Oxford Guide to
Brief and low intensity interventions for children and young people

Sophie D. Bennett, Pamela Myles-Hooton, Jessica L. Schleider and Roz Shafran

Cognitive Behavioural Therapy
Oxford Guide to Brief and Low Intensity Interventions for Children and Young People
OXFORD GUIDES IN
COGNITIVE BEHAVIOURAL THERAPY

Oxford Guide to the Treatment of Mental Contamination
Rachman, Coughtrey, Shafran, and Radomsky

Oxford Guide to Low Intensity CBT Interventions
Bennett-Levy, Richards, Farrand, Christensen, Griffiths, Kavanagh, Klein, Lau, Proudfoot, Ritterband, White, and Williams

Oxford Guide to Surviving as a CBT Therapist
Mueller, Kennerley, McManus, and Westbrook

Oxford Guide to Metaphors in CBT
Stott, Mansell, Salkovskis, Lavender, and Cartwright-Hatton
We would like to dedicate this book to our patients, family, friends and colleagues who have supported and inspired us throughout our careers.
Preface

Millions of children across the world will experience mental health difficulties. If it were your child, what would you want for them? Access to early treatment with therapies that have been shown to work? Treatment delivered in a way that suited your child and that minimized disruption to your child’s life at school and at home, the lives of your other children, and your own commitments at work or home? You almost certainly would not want to be told your child can’t access support for several months or years, or that their difficulties are ‘too mild’ and to wait until a more serious problem develops.

Yet many families across the world are in precisely this situation—unable to access evidence-based support and frequently facing extensive waiting lists for children and young people’s mental health services, which are increasingly overstretched. Brief and low intensity (LI) interventions are one way to increase access to essential evidence-based therapies and are now recommended by several national guidelines as first-line interventions for many mental health difficulties. The purpose of this book is to provide a comprehensive resource for therapists, services, and clinical training providers regarding the use, delivery, and implementation of brief and LI evidence-based psychological interventions for children and young people. We define children and young people broadly as under 18s, but we did not want to constrain chapter authors as many agencies consider young people to be up to 25 years old. Chapter authors may refer to children, adolescents, young people, and youth, and define their own terms within their chapters. Similarly, brief and LI evidence-based interventions are not easy to define and Chapter 1 discusses this issue in more depth.

In the UK, there are new workforces trained specifically in such interventions—‘children’s well-being practitioners’ and ‘education mental health practitioners’. We have provided a practical focus throughout the book as a resource for these practitioners. However, many countries do not have practitioners trained specifically in LI approaches (e.g. the US) and this book provides an overview of how they may be implemented alongside traditional higher intensity therapies. The chapters are intended as concise overviews of topic areas to demonstrate the wide variety of difficulties and settings that LI approaches may cover. Each chapter includes recommended reading so that readers can investigate topics of interest in more depth.

The book is divided into four sections.

Section 1 provides an overview of brief and LI interventions: what it is (Chapter 1), why it is helpful (Chapter 2), the current evidence base (Chapter 3), its use in prevention/early interventions (Chapter 4), the health economic argument (i.e. cost-effectiveness) (Chapter 5), and recognizing and understanding the side effects (or
Section 2 is practically focused for practitioners, including case examples and relevant record and homework sheets. Section 2A details the common elements in LI interventions: assessment (Chapter 7), using routine outcome monitoring (Chapter 8), and implementing interventions with fidelity while maintaining flexibility to respond to clients’ needs (Chapter 9). Section 2B then considers problem-specific interventions, beginning with longer chapters for some of the most common mental health difficulties in children and young people, which are the focus of training for the new workforces in the UK: anxiety (Chapter 10), depression (Chapter 11), behavioural problems (Chapter 12), and sleep difficulties (Chapter 13). The chapters that follow also provide a practical overview of brief and LI interventions for obsessive–compulsive disorder (Chapter 14), autism (Chapter 15), Tourette syndrome and tic disorders (Chapter 16), chronic physical illness (Chapter 17), and psychosis (Chapter 18).

Section 3 considers what is needed from a service perspective, from supervision requirements and the practicalities of delivering supervision for brief and LI interventions (Chapter 19), to considerations about implementation in services (Chapter 20), and understanding current models of delivery (stepped care—Chapter 21, and an overview of the model in England—Chapter 22).

