NICE GUIDANCE AND EVIDENCE REVIEW MATRIX

2022

0 - 18 YEAR OLDS

Norfolk and Waveney
Children and Young People's mental health service

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Introduction

The present Matrix focuses on summarising evidence-based recommendations for the treatment of mental health difficulties and the support of children and young people up to age 18 and their families or carers. The Matrix is intended to be a guide and useful resource to mental health professionals, providers, and commissioners. However, the Matrix does not consider comorbidity of difficulties and although it highlights evidence-based interventions these do not always meet the needs of the young people we support. Please consider individual and contextual differences in combination with clinical judgement, expertise and practice-based evidence to inform care whilst collaboratively planning support and interventions.

The Matrix describes the National Institute for Health and Care Excellence (NICE) Guidelines and further meta-analysis and systematic reviews that have since then been published on the treatment of the various mental health presentations. The Matrix also highlights emerging and contemporary evidence-based interventions and support that may not have been otherwise captured on the NICE Guidelines or research reviews. All interventions should be taken into consideration alongside clinical expertise and practice-based evidence, and we hope they can help clinicians and services to expand the offer of support available to children, young people and their families.

The Matrix will likely not cover all mental health presentations for children and young people but is designed to cover those that are most common. For further support around the evidence-base for other presentations and transdiagnostic interventions please do liaise with your service clinical and operational leads. Please note the research and emerging evidence is not comprehensive and we encourage you to assess the literature further and examine its safety and suitability for your service users if planning to implement new practices.

The Matrix largely focuses on psychosocial interventions and is divided into two parts:

Part I: Brief summary reference guide of the NICE Guidelines, including the recommended course of support and intervention, and contemporary research evidence for each mental health need or neurodevelopmental differences. Click on the links to be signposted to further detailed information on Part II or to the research papers.

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You will find the above arrow in this section. Please note the arrow indicates the sequence of interventions that are recommended to be offered. It indicates the first line of treatment followed by an escalation in support or when the interventions may not be appropriate or suitable for the child, young person or family.

Part II: Detailed description of the NICE Guidelines, further research on well-established psychosocial interventions and support, contemporary and emerging evidence for the treatment of each mental health need and support for neurodevelopmental differences. Click on the links to be signposted to specific NICE Guidelines webpages or to the research papers for further in depth reading. Please contact the NHS Healthcare Library Service if you are unable to access or read the complete version of the paper.

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Anxiety, Fears & Worries

Presentation	NICE Guidelines Intervention Pathway (QS53, CG159, CG31, NG116)	Contemporary Research Evidence
Anxiety, Fears & Worries	Low intensity self-help ↓ High intensity psychological therapies	• Parent-delivered cognitive behavioural therapy (CBT) (Thirlwall et al., 2013; Creswell et al., 2017; Evans et al., 2019)
Social Anxiety	Individual or group Cognitive Behavioural Therapy (CBT) focused on social anxiety	• Mindfulness-based therapy • Acceptance and Commitment Therapy • Internet-based therapy • Virtual reality exposure • Attention bias modification (Pelissolo, 2019)
Obsessive Compulsive Disorder (OCD)	*Mild impairment*: guided self-help *Moderate to severe impairment*: individual or group CBT including Exposure and Response Prevention (ERP) that involves the family or carers	• Family based interventions (McGrath & Abbott, 2019)
Body Dysmorphia	CBT including ERP ↓ Selective Serotonin Reuptake Inhibitor (SSRI)	• Parent-oriented CBT (Brezinka, Maildander & Walitza, 2020) • iCBT (Aspval et al., 2018, 2021)
Post-Traumatic Stress Disorder (PTSD)	Active monitoring ↓ Individual trauma-focused CBT ↓ Eye Movement Desensitisation and Reprocessing (EMDR)	• Play therapy (Mavranezouli et al.,2020; Braito et al., 2021; Parker et al., 2021). • Art therapy or art psychotherapy (Braito et al., 2021) • Parent training (Mavranezouli et al.,2020) • Supportive counselling (Mavranezouli et al.,2020) • Family therapy (Mavranezouli et al.,2020)

Depression/Low Mood

Presentation	NICE Guidelines Intervention Pathway (NG134)	Contemporary Research Evidence
Mild Depression	Consider options based on developmental level – digital CBT, group CBT, group non-directive supportive therapy (NDST), group interpersonal psychotherapy (IPT) ↓ If the previous options do not meet the service user's needs or are unsuitable – attachment-based family therapy, individual CBT	• Psychoeducational Interventions (PIs) (Jones et al., 2018) • Exercise interventions (Hu et al., 2020)
Moderate to Severe Depression	Consider options based on developmental level – family-based IPT, family therapy, psychodynamic psychotherapy, individual CBT ↓ If the previous options do not meet the service user's needs or are unsuitable – IPT-A (IPT for adolescents), family therapy, brief psychosocial intervention, psychodynamic psychotherapy	• Brief Behavioural Activation (Brief BA) (Pass et al., 2017, 2018; Lewis-Smith et al., 2021; Watson et al., 2021). • Brief Psychosocial Interventions (BPI) (Goodyer et al., 2017)

Antisocial Behaviour and Conduct Problems

Age	NICE Guidelines Intervention Pathway (CG158)	Contemporary Research Evidence
3 – 11	Group parent training programmes ↓ Offer individual parent training programmes to parents who are not able to participate in a group Parent and child training programmes to children and young people if their problems are severe and complex Group foster carer/guardian training programmes ↓ Offer individual carer/guardian training programmes if not able to participate in a group	• Video interaction guidance (O'Hara et al. 2019) • Incredible Years (Leigten et al., 2017, 2019; Overbeek et al., 2020) • Child-focused social skills or CBT (Kuhn et al., 2022)
9 – 14	Group social and cognitive problem-solving programmes	
11 – 17	Multimodal interventions involving the child or young person and their parents and carer (e.g., multisystemic therapy)	

ADHD

Age	NICE Guidelines Intervention Pathway (NG87)	Contemporary Research Evidence
Under 5	Group parent-training programmes for parents or carers	• Incredible Years (Leigten et al., 2017) • The New Forest Parenting Programme for 3 – 11 years olds (Sonuga-Barke et al., 2018, Larsen et al., 2020). Family home delivery and self-help versions available (Daley, Tarver & Sayal, 2020)
5+	Group-based ADHD-focused support for parents or carers Individual parent-training programmes for parents and carer of children and young people with oppositional or conduct disorder Consider CBT for young people when symptoms are causing significant impairment	

Autism

Presentation	NICE Guidelines Intervention Pathway (CG128)	Contemporary Research Evidence
Autism	• Social and physical adjustment • Specific social-communication intervention • Anticipate and prevent behaviour that challenges • Psychosocial interventions for behaviour that challenges • Families/carers needs assessment	• Reciprocal imitation training (RIT), symbolic play (SP) and music therapy (Maw & Haga, 2018) • Physical activity (PA) for adolescents (Sorensen & Zarret, 2014) • Social skills training (SST) (Soares et al., 2020) • Behavioural Intervention Technologies (BITs) (Soares et al., 2020) • Mindfulness-based training for young people and their parents (Salem-Guirgis et al., 2019) • Yoga and mindfulness-based interventions for children and adolescents (Semple, 2019) • CBT (Wang et al., 2021)

Attachment difficulties

Presentation	NICE Guidelines Intervention Pathway (NG26)	Contemporary Research Evidence
Interventions for attachment difficulties in CYP on the edge of care Edge of care preschool-age children who have been or are at risk of being maltreated Primary and secondary school-age children and young people who have been, or are at risk of being maltreated	Video feedback programme (VFP) ↓ If parents do not want to take part on VFP offer parental sensitivity and behaviour training If little improvement is perceived following participation on VFP, arrange a multi-agency review before further interventions ↓ Home visiting programme Parent-child psychotherapy Trauma-focused CBT	• Screening tool (Milford & Oates, 2009) • Coping with Crying – NSPCC (NSPCC, 2022) • Turing into Kids (TIK) (3 – 15 years old) (Havighurst, Murphy & Kehoe, 2021) • Family System Play Therapy (Daley, Miller, Bean & Oka, 2018)
Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care Preschool-age Primary age	Video-feedback programme (VFP) Intensive training and support for foster carers, special guardians and adoptive parents combined with group therapeutic play sessions.	• Attachment & Biobehavioural Catchup (ABC) (Dozier, Roben, Caron, Hoye & Bernard, 2018).

Late primary and early secondary age	Group-based training and education programme for foster carers, guardians/adoptive parents combined with group-based training and education programme for CYP.	
Interventions for attachment difficulties in children and young people in residential care	Parental sensitivity and behaviour training adapted for professionals	• Group play therapy (Baggerly, 2009; Dousti, Pouyamanesh, Aghdam & Jafari, 2018; Mousavi & Safarzadeh, 2016) • Attachment based Theraplay (Franic, Bennion & Humrich, 2017) • Promoting interpersonal relationships, motivation and future focus (Lou et al., 2018). • Video-games interventions (Aventin, Houston & Macdonald, 2014; Schuurmans, Nijhof, Engels & Granic, 2018) • Trauma interventions (Bentovim, Gray & Pizzey, 2018)

Eating Disorders

Presentation	NICE Guidelines intervention pathway (NG69)	Contemporary Research Evidence
Anorexia Nervosa	Psychoeducation; monitor of weight, mental and physical health; working with MDT; involve guardians where appropriate. ↓ Anorexia-nervosa-focused family therapy (with and/or without family) ↓ Individual CBT, adolescent-focused psychotherapy for anorexia nervosa.	• Acceptance and commitment therapy (ACT) (Karekla, Nikolaou & Merwin, 2022) • Consider increased risk of additional MH difficulties post ED treatment (Stewart et al., 2022) • Parental criticism can negatively impact effectiveness of family therapy. Consider expressed emotion in care giver and make judgement on the appropriateness of family therapy. The Five Minute Speech Sample can be used to identify expressed emotion (Allan et al., 2018; Lock & Grange, 2018)
Binge Eating Disorder	Binge-eating-disorder-focused guided self-help programme ↓ Group eating-disorder-focused cognitive behavioural therapy (CBT-ED) ↓ Individual CBT-ED.	• Condensed Dialectical Behavioural Therapy (DBT) skills group for 14–18-year-olds (Pluhar et al., 2018 ; Kamody et al., 2019; Kamody et al., 2020) • CBT and DBT (Pearson, Zapolski & Smith, 2014)
Bulimia Nervosa	Bulimia-nervosa-focused family therapy (FT-BN) ↓ Individual eating-disorder-focused CBT (CBT-ED)	• Lack of evidence to support alternative treatment (Hail & Le Grange, 2018; Lenton-Brym, Rodrigues, Johnson, Coutuier & Toulany, 2020)

Further considerations:

Transgender youth (Geilhufe et al., 2021)

Guides for supporting friends and/or family members with ED can be found here:

Eating disorders: a guide for friends and family

Family Lives: eating disorders

Self-harm

Presentation	NICE Guidelines Intervention Pathway (CG16, CG133, GID-NG10148)	Contemporary Research Evidence
Self-harm	Psychosocial assessment Care plan Risk management plan Provision of information about the treatment and management of self-harm Psychological intervention Harm reduction	Evidence-based risk management in the community (Clarke et al., 2019) Family-based interventions for suicidal ideation and behaviour show promising results (Freya et al., 2022) Preliminary evidence for manualized CBT interventions to be effective in reducing self-harming behaviours in young people (Taylor et al., 2011) RUSH – 8 sessions based on NICE guidelines, counselling approaches and specialist advice giving. 4-6 week follow up indicated significant reducing in self-report self-harm frequency, anxiety and depression (Cross & Clarke, 2022)

For additional resources on the presentations:

Centre for Clinical Interventions

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Anxiety	Anxiety Disorders (QS53) Anxiety disorders are generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive-compulsive disorder and body dysmorphic disorder. NICE guidelines indicate that evidence-based psychological interventions include both low-intensity interventions incorporating self-help approaches and high-intensity psychological therapies should be considered depending on the particular anxiety disorder (please see below).	**Anxiety** An umbrella review (Correll et al., 2021) suggested the following treatments for anxiety: • individual CBT • group CBT • digital CBT. CBT interventions linked to reduced anxiety diagnoses and/or symptoms (Schwartz et al. 2019): • Cool Kids • Cool Little Kids Plus Social Skills • Coping Cat/C.A.T. Project • Coping Koala • One-Session Treatment • Parent Education Program • Skills for Academic and Social Success • Strongest Families • Timid to Tiger.	**Anxiety** There is promising evidence full guided parent delivered CBT is an effective and cost-effective first-line treatment for child anxiety (Thirlwall et al., 2013) even when compared with other forms of brief intervention (individual solution-focused brief therapy) (Creswell et al., 2017). Parent-delivered CBT has been associated with a significant reduction in child anxiety symptoms and most did not require further treatment (Evans et al., 2019). Other than reducing child anxiety, parent delivered CBT has been shown to improve parental tolerance of the child's negative emotions and has proved to be appropriate even when the parent is highly anxious (Hiller et al., 2016). In a qualitative study (Allard et al., 2021), parents reported wide ranging benefits, both for the individual child and the wider family – in terms of symptoms and general functioning, but also family relationships. These findings are in relation to a clinician-guided parent-delivered CBT comprised of 8 sessions with parents (4 face-to-face and 4 telephone reviews) of children aged **5 to 12 years old** where the clinician's role is to encourage parents to work through a self-help guide manual *Overcoming your Child's Fears and Worries* (by Cathy Creswell & Lucy Willets), rehears key skills with parents and help parents to problem-solve challenges that arise. **Full guided parent-delivered CBT** Week 1 — Face-to-face session (1 h): • introduction to anxiety • discussion of possible causal and maintaining factors, and the implications for treatment • discussion of how to identify child anxious thoughts and challenge them Week 2 — Face-to-face (1 h): • introduction to cognitive restructuring and practice • discussion of parental responses to anxiety Week 3 — Telephone session (20 min): review tasks Week 4 — Face-to-face (1 h): devise graded exposure plan Week 5 — Telephone session (20 min): review tasks Week 6 — Telephone session (20 min): review tasks Week 7 — Face-to-face (1 h): • introduction to problem-solving and practice • review progress • discussion of how to continue helping their child and plan long-term goals Week 8 — Telephone session (20 min): review tasks

Presentation	NICE Guidelines	Research	Latest Emerging Evidence

Social Anxiety	Social Anxiety (CG159)
	
	Treatment principles
	
	All interventions for children and young people with social anxiety disorder should be delivered by competent practitioners. Psychological interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention. Practitioners should consider using competence frameworks developed from the relevant treatment manual(s) and for all interventions should:
	
	• receive regular high-quality supervision
	• use routine sessional outcome measures, for example:
	  ○ the LSAS – child version or the SPAI-C, and the SPIN or LSAS for young people
	  ○ the MASC, RCADS, SCAS or SCARED for children
	• engage in monitoring and evaluation of treatment adherence and practitioner competence – for example, by using video and audio tapes, and external audit and scrutiny if appropriate.
	
