

# **Pilot Mixed-Methods Evaluation of Interpersonal Counselling for Young People with Depressive Symptoms in Non-Specialist Services**

**Dr Paul O. Wilkinson, Mrs Viktoria Cestaro, Dr Ian Pinchen**

**Word count:**

**Abstract: 230**

**Main body of text 3883**

Dr Paul O Wilkinson (corresponding author),  
University Lecturer and Honorary Consultant in Child and Adolescent Psychiatry,  
University of Cambridge Department of Psychiatry; Cambridgeshire and Peterborough NHS  
Foundation Trust,  
Douglas House,  
18b Trumpington Road,  
Cambridge,  
CB2 8AH.  
[pow12@cam.ac.uk](mailto:pow12@cam.ac.uk)

Mrs Viktoria Cestaro  
Counselling Psychologist  
Suffolk South Integrated Delivery Team  
Norfolk and Suffolk NHS Foundation Trust  
G Block  
Hospital Road  
Bury St Edmunds  
Suffolk  
IP33 3 NR  
[viktoria.cestaro@nsft.nhs.uk](mailto:viktoria.cestaro@nsft.nhs.uk)

Dr Ian Pinchen  
Freelance qualitative researcher  
IP Consulting  
Summerhouse  
49 Woodlands Park  
Cambridge  
CB3 0QB  
[pincheni@gmail.com](mailto:pincheni@gmail.com)

**Background.** The majority of young people receiving treatment for depressive symptoms in the UK receive this from staff with minimal specialist mental health/therapeutic training. There is no evidence to guide them as to what treatments are likely to be effective. Interpersonal counselling (IPC) is a reduced form of interpersonal psychotherapy, and may be an appropriate treatment to use in this population.

**Objectives.** To test the effectiveness and acceptability of IPC delivered by youth workers to young people with primarily depressive symptoms.

**Methods.** Youth workers received a two day training course in IPC, followed by regular supervision. They delivered IPC to 23 young people who they would normally see in their service, with depressive symptoms as their main problem. Symptoms were assessed by the Revised Children Depression and Anxiety Scale (RCADS). Qualitative interviews of youth workers and young people assessed acceptability.

**Findings.** Mean(sd) RCADS depression-T scores fell from 78.2(11.1) to 52.9(16.8). All young people and youth workers interviewed were positive about it. Participants detailed specific advantages of IPC above standard counselling, including practical help, the use of goals, psychoeducation and integrating a self-rated questionnaire into treatment.

**Conclusions and Clinical Implications.** IPC is likely to be an effective and acceptable treatment for young people with primarily depressive symptoms seen in local authority non-specialist mental health services. Further research is needed to determine if it is more effective than current treatment as usual.

**What is already known about this subject?**

- Mild depression is common and disabling
- In the UK, most cases of adolescent mild depression are treated by non-specialist staff with no formal mental health/psychological therapy training
- Interpersonal counselling (IPC) is a reduced form of interpersonal therapy – a NICE-recommended treatment for adolescent depression
- IPC could potentially be delivered by non-specialist staff after brief training

**What are the new findings?**

- IPC, delivered by non-specialist youth workers, led to a mean reduction of depressive symptoms of 2.5 population standard deviations
- IPC was liked by young people, with them identifying specific advantages of this structured therapy over standard counselling
- IPC was liked by youth workers, with them identifying specific advantages of this structured therapy over standard counselling

**How might it impact on clinical practice in the foreseeable future?**

- Previously untrained youth workers could be trained in IPC, which may be an effective and acceptable brief treatment for mild/moderate depression in adolescents

## **BACKGROUND**

There is extensive and growing demand for services to meet the needs of young people experiencing poor mental health [1]. Depression is a common health problem during adolescence and is associated with adverse academic, social and health outcomes [2,3]. Adolescent lifetime prevalence of major depressive disorder (MDD) is 11-20%[4,5]. However, mild/sub-threshold depression is much more common in adolescents than full MDD [6]. Such mild depression is associated with significant personal and public health consequences [7] and is a strong predictor for future onset of full MDD[8].

