# Transformation of Mental Health Services

# for Children and Young People in England

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**Abstract**

A national program to transform child and adolescent mental health services has been launched in England. It is called the 'Child and Young People's Improving Access to Psychological Therapies' (CYP IAPT) program. Fundamental components of the program are the implementation of evidence-based psychological therapies for common mental health problems, service user participation, routine outcomes monitoring, and training for therapists, supervisors and managers. This chapter describes the design, implementation and planned evaluation of the CYP IAPT program.

**Introduction**

In 2011, the Department of Health in England announced a project aimed at improving mental health services for young people. To achieve this goal, the United Kingdom (UK) Government supported the development of the Child and Adolescent Mental Health Services (CAMHS), which are part of the National Health Service (NHS), to become better equipped to treat the high prevalence of mental health problems and make the best use of limited resources in a time of public health austerity. The mechanism for this service transformation program is the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) program, which has adapted lessons learned from the adult IAPT program that has been running since 2008. The aim of the adult program is to make evidence-based psychological therapies for depression and anxiety disorder more widely available in the NHS. It uses a stepped-care approach. A recent analysis from the first year covering 19,395 patients found that 63.7% showed reliable improvement and 40.3% of patients were reliably recovered (Gyani, Shafran, Layard & Clark, in press).

In Great Britain, nearly 10% of children and adolescents in the community have a diagnosable mental health disorder, the most prevalent being Conduct Disorder (CD) (6.6%) (Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Approximately 6% of 5–16-year-olds have CD, and 3.7% have an emotional, anxiety, or depressive disorder (Meltzer, Gatward, Goodman, & Ford, 2000). In total, 14% of 16–19-year-olds have a diagnosable mental health disorder (Green et al., 2005). A further 10% have significant problems or risk factors which would indicate vulnerability to developing a mental health disorder. The UK continues to trail other Western industrialized countries on UNICEF's league of childhood wellbeing. Poor mental health in early years and adolescence can lead to significant inequality throughout life. Fifty percent of severe adult mental disorders (except dementia) present by the age of 15, and almost 74% by the age of 18 (Kessler et al., 2005; Kim-Cohen et al., 2003). Half of children diagnosed with CD are likely to develop Antisocial Personality Disorder. Despite these startling figures, it is estimated that only 2.5% of children and young people ever reach specialist services for children and adolescents' mental health (Kelvin, 2005).

Mental illness during childhood and adolescence in the UK costs £11,030 to £59,130 (approximately $17,000-$69,130) annually per child, with substantial cost benefits accruing from intervention using evidence-based therapies (Little & Edovald, 2012; Suhrcke, Puillas,

& Selai, 2008). Children with conduct problems cost around 10 times as much as children without conduct problems; these costs are distributed across many agencies, including health, social services, education, and youth justice. The lifetime costs of each 1-year cohort of children in the UK with CD have been estimated at £5.2 billion The cost of crime attributable to adults who had conduct problems in childhood is estimated at £60 billion per year in England and Wales, of which £22.5 billion is attributable to CD and £37.5 billion to subthreshold CD (Sainsbury Centre for Mental Health, 2009). The economic case for early intervention with pediatric mental health problems is overwhelming, yet less than 5% of current spending on mental health goes to services aimed at children and young people (Kennedy, 2010).

The CYP IAPT program was designed to transform the existing CAMHS. The rationale behind the transformation was that CAMHS is primarily a psychologically based service, with existing services facing the major challenge of working with limited resources to meet the needs of an increasing number of children and young people with mental health problems. Many services had a reputation for being difficult to access by patients and the general practitioners referring to them, long waiting times, and a high frequency of missed appointments. A review indicated that such services were often not able to provide evidence-based treatments because of clinician skills shortages, and were not routinely collecting outcomes data, which made it difficult to evaluate their clinical or cost effectiveness (Department of Health, 2008). Evaluations of 'Treatment as Usual' interventions elsewhere were not encouraging (Weisz et al., 2013). In 2011, in an attempt to address these challenges, the Government announced an initial investment of £32 million over 4 years (approximately US $33.2 million) into the roll-out of evidence-based psychological therapies to those below the age of 18.

The CYP IAPT project took key principles and lessons learned from the Adult IAPT program, which began in 2007. In total, the Government has invested over £400 million (equivalent to approximately US $620 million) in this program within the National Health Service (NHS). The program's aim is to provide clinical services across England offering evidence-based psychological therapies for adults with depression and anxiety disorders. The psychological therapies available are those recommended by the National Institute for Health and Care Excellence (NICE; formerly the National Institute for Health and Clinical Excellence). Two demonstration sites indicated that the program had promise (Clark et al., 2009). By 2012, after its first 3 years, over 1 million people had entered treatment, with 680,000 completing therapy; recovery rates were consistently in excess of 45% ,with 65% significantly improved; over 45,000 people moved off sick pay and benefits, making the program economically viable; and almost 4,000 new practitioners were trained to deliver interventions at high and low intensities (Department of Health, 2012). Subsequent analyses showed that the program was cost-effective (Radhakrishnan et al., 2013) and that it also had a role to play in the treatment of patients with comorbid long-term conditions (de Lusignan et al., 2013).

Four years after the adult program began, the Government described its intention to extend IAPT to children and young people in its document '*No health without mental health*' (Department of Health, 2011). The Department of Health consulted with young people and professionals to establish a project that would fully integrate into existing service models the key IAPT principles of best evidence-based practice, frequent routine outcomes monitoring used to guide therapy sessions, strong case management and supervision. One of the key aspects of the adult model, stepped care, was not included because professionals and young people both agreed that this model might create a perception in young clients and their families that they had 'failed' therapy if they were stepped up to more intensive treatment.

