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REVIEW

A Current Review of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) Program: Perspectives on Developing an Accessible Workforce

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Abstract: The CYP IAPT program has played a leading role in workforce development in the Child and Adolescent Mental Health Service (CAMHS) in England since its inception in 2011. Despite promising evidence of CYP IAPT's benefits, significant wait times for CAHMS have convinced policy makers that a new direction for CYP IAPT is required. Since 2017, the CYP IAPT program has changed its aim from workforce development to workforce expansion, with the project aiming to train 1700 new psychological practitioners by 2021. The CYP IAPT program now consists of three training streams (a) a low-intensity workforce, (b) a schools-based workforce, and (c) a high-intensity workforce based on the original CYP IAPT curriculum. The purpose of this paper is to outline the three CYP IAPT workforce streams. As will be reviewed, changes to CYP IAPT have occurred within the context of emerging ideas from dissemination science and government reviews that outline the shortcomings of traditional service models. Consequently, CYP IAPT practitioners are now increasingly being trained in the delivery of novel psychological interventions to address some of these shortcomings. A range of low-intensity interventions are being deployed by CYP IAPT practitioners to target mild-to-moderate anxiety, depression, and conduct. A recent meta-analysis indicates that low-intensity psychological interventions show promise for children and adolescents in efficacy trials. Nevertheless, further research is required to understand its effectiveness in real-world settings and to see if treatment effects are sustained over time. As such, this paper recommends that CYP IAPT services evaluate the long-term effectiveness of low-intensity work and subject their methods and findings to peer review.

Keywords: psychological therapies, dissemination, mental health disorders, child/adolescent, guided self-help, cognitive behavior therapy

Introduction

The Children and Young People's Improving Access to Psychological Therapies Programme (CYP IAPT) has played a key role in improving the provision of care for children and adolescents in England since its inception in 2011.[1] Between 2011–2016, the CYP IAPT programme offered workforce development for staff working in Child and Adolescent Mental Health Services (CAMHS), local authorities, and non-government organisations across England. During this period, the CYP IAPT programme trained over 1000 therapists in evidence-based psychological therapies and 207 managers and supervisors in evidence-based service delivery models.[2] The

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principal aim of the CYP IAPT programme was "service transformation". The rationale was that services would be transformed by training practitioners in routine outcome monitoring, service user participation, and evidence-based psychological therapies. The CYP IAPT service transformation initiative also offered National Health Service (NHS) clinicians access to evidence-based training through e-learning and outreach consultation.[1]

Despite promising evidence of CYP IAPT's benefits,[3] rising demand for services convinced policy makers that a new direction for CYP IAPT was required to alleviate pressure on specialist CAMHS.[4,5] As such, the Department of Health modified the remit of CYP IAPT so that its aim would be to train and expand the CAMHS workforce.[4] The Department of Health concluded that traditional training pathways (eg, clinical psychology, family therapy, child psychotherapy) were failing to meet the demands being placed on the NHS,[6] and that a "low-intensity" workforce was required to provide prevention and treatment for children and adolescents with common mental health problems.[7] A new low-intensity workforce might help to reduce wait times and free specialist clinicians (eg, clinical psychologists) to work with more complex cases – a service delivery model known as "task shifting" in the health dissemination literature.[8,9]

In 2017, a new workforce initiative came into effect with around 210 trainees across the country starting an innovative CYP IAPT curriculum based on Guided Self-Help (GSH) principles. In 2018–2019, the program continued to expand with approximately 630 trainees commencing at multiple training sites across England. Furthermore, a new pilot started in 2019 with a smaller number of trainees placed in schools, which is a part of a government plan to increase mental health support in schools and colleges.[6] Overall, these changes represent large investments of public money in CAMHS and have been described by the Department of Health as "transformational".[10] Another significant aspect of these changes is that it will bring CYP IAPT more in line with the adult IAPT service (see Clark et al[11] for a review), a program that has been described as the largest centralised psychological therapies initiative in the world.[12] Currently, there are no published articles in the peer review literature describing recent changes to the CYP IAPT program. As such, the purpose of the present article is to describe the new CYP IAPT workforce, outline the curriculum, and discuss the challenges facing CYP IAPT as it attempts to expand the CAMHS workforce.