In the UK, such cases of mild depression are not likely to meet treatment thresholds for specialist (tier 3) child and adolescent mental health services. Instead, young people with mild depression are seen by staff working in local authority child and family services, schools and voluntary agencies. Most of those working with depressed young people within these non-specialist services are not qualified mental health professionals and have no formal training in delivering evidence-based treatments for people with depression. There is a lack of evidence to guide the treatment of young people with mild depression seen within these services [9–11].

‘Task shifting’ refers to ‘a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers’ [12]. By increasing the numbers of staff providing a service, it widens access to treatment, as well as providing treatment closer to the communities where people live [12]. The World Health Organisation sees this being particularly useful in resource poor countries, with this approach widely implemented in HIV care in Africa [12]. It has also been implemented successfully in high income countries, for example the use of nurse prescribers in the UK [12]. Appropriate training and supervision are crucial to maintain quality [12]. Systematic review has demonstrated task shifting to increase access, provide good quality care and be cost-effective [13].

Given the lack of trained staff able to deliver evidence-based psychological therapy to young people in the UK, this seems to be a field where task shifting could be effective.

Interpersonal psychotherapy (IPT) is a NICE-recommended treatment with a strong evidence base for adolescents with moderate to severe depression [11,14,15]. In common with other evidence-based treatments for adolescent depression, IPT must be delivered by a qualified mental health professional with extensive training and so is unlikely to be a feasible treatment option outside of specialist CAMHS. Interpersonal counselling (IPC) is an adaptation of IPT with three main differences: the treatment duration is shorter (3-6 sessions); it is designed for clients with mild depression; and it can be delivered by non-mental health professionals after participation in a brief training course. Thus IPC delivered by non-specialist staff in non-specialist young person's services may be a feasible and effective application of task shifting.

IPC has been found to be an effective treatment for adults with mild to moderate depression [16,17] but its effectiveness as a treatment for adolescent depression has yet to be tested. Although there are many similarities between adult and adolescent depressions, there are also important differences, particularly in treatment response [9]. Adult and young people's services also differ in their organisation, ethos and staff training [18].

## **OBJECTIVES**

This mixed methods single arm pilot study trained local authority youth workers to deliver IPC to the young people they would normally treat for depressive symptoms. It set out to test, in this therapist and client population:

1. Does IPC reduce depressive symptoms?
2. Is IPC acceptable to young people?
3. Is IPC acceptable to local authority youth workers?

## **METHODS**

### **Participants**

IPC trainees: IPC was delivered by five local authority youth workers from Suffolk, UK local authority 'Early Help Teams'. They had backgrounds in youth work and/or counselling and all had experience of working with young people and families. These workers had no specific prior training in delivering formal psychological therapies, and had not received formal mental health professional training (such as nursing, clinical psychology or social work). They were identified by managers as being appropriate for this training.

IPC Clients: Inclusion criteria were made simple to increase generalisability of the study, and make recruitment easier for youth workers. Firstly the client would need to be an adolescent who would normally receive intervention from the Suffolk local authority Early Help Teams. The problems must not be so severe that the client would normally be referred straight to specialist services (eg due to significant suicidality), but the client must have enough problems that the Early Help Teams would normally see them. Secondly, the client's main problem must be depressive symptoms, as opposed to (for example) anxiety, substance use or disruptive behaviour. Thirdly, clients must have some interpersonal issue. Fourthly, clients must be willing to try psychological therapy. In the case of doubts (and in all training cases), suitability was discussed with VC. There were no exclusions based on presence of secondary problems or developmental disorders. Inclusion was not based on DSM/ICD diagnostic criteria: firstly it was agreed that this would not be normal practice for youth workers and it would not be appropriate/acceptable to expect this; secondly IPC is designed for mild and sub-threshold depression, so it is not necessary for clients to meet full criteria.

