model\textsuperscript{18,52}, that directly target the eating disorder) of adolescent Anorexia Nervosa (AN) over individual treatments, particularly in long-term maintenance of treatment gains and notably low attrition rates – a common problem in ED trials\textsuperscript{14,36}. Further, moderator analyses of AN patients with more severe eating pathologies show benefit from FBT in comparison to individual therapies\textsuperscript{48}. Although no specific Family Therapy model has been proven to be more effective, a ‘separated’ form of FBT may be more effective when treating young people that exhibit obsessive compulsive tendencies\textsuperscript{2}, where there is high expressed emotion, or where they cannot tolerate conjoint work. This reflects that a choice of psychological treatments for anorexia nervosa should be available as part of mental health services. Brief Reward Programmes are effective when used for short-term weight gain limited to 4-5kg to minimise the punitive element\textsuperscript{4,8}. Regular physical monitoring is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration\textsuperscript{56}. Systematic evaluations of supervised physical exercise following weight restoration in adolescents with anorexia or bulimia have found no adverse effects and appears to be safe\textsuperscript{59,73}.

Specialist inpatient care that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions may be required, but there is no evidence that it is superior to out-patient treatment\textsuperscript{56}. There is preliminary evidence that shorter hospitalisations for medical stabilisation of weight when combined with FBT has similar outcomes to longer hospitalisation for weight restoration (WR) + FBT\textsuperscript{49}. For severe AN, even if patient is hospitalized for medical stabilisation or weight restoration, out-patient FBT should be offered following patient’s release from inpatient services\textsuperscript{25,51}. Services should be as close to home as possible to allow families to maintain links\textsuperscript{8}.
### Anorexia Nervosa

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>1/2</td>
<td>Low</td>
<td>Advice, self-help groups and internet resources</td>
<td>/ C(^1)</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Family-based treatment (FBT)</td>
<td>A(^{43,51,58}) A(^{25,43,51,53,58})</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>'separated' model of FBT (see narrative)</td>
<td>B(^{17,43}) A(^{17,18,19,43})</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Behavioural interventions (Brief Reward Programmes)</td>
<td>B(^{43}) B(^{39,43})</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>CBT/CBT-E (may be in combination with parental counselling)</td>
<td>/ C(^{25,32})</td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3/4</td>
<td>High</td>
<td>Adolescent Focused Therapy/Ego-oriented Individual Therapy</td>
<td>/ B(^{54,64})</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>High</td>
<td>Specialist inpatient care in combination with psychosocial interventions. **No evidence that it is superior to out-patient treatment(^{31})</td>
<td>B(^{58}) B(^{58})</td>
</tr>
</tbody>
</table>

Bulimia Nervosa, Overeating and Atypical eating disorders

Bulimia Nervosa

Sub-diagnostic clinical symptoms are more common with around 2-3% of teenagers experiencing clinically significant symptoms of Bulimia Nervosa (BN) but not meeting full criteria for diagnosis\(^{20,45}\).

Most patients with bulimia nervosa can be managed on an outpatient basis\(^{41, 57, 60}\) with less than 5% requiring inpatient care\(^{22}\). Care should be tailored to individuals rather than a rigid pattern or treatment\(^{60}\) Bulimia nervosa may have a better prognosis if treated early\(^{48}\).

Interpersonal Psychotherapy (IPT) has a growing evidence base in adults\(^{3, 21}\) and may be considered as an alternative to CBT, but can take longer to achieve results. CBT has the strongest evidence but much of this is derived from adult studies with a small number of RCTs in adolescents confirming efficacy\(^{49}\). FBT has shown equivalent outcomes in two RCTs but at significantly greater economic cost to services.

Binge eating disorder

Overeating associated with other psychological disturbance (ICD-10), or binge eating disorder (BED:DSM-V and likely ICD 11) is marked by episodes of loss of control eating, but it differs from bulimia nervosa because individuals do not engage in the same extreme weight control measures (i.e. purging) following a binge. While some validation studies have indicated that BN and BED\(^{21}\) may represent the same disorder on a single continuum\(^{29}\), a study of a large community sample indicated that BN is associated with significantly poorer outcomes in comparison to binge eating.

Overeating typically does not reach the severity of a ‘disorder’ other than in the context of obesity, particularly when the disordered eating affects the individual’s ability to lose weight\(^{37}\).
In the general population, the prevalence of BED has been estimated at approximately 1-3%\textsuperscript{34,33}, but these statistics are out-of-date and do not reflect the rapidly developing problem of obesity at a population level. Debate about whether obesity should be classified as a mental health problem as well as a public health issue may have contributed to the relative lack of research in this area to establish prevalence and nature, as well as interventions, in comparison to other eating disorders.

In the context of psychological treatments for BED, individuals should be informed that these treatments typically target binge eating, but have a limited effect on weight. Interventions for comorbid obesity may be offered concurrently or consecutively with psychological treatments for BED\textsuperscript{58}. Cognitive Behavior Therapy for Binge Eating Disorder (CBT-BED) should be adapted to be developmentally appropriate and should attempt to involve parents or carers.

**Atypical eating disorder**

Atypical eating disorders or partial ED syndromes occur in approximately 2-5% of young females\textsuperscript{34} and are the most commonly diagnostic group in clinical practice\textsuperscript{21}.

In spite of this, due to the heterogeneity of their clinical presentations, little research has assessed treatments for this group of young people. In the absence of evidence to guide the management of atypical eating disorders, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient’s eating disorder\textsuperscript{58}. 
**Bulimia Nervosa, Overeating and Atypical eating disorders**

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>Evidence-based self-help programme**</td>
<td></td>
</tr>
<tr>
<td>Subclinical/Mild</td>
<td>1/2</td>
<td>Low</td>
<td>/</td>
<td>B 12*.58,66,69*.74*</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Medium</td>
<td>Guided CBT self-help**</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bulimia</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Cognitive behaviour therapy for bulimia nervosa</td>
<td>C 58</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Family-Based Therapy (FBT-BN)</td>
<td>B 46.66</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Evidence-based self-help programme**</td>
<td>B 12*.58,66,69*.74*</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Guided CBT self-help**</td>
<td>B 46,66,74*</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Interpersonal Psychotherapy (IPT-BN)</td>
<td>C 3*.22*.58*</td>
</tr>
<tr>
<td>Binge Eating Disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Cognitive Behavior Therapy for Binge Eating Disorder (CBT-BED)</td>
<td>C 58</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Interpersonal Therapy</td>
<td>B 35,55,70,71</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Family Therapy</td>
<td>C 35,62</td>
</tr>
</tbody>
</table>

* Evidence from adult studies and adult recommendations.

** Additional encouragement and support from healthcare professional(s) may improve outcomes."
Insomnia

Abnormal or disordered sleep can be characterised by delayed sleep onset, prolonged night time wakenings or difficulties achieving adequate restorative sleep. Developmental, environmental and social factors have been identified as key indicators and risk factors for understanding and treating disordered sleep across both childhood and adolescence.

Longitudinal studies have shown problematic sleep presenting in childhood is significantly associated with poorer sleep in adolescence\(^\text{19}\). Timely interventions are required as the immediate and long term effects of disordered sleep are thought to negatively impact on mood regulation, mental health, family and peer relationships, learning and academic attainment\(^1,2,16,19\). Therefore the recognition and management of sleep disorders in childhood and adolescence is important in achieving positive treatment outcomes and relapse prevention.

Psychological interventions modelled to address disordered sleep have been developed from the established evidence from adult populations and emerging outcomes from child and adolescent studies. There is growing evidence for the efficacy of multi-modal approaches that encompass psycho-education for sleep (e.g. sleep hygiene practices) and sleep disorders, problem solving and skills based behavioural training and the development of relaxation and cognitive coping strategies. Further, another multi-modal approach within an evidence-based clinic combined both behavioural interventions and CBT-I (CBT adapted for insomnia) in treating both children and adolescents\(^3\).