	Be aware of the impact of the home, school and wider social environments on the maintenance and treatment of social anxiety disorder. Maintain a focus on the child or young person's emotional, educational and social needs and work with parents, teachers, other adults and the child or young person's peers to create an environment that supports the achievement of the agreed goals of treatment.
	
	Treatment for children and young people with social anxiety disorder
	
	Offer individual or group CBT focused on social anxiety to children and young people with social anxiety disorder. Consider involving parents or carers to ensure the effective delivery of the intervention, particularly in young children.
	
	Delivering psychological interventions for children and young people
	
	Individual or group CBT should consist of the following, taking into account the child or young person's cognitive and emotional maturity:
		Social Anxiety
		
		Leigh and Clark (2018) have highlighted CBT tends to not target specific anxiety disorders in children and young people. However, a number of studies have shown that outcomes from generic CBT are less good for young people with Social Anxiety after treatment compared with young people with other anxiety diagnosis. Therefore, psychological therapies designed specially for social anxiety have been developed, namely:
		• Cognitive Behavioural Group Therapy (Albano et al., 1995) – it involves psychoeducation and skills training (social skills and anxiety management strategies) followed by exposure tasks.
		• Social Effectiveness Therapy (Baer & Garland, 2005) and its parallel version for 8-12 years olds Social Effectiveness Therapy for Children (Beidel et al., 2000). It is a behavioural group treatment comprising psychoeducation, social skills training and exposure.
		• Skills for Academic Success (Masia-Warner et al., 2005; 2007), a low-intensity school-based intervention.
		
		Please note that group CBT was superior to individual CBT in head-to-head comparisons (small effect size). The majority of systematic evaluations of interventions for social anxiety disorder in children and young people have taken a group approach. However, studies with adult populations indicate that individually delivered treatments are associated with better treatment outcomes and are more cost-effective (NICE, 2013).
			Social Anxiety
			
			CBT, in individual or in group settings, is the most validated psychosocial approach, and includes various techniques such as psychoeducation, behavioural exposure and cognitive therapy. However, recent developments of CBT, with interesting applications in Social Anxiety management, include third wave approaches such as mindfulness-based therapy, acceptance and commitment therapy (ACT), internet-based therapy, virtual reality exposure, and attention bias modification (Pelissolo, 2019).

	• 8–12 individual sessions of 45 minutes' duration or 8–12 sessions of 90 minutes' duration with groups of children or young people of the same age range • psychoeducation, exposure to feared or avoided social situations, training in social skills and opportunities to rehearse skills in social situations • psychoeducation 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 Consider psychological interventions that were developed for adults for young people (typically aged 15 years and older) who have the cognitive and emotional capacity to undertake a treatment developed for adults.		
Presentation	**NICE Guidelines**	**Research**	**Latest Emerging Evidence**
Obsessive-Compulsive Disorder and Body Dysmorphic Disorder	Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD) (CG31) **Initial Treatment Options** For children and young people with **OCD with mild functional impairment**, guided self-help may be considered in conjunction with support and information for the family or carers. Children and young people with **OCD with moderate to severe functional impairment, and those with OCD with mild functional impairment for whom guided self-help has been ineffective or refused**, should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child as the treatment of choice. Group or individual formats should be offered depending upon the preference of the child or young person and their family or carers. All children and young people with **BDD** should be offered CBT (including ERP) that involves the family or carers and is adapted to suit the developmental age of the child or young person as first-line treatment. If psychological treatment is declined by children or young people with OCD or BDD and their families or carers, or they are unable to engage in treatment, an SSRI may be considered with specific arrangements for careful monitoring for adverse events. The co-existence of comorbid conditions, learning disorders, persisting psychosocial risk factors such as family discord, or the presence of	**OCD** An umbrella review (Correll et al., 2021) suggested the following treatments for OCD: • CBT • Behavioural Therapy with ERP **BDD** Watson and Ban (2021) have highlighted CBT as an effective way to manage BDD, and also identified the following as relevant: • Psychoeducation on the reality of fake ideologies • Promoting positive body image • Improving young people's understanding of themselves • Reducing young people's desire for self-perfection • Conducting a risk assessment and risk management.	**OCD** McGrath and Abbott (2019) conducted a meta-analysis and systemic review examining the effect of Family-Based Interventions in OCD symptoms outcomes as well as on a range of family factor outcomes (including family assistance, cohesion, conflict, and general family functioning) for children and adolescents with OCD. Overall, Family-Based Interventions were found to be effective at post-test and follow-up. The findings of the current study highlight the importance of reducing family-related maintaining factors, such as family assistance by specifically targeting these family factors in OCD interventions for young people to optimise treatment response. Family assistance is the process whereby other family members participate or assist with a child's OCD symptoms. It can range from active participation in symptoms (e.g., answering a child's repetitive questions in an attempt to reduce their distress) to family members assisting with the avoidance of anxiety-provoking situations, providing reassurance and waiting for the completion of rituals, and/or modifying daily routines to assist with OCD. The current findings indicate that FA is not the only critical family variable to target in treatment to enhance outcomes. In fact, the more family factors targeted, the greater are these outcomes. This study's findings add further support to preliminary results presented in the treatment literature that specific family factors, such as family cohesion, conflict, and parental blame of the young person, can affect response to treatment for young people with OCD. **BDD** Treatment recommendations for OCD in very young children (**between the age of 3 and 8 years)** include parent-oriented CBT with an emphasis in reducing family assistance (Brezinka, Mailander & Walitza, 2020).

	parental mental health problems, may be factors if the child or young person's OCD or BDD is not responding to any treatment. Additional or alternative interventions for these aspects should be considered. The child or young person will still require evidence-based treatments for his or her OCD or BDD. **How to use psychological interventions** Psychological treatments for children and young people should be collaborative and engage the family or carers. When using psychological treatments for children or young people, healthcare professionals should consider the wider context and other professionals involved with the individual. The recommendations on the use of psychological interventions for adults may also be considered, where appropriate. In the cognitive-behavioural treatment of children and young people with OCD or BDD, particular attention should be given to: • developing and maintaining a good therapeutic alliance with the child or young person, as well as their family or carers • maintaining optimism in both the child or young person and their family or carers • collaboratively identifying initial and subsequent treatment targets with the child or young person • actively engaging the family or carers in planning treatment and in the treatment process, especially in ERP where, if appropriate and acceptable, they may be asked to assist the child or young person • encouraging the use of ERP if new or different symptoms emerge after successful treatment • laising with other professionals involved in the child or young person's life, including teachers, social workers and other healthcare professionals, especially when compulsive activity interferes with the ordinary functioning of the child or young person • offering 1 or more additional sessions if needed at review appointments after completion of CBT. In the psychological treatment of children and young people with OCD or BDD, healthcare professionals should consider including rewards in order to enhance their motivation and reinforce desired behaviour changes.		There is preliminary evidence that iCBT is effective in reducing ODC symptoms in children and young people and can be an alternative as helpful as in-person CBT (Aspval et al., 2018, 2021). Clink here for a video. ImaginYouth — A Therapist-Guided Internet-Based Cognitive-Behavioural Programme for Adolescents and Young Adults With Body Dysmorphic Disorder (Hartmann et al., 2021). Description of modules, number of sessions and content, and associated homework here

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Post-Traumatic Stress Disorder (PTSD)	Post-Traumatic Stress Disorder (PTSD) (NG116) **Psychological interventions for the prevention and treatment of PTSD in children and young people** **Prevention for children and young people:** Consider active monitoring or individual trauma-focused cognitive behavioural therapy (CBT) within 1 month of a traumatic event for children and young people aged under 18 years with a diagnosis of acute stress disorder or clinically important symptoms of PTSD. Consider a group trauma-focused CBT intervention for children and young people aged 7 to 17 years if there has been an event within the last month leading to large-scale shared trauma. Group trauma-focused CBT interventions for children and young people who have been exposed to large-scale shared trauma within the last month should: • be based on a validated manual • typically be provided over 5 to 15 sessions • be delivered by trained practitioners with ongoing supervision • include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning • involve elaboration and processing of the trauma memories • involve restructuring trauma-related meanings for the individual • provide help to overcome avoidance. **Treatment for children and young people:** Consider an individual trauma-focused CBT intervention for children aged 5 to 6 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. Consider an individual trauma-focused CBT intervention for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a traumatic event.	**PTSD** An umbrella review (Correll et al., 2021) suggested CBT for the treatment of PTSD. A research review and network meta-analysis (Mavranezouli et al., 2020) has looked at psychological and psychosocial treatments for children and young people with PTSD. It has concluded trauma-focused CBT (TF-CBT), in particular individually delivered forms such as cognitive therapy, narrative exposure, exposure/prolonged exposure and Cohen TF-CBT/Cognitive Processing Therapy, appear to be most effective in reducing PTSD symptoms and achieving remission in children and young people with PTSD at end of treatment. Cognitive therapy for PTSD was shown to be the most effective intervention in reducing PTSD symptoms at treatment endpoint (albeit based on small samples and only single-event trauma), followed by combined somatic/cognitive therapies, child–parent psychotherapy, combined TF-CBT/parent training, and meditation; however, results for these interventions were also based on a very limited evidence base.	**PTSD** Play therapy showed similar effects to exposure/prolonged exposure. EMDR and group TF-CBT also appeared to be effective in reducing PTSD symptoms in children and young people with PTSD at treatment endpoint, but with smaller effects compared with other interventions. Parent training alone, supportive counselling and family therapy showed smaller effects in reducing PTSD symptoms (Mavranezouli et al., 2020). There is also evidence that child-centred play therapy (Parker et al., 2021) and art therapy or art psychotherapy (Braito et al., 2021) may benefit children who have experienced trauma or who have PTSD symptoms.

	Offer an individual trauma-focused CBT intervention to children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event. Individual trauma-focused CBT interventions for children and young people should: • be based on a validated manual • typically be provided over 6 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas • be delivered by trained practitioners with ongoing supervision • be adapted to the child or young person's age and development • involve parents or carers as appropriate • include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning • involve elaboration and processing of the trauma memories • involve processing trauma-related emotions, including shame, guilt, loss and anger • involve restructuring trauma-related meanings for the individual • provide help to overcome avoidance • prepare them for the end of treatment • include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries). Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT.		

Presentation	NICE Guidelines	Research	Latest Emerging Evidence

Depression	Depression (NG134)
	
	Managing mild depression
	
	Watchful waiting
	
	For children and young people with diagnosed mild depression who do not want an intervention or who, in the opinion of the healthcare professional, may recover with no intervention, a further assessment should be arranged, normally within 2 weeks ('watchful waiting').
	
	Healthcare professionals should make contact with children and young people with depression who do not attend follow-up appointments.
	
	Treatments for mild depression
	
	For children and young people with learning disabilities, see the recommendations on psychological interventions in the NICE guideline on mental health problems in people with learning disabilities.
	
	Antidepressant medication should not be used for the initial treatment of children and young people with mild depression.
	
	Discuss the choice of psychological therapies with children and young people with mild depression and their family members or carers (as appropriate). Explain:
	
	• what the different therapies involve
	• the evidence for each age group (including the limited evidence for 5- to 11-year-olds)
	• how the therapies could meet individual needs, preferences and values.
	
	Base the choice of psychological therapy on:
	
	• a full assessment of needs, including:
	  ○ the circumstances of the child or young person and their family members or carers
	  ○ their clinical and personal/social history and presentation
	  ○ their maturity and developmental level
	  ○ the context in which treatment is to be provided
		Depression
		
		An umbrella review (Correll et al., 2021) suggested the following interventions for the treatment of depression:
		• CBT
		• IPT
		• Problem-Solving Therapy
		• Family Therapy.
		
		A systematic review and meta-analysis suggested that behavioural activation may be effective in the treatment of depression in young people (Tindall et al., 2017). Additionally, a meta-analysis (Oud Et al., 2019) and systematic review (Martin & Oliver, 2019) suggested CBT containing a combination of behavioural activation and challenging thoughts component (as part of cognitive restructuring) or the involvement of caregiver(s) in intervention was associated with better outcomes for youth on the long term.
		