## **Intervention and Training**

Interpersonal counselling is a structured time-limited individual psychological therapy. It is a collaborative goal-orientated therapy, which particularly focuses on the two way links between interpersonal relationships and depressive symptoms – improving understanding of those links and improving relationships should improve depressive symptoms. PW and VC adapted the initial manual for IPC developed by Weissman and Verdeli (2013 version), with permission, to make it more adolescent-appropriate. At the initial training course, the trainees helped with additional modifications. The manual is available from PW. Clients are assessed at session zero, where baseline questionnaires are given, suitability for IPC is determined and the IPC model is explained; following this, trainees discuss suitability with their supervisor. There are then three phases of therapy: an initial session offers psychoeducation about depressive symptoms and IPC, discusses current coping strategies, gathers information on interpersonal relationships and their link with depressive symptoms, agrees a focus area (big changes, grief, relationship disputes or loneliness & isolation) and agrees SMART goals. The middle sessions (one-four sessions) review progress made since the last session and contain specific work on the problem area and goals, using general IPC strategies, and strategies specific to the focus area. The final session reviews progress over the IPC, and discusses relapse prevention strategies and future need/referral routes for therapy (which may mean referral to more specialist services if problems persist). Ending is addressed explicitly throughout treatment.

PW is a consultant child and adolescent psychiatrist and IPT-UK-accredited IPT practitioner, supervisor and trainer. VC is a counselling psychologist and IPT-UK-accredited IPT practitioner, supervisor and trainer. PW and VC delivered a two day training course in IPC to six local authority youth workers. All trainees read a short book on IPT before the course [19]. These youth workers then delivered IPC with group supervision from VC. For at least the first two cases, this was weekly, with rating of audiotapes. Supervision gradually reduced to once per month. All four IPC trainees

who contributed cases to the evaluation met IPT-UK accreditation criteria for IPC (four audiotaped sessions above pass threshold, with at least one from each treatment phase, over two cases) over the course of the pilot.

## **Procedure**

### **Quantitative**

Youth workers gave young people self-rating questionnaires during therapy sessions. This is a routine part of IPC and IPT practice. The 47 item self-rated Revised Children Depression and Anxiety Scale (RCADS) was used at the start and end of treatment. The RCADS is recommended by NHS-England's Children and Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT) for routine monitoring of emotional symptoms, and has good psychometric properties [20]. There are sub-scales covering depression, obsessive-compulsive symptoms, separation anxiety, panic, generalised anxiety and social anxiety. Where one-two items were missing on a sub-scale, values were imputed based on mean for other sub-scale items. Age/gender normed T-scores (population mean 50, sd 10) were derived, based on participant school year at study entry. The 10 item depression subscale was given at every session (and integrated into normal therapeutic practice), and was the primary outcome measure. Scores for each participant at all assessment points were plotted (with correct time), alongside a regression line for all participants (calculated using linear and quadratic terms with the xtmixed function of Stata 14). As this was a single arm pilot study, statistical testing was not appropriate.

### **Qualitative**

Five IPC trainees and six IPC clients agreed to have semi-structured qualitative interviews, by IP, who is not clinically-trained and not involved in the IPC service delivery or training. Young person interviews focused on what they thought about the IPC, how it could be improved, and what they thought about the questionnaires. IPC trainee interviews focused on training, supervision, what

they thought about the IPC, how it could be improved, and what they thought about the questionnaires. The complete interview guide is in appendix 1.

For the initial ten young people (and all qualitative interviews), the evaluation was conducted as a monitored trial, with approval from the UK Social Care Ethics Committee and Suffolk County Council Research Governance Panel. Where young people were aged 16 and over, they gave informed written consent. Where young people were under 16, a parent gave written informed consent and the young person gave assent. Following the success of this initial controlled pilot, Suffolk CC decided to continue and expand IPC provision; as this was no longer a novel treatment, Suffolk County Council Research Governance Panel agreed that future data collection could continue as routine service data collection, and anonymised data sent to PW for evaluation.

## **RESULTS**

### **Quantitative**

Table 1 shows demographic variables and details on number of sessions/duration of therapy. 15/23 (65%) of participants were female and median age was 15 years. Participants received a median of 6 IPC sessions, over a median of 9.1 weeks, following session zero.

Table 1 here

Table 2 shows RCADS scores at session zero, session one (for depression) and the final session. Mean(sd) baseline RCADS depression T-score (RCADS-D-T) was 78.2 (11.1), 2.8 standard deviations above the population mean. Three participants did not have RCADS for non-depression items. They had higher baseline mean RCADS-D-T (mean 86.3 vs 76.9). Participants had a median of two (IQR 1-2) comorbid disorders in the 'probable' range, most commonly panic.