One RCT combined CBT-I with Bright Light Therapy in the treatment of adolescent insomnia, with the latter aimed at addressing the changes in circadian rhythm patterns associated with the developmental phase of adolescence\(^6\). This RCT yielded moderate-to-large improvements, with well-maintained gains at 6 months.
### Insomnia

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subclinical/ Mild</td>
<td>1/2</td>
<td>Low</td>
<td>School-based prevention and early intervention well-being programme</td>
<td>/</td>
</tr>
<tr>
<td>Mild/ Moderate</td>
<td>2/3</td>
<td>Low</td>
<td>Parenting / Family Psycho-education and Behavioural Programmes***</td>
<td>A&lt;sup&gt;7,8,9,10*,15&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate/ Severe</td>
<td>3</td>
<td>High</td>
<td>Individual Cognitive Behavioural Therapy (CBT-I) with Parental/Family Involvement</td>
<td>B&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Group Cognitive Behavioural Therapy with Integrated Parental/Family Involvement</td>
<td>B&lt;sup&gt;18&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Brief Parental Behavioural Extinction Intervention</td>
<td>B&lt;sup&gt;5,12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Medium</td>
<td>Internet delivered CBT-I</td>
<td>/</td>
</tr>
</tbody>
</table>

*Recommendations for children do not include infancy.

**See Morgenthaler et al (2006)<sup>13</sup> for discussion on guidelines for practice.

***Also supported in infants<sup>11</sup>.

****CBT-I plus Bright Light Therapy<sup>6</sup>.
Mood Disorders, including Depression and Mood Dysregulation

At any point in time about 1 in 100 children and 1 in 33 adolescents are likely to be suffering from depression\(^4\). Published research indicates that the cumulative prevalence of depression up to age 18 is 28%: 35% for girls and 19% for boys\(^{42, 43}\). Depressive disorders are equally frequent in boys and girls until puberty\(^5\), after which there is a predominance of girls (approximately 2:1)\(^1, 13, 36, 41, 72\).

The course and causes of depression in children and adolescents is varied but for many young people will be severe with several episodes of depression and associated self-harm and/or suicide. Without treatment about 10% recover spontaneously within three months but at 12 months around 50% remain clinically depressed\(^{57}\).

For children and adolescents depression impacts significantly on their ability to meet key developmental tasks such as forming close peer relationships and first romantic relationships, achieving academic and vocational goals and successfully leaving home. Those young people who have an episode of depression before age 15 and a second episode before 20 are likely to have more severe, chronic, suicidal depressions, greater anxiety comorbidity, worse social functioning at 15 years, and poorer psychosocial outcomes at 20\(^{28}\).

In community studies of depression, comorbidity with other mental health problems is common. The most frequently occurring comorbid disorders are dysthymia and anxiety disorders, followed by disruptive disorders. Depressive disorders often develop after the other disorders are established\(^7, 27, 44\).

The strongest evidence exists for individual psychological treatments, namely CBT and Interpersonal Psychotherapy (IPT). Family and Group treatment have a less robust evidence base. Brief therapies and computerised CBT have an emerging evidence base. An emerging evidence base for group based interventions may lead to a future recommendation for group CBT in children and young people with mild depression and could be provided by appropriately trained professionals in primary care, schools, social services and the voluntary sector or in tier 2 CAMHS\(^{58}\).
### Mood Disorders, including Depression and Mood Dysregulation

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adolescent</td>
</tr>
<tr>
<td><strong>Sub-clinical/Mild</strong></td>
<td>2</td>
<td>High</td>
<td>Group CBT</td>
<td>B(^{1,25,30,49,55,56,57,58,73})</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>High</td>
<td>Computerised CBT</td>
<td>B(^{51,58,65})</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>High</td>
<td>CBT (brief-8 sessions)</td>
<td>B(^{71})</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>Low</td>
<td>Cognitive Bibliotherapy</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>Low</td>
<td>Watchful Waiting (further assessment within 2 weeks)</td>
<td>C(^{57})</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Relaxation</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>1/2</td>
<td>High</td>
<td>Non-directive Therapy</td>
<td>/</td>
</tr>
<tr>
<td><strong>Moderate/Severe</strong></td>
<td>3/4</td>
<td>High</td>
<td>CBT</td>
<td>A(^{1,11,12,14,19,22,24,29,40,49,57,60,61,63,73,74,75,8,11,12,13,19,22,24,29,40,49,57,60,61,63,65,73})</td>
</tr>
</tbody>
</table>
### Evidence Tables – Children and Young People (Last updated 2015)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Interpersonal Psychotherapy for Adolescents (IPT-A)</td>
<td>40,57,80,61,83,73,74,75</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Systemic Family Therapy/ Other Family Therapies</td>
<td>6,8,57,69</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Psychodynamic Psychotherapy &amp; Psychoanalysis</td>
<td>33,69,70</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Psychological therapy in combination with SSRIs should be used when a psychological intervention alone is not effective and there is no response within 6-8 weeks.</td>
<td>57,58</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Antidepressant medication should not be used for the treatment of young people with moderate to severe depression without concurrent treatment with a psychological therapy.</td>
<td>21,57</td>
</tr>
</tbody>
</table>

Evidence Tables – Children and Young People (Last updated 2015)
Schizophrenia/Psychosis

The range of psychoses and schizophrenia are characterised by distortions of thinking and perception and a distorted affect. The symptoms associated with these difficulties are known as positive symptoms. Negative symptoms such as apathy, social withdrawal, poverty of speech and incongruent emotional responses may also be present. Scholastic ability and self-care may also be affected\(^8\).

There are very few studies determining the incidence of schizophrenia in childhood and adolescence. One study identified the ages at first hospitalisation being 15-25 for males and 25-35 for females, although some females were identified before 25 years\(^17\). The peak ages for onset are 13-30 years\(^3\). In another study, the prevalence in children was identified as much lower than adolescents, being 2 per 10,000 children under 12 years\(^5,6\).

The onset of Schizophrenia is therefore rare before 13 years of age\(^3\). The earlier the onset the more severe the disorder\(^5,6\). Early detection and treatment are important in reducing the effects of the disorder\(^7\).

There has been an increase in research investigating the benefits of psychological interventions for patients with an early onset or adolescent onset psychosis, and emerging evidence examining psychological treatments in children. However, most of these studies span client groups between teenage years and early twenties. The first-line psychological treatment suggested for all stages and age ranges of individuals diagnosed with schizophrenia is individual cognitive behavioural therapy, with or without the inclusion of family therapy. However, psychological treatments produce more effective results when delivered in conjunction with psychotropic medication, and it is suggested psychotropic medications always accompany set interventions\(^14\).

