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Are Depressed Adolescents Routinely Offered CBT? A Brief Review of Current Practice

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Abstract. An increasing body of research in support of cognitive-behavioural therapy (CBT) for adolescent depression has emerged during the last two decades. However, it has been suggested that empirically supported treatments are seldom carried out in clinical practice. Although the reasons for this are likely to be diverse, it is argued that mental health services have an ethical responsibility to offer evidence-based interventions. Whether empirically supported interventions, such as CBT, are consistently offered to depressed adolescents attending Child and Adolescent Mental Health Services (CAMHS) is currently unknown. A primary aim of this study was to survey the use of CBT for depression in a number of United Kingdom (UK) CAMHS settings. A postal questionnaire was sent to 117 members of the BABCP Children, Adolescents and Families Special Interest Branch, of which 44 completed questionnaires were returned. Descriptive statistics indicate that just over half of the organizations represented routinely offered CBT to depressed adolescents. CBT practice and the transportation of evidence-based research findings to CAMHS settings are discussed.

Keywords: CAMHS, adolescent depression, evidence base, CBT.

Introduction

According to Harrington, Kerfoot and Verduyn (1999), offering psychological interventions that lack empirical support may lead to poor outcome and may even be harmful. Empirically supported treatments, however, are seldom carried out in clinical practice, according to Connor-Smith and Weisz (2003). Although the reasons for this are unclear and are likely to be multifarious, it has been suggested that community services for depressed young people are more likely to offer eclectic therapies, which vary in accordance with the theoretical orientation of the clinician (Addis and Krasnow, 2000). Support for this view was found in a study by Weersing and Weisz (2002), which evaluated the effectiveness of psychotherapy for

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depressed young people attending a community mental health centre (CMHC) in comparison with evidence based treatments (e.g. CBT) in 13 clinical trials, using a benchmarking strategy. Findings supported the authors' hypothesis that the depressed young people attending the community services did not improve as much as those who had taken part in the randomized control trials (RCTs). This finding was largely attributed to the difference in therapeutic interventions. Eclectic therapies were employed in the community service settings whereas cognitive behavioural therapies were utilized in the RCTs. The investigation did not directly compare CMHC therapies and CBT in a randomized trial, but the authors concluded that therapy differences were a reasonable explanation for the differences in outcome (Weersing and Weisz, 2002). A meta-analytic review carried out by Weisz, Weiss, Han, Granger and Morton (1995) found no evidence of effective treatments for children and adolescents in clinical settings, further exposing a disparity between empirical research and clinical practice.

There is an urgent need to appraise current mental health service provision for depressed adolescents as this disorder is known to have high prevalence rates and is a potent risk factor for suicide (Gould et al., 1998). However, the paucity of treatment outcome research for child and adolescent depression, culminating in a total of 18 studies on which the recently published National Institute for Clinical Excellence (NICE) guidelines were based, is rather limited (Murray and Cartwright-Hatton, 2006). In the meantime, CBT has recently been recommended as a first line approach for moderate to severe depression in children and adolescents (NICE, 2005), raising the question as to whether CAMHS are currently equipped to follow these guidelines. Investigating whether CAMHS across the UK are presently offering CBT to depressed adolescents was a primary aim of this study.

Method

Design

Data were elicited by questionnaire and analysis was primarily quantitative with some qualitative analysis of text. Not all analyses are included in this abbreviated report of the study but are described in a fuller version that may be obtained from the first author.

Participants

The participant sample was intentionally biased towards CBT practitioners as the survey investigated the availability of this treatment approach for depressed adolescents and additional practice issues relating to the transportation of research to clinical practice. A postal questionnaire was sent to 117 members of the BABCP Special Interest Branch (SIB) for Children and Adolescents. It was predicted that this discrete sub-group of the BABCP would embody a range of professionals representing a selection of CAMHS across the country. The inclusion criteria required therapists to be practitioners using CBT with depressed young people in the age range 13–18 years.

Procedure

The questionnaire was piloted with a small group of trainee clinical psychologists and CAMHS colleagues. Feedback regarding lack of clarity and/or ambiguity of questions led to

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Table 1. Core professions of participants

Core profession	Prevalence
Psychology	45%
Nursing	22%
Social work	13%
Medicine	13%
Other	4%

modifications. An explanatory letter and survey questionnaire were subsequently distributed in early March 2004 with a 2-week deadline for return, at the end of which, 36 completed questionnaires were received. After a further mailing, another 8 were returned, giving a final total of 44. Ten respondents did not complete the questionnaire as they did not fulfil inclusion criteria. Two completed questionnaires arrived too late for inclusion in the study.

Results

Characteristics of participants

There was a significant gender bias with 73% ($n = 32$) of the sample being female.

As shown in Table 1, psychology was the most prevalent core profession.

Primary therapeutic approach

Respondents were asked to select one of a list of therapies to describe their primary therapeutic approach. The most frequently reported approach was CBT (68%), of which 14% ($n = 6$) were BABCP accredited CBT therapists.

CBT for depressed adolescents attending the service

Respondents were asked whether CBT was routinely offered to depressed adolescents and, if so, the justification for provision of CBT, or an alternative therapy. Three suggested rationales were offered for respondents to choose from. Some respondents selected more than one reason. Fifty-seven percent ($n = 25$) reported that CBT was regularly offered to depressed adolescents. The justification for offering CBT suggested that evidence base was the highest (82%), followed by the availability of CBT therapists (50%). Other non-specified reasons represented 9% ($n = 4$). In contrast, in 75% ($n = 33$) of the sample, the most frequently reported rationale for offering alternative therapy was the therapist's theoretical orientation, followed by 31% ($n = 14$) reporting other non-specified reasons and 13% ($n = 6$) reporting a stronger evidence base for an alternative therapy.

Therapeutic modality

Respondents were presented with five modalities from which more than one could be selected to describe their most common practice. Eighty-eight percent reported using individual therapy,

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followed by 79% using combined individual and parent, 72% using self-help modalities, 47% using a family approach and 11% using group therapy.

Discussion

This study examined whether CBT was typically offered to depressed young people attending a range of CAMHS across the UK. Just over half of the sample reported that CBT was routinely offered, with 43% suggesting that this was not the case. It is likely that the biased CBT practitioner sample led to the inclusion of CAMHS most likely to offer CBT, limiting the generalization of findings.

The therapist's theoretical preference was reported to be a significant determinant of the type of therapy offered, according to three-quarters (75%) of the sample, supporting the suggestion that services provided to depressed young people are often based upon the therapist's theoretical choice and skills rather than upon empirical support (Addis and Krasnow, 2000). The largest evidence base for childhood depression is group delivered CBT (NICE, 2005). Findings from this study suggested that this modality was rare, highlighting a difference between efficacy research and clinical practice.

According to this brief report, findings regarding the availability of CBT for depressed adolescents attending CAMHS are encouraging but indicative of the need for growth if NICE guidelines are to be effectively and reliably implemented. Alternative empirically supported psychological interventions for adolescent depression recommended in NICE guidelines were not investigated in this study but are equally worthy of exploration. Future research into the availability and delivery of empirically supported therapies for children and young people attending CAMHS across the UK is urgently needed if NICE guidelines are to be successfully embraced.

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