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TRANSCRIPT OF “FILE ON 4” – “COUNTING THE COST: ANTIDEPRESSANT USE IN CHILDREN”

CURRENT AFFAIRS GROUP

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PRODUCER:	Carl Johnston
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"FILE ON 4"

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MUSIC – UNKLE 'KANED AND ABEL'

CONNOLLY: In Britain, more children and young people than ever before are being prescribed antidepressants, and the specialist services designed to help them are at breaking point.

GARG: The pressures felt by myself and my colleagues are enormous. Sometimes you have to have a threshold for accepting patients into the services, so you try and see the most severely ill first, because there just aren't enough clinicians.

CONNOLLY: File on 4 has obtained new figures showing that prescriptions of antidepressants to under 18s are growing year on year.

BUSH: Frontline professionals are turning to prescription pads because they are thinking, I'm seeing someone in front of me in crisis - how do I offer them some kind of alleviation from that?

CONNOLLY: And we reveal failures in the system which mean the risks of taking these powerful drugs aren't being properly managed.

ROMERO: You'd see it all building up in her and she said, 'Mum, I want to hurt myself, but I don't even know why,' and she said, 'I'm sure it's the tablets; they are messing with my head.'

TRACEY: He was the one in his group that was always there to sort out problems for everyone else. He'd sort of say to me, 'Mum, Mum, I've just got to pop out; there's something going on with a couple of the girls,' or, you know, 'And I've got to go and sort it all out for them.'

CONNOLLY: That's Tracey Key. She's invited me to her home in Bexleyheath in Kent, to talk about her son, Reece. Stepdad, Simon, is here, too, and smiles broadly as he starts to tell me about Reece's love of sport.

SIMON: He'd tried a few different sports, and I think American football suited him more than most. He was a running back and he was a very talented running back and he'd go on, run, come off, have a little rest, and I think that absolutely suited him down to the ground, and he absolutely loved it, didn't he? He loved the camaraderie of it, the respect, and he made a lot of good American football friends as well.

TRACEY: Yeah, yeah, they've actually got his initials on their helmets now, and they actually have a certain play that they have to shout out, 'Reece' now, so and it means that they do a certain movement, so …..

CONNOLLY: That's very special.

TRACEY: Yeah, yeah, definitely, yeah. He'd, he just seemed to affect people like that, didn't he really? He was an amazing young boy, young man, and we miss him so much.

SIMON: Yes.

CONNOLLY: Reece's signature trait seems to be a good personality, upbeat, but obviously there was something going on in the background.

TRACEY: Unfortunately, it was only in retrospect when we look back, he was a normal teenager, he had mood swings, but we never believed that they were any more than that. Up until the very last day that we saw him, we had no idea that he was going through any of this.

MUSIC – DJ SHADOW 'TRIPLICATE'

CONNOLLY: Silently, privately, Reece had been struggling. What started out as low moods had escalated. He bottled it up, hiding his true feelings from friends and family. But in December of 2015, unknown to his parents, Reece's behaviour started to change.

SIMON: He pulled out of a history class. He told a teacher that he just couldn't concentrate and the classroom was too noisy, and there was only eight people in the class. There was a lovely teacher, a pastoral lady that looked after him, and she also remembers him just being unusually vacant, which is not like Reece. Reece was full of life. And then on the Friday he didn't turn up at school, which was very unusual. Then on the Saturday, he talked to one of his best friends and said he was feeling depressed and could we get together with a group of friends that evening, and one of his best friends approached him and said, 'Look what's going on, you know, you've helped all of us in the past, let us help you - what's going on?' And he said to her that, I don't want to talk about it because I'm worried my friends might judge me. And they would never have judged him, you know, we've met them and they're so kind, they're so loving. But that was on the Saturday and then Tracey picked him up on the Saturday and he was outside with his friends, just joking and laughing for a little while, and then again, we saw him on the Sunday morning, we'd talked about Christmas presents, because it was getting near Christmas.

TRACEY: On a Sunday, he had a job at Tesco's in the evening, which finished at 8 o'clock, so we was expecting him home for dinner, and he didn't turn up, so I started to call his mobile phone. There was no answer, so I started to contact his friends for them to try and find him. And it was about 10.30 we got a knock on the door and that was it, that was when it all changed [CRIES] Sorry.