		Attachment-Based Family Therapy has been studied through randomized control trials (Diamond et al., 2010; Diamond et al., 2019) and has been showed to be effective in reducing suicidal ideation and depressive symptoms in adolescents (12-18 years).
			Mild depression
			
			Over recent years there has been growing interest in psychoeducational interventions (PIs) for the prevention and management of adolescent depression. PIs involves the delivery of accurate information to individuals, families and carers about mental health or a specific diagnosis (including possible causes and symptoms), management (including associated risks/side-effects) and prognosis, and how affected individuals can stay well. A systematic review (Jones et al., 2018) was conducted of the published literature on PIs for adolescents with (or at risk of) depression. Studies showed PIs may have a beneficial effect on a range of measures, including knowledge/understanding of depression and its effects, behaviour and attitudes, treatment adherence, and depression and other mental health and wellbeing outcomes. Increased parental and child understanding which may be facilitated by PIs, can lead to improved communication, conflict resolution and problem-solving, and this appears to be important in managing/preventing depressive symptoms in adolescence. Evidence for the effectiveness of PIs is limited, but based on the evidence to date PIs in adolescent depression show some promise, although further well-designed multi-centre trials are needed. All this is consistent with a review of PIs for depression in adults, which concluded that whilst few studies have been published in this field, PIs can help improve the clinical course, treatment adherence and psychosocial functioning in adults, and family PI is seen as part of its 'optimal treatment'. PIs can have a role in preventing/managing adolescent depression, as a first-line or adjunctive approach.
			
			A systematic review of metanalysis (Hu et al., 2020) has concluded there is preliminary evidence suggesting exercise interventions have a beneficial effect on depressive symptoms across a wide age-range, including children and young people.

	○ comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities • patient and carer preferences and values (as appropriate). For **5- to 11-year-olds with mild depression** continuing after 2 weeks of watchful waiting, and without significant comorbid problems or active suicidal ideas or plans, consider the following options adapted to developmental level as needed: • digital cognitive–behavioural therapy (CBT) • group CBT • group non-directive supportive therapy (NDST) • group interpersonal psychotherapy (IPT). If these options would not meet the child's clinical needs or are unsuitable for their circumstances, consider the following adapted to developmental level as needed: • attachment-based family therapy • individual CBT. For **12- to 18-year-olds with mild depression** continuing after 2 weeks of watchful waiting, and without significant comorbid problems or active suicidal ideas or plans, offer a choice of the following psychological therapies for a limited period (approximately 2 to 3 months): • digital CBT • group CBT • group NDST • group IPT. If the options in recommendation would not meet the clinical needs of a 12- to 18-year-old with mild depression or are unsuitable for their circumstances, consider: • attachment-based family therapy or • individual CBT. Provide psychological therapies in settings such as schools and colleges, primary care, social services and the voluntary sector. If mild depression in a child or young person has not responded to psychological therapy after 2 to 3 months, refer the child or young person for review by a CAMHS team.		

	Follow the recommendations on treating moderate to severe depression for children and young people who have continuing depression after 2 to 3 months of psychological therapy (see the section on moderate to severe depression).
	
	Treatments for moderate to severe depression
	
	For children and young people with learning disabilities, see the recommendations on psychological interventions in the NICE guideline on mental health problems in people with learning disabilities.
	
	Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS team.
	
	Discuss the choice of psychological therapies with children and young people with moderate to severe depression and their family members or carers (as appropriate). Explain:
	
	• what the different therapies involve
	• the evidence for each age group (including the limited evidence for 5- to 11-year-olds)
	• how the therapies could meet individual needs, preferences and values.
	
	Base the choice of psychological therapy on:
	
	• a full assessment of needs, including:
	  ○ the circumstances of the child or young person and their family members or carers
	  ○ their clinical and personal/social history and presentation
	  ○ their maturity and developmental level
	  ○ the context in which treatment is to be provided
	  ○ comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities
	  ○ patient and carer preferences and values (as appropriate).
	
	For 5- to 11-year-olds with moderate to severe depression, consider the following options adapted to developmental level as needed:
	
	• family-based IPT
	• family therapy (family-focused treatment for childhood depression and systems integrative family therapy)
	• psychodynamic psychotherapy
			Moderate to severe depression
			
			There is growing evidence that Brief Behavioural Activation (Brief BA) is a promising innovation in the treatment of adolescent (14-17 years) depression and both young people and parents reported high levels of acceptability and satisfaction with the approach (Pass et al., 2017). Early evidence supports the use of Brief BA to treat adolescent depression in schools with some adaptation (Pass et al., 2018).
			
			Brief BA is a manualised treatment (*Brief Behavioural Activation for Adolescent Depression: A Clinician's Manual and Session-by-Session Guide* by Laura Pass and Shirley Reynolds) for depression symptoms in adolescents and involves activity monitoring and scheduling, consideration of values and important life areas, increasing valued behaviours, and contracting support from others. Other components are: psycho-education about adolescent depression in the context of adolescent development, a greater focus on collaboration and engagement of the young person in therapy, adolescent case examples, a manual for young people, involvement of parents/carers in treatment (including a treatment manual for parents), and the addition of problem solving as a therapeutic technique.
			
			Qualitative studies (Lewis-Smith et al., 2021; Watson et al., 2021) indicate that therapist support, and both specific Brief BA strategies (e.g., connecting with values), more generic therapeutic strategies (e.g. self-monitoring) may help treat symptoms of depression in adolescents.
			
			Brief Psychosocial Interventions (BPI) (a manualised problem-focused psychoeducation package of up to 12 sessions, consisting of to 8 individual and 4 family/parent sessions) have also shown to be an effective choice of treatment for adolescents (11-17 years) with moderate to severe depression (Goodyer et al., 2017). BPI empathise the importance of psychoeducation about depression and action-oriented, goal-focused, interpersonal activities as therapeutic strategies. Specific advice is given on improving and maintaining mental and physical hygiene, engaging in pleasurable activities, engaging with and maintaining schoolwork and peer relations, and diminishing solitariness (Goodyer et al., 2017).

	• individual CBT. For 12- to 18-year-olds with moderate to severe depression, offer individual CBT for at least 3 months. If individual CBT would not meet the clinical needs of a 12- to 18-year-old with moderate to severe depression or is unsuitable for their circumstances, consider the following options: • IPT-A (IPT for adolescents) • family therapy (attachment-based or systemic) • brief psychosocial intervention • psychodynamic psychotherapy.		

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Antisocial behaviour and conduct disorders	Antisocial behaviour and conduct disorders (CG158) Psychosocial interventions 3 – 11: Parent training programmes Offer group parent training programmes to the parents of children and young people aged between 3 and 11 years old who: • have been identified as being at high risk of developing oppositional defiant disorder or • have oppositional defiant disorder or conduct disorder or • are in contact with the criminal justice system because of antisocial behaviour. Group parent training programmes should involve both parents if possible and in the best interest of the child or young person, and should: • typically have between 10 and 12 parents in a group • be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills • typically consist of 10 to 16 meetings of 90 to 120 minutes' duration • adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial). Offer an individual parent training programmes to the parents of children and young people aged between 3 and 11 years old who are not able to participate in a group parent training programme and whose child: • have been identified as being at high risk of developing oppositional defiant disorder or • have oppositional defiant disorder or conduct disorder or • are in contact with the criminal justice system because of antisocial behaviour. Individual parent training programmes should involve both parents if this is possible and in the best interests of the child or young person, and should: • be based on a social learning model, using modelling, rehearsal and feedback to improve parenting skills	Antisocial behaviour and conduct disorders In an umbrella review (Correll et al ., 2021), the findings indicated that a combination of parental (including parental training) and child behavioural interventions should be regarded as the first-line treatment. A meta-meta-analysis (Mingebach et al, 2018) suggested parent-based interventions are effective in the treatment of child externalizing behaviour problems. These interventions are cost-effective and result in positive long-term effects. Particular interventions are already based on a broad empirical data base, for instance: • Incredible Years • Parent-Child Interaction Therapy (PCIT) • Tiple P. Another meta-analysis (Leijten et al., 2019) suggested it might be helpful for parenting programmes to cover: • positive reinforcement (e.g. praise, rewards) • nonviolent discipline techniques (e.g. use of natural/logical consequences, time-out) • proactive parenting (e.g. monitoring) • relationship building (e.g. parent-child play) • active listening • parental self-management (e.g. emotional regulation skills, problem-solving skills, partner support). A review has identified that Video Interaction Guidance can be considered as it can help improve sensitivity in parents of children who are at risk for poor attachment and improve children's behaviour, however further evidence is needed (O'Hara, et al., 2019). Further information on Video Interaction Guidance available on the Association for Video Guidance UK here.	Antisocial behaviour and conduct disorders A research review (Leigten at al., 2017) found the Incredible Years effective in reducing children's externalizing behaviours (i.e. conduct problems and ADHD). Additionally, a meta-analysis (Leijten et al., 2019) suggested the Incredible Years is more likely to benefit families with more severe problems in terms of children's conduct difficulties and maternal depressive symptoms. The findings suggested that these families may improve on multiple fronts at the same time—on both child and maternal mental health. This may be because these families have the most room for improvement. In addition, especially in families most vulnerable for parent and child mental health problems, symptoms of children's conduct problems and parental depression might form a feedback system in which these symptoms reinforce each other—a feedback system that parenting programs strive to break. Another study (Overbeek et al., 2020) evaluated the longer-term effects of this intervention and concluded that the Incredible Years is an effective parenting intervention to sustainably reduce parent-perceived conduct problems of children. Two and a half years after the programme, parents still perceived less conduct problems in their children. More information on the various Incredible Years Programmes here. An evidence review suggested (Kuhn et al., 2022) that if parents or carers of children 12 years and younger are not able or available for intervention, providing child-focused social skills or CBT interventions may be a suitable alternative. CBT interventions were defined as including an explicit focus on the identification and regulation of thoughts, feelings, and behaviour that lead to externalizing problems. For example, identifying and restructuring hostile attribution biases, or learning relaxation or skills to inhibit impulsive aggressive behaviour. Social skills interventions were defined as interventions that utilized social skills training or social information processing approaches to build concrete prosocial skills or reduce aggression within a social context.

- typically consist of 10 to 16 meetings (groups) or 8 to 10 meetings (individual) of 90 to 120 minutes' duration
- adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial).

Parent and child training programmes for children with complex needs

Offer individual parent and child training programmes to children and young people aged between 3 and 11 years if their problems are severe and complex and they:

- have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder
- have oppositional defiant disorder or conduct disorder or
- are in contact with the criminal justice system because of antisocial behaviour.

Individual parent and child training programmes should involve both parents, foster carers or guardians if this is possible and in the best interests of the child or young person, and should:

- be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills
- consist of up to 10 meetings of 60 minutes' duration
- adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial).

Foster carer/guardian training programmes

Offer a group foster carer/guardian training programme to foster carers and guardians of children and young people aged between 3 and 11 years who:
have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or
have oppositional defiant disorder or conduct disorder or
are in contact with the criminal justice system because of antisocial behaviour.

Group foster carer or guardian training programmes should involve both of the foster carers or guardians if this is possible and in the best interests of the child
or young person, and should:

	• modify the intervention to take account of the care setting in which the child is living • typically have between 8 and 12 foster carers or guardians in a group • be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills • typically consist of between 12 and 16 meetings of 90 to 120 minutes' duration • adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial). Offer an individual foster carer/guardian training programme to the foster carers or guardians of children and young people aged between 3 and 11 years who are not able to participate in a group programme and whose child: • has been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or • has oppositional defiant disorder or conduct disorder or • is in contact with the criminal justice system because of antisocial behaviour. Individual foster carer/guardian training programmes should involve both of the foster carers if this is possible and in the best interests of the child or young person, and should: • modify the intervention to take account of the care setting in which the child is living • be based on a social learning model using modelling, rehearsal and feedback to improve parenting skills • consist of up to 10 meetings of 60 minutes' duration • adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial). **9 – 14: Child-focused programmes** Offer group social and cognitive problem-solving programmes to children and young people aged between 9 and 14 years who: have been identified as being at high risk of developing oppositional defiant disorder or conduct disorder or have oppositional defiant disorder or conduct disorder or are in contact with the criminal justice system because of antisocial behaviour.		

	Group social and cognitive problem-solving programmes should be adapted to the children's or young people's developmental level and should: • be based on a cognitive–behavioural problem-solving model • use modelling, rehearsal and feedback to improve skills • typically consist of 10 to 18 weekly meetings of 2 hours' duration • adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial). 11 – 17: Multimodal interventions Offer multimodal interventions, for example, multisystemic therapy, to children and young people aged between 11 and 17 years for the treatment of conduct disorder. Multimodal interventions should involve the child or young person and their parents and carers and should: • have an explicit and supportive family focus • be based on a social learning model with interventions provided at individual, family, school, criminal justice and community levels • be provided by specially trained case managers • typically consist of 3 to 4 meetings per week over a 3- to 5-month period • adhere to a developer's manual and employ all of the necessary materials to ensure consistent implementation of the programme (the manual should have been positively evaluated in a randomised controlled trial).		