Table 2 here

Figure 1 shows trajectory of RCADS-D-T in all participants. All participants had a reduction; mean (sd) reduction was 25.3 (15.5). Proportion of participants with depression in the 'probable' range was 83% at baseline and 13% at the end. After a median split by baseline RCADS-D-T, mean reduction in RCADS-D-T was 22.6 and 28.2 in the lower and higher baseline RCADS-D-T groups, respectively. Reduction in other RCADS T-scales was 10-15.

Figure 1 here

## **Qualitative**

### **Young People**

The first ten young people in the pilot were invited to qualitative interviews. Six took part (five female). Young people gave three key positives about IPC:

1. Having someone to talk to: this preceded every other activity and benefit, and involved three key elements:
  - Someone who would listen to the young person

- Someone who would offer advice
- Someone who would be part of a feedback loop as and when advice/decisions were enacted in the course of the young person's week

*'So I thought if I spoke about it with someone that I didn't know before, I thought it would help me. And it helped me so much more than I thought. Like, just talking about it, rather than just having to build it all up all the time. I like to have someone there to speak to rather than just keeping it to myself all the time.'*

2. It is 'focused' and sets clear goals/targets. These helped young people to do things to help them move forwards.

*'Setting goals each week did help because even if I didn't want to talk to someone, I would know that my goal for the end of the week **was** talking to someone...'*

It was helpful for goals to be broken down into small stages:

*'So I would talk to another person... Because the first week was just messaging someone that I wouldn't really (normally) talk to. And then after a little while, I could actually talk to them face-to-face and it helped a little bit because once I spoke to them, I felt like I've gained another friendship.'*

Achievement of goals helped to boost self-esteem, an important outcome in depression treatment:

*'One of my goals was like, go to the gym for an hour at least, I think it was about four times in that week and I did. So I was really proud of myself for that.'*

If a goal were not achieved, the problem could then be tackled another way:

*'If I didn't manage to do it, then I would try and come about the task a different way.'*

3. Most found the RCADS useful and helpful

*'When I came into counselling and we were talking about how my week went and I think that the questionnaires at the beginning did help me because it would get me thinking about what went on through the weekend.'*

The RCADS helped young people to recognize when symptoms were getting worse and the resultant need for action:

*'I can just tell that I'm...that out of every meeting I can just like...with my score, whatever, or marking down what's gone wrong and what's gone right, I can kind of figure out, like if I get...if I ticked off one of the emotions as higher, I know that's, if I'm going through that [problem of isolation], I've got to go downstairs and not isolate myself....'*

Some young people found some elements of IPC difficult, including feeling 'uncomfortable' about talking about some problems, which led to them not telling their counsellor about everything. This is not unique to IPC – indeed one young person spoke about how they could not open up in the past when they had school counselling (not IPC), but were able to open up well when they had IPC. One young person made comments that the RCADS did take quite a lot of time, when they would rather have been talking; some found the RCADS quite a strange 'alien' thing to do at first, but got used to

it, and found it relevant. One young person found it difficult that their counsellor was also involved in case management and meetings at school.

While some managed the end of therapy well, some were anxious about ending and felt more sad/less confident after therapy ended.

*'But when it stopped, it was kind of as if my body went into shock and I was going like, "Oh I haven't got that confidence anymore." And I kind of just shrunk back down and I didn't want to go out anymore. I didn't want to be happy. I didn't want to be with my family. And it was just stuff like that. It wasn't [the counsellor's] fault. It was the fact that I've become too reliant on it and I scared myself in thinking that I couldn't do without it.'*

One young person felt a bit worse after IPC ended, but was then able to reflect on how they were benefiting from using the new skills they had learnt in IPC:

*'It did go down a bit like, after I left [the counselling came to an end]. Shortly after, my [siblings] have gone downhill again and everything flared up at home so... I manage them better now because I know what to do if I feel like, stressed about something.'*

Overall, all six young people interviewed said they would recommend IPC to other young people, and two had already informally used IPC methods in helping their friends.

## **IPC Trainees**

All five IPC trainees who went on to supervised practice were interviewed. Three were female. Ages ranged from mid-20s to mid-40s. Counsellors unanimously thought that young people were positive about IPC and found it helpful.