The CYP IAPT Workforce

A number of factors have played a role in the expansion of the CYP IAPT workforce. For example, advances in implementation science have made it possible to explore new models of service delivery that increase the scalability and accessibility of psychological therapies (eg, digital therapies, the use of paraprofessionals, task shifting; see Kazdin et al[9] for a review). Additionally, current policy developments – including a government Green Paper[6] – recommend reduced wait times for specialist CAMHS and the provision of care in non-clinical settings (eg, schools). The government has described its new plan to provide support in schools as "ambitious".[10] Over the long term, there is an aim to increase the CAMHS and schools-based workforce by up to 8000 new staff.[10] To put this into context, this is comparable in scale to the current NHS CAMHS workforce, which is comprised of around 7000 full-time equivalent professionals. It is anticipated that CYP IAPT will play a significant role in the training of these new workers.

In this section, dissemination models and government policies will be explored to further elucidate the rationale for recent developments in the CYP IAPT program. The discussion will end with a description of the new CYP IAPT workforce streams. The workforce streams include (a) a low-intensity workforce, (b) a schools-based workforce, and (c) a high-intensity workforce. These workforce streams aim to meet the demands of policy makers and will significantly reorganize CAMHS provision in England once fully implemented. These changes are part of a wider suite of NHS reforms that aim to reduce wait times for specialist CAMHS down to four weeks.[6]

Service Delivery Models

Commentators[13–15] argue that innovative solutions are required to solve the complex problems facing CAMHS services worldwide. There is emerging evidence that access to youth mental health may be increased by offering treatment outside of traditional healthcare environments,[16] with some young people perceiving non-clinical environments as less stigmatizing.[17,18] Treatment outcomes delivered in schools,[19] primary care,[20] or through the internet[21] are often equivalent to outcomes delivered by traditional mental health services, especially for mild-to-moderate problems. Many CAMHS services across England prioritize severe and complex cases, which means children with mild-to-moderate problems often experience significant wait times.[6] The key problem with this approach is that

psychiatric symptoms tend to persist or escalate with time for a significant minority of children.[22–24] For example, in one longitudinal study using a general population sample,[23] over 50% of children who experienced clinical symptoms at baseline also scored in this range when assessed 12 months later. As such, timely treatment delivered to all cases across the severity spectrum could be conceptualized as preventative. To illustrate, one study showed that anxious children who responded to CBT during childhood were less vulnerable to drug misuse as young adults.[25]

In light of this evidence, some authors[26,27] argue that the solution lies in developing new models of care that help patients receive an appropriate dose of psychological therapy in a timely manner. For example, the Thrive Framework recommends basing treatment decisions on clinical need rather than severity level or diagnosis.[28] Likewise, stepped care models demonstrate economic benefits in CAMHS settings[29–31] and are supported by the World Health Organization (WHO)[32] and the National Institute of Health Care Excellence (NICE).[33] Although stepped care has been successfully implemented in adult IAPT services,[34] such initiatives have had limited implementation in CAMHS, despite there being emerging evidence for the effectiveness of low-intensity treatments when delivered within a stepped care framework for youth.[35]

Government Reviews

A number of important government reviews have informed mental health policy and funding in England over the past four years.[4–6,36] The Mental Health Taskforce to the NHS in England set out an ambitious service transformation plan for CAMHS in the *Five Year Forward View of Mental Health*,[5] which led to funding being made available to train 1700 low-intensity CYP IAPT therapists.[7,37] Furthermore, a recent government Green Paper by the Departments of Health and Education, *Transforming Children and Young People's Mental Health Provision*,[6] recommended plans and funding for a schools-based mental health workforce, with rollout to reach 20,000 schools and colleges by 2023.