For children still of school age it is also recommended to liaise with school to address educational needs and stigmatisation or provide adjunctive therapies\(^10,14,15\). Additionally, social skills training interventions have been shown to be efficacious, but have not recommended as an intervention on their own but rather as a component of a wider treatment plan\(^14,15\).
### Schizophrenia/Psychosis

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Diagnosis</td>
<td>2/3</td>
<td>Low</td>
<td>Individual CBT with or without family intervention, including problem solving and crisis management work</td>
<td>A&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Cognitive Behavioural Therapy for: Prodromal symptoms</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Transition</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Functioning</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Stress Relief</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Family Intervention with or without Individual CBT</td>
<td>A&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>3/4</td>
<td>High</td>
<td>Cognitive Behavioural Therapy for: acute symptoms</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Functioning</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Mood related to first episodes</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Family Intervention with or without Individual CBT</td>
<td>A&lt;sup&gt;18,19**&lt;/sup&gt;</td>
</tr>
<tr>
<td>Severe</td>
<td>3/4</td>
<td>High</td>
<td>Arts Therapies for Alleviation of Negative Symptoms</td>
<td>C&lt;sup&gt;14&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Self-harm and Interpersonal Difficulties

In an international community sample of young people 13.5% of females and 4.3% of males reported an episode of self-harm within their lifetime, and 8.9% and 2.6% respectively reported an episode during the last year. In a recent study in England, 27% of young adolescents reported thoughts of self-harm and 15% reported at least one act of self-harm. Adolescents surveyed in Scotland reported slightly higher levels of self-harm during the last year: 13.6% of girls and 5.1% of boys, similar to the prevalence reported in England. Overall 12% of self-harm episodes reported in the previous year resulted in presentation to hospital, while of those who self-harmed, 18% had sought help for psychological difficulties of anxiety or depression. Where adolescents reported a lifetime history of self-harm, girls were three times more likely to report self-harm than boys. Between a quarter and a half of those completing suicide have previously self-harmed. In a study for resistant depression in adolescence, self-harm history predicted both future self-harm incidents and suicidal attempts and was a stronger predictor of future attempts than a history of attempts.

Several therapeutic models indicate positive outcomes in the treatment of self-harm yet the evidence base for efficacious interventions for self-harm for children and adolescents is extremely limited and in most cases insufficient to make any negative or positive treatment recommendations.

NICE (2013) suggests Rapid Response Treatment in A&E, while highlighting the limited available evidence. Based on the available research, rapid response treatment (including assessment, formulation and intervention including identifying the nature of crisis, the precipitating events, and the strengths and weaknesses of the adolescent’s support system, and reframing any misconceptions, maladaptive behaviours, and communication patterns that contributed to the client’s or family’s stress) appears to be promising in improving adherence of subsequent treatment as well as in reducing suicide-related outcomes. Additionally, in a clinical guideline for the long term management of self-harm, NICE (2011) suggests considering 3-12 sessions of psychological treatment that “should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements”, a recommendation that applies to both adults and adolescents.
In Scotland, a National Strategy and Action Plan, Choose Life (www.chooselife.net), has set a target to reduce death resulting from suicide by 20% by 2013. Choose Life co-ordinators are tasked with agreeing, developing and implementing a local suicide prevention plan. This work includes awareness raising programmes such as SuicideTALK and SafeTALK which are available to all, Applied Suicide Intervention Skills Training (ASIST) aimed at professionals, volunteers and informal helpers, and Skills Based Training on Risk Management (STORM) which is intended for frontline workers in health social and criminal justice services. Based on statistics measured between 2011 and 2013, the target has almost been reached, with a 19% fall in suicide rates between 2000-2002 and 2011-2013. The percentage differs by gender, with a 21% fall in suicide rate for males, and 14% for women.
## Self-harm and Interpersonal Difficulties

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>A&amp;E</td>
<td>High</td>
<td>Rapid Response Out-Patient Team</td>
<td>B&lt;sup&gt;8,20,24,26,28&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High (12 sessions)</td>
<td>Cognitive Behavioural Therapy for deliberate self-harm + treatment as usual</td>
<td>B&lt;sup&gt;31,39,40,42&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High (min. 6 Sessions)</td>
<td>Developmental Group Psychotherapy (containing elements of CBT, DBT and psychodynamic approaches)</td>
<td>C&lt;sup&gt;9,22,34,39&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Attachment-Based Family Therapy</td>
<td>C&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Dialectical Behaviour Therapy</td>
<td>C&lt;sup&gt;7,17,19,22,43&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Problem-Solving Therapy</td>
<td>C&lt;sup&gt;23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Multi-Systemic Therapy</td>
<td>C&lt;sup&gt;15&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Mentalisation based treatment</td>
<td>C&lt;sup&gt;38&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Substance Use Disorders

Substance use disorder (SUD) is measured on a continuum of severity ranging from mild to severe, whereby 2-3 symptoms indicate mild SUD and 6+ indicate severe. The DSM-5 recognises alcohol, cannabis, phencyclidine, other hallucinogens, inhalants, opioids, sedative, hypnotic, or anxiolytics, stimulants, tobacco and others as substances for which a person can develop and maintain a substance use disorder for 3.

Although substance abuse and dependence has been extensively researched across a wide range of human populations, SUD in childhood and adolescence has previously been neglected. However, prevalence rates of co-morbid and stand-alone SUD within youth have increased within the past decade, accompanied by an increased need for research and treatment recommendations.

Although there is no gold-standard treatment of SUD for children and adolescents to date, multi-component interventions, often including family-based, behavioural and motivational components in addition to CBT are often efficacious in adolescent populations. Emerging research has also suggested that culturally sensitive alterations to interventions increase efficacy and treatment gains. Further, school-based interventions have been proven effective in adolescents and act as an easily accessible, cost-effective and feasible means of treatment 1, 14, 15, 16, 4.

Another increasing area of interest is preventative measures geared towards decreasing probability of development of SUD, heavy drinking and heavy drug use among youth, including multi-component and school-based interventions 9, 16. Many preventative and brief-intervention measures include family or parent components, and some evidence suggests a greater success rate with inclusion of such components in preventative interventions 15, 16, 7.
## Substance Use Disorders

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Alcohol</th>
<th>Other</th>
<th>School-Age</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild, moderate and severe</td>
<td>2-4</td>
<td>High</td>
<td>Individual CBT, with or without medication</td>
<td>A&lt;sup&gt;1, 2&lt;/sup&gt;</td>
<td>x</td>
<td>/</td>
<td>A&lt;sup&gt;1, 2&lt;/sup&gt;</td>
</tr>
<tr>
<td>2-4</td>
<td>High</td>
<td>Group-based CBT</td>
<td>x</td>
<td>x</td>
<td>/</td>
<td>A&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>High</td>
<td>Multicomponent Interventions: often including family-based or multisystemic programs, CBT, BI, MI</td>
<td>x</td>
<td>x</td>
<td>A&lt;sup&gt;1&lt;/sup&gt;</td>
<td>A&lt;sup&gt;1, 7, 5, 6&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>High</td>
<td>Family/Systemic-base Therapy or Prevention (adolescent)</td>
<td>x</td>
<td>x</td>
<td>A&lt;sup&gt;7, 8&lt;/sup&gt;</td>
<td>A&lt;sup&gt;10, 2, 7, 8, 5&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2-4</td>
<td>High</td>
<td>Motivational Interviewing</td>
<td>x</td>
<td>x</td>
<td>B&lt;sup&gt;11&lt;/sup&gt;</td>
<td>B&lt;sup&gt;11, 12, 2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>High</td>
<td>School-based Preventative Measures Interventions</td>
<td>x</td>
<td></td>
<td>A&lt;sup&gt;13, 14, 15&lt;/sup&gt;</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>
Trauma: Post-Traumatic Stress Disorder (PTSD)

Lifetime prevalence (to age 18) of Post Traumatic Stress Disorder (PTSD) in the general population has been found in 8% of females and 2.3% of males\textsuperscript{60} with 1.5% in total experiencing severe impairment as a consequence. Incidence increases steadily with age, as would be expected in a condition triggered by life events.

Studies of at-risk child populations have demonstrated varying prevalence rates from around 3\%\textsuperscript{36} to 36\%\textsuperscript{32}. PTSD occurs across ethnic and cultural groups, but may be manifested in different ways\textsuperscript{2,21,23,56}.