IPC trainees noted six particular benefits:

1. The clear structure:

*'I think it's...yeah, it seems like a good fit... So as I said, it's structured, young people are used to structure, aren't they, and doing things repetitively?'*

2. The time-limited nature:

*'With the young people I've worked with, I think that six weeks is a good number. One thing that's good about the therapeutic way that we work is, every week we'll say, "Well, this is session three of six, how do you feel?" or "Session four, right, we're coming...working towards an end here, how do you feel about this?" And I think sometimes young people have got to a point where they've kind of talked it out and threshed it out enough really.'*

*'And it probably could go on forever with her and it's been explained that actually, you know what to do now, you've gotten these tools. It's about doing them...'*

3. It is 'focused' and sets clear goals/targets, which can be worked on incrementally:

*'The fact that it's focused is good for them because they've got an aim, haven't they? You've given them direction, they go out, they work in that direction, they come back. They try it, it*

*works, it doesn't work. Okay, so what else are we going to do? So I think that's quite good for adolescents.'*

*'So her target was simply, one week she was going to go sit with a friend in the dinner hall. That was a big deal to her. She's been sat in the library for years, not talking to anybody at lunchtime. Lunchtime's a massive thing for young people... All the kids go to somewhere on a Friday night around here. She's actually going to go, you know, she's going to make plans to do things at weekends. So, them little targets.'*

4. It offers practical help, rather than just offering a listening ear as other approaches do:

*'So that's what's been missing for some of them when they've done the sort of just talking counselling before. That they like that sort of balance of both; the pair (talking and doing).'*

*'I'm going to talk about this really c\*\*p time, this one [session]. But actually, there's something practical I'm going to do.'*

5. The specific psychoeducation is helpful:

*'And the psycho-education, young people are kind of open to learning about stuff. It's not as though they've never heard it before necessarily or they switched off or something. They're quite open to learning more about... because, you know, they're experiencing things with their depression that they actually don't know are quite common.'*

6. The RCADS was easy to integrate into counselling. It was helpful in showing progress. It was helpful in deciding what needed working on in a session:

*'Because the mini RCADS... not only do they tell you what you're going to talk about, until you're there and you've done it (i.e. have set and achieved a target)... (they tell you) what you're going to discuss and what you're going to look at during the course of that session..., you know, the goals that you're going to put in place will really come from that.'*

All counsellors were positive about the training course, describing it as engaging, well-structured and practical. The pre-course reading was helpful. Some found it too intensive, and would have preferred more time for reflection, and more variety (eg more video clips). They also suggested a subsequent refresher day. Supervision was seen as incredibly important and helpful, and the group format was appreciated, as it meant trainees could learn from each others' cases.

*'I don't think you could have delivered the IPC with the initial training alone. It needed to be with the supervision. You couldn't have had this separate.'*

Most trainees had a significant delay between ending the course and taking on their first case, which they found difficult. Counsellors felt that six sessions were enough, and that if more treatment was needed after this, then the clients probably needed referral for another treatment/service.

## **CONCLUSIONS**

23 young people received a course of IPC, with a median of six sessions. These young people were seen in tier 1 local authority children and young people's services, and had the severity of problems normally seen in those services. Of note, baseline symptoms were high, with depression scores 2.8

standard deviations above the population mean, and an average of two co-morbid emotional disorders. Thus IPC was not just evaluated in young people with mild problems.

For all young people, depressive symptoms improved, at a mean of 2.5 population standard deviations. RCADS caseness for depression fell from 83% to 13%. Of note, improvement was similar with those with more severe and those with milder symptoms, suggesting it is not just helpful for those with milder problems. This demonstrates that when youth workers with no formal mental health training are trained in IPC, and deliver it to the young people they normally see with low mood, these young people have a large reduction in depressive symptoms. Thus it may be an effective treatment in this population.

IPC was also an acceptable treatment to both young people and youth workers. All those interviewed were positive about it. In particular, both groups identified specific advantages of IPC above it providing a sympathetic ear (a major feature of the counselling approach often used by these services). In particular our participants liked the fact that it is practical (not just listening), is focused with clear goals and offers psychoeducation. Participants were also positive about the use of self-rating questionnaires that were integrated into the therapy. This suggests IPC may provide benefits above current counselling approaches. Youth workers identified that supervision was an essential component of the IPC, over and above the training course (of note, many trainings this professional group receive are not followed up with supervision). Thus it is important to include supervision costs in service planning.