Instead, the program developed a strong culture of participation by service users. Service users have been involved in the delivery of training to therapists, supervisors, and managers as well as the selection of sites and dissemination of the program.In February 2012, the UK Deputy Prime Minister announced further funding for CAMHS (including the roll-out of evidence-based psychological therapies) totaling up to £22 million for 2012–2015. The additional funding was provided to achieve the following aims:

- Extension of the geographical reach of the transformation of services;

- Increase in the number of therapies offered, specifically, to include (a) Systemic Family Therapy (SFT) for young people with depression, self-harm, CD and eating disorders, and (b) Interpersonal Psychotherapy (IPT) for young people with anxiety and/or depression;

- The creation of an 'ePortal' to include e-learning for NHS clinicians, staff working with children and young people in universal settings, and school youth counselors and supervisors, a blended learning e-curriculum for CYP IAPT, and exploring options for e-therapies (including computerized cognitive behavioral therapy (CBT) and other low-intensity e-enabled interventions), and also the CYP IAPT curriculum online;

- Enhancing the capability of services with an outreach program to deliver liaison, consultation, outreach, training and support to staff in the services who were not attending the in-depth training sessions provided by higher education institutions (HEIs);

- The development of an accreditation framework for training courses, individuals (practitioners and supervisors) and services.

## Aims of the CYP IAPT Project

The primary aim of the CYP IAPT project is to transform existing mental health services for children and young people so that they have improved access to the best possible psychological services in a way that they find acceptable and relevant. It focuses on embedding therapies recommended by NICE that have been proven to work across services. Investing in the most effective methods available to reduce the substantial disease burden associated with child mental health problems requires a rigorous examination of opportunities to prioritize interventions that produce more health gain for the same money – or, more importantly, the same for less.

Studies have shown that that using evidence-based psychotherapies (EBPs) achieves superior outcomes over usual care, with reported advantages for EBPs in recovery rates (18%), effective engagement of parents, reduced use of medication and other services, overall cost, and possibly speed of improvement (Chorpita & Daleiden, 2010; Weisz et al., 2013). Furthermore, Weisz and colleagues (Weisz et al., 2011; Weisz et al., 2012) compared the introduction of manualized EBPs with a more flexible approach in which intensive outcomes monitoring was used to identify the particular combinations of EBP components that achieved the greatest responses in young people, in order to improve the effectiveness of treatment. The use of manualized EBP treatment – specifically, 'Coping Cat' for anxiety (Kendall, 1994), 'Primary and secondary control enhancement for depression' (Weisz et al., 1997) and 'Defiant Children' for conduct and noncompliant behavior (Barkley, 1997) – delivered a 19–20% increase in individuals moving to subdiagnostic levels, relative to usual care. The use of outcomes monitoring to guide treatment decisions resulted in a further 15% improvement in the number of young people who no longer met diagnostic criteria. The total benefit was over 34% improvement in response to treatment, in addition to any cost savings delivered as part of the implementation of EBPs. Studies have therefore consistently

identified the advantage of EBPs over usual treatment, not simply in terms of delivering better outcomes, but also in substantial savings of money, time, and other resources (Weisz et al., 2012). This translates into greater access to therapy that is known to work for children and young people.

CYP IAPT requires services to improve their collaboration with community stakeholders (i.e., young people and families) through enhanced participation (including allowing self-referral) and routine outcomes monitoring based around goals as well as symptom measures. It also trains service leaders, supervisors and practitioners in a curriculum based on best evidence.

Evidence-based practice also entails the identification of service users' treatment preference and the systematic observation of clinical progress during the course of each treatment, as well as the aggregation of outcomes based on comprehensive study of practice (as discussed later in this chapter). To meet these requirements, the CYP IAPT project aims to make sure that all those involved in the services – not just those who are being directly trained by the project – make use of intensive (session-by-session) outcomes monitoring.

The specific inter-linked aims of the project are to:

**Outcomes**

1.  Improve and demonstrate outcomes for all children, young people and their families in receipt of the service;

2.  Deliver treatment outcomes as close as possible to those in clinical trials, initially for those suffering from depression, anxiety and conduct problems. In the future, as the curricula develop, self-harm and eating disorders will be included;

**Evidence base**

3.  Demonstrate the cost benefit of investment in CYP IAPT;

4. Encourage further investment in evidence-based treatments for children and young people;

**Choice and personalization**

5. Improve the choice and quality of NICE-approved treatments available to children and young people who have an anxiety disorder, depression, self-harm, eating disorders or conduct problems;

6. Improve access to and acceptability of services in terms of access through self-referral, times, settings, methods of treatment, and cultural appropriateness;

**Workforce**

7. Improve training and workforce capability and capacity in universal settings such as schools (through links to web-based services, the MindEd and Counselling ePortal), and targeted and specialist settings through face-to-face, blended and e-learning opportunities;

8. Embed outcomes monitoring and use of outcomes in supervision across CAMHS, and through links to the ePortal and Counselling MindEd e-learning for counselors, support its inclusion in counseling;

9. Improve the capacity and capability of specialist CAMHS to deliver training, consultation and support to staff working in universal and early targeted settings;

10. Develop a sustainable method to evaluate quality assurance in the workforce through accreditation.

**Evidence and promote good practice**

11. Ensure that the CYP IAPT model's methodology and tools are freely available to all CAMHS partnerships to promote the benefits of routine outcomes monitoring, evidence-based practice and service users' and carers' participation.

To achieve these ambitious aims, a fundamental component of the project is the building of supportive learning networks that link outstanding HEIs with the transformation of CAMHS partnerships in *collaboratives* that stretch across regional boundaries. The project was explicit that the transformation was aimed at the local area partnerships that exist in CAMHS commissioned by health and social care and provided by statutory, private, and third-sector providers rather than being aimed solely at NHS services and commissioners.