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
ADHD	Supporting people with ADHD (NG87) Following a diagnosis of ADHD, have a structured discussion with people (and their families or carers as appropriate) about how ADHD could affect their life. This could include: • the positive impacts of receiving a diagnosis, such as: — improving their understanding of symptoms — identifying and building on individual strengths — improving access to services • the negative impacts of receiving a diagnosis, such as stigma and labelling • a greater tendency for impulsive behaviour • the importance of environmental modifications to reduce the impact of ADHD symptoms • education issues (for example, reasonable adjustments at school and college) • employment issues (for example, impact on career choices and rights to reasonable adjustments in the workplace) • social relationship issues • the challenges of managing ADHD when a person has coexisting neurodevelopmental or mental health conditions • the increased risk of substance misuse and self-medication • the possible effect on driving (for example, ADHD symptoms may impair a person's driving and ADHD medication may improve this; people with ADHD must declare their diagnosis to the DVLA if their ADHD symptoms or medication affect their ability to drive safely). This structured discussion should inform the shared treatment plan. Inform people receiving a diagnosis of ADHD (and their families or carers as appropriate) about sources of information, including: • local and national support groups and voluntary organisations • websites • support for education and employment. People who have had an assessment but whose symptoms and impairment fall short of a diagnosis of ADHD may benefit from similar information.	ADHD A recent meta-analysis (Groenman et al., 2022) has found behavioural treatments to be effective in reducing ADHD symptoms, behavioural problems and impairment as perceived by parents or teachers post-treatment. Behavioural interventions were defined as interventions directed at changing children/adolescents' behaviours (i.e., increasing desirable behaviours and decreasing undesirable behaviours), using (cognitive)–behavioural therapeutic techniques. These include cognitive-behavioural interventions, such as parent- and teacher-mediated treatments, as well as cognitive-behavioural interventions aimed directly at the child/adolescent, such as behavioural skills training or cognitive-behavioural therapy. The meta-analysis also concluded that those who have severe conduct or ADHD symptoms, a conduct disorder diagnosis, or are single parents should be prioritised for treatment, as they may evidence worsening of symptoms in the absence of intervention. Behavioural parent training is an evidence-based intervention for children with attention-deficit/hyperactivity disorder (ADHD). To enhance the development of more effective future parent training interventions, a study (Dekkers et al., 2022) aimed to investigate which behavioural techniques were associated with better or worse parental outcomes. A higher dosage of techniques focusing on the manipulation of antecedents of behaviour was associated with better outcomes on parenting sense of competence and parental mental health, and a higher dosage of techniques focusing on reinforcement of desired behaviours was related to larger decreases in negative parenting. Higher dosages of psychoeducation were negatively related to parental outcomes.	ADHD A research review (Leigten at al., 2017) aiming to better understand the programme's benefits and harms concluded that the Incredible Years improves family well-being. In addition to reducing children's conduct problems, the programme reduced parent-reported ADHD symptoms in children, parental use of corporal punishment, threats and shouting, and it increased parents' use of praise. However, the programme did not reduce children's internalizing behaviour (e.g., emotional problems). There were no suggestions of harm. More information on the various Incredible Years Programmes here. The New Forest Parenting Programme (NFPP) is for parents with a child between the ages of three and 11 with moderate to severe symptoms of ADHD. NFPP takes place in the family's home through eight weekly visits. During these visits, parents are made aware of symptoms and signs of ADHD and the ways in which they may affect their child's behaviour and their relationship with their child. Parents also learn strategies for managing their child's behaviour and attention difficulties. The programme can be extended from an 8- to a 12-week version, which meant it could be delivered at a slower pace with more emphasis on reinforcing messages to help parents with literacy or intellectual problems. New modules addressing: (a) child sleep problems, learning difficulties and language problems and (b) parental mental health problems and learning difficulties, were added and employed if needed. More details on its positive impact here. In a comparison study (Sonuga-Barke et al., 2018), the finding indicated was equally effective as the group programme Incredible Years but to be more cost-effective. The findings of a randomized controlled study (Larsen et al., 2020) indicated NFPP was associated with improvements in psychosocial health-related quality of life at post-treatment and follow-up. Parent efficacy and family stress scores at post-treatment significantly mediated improvement in health-related quality of life at follow-up. Although parent interventions are recommended as a frontline treatment approach for children with ADHD, a number of practical and situational barriers can impact accessibility and availability. Self-help parent interventions offer a potential alternative to therapist-led interventions when barriers prevent access to face-to-face treatment. Tarver, Daley & Sayal (2021) used qualitative methods to explore participants' views and acceptability of the self-help version of the New Forest Parenting Programme (NFPP-SH). The findings suggest that parents had favourable views of the self-help version, however, some parents may need additional support to overcome barriers associated with completing an intervention at home.

	Provide information to people with ADHD (and their families and carers as appropriate) in a form that: • takes into account their developmental level, cognitive style, emotional maturity and cognitive capacity, including any learning disabilities, sight or hearing problems, delays in language development or social communication difficulties • takes into account any coexisting neurodevelopmental and mental health conditions • is tailored to their individual needs and circumstances, including age, gender, educational level and life stage. **Supporting families and carers** Ask families or carers of people with ADHD how the ADHD affects themselves and other family members, and discuss any concerns they have. Encourage family members or carers of people with ADHD to seek an assessment of their personal, social and mental health needs, and to join self-help and support groups if appropriate. Think about the needs of a parent with ADHD who also has a child with ADHD, including whether they need extra support with organisational strategies (for example, with adherence to treatment, daily school routines). Offer advice to parents and carers of children and young people with ADHD about the importance of: • positive parent– and carer–child contact • clear and appropriate rules about behaviour and consistent management • structure in the child or young person's day. Offer advice to families and carers of adults with ADHD about: • how ADHD may affect relationships • how ADHD may affect the person's functioning • the importance of structure in daily activities. Explain to parents and carers that any recommendation of parent-training/education does not imply bad parenting, and that the aim is to optimise parenting skills to meet the above-average parenting needs of children and young people with ADHD.		Clinicians and service commissioners may wish to consider offering this intervention to parents of children with ADHD, especially soon after diagnosis when parents may be seeking additional information, or when barriers to face-to-face treatment exist. A small-scale randomized controlled trial (Daley, Tarver & Sayal, 2020) investigated the adjunctive benefits of the self-help version when offered in addition to treatment as usual (TAU) compared with TAU alone. This study provided further support for self-help interventions as potentially low-intensity and cost-effective alternatives to therapist-led parenting interventions resulting in beneficial effects for parenting efficacy and child social performance at school. However, no additional effect on child behaviour was found. The self-help intervention pack contains an introductory DVD and the NFPP-SH manual (Laver-Bradbury, Thompson, Weeks, Daley, & Sonuga-Barke, 2010) consisting of two parts: (a) psychoeducation, and (b) a six-step programme including empirically supported behavioural management strategies. The programme also includes ideas for parent-led games and activities aimed at targeting self-regulatory and executive function deficits often present in children with ADHD. For more information on The Forest Parenting Programme click here.

	Involving schools, colleges and universities When ADHD is diagnosed, when symptoms change, and when there is transition between schools or from school to college or college to university, obtain consent and then contact the school, college or university to explain: • the validity of a diagnosis of ADHD and how symptoms are likely to affect school, college or university life • other coexisting conditions (for example, learning disabilities) are distinct from ADHD and may need different adjustments • the treatment plan and identified special educational needs, including advice for reasonable adjustments and environmental modifications within the educational placement • the value of feedback from schools, colleges and universities to people with ADHD and their healthcare professionals. **Involving other healthcare professionals** When a person with ADHD has a coexisting condition, contact the relevant healthcare professional, with consent, to explain: • the validity, scope and implications of a diagnosis of ADHD • how ADHD symptoms are likely to affect the person's behaviour (for example, organisation, time management, motivation) and adherence to specific treatments • the treatment plan and the value of feedback from healthcare professionals. **Planning treatment** Healthcare providers should ensure continuity of care for people with ADHD. Ensure that people with ADHD have a comprehensive, holistic shared treatment plan that addresses psychological, behavioural and occupational or educational needs. Take into account: • the severity of ADHD symptoms and impairment, and how these affect or may affect everyday life (including sleep) • their goals • their resilience and protective factors • the relative impact of other neurodevelopmental or mental health conditions. Regularly discuss with people with ADHD, and their family members or carers, how they want to be involved in treatment planning and decisions; such discussions should take place at intervals to take account of changes in circumstances (for example, the transition from		

	children's to adult services) and developmental level, and should not happen only once. Before starting any treatment for ADHD, discuss the following with the person, and their family or carers as appropriate, encouraging children and young people to give their own account of how they feel: • the benefits and harms of non-pharmacological and pharmacological treatments (for example, the efficacy of medication compared with no treatment or nonpharmacological treatments, potential adverse effects and non-response rates) • the benefits of a healthy lifestyle, including exercise • their preferences and concerns (it is important to understand that a person's decision to start, change or stop treatment may be influenced by media coverage, teachers, family members, friends and differing opinion on the validity of a diagnosis of ADHD) • how other mental health or neurodevelopmental conditions might affect treatment choices • the importance of adherence to treatment and any factors that may affect this (for example, it may be difficult to take medication at school or work, or to remember appointments). Record the person's preferences and concerns in their treatment plan. Ask young people and adults with ADHD if they wish a parent, partner, close friend or carer to join discussions on treatment and adherence. Reassure people with ADHD, and their families or carers as appropriate, that they can revisit decisions about treatments. Children under 5 years NICE currently recommends offering group parent-training programme to parents or carers of children under 5 years with ADHD as first-line treatment. At the time that this recommendation was published, there was insufficient evidence from trials evaluating group- and individual-parenting training approaches in the treatment of ADHD and so NICE extrapolated from evidence from studies of parenting training for conduct problems, when giving this advice. Given that ADHD and conduct problems, although often co-existing, are different disorders with a different aetiology, pathogenesis and prognosis, which require different treatments, establishing the relative efficacy and cost-effectiveness of individual and group approaches for preschool ADHD is an important mental health research priority.		

	If after an ADHD-focused group parent-training programme, ADHD symptoms across settings are still causing a significant impairment in a child under 5 years after environmental modifications have been implemented and reviewed, obtain advice from a specialist ADHD service with expertise in managing ADHD in young children (ideally a tertiary service). Do not offer medication for ADHD for any child under 5 years without a second specialist opinion from an ADHD service with expertise in managing ADHD in young children (ideally a tertiary service). Children aged 5 years and over and young people NICE has highlighted the fact evidence indicated that some parents and carers of children aged 5 years and over and young people can benefit from group support. After discussion of current good practice and consideration of the balance of benefits and costs, the committee decided to recommend offering additional support that could be group-based ADHD-focused support and as few as 1 or 2 sessions for parents and carers of all children and young people with ADHD. Give information about ADHD and offer additional support to parents and carers of all children aged 5 years and over and young people with ADHD. The support should be ADHD focused, can be group based and as few as 1 or 2 sessions. It should include: • education and information on the causes and impact of ADHD • advice on parenting strategies • with consent, liaison with school, college or university • both parents and carers if feasible. If a child aged 5 years or over or young person has ADHD and symptoms of oppositional defiant disorder or conduct disorder, offer parents and carers a parent-training programme in line with recommendations in NICE's guideline on antisocial behaviour and conduct disorders in children and young people, as well as group-based ADHD-focused support. Consider individual parent-training programmes for parents and carers of children and young people with ADHD and symptoms of oppositional defiant disorder or conduct disorder when: • there are particular difficulties for families in attending group sessions (for example, because of disability, needs related to diversity such as language differences, learning disability [intellectual disability], parental ill-health, problems with		

	transport, or where other factors suggest poor prospects for therapeutic engagement) • a family's needs are too complex to be met by group-based parent-training programmes. Consider a course of cognitive behavioural therapy (CBT) for young people with ADHD who have benefited from medication but whose symptoms are still causing a significant impairment in at least one domain, addressing the following areas: • social skills with peers • problem-solving • self-control • active listening skills • dealing with and expressing feelings.		

