Children’s & Young Person’s IAPT Direction of Travel

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Foundations

- The commitment to a CYP IAPT development builds on much foundation work
- In particular Lord Richard Layard, together with representatives of CAMHS stakeholders and DH officials
- This has highlighted the importance of both learning from the adult IAPT &
- The Need for a CYP specific development, not simply a ‘smaller’ version of the adult IAPT

Why CYP IAPT Specificity?

- Services Are Different
  - CYP want different services
    - Far fewer in patient beds
    - CYP specific skill sets, developmentally sensitive, and multi-systems focused
    - CYP psycho-social context is very different, school, family, care
    - So, engagement and forums of delivery are different
  - Developmental Psychopathology
    - CYP are different from adults
      - Developmental psychopathology (see next slide)
      - With a separate evidence base, that cannot simply be read across from adult evidence base
A Life-Course Perspective: Children and Young People

- Developmental Psychopathology:
  - Change in symptom trajectories across time and development
  - Effects of development on symptom evolution and expression
  - Effects of symptoms on developmental trajectories
  - Systemic thinking driven by Family & Social complexity
- Driven by child development, socio-emotional, cognitive & affective development, attachment, neurodevelopment, genetics etc.

A Life-Course Perspective: Children and Young People

- Symptoms and disorders in CAMHS vary
  - Clear cut presentations
  - Disorders in evolution
  - Early forms of disorders with continuity to adult disorder
- Which can make identification challenging and,
- Means that services tend to include a wider range of presentations (than traditional adult services)

Compelling Case For Effective Evidence Based Interventions in CYP

- ‘Early intervention’
  - 50% of all adult disorders by age 26 are present by age 15 yrs
  - 73.9% by age 18 years
Age at first diagnosis of any disorder among persons meeting criteria for 17 DSM-IV mental disorders at 26 years of age


What Are the Long Term Consequences?

- Longitudinal population follow up studies illustrates this very well
- Based on the 1946 British Birth Cohort Survey

The British 1946 Birth Cohort

- Sample of 5,362 babies born in one week March 1946
- Prospective information on development from 6 weeks
- 12 contacts up to age 16, 9 up to age 63, more planned
Colman et al 2004, 2009 analysis of the British Birth Cohort

3 groups based on worst 6% of adolescent internalizing symptoms:

- Mental disorder at both age 13 and 15 (repeated disorder, n=46)
- One episode of mental disorder at age 13 or 15 (single episode disorder, n=277)
- No mental disorder (no disorder, n=3,002)

![Table](#)

**Associations between adolescent cases of CMD & mental health in adulthood in the British 1946 birth cohort**

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>Adolescent Non-cases (%)</th>
<th>Adolescent Episodic Cases (%)</th>
<th>Adolescent Persistent Cases (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>30.2%</td>
<td>12.1%</td>
<td>28.8%</td>
</tr>
<tr>
<td>36</td>
<td>5.2%</td>
<td>11.1%</td>
<td>27.6%</td>
</tr>
<tr>
<td>43</td>
<td>6.0%</td>
<td>3.3%</td>
<td>28.2%</td>
</tr>
</tbody>
</table>

**Episodic vs. non-cases (OR (95% CI))**

<table>
<thead>
<tr>
<th>Age</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>2.51 (1.46, 4.31)</td>
</tr>
<tr>
<td>36</td>
<td>1.60 (0.98, 2.68)</td>
</tr>
<tr>
<td>43</td>
<td>2.04 (1.14, 3.65)</td>
</tr>
</tbody>
</table>

**Persistent vs. non-cases (OR (95% CI))**

<table>
<thead>
<tr>
<th>Age</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>7.64 (3.27, 17.83)</td>
</tr>
<tr>
<td>36</td>
<td>4.52 (2.82, 7.15)</td>
</tr>
<tr>
<td>43</td>
<td>3.95 (1.68, 9.21)</td>
</tr>
</tbody>
</table>

Colman et al. 2004

Repeated Adolescent Mental Disorder & Adult Outcomes

- 3 to 10 times more likely to have adult mental disorder, after adjusting for many possible confounding factors
- 4 to 10 times more likely to undergo psychiatric treatment in adulthood, after adjustment
- These effects last long into adult life
What Difference Can We Make?