Interviews revealed some problems with the IPC. In particular, ending was difficult. Further research is needed to identify whether this is different to other counselling approaches, and whether it would be helped by more sessions/more focus on ending (full IPT has 2-4 sessions where ending is worked on). Some problems have led to amendment of delivery of our training: we now

offer a booster day 9 months after the initial course; we work hard to try to make sure cases are lined up for treatment soon after the initial course and we advise having different people doing casework/multiagency liaison to the IPC.

## **Limitations**

This was single arm uncontrolled study. We therefore do not know if similar reductions in depressive symptoms would have occurred with treatment as usual delivered by youth workers or indeed with no treatment at all. A randomised controlled trial of IPC vs treatment as usual in this client/worker population is now needed. Diagnostic assessments were not conducted as these are not standard part of youth worker practice. RCADS thresholds just give an estimation of depression diagnostic status.

## **CLINICAL IMPLICATIONS**

Six sessions of IPC is likely to be an effective and acceptable treatment for young people with primarily depressive symptoms seen in local authority non-specialist mental health services. The current workforce can be trained to deliver this brief therapy, thus it may be cost-effective and practical within current budgetary constraints.

**Acknowledgements**

We would like to thank the therapists and their managers for enthusiastically taking on IPC and helping us with the evaluation. We would like to thank Prof Myrna Weissman for permission to use and adapt her IPC manual.

**Contributors**

PW and VC conceived the therapy development and evaluation plan. IC led the qualitative analysis, with input from PW and VC. PW conducted the quantitative analysis. PW, VC and IP wrote and approved the final manuscript.

**Funding**

The research evaluation was funded by CLAHRC-East of England; and Cambridgeshire and Peterborough NHS Foundation Trust R&D Strategic Funding. The therapy, training and supervision were funded by Suffolk County Council.

**Competing Interests**

PW and VC work as interpersonal psychotherapy practitioners, supervisors and trainers; and are developing IPC services in the area where the pilot took place. PW has conducted paid consultancy for Lundbeck and Takeda.

**Ethics Approval**

The study was approved by UK Social Care Ethics Committee (1<sup>st</sup> half of study only) and Suffolk County Council Research Governance Panel (whole study)

**Table 1.** Baseline Demographics and Therapy Details

	Median (IQR)	Range/Percentages
Gender (male:female)	8:15 (35% : 65%)	(35% : 65%)
Age	15 (2)	11-17
Number of sessions (after session zero)	6 (2)	1 - 8
Time interval session 0 – session 1, weeks	2.9 (3.3)	0.2 - 10
Time interval session 1 – final session, weeks	9.1 (4.3)	0 - 26.1