CONNOLLY: That's okay.

SIMON: So at about 10.30, as I say, there was a knock on the door and there was four or five policemen outside. You just know when Tracey was shouting it wasn't going to be good. I can remember thinking, I'm hoping their going to say he was in a car accident but he's okay, you know, he's broken his leg, he's in hospital, he's recovering, he's fine. But of course they don't say that and they tell you a young boy's died of suicide and it's Reece. And I can remember when they told us, we were in the dining room and I just literally fell backwards, just hit the wall backwards, because you just can't comprehend or believe what they're telling you.

MUSIC – DJ SHADOW 'TRIPLICATE'

CONNOLLY: On December 6th, 2015, Reece was found hanged in a local park. A green, wide-open space the family would sometimes visit together. He was 17. In the months that followed, the family tried to come to terms with that happened. They started asking questions and soon discovered Reece had been prescribed antidepressants by a local GP.

TRACEY: We went and spoke to his doctors, because we had found out that he had been taking some tablets and got shown his doctor's records. And it was in June that he initially went to the doctor's about low mood, and they advised him to have some counselling. That didn't happen, and then the next time he went to the doctor's was in November and was expressing to them that the low mood was continuing and that he had started self-harming. He did actually request to go onto antidepressants, and the doctor that he saw that day said that he wasn't willing to give him the antidepressant, but he would like him to come back in a week's time and see him again. So he went back, he saw a different doctor; that doctor said that he would prescribe antidepressants and for there to be contact with school to organise some counselling. He had also tried to get Reece to tell us, but Reece had said that he didn't want us to know, he didn't want us to worry. So on the 30th November, he was given Sertraline antidepressant.

SIMON: At the end, he was only on that medication for seven days, and during that seven days he became quite vacant. The teachers actually noticed that he didn't seem himself. He dropped out, didn't attend school, which was very unlike him.

CONNOLLY: The inquest into Reece's death recorded a verdict of death by suicide and no blame was assigned to Reece's doctors nor to Sertraline, the anti-depressant he was prescribed. However, in England, there are official guidelines doctors are encouraged to follow. They're issued by the National Institute for Health and Care Excellence – or NICE – and advise doctors to refer patients under 18 to specialised mental health services for talking therapies before antidepressants are prescribed. One of the preferred talking therapies is CBT – or Cognitive Behavioural Therapy. The guidelines also recommend that the drug Reece was prescribed, Sertraline, is only used when certain criteria are met. They include first trying psychological therapies and another first-line drug, Fluoxetine. What's more, the guidelines say the child and their parents should be fully involved in discussions about the benefits and the risks of the treatment. In Reece's case, those guidelines appear not to have been followed. Marc Bush, Director of Policy at mental health charity, Young Minds, believes more antidepressants are being prescribed by GPs as children can't get access to Child and Adolescent Mental Health Services known as CAMHS.

BUSH: Every day, we're talking to children, young people, families who are in distress, they're looking for support. They turn to specialist services and actually the waiting times are too long, so they end up at their GP. They ask their GP for support. The GP looks at them and says, 'Actually, I can't access the specialist services for you,' so they think creatively at what they might do and sometimes they refer for psychotherapeutic interventions and sometimes they turn to the prescription pad.

CONNOLLY: Today, as we speak, what can you tell me about the length of time that young people, children – and indeed their parents – will wait to get access to CAMHS?

BUSH: A really important report by the Education Policy Institute found that people were waiting up to 6 to 9 months to access specialist services. Some are describing that they should have access within 4 or 10 weeks, so that's a huge amount of time to wait. In fact, in its own green paper, the Government recently suggested that the average waiting time for general access to CAMHS is around 12 weeks, which is a long time to be in distress, particularly if you're entering crisis. And that is why frontline professionals, with all the best intentions in the world like GPs, are turning to prescription

BUSH cont: pads, because they're thinking, I'm seeing someone in front of me in crisis with a level of distress I don't want to leave them with. How do I offer them some kind of alleviation from that?