The Green Paper commissioned a systematic review of the evidence to see "what works" within child and adolescent mental health. Although the review identified a number of evidence-based principles, one conclusion has important implications for workforce development. The systematic review concluded that therapists do not always require intensive professional training to be effective with mild-to-moderate conditions. That is, the review states that treatment can be delivered by "trained nonclinical staff with adequate supervision"[6] as they have comparable outcomes to professional therapists. Although the authors are yet to subject their methodology to peer review, similar findings have been reported elsewhere in the literature.[38]

Given these points, an evidence-informed service-delivery model for CAMHS might include: (a) providing timely treatment across the severity spectrum, (b) increasing access to treatment in non-clinical settings, (c) using a stepped care approach, and (d) developing a diverse professional workforce mix that consists of low-intensity workers and traditionally trained therapists.

The New Direction in CYP IAPT Training

Taken together, these ideas support a new direction for service provision in CAMHS and CYP IAPT. Changes to the CYP IAPT training framework started in 2017 with the introduction of a low-intensity workforce stream, and continued in 2019 with the addition of a school-based workforce stream. These changes were informed by the principles, policies, and objectives reviewed above.[8,37] The three training streams aim to address prevention, work in schools, and specialist care. At the time of publication, the CYP IAPT training streams were as follows:

(a) a community-based workforce that delivers low-intensity psychological interventions for common mental health problems (ie, mild-to-moderate anxiety, depression, and conduct) in CAMHS, local authorities, and third-sector organizations – known as Child Wellbeing Practitioners (CWPs);
(b) a schools-based workforce that delivers the same interventions delivered by the CWPs, but within an educational setting – known as Educational Mental Health Practitioners (EMHPs); and
(c) a high-intensity workforce based on the original CYP IAPT training model (see Shafran et al[1] for a review) targeted to expand the specialist workforce (ie, CBT, systemic practice, parent training, counselling interventions for ages 0–5, counselling interventions for autism spectrum disorder and learning disabilities, and interpersonal psychotherapy)[37] – known as the CYP IAPT Therapy Course/Recruit-to-Train Program.

As an overview, Table 1 shows the relationship between referral problems, treatments, and the CYP IAPT workforce that supports various patient populations.

Table 1 Psychological Problems, Treatments, and Relevant CYP IAPT Workforce

Presenting Problem	Treatments	Workforce
Mild-to-moderate depression, anxiety, and conduct	Low-intensity treatments	CWP & EMHP
Mild-to-severe depression, anxiety, trauma, and conduct	High-intensity CBT, IPT-A, and behavioral parent training	High-intensity CYP IAPT/ recruit-to-train
ASD with co-occurring depression, anxiety, and conduct	CBT, behavior therapy, & ASD-specific interventions	High-intensity CYP IAPT/ recruit-to-train
Behavioral and emotional problems for 0–5s	Behavioral parent training & VIG	High-intensity CYP IAPT/ recruit-to-train

Abbreviations: CWP, Child Wellbeing Practitioner; EMHP, Educational Mental Health Practitioner; CBT, Cognitive Behavior Therapy; IPT-A, Interpersonal Psychotherapy for Adolescents; ASD, Autism Spectrum Disorder; VIG, Video Interaction Guidance.

CYP IAPT Curriculum: Overview and Objectives

This section gives an overview of the "new workforce" curriculum (ie, CWP and EMHP curricular collectively). Specifically, this section will review the CWP and EMHP curricula by examining (a) interventions taught on the program, (b) the length and nature of the training, and (c) evidence-based principles common to all CYP IAPT trainings. This review will hopefully help readers understand the skillset of these new workers and the scope and limits of their practice. Finally, the high-intensity CYP IAPT curriculum will not be reviewed in this paper. It remains largely unchanged since its inception in 2011. As such, interested readers can find a number of excellent reviews summarizing this curriculum elsewhere (eg, Fonagy et al[39] and Shafran et al[1]).