Finally, Section 4 looks to the future with chapters about exciting developments in the area: providing single sessions of interventions (Chapter 23), using computer games (Chapter 24), providing sessions ‘one at a time’ (Chapter 25), using peer support (Chapter 26), and using apps (Chapter 27) to deliver interventions. Finally, Chapter 28 considers how brief and LI interventions may be used to target transdiagnostic mechanisms.

There are not enough pages in one book to cover all of the advances in brief and LI interventions for children and young people but we hope that the book provides a snapshot of why and how LI interventions can play a role within children and young people’s mental health.

We want to make sure that all children and young people who have mental health difficulties are able to access treatment that works, when they need it, and in the way they want it. We want them to go on to live happy and fulfilled lives. We hope that this book inspires you to think about how brief and LI interventions may be one tool that can help achieve this.
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<td>Behavior and Feelings Survey</td>
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<td>BIP</td>
<td>Barninternetprojektet</td>
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<td>Camp-Cope-A-Lot</td>
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<td>coronavirus 2019</td>
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<td>EBP</td>
<td>evidence-based practice</td>
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<td>exposure and response prevention</td>
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<td>GBO</td>
<td>Goals-Based Outcome</td>
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<td>Helpful Aspects of Supervision Questionnaire</td>
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<td>habit reversal training</td>
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<td>Improving Access to Psychological Therapies</td>
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<td>Incredible Years</td>
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<td>LI</td>
<td>low intensity</td>
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<td>MATCH</td>
<td>Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems</td>
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<td>mobile health</td>
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<td>mental health support team</td>
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<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<td>OAAT'T</td>
<td>one-at-a-time therapy</td>
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<td>OCD</td>
<td>obsessive–compulsive disorder</td>
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<td>ODD</td>
<td>oppositional defiant disorder</td>
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<td>QALY</td>
<td>quality-adjusted life year</td>
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<td>RCADS</td>
<td>Revised Child and Adolescent Anxiety and Depression Scales</td>
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<td>RCT</td>
<td>randomized controlled trial</td>
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<td>REM</td>
<td>rapid eye movement</td>
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<td>ROM</td>
<td>routine outcome measure</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
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<tr>
<td>SF-6D</td>
<td>Short-Form Six Dimensions</td>
</tr>
<tr>
<td>SPARX</td>
<td>Smart, Positive, Active, Realistic, X-factor thoughts</td>
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<tr>
<td>STIC</td>
<td>Show That I Can</td>
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<tr>
<td>TDI</td>
<td>technologically delivered intervention</td>
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<tr>
<td>TPA</td>
<td>Top Problems Assessment</td>
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<tr>
<td>YGTSS</td>
<td>Yale Global Tic Severity Scale</td>
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<tr>
<td>ZPD</td>
<td>zone of proximal development</td>
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</tbody>
</table>
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SECTION 1
AN OVERVIEW
1

Brief and low intensity cognitive behavioural therapy for children and young people

Definitions and applications

Pamela Myles-Hooton

Learning objectives

- To describe the prevalence of mental health problems in children and young people.
- To understand the historical context and current need for low intensity cognitive behavioural therapy.
- To appreciate the complexities of diversity applications of interventions under the umbrella term ‘brief cognitive behavioural therapy.’
- To understand the importance of reaching a consensus of low intensity cognitive behavioural therapy for research and clinical purposes.

Introduction

Low intensity cognitive behavioural therapy (LICBT) is a relatively new approach to delivering evidence-based psychological interventions for adults presenting with common mental health problems, and an even newer approach for working with children and young people. Over recent years, empirically validated LI psychological treatments for children and young people have started to emerge.

In this book, readers will learn about a myriad of applications of LICBT for children and young people, including LICBT approaches using diverse delivery methods (online, face-to-face, bibliotherapy, and telehealth) and targeting widely varying clinical problems (from depression and anxiety to behavioural problems and autism spectrum disorder). In many respects, the potential utility of LICBT for children and young people appears endless, but to date, information about these LI supports has not been collated into a single source.

A key reason for producing this Oxford Guide to Brief and Low Intensity Interventions for Children and Young People is to do just that: to create a go-to guide
for providing efficient, brief, and effective treatment to children and young people with mental health needs. The interventions described in the upcoming chapters are diverse in form and function, yet all are evidence-based treatments intentionally designed to help broaden the accessibility of appropriate supports to young people and their carers. By consolidating information on the delivery of LICBT, this book may support more therapists in providing such services thus broadening the availability of LI support to far more children and young people than traditional, longer-term CBT could accommodate.