There are three major components of the project: (1) Training for practitioners, supervisors and service managers/leads; (2) Collaborative practice of EBPs, using routine patient-reported outcomes; (3) The transformation of all CAMHS in England, linking research evidence, patient preferences and values, and clinician observations into an improved model of care delivery.

### Training for Practitioners, Supervisors, and Service Managers/Leaders

The collaboratives provide training for practitioners in interventions with a substantial evidence base in specific common mental health problems seen in children and young people. At the same time, the collaboratives train supervisors and service managers and clinical leads, supporting them to lead local transformation.

The practitioners' training that is delivered by the HEIs is a key element of the program. The aim is for practitioners to be delivering these therapies to the standards of the research trials, where the way in which a therapy is delivered is carefully specified and monitored. The training comprises a generic module emphasizing the importance of evidence-based practice, collaborative care, and routine outcomes monitoring, and modality-specific components. In the first year, the project offered sites the opportunity to train in two specific evidence-based therapies for a range of common disorders in children and young people:

- For a range of emotional disorders such as anxiety and depressive disorders – manualized implementation of Behavioral Therapy (BT) or CBT treatment packages such as Coping Cat (see Kendall, 2012 for the range of empirically supported therapies);

- For behavioral problems (Oppositional Defiant Disorder or CD) – parenting programs such as the Incredible Years program (see Webster-Stratton & Reid, 2010) for 3–10-year-olds.

**Core implementation components**

Research evidence on the dissemination and transportability of EBPs highlights both system issues and characteristics of interventions that are important to increasing the acceptability of such interventions in typical care settings (Daleiden, Chorpita, Donkervoet, Arensdorf, & Brogan, 2006; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). To date there is no universally agreed model for the ideal method of implementing an evidence-based approach. Aarons et al. (2011) review a number of models to "summarize factors at multiple levels of the social and organizational context that potentially influence the process of translating research into effective improvements in practice" (p. 5). A number of parameters may define increased success in adopting evidence based-practices: these include leadership (Aarons et al., 2011; Feldstein & Glasgow, 2008), the fit between the innovation and the norms and values, such as shared professional orientation and patient-centeredness (Aarons et al., 2011; Solomons & Spross, 2011), and attitudes/motivation toward innovations that affirm a holistic approach towards quality improvement (Godin, Bélanger-Gravel, Eccles, & Grimshaw, 2008; Greenhalgh et al., 2004). The core implementation components of CYP IAPT were based on the seven-point implementation model proposed by Fixsen, Blase, Naoom, and Wallace (2009).

(1) The process begins with *site and staff selection.* This is a two-stage process. First, CAMHS settings ready for implementation of EBPs are identified. Secondly, within each site individual CAMHS professionals who were suitable for training are selected. This latter process goes beyond academic qualifications or experience factors, and includes knowledge of the field, basic professional skills, common sense, sense of social justice, ethics, willingness to learn, willingness to intervene, good judgment, and empathy. Both parts of the selection process are supported by formal applications and structured interviews overseen by the central CYP IAPT implementation team.

(2) *Pre-service training* focuses on the training of supervisors and managers. CYP IAPT recognizes that supervision that is guided by evidence is a skill that needs to be reinforced. The learning collaboratives have therefore been training supervisors to ensure that they can support practitioners to provide the best possible therapies, using evidence yielded by routine outcomes monitoring. Evidence from dissemination and implementation research emphasizes the importance of ongoing supervision or consultation in the implementation of EBPs (Beidas, Edmunds, Marcus, & Kendall, 2012). Supervisors receive training of 10–14 days. Their training includes sessions on Understanding Children and Young People's IAPT and Promoting Psychological Knowledge; principles, theories and models of supervision; facilitating therapeutic processes; maximizing the utility of routine outcomes monitoring; and the use of a structured supervision assessment such as the 'Supervision: Adherence and Guidance Evaluation' (SAGE) (Milne, Reiser, Cliffe, & Raine, 2011). The supervision competence framework developed by University College London as part of its suite of frameworks makes the supervision skills required explicit (http://www.ucl.ac.uk/clinical-psychology/CORE/Competence-Frameworks/competence_frameworks-new.htm).

(3) *The supervision and coaching* stage involves training the practitioners in the EBPs. National curricula for the training of practitioners (and supervisors and service

leaders/managers, as described above) have been developed by expert consensus and ratified by the HEIs. The curricula themselves were written by the CYP IAPT Project Education and Curriculum Task and Finish Group and subgroups, Service Development Group and Outcomes and Evaluation Group. The training for practitioners is a year-long, postgraduate diploma. All practitioners are trained together on the core curriculum, which covers the key values and skills for the project and comprises half the course credit value. Practitioners are then divided into groups according to their specialist modality. The total course for practitioners equates to 1,200 hours' work and the practitioners attend the HEI on 2 days each week for an academic year. One of these days is a full day of teaching/workshops, while the other focuses more on supervision and small-group skills practice.

(4) *Workplace supervision and performance evaluation* is an essential part of the implementation process. The practitioners have supervision of their caseload in the service concurrent to the taught components of the course described above. Required assessments include case reports and passing therapy sessions that are rated according to standardized scales for the specific modality such as the Cognitive Therapy Scale –Revised * PAM – please can you put best reference?*. Performance evaluation is designed to assess the use and outcomes of the practitioners' skills. The first – and most important – use of performance evaluation information is to help the practitioner continue to improve his/her effectiveness with service users. Assessments of practitioner performance and measures of fidelity also provide feedback that is useful to trainers at the HEIs, clinical supervisors, service managers, and the central CYP IAPT implementation team as to the progress of implementation efforts and the usefulness of the processes of selection, training, and supervision put in place by the program.