CONNOLLY: For Tracey and Simon, the reasons why some GPs resort to operating outside the guidelines when prescribing antidepressants serve as cold comfort. But still, they appreciate the difficult decisions doctors face.

SIMON: I don't blame the doctors, I think they have an extremely difficult job and, you know, they're damned if they do and damned if they don't. That said, there are NICE guidelines which, you know, in theory they should follow, but I know one of the concerns is that they're thinking, if I do refer them to CAMHS, there's potentially a waiting list, and the average is 12 weeks, which is excessive, so they're thinking, well, do I wait 12 weeks or do I at least start some medication? From what we've gone through, our view would be, don't give the medication, you must follow the guidelines, but I can imagine it's a very difficult call for the doctor to make.

CONNOLLY: Both of the doctors Reece saw worked at a local surgery. The first appointment in November was with Dr Edwin Lim, whilst the second was with Dr Jhumur Moir, who prescribed the antidepressant, Sertraline, to Reece. File on 4 contacted both doctors Lim and Moir to ask why, as per NICE guidelines, Reece was not referred to a child and adolescent psychiatrist before antidepressants were prescribed, why his parents weren't told he had been prescribed the drug and, crucially, why the recommended steps of talking therapies and the other drug, Fluoxetine, weren't used first. But while they expressed their sympathy to Reece's family, they told us they couldn't comment on his care for reasons of patient confidentiality.

MUSIC – DJ SHADOW 'THE OUTSIDER'

CONNOLLY: New information obtained by File on 4 via Freedom of Information requests has revealed a significant rise in the number of antidepressants prescribed to children and young people over the last three years. This information looks specifically at a class of antidepressants called SSRIs – or Selective Serotonin Reuptake

CONNOLLY cont: Inhibitors. Wales couldn't provide data, but the NHS in England, Scotland and Northern Ireland supplied figures spanning the three year period between April 2015 and March 2018. In England, there was a 15% rise in the number of antidepressants prescribed to patients under 18. Scotland saw a 10% rise, whilst in Northern Ireland those figures were up 6%. On average, across the three countries, that adds up to an overall increase of 14%. In total, more than 950,000 prescription items over the three years. And whilst the majority of antidepressants prescribed were for patients aged over 13, worryingly the steepest increase was seen in the youngest patients - those aged 12 and under - where the number of prescriptions rose on average by 24% from a total of nearly 14,500 to close to 18,000. Dr Shruti Garg, a CAMHS consultant and researcher at the University of Manchester, sheds some light on the factors driving this surge in numbers.

GARG: We've published a recent paper in 2017 which has shown that the antidepressant prescribing rates have doubled between 2006 and 2015. And the increase might be, number one, because of the increased recognition of mental health difficulties in children and young people, possibly the reduction in stigma in accessing help, but also one of the reasons might be because of the pressures that are faced across CAMHS services in the country. CAMHS services across most parts of the country cover only up to the age of 16, adult mental health services start at 18, so there is a gap for the provision of services across these ages and perhaps that's one of the reasons why the needs of these children are unmet and perhaps they are going to their GPs, where the GPs are prescribing these, or they're coming late to these services later, where they're recognised later.

CONNOLLY: Dr Garg goes on to explain the reality of a being CAMHS clinician at the coalface.

GARG: As a jobbing clinician, I can say that the pressures felt by myself and my colleagues are enormous. Having to keep to the target waiting list, but also the increasing number of referrals coming through means that sometimes you have to have a threshold for accepting patients into the services and it might mean there are longer waiting lists and so by the time you see children and adolescents you obviously have a triage system so you try and see the most severely ill first, because there just aren't enough clinicians to see the children.

CONNOLLY: Dr Garg's bleak assessment of the situation is echoed in a recent report titled Silent Catastrophe. It focuses on the inner workings and failings of CAMHS. Dr Nick Waggett is Chief Executive of the Association of Child Psychotherapists – the organisation behind the report.