There has been an increase in research into the effectiveness of these more cost-effective approaches over the past 40 years. Rather than practitioners needing to have completed many years of training to deliver evidence-based approaches, there has been a shift towards briefer, more targeted training in specific interventions across a wide range of mental health professionals from varied backgrounds. Over the decades, there has been significant development of self-help books and online materials based on the principles of CBT. There has been a gradual move towards using remote communication technologies for therapeutic contact which exploded with the arrival of COVID-19 which rendered face-to-face interaction inaccessible for a significant period of time. There has also been a societal shift towards ‘democratizing’ CBT to make its core concepts more available to higher numbers of people than was previously the case.

In children and young people’s mental health services, LICBT is relatively new to the scene. Readers will learn of the many applications of LICBT for children and young people experiencing mental health problems. Some of these applications are well established and have been embraced by the children and young people’s mental health programme in England while others show promise through emerging research. The aim of this book is to provide readers with working, actionable knowledge of a broad range of interventions from the established and emerging evidence base.

**Mental health problems in children and young people**

Although the majority of children grow up psychologically well, surveys indicate that more children and young people experience problems with their mental health than was the case 40+ years ago. This may be down to the way we live now compared to several decades ago and how this impacts children’s experience of growing up. Rates of mental health problems in children and young people in the UK rose over the period from 1974 to 1999, particularly conduct and emotional disorders (Collishaw, Maughan, Goodman, & Pickles, 2004). More recent surveys indicate that emotional disorders have become more common in 5- to 15-year-olds: up from 4.3% in 1999 and 3.9% in 2004, to 5.8% by 2017 in the UK. The increase since 2004 in emotional disorders is evident in both boys and girls (NHS Digital, 2018).
The survey published by NHS Digital found that 1 in 12 (8.1%) 5- to 19-year-olds had an emotional disorder, with rates higher in girls (10.0%) than boys (6.2%). Anxiety disorders (7.2%) were more common than depressive disorders (2.1%). Approximately 1 in 20 (4.6%) 5- to 19-year-olds had a behavioural disorder, with rates higher in boys (5.8%) than girls (3.4%). A follow-up survey (Health and Social Care Information Centre, 2020) indicated that the incidence of probable mental health disorder at any given time has increased from one in nine (10.8%) to one in six (16%) in children aged 5–16 years.

In children, mental health disorders have a damaging effect on individual and socioeconomic factors and can have a significant negative impact on healthy transition into adulthood. Approximately 50% of mental illness in adulthood (excluding dementia) starts before the age of 15 and 75% by age 18 (The Dunedin Study, n.d.).

The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme commissioned by Health Education England has played a leading role in improving access to psychological treatments through workforce development since it began in 2011. In recent years, ‘CYP-IAPT’ has been formally disbanded and transitioned into an expected standard of delivery of Children and Young People's Mental Health (CYP MH) services. Despite promising evidence of the programme’s many benefits, significant wait times remained and since 2017 the programme changed its aim from workforce transformation to workforce expansion, with the aim of training 1700 new psychological practitioners by 2021. There are now three training streams (1) a LI workforce (children's well-being practitioners), (2) an education-based workforce (education mental health practitioners, and (3) a high intensity workforce (based on the original curriculum which includes training in CBT, systemic family therapy, interpersonal therapy for depression in adolescents, and evidence-based parent training). As a result, practitioners in children and young people's services are increasingly being trained in the delivery of a range of LI interventions to help target mild-to-moderate anxiety, depression, and conduct problems. For more details on the children and young people's mental health training initiative commissioned by Health Education England, see Chapter 22.