(5) In addition to the selection, training, support and evaluation of staff, *decision support data systems* are a key part of the project. These supply formal information not only

in relation to service user outcomes, but also quality improvement information, organizational fidelity measures to assess key aspects of the overall performance of the organization, and data to support decision-making to assure continuing implementation of the core intervention components over time. This aspect of service implementation is discussed separately in the next section of the chapter.

(6) *Facilitative administration* is key to any effective service-improvement implementation and is central to the success of disseminating EBPs. Facilitative administration provides leadership and makes use of a range of data inputs to inform decision-making, support the overall processes, and keep staff organized and focused on the desired intervention outcomes. Policies, procedures, structures, culture, and climate are given careful attention to ensure they are aligned with the needs of practitioners learning and implementing EBPs. To this end, the training of service managers/clinical leads is an integral component of the project. This comprises approximately 12 days of training which aims to develop competency in leading service change to deliver evidence-based, quality-driven, outcomes-informed services. Additional aims are: (a) to have critical knowledge of the theoretical, research and implementation literature that underpins service change and (b) to enable service leaders to make the necessary changes in their services during the training course. The course typically involves producing a 4-5,000-word report on a local project, conducted as part of the training that initiates and evaluates a local service change consistent with the principles and ethos of the national project.

(7) Finally, *systems interventions* are strategies to work with external systems to ensure the availability of the financial, organizational, and human resources required to support the implementation of evidence-based practice. How CYP IAPT aims to achieve the transformation of CAMHS in England, linking research evidence, patient preferences and

values, and clinician observations into an improved model of care delivery, is discussed later in the chapter.

The order of implementation of these components is schematically illustrated in Figure 1. It should be noted that these elements are all inter-related (integrated) and compensatory, such that the absence or poor quality of one component can be compensated by an improvement in another.

[Insert Figure 1 here]

**Collaborative Practice of EBPs, Using Routine Patient-Reported Outcomes**

It is essential that clinical services across the spectrum of health care are outstanding in terms of the quality of information they collect and information about the effectiveness of the care they offer. Routine collection of outcomes data is a 'mission critical' commitment in the CYP IAPT project. It serves two functions: (a) the 'diagnosis' of service user preference and (b) the systematic observation of clinical progress during the course of treatment as well as the aggregation of knowledge on outcomes, based on a comprehensive study of practice (Frueh, Ford, Elhai, & Grubaugh, 2012). Evidence on clinical process, outcomes, and decision-making is collected systematically, often session by session, and is used as a core part of EBP (Bickman & Hoagwood, 2010; Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Dew & Bickman, 2005; Garland, Bickman, & Chorpita, 2010; Kelley, de Andrade, Sheffer, & Bickman, 2010; Shimokawa, Lambert, & Smart, 2010; Whipple & Lambert, 2011). These data are key to constructing a picture of the contextual efficacy of a therapy in practice, but are also available to guide the treatment of individuals in the most effective way. Children and young people (and, where appropriate, parents) agree a set of goals that are meaningful to them; these goals are monitored regularly, along with the use of measures to

see to what extent each session has been useful, and validated symptom measures are also collected. This information helps young service users to understand how their treatment is progressing, take control of their care, and make decisions, along with the practitioner and family, about what treatment is needed and how helpful particular treatments have been.

Outcomes monitoring also allows individual practitioners and services to evaluate and review their work and make changes where necessary. Clinicians have difficulty judging when cases are likely to deteriorate or fail to improve (Lambert & Ogless, 2004). Patients who are not "on track" but whose outcome is being routinely monitored are offered additional sessions, clearly showing that practitioners were able to pick up on the fact that treatment was not proceeding optimally and took time to work on this (Lambert, 2010). Beyond this, routine outcomes monitoring provides a source of information for a focus of supervision in the context of CYP IAPT, bringing attention to where it is most needed (Worthen & Lambert, 2007). Meta-analyses have demonstrated that measuring, monitoring, and predicting treatment failure enhances treatment outcomes for patients who initially respond negatively to treatment (Lambert, 2005). For example, a recent study (Bickman et al., 2011) evidenced that sharing feedback with clinicians on the mental health outcomes of youths they were treating improved outcomes for the young people in terms of speed of improvement.

In CYP IAPT, data managers, clinicians, managers, clinical leads, and service leads have been working together to support all practitioners in the services in 'Year One' sites to routinely monitor sessions, ideally every session. Session-by-session data analysis becomes an integral part of the weekly supervision of practitioners. An extensive guide to how best to use the measures has been produced (http://www.iapt.nhs.uk/silo/files/a-practical-guide-to-using-service-user-feedback--outcome-tools-.pdf). Their use typically leads to supervision sessions that are structured and goal-focused. The practicalities of session-by-session monitoring across an entire service present some important logistical challenges. In 2013, it

was announced that funding would be made available for the use of technology to support this endeavor so that young people could report their symptoms on electronic devices such as tablet computers during a session. The results of routine outcomes monitoring help services to understand, quantify, and demonstrate how a treatment impacts on the lives of the children and young people being treated. In addition, the services submit a dataset and the assessment, review, and symptom measures to the central project team to facilitate analysis of the project as a whole.

Using the outcome measures is just one part of the collaborative approach that is critical to the success of CYP IAPT. The project is making a concerted effort to empower young service users by establishing their position as equal partners in the therapeutic relationship (http://www.youtube.com/watch?v=vSM9Z1oDYjw). All services involved in the project are committed to hearing the views of children, young people, and families, and acting on them to make improvements and share good practice. As well as working closely with children and adolescents who are seeing CYP IAPT practitioners, the implementation team is also being advised by groups of young advisors from across the country who have had a key role in the development of every stage of the project, from interviewing potential teams and presenting at conferences to helping with the design of training courses and even teaching on them. Services are considering how to change to accept self-referrals or referrals from schools rather than necessitating a referral via the primary care physician. Many services are working towards offering evening clinics so that young service users can be seen after school and in the holidays rather than having to miss school time.