Cognitive theories of childhood PTSD highlight the need to consider how developmental stages (e.g. language development) influence how a child may encode and resolve a traumatic experience\textsuperscript{73}. Due to the implications of the cognitive social and emotional development of the affected child, there is no clear consensus about the typical presentation of PTSD in children\textsuperscript{1,7,38,73}. Younger children may display fewer re-experiencing and little avoidance behaviour\textsuperscript{32}, and more behavioural symptoms (play re-enactment, aggression)\textsuperscript{74,80}. Intervention for co-morbid problems such as depression\textsuperscript{1}, anxiety and substance use\textsuperscript{6,9} in children and young people who have experienced trauma are as important as for PTSD\textsuperscript{34}. 
## Post-Traumatic Stress Disorder (PTSD)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child</td>
</tr>
<tr>
<td>Mild</td>
<td>1</td>
<td>Low</td>
<td>Following a traumatic incident, parents/carers should be informed of the possibility of development of PTSD with symptoms described. If symptoms persist beyond one month, contact GP.</td>
<td>C&lt;sup&gt;61&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Stepped-care model may be beneficial: including psycho-education, provide individual coping skills, and trauma exposure; provision of multiple sessions to at-risk children</td>
<td>A&lt;sup&gt;5,47,49&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate-High</td>
<td>3/4</td>
<td>High</td>
<td>Trauma-focused developmentally appropriate CBT for children aged over 7 years</td>
<td>A&lt;sup&gt;14,19,39,48,61,75,76&lt;/sup&gt;</td>
</tr>
<tr>
<td>Moderate</td>
<td>3/4</td>
<td>High</td>
<td>Eye Movement Desensitization &amp; Reprocessing (EMDR)</td>
<td>C&lt;sup&gt;2,30,37,38,61,79&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Group based grief/trauma-focused psychotherapy</td>
<td>C&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Narrative Therapy</td>
<td>C&lt;sup&gt;39&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Anxiety Management training/ Exposure &amp; parent training</td>
<td>C&lt;sup&gt;30,52&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

*‘Level of severity’ refers to the symptomatology with which a child or young person presents, not the severity of the traumatic event.*
**Trauma: Complex Trauma**

‘Complex trauma’ can arise from a child’s exposure to multiple and/or chronic traumas, such as war, childhood maltreatment and domestic abuse, which typically result in a wide constellation of difficulties not adequately captured by the diagnosis of PTSD\(^{10,15}\).

Complex trauma is not yet a recognised diagnosis, although it is being considered for inclusion in ICD-11. Consequently, empirical evidence centres on specific types of trauma. Sexual trauma has a specific and robust evidence base and is therefore considered separately. Refugee children are also considered due to their individual characteristics.

While sexual and physical assault can and often are parameters of complex trauma, it is important to note that these overt forms of abuse can co-occur with neglect\(^{57}\). Further, sustained forms of neglect can by themselves also lead to complex trauma\(^{69}\). A study estimating the prevalence of child abuse and neglect in the UK found that 11% of respondents had experienced sexual abuse involving contact, 7% reported physical abuse, and 6% emotional abuse. With respect to neglect, 6% reported absence of care, and 5% an absence of supervision\(^{57}\).

The response of the victimised child’s caregiver(s), particularly the mother, is one of the most critical mediating factors in determining a child’s adaptive response to the victimisation\(^{15,31}\). It follows that many psychological treatments target the child and their carer\(^{20}\). Current expert opinion has advocated a phase-based approach to treating children who have suffered complex trauma, though systematic empirical evidence is needed to substantiate this approach\(^{13,51}\). A key element of this approach is to facilitate when and how to address trauma memories so that the child or young person has sufficient safety and stabilisation in place to make use of intervention without becoming overwhelmed or re-traumatised.
Sexual Trauma

 Estimates of prevalence and incidence of sexual trauma vary widely due to methodological problems including how it is defined\textsuperscript{54}. International meta-analytic data found approximately 20% of females and 8% of men had experienced some type of sexual abuse by the age of 18\textsuperscript{66}. Identification and management of risk, and ensuring children’s safety, is central to any treatment response to sexual trauma. In cases of intra-familial abuse, it is of pivotal importance that the offender does not live in the same location or in close proximity to the child victim, and that the offender undertake a treatment programme\textsuperscript{24}.

 It has been suggested a multi-modal approach to treatment is core to this area, including use of specific treatment approaches where indicated (e.g. anxiety management, social skills, anger, problem solving skills based work). Therapeutic intervention with sexually traumatized children/young people (and those who have experienced sexually inappropriate treatment) should not be in isolation and should involve liaison with their wider system. Education, consultation and support to the system are an extremely important part of intervention in most cases. This can happen whether or not the child/young person is receiving individual intervention. Meta-analytic data suggest that longer interventions confer additional benefit to children on a variety of outcomes, and that group and individual treatment modalities are equally effective\textsuperscript{41,77}. Treatment engagement/retention is notably poor among foster children, but evidence-based engagement strategies directed at foster youth and foster parents can be successfully implemented to improve treatment retention\textsuperscript{24}. Many treatment modalities, including TF-CBT, treat both the child and non-offending parent concurrently\textsuperscript{20}. TF-CBT is the best-evidenced treatment for this population.
Refugee children

Refugee children who have resettled in high-income Western countries are at increased risk for mental health difficulties, with exposure to violence being a key risk factor that often displays a dose-response relationship\(^\text{28}\). In a systematic review of serious mental health problems among resettled refugees in Western countries, the prevalence of PTSD among children was estimated at 11% (7%-17\%)\(^\text{29}\). Unaccompanied asylum seeking children are at particularly high risk of mental health difficulties\(^\text{27}\).

The current evidence-base for psychological treatment options for children is of very low quality\(^\text{68}\). Tailored CBT, testimonial psychotherapy, narrative exposure therapy and EMDR have all had positive gains in small, uncontrolled studies\(^\text{27,28,65}\), but there is a need for more robust evidence to allow a specific recommendation to be made.
## Complex Trauma

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Complex Trauma**</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Trauma-focused CBT</td>
<td>B&lt;sup&gt;51&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Real Life Heroes&lt;sup&gt;59&lt;/sup&gt;: Attachment-centered intervention</td>
<td>C&lt;sup&gt;44,45,46&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Trauma-focused Art Therapy</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sexual Trauma**</td>
<td></td>
</tr>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>CBT/Trauma-focused CBT (Group/Individual)*</td>
<td>A&lt;sup&gt;11,12,14,18,19,20,39,48,51,54,55,59,61,70,71&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Risk Reduction through Family Therapy</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Early intervention parent/carer abuse specific therapy (where not perpetrator of abuse)</td>
<td>B&lt;sup&gt;4,16,18,35,41,49,70&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Art Therapy</td>
<td>B&lt;sup&gt;57,58,59&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Eye Movement Desensitization and Reprocessing</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Child-Parent Psychotherapy</td>
<td>B&lt;sup&gt;57&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Psychodynamic individual therapy</td>
<td>/&lt;sup&gt;64&lt;/sup&gt;</td>
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</tbody>
</table>
**Evidence Tables – Children and Young People (Last updated 2015)**

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>High</td>
<td>Longer term child-parent parallel treatment</td>
<td>C³¹,³²</td>
<td>C⁴¹,³²</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Play therapy</td>
<td>C³¹</td>
<td>C⁴¹</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Cognitive Processing Therapy</td>
<td>/</td>
<td>C⁵⁰</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Prolonged Exposure Therapy</td>
<td>/</td>
<td>B³³</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refugee Children Exposed to War</td>
<td>Child</td>
<td>Adolescent</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Narrative Exposure Therapy (KIDNET)</td>
<td>C³²</td>
<td>C³²</td>
</tr>
<tr>
<td>2</td>
<td>High</td>
<td>School-based Group CBT</td>
<td>C²⁶</td>
<td>C²⁶</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Group-based TF-CBT</td>
<td>/</td>
<td>C⁵⁹</td>
</tr>
</tbody>
</table>

*"Level of severity' refers to the symptomatology with which a child or young person presents, not the severity of the traumatic event.*

** The sections on sexual trauma and complex trauma are not mutually exclusive
Neuropsychology: Acquired Brain Injury (ABI)

ABI is a broad term covering neurological diagnoses that involve some level of cognitive dysfunction. The most typical conditions include traumatic brain injury, childhood cancer, central nervous system infection and stroke. A significant and controversial cause of brain injury in infants also relates to non-accidental injuries. All of these conditions put children at significant risk of difficulties in terms of information processing, language, visuo-spatial skills, memory, attention, executive functioning, emotional and behavioural regulation. These difficulties are then likely to impact on mental health, educational attainment, employment and independent living skills.