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Autism	**Autism in under 19s (CG128)** Making adjustments to the social and physical environment and processes of care Take into account the physical environment in which autistic children and young people are supported and cared for. Minimise any negative impact by: • providing visual supports, for example, words, pictures or symbols that are meaningful for the child or young person • making reasonable adjustments or adaptations to the amount of personal space given • considering individual sensory sensitivities to lighting, noise levels and the colour of walls and furnishings. Make adjustments or adaptations to the processes of health or social care, for example, arranging appointments at the beginning or end of the day to minimise waiting time. **Psychosocial interventions** Consider a specific social-communication intervention for the core features of autism in children and young people that includes play-based strategies with parents, carers and teachers to increase joint attention, engagement and reciprocal communication in the child or young person. Strategies should: • be adjusted to the child or young person's developmental level • aim to increase the parents', carers', teachers' or peers' understanding of, and sensitivity and responsiveness to, the child or young person's patterns of communication and interaction • include techniques of therapist modelling and video-interaction feedback • include techniques to expand the child or young person's communication, interactive play and social routines. The intervention should be delivered by a trained professional. For pre-school children consider parent, carer or teacher mediation. For school-aged children consider peer mediation.	**Autism** An umbrella review (Correll et al., 2021) suggested various psychosocial interventions have proven efficacy on a broad set of outcomes, ranging from anxiety (CBT), to irritability, aggressive behaviour and functioning (parent-child interaction therapy), to the primary efficacy outcome and functioning (social skills training, and behavioural therapy with imitative component) in children and young people with ASD. These benefits are not only observed vs. waiting list, but also against other active interventions. Given the different outcomes that these treatment modalities target, a variety of therapeutic tools can be considered, according to the patient's and family's resources, needs and choice, as well as the disease course and the presence of environmental stressors. A systematic review (Sampaio et al., 2021) has suggested that early intervention, combining behavioural and developmental approaches, for children with suspected ASD was cost-effective. In another systematic review and meta-analysis, Tarver et la., 2019 assessed evidence for the efficacy of behavioural parent interventions (BPIs) for disruptive and hyperactive child behaviour in ASD, as well as parenting efficacy and stress. It is known that emotional and behavioural problems (EBPs) are common in ASD and can manifest in the form of non-compliance, aggression, anxiety, and hyperactivity. The results indicated BPIs are effective in reducing parent-reported child disruptive behaviour, hyperactivity, and parent stress. Given evidence of child behaviour influencing parent stress, parent stress may decrease as a consequence of improved perception of disruptive child behaviour. On the contrary, poor coping strategies and low levels of social support have been found to predict parenting stress in parents of children with ASD. BPIs may work to provide parents with new management strategies, improving their resource and capacity to cope, thereby decreasing feelings of parenting stress. However, parents presenting with high levels of stress will likely require additional support directly addressing their well-being. This study also noted that BPIs in ASD might benefit from the addition of components targeting anxiety and internalizing conditions. There is evidence that levels of problem behaviour are associated with internalizing disorders in ASD suggesting that interventions targeting anxiety/low mood could also improve disruptive behaviour.	**Autism** Maw & Haga (2018) have conducted a systematic review and meta-analysis of existing interventions for ASD in preschool-aged children based on cognitive, developmental, and behavioural approaches and explored the factors that may impact the effectiveness of the intervention. The authors found that reciprocal imitation training (RIT), symbolic play (SP) and music therapy showed the largest effects for improving the communication and social interactions of affected children. The quality of the care provider, duration of the intervention, and intensity of the intervention were discovered as influencing factors for effective intervention outcomes. In this review, intervention delivery by trained therapists who were professionally supervised by experts produced better outcomes than intervention provided by parents and teachers. It was also concluded that music therapy was the most effective intervention with shorter duration and lower intensity of intervention. Major improvements were reported in the areas of the parent-child relationship, speech and language production, joint attention behaviours, and non-verbal social communication. The findings of this study were consistent with a Cochrane review (Geretsegger et al., 2014), which assessed the effects of music therapy for people with ASD and concluded that music therapy might help increase social adaptation skills in children with ASD and promote the quality of parent-child relationships. In that study, music therapy was superior to the control group in terms of social interaction which included non-verbal communicative skills, verbal communication skills, and social-emotional reciprocity. Sorensen and Zarrett (2014) have conducted a comprehensive review aiming to explore which suggested an emerging evidence based for benefits of physical activity (PA) for adolescents with ASD. The existing literature suggests an emerging evidence-base for benefits of PA for adolescents with ASD. The strongest evidence from the present review supports benefits related to motor development and physical fitness and decreases in repetitive, stereotyped, and self-injurious behaviours, yielding the largest number of moderate to strong effect sizes. Despite lower levels of representation in the literature, social-emotional effects of PA also yielded relatively large effects. The present review revealed minimal evidence of increases in cognitive performance for adolescents, but some evidence for improvements in executive function specifically (e.g., working memory, cognitive control/attention, and goal-setting), as well as some evidence for benefits related to self-regulation (e.g., decreases in aggression and disruptive behaviours). However, more research is needed regarding the effects of PA on specific facets of cognitive ability and executive function to further clarify this nuanced relationship.

	Anticipating and preventing behaviour that challenges. Assess factors that may increase the risk of behaviour that challenges in routine assessment and care planning in autistic children and young people, including: • impairments in communication that may result in difficulty understanding situations or in expressing needs and wishes • coexisting physical disorders, such as pain or gastrointestinal disorders • coexisting mental health problems such as anxiety or depression and other neurodevelopmental conditions such as ADHD • the physical environment, such as lighting and noise levels • the social environment, including home, school and leisure activities • changes to routines or personal circumstances • developmental change, including puberty • exploitation or abuse by others • inadvertent reinforcement of behaviour that challenges • the absence of predictability and structure. **Psychosocial interventions for behaviour that challenges** If no coexisting mental health or behavioural problem, physical disorder or environmental problem has been identified as triggering or maintaining the behaviour that challenges, offer the child or young person a psychosocial intervention (informed by a functional assessment of behaviour) as a first-line treatment. **Families and carers** Offer families (including siblings) and carers an assessment of their own needs, including whether they have: • personal, social and emotional support • practical support in their caring role, including short breaks and emergency plans • a plan for future care for the child or young person, including transition to adult services.		Highly promising intervention strategies include prompts, modelling, praise, and structured teaching. The only study reporting effects at follow-up (Bahrami et al. 2012) used highly structured teaching techniques similar to the TEACCH model. Emerging evidence also exists for self-determination theories (SDT)-related approaches (e.g., goal-setting, promotion of autonomy, and self-efficacy; Pan 2011; Todd and Reid 2006; Todd et al. 2010). Soares et al., 2020 conducted a meta-analysis of in-person and technological interventions with regards to social skills training (SST) for ASC, one of the most common interventions to help address social difficulties in individuals with ASD. Traditional SST teaches children with ASD to interact with their peers by providing face-to-face, in vivo instruction on conversation, friendship, and problem-solving skills. Novel methods of SST delivery include the use of Behavioural Intervention Technologies (BITs), technology-based interventions aimed at producing positive behavioural and psychological changes as either an adjunct to or a replacement for face-to-face interventions. This study compared the efficacy of BITs-SST with more traditional, evidence-based approaches to social skills training. The lack of significant differences in efficacy for face-to-face-SST and BITs-SST provides initial support for new approaches that may expand the options for social skills training for children and adolescents with ASD. If rigorous empirical evaluations of BITs continue to yield comparable results, these new approaches (e.g., BITs-SST) could potentially increase accessibility of social skills training, as technology-based intervention can serve large numbers of children with minimal reliance on the availability of mental health professionals. Furthermore, the BITs-SST included in this meta-analysis included participants with a range of functioning levels; thus, BITs-SST could have promise for addressing the diverse presentation of ASD symptoms. This meta-analysis provides preliminary support for BITs-SST and indicates that further investigation of their efficacy may be justified, especially considering that BITs-SST may be an appealing medium for children and adolescents. There is a growing body of research suggesting that mindfulness-based training for youth with ASC and their parents may improve youth and parent psychosocial functioning. A study (Salem-Guirgis et al., 2019) evaluated the use of MYmind, a 9-week concurrent group-based mindfulness intervention in which youth with autism and their parents simultaneously receive group specific mindfulness training. The findings showed improvements in the parents' ability to be less reactive, observe and describe their emotions, and listen to their children with full attention and without judgment at follow-up, though the effects related to nonjudgment did not last into follow-up. Parents noted improved overall autism symptoms and social motivation at post-programme and follow-up (and trends towards significance in social communication), along with significant improvements in restrictive and repetitive behaviours at follow-up. Overall, youth and parents perceived quality of life gains, and most also believed that relationships within their dyad had improved following the program. MYmind has the potential to contribute to emotion

			regulation and adaptability in youth with autism, and mindfulness in parents, though more rigorous controlled trials are needed. In a review of the current evidence, Semple (2019) concluded there is preliminary evidence to suggest that yoga and mindfulness-based interventions for children and adolescents with ASD are feasible and may improve a variety of prosocial behaviours, including communication and imitative behaviours; increased tolerance of sitting and of adult proximity; self-control; quality of life; and social responsiveness, social communication, social cognition, preoccupations, and social motivation. Reductions in aggressive behaviours, irritability, lethargy, social withdrawal, and noncompliance were also reported. A systematic review (Wang et al., 2021) evaluated the effectiveness of CBT on symptoms of ASC and social-emotional problems in children and adolescents with ASC. The results revealed that CBT improved the symptoms of ASC and social-emotional problems based on informant-reported and clinician rated outcomes, whereas CBT had no significant effect on the above outcomes based on self-reported outcomes. Moreover, the symptoms of ASC based on task-based outcomes were significantly improved in children or adolescents with ASC who received CBT. The National Autistic Society provides training for professionals on manualised parent education training programmes for parents and carers of children and young people with a diagnosis of ASC. The programmes aim to equip parents and carers to develop a greater understanding of their child or young person's needs and develop a consistent approach across settings (e.g. home and school). There are different programmes available based on age group and the different needs of each developmental phase: • EarlyBird (under 5 years old) • EarlyBird Plus (4-9 years old) • Teen Life (10 to 16 years old) EarlyBird and EarlyBird Plus have received strong parental support for its acceptability but lower-level evidence of efficacy (Dawson-Squibb et al., 2018). Further research needs to be completed. **The SPELL Framework** SPELL stands for Structure, Positive approaches and expectations, Empathy, Low arousal and Links. SPELL is the National Autistic Society's framework for understanding and responding to the needs of autistic children and adults. It focuses on five principles that have been identified as vital elements of best practice when working with autistic people and emphasises ways to change the environment and our approaches to meet the specific needs of each person. The SPELL framework recognises the individual and unique needs of each child and adult and emphasises that planning and intervention be organised on this basis.

			The SPELL framework can be used with all autistic people, regardless of age or level of support needs.

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Attachment difficulties	**Interventions for attachment difficulties in children and young people on the edge of care (NG26)** Health and social care professionals should offer a video feedback programme to the parents of preschool-age children on the edge of care. Ensure video feedback programmes are delivered in the parental home by a trained health or social care worker who has experience of working with children and young people and: • consist of 10 sessions (each lasting at least 60 minutes) over 3–4 months • include filming the parents interacting with their child for 10–20 minutes every session • include the health or social care worker watching the video with the parents to: • highlight parental sensitivity, responsiveness and communication • highlight parental strengths • acknowledge positive changes in the behaviour of the parents and child. If there is little improvement to parental sensitivity or the child's attachment after 10 sessions of a video feedback programme for parents of preschool-age children on the edge of care, arrange a multi-agency review before going ahead with more sessions or other interventions. If parents do not want to take part in a video feedback programme, offer parental sensitivity and behaviour training: • first consists of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over a 6-month period • is delivered by a trained health or social care professional • includes: • coaching the parents in behavioural management (not applicable for children aged 0–18 months) and limit setting • reinforcing sensitive responsiveness • ways to improve parenting quality • homework to practise applying new skills.	**Interventions for attachment difficulties in children and young people on the edge of care** No DSM criteria for insecure attachment – only RAD. Video feedback (VF) programme Balldin, Fisher & Wirtberg (2016) conducted a system analysis and found that VF programmes had positive effects on maternal sensitivity and children's behaviour. Parental sensitivity and behaviour training versus any comparison Wright & Edginton (2016) conducted a systematic review and found that providing early maternal sensitivity intervention pre-birth was affective in promoting secure attachments with their children. Cornell & Hamrin (2008) suggest that combining psychoeducation for caregivers and psychotherapy for caregivers and CYP are the most effective interventions for attachment difficulties. Brisch et al., (2003) found The Preventive Psychotherapeutic Intervention Program was statistically significant in protecting a child-parent interaction and subsequently the children's neurological development. Marvin & Whelan (2003) state that effective interventions for attachment difficulties with explore the child and caregiver roles in both the problems and solutions. A dual intervention that considers the dyadic relationship within attachment with be the most successful approach in promoting healthy attachments.	**Interventions for attachment difficulties in children and young people on the edge of care** Milford & Oates (2009) suggest using a screening tool to identify the potential risks of maternal MH problems and subsequent attachment difficulties. By identifying the level of concern (low, medium or high), services can offer tailored interventions to reduce the likelihood of children and young people (CYP) developing attachment difficulties and may provide a key resource for early intervention. Coping with Crying (NCPCC, 2022) is a CPD course that is designed for anyone supporting parents with their babies crying. This intervention aims to reduce the risk of non-accidental head injuries but may also contribute to helping develop a secure relationship between caregiver and baby. The CPD course costs £35 per person and take approximately 1 hour to complete. A group parenting programme called Turning in to Kids (TIK) targets parents' emotional socialisation, emotional coaching and emotional regulation to improve their children and young people's (3 – 15 years old) emotional and behavioural functioning (Havighurst, Murphy & Kehoe, 2021). All CYP in the sample of the study displayed significant emotional and/or behavioural difficulties that required psychological intervention. Reasons for referrals including sexual, physical and emotional abuse, neglect, witnessing violence, and attachment difficulties etc. The majority of the children and young people experienced complex and multiple trauma. Results indicated that the TIK parenting programme had significant positive effects on parental wellbeing and CYP emotional regulation and behaviour. This study uses philosophies of parental sensitivity and behaviour training, along with providing practical skills for parents/caregivers, that clinicians may find useful when providing intervention for attachment difficulties. Observing a child's attachment to one singular figure, as determined by historical research and interventions (such as the Strange Situation Procedure) is not enough to predict future outcomes of a child (Lai & Carr, 2018). A more holistic approach to attachment and the wider attachment network to the infant should be considered when working with CFYP who are experiencing attachment difficulties (Lai & Carr, 2018). Daley, Miller, Bean & Oka (2018) suggest an integrated approach of Family System Play Therapy in treating children with insecure attachments. They offer a systematic treatment model of integrated family therapy and play therapy. This model is built on evidence-based approaches of family therapy and play therapy, and offers a more holistic approached to supporting children and young people mental health difficulties, including attachment. Components of the integrated theory:

If parents do not want to take part in a video feedback programme or parental sensitivity and behaviour training, or, if there is little improvement to parental sensitivity or the child's attachment after either intervention and there are still concerns, arrange a **multi-agency review before going ahead with more interventions.**

If the multi-agency review concludes that further intervention is appropriate, consider a **home visiting programme** to improve parenting skills delivered by an appropriately-trained lay home visitor or a healthcare professional such as a nurse.

- consist of 12 weekly or monthly sessions (lasting 30–90 minutes) over an 18-month period
- include observing the child (not using video) with their parents
- give the parents advice about how they can improve their communication and relationship with their child by:
- supporting positive parent–child interaction using role modelling
- reinforcing positive interactions and parental empathy
- provide parental education and guidance about child development.