## Transformation of all CAMHS in England

The emphasis on collaborative practice, participation, training a number of staff simultaneously, and frequent session-by-session monitoring poses a challenge for even the

best-organized service. Research tells us that the success of disseminating and implementing evidence-based practice depends on developing a good fit with service and management priorities (Fixsen, Blase, & Van Dyke, 2011). CYP IAPT would not work without the senior managers who are responsible for launching the program receiving essential training, not just in the program's principles, but also in the best evidence-based methods for bringing about organizational change (see chapter by Charles Glisson, this volume).

The criteria for service transformation have been laid out by a key national subgroup of senior service managers and implementers of the program, which has defined key features of a CYP IAPT service. These characteristics will be overseen and peer-reviewed by an accreditation system created with other CYP IAPT services. While a definitive list of these characteristics has not yet been drawn up, the following are indicative items. Ideally, those working in a CYP IAPT service should perceive little distinction between their usual work and EBPs (Aarons et al., 2012). Much of what is expected by the project therefore falls within the domain of attitudinal change. Practitioners are expected to put the wellbeing of clients first, to be competent, and to have up-to-date knowledge, and should demonstrate an overarching concern for clients' attitudes and preferences. In turn, practitioners in CYP IAPT services should feel a sense of accomplishment from being part of the organization and from their personal involvement with clients, and should experience feeling 'listened to' by management and respected for their skills and knowledge. Children and young people must be involved not just in service delivery but also in service design and promotion, including specifying the service model, and, where possible, must be part of delivering the educational program for practitioners. Parents contribute to the delivery of therapy for the child but deserve to have their needs attended to in turn. Above all, all those attending CAMHS have the right to feel listened to and appropriately responded to – not solely according to their diagnosis but in terms of their personal need. There is an implied shift in stance to the

practitioner as a facilitator with expertise, rather than an expert with power. Everything we do must add value to the user, providing just the right amount of input while constantly asking: "Is this working for this young person?"

In addition to these 'softer' goals, service changes should manifest in specific shifts in practice. An adequate CYP IAPT service must be cautiously diagnosis-based and must be able to report treatment outcome in at least 50% of referred cases on the basis of a standardized client- or carer-rated measure. The service must be able to offer medication where needed (particularly for Attention Deficit Hyperactivity Disorder and depression), CBT for depression and anxiety, parenting training groups for oppositional problems, and family therapy linked to conduct problems for adolescents. Therapies must be offered by clinicians trained to IAPT practitioner criteria. Services must take active steps to increase access, including the provision of multiple access points, telephone advice and psychoeducation, and carry out monitoring of the different ethnic communities accessing the service to show that they are accessible to diverse communities. They should offer web-based interventions for parents to ensure immediate help, adequate signposting and low-intensity, evidence-based interventions. School-based services should be available, but these also must be evidence-based and proactive in protecting children and young people from stigma within the school setting. There should be joint agency protocols in relation to risk, social care, and adult mental health issues in cases where these are known to affect the outcomes in relation to the young person, and they should pay due regard to safeguarding issues based on a joint agency approach, strong outreach provision, 24/7 risk teams, and active links with local hospital emergency services. Where possible, mental health interventions for adults and children/young people should be integrated, as families with complex needs have the poorest outcomes.

## The Process

Implementation of scientifically validated innovations has evolved from an attitude of "Let it happen" (where evidence is published for whoever wants to use it), through various forms of "Help it happen" (with stricter definitions of what is evidence-based, using meta-analytic results to generate guidance for services) to the realization that EBPs will be disseminated and implemented only if we "Make it happen" and engage in active planning activity to adopt and sustain the use of innovations (Fixsen et al., 2009; Fixsen et al., 2011). Fixsen and colleagues (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) have identified the critical stages to follow to achieve sustainable innovation, as outlined below.

(1) *The Exploration Stage* begins when individuals within an organization learn about new possibilities, engage leaders, seek information about the methods that would be required, and arrive at a decision to proceed with implementing an evidence-based program or other innovation. The Implementation team at the Department of Health (now at NHS England) initiated the exploration stage. The decision was made to issue a national call to clinical services, HEIs, and commissioners to instigate collaborations and to bid to be part of the CYP IAPT project. The funding packages included (1) support (backfill to cover the cost of employing other staff to replace those on the course and training fees) for trainees and supervisors who had the appropriate competencies to take on training and use it in their clinical practice, including consultation and liaison with other services, (2) support for the training of service managers, (3) funding for improvements to the IT infrastructure required to deliver outcomes monitoring as part of the project, (4) funding for local participation by children, young people and parents, and (5) funding to assist with whole-system service improvement and improvement to access. Partnerships of NHS Trusts, local commissioners and voluntary services would be expected to join with HEIs to form collaboratives.

(2) *The Installation Stage* follows contracting (although in practice they may be concurrent) and consists of securing the resources to support implementation activities and the uses of the chosen interventions in practice. For CYP IAPT, the bidding process for contracts with the Department of Health was competitive. The interviewing process involved panels of professionals and children and young people. Successful learning collaboratives demonstrated that they would be able to use the resources offered to improve access, embed evidence-based practice and frequent/session-by-session outcomes monitoring. Three collaboratives met the required standards and were funded in the first year. In the second year, the process was similar, although the recruitment of partners from the voluntary sector was overtly encouraged and funding arrangements for supervisors was modified to encourage sites to train more supervisors. Two further collaboratives were selected. In the third year, collaboratives competed for the delivery of training for two new therapies for the project: Systemic Family Practice (SFT) and Interpersonal Psychotherapy (IPT) for adolescents with depression. The competitive component of the installation stage may be critical in achieving alignment around CYP IAPT priorities within the relevant local networks.