Traumatic brain injury (TBI) is the most common cause of death or disability in childhood and a recent UK study estimates that every year, 280 children per 100,000 require hospitalisation for 24 hours or more following a TBI. Almost two thirds of these children (63%) are between 5–15 years of age at the time of the injury and are likely to be in mainstream education. The prevalence of childhood cancers likely to lead to neurocognitive impairment (leukaemia, brain and spinal tumour) is around 423 per million (NICE, 2005). There continues to be debate about the longer term impacts of mild TBI, which makes up around 90% injuries, with a lack of good quality longitudinal research. However, cross sectional studies, including those recently conducted in Scotland, have reported high rates of cognitive, emotional and behavioural problems, as well as reduced quality of life in children following all severities of TBI. Childhood acquired TBI can often result in ‘silent’ deficits that do not manifest until a child fails to make the normal developmental gains associated with maturation. Therefore, ensuring longitudinal follow up is essential, particularly for those with more significant injuries. At the moment there are no SIGN/NICE guidelines concerning the post-acute management of ABI in children and adolescents.
Neuropsychological assessment itself can act as an early intervention, and can be a crucial aspect of developing care and education plans. Whilst evidence is limited, there are sufficient studies and case reports to suggest that neuropsychological interventions can have a significant positive impact on cognitive, academic and adaptive functioning. The inclusion of family- or parent-based components in ABI rehabilitation efforts is increasingly encouraged, and has been found to result in end-of-treatment improvements in certain domains. Furthermore, the Amsterdam Memory and Attention Training for Children (AMAT-C), music therapies, art-based social therapies, and virtual reality-based interventions are all potentially effective interventions that have all gained recent attention, however still require additional research to determine efficacy.
# Neuropsychology: Acquired Brain Injury (ABI)

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild/Moderate</strong></td>
<td>1-3</td>
<td>High</td>
<td>Problem-solving interventions</td>
<td>A&lt;sup&gt;44&lt;/sup&gt;</td>
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<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Early Counselling and Education</td>
<td>B&lt;sup&gt;37&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>High</td>
<td>Parent or Family-based Skills programmes</td>
<td>B&lt;sup&gt;7,8&lt;/sup&gt;/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Assessment of cognitive impairments, with feedback, liaison and recommendations</td>
<td>B&lt;sup&gt;30,31,32,33&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Cognitive Remediation of attention deficits</td>
<td>B&lt;sup&gt;49&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Metacognitive training for memory deficits</td>
<td>B&lt;sup&gt;17&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Moderate/Severe</strong></td>
<td>3/4</td>
<td>High</td>
<td>Cognitive Remediation of / Neuropsychological training for attention deficits</td>
<td>A&lt;sup&gt;9,10,18,41,44,51&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Metacognitive and process training for memory deficits</td>
<td>A&lt;sup&gt;17,43,51&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Problem-solving interventions</td>
<td>B&lt;sup&gt;34,13&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Assessment of cognitive impairments, with feedback, liaison and recommendations</td>
<td>B&lt;sup&gt;11,22,35&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Metacognitive and cognitive-behavioral training for executive dysfunction</td>
<td>B&lt;sup&gt;19,47&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

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Evidence Tables – Children and Young People (Last updated 2015)
<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Parent or Family-based Skills programmes</td>
<td>B^{3,8,7}</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>Low</td>
<td>Motivational Interventions for rehabilitation (i.e. token economies)</td>
<td>B^{48}</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Training in use of external aids for memory deficits</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Behavioral intervention for executive dysfunction</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>2-4</td>
<td>High</td>
<td>Educational support</td>
<td>C^{40}</td>
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<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Metacognitive training for social skills</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3/4</td>
<td>High</td>
<td>Cognitive-behavioral therapy for psychological problems</td>
<td>C^{39}</td>
</tr>
</tbody>
</table>

Evidence Tables – Children and Young People (Last updated 2015)
Neuropsychology: Epilepsy

Epilepsy is the most common serious neurological disorder, with an estimated prevalence in Scotland of around 4,200 children and young people\textsuperscript{13}. Around 800 new principal diagnoses are made in children each year in Scotland, although the rate of misdiagnosis can be high due to the complexity of the condition\textsuperscript{13}.

The effects of epilepsy extend far beyond having seizures, and include high rates of learning disability, mental health disorder, reduced academic attainment and quality of life (QoL) and social isolation, all of which can extend across the lifespan\textsuperscript{14,17}.

NICE\textsuperscript{14} recommend that neuropsychological assessment should be considered as it is important to evaluate possible learning disability and cognitive dysfunction, with particular emphasis on language and memory function. NICE also recommends psychological interventions such as CBT in conjunction with anti-epileptic medication to contribute towards improved quality of life, and in particular with children with drug-resistant epilepsy.

SIGN guidelines state that around 50\% of children with epilepsy require additional support at school and have double the rate of behavioural and psychiatric disorders compared with the general childhood population. Rates of ADHD in epilepsy have been found to be as high as 40\%. SIGN recommends that all children with epilepsy should have their behavioural and academic progress reviewed, and that those with difficulties should have appropriate educational and psychological intervention.

Children with epilepsy have been found consistently to be more behaviourally disturbed, with lower self-esteem, and to experience poorer academic attainment than children with other chronic diseases of childhood such as diabetes or asthma\textsuperscript{6,1}. Some studies have suggested that early neuropsychological assessment can identify those with high risk for academic failure and can potentially lead to improved educational support\textsuperscript{3,4}. However, recent research suggests that even those children with normal intellectual ability and moderate seizure control can also have learning problems placing them at risk of poorer attainments\textsuperscript{5}. 
Epilepsy has been associated with markedly reduced quality of life with problems accessing normal social activities, maintaining friendships and coping with mood and behaviour problems\textsuperscript{10,11}. There is an emerging evidence base for the effectiveness of group based psychosocial interventions\textsuperscript{5,18} along with the development of standardised QoL scales useful in assessing interventions\textsuperscript{19}, and also for the effectiveness of CBT as an individual treatment\textsuperscript{16}. In addition, CBT has also been recommended as an effective treatment for co-morbidities common in epilepsy, such as anxiety and depression\textsuperscript{8,12}. Music therapy as an adjunctive therapy has proven efficacious in certain patients, however more robust evidence is still required\textsuperscript{9}.
## Neuropsychology: Epilepsy

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Adolescent</td>
<td>2/3 Low</td>
<td>Relaxation Therapies as adjutant to pharmacological treatment</td>
<td>A15</td>
<td>A15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A15, 16</td>
<td>A15, 16</td>
</tr>
<tr>
<td></td>
<td>3/4 High</td>
<td>cognitive behavioural therapy</td>
<td>B3, 4, 5, 12, 18</td>
<td>B3, 4, 5, 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Neuropsychological assessment</td>
<td>B3, 4, 5, 12, 18</td>
<td>B3, 4, 5, 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cognitive-behavioural therapy for comorbid anxiety/depression</td>
<td>B2,8,12, 18</td>
<td>B8,12</td>
</tr>
<tr>
<td></td>
<td>2-4 Low</td>
<td>Education interventions</td>
<td>B3, 4, 5, 12, 18</td>
<td>B3, 4, 5, 18</td>
</tr>
<tr>
<td></td>
<td>2-4 High</td>
<td>Group interventions to improve psychosocial adjustment</td>
<td>C11</td>
<td>B7, 18</td>
</tr>
</tbody>
</table>
Paediatric Psychology: Introduction

Between 10 - 30% of children are affected by chronic illness or physical health problems\textsuperscript{6,9}, and around 10% of children (under 19 years) are admitted to hospital each year\textsuperscript{4}. Children with chronic illnesses have been found to have a 10%-37% risk of developing psychological difficulties with a recognised increased risk of developing psychological and behavioural problems compared to healthy children\textsuperscript{7,9,10}.