**Table 2.** RCADS Clinical Scores at Baseline and End

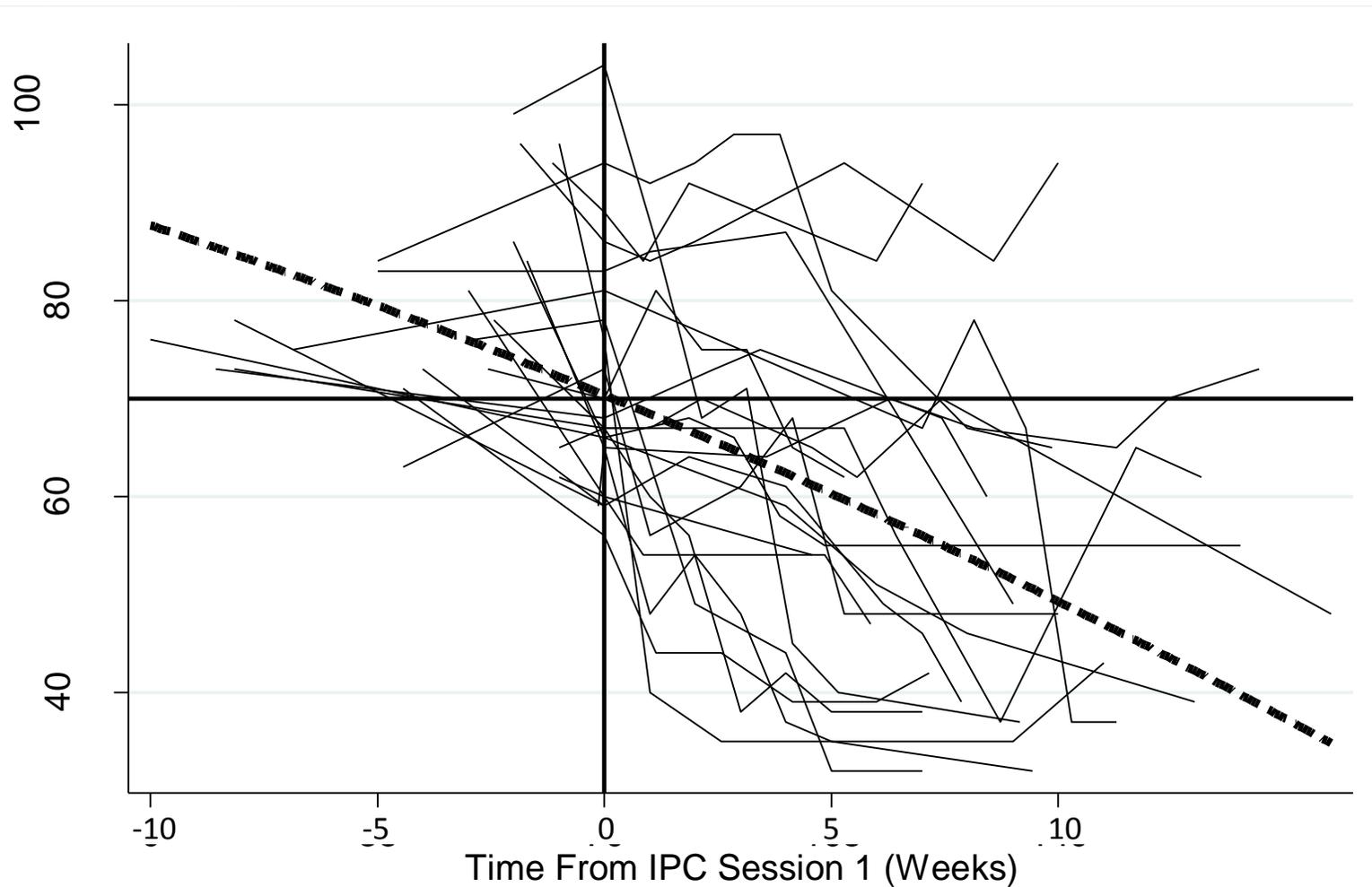
	n	Session 0, mean (sd)	N (%) above 70	Session 1, mean (sd)	Final Session, mean (sd)
Depression (raw)	23	18.7 (4.4)	-	16.3 (5.1)	8.7 (6.4)
Depression T	23	78.2 (11.1)	19 (83%)	72.1 (12.4)	52.9 (16.8)
Separation anxiety T	20	73.6 (16.7)	10 (50%)	-	59.0 (13.3)
Social anxiety T	20	57.4 (10.7)	3 (15%)	-	47.4 (12.1)
Generalized anxiety T	20	60.8 (9.1)	3 (15%)	-	47.3 (13.8)
OCD T	20	62.1 (9.9)	5 (25%)	-	49.0 (9.9)
Panic T	20	74.8 (17.9)	11 (55%)	-	60.7 (17.2)