(3) *The Initial Implementation Stage* is when the organization starts learning how to carry out the evidence-based program with competence when interacting with the intended beneficiaries of the program. In CYP IAPT, a training year is envisioned for this stage, to allow time for practitioners and other staff to develop their competencies, organizational supports to be put in place, leadership in EBPs to be enhanced, and system resources to be redirected toward facilitating the full and effective use of CYP IAPT services for by the local community. At this stage the use of routine outcomes monitoring is restricted to CYP IAPT trainees only. We recognize that the initial year is a potentially challenging period for the process because of the novelty of practice and system organization for all involved.

(4) In *the Full Implementation stage*, individuals, organizations, and system units gain competence and confidence with the new ways of working. Within CYP IAPT, the implementation at a site may be said to be in this stage when 50% or more of practitioners have begun to routinely collect outcomes data so that the intended outcomes can be assessed. CYP IAPT expects that the intervention and the implementation supports will need time to be embedded in the organization, so financial support for service transformation continues to be provided for the subsequent year.

(5) *Innovation* is not an explicit feature of the CYP IAPT program, but local innovation is anticipated as the partnership learns about the success of the program itself and the conditions under which it can be used with good fidelity and good effect. The provision of a national dataset (derived from routine outcomes monitoring) as a reference point for outcomes will present opportunities to refine and expand both the *treatment* practices and programs and the *implementation* practices and programs.

(6) A great deal of thought was given to the *Sustainability* phase of CYP IAPT. It is recognized that after 2–4 years of bedding down, the implementation of EBP-oriented practice will need to be sustained. There will be turnover of staff, changes in funding streams, and program requirements will be modified. The goal is the long-term survival and continued effectiveness of the implementation; this requires a national system of quality assurance of training, performance, and service characteristics. CYP IAPT is putting in place an accreditation system both for practitioners and for the training programs, administered by professional associations in charge of maintaining registers of CBT, Parenting, IPT and SFT practitioners. The accreditation of services will require regular peer-review by services that have reached high national standards of performance and have effectively implemented the service transformation goals of the program. This work is ongoing but we are able to report that the professions engaged in CAMHS have agreed to participate and are integrating CYP

IAPT principles into their regular accreditation processes, creating a unique national category of CYP IAPT practitioners in the four therapies used in the program.

The aim is for the collaboratives to grow in each year of the program by adding new sites, which are mentored by sites that have already been through the transformation process. Although CYP IAPT is demanding, we are also seeing increasing interest from parts of the country that have yet to be involved directly in the project but wish to adopt its approach. We hope that the program will be associated with substantial improvement in outcomes for families. Furthermore, we hope that the collaborative spirit that has accompanied the development of the program from its earliest days of project planning, through curriculum development, the creation of a new system for monitoring outcomes measurement, establishing new organizational structures, collaboration between HEIs and CAMHS partnerships, and between universities involved in delivering training, will itself be a model for how service transformation can become a reality not just in England but worldwide.

The project is currently developing a plan to support the accreditation of individual practitioners and therapy-specific courses. The accreditation of the service transformational course and of services will require a different approach. The Quality Network for Community CAMHS offers a peer review and accreditation system for CAMHS teams, and is developing a service-based system which incorporates the quality markers of CYP IAPT. The project team is investigating sources of accreditation for the transformational leadership courses and their participants.

## Evaluation of the Project

Some researchers may be blissfully unaware of the meaning behind the initials 'KPI', but in the NHS they are as well known as 'CBT.' They stand for 'Key Performance Indicator', which is the Government's means of evaluating the outcome of its policies and

projects. KPIs set out how to evaluate whether the objective of a program has been reached. The KPIs for the CYP IAPT project were developed on the basis that a transformed service needs to be measured by its impact on:

(a) Young people and their families – through linkage to the views of young people on what makes a 'perfect service' (YoungMinds, 2011);

(b) A combination of quantitative indicators that measure the impacts on clinical outcomes, waits, people that do not attend etc, and examples of ways of measuring these from several sources.

The project collects a Minimum Data Set (a number of measures) and provides extensive guidance on the use of outcome measures (http://www.iapt.nhs.uk/cyp-iapt/routine-outcome-monitoring-as-part-of-iapt/cyp-iapt-dataset-version-2/) both to evaluate the project as a whole but also for clinical use to assess the outcome of each individual service user. A package of measures is used, including standardized child and parent measures for initial assessment (the Revised Child Anxiety and Depression Scale; Chorpita, Moffitt, & Gray, 2005; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000) and the Strengths and Difficulties Questionnaire (Goodman, 1997). General review measures are also provided. Session-by-session measures include tracking of goals, general wellbeing, one symptom-specific measure (or measure of impact if none of the symptom scales are appropriate) and feedback on each session comprising four questions or a session rating scale to assess how the session was experienced by the young person.

<center>**Challenges**</center>

**Variation in quality of services**

The experience to date is that there is wide variation in the quality of services. Capacity and ability to bring about service change in CAMHS is dependent on wider support across the local health economy. Even in areas where there is considerable enthusiasm for the general principle, there are sections of local CAMHS that required extra support and encouragement to make the changes.

**Technological/Information management**

To collate and analyze the data from this national project is a daunting task. At the start of the project, the UK Government's Informatics Centre was not ready to collate or analyze CYP IAPT data. The capacity of local services to routinely collect data (in terms of training, capacity, equipment, and software development) is highly variable. As we have described above, session-by-session outcomes monitoring is crucial in order to track service users' progress and monitor the effectiveness of services. However, the collection of routine outcomes data is putting a significant burden on services. Each collaborative has a 'data lead' who is working with the national CYP IAPT team to understand what needs to be put in place to minimize the burden of data collection and disseminate best practice. The project is also linking with collaboratives and system suppliers to investigate innovative ways of using technologies such as tablet computers for collecting data in sessions.