This has major implications, not only for the emotional and social development of the young person, but also for their families and others involved in the child’s care. Furthermore, with ongoing advances in medical science leading to increasingly complex and demanding treatments, children are surviving chronic and life threatening conditions to a far greater degree than in the past, and it is likely that, in turn, this will result in an increase in the number of children and young people presenting with psychological need.

It is increasingly recognised that psychological factors have an impact on the outcome and quality, actual and perceived, of healthcare\textsuperscript{1,2,13,14}. Recent government guidelines recommend that psychological services should be considered as an integral part of children’s medical health care. There is a growing evidence base to support the clinical effectiveness of psychological interventions for a number of medical conditions\textsuperscript{2,5,16}. SIGN Guidelines on the management of diabetes state that “children and adults with type 1 and type 2 diabetes should be offered psychological interventions (including motivational interviewing, goal setting skills and CBT) to improve glycaemic control in the short and medium term”\textsuperscript{14} and in the SIGN guidelines on the management of asthma, family therapy is recognised as having a role in cases of difficult childhood asthma\textsuperscript{15}. Furthermore, research on psychological influences of health care use has shown that there is a link between psychological distress and increased use of health care\textsuperscript{3,8}. It is recognised that psychological input can have a direct impact on health outcomes by addressing problems such as adherence to treatment and managing pain as well as reducing psychological distress. In addition, addressing the child’s and family’s emotional needs alongside their physical health needs helps increase satisfaction with care (National Service Framework for Children in Hospital\textsuperscript{4,11,12}. Furthermore, the psychological well being of medical patients has an impact on treatment and recovery and psychological interventions can often lead to a shorter stay in hospital and fewer medical appointments. Therefore addressing psychological factors may result...
in reduced overall costs of treatment through shorter length of stay, greater adherence to medical management and reduced rate of abandoned procedures due to distress and lack of cooperation.

**Paediatric Psychology: Adherence**

Adherence refers to how well an individual’s behaviour corresponds with agreed recommendations from a healthcare provider\(^\text{18}\). Poor medication adherence is especially common in chronic illness and is associated with poorer outcomes. The following table outlines the main research to date looking at the efficacy of psychological interventions to promote adherence. However, it should be noted that improvements in adherence have been shown to tend to diminish over time and therefore interventions targeting adherence need to be an ongoing part of the clinical management of a paediatric chronic illness\(^\text{12}\).

In addition, interventions aimed at optimising adherence in children and young people should also focus on the need for assessment of any underlying anxiety or depression as this is likely to have a negative impact on the ability of a child or young person to adhere successfully to recommended treatment. Interventions should therefore focus on both barriers to adherence and any underlying anxiety or depression\(^\text{9}\).

As of recently, technology has been increasingly utilized to deliver adherence promoters within a paediatric population\(^\text{20}\). Text-message reminders, telephone reminders and other patient-reminder systems (i.e. internet) have been highlighted as both feasible and successful in promoting adherence\(^\text{3, 19, 25, 34}\).
### Paediatric Psychology: Adherence

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Behavioural (eg monitoring, goal setting, rewards, contingency planning, problem solving, sticker charts)</td>
<td>A(^6,8,15,17,18)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Behavioural + Education</td>
<td>A(^4,8,17,29,38)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Low</td>
<td>Educational Support- multi-families</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Multicomponent intervention (social skills or family therapy + behavioural or education, self-management training, motivational component)</td>
<td>A(^11,17,18,26,32)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Multicomponent intervention</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Low</td>
<td>Educational Support- multi-families</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Behavioural family systems therapy (diabetes) (problem solving, communication, cognitive restructuring, functional-structural family therapy)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Structured parent training programme (psychoeducation, stress management, problem solving) Multidisciplinary</td>
<td>A(^31)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Motivational Interviewing / Strength Based Approaches/Solution Focused</td>
<td>B(^27)</td>
</tr>
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<td>2/3</td>
<td>Low</td>
<td>Counselling and Education</td>
<td></td>
<td>B(^24)</td>
</tr>
<tr>
<td>Level</td>
<td>Frequency</td>
<td>Intensity</td>
<td>Intervention Description</td>
<td>Rating</td>
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<td>-------</td>
<td>-----------</td>
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<td>--------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>2/3</td>
<td>High</td>
<td>Parent-Youth Teamwork Intervention (including education and promotion of parental inclusion in management)</td>
<td>/</td>
<td>B³</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Home based telemedicine</td>
<td>C¹</td>
<td>C¹</td>
</tr>
<tr>
<td>3</td>
<td>Low</td>
<td>Positive Psychology Interventions (Diabetes)</td>
<td>/</td>
<td>C¹⁵</td>
</tr>
<tr>
<td>Moderate–Severe/Complex</td>
<td>3</td>
<td>High</td>
<td>Multisystemic therapy</td>
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<tr>
<td>3</td>
<td>High</td>
<td>Home based Behavioural Family Systems Therapy</td>
<td>/</td>
<td>B¹⁴</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
<td>Multicomponent Therapy</td>
<td>/</td>
<td>C²²</td>
</tr>
</tbody>
</table>
Paediatric Psychology: Chronic Pain

Chronic Pain affects 15%-30% of school age children and adolescents and has major implications for overall quality of life. Many children with chronic pain experience significant pain-related disability such as limited social and physical activities and frequent school absences\textsuperscript{11}.

In addition, pain is a significant social stressor for the family often resulting in parental absences from work to care for the child placing additional emotional and financial stresses on families as a whole. Children experiencing chronic pain are also more likely to report higher levels of distress, anxiety and depression and children with chronic pain are at greater risk of continuing into adulthood with chronic pain, physical symptoms and psychological difficulties\textsuperscript{11,12}.

Psychological interventions have been demonstrated to be effective in diminishing pain and several good meta-analyses have been conducted demonstrating the efficacy of interventions\textsuperscript{3,11}. Whilst to date, the majority of studies on chronic pain in paediatrics have focused on reduction in pain (with a reduction of 50% or more seen as successful), more recent research has begun to look at other aspects of function including level of disability, daily functioning and eating\textsuperscript{11,12,17}.