A recent UK mental health survey estimated that 12.8% of 5–19 year olds met clinical threshold for a diagnosable mental health disorder in 2017.[40] The survey estimated that 33.6% of these children received no professional help for their difficulties. Improving access to treatment has been a key objective of CYP IAPT since its establishment.[4] Nevertheless, if prevalence surveys are correct, increasing access will require a significant expansion of the mental health workforce. One proposed solution to scaling-up psychological interventions is to develop a mixed workforce of professionals.[41] That is, a workforce that consists of traditional professionals (eg, clinical psychologists, child psychotherapists, family therapists) supported by a workforce of practitioners that deliver low-intensity interventions. The CWPs and the more recently established EMHPs were introduced to fulfill this aim.

Innovative workforce models are required to meet the challenges and demands facing CAMHS and the NHS. The Mental Health Workforce Plan for England[7] identified the adult IAPT service as an example of such a model. Adult IAPT workers are trained and closely supervised for 12 months in the delivery of low-intensity psychological interventions. Despite shorter training than conventional therapists, studies indicate that IAPT workers achieve comparable recovery rates[34,42,43] to professionally trained therapists.[44] The CWP and the EMHP training models have been built on the success of the adult IAPT program. The CWP curriculum was developed in 2017 by the CWP Expert Curriculum Group chaired by the National Clinical Adviser for Child and Young People's Mental Health for NHS England – Peter Fonagy (P. Fonagy, email communication, June 2019). The EMHP curriculum adopted the CWP curriculum in 2019, but EMHPs also receive additional training on working within an educational context.

The new workforce curriculum trains practitioners in the delivery of low-intensity interventions for low-to-moderate mental health problems. The primary intervention philosophy adopted by the curriculum is based on guided self-help (GSH) principles. In GSH, a practitioner helps patients manage mental health problems by recommending self-help strategies. To illustrate, a prototypical GSH intervention for child anxiety disorders consists of (a) a self-help manual that assists parents to develop an exposure hierarchy, (b) four 1 hr face-to-face sessions with a therapist and (c) four 20 mins telephone sessions.[45] The role of the practitioner is to encourage the parent to work through the manual, practice skills, and problem solve intervention barriers. A randomized controlled trial (RCT) showed that parent-led GSH achieved a 50% recovery rate for child anxiety disorders, compared with a 25% recovery rate in the waitlist control group.[45]

Similar RCTs have been conducted examining the benefits of GSH for low mood, adolescent anxiety, and childhood conduct. Overall, GSH benefits some children and adolescents, especially when problems are mild or moderate. For example, a recent meta-analysis by Bennett et al[46] showed that GSH is a promising treatment for mental health problems in children and adolescents. Effect sizes for GSH were in a medium-to-large range for anxiety (Hedges' g 0.64, 95 CI 0.38–0.90), behavior (Hedges' g 0.44, CI 0.28–0.60), and depression (Hedges' g = 0.47, 95 CI 0.21–0.72) when

compared with a control group (ie, waiting list, attention, nonactive, and treatment-as-usual). Nevertheless, despite these promising findings, the meta-analysis showed that GSH is less effective than traditional therapies such as CBT.