**Service transformation**

The early experience is that insufficient numbers of staff have been trained in some services to effect the whole-service change that is required. Issues raised include a need for greater leadership skills at senior levels in NHS Trusts to ensure the CYP IAPT core

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principles are embedded in practice (e.g., the use of routine outcomes monitoring). The vision

of the collaborative structure was that it would facilitate the growth of local learning

networks for practitioners, supervisors, and managers. However, experience has shown that

such growth needs considerable nurturing and dedicated project management support to make

it a reality in localities (e.g., through the provision of learning sets, training days, etc). The

Department of Health is now commissioning this and is aware of the need for continued

support and training in service user participation throughout all aspects of service delivery

and redesign, especially for hard-to-reach groups.

**Project Governance**

In research trials, there is likely to be a Steering Group overseeing the governance of

the project. Similarly, in the roll-out of EBPs, there is a highly complex governance structure

that changes with the reorganization of the structure of the NHS as a whole. The governance

arrangements for CYP IAPT are shown in Figure 2.

[Insert Figure 2 here]

The project is supported by an Expert Reference Group, with members representing a

range of interests, to advise on the delivery of the project. The Expert Reference Group has

established a series of Task and Finish Groups, which undertake specific tasks, such as the

production of guidance on the use of outcome measures. In addition, there are further, wider

independent groups that act as 'critical friends':

- The British Psychological Society and Royal College of Psychiatrists are jointly

    hosting an independent group of professionals including nurses, social workers,

    family therapists, commissioners and voluntary sector organizations.

- Young people are involved at a local and national level, with the project commissioning national coordination and support to sites. The project also intends to commission an organization to support consultation with parents, although it is of interest that an initial tender in May/June 2012 received no applications.

The day-to-day planning and coordination was initially achieved through a small project group made up of the Clinical Lead for CYP IAPT, the CAMHS Professional Lead, the Senior Responsible Officer for the Department of Health, the Children and Young People's Mental Health Policy Lead and Policy Manager, a Project Lead, and a Project Manager for the extended scope of CYP IAPT, assisted by Project Support Officers. The central IAPT team also provided support as required, in particular from the project manager from IT. Since April 2013 and the move to NHS England, the project group has been reduced to the Clinical Lead for CYP IAPT, a Project Lead and a Project Manager for the extended scope of CYP IAPT, the Informatics Project Manager, and the Research and Communications Officer within the Research Department of Clinical, Educational and Health Psychology at University College London, assisted by a Project Support Officer. This *Project Implementation Group* (Fixsen et al., 2011) is very familiar with the new interventions from both a theoretical and a practice point of view, knows how to implement these innovations with fidelity and good effect, and has the capacity to accumulate data and experiential knowledge. The group meets weekly in order to function efficiently. The chairs of the Task Group meet every two months. Implementation teams can improve the success rates of service implementation from 14 to 80% and reduce the time frames for successful use from as much as 17 years to approximately 3 years (Fixsen et al., 2011).

## Future Directions

As of 2013, changes to the NHS in England have changed the fundamental architecture of the system within which CYP IAPT is placed. The long-term future for the CYP IAPT methodology is to place the learning fully within the bodies that commission and provide services' workforce development both for new and existing staff at all levels. The increased focus on the relationship between physical and mental health, partly in recognition of the economic impact of such comorbidities (Naylor et al., 2012), and the broader economic environment in which services are delivered will impact on services. There is a drive to ensure that physical and mental health are given 'parity of esteem', and so mental health services must be given greater priority in commissioning.

The CYP IAPT project is informing the development of CAHMS currencies that will in time form the basis for a new 'Payment by Results' system. 'Payment by Results' is already in use in acute medicine, with hospitals paid a fixed tariff for each type of patient treated rather than receiving a block of income. Payment by Results for adult mental health is currently in development, but services for young people are lagging behind. The aim is to ensure that commissioning of services for young people takes complexity and need into account as well as activity.

The move of the project from the Department of Health to NHS England, the body now responsible for oversight of commissioning within the NHS, will also focus the project in terms of how it enables services to demonstrate that they are 'commissioning ready', and support commissioners to understand what it is they are or should be commissioning. The project aims to work with services covering 60% of 0–19-year-olds by the end of 2015, so there is still work to be done to consider how the rest of the country can be supported to ensure the delivery of evidence-based, outcomes-focused, and accessible services.

**Summary and Conclusions**

In summary, the CYP IAPT project offers a promising start to service transformation to develop reflective collaborative services that offer children, young people and families increased access to EBPs across England. Further evaluation of the success of the project, including assessment of whether or not services can meet the KPIs after involvement with the project in the short, medium and long term, is desirable. The change so far has been made possible only through the commitment of key influential policymakers to improve the lives of children and young people with mental health problems. The project is ambitious and unique, but challenges remain. However, meeting those challenges is essential if we are to ensure that all children and young people have access to EBPs in an accessible, client-centered service that meets their individual needs.

## Acknowledgements

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**Figure 1: CYP IAPT Core Implementation Components**