Preschool-age children who have been or are at risk of being maltreated

Consider parent–child psychotherapy for parents who have maltreated or are at risk of maltreating their child to improve attachment difficulties, ensuring that safeguarding concerns are addressed.

- is based on the Cicchetti and Toth model
- consists of weekly sessions (lasting 45–60 minutes) over 1 year
- is delivered in the parents' home by a therapist trained in the intervention
- directly observes the child and the parent–child interaction
- explores the parents' understanding of the child's behaviour
- explores the relationship between the emotional reactions of the parents and perceptions of the child, and the parents' own childhood experiences.

Primary and secondary school-age children and young people with, or at risk of, attachment difficulties

Consider parental sensitivity and behaviour training, adapting the intervention for the age of the child or young person.

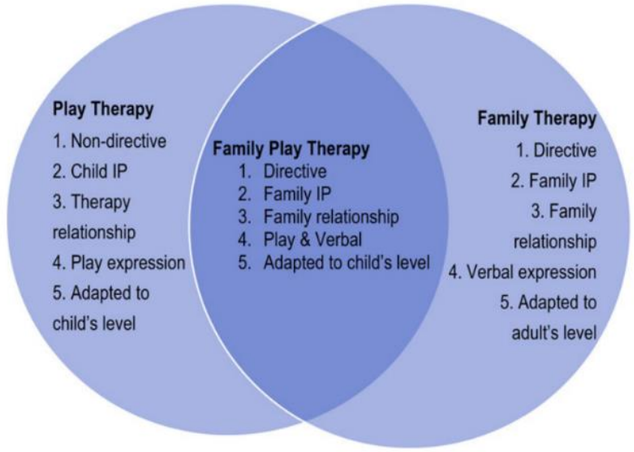
Primary and secondary school-age children and young people who have been, or are at risk of being, maltreated

For children and young people who have been maltreated, and show signs of trauma or post-traumatic stress disorder, offer trauma-focused

Home visiting

Grube & Liming (2018) conducted a systematic review on Attachment and Biobehavioural Catch-up (ABC) which is a 10-week home visiting programme for children 6 months – 2 years old. Grube & Liming (2018) suggested that ABC is effective for improving emotional regulation, improving internalising and externalising behaviours, increasing normative developmental functioning and overall attachment quality. However, the sample largely consisted of children with attachment difficulties within the home, and therefore the intervention may not provide the intensity of support needed for CYP with attachment difficulties in alternative settings (such as foster, adoptive or residential care).

No clear evidence-base for TF-CBT for CYP with attachment difficulties.



This model is conducted in 2 phases:

1. Parent consultation and observation. Parents describe the presenting problems. Therapist describes the process of family therapy. Parents are provided with psychoeducation on principles of child development. In the first 2 therapy sessions, therapist observes the interactions and play between parents and child with minimal intervention. Therapists makes observations on family structural dynamic including family roles, hierarchy, alliances, triangles, rules, restrictions, particular behaviours etc. Notice when child does or does not invite parental involvement in play. Notice triggered emotions associated with roles and play. Observe for parental shifts in their focus on the child and shift between play and parent-orientated behaviour (disciplining, distracting etc.)
2. Treatment. It is important that the therapist has access to basic play materials (including art materials, balls, foam swords, play food, toy cash registers, doctor's kit, dolls, cars, dress up, puppets/figurines etc). The therapist draws attention to the observe family dynamics maintain symptomatic behaviour in the CYP and supports familial re-structuring to alleviate these symptoms. Examples may be establishing parent as authority; facilitating emotional expression; facilitating parents as a safe space etc. Therapist uses play to demonstrate and explore current behaviour and behavioural changes. Therapist may suggest or guide play that explores different roles/structures/rules to support the family dynamics and CYPs symptomatology. Monthly parent consultation sessions (without the child present) should occur to discuss themes, meanings and the experiences of family play.

Closure of therapy is initiated by parental reports and therapist observations of a reduction in the CYP symptomatic behaviours.

	cognitive behavioural therapy, and other interventions in line with the NICE guideline on post-traumatic stress disorder. Consider parental sensitivity and behaviour training, ensuring that safeguarding concerns are addressed and adapting the intervention for the age of the child or young person.		This treatment model is proposed to be effective for attachment difficulties as it considers a more holistic view of attachment and considers the role that the family dynamic, rather than one specific attachment, will have on the CYP mental health (Daley et al., 2018). Moreover, an integrated family play therapy approach allows therapists to more clearly define the issues within the family context that are driving the CYPs symptomology and not only address this during the therapy discussed, but define the most suitable support following this (e.g. continued family therapy or individual therapy) (Daley et al., 2018). Family therapy and/or play therapy must only be conducted by a certified family/play therapist. Emerging research suggests that Sand Therapy, as a specific means of play therapy, is effective in reducing the negative emotional and behavioural symptoms of attachment difficulties for children (Roesler, 2019). This follows a psychodynamic approach and allows CYP to work through their traumatic experiences with the caregivers. Sand play therapy qualification cost approximately £2000pp and requires a counselling qualification. More information can be found here. Advice for parents/carers with CYP who are exhibiting emerging attachment difficulties: Supporting children with attachment difficulties - information for parents/carers - Educational Psychology & Specialist Support (norfolkepss.org.uk) Video for parents/carers to help them understand attachment and attachment difficulties: Circle of Security Animation - YouTube Dream on - Young Voices in Care: Teenagers from Hull worked with a production company to create a 5-minute video to help people understand what it is like for children within the care system. Dream On - YouTube NSPCC Report: The report looked at the views of looked after children and young people in the care system and is a helpful read for practitioners. Promoting the wellbeing of children in care: messages from research (nspcc.org.uk)

	Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care **Preschool-age children:** Video feedback programme to foster carers, special guardians and adoptive parents. **Primary school-age children:** Intensive training and support for foster carers, special guardians and adoptive parents before the placement and for 9–12 months after, including: • positive behavioural management methods • help with peer and parent/carer relationships for the child • support for schoolwork • help to defuse conflict • supervision by daily telephone contact • weekly support group meetings • a 24-hour crisis intervention telephone line. Combine intensive training and support with group therapeutic play sessions for the child for the same duration. After placement, include: • weekly sessions (lasting 60–90 minutes) over the 9–12-month period. • are delivered by a trained health or social care professional • include monitoring of behavioural, social and developmental progress. **Late primary and early secondary school-age children and young people** Group-based training and education programme for foster carers, special guardians and adoptive parents, including: • consist of twice-weekly sessions (lasting 60–90 minutes) in a group for the first 3 weeks, then weekly sessions over the remaining school year • are delivered by a trained facilitator • have a behavioural reinforcement system to encourage adaptive behaviours across home, school and community settings • provide weekly telephone support if needed • give homework to practise applying new skills.	**Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care** Parenting interventions, such as the VFP, have limited effectiveness for foster or adoptive parents (Everson-Hock et al., 2011). Parenting groups for foster and adoptive parents are not intensive enough to support this population of children given their traumatic experiences and attachment difficulties (Wassal et al., 2011). Job, Ehrenberg & Hilpert (2020) conducted a RCT on the parenting intervention 'Taking Care Triple P for foster parents'. They found no advantages of the intervention group compared to the control who received no parenting intervention. Job et al., (2020) suggested that the Taking Care Triple P is associated with lowering the risk of harm for foster children, but also lacks significant benefits.	**Interventions for attachment difficulties in children and young people in the care system, subject to special guardianship orders and adopted from care** Attachment & Biobehavioural Catchup (ABC) is a 10-week, in-home intervention initially developed for fostered children primarily aged between 6 months – 2 years (Dozier et al., 2018). The focus of the intervention is to support caregivers to provide healthy regulation skills to the child's behaviour and stress response; to teach caregivers to be highly responsive to child's emotions; and to increase the caregivers nurture care to promote secure attachments (Dozier et al., 2008). The session structure is as follows: • 1-2: Focus on the importance of nurture and emphasise that children need nurture even if they don't signal for it. Explore that children's behaviour can elicit powerful feelings from carer. • 3-4: Explore positive affect & enjoyment – including providing activities to build on these during play. • 5-6: Consider how carer behaviours may be perceived as overwhelming and threatening (such as play fights, intense tickling etc). • 7-8: Reflect on carers own self and how their past influences reactions. • 9-10: Reviewing intervention targets and consolidating gains. • Throughout the intervention ensure that frequent and 'in the moment' feedback is providing to the interactions between child and caregiver. Bernard et al., (2012) conducted an RCT on ABC and found that caregivers who received ABC developed increase rates of secure attachments with their foster children compared to the control group, including at follow up. A systematic review found that ABC, compared to control groups, showed positive effects (NICE, 2021). **Incredible Years** is a trauma informed, evidence-based parenting programme (Conn et al., 2018). The programme is suitable for foster parents of children aged 2 -7 years old and assesses its effectiveness through child behaviour, foster parent stress and attitudes, and perceived effect on parenting (Conn et al., 2018). Conn et al., (2018) found that Incredible Years showed positive affects on foster parents' perception of their child's behaviour; offered a new perspective on the value of play; and enhanced parenting skills through specific tools. The positive impact of enhanced parenting skills improved family relations that were sustained over time which subsequently supports children's mental health and development (Conn et al., 2018).

	Combined with a **group-based training and education programme** for late primary and early secondary school-age children and young people, including: • consist of twice-weekly sessions (lasting 60–90 minutes) in a group for the first 3 weeks, then individual weekly sessions over the remaining school year • are delivered by trained mentors, which may include graduate level workers, at a time that ensures schooling is not disrupted • teach skills to help reduce involvement with peers who may encourage misbehaviour, and to increase their levels of self-confidence • encourage them to get involved in a range of educational, social, cultural and recreational activities • help them develop a positive outlook. **Modify interventions for young people in the care system**, subject to special guardianship orders and adopted from care when needed to allow for: • physical and sexual development • transition to adolescence • re-awakening of emotions about their birth parents or original family. Take into account that these factors can complicate therapeutic interventions and relationships with foster carers, special guardians and adoptive parents. Discuss making contact with their birth parents or original family sensitively.		

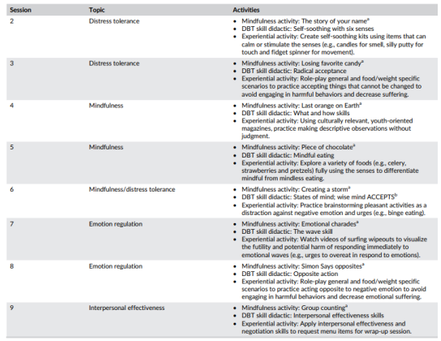
	Interventions for attachment difficulties in children and young people in residential care Professionals with expertise in attachment difficulties should: • work with the residential staff group and identify any key attachment figures to work specifically with the child or young person in residential care • offer parental sensitivity and behaviour training adapted for professional carers in residential care. Modify interventions for young people in residential care when needed to allow for: • physical and sexual development • transition to adolescence • re-awakening of emotions about their birth parents or original family. Take into account that these factors can complicate therapeutic interventions and relationships with professional carers. Discuss making contact with their birth parents or original family sensitively. No recommendation for Reactive Attachment Disorder For more information and evidence on interventions to promote physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers, please see this review – NICE, 2021. For more information and evidence on interventions to support positive relationships for looked-after children, young people and care leavers, please see this review – NICE, 2021.	Interventions for attachment difficulties in children and young people in residential care No available evidence.	Interventions for attachment difficulties in children and young people in residential care Group Play Therapy (GTP) has been found to be effective in reducing insecure attachment and increasing children's social skills (Baggerly, 2009; Dousti, Pouyamanesh, Aghdam & Jafari, 2018; Mousavi & Safarzadeh, 2016). This is achieved through incorporating activities that emphasise accepting reality, increasing self-awareness, self-regulating, autonomy, improving self-esteem and group attachment. GPT sessions incorporating the above provide a foundation for increasing secure attachments and social skills. GPT could be utilised as an efficient and cost-effective intervention for CYP within a residential care setting. Looked after children may not be able to access education due their emotional instability. **Attachment based Theraplay** for looked after children between the ages of 5-9 years old was found the bridge the gap of education and mental wellbeing for this age group and found noticeable changes in children's relationship skills, confidence and engagement with education (Franic, Bennion & Humrich, 2017). This is supportive of a child's overall wellbeing and therefore their mental health. CYP growing up in residential care are disproportionately more likely to develop MH difficulties compared to the general population (Lou, Taylor & Di Folco, 2018). Lou et al., (2018) explored the conceptualisations, operationalisations and measurements of resilience in CYP living in residential care settings and suggests that **promoting interpersonal relationships, motivation and future focus were positive in developing resilience against MH difficulties**. Higher levels of resilience were subsequently associated with better developmental outcomes (Lou et al., 2018). Preliminary evidence suggests that **video-game interventions** for YP in residential care can have moderate impacts on anxiety and externalising mood disorders (Aventin, Houston & Macdonald, 2014); along with improving life skills (Schuurmans, Nijhof, Engels & Granic, 2018). However, this innovate research design is in its infancy and additional research is needed to conceptualise this. CYP living in residential care with attachment difficulties often experience multiple and complex trauma. Bentovim, Gray and Pizzey (2018) produced a guide which provides sufficient detail in evidence-based interventions that are recommended by NICE guidelines for CYP that have experienced trauma.