WAGGETT: The outcome of children and young people not getting effective treatment in the right place at the right time is that they are ending up in A&E, they are self-harming, they are suicidal. Children have to have very, very severe suicidal thoughts and to have attempted suicide, perhaps on one or more occasions, in order to be seen, so the idea of early intervention and prevention is lost in that scenario because actually all of the resources are consumed in managing the short-term risk. The general public has a conception that, whilst it's difficult to get into CAMHS, there's a perception that once they get there then they'll receive expert, high-quality, intensive treatment in the way one would expect if one was referred to hospital for, say, diabetes or cancer. But actually, our report shows that there's been this hollowing out of those specialist services in many areas, so that something somewhat superficial is being delivered, that isn't reaching the long-term, underlying, deeply traumatic causes of many childhood mental health problems.

ACTUALITY OF SQUASH MATCH

CONNOLLY: I'm at York University, looking down over a squash court where Rosie Evans and her pal, Ailey, are playing. It's a good-humoured head to head, complete with playful banter. But still, there's a slight edge to it. It's clear that each of them wants to win, and will push themselves to overcome what stands in the way. A trait, in the past, that helped Rosie in her battle with mental illness – and with accessing the specialist services she desperately needed.

EVANS: When I look back, I kind of displayed symptoms of anxiety and obsessive compulsive disorder when I was quite young, so maybe 7 or 8, but it wasn't until I was around 13, 14 when I started to realise that some of the things I was thinking, some of the intrusive thoughts that I'd have weren't normal or weren't what other people were experiencing. And it wasn't until I was around 16 that someone else noticed, the teacher at school noticed something was going on, so I then went to the GP. I actually went because I couldn't breathe properly, and so I thought it was a physical problem. I'd not really

EVANS cont: considered the fact it could be a mental health problem. And then, when the GP diagnosed me with anxiety disorder, I was quite shocked, to be honest.

CONNOLLY: In the years that followed, Rosie was further diagnosed with anorexia. And when her condition began to spiral, she struggled to access vital mental health services.

EVANS: The problem with that at the time was that I was about to turn 18. Eighteen is an adult and so the Children and Adolescent Mental Health Service or CAMHS won't take anyone who is 18, so that was kind of my biggest struggle. It took months, and that's probably one of the reasons why I did end up being hospitalised – because I couldn't get that help soon enough.

CONNOLLY: Eventually Rosie was admitted to a specialised mental health unit and, gradually, her condition started to improve.

EVANS: I was an inpatient for eight months and then I had three months day care treatment, so I would go to the hospital, but for the day, and then come home in the evening. And then I had outpatient treatment over there as well.

CONNOLLY: As part of her treatment, Rosie was taking Sertraline – a drug which for under 18s is recommended by NICE, but only after the first-line treatment of Fluoxetine has been tried. A third drug, Citalopram, is also included in the NICE guidelines as a potential treatment for depression in young people.

ACTUALITY IN OXFORD, CHURCH BELLS

CONNOLLY: From the young people who take antidepressants to GPs to parents, opinions vary hugely on just how safe and effective these drugs are. So, what does the research, the clinical trials that paved the way for these drugs to be approved in the first place tell us? I've come to Oxford to meet a man who can hopefully shed some light on exactly that.

CIPRIANI: I'm Andrea Cipriani. I'm a psychiatrist and clinical academic at the Department of Psychiatry of the University of Oxford.

CONNOLLY: In 2016, Professor Cipriani and his team published the explosive results of a study on how effective antidepressants are when used to treat children and young people with depression. Fluoxetine, Sertraline and Citalopram are among those drugs included in the study.

CIPRIANI: So we looked at two main outcomes as primary objectives of our study. The first was efficacy of the drugs and the second one was tolerability, so efficacy was measured as change in depressive symptoms and tolerability as the number of people who stopped the drug because of side effects over 8 to 12 weeks. And we found that in terms of efficacy, the only antidepressant that on average is better than placebo is Fluoxetine. This is why the bottom line message of our paper is that Fluoxetine can be the first line treatment for major depression in children or adolescence if an antidepressant is indicated.

CONNOLLY: What of the other two antidepressants recommended by NICE in certain circumstances?