To date, the majority of the research into chronic pain in children and young people has focused on chronic headache (tension type and migraine), recurrent abdominal pain, musculo-skeletal pain and some condition specific studies and therefore the recommendations in the following table come from this body of evidence. However, more recent reviews highlight that in the paediatric population, non-organic factors may be as important as organic factors in maintaining pain and that the distinction often made between these two terms is probably artificial\textsuperscript{12}. It would therefore seem reasonable that interventions presented would generalise across other chronic pain conditions in the paediatric population. Due to the specific evidence base for headache pain, this has its own subsection in the table.
### Paediatric Psychology: Chronic Pain

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate/Severe</td>
<td>3</td>
<td>High</td>
<td>Cognitive Behavioural Therapy</td>
<td>A⁴,5,10,12</td>
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<td></td>
<td>3</td>
<td>High</td>
<td>Relaxation</td>
<td>A⁴,5,10,12</td>
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<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Biofeedback</td>
<td>A⁴,5,10,12</td>
</tr>
<tr>
<td>Mild/Moderate</td>
<td>2/3</td>
<td>Low</td>
<td>Computer CBT (7+)</td>
<td>B¹⁵</td>
</tr>
<tr>
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<td>Acceptance and Commitment Therapy</td>
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<td>Headache Pain</td>
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</tr>
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<td>Medium</td>
<td>Computer CBT (7+)</td>
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<td></td>
<td>Internet-delivered Family CBT (11+)</td>
<td>C¹¹</td>
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<tr>
<td>Moderate/Severe</td>
<td>Grade</td>
<td>Therapy</td>
<td>Evidence</td>
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<tr>
<td></td>
<td>3</td>
<td>High Biofeedback</td>
<td>A&lt;sup&gt;4,5,6,10,12&lt;/sup&gt;</td>
<td>A&lt;sup&gt;4,5,6,10,12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High Relaxation</td>
<td>A&lt;sup&gt;4,5,10,12&lt;/sup&gt;</td>
<td>A&lt;sup&gt;4,5,10,12&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High Cognitive Behavioural Therapy</td>
<td>A&lt;sup&gt;4,5,10,12&lt;/sup&gt;</td>
<td>A&lt;sup&gt;4,5,10,12&lt;/sup&gt;</td>
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<tr>
<td>Tier 3</td>
<td>High</td>
<td>Acceptance and Commitment Therapy</td>
<td>C&lt;sup&gt;13&lt;/sup&gt;</td>
<td>C&lt;sup&gt;13,14&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Paediatric Psychology: Procedural Distress and Preparation for Procedures

For most children, at least initially, medical procedures, especially those involving needles, are an unpleasant experience and can result in considerable psychological distress for them and their carers.

Maintaining the psychological wellbeing of children is an important component of child-centred treatment, associated with better adjustment and health outcomes\textsuperscript{13}; and a strong evidence base exists for psychological strategies to reduce distress and the experience of pain in children and young people undergoing procedures. This may be particularly salient for trait-anxious children who have a tendency to recall events as more painful\textsuperscript{35}; and as anticipatory state anxiety is negatively associated with the success of procedural sedation\textsuperscript{36}, children with chronic conditions are arguably more susceptible to this positive feedback loop resulting from increased exposure to painful procedures. Anxiety reduction is therefore particularly important for children with chronic conditions. Experiencing medical fear as a child is also predictive of avoidance of medical situations as an adult, thus early intervention may yield lifetime benefits\textsuperscript{34}.

Child coping during procedures has also been shown to be influenced by others, including parents and medical staff and there is some evidence to suggest that parental modelling of anxious behaviour affects children\textsuperscript{40,45}, and parents adjusting to a child’s diagnosis report higher levels of anxious symptoms\textsuperscript{13}. Parental expectations of procedure-related pain reliably predict paediatric procedure-related pain\textsuperscript{29} and this association highlights the value of carrying out psychological interventions with parents to support their children\textsuperscript{13}. Training parents to support their child using distraction increases child coping and reduces distress\textsuperscript{5}. Furthermore, the opportunity for parents to support their child extends beyond the treatment room as specified in, for example, the “Prescriptive Model of Medical and Coping Intervention”\textsuperscript{6}.
As well as psychological support for managing pain and distress related to procedures, timely provision of information regarding imminent procedures is strongly recommended by bodies such as The Child Friendly Healthcare Initiative (CFHCI)\(^{39}\) and has been shown to reduce distress and increase co-operation\(^{17}\). National policy stipulates the importance of the provision of appropriate support to children who are due to undergo potentially distressing procedures and involve them in a developmentally appropriate manner to both reduce distress and facilitate participation\(^{37,38}\). Highly recommended interventions focus on distraction, hypnosis and cognitive-behavioural strategies in children and young people, whilst attachment-based interventions are prioritised for infants. There is a small evidence base supporting music interventions, although it is not known what function these might serve independently of distraction.
### Procedural Distress and Preparation for Procedures

<table>
<thead>
<tr>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Infants / Child / Adolescent</td>
<td></td>
</tr>
<tr>
<td>3/4</td>
<td>Low</td>
<td>Distraction (including the use of virtual reality)</td>
<td>A&lt;sup&gt;4,20,42,43,44&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Hypnosis</td>
<td>A&lt;sup&gt;1,4,25,42,43,44&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventions for preterm infants: kangaroo care, sucking-related interventions, and</td>
<td>A&lt;sup&gt;33&lt;/sup&gt;</td>
</tr>
<tr>
<td>2/3</td>
<td>Low</td>
<td>swaddling/facilitated tucking interventions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Interventions for neonates: sucking-related interventions and rocking/ holding</td>
<td>A&lt;sup&gt;33&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Hypnosis</td>
<td>A&lt;sup&gt;4,25,28,42,43,44&lt;/sup&gt;</td>
</tr>
<tr>
<td>2/3</td>
<td>Low</td>
<td>Distraction</td>
<td>A&lt;sup&gt;4,7,16,31,32,42&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>CBT (e.g coping skills, graded exposure and distraction)</td>
<td>A&lt;sup&gt;2,42,43&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Preparation for procedures: therapeutic play, coping skills</td>
<td>A&lt;sup&gt;24,27&lt;/sup&gt;</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Preparation for procedures: interactive, cartoon characters/ stories, parental</td>
<td>B&lt;sup&gt;2,4,7,11,19,22,23&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>involvement, familiarisation with medical instruments, role playing)</td>
<td></td>
</tr>
</tbody>
</table>

Note: A and B superscript numbers refer to references in the text.
<table>
<thead>
<tr>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/4</td>
<td>High</td>
<td>Parent coaching/training (positioning, distraction, coping skills, exposure and shaping)</td>
<td>B²,9,30,47</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>/</td>
</tr>
<tr>
<td>3/4</td>
<td>High</td>
<td>Music interventions</td>
<td>C815</td>
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Support, Coping and Adjustment in Children, Young People and Families of Children with Chronic Illness

Chronic illness is defined as a persistent or long-term illness, either life-threatening or not, that is generally difficult to cure or incurable. There is a wide range of chronic illnesses that impact children and young people. Asthma, cystic fibrosis, diabetes, cerebral palsy and cancer are some examples of chronic illness that may occur in paediatric populations.

These types of illness are often preceded by a variety of risk factors and causes that can result in impairment or struggle in social, developmental, psychological and functional domains. Furthermore, many of these illnesses require daily self-management and effective coping and adjustment techniques to prevent non-adherence to treatment regimes, which has been documented to be as high as 75% in adolescents, and may be associated with poorer adjustment.

In addition to the impacts of chronic illness upon the patient, families often carry emotional and physical burdens with negative impact on their psychological health. As such, adjustment and coping for families of children and young people with chronic illnesses is pivotal, and coping- or support-related interventions for children and young people should include family components. Subsequently, maladjustment of parents/caregivers and family members of the affected youth can impact the youth’s adjustment or ability to cope. Timing of intervention is also important, especially at the time of diagnosis and key points in the illness journey.
Multiple different group and individual interventions exist to promote adjustment and coping in children and young people. Either educational, cognitive, social or a mix of these components are often included in relevant interventions, and it has been evidenced that family-inclusion is beneficial. Currently there is no set gold-standard measure for coping, adjustment or support of chronic illness in children and adolescents, however cognitive-behavioral based programmes or therapies and adherence promoting interventions have been proven to be efficacious. For parents and siblings specifically, interventions based on education and social support seem to result in positive outcomes.