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Eating Disorders	Anorexia nervosa (NG69) Provide support and care for all people with anorexia nervosa in contact with specialist services, whether or not they are having a specific intervention. Support should: • include psychoeducation about the disorder • include monitoring of weight, mental and physical health, and any risk factors • be multidisciplinary and coordinated between services • involve the person's family members or carers (as appropriate). When treating anorexia nervosa, be aware that: • helping people to reach a healthy body weight or BMI for their age is a key goal and; • weight gain is key in supporting other psychological, physical and quality of life changes that are needed for improvement or recovery. When weighing people with anorexia nervosa, consider sharing the results with them and (if appropriate) their family members or carers. Consider anorexia-nervosa-focused family therapy for children and young people (FT-AN), delivered as single-family therapy or a combination of single- and multi-family therapy. Give children and young people the option to have some single-family sessions: • separately from their family members or carers and • together with their family members or carers. FT-AN for children and young people with anorexia nervosa should: • typically consist of 18 to 20 sessions over 1 year • review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last • emphasise the role of the family in helping the person to recover • not blame the person or their family members or carers • include psychoeducation about nutrition and the effects of malnutrition • early in treatment, support the parents or carers to take a central role in helping the person manage their eating, and emphasise that this is a temporary role	Anorexia nervosa Rosello (2020) reviewed parent group intervention groups for CYP referred to a community Eating Disorder (ED) service. Rosello (2020) found that the parent group interventions and parental understanding and involvement with their children's ED was associated with weight gain and improved ED psychopathology, including in the 6 months after the intervention. Lock et al., (2010) conducted a RCT with 121 adolescents with anorexia nervosa (AN), randomised to either FBT or individual adolescent-based therapy (AFT) and found that significantly more patients receiving FBT achieved full remission at 6 months (40% FBT vs 18% AFT) and at 12 months (49% FBT vs 23% AFT). Lock et al (2005) conducted a RCT with 86 adolescents with AN, randomised to either a 6 month or 12-month treatment programme of FBT. They found that a short-term course of FBT seems to be as effective as a long-term course for adolescents with AN. However, if they have more severe eating-related obsessive cognitions or come from non-intact/single-parent households, post hoc analyses revealed they may benefit from longer treatment.	Anorexia nervosa Karekla, Nikolaou & Merwin (2022) found that utilising Acceptance and Commitment Therapy (ACT) was effective in prevention the developing of ED in young woman. ACT-based ED early intervention programme for youth displaying ED symptomology. Young woman who participated in the innovative programme AcceptMe had significantly lower weight and shape concerns at the end of the programme compared to the control group. There was a 14.5 times higher chance that young women in the control group were at risk of developing an ED compared to the AcceptMe group. In addition, Karekla, Nikolaou and Merwin (2022) found that their AcceptMe programme, based on ACT, had greater positive effects compared to CBT-ED for individuals with comorbid ED and anxiety or depression. Karekla, Nikolaou and Merwin (2022) stated that the findings of the research suggested that utilising ACT can be: • effective across the spectrum of ED • useful for prevention and treatment • increases psychological flexibility. Stewart et al., (2022) conducted a study, in collaboration with former service users, to assess the long-term effectiveness of evidence-based ED treatment in YP 7 years post treatment. The study found that only 6.7% of participants (N=149) reported having an ED disorder at follow up, but 53.6% report other mental health (MH) difficulties, specifically depression and/or anxiety. 30% of participants sought help for their ED and a further 20% had prolonged and intensive ED treatment. However, 70% of the sample sought help for other MH difficulties. This study suggests that specialist ED interventions have prolonged effectiveness at follow-up, however, participants had an increase in additional MH difficulties. This research demonstrates that **services should be proactive in providing holistic and person-centred interventions and ensuring CYP are supporting for their overall MH.** Services should ensure that CYP are encouraged to contact the appropriate services for any MH difficulties. Services could provide CYP with a "discharge" pack containing self-help guides and information to ensure they are fully equipped post treatment. Given the emphasis on family relationships with the framework of ED, post-treatment information could be shared with the family network so they are equipped with resources.

	• in the first phase, aim to establish a good therapeutic alliance with the person, their parents or carers and other family members • in the second phase, support the person (with help from their parents or carers) to establish a level of independence appropriate for their level of development • in the final phase: • focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention • address how the person can get support if treatment is stopped. Consider support for family members who are not involved in the family therapy, to help them cope with distress caused by the condition. Consider giving children and young people with anorexia nervosa additional appointments separate from their family members or carers. Assess whether family members or carers (as appropriate) need support if the child or young person with anorexia nervosa is having therapy on their own. If FT-AN is unacceptable, contraindicated or ineffective for children or young people with anorexia nervosa, consider individual CBT-ED or adolescent-focused psychotherapy for anorexia nervosa (AFP-AN). Individual CBT-ED for children and young people with anorexia nervosa should: • typically consist of up to 40 sessions over 40 weeks, with: • twice-weekly sessions in the first 2 or 3 weeks • 8 to 12 additional brief family sessions with the person and their parents or carers (as appropriate) • in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition • in family sessions: • identify anything in the person's home life that could make it difficult for them to change their behaviour, and find ways to address this • discuss meal plans • aim to reduce the risk to physical health and any other symptoms of the eating disorder • encourage reaching a healthy body weight and healthy eating • cover nutrition, relapse prevention, cognitive restructuring, mood regulation, social skills, body image concern and self-esteem	There is **limited research for the effectiveness of CBT-ED for AN for CYP**. Available research suggests there is no difference in outcomes between FBT and CBT treatments for CYP with ED (Ball & Mitchell, 2004; Gowers et al., 2007). However, this does not consider cases where parental support is lacking or completely absent, of which FBT relies on positive parenting.	Herle et al., (2019) conducted a longitudinal study on trajectories of eating disorders from childhood to adolescence and suggested that **early eating behaviours may manifest as later eating disorders in adolescence**. This research highlights the importance of preventative strategies in eating disorders and a factor that services should consider when assessing CYP for overall MH difficulties. Where eating behaviours are present within an assessment, services should provide specific interventions to tackle this behaviour to reduce later prevalence of the disorder. Nicholls & Yi (2012) found that a parent group intervention to identify risk factors of ED and encourage positive and supporting communication with their CYP, may be effective in preventing the developing of ED. Lock & Grange (2018) reported that **high levels of parental criticism at the start of family intervention can have negative impacts on family therapy, including predicated treatment drop out**. Allan et al., (2018) suggested that where maternal criticism is high, separated family therapy is more effectiveness for long term outcomes of CYP ED. Services should therefore consider the parental influence on the CYP ED symptomology prior to family therapy, and make an informed decision about whether this should be conducted as joint or separate therapy. Expressed emotion (EE) identifies critical/hostile attitudes towards a service user. EE has historically been measured using a standardised Camberwell Family Interview (CBI) which is difficult to obtain (Hooley & Parker, 2006). More contemporary research suggests that The Five Minute Speech Sample (FMSS), which is more efficient to use, holds equal validity to the CBI and therefore an effective tool to use in identifying EE (Hooley & Parker, 2006). This may be an effective tool for services to utilise when offering family therapy to service users, that will subsequently increase the success of ED treatment and reduce remission rates. **Further Considerations** Geilhufe et al (2021) conducted an overview of the current research on risk factors and clinical recommendations for transgender and gender expansive (TGE) CYP with a diagnosed ED. Overall, the found that **that CYP with TGE have rates of self-harm, suicidal ideation and suicide attempts that are 24 times higher than cisgender females with ED.** **40% of transgender adolescence receiving ED treatment chose not to disclose their gender identity; 10% did disclose but were ignored; and 100% of participants reported a negative experience of their ED treatment.** To the best of our knowledge there is no clear guidance for supporting TGE within an ED service, including lack of training in gender-affirmative clinical care (Geilhufe et al., 2021). Therefore, services should utilise training and learning opportunities to provide the best care for their service users. The aim should be for service users to feel heard and understood, and their feelings around their gender/sexuality should be taken seriously.

	• create a personalised treatment plan based on the processes that appear to be maintaining the eating problem • take into account the person's specific development needs • explain the risks of malnutrition and being underweight • enhance self-efficacy • include self-monitoring of dietary intake and associated thoughts and feelings • include homework, to help the person practice what they have learned in their daily life • address how the person can get support if treatment is stopped. AFP-AN for children and young people should: • typically consist of 32 to 40 individual sessions over 12 to 18 months, with: • more regular sessions early on, to help the person build a relationship with the practitioner and motivate them to change their behaviour • 8 to 12 additional family sessions with the person and their parents or carers (as appropriate) • review the needs of the person 4 weeks after treatment begins and then every 3 months, to establish how regular sessions should be and how long treatment should last • in family sessions and in individual sessions, include psychoeducation about nutrition and the effects of malnutrition • focus on the person's self-image, emotions and interpersonal processes, and how these affect their eating disorder • develop a formulation of the person's psychological issues and how they use anorexic behaviour as a coping strategy • address fears about weight gain, and emphasise that weight gain and healthy eating is a critical part of therapy • find alternative strategies for the person to manage stress • in later stages of treatment, explore issues of identity and build independence • towards end of treatment, focus on transferring the therapy experience to situations in everyday life • in family sessions, help parents or carers support the person to change their behaviour • address how the person can get support if treatment is stopped. Other considerations For people with anorexia who are not having treatment (for example, because it has not helped or because they have declined it) and who do not have severe or complex problems: • discharge them to primary care	<u>Lack of evidence for AFP-AN.</u>	For TGE CYP, family acceptance and support are a clear indicator of their MH and wellbeing. TGE CYP who experience significant discrimination and no protective factors have a 71% chance of binge eating, compared to 40% of those with family support (Geilhufe et al., 2021). Therefore, as NICE guidance recommends family treatment at the focus of ED, the EE of family members working a service user is TGE is of critical importance for the CYP outcomes. Specific clinical goals around family acceptance should be considered, along with providing caregivers with resources to support their CYP's gender experience and process their own emotions of this.

	• tell them they can ask their GP to refer them again for treatment at any time. For people with anorexia who have declined or do not want treatment and who have severe or complex problems, eating disorder services should provide support as covered in the recommendation on providing support and care in the section on treating anorexia nervosa. Only offer dietary counselling as part of a multidisciplinary approach. Encourage people with anorexia nervosa to take an age-appropriate oral multi-vitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values. Include family members or carers (as appropriate) in any dietary education or meal planning for children and young people with anorexia nervosa who are having therapy on their own. Offer supplementary dietary advice to children and young people with anorexia nervosa and their family or carers (as appropriate) to help them meet their dietary needs for growth and development (particularly during puberty).		
Presentation	**NICE Guidelines**	**Research**	**Latest Emerging Evidence**
Eating Disorders	Binge eating disorder (NG69) (The following are the same treatment recommendations for adults) Explain to people with binge eating disorder that **psychological treatments aimed at treating binge eating have a limited effect on body weight and that weight loss is not a therapy target in itself**. Refer to the NICE guideline on obesity identification, assessment and management for guidance on weight loss and bariatric surgery. Offer a binge-eating-disorder-focused guided self-help programme. Binge-eating-disorder-focused guided self-help programmes should: • use cognitive behavioural self-help materials • focus on adherence to the self-help programme • supplement the self-help programme with brief supportive sessions (for example, 4 to 9 sessions lasting 20 minutes each over 16 weeks, running weekly at first) • focus exclusively on helping the person follow the programme.	**Binge eating disorder** No review for binge-eating self-help for adolescence.	**Binge eating disorder** A condensed dialectical behaviour therapy (DBT) skills groups for 4-6 YP aged 14–18-year-olds was found to be effective in reducing emotional eating and binge-eating behaviour (Pluhar, Kamody & Sanchez, 2018; Kamody et al., 2019; Kamody et al., 2020). The group intervention consisted of 10 sessions. Session 1 was an introduction and assessment session (2 hours). Sessions 2 - 9 all began with a mindfulness-based activity and then a core DBT skill as seen in the table below (1 hour). Participants were also given homework and diary cards. The final session was a reflective exercise (2.5 hours).

	If guided self-help is unacceptable, contraindicated, or ineffective after 4 weeks, offer group eating-disorder-focused cognitive behavioural therapy (CBT-ED). Group CBT-ED programmes for adults with binge eating disorder should: • typically consist of 16 weekly 90-minute group sessions over 4 months • focus on psychoeducation, self-monitoring of the eating behaviour and helping the person analyse their problems and goals • include making a daily food intake plan and identifying binge eating cues • include body exposure training and helping the person to identify and change negative beliefs about their body • help with avoiding relapses and coping with current and future risks and triggers. If group CBT-ED is not available or the person declines it, consider individual CBT-ED for binge eating disorder. Individual CBT-ED with binge eating disorder should: • typically consist of 16 to 20 sessions • develop a formulation of the person's psychological issues, to determine how dietary and emotional factors contribute to their binge eating • based on the formulation: • advise people to eat regular meals and snacks to avoid feeling hungry • address the emotional triggers for their binge eating, using cognitive restructuring, behavioural experiments and exposure • include weekly monitoring of binge eating behaviours, dietary intake and weight • share the weight record with the person • address body-image issues if present • explain to the person that although CBT-ED does not aim at weight loss, stopping binge eating can have this effect in the long term • advise the person not to try to lose weight (for example, by dieting) during treatment, because this is likely to trigger binge eating.	CBT-ED for adolescence is effective and cost efficient for reducing symptomology at the end of treatment and post treatment review (Hilbert, 2013).	 Further information on the mindfulness skills used can be found here. Pearson, Zapolski and Smith (2014) defined 2 risk pathways for adolescence with binge eating disorder: negative urgency (characterised by impulsivity) and negative affect (characterised by depressive symptomology). Pearson, Zapolski and Smith (2014) suggests an intervention that addresses both pathways are more successful than those that capture only one or neither. More specifically, DBT and CBT were argued to be the most affected interventions that addresses both negative urgency and negative affect (Pearson, Zapolski & Smith, 2014).