CIPRIANI: In terms of Fluoxetine versus Sertraline or Fluoxetine versus Citalopram, Fluoxetine was not statistically significantly better than Sertraline and Citalopram, so there was a tendency to show that it works better than these two drugs, but the difference is not significant.

MUSIC – DJ SHADOW 'THE OUTSIDER'

CONNOLLY: Figures File on 4 obtained through our Freedom of Information request reveal that in the last three years across England and Scotland, almost 44,000 patients under 18 were prescribed Citalopram. And in that same period, there's been a 30% increase in Sertraline being prescribed to children and young people. Northern Ireland could not provide figures for either drug. We asked NICE why their guidelines continued to include Sertraline and Citalopram, given the findings of Professor Cipriani's study. They

CONNOLLY cont: acknowledged the research, but said there are limitations to it and as such it's unlikely that Sertraline and Citalopram will be removed from their guidelines. What, then, is the definitive answer? Do the drugs work, and if so, which is the best bet? The truth is, nobody seems 100% sure. GPs, psychiatrists, eminent professors - they're all at the mercy of clinical trials, which have been open to interpretation and dispute. And that includes Professor Cipriani, whose study has attracted some criticism from his peers and from the pharmaceutical industry. Ian Goodyer, Professor of Child and Adolescent Psychiatry at the University of Cambridge, is among those critics.

GOODYER: What Andrea did was use a really complicated statistical manipulation, and there is quite a bit of debate as to whether the method he used is quite the right one or not. Only five thousand adolescents have ever been studied in a systematic scientific way, and only four studies would meet basic standard criteria – that's about slightly less than a thousand of those.

CONNOLLY: He believes that one of these studies – the results of which was included in Professor Cipriani's report – is worth highlighting.

GOODYER: If you look at the best study, which is of 450 teenagers, Fluoxetine has the best effect size of any treatment, and about 67% of patients will respond very well within 18 to 20 weeks and about 80% will respond quite well by 36 weeks. So if it was me, I would take Fluoxetine. If I was 16 years old, severely depressed and wasn't particularly keen on listening to someone telling me about my life, I wouldn't hesitate, I would take Fluoxetine. Are there other antidepressants? Now that is less certain. I don't think the evidence is strong enough.

CONNOLLY: As well as the questions over the efficacy of the other drugs currently on the NICE guidelines when used to treat young people, we've discovered that neither of them – Sertraline or Citalopram – are licensed by the regulator, the MHRA, for the treatment of under 18s with depression. We also contacted the manufacturers of these drugs. Pfizer, who originally developed Sertraline, told us it has helped millions of people and is safe and effective when used in accordance with the label. But they did say the drug should not be used in the treatment of children and adolescents, except for patients with obsessive compulsive disorder between the ages of 6 and 17. Lundbeck, the company behind

CONNOLLY cont: Citalopram, said the drug is approved for treatment of major depressive episodes in adults, but is not to be used in the treatment of children and adolescents under the age of 18 years. So, on that basis, we asked NICE why their guidelines continue to include Sertraline and Citalopram. They told us that they do allow the use of some medicines outside their licensed indication in certain circumstances, including where use is common practice, where there is good evidence for it or where no other medicine is licensed for the condition.

MUSIC – DJ SHADOW 'THE OUTSIDER'

CONNOLLY: In fact our FOI findings show widespread prescribing of other drugs not on the NICE guidelines at all. Between April 2015 and up to the end of March this year, antidepressants not included in the NICE guidelines were prescribed nearly 10,000 times across England and Scotland. So, how do clinicians decide what treatment to offer? Dr Shruti Garg believes drugs can be a useful option.

GARG: The evidence suggests that a combination of drug treatment and psychological therapies work. They may not work for a proportion of children, but clinically my experience has been that they are also effective. We haven't got very many other effective treatments and when you're sitting across from a child or adolescent who has severe depression, you want to do everything that you want to help them, obviously using safe and effective therapies, and so I wouldn't like to withhold treatment when I know that there is a possibility of it working.