As of recently, using technology to administer relevant interventions has increased in popularity and internet- and telephone-based interventions have become of interest. Additionally, spiritual coping in children with chronic illness has been depicted as both important and relevant, however it still remains unclear as to how to feasibly incorporate this into a generalised, clinical setting.
### Paediatric Psychology: Support, Coping and Adjustment in Children, Young People and Families of Children with Chronic Illness.

<table>
<thead>
<tr>
<th>Level of Severity</th>
<th>Service Tier</th>
<th>Intensity of Intervention</th>
<th>Purpose</th>
<th>Type of Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild – Severe</td>
<td>3</td>
<td>High</td>
<td>Coping + Support</td>
<td>Cognitive-Behavioural based programmes or Therapy</td>
<td>A^10, A^10, A^6,4,10</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>High</td>
<td>Coping + support</td>
<td>Residential Camp (including psychoeducation- and social-sessions)</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Coping + Support</td>
<td>Social Support Group</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>High</td>
<td>Coping + Support</td>
<td>Multi-component Family Therapy (psychoeducation, parenting skills, problem prevention)</td>
<td>A^11,7</td>
</tr>
<tr>
<td></td>
<td>2/3</td>
<td>Low</td>
<td>Adherence/Coping + support</td>
<td>Psychoeducation</td>
<td>/</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Low</td>
<td>Coping + support</td>
<td>Peer Support Group</td>
<td>C^2, /</td>
</tr>
</tbody>
</table>

Notes:
- A: Evidence-based
- B: Evidence-informed
- C: Expert consensus
- /: Not applicable

*(Last updated 2015)*
Paediatric Psychology: Transition from Paediatric to Adult Services

Prevalence of disability or long standing illness in children and young people up to the age of 15 is 7.5%\(^7\), while in 2014, 12% of young people aged 16 to 24 years reported a long-term illness or disability in 2014\(^8\).

Transitions between care services are periods when young people are especially vulnerable to losing continuity in the care they receive\(^6\). Transition planning should include the young people and their families in decision making, while services should provide adequate and sufficient information and advice to the young person. The planning and transfer should include both the paediatric and adult services. Although there appears to be best practice recommendations, evidence suggests that services fail to reflect the guidance and policies available\(^6\). Young people’s experience reflects this gap between recommendations and practice; young people express feeling insecure and unprepared for the culture of adult services\(^4\). In a UK study on transition from CAMHS to AMHS less than 5% of young people experienced optimal transition\(^9\).

Specific groups are additionally vulnerable, including young people in care, young people excluded from school and young people with specific disorders, such as ADHD\(^3\).

Transition from paediatric to adult services includes programmes of significant heterogeneity in duration, focus, and age of transition. Evidence suggests that duration of interventions varies from one-off events to more than 3 years\(^2\). Interventions can be categorised according to their foci as: staff focused, patient focused or service focused. Staff focused interventions refer to a named coordinator and to joint clinics. Patient focused interventions include disease specific education and self-management or skills training. Service focused interventions include young adult clinics or telephone support programmes. The age of transition varies, and further research is needed to determine the age range at which transition should occur, taking into consideration the patient’s readiness\(^2,4,5\).

Similarly, research evaluating interventions is limited, there are very few randomized controlled trials or controlled trials. A large number of data derives from qualitative research, while most of the evaluation studies adopt a pre- to post-test comparison. To date, only two randomised controlled trials were identified, both of which found no significant effect\(^1,9\). One study reported using a paediatric nurse-delivered CBT model\(^1\).
whilst the other used brief coordinated telephone support\textsuperscript{9}. Outcomes typically focus on physical rather than holistic health and functioning outcomes. Whilst acknowledging psychological aspects of transition, these are not fully-formed psychological interventions, and their poor outcomes suggest that low-intensity psychology-informed transition interventions cannot provide a viable alternative to specialist psychological consultation and intervention within wider service coordination and planning that considers the young person’s psychological and physical health needs. More systematically evaluated trials are needed to meet the concerns of young people.
### Paediatric Psychology: Transition from Paediatric to Adult Services

<table>
<thead>
<tr>
<th>Level of Service</th>
<th>Service Tier</th>
<th>Type of Intervention</th>
<th>Adolescent</th>
</tr>
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<tbody>
<tr>
<td>Specialist</td>
<td>3/4</td>
<td>Joint paediatric/adult clinics (inc. young adult clinic embedded in adult clinic)</td>
<td>C2</td>
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<tr>
<td>Specialist</td>
<td>3</td>
<td>Transition Preparation Training (CBT)</td>
<td>/1</td>
</tr>
<tr>
<td>Specialist</td>
<td>3</td>
<td>Comprehensive Transition Programme</td>
<td>/10</td>
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### NICE & SIGN Guidelines with Relevance to CAMHS Practice

#### Anxiety Disorders, inc Panic Disorder

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#### Antisocial Behaviours and Conduct Disorders

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#### Attention-Deficit Hyperactivity Disorder (ADHD)

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National Institute for Health and Clinical Excellence (2009). When to suspect child maltreatment. NICE |
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Acknowledgements

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<td><strong>Children’s Attachment:</strong></td>
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<td>Niki Georgakakou, University of Edinburgh  Dr Emily Taylor, University of Edinburgh</td>
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<td>Eating Disorders: Anorexia, Bulimia, Overeating and Atypical Eating Disorders</td>
<td>Claire-Ann Banga, University of Edinburgh  Dr Emily Taylor, University of Edinburgh  Dr Fiona Duffy, Senior Teaching Fellow, University of Edinburgh/Consultant Clinical Psychologist, NHS Lothian</td>
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<td>Claire-Ann Banga, University of Edinburgh  Prof. Matthias Schwannauer, University of Edinburgh  Dr Ken MacMahon, Senior Lecturer, University of Edinburgh/ Hon Consultant Clinical Psychologist, NHS Lanarkshire</td>
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<td>Mood Disorders, including Depression and Mood Dysregulation</td>
<td>Niki Georgakakou, University of Edinburgh  Prof. Matthias Schwannauer, University of Edinburgh  Cathy Richards, Consultant Clinical Psychologist, NHS Lothian</td>
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<td>Sarah Brown, University of Edinburgh  Prof. Matthias Schwannauer, University of Edinburgh  Dr Bruce Downey, Clinical Paediatric Neuropsychologist, NHS Grampian</td>
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</table>
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Dr Louise Duffy, Consultant Clinical Psychologist, NHS Lothian |
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<table>
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<tr>
<th>Topic</th>
<th>Authors</th>
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| Paediatric Psychology: Coping and Adjustment to Chronic Illness in CYP including Support for Parents and Families | Sarah Brown, University of Edinburgh  
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Reference Section

Early Intervention and Infant Mental Health Risks and Disorders


Assessment and Intervention Program in very low birth weight infants at 24 months corrected age. Journal of Pediatrics, 156, 359-365.


Children’s Attachment: Attachment in Children and Young People who are Adopted From Care, In Care or at High Risk of Going Into Care


**Autism Spectrum Disorders**


**Disruptive Behaviour Disorders (Disorders of Conduct)**


*Social Learning Theory based Parent Management Training – (Starred entries indicate UK research)

**Anxiety Disorders Inc. Panic Disorder**


**Anxiety Disorder: Obsessive Compulsive Disorder**


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Bipolar Disorder


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**Trauma: PTSD and Complex Trauma**


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**Acquired Brain Injury**


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Paediatric Psychology: Introduction


**Paediatric Psychology: Adherence**


Paediatric Psychology: Chronic Pain


**Paediatric Psychology: Procedural Distress and Preparation for Procedures**


**Paediatric Psychology: Support, Coping and Adjustment in Children, Young People and Families of Children with Chronic Illness**


**Paediatric Psychology: Transition from Paediatric to Adult Services**