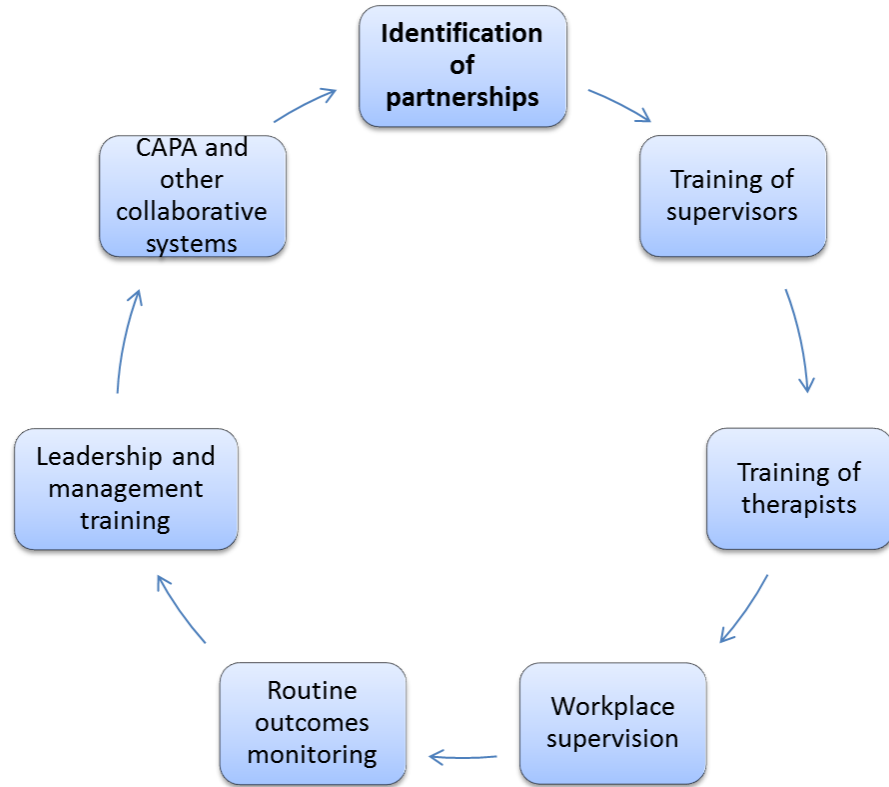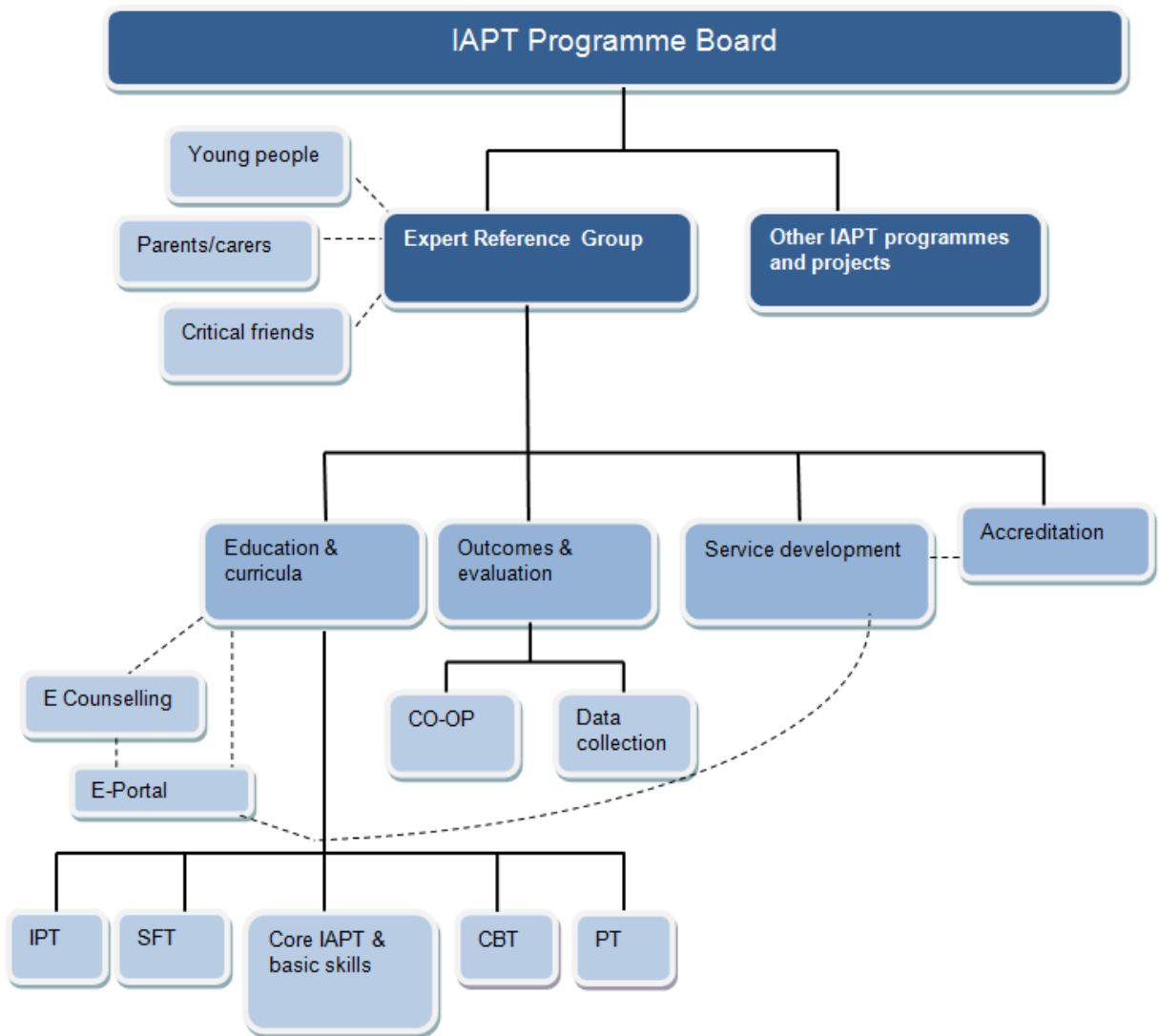(CAPA=Choice and Partnership Approach; Kingsbury & York, 2009)

**Figure 2: The Governance Structure of CYP IAPT**



CO-OP = Children and Young People's Improving Access to Psychological Therapies

Outcomes Oriented Practice

IPT = Interpersonal Psychotherapy

SFT = Schema Focused Therapy

PT = Parent Training

CBT = Cognitive Behavior Therapy