CONNOLLY: A further dilemma facing clinicians like Dr Garg are the potential side effects of some drugs. There are widely-held concerns over the potential links between SSRIs and suicidal thoughts in young patients, particularly when the drugs are first taken. In 2016, research published in the British Medical Journal said doctors should avoid prescribing some antidepressants to children and teenagers because they are associated with a doubling in the risk of aggression and suicide. Among those it studied were Fluoxetine and Sertraline. We asked the manufacturers about the risks their products pose when it comes to suicidal behaviour. For Fluoxetine, Eli Lilly said the drug is approved to the treatment of paediatric depression and continues to be considered to have a positive benefit risk profile by regulatory authorities all around the world. They acknowledged

CONNOLLY cont: though that the Summary of Product Characteristics for Fluoxetine and other SSRIs includes a specific warning about suicide-related behaviours in paediatric patients. With respect to Sertraline, Pfizer told us it is safe when used in accordance with the label and prescribed by a healthcare professional. But they also said suicide-related behaviours were more frequently observed in clinical trials among children and adolescents treated with antidepressants compared to those treated with placebo. And both companies highlighted the need for children and young people to be carefully monitored for the appearance of suicidal symptoms. Dr Shruti Garg again.

GARG: I think it's incredibly important that patients are monitored quite closely in the initial few weeks after initiating prescription of antidepressant treatment. In terms of monitoring, routinely what I would do is have a telephone review with them at the end of the first week and see them in the outpatient clinic within two weeks.

ACTUALITY IN CAR

CONNOLLY: But as I'm about to discover, that doesn't always happen.

MUSIC – FELT 'UPSURGING BELIEF'

SAT NAV: Please turn next right, then you will arrive at your destination.

ACTUALITY CAR DOOR OPENING AND CLOSING

CONNOLLY: Nicky, how are you?

ROMERO: Hello, hi.

CONNOLLY: Paul Connolly. Who's this?

ROMERO: This is Marley.

ACTUALITY WITH DOG

CONNOLLY: Marley, how are you doing? Marley is friendly.

ROMERO: Yes, very friendly.

CONNOLLY: Well, that's good news. And are we going for a walk?

ROMERO: Yeah okay.

CONNOLLY: Okay.

ROMERO: She was an amazing girl. Obviously I'm biased, she was my daughter, but she was really kind, quiet, very shy, really good sense of humour, always coming out with funny little remarks and giggling.

CONNOLLY: That's the voice of Nicky Romero. From an early age, her daughter, Becky, wrestled with mental illness. And I've made the trip to their home in Bristol to hear more about her and what she went through.
When did you first notice the early signs? The early warning signs of mental illness.

ROMERO: Probably from about the age of nine, because she was being bullied from the age of four and she was really struggling with that. But things got really serious when I was trying to take her into school one day and she was just bashing her head against the brick wall and she refused to go in. When we talked about it, she said a lot of it was to punish herself, because she felt like she was a bad person, because if nobody likes her – she's not likeable - then she must be a bad person. Erm, sorry. And a lot of it was because if, like at school, things the boys and girls were saying to her and she felt it was all true – so many people say the same things to her it must be true – because people would call her fat and ugly, and she was wasn't ugly she was beautiful [CRYING].

CONNOLLY: Do you want to take a break for a sec?

ROMERO: No, I'm ok.

CONNOLLY: Are you sure? Are you sure? Okay.

ROMERO: Here we go. Good girl. Take your lead off. Watch the step and watch the step there.

CONNOLLY: Nicky ushers me through the kitchen and into a long, narrow dining room. We find seats at a round, polished mahogany table loaded with books and loose sheets of paper. She tells me that when Becky was just 15, she tried a number of times to take her own life, despite receiving treatment locally through CAMHS in Bristol.

ROMERO: We went back to obviously the doctors, because she'd tried to take her life. We went into the hospital and they kept her there for two nights and she basically said, 'If you send me home I'm going to do it again.' And I just kind of stomped me foot down and said, 'You've got to help her, she can't come home.' But they said, 'You have to, we haven't got anywhere to keep her tonight.' Then we had a phone call the next day saying that a place had become available at Pebble Lodge in Bournemouth, and on the Saturday we took her down.

CONNOLLY: When in Pebble Lodge, what kind of care, what kind of treatment did Becky receive?