**Historical context**

The concept of LICBT has grown in importance over the past decade in response to the need to provide efficient, effective interventions that can meet the growing demand for mental health treatment. Such interventions are at the heart of the adult IAPT programme in England (Clark, 2018) and to the transformation of children and young people's mental health services in England (Shafran, Fonagy, Pugh, & Myles, 2014), but are also central to addressing the global need to access effective interventions across the age range and contexts (Michelson et al., 2020). In England, due partly to the IAPT programme's structure, such interventions are frequently the first level of intervention provided to adults with depression and specific forms of
anxiety who are then ‘stepped up’ to a higher ‘dose’ of treatment if there is an insufficient response to LI interventions. LI interventions are designed to require less therapeutic input than conventional treatment and therefore considered ‘LI’ from the provider’s perspective. Such treatments were building on a pre-existing, established evidence base of brief CBT interventions, such as four sessions of problem-solving for emotional disorders provided over 6 weeks in primary care (Catalan et al., 1991), self-help interventions for anxiety and depression (Marks et al., 2003), and abbreviated versions of full CBT protocols (Cape, Whittington, Buszewicz, Wallace, & Underwood, 2010; Clark et al., 1999). In this programme, high intensity therapy refers to traditional CBT delivered by a qualified mental health practitioner, face-to-face, typically weekly for 12–20 sessions.

**LICBT: the concept and definition**

There is some confusion in the terminology used to describe different forms of CBT, in particular LICBT. Such confusion has implications for research, clinical practice, and service organization. Shafran, Myles-Hooton, Bennett, and Ost (2021) aimed to describe the key components of LICBT in comparison to brief traditional high intensity CBT. The authors proposed that LICBT (1) utilizes self-help materials, (2) is 6 hours or less of contact time with each contact being typically 30 minutes or less, and (3) any input (i.e. support or guidance) can be provided by trained practitioners or supporters. These components distinguish the intervention from brief traditional high intensity CBT which (1) is based on the standard evidence-based CBT treatment, with therapy contact time 50% or less than the full CBT intervention; and (2) is usually delivered by someone with a core mental health professional qualification or equivalent. Brief CBT can refer to either LICBT and/or brief high intensity CBT. The authors aimed to make the distinction between these different forms of intervention to stimulate debate and help consistent and appropriate categorization for future research and practice.

Table 1.1 compares and contrasts the nature of brief high intensity CBT interventions with LICBT to clarify differences and pave the way for a consensus for clinical and research purposes. Bennett-Levy, Richards, Farrand, Christensen, and Griffiths (2010) considered the central components of LI interventions to comprise a reduction in time spent with patients, use of specifically trained practitioners, use of CBT resources whose content is ‘less intense’ such as self-help books, and improved access to early intervention and preventative CBT components. The ‘intensity’ of psychological treatments was considered only as ‘time to deliver’ in the meta-analysis of van Stratten, Hill, Richards, and Cuijpers (2014). The comparison in Table 1.1 draws heavily on previous definitions but is also integrated with descriptions from other sources and, where specified, research data.
Table 1.1 A comparison of LICBT and brief traditional high intensity CBT

<table>
<thead>
<tr>
<th>LICBT</th>
<th>Brief traditional high intensity CBT</th>
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<tr>
<td><strong>Who delivers the intervention?</strong></td>
<td>Input is usually provided by mental health workers with a core professional qualification or equivalent (e.g. accredited CBT practitioners)</td>
</tr>
<tr>
<td>Any input is usually provided by practitioners or supporters who have been specifically trained to deliver the intervention. There is often no input (e.g. unguided self-help books, technology-based programmes)</td>
<td></td>
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<tr>
<td><strong>Who is it suitable for?</strong></td>
<td>Typically used widely for disorders where longer traditional CBT would be appropriate</td>
</tr>
<tr>
<td>Widely used to address anxiety and depression across the age range and behavioural problems in children (e.g., Bennett et al., 2019; Cuijpers, Donker, van Straten, Li, &amp; Andersson, 2010). Evidence supports its use for cases of all severity (Bower et al., 2013; Karyotaki et al., 2018). Typically not advocated where there are significant risk issues</td>
<td></td>
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<tr>
<td><strong>What is delivered?</strong></td>
<td>Intervention is an abbreviated version of full CBT, supplemented with provision of between-session materials and exercises</td>
</tr>
<tr>
<td>Interventions are based on the principles of generic CBT to enable individuals to learn specific techniques (e.g. graded exposure, cognitive restructuring, problem-solving) with the goal of alleviating emotional distress and improving functioning. Between-session reading and exercises are central</td>
<td></td>
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<tr>
<td><strong>Where— is it delivered?</strong></td>
<td>Traditionally provided face-to-face or via video facility and less often via email/text</td>
</tr>
<tr>
<td>When guidance is provided to support the self-help materials, it is typically done via telephone