Session	Topic	Activities
2	Distress tolerance	• Mindfulness activity: The story of your name* • DBT skill didactic: Self-soothing with six senses • Experiential activity: Create self-soothing kits using items that can calm or stimulate the senses (e.g., candles for smell, silly putty for touch and fidget spinner for movement).
3	Distress tolerance	• Mindfulness activity: Losing favorite candy* • DBT skill didactic: Radical acceptance • Experiential activity: Role-play general and food/weight specific scenarios to practice accepting things that cannot be changed to avoid engaging in harmful behaviors and decrease suffering.
4	Mindfulness	• Mindfulness activity: Last orange on Earth* • DBT skill didactic: What and how skills • Experiential activity: Using culturally relevant, youth-oriented magazines, practice making descriptive observations without judgment.
5	Mindfulness	• Mindfulness activity: Piece of chocolate* • DBT skill didactic: Mindful eating • Experiential activity: Explore a variety of foods (e.g., celery, strawberries and pretzels) fully using the senses to differentiate mindful from mindless eating.
6	Mindfulness/distress tolerance	• Mindfulness activity: Creating a storm* • DBT skill didactic: States of mind; wise mind ACCEPTS • Experiential activity: Practice brainstorming pleasant activities as a distraction against negative emotion and urges (e.g., binge eating).
7	Emotion regulation	• Mindfulness activity: Emotional charades* • DBT skill didactic: The wave skill • Experiential activity: Watch videos of surfing wipeouts to visualize the futility and potential harm of responding immediately to emotional waves (e.g., urges to overeat in respond to emotions).
8	Emotion regulation	• Mindfulness activity: Simon Says opposites* • DBT skill didactic: Opposite action • Experiential activity: Role-play general and food/weight specific scenarios to practice acting opposite to negative emotion to avoid engaging in harmful behaviors and decrease emotional suffering.
9	Interpersonal effectiveness	• Mindfulness activity: Group counting* • DBT skill didactic: Interpersonal effectiveness skills • Experiential activity: Apply interpersonal effectiveness and negotiation skills to request menu items for wrap-up session.

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Eating Disorders	Bulimia nervosa (BN) (NG69) Offer bulimia-nervosa-focused family therapy (FT-BN) to children and young people with bulimia nervosa. FT-BN for children and young people with bulimia nervosa should: • typically consist of 18 to 20 sessions over 6 months • establish a good therapeutic relationship with the person and their family members or carers • support and encourage the family to help the person recover • not blame the person, their family members or carers • include information about: • regulating body weight • dieting • the adverse effects of attempting to control weight with self-induced vomiting, laxatives or other compensatory behaviours • use a collaborative approach between the parents and the young person to establish regular eating patterns and minimise compensatory behaviours • include regular meetings with the person on their own throughout the treatment • include self-monitoring of bulimic behaviours and discussions with family members or carers • in later phases of treatment, support the person and their family members or carers to establish a level of independence appropriate for their level of development • in the final phase of treatment, focus on plans for when treatment ends (including any concerns the person and their family have) and on relapse prevention. • Consider support for family members who are not involved in the family therapy, to help them to cope with distress caused by the condition. If FT-BN is unacceptable, contraindicated or ineffective, consider individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) for children and young people with bulimia nervosa. Individual CBT-ED for children and young people with bulimia nervosa should: • typically consist of 18 sessions over 6 months, with more frequent sessions early in treatment • include up to 4 additional sessions with parents or carers • initially focus on the role bulimia nervosa plays in the person's life and on building motivation to change	Bulimia nervosa CBT guided self-help for adolescence with BN showed significant reductions in binge eating after six months, but this was not retained after a one year follow up (Schmidt & Beecham, 2007). Le Grange et al., (2007) compared FBT-BN, and supportive psychotherapy in a sample of 80 adolescents. They found that **FBT-BN had significantly higher binge and purge abstinence at end of treatment (39% vs 18%) and at the 6 month follow up (29% vs 10%)**. In 2015, Le Grange et al did a similar study but comparing FBT-BN with CBT-ED as well, and found that FBT-BN again had significantly higher abstinence rates at the end of treatment and the 6 months follow up, compared to CBT-ED. Hail & Le Grange., (2018) suggest that involving family members can offer positive improvements to treatment, however additional research should consider how this may be adapted for more successful treatment rates.	Hail & Le Grange (2018) identify that there is **a lack of research into treatments for CYP with BN**. Lenton-Brym, Rodrigues, Johnson, Coutuier & Toulany (2020) conducted a scoping review and identified **a significant gap in the evidence base to guide effective primary care-based interventions for CYP with BN.**

	• provide psychoeducation about eating disorders and how symptoms are maintained, while encouraging the person to gradually establish regular eating habits • develop a case formulation with the person • teach the person to monitor their thoughts, feelings and behaviours • set goals and encourage the person to address problematic thoughts, beliefs and behaviours with problem-solving • use relapse prevention strategies to prepare for and mitigate potential future setbacks • in sessions with parents and carers, provide education about eating disorders, identify family factors that stop the person from changing their behaviour, and discuss how the family can support the person's recovery. **Other specific feeding and eating disorders (OSFED)** For people with OSFED, consider using the treatments for the eating disorder it most closely resembles. Eating disorders and comorbid mental health difficulties. When deciding which order to treat an eating disorder and a comorbid mental health condition (in parallel, as part of the same treatment plan or one after the other), take the following into account: • the severity and complexity of the eating disorder and comorbidity • the person's level of functioning • the preferences of the person with the eating disorder and (if appropriate) those of their family members or carers. Refer to the NICE guidelines on specific mental health problems for further guidance on treatment. **Growth and development** Seek specialist paediatric or endocrinology advice for delayed physical development or faltering growth in children and young people with an eating disorder. Food Intake Disorders No recommendations for Avoidant Restrictive Food Intake Disorder (AFRID) No recommendations for Rumination Disorder No recommendations for PICA	There is evidence that CBT-ED is a strong alternative for the cases when FBT-BN is not suitable or is not working. Craig et al., (2019) studied a group of 54 adolescents with eating disorders who were offered CBT-ED and found significant reductions in both clinical impairment and eating attitudes.	

Presentation	NICE Guidelines	Research	Latest Emerging Evidence
Self-harm	Short-term management and prevention of recurrence (CG16) **Psychological, psychosocial and pharmacological interventions** Referral for further assessment and/or treatment should be based upon a comprehensive psychosocial assessment, and should be aimed at treating a person's underlying problems or particular diagnosis rather than simply treating self-harming behaviour, although intensive therapeutic help with outreach may reduce the risk of repetition. Whatever the treatment plan, primary care and mental health services should be informed. Following psychosocial assessment for people who have self-harmed, the decision about referral for further treatment and help should be based upon a comprehensive psychiatric, psychological and social assessment, including an assessment of risk, and should not be determined solely on the basis of having self-harmed. Clinicians should ensure that service users who have self-harmed are fully informed about all the service and treatment options available, including the likely benefits and disadvantages, in a spirit of collaboration, before treatments are offered. The provision of relevant written material with time to talk over preferences should also be provided for all service users. The mental health professional making the assessment should inform both mental health services (if they are involved already) and the service user's GP, in writing, of the treatment plan. For the further management of people who have self-harmed, see below. Longer-term treatment and management of self-harm (CG133) **Provision of care** Mental health services (including community mental health teams and liaison psychiatry teams) should generally be responsible for the routine assessment and the longer-term treatment and management of self-harm. In children and young people this should be the responsibility of tier 2 and 3 CAMHS.	A systematic review (Witt et al., 2021) suggests that individual Dialectic Behavioural Therapy (DBT) effectively reduces self-harm in children and young people. Mentalisation-based therapy might also have some positive effects in reducing self-harm.	Evidence-based and evidence-informed interventions for managing risk in young people in the community could include (Clarke et al., 2019): • safety planning, including identifying early signs of overwhelm and implementing useful, for instance, CBT and/or DBT based coping strategies • limiting access to risk objects • increased monitoring by parent or trusted adult • reducing risk factors through engagement with educational setting and families • working with the parents or cares. A systematic review of family-based interventions from 2010 to 2019 for suicidal ideation and behaviour indicated the intervention categories below showed promising results for suicide-related outcomes (Freya et al., 2022): • CBT + Parent Training • CBT + Systemic Principles • DBT + Family Training • Systemic Principles • Psychoeducation. Brief community-based psychological crisis interventions as the ones described below can reduce the use of unnecessary restrictive measures and have showed to be effective and acceptable to young people: • Family-based interventions (Ginnis et al., 2015; Wharff et al., 2012; Wharff et al., 2017; Cottrell et al., 2018; Cottrell at al., 2020; Rengasamy et al., 2019) • Therapeutic assessment (Ougrin et al., 2011, 2012) • Parent only (Pineda & Dadds, 2012) • Interpersonal psychotherapy (Haruvi-Catalan et al., 2020). Clinical recommendations suggest a collaborative approach given the importance of engaging both the young person and families/carers throughout the intervention and promote further de-escalation and aid treatment planning. Another recommendation involved using a therapeutic assessment which increases the likelihood of further engagement with mental health support. Potential benefits include: no waiting time for psychological support, avoiding long-term hospitalisation, least restrictive practice, and reduced cost to health services (Ginnis et al., 2015); and increase in family/carer resilience skills (Pineda & Dadds, 2012). Additionally, it is important to proactively target children and young people showing risk factors such as historical self-harm events (Cottrell et al., 2020).

	Tier 2 CAMHS: primary care; Tier 3 CAMHS: community child and adolescent mental health teams. **Care plans** Discuss, agree and document the aims of longer-term treatment in the care plan with the person who self-harms. These aims may be to: • prevent escalation of self-harm • reduce harm arising from self-harm or reduce or stop self-harm • reduce or stop other risk-related behaviour • improve social or occupational functioning • improve quality of life • improve any associated mental health conditions. Review the person's care plan with them, including the aims of treatment, and revise it at agreed intervals of not more than 1 year. Care plans should be multidisciplinary and developed collaboratively with the person who self-harms and, provided the person agrees, with their family, carers or significant others. Care plans should: • identify realistic and optimistic long-term goals, including education, employment and occupation • identify short-term treatment goals (linked to the long-term goals) and steps to achieve them • identify the roles and responsibilities of any team members and the person who self-harms • include a jointly prepared risk management plan (see below) • be shared with the person's GP. • 'Significant other' refers not just to a partner but also to friends and any person the service user considers to be important to them. **Risk management plans** A risk management plan should be a clearly identifiable part of the care plan and should: • address each of the long-term and more immediate risks identified in the risk assessment • address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide		There is preliminary evidence for manualized CBT interventions to be effective in reducing self-harming behaviours in young people (Taylor et al., 2011). Other studies have also looked at using technology (Apps) to help manage and reduce self-harm alongside other interventions (Stallard et al., 2018). Cross & Clarke (2022) implemented a community-based pilot study (RUSH) with the following aims: reduce repeat attendance and re-admission to local emergency departments (ED) for self-harm; offer an engaging, easy access, acceptable, non-hospital based community provision with initial contact made within 48 hours of the referral; to reduce frequency and severity of self-harm; to maximise engagement; and to offer all CYP accessing the self-harm pathway an evidence-informed therapeutic psycho-social assessment. The criteria were CYP between 11-18; leaving within the local area (Central Norfolk); engaged in repeat self-harm and were at risk of being admitted to ED. The intervention offered was 8 sessions and were based on the NICE guidelines, counselling approaches and specialising advice-giving (relationships, debt/housing, health etc). Risk was regularly monitored. Following the 8 sessions, CYP were either discharged, escalated or referred/signposted to other services. At a 4-6 week follow up, results showed that there was a statistically significant reduction in self-reported self-harm frequency, anxiety and depression.

	• include a crisis plan outlining self-management strategies and how to access services during a crisis when self-management strategies fail • ensure that the risk management plan is consistent with the long-term treatment strategy. Inform the person who self-harms of the limits of confidentiality and that information in the plan may be shared with other professionals. Update risk management plans regularly for people who continue to be at risk of further self-harm. Monitor changes in risk and specific associated factors for the service user, and evaluate the impact of treatment strategies over time. **Provision of information about the treatment and management of self-harm** Offer the person who self-harms relevant written and verbal information about, and give time to discuss with them, the following: • the dangers and long-term outcomes associated with self-harm • the available interventions and possible strategies available to help reduce self-harm and/or its consequences • treatment of any associated mental health condition. Ensure that people who self-harm, and their families, carers and significant others where this is agreed with the person, have access to information for the public that NICE has produced for this guideline and for the short-term management of self-harm (NICE clinical guideline 16). **Interventions for self-harm** Consider offering 3 to 12 sessions of a psychological intervention that is specifically structured for people who self-harm, with the aim of reducing self-harm. In addition: • The intervention should be tailored to individual need, and could include cognitive-behavioural, psychodynamic or problem-solving elements. • Therapists should be trained and supervised in the therapy they are offering to people who self-harm. • Therapists should also be able to work collaboratively with the person to identify the problems causing distress or leading to self-harm.		

	Do not offer drug treatment as a specific intervention to reduce self-harm. Harm reduction If stopping self-harm is unrealistic in the short term: • consider strategies aimed at harm reduction; reinforce existing coping strategies and develop new strategies as an alternative to self-harm where possible • consider discussing less destructive or harmful methods of self-harm with the service user, their family, carers or significant others where this has been agreed with the service user, and the wider multidisciplinary team • advise the service user that there is no safe way to self-poison. Further clinical guidelines on self harm (assessment, management and preventing recurrence) are in development (GID-NG10148)		

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