Although more research is required to further establish the evidence base for GSH within pediatric populations, the justification for adopting GSH in CYP IAPT is based on a broader range of considerations, such as ease of implementation, cost-effectiveness, and straightforward therapist training.[8] To illustrate, the adult IAPT program has shown that GSH can be rolled out and upscaled quickly. Over a 11-year period, IAPT has grown to service around 960,000 people per year. Around 48% of treatment episodes in the adult IAPT program are low-intensity cases (eg, guided self-help, computer-based CBT)[11] with 36% of the IAPT workforce classed as "low-intensity workers".[47] The adult IAPT program has demonstrated that GSH practitioners can be effectively trained within a short timeframe (ie, 12 months) – with around 2520 low-intensity workers qualifying in the program's first seven years.[47] Although the low-intensity approach has increased access for adults, there has been limited dissemination of the GSH approach within CAMHS settings. This is despite the fact that child and adolescent studies show that GSH is more cost-effective than traditional therapies,[30,31] and GSH options do not seem to compromise recovery for children and adolescents – especially when delivered within a stepped care framework.[35]

Training Model for Child Wellbeing Practitioners and Educational Mental Health Practitioners

The CWP and EMHP trainees enroll in a postgraduate qualification for 12 months at a higher education institute and are employed by a participating NHS CAMHS, local authority, or third sector organization. During their education and placement, practitioners are trained to deliver the following interventions for children and adolescents aged between 6–18 years:

(a) parent-led GSH for primary-school-aged children with mild-to-moderate anxiety disorders;[45]
(b) guided self-help for mild-to-moderate adolescent depression, based on behavior activation principles;[48]
(c) guided self-help for mild-to-moderate adolescent anxiety disorders, based on CBT principles; and
(d) parent-led GSH for mild-to-moderate behavior problems (primary-school-aged), based on social learning theory.[49]

Services are responsible for screening cases and providing onsite clinical supervision. The CWPs and EMHPS are not trained in the treatment of posttraumatic stress disorder, obsessive compulsive disorder, nor severe and complex mental health presentations. Severe and complex cases are seen by existing CAMHS professionals (eg, clinical psychologists, family therapists) or high-intensity CYP IAPT therapists. All CYP IAPT trainings – including the CWP and EMHP programs – incorporate the following common elements: (a) didactic lectures on clinical interventions (b) weekly onsite clinical supervision (c) videotaping trainee performance, and (d) mandatory use of routine outcome monitoring (ROM) feedback.[1] Mandatory ROM measures include the Revised Child Anxiety and Depression Scale (RCADS),[50] the Strengths and Difficulties Questionnaire (SDQ),[51] and the Goal-Based Outcomes (GBO) scale.[52] Furthermore, all CYP IAPT training programs place a strong emphasis on evidence-based practice within the context of service user involvement, shared decision making,[53] and goal-based work.[54]

Lastly, although CWP and EMHP services are generally limited to 8 sessions of treatment, a key feature of these services is not the number of sessions per se, but the principle that intervention should be brief and time-limited.

Future Challenges

We have outlined the current state of the CYP IAPT program and summarized the theoretical ideas informing its development. Government policies and NHS commitments indicate that the CYP IAPT program has a positive future with ongoing funding allocated to continue its expansion. Furthermore, implementation science principles support the increased deployment of the CYP IAPT approach, such as stepped care, routine outcome monitoring, and task shifting. The CYP IAPT program, however, is not without its critics. The program has been criticized for focusing too much on cognitive behavioral therapies and short-term treatments.[55] Furthermore, there is growing awareness that the adult version of the IAPT program has shortcomings. Cited problems in the adult program include low recovery rates,[56] treatment models failing to take contextual factors into account,[57] and high therapist burnout.[58] Because CYP IAPT is being expanded, there needs to be greater scrutiny of the CYP IAPT model to make sure mistakes made in the

adult program are not repeated in the child and adolescent sector.