## References

- 1 Frith E. CentreForum Commission on Children and Young People's Mental Health: State of the Nation. 2016. <http://centreforum.org/live/wp-content/uploads/2016/04/State-of-the-Nation-report-web.pdf>
- 2 Lewandowski E, Aciri M, Hoagwood K, *et al.* Evidence for the Management of Adolescent Depression. *Pediatrics* 2013;**132**:e996–1009.
- 3 Copeland WE, Wolke D, Shanahan L, *et al.* Adult functional outcomes of common childhood psychiatric problems a prospective, longitudinal study. *JAMA Psychiatry* 2015;**72**:892–9. doi:10.1001/jamapsychiatry.2015.0730
- 4 Lewinsohn PM, Rohde P, Seeley JR. Major depressive disorder in older adolescents: prevalence, risk factors, and clinical implications. *Clin Psychol Rev* 1998;**18**:765–94. [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=9827321](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=9827321)
- 5 Avenevoli S, Swendsen J, He JP, *et al.* Major Depression in the National Comorbidity Survey–Adolescent Supplement: Prevalence, Correlates, and Treatment. *J Am Acad Child Adolesc Psychiatry* 2015;**54**:37–44.e2. doi:10.1016/j.jaac.2014.10.010
- 6 Pickles A, Rowe R, Simonoff E, *et al.* Child psychiatric symptoms and psychosocial impairment: relationship and prognostic significance. *Br J Psychiatry* 2001;**179**:230–5. [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=11532800](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=11532800)
- 7 Ayuso-Mateos JL, Nuevo R, Verdes E, *et al.* From depressive symptoms to depressive disorders: The relevance of thresholds. *Br J Psychiatry* 2010;**196**:365–71. doi:10.1192/bjp.bp.109.071191
- 8 Judd L, Akiskal H, Paulus M. The role and clinical significance of subsyndromal depressive symptoms (SSD) in unipolar major depressive disorder. *J Affect Disord* 1997;**45**:27.
- 9 Thapar A, Collishaw S, Pine DS, *et al.* Depression in adolescence. *Lancet* 2012;**379**:1056–67. doi:10.1016/S0140-6736(11)60871-4
- 10 NICE. Addendum to clinical guideline 28, depression in children and young people. 2015. <https://www.nice.org.uk/guidance/cg28/evidence/addendum-193488882>
- 11 NICE. *Depression in Children and Young People: identification and management in primary, community and secondary care*. London: : British Psychological Society, Royal College of Psychiatrists 2005. <http://www.nice.org.uk/CG028>
- 12 World Health Organisation. Task shifting to tackle health worker shortages. 2006. doi:10.1016/S0033-3506(01)00422-X. [http://www.who.int/healthsystems/task\\_shifting/TTR\\_tackle.pdf?ua=1](http://www.who.int/healthsystems/task_shifting/TTR_tackle.pdf?ua=1)
- 13 Callaghan M, Ford N, Schneider H. A systematic review of task- shifting for HIV treatment and care in Africa Review. *Hum Resour Health* 2010;**8**:8.
- 14 Mufson L, Dorta KP, Wickramaratne P, *et al.* A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry* 2004;**61**:577–84. [http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list\\_uids=15184237](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=15184237)
- 15 Zhou X, Hetrick SE, Cuijpers P, *et al.* Comparative efficacy and acceptability of psychotherapies for depression in children and adolescents: A systematic review and network meta-analysis. *World Psychiatry* 2015;**14**:207–22. doi:10.1002/wps.20217
- 16 Kontunen J, Timonen M, Muotka J, *et al.* Is interpersonal counselling (IPC) sufficient treatment for depression in primary care patients? A pilot study comparing IPC and interpersonal psychotherapy (IPT). *J Affect Disord* 2016;**189**:89–93. doi:10.1016/j.jad.2015.09.032
- 17 Menchetti M, Rucci P, Bortolotti B, *et al.* Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomised

- controlled trial. *Br J Psychiatry* 2014;**204**:144–50. doi:10.1192/bjp.bp.112.122663
- 18 Singh SP. The Great Divide: Transition of Care from Child to Adult Mental Health Services. *Curr Opin Psychiatry* 2009;**22**:386–90.
- 19 Weissman MM, Markowitz JC, Klerman GL. *Clinician's Quick Guide to Interpersonal Psychotherapy*. New York: : Oxford University Press 2007.
- 20 Chorpita BF, Moffitt CE, Gray J. Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. *Behav Res Ther* 2005;**43**:309–22. doi:10.1016/j.brat.2004.02.004

**Figure 1.** Trajectories of RCADS Depression T scores for all participants



**Key:** Thinner lines represent trajectories for individual clients.

The thick dotted line represents the regression line across participants

Reference lines are provided: vertical (session one) and horizontal (RCADS 'probable' caseness threshold)

For one participant, the final, outlying point was not included, to aid visualisation – that assessment was at 26 weeks, when RCADS-D was one point higher than the previous assessment at 10 weeks