- To Adult Outcomes

Attributable Fractions for the Population

The proportion of disorder that would be removed if the prior diagnosis were removed (AFPs)

- Adjusting for gender
  - 26% for adult anxiety
  - 23% for adult depression
  - 24% for adult substance use disorder
  - 32% for adult mania
  - 46% for adult eating disorder
  - 25% for adult schizophreniform disorder
  - 41% for adult antisocial personality disorder.

- Removed or prevented not a great concept, but "treatment" could reduce the later burden of mental ill-health
- Conduct disorder & anxiety outcomes are broad and need attention
  - Effective (Nice Approved) Interventions exist

Courtesy of Professor Peter Jones

What Difference Can We Make to CYP?
Effectiveness of Psychotherapies in CAMHS

- Meta-analysis by Prof John Weisz: Harvard USA
- NOTE: this data is talking treatments only
- Does not include medications
What Happens If we Apply Non Evidence Based Practice

- May be called ‘Usual Care’ in studies
- Where usual care has some or all of the following characteristics

Characteristics of such ‘Usual Care’

- Unstructured listening and empathic reflection
- Building a warm relationship
- Being flexible and spontaneous
- Being supportive and encouraging
- Being eclectic and using multiple methods
- But generally lacking a focus, structure and without formulation or systematised user informed outcome feedback

Effectiveness of such care in CAMHS

- Clinical trials on such care show very little effect above placebo/spontaneous recovery ES 0.03 (above placebo and spontaneous recovery)
- More sessions of such care do not improve outcomes
- Combining several forms of such care in systems does not improve outcome
- In parenting interventions can be harmful (Scott et al.)
Some Benefits of Such Usual Care

- That is not to deny the importance of elements of such care in relationship building to
- Enable the delivery of effective care
- But this should not be confused with effective treatment
Why Evidence Based Practice Is Important in Treatments

- Research based on clinical trials shows
  - Substantial benefit with medium to large effect sizes
  - Benefits of similar magnitude to adult psychotherapies
  - Specific to treated problems
  - Maintained at 6 months FU

So What Is It About Evidence Based Interventions That Works?

Evidence Based Treatments Characteristics (J. Weisz, 2005)

- Work with CYP & parents/carers to identify the problems & set goals
- Measure progress towards goals
- Build specific coping skills through practice
- Give specific tasks, homework
- Structured, protocol based and goal orientated (usually manualised)
- Derived from interplay of research and clinic treatments
So What Does This Mean For The CYP IAPT Programme?

- Take account of input and views of CYP
- Learning from the implementation of the Children’s NSF (2004)
- Incorporate the implications of the evidence

A Formula For Effective Client informed Services

- Outcomes & supporting evidence focussed practice
- Structured Clinical Care (NICE Guideline & DH Guidance on managing Risk, 2007)
- Built around careful case formulation
- A Bio-Psycho-social approach
- Whole Systems approach
- With additional Specialised treatments built upon these foundations

A Formula For Effective Services II

- Stretching across the care pathways
  - Staff capable of teaching, training, liaising and consulting
  - To staff across the pathway
  - Collaborative, seamlessness, using modern technology to assist
  - Clinically and cost effective services
Looking Forward….User Informed

- **Up-skilling** existing staff and perhaps some capacity building (NICE approved and Best Evidence Based Practice Interventions)
- **Up-rating existing service structures and processes** (Outcomes focussed, day to day clinical process outcomes and PROMS informed)
- **Embedding evidence based practice** in day to day delivery (continuity beyond training)
- **In a whole care pathway collaborative continuous learning cycle** (maximise impact)
- **Adapted to local differences** in need and existing service levels (local sensitivity)

Next Steps

- We are at an early stage of development
- The DH will be listening and taking back messages from this meeting & a subsequent meeting organised by the BPS/RCPsych later this month
- To further inform the development process
- With a view to establishing an expert reference group to guide the development of programme in the new year

Contact

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