One concern facing the future of CYP IAPT is the effectiveness of its treatments. Several low-intensity therapies currently used in CYP IAPT are modifications of adult treatments, and have not been thoroughly tested in child and adolescent populations. Despite emerging evidence supporting the short-term efficacy of GSH as a treatment option for children and adolescents, more needs to be understood about its long-term efficacy and its effectiveness outside research trials. As reviewed above, GSH is effective when compared to a no-treatment control group, but it is not as effective as face-to-face CBT. Furthermore, the long-term effectiveness (ie, >12 months post treatment) of GSH compared to standard treatment is currently unknown.[59] Research findings and clinical opinion are rapidly evolving in this area. To illustrate, the 2005 NICE guideline for depression in children and young people recommended GSH for mild depression.[60] Nevertheless, the most recent (June 2019) NICE guideline[33] for depression does not recommend GSH because NICE concluded that treatment effects are not sustained over time. As an alternative, NICE recommends digital CBT for mild depression in children and adolescents. It is possible that CWPs and EMHPs will receive training on Digital CBT in the future so that the curriculum remains NICE compliant. Nevertheless, this example illustrates how best practice in this field is still developing and evolving.

Given the fact that the evidence base in this field is still emerging, it is imperative that a robust evaluation of the CWP and EMHP programs is implemented. Evaluations of the CWP program are currently underway with sites collecting session-by-session treatment data. Additionally, the government Green Paper states that the EMHP program and its associated school-based teams (ie, Mental Health Support Teams) will be "robustly evaluated".[6] Nevertheless, despite these aspirations, it should not be taken as a given that these aims will be realized. The CAMHS sector in England has a poor track record of collecting outcomes data. For example, a recent evaluation by the Child Outcome Research Consortium (CORC) experienced significant difficulties evaluating routine practice in CAMHS due to low compliance with data collection. In the CORC evaluation, only 25% of closed CAMHS cases had paired (ie, pre and post treatment measures) child-report data.[2] The CWP and the EMHP programs could look to the adult IAPT program for guidance on how to conduct a high-quality service evaluation. The adult IAPT program obtains complete clinical data for around 98.5% of cases.[11,61] Importantly, missing data in the adult IAPT program is treated in a similar manner to a research trial. That is, cases without post-treatment scores are assigned a "non-recovered" status. Running a statistical analysis on an incomplete dataset runs the risk of biased results and invalid conclusions.[62] If such a conservative strategy were taken in the CORC evaluation of CAMHS, 75% of cases would have been automatically assigned a "non-recovered" status.

The CWP and EMHP programs are in a pilot phase at this stage. Lessons learnt from the CORC evaluation and adult IAPT should be taken on board when evaluating the new workforce initiative so that its impact on child mental health can be accurately assessed over the coming years. Initial signs suggest positive indicators from the first two years of the CWP pilot, but we await with anticipation for the national data to be published. Anecdotal feedback suggests that sites (eg, London and the South East; South West England) using software-assisted ROM systems have more complete datasets than sites relying on manual entry. As such, we recommend that all CWP and EMHP sites implement technology-assisted ROM systems, and that services evaluate the long-term effectiveness of low-intensity work and subject their methods and findings to peer review.

Conclusion

Innovative solutions are required to improve access and reduce wait times for children and adolescents requiring mental health support in England. The CYP IAPT program is attempting to achieve these aims by increasing the size of the CAMHS workforce, offering low-intensity treatments, and providing support in schools. The CWPs and EMHPs are part of a new workforce that deliver low-intensity interventions for anxiety, depression, and conduct. The CWP and EMHP treatment philosophy is based on GSH; however, the programs also incorporate CYP IAPT principles such as goal-based work, routine outcome monitoring, and shared decision making. Although there is evidence supporting the use of GSH in clinical practice with children and adolescents, there are still questions about its long-term effectiveness and the types of patients it is best suited to help. As such, it is imperative that the new workforce program is effectively evaluated. The adult IAPT program's service evaluation model represents best practice in the field. The CYP IAPT program should embrace lessons learnt from past unsuccessful CAMHS evaluations and adopt best-practice service evaluation models to ensure the current "transformative" changes are truly effective in improving the lives of children and young people.

Disclosure

Chris Ludlow, Russell Hurn, and Stuart Lansdell work on CYP IAPT programs at the Anna Freud Centre/University College London and report no other conflicts of interest in this work.

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