ROMERO: When I questioned them about that, they said the plan was to get her back up to Bristol, there was no point starting any of these therapies while she was there, so she had no CBT at all.

CONNOLLY: Four weeks after being admitted to Pebble Lodge – 80 miles away from home - Becky was given permission to head home for the weekend, something she was keen to do. But whilst at home, the family received a phone call to say she was being discharged, effective immediately, although a community care package was put in place. Becky's parents were desperate for her to stay at Pebble Lodge, as they believed she still posed a very real danger to herself. But the decision stood. Now back with her parents, Becky told them she was feeling side effects of the new medication she had been prescribed just three days earlier before she left Pebble Lodge. It was Fluoxetine.

ROMERO: We'd had a few talks with the psychiatrist and he assured me that these tablets, they were antidepressants, they usually work okay, that it would be reviewed regularly and that she would get CBT treatment alongside the medication.

CONNOLLY: According to the NICE guidelines, someone of Becky's age, they'd basically need to keep an eye on her in the immediate period after those types of antidepressants – Fluoxetine - is prescribed. Was there any follow-up?

ROMERO: There was no follow-up at all. Nobody medically trained came to see her at all.

CONNOLLY: Part of the care plan was for there to be communication by text with Becky. But only one text was sent, asking simply, 'How are you?' Becky's condition quickly deteriorated.

ROMERO: She kept getting very agitated, angry, which was totally out of character for her. She'd get really sort of, 'Grrrrr.' You could see it all building up in her, and she said, 'Mum, I want to hurt myself but I don't even know why,' and she said, 'I'm sure it's the tablets, they're messing with my head.' On the Wednesday we went to watch her sister in a school play, they did the Lion King. We came home, we sat on the sofa and watched Neighbours – we always watched that together – and then she just, it was so normal, she just suddenly picked up her phone and started typing and she said, 'I'm going upstairs,' which is, there's nothing unusual about that. She would do that if someone's online talking, she's typing, she'd go upstairs for privacy and that was the last time I saw her.

MUSIC – FELT 'UPSURGING BELIEF'

CONNOLLY: The following morning, Becky's parents noticed she wasn't in her room and the bathroom door was locked. They sensed something wasn't right, so rushed to break it down. When inside, they found their daughter dead. In December 2017, an inquest ruled that Becky's death was accidental as, in the view of the Coroner, there was insufficient evidence to show she intended to take her own life. Further, the Coroner said that Becky's death was contributed to by the two NHS mental health trusts involved in her care.

CONNOLLY cont: Avon and Wiltshire Mental Health Partnership told us they'd reviewed their services and issued robust guidance for discharge from all adolescent inpatient units. Dorset HealthCare admitted that arrangements to support Becky should have been better when professional responsibility for her care was transferred between the two NHS Trusts.

MUSIC – DJ SHADOW 'THE OUTSIDER'

CONNOLLY: Throughout the making of this programme, we've heard that pressure on services is leading to an increasing reliance on antidepressants. And that same pressure means when drugs are prescribed, the young patients taking them aren't always supervised and managed as they should be. We contacted the health authorities in England, Scotland and Northern Ireland to ask what plans there are to improve child mental health services. The Department of Health in England told us they'd pledged £1.7 billion to transform CAMHS. This, they say, will help to provide greater access to a wider range of therapies, although there will continue to be some patients who will benefit from using anti-depressants. In Scotland, Minister for Mental Health Clare Haughey told us young people's mental health was a priority and that £5 million has been invested to create a new taskforce to improve CAMHS services. The Health and Social Care Board in Northern Ireland said that because of pressures on social services and limited resources, several streams of work in the area of child and adolescent mental health had been prioritised. It added that the vast majority of referrals accepted into CAMHS are seen within nine weeks – and it's also identified an additional investment of £1 million for CAMHS projects. Marc Bush of mental health charity, Young Minds, believes this renewed commitment must translate to real change.

BUSH: It's a brave step forwards, it's the right commitment we need. Is it happening fast enough? No. Is it having as much impact as it should be? Not quite yet, but there's still time to make increased commitment with new ambitions for mental health legislation. We can push this further and make sure that all children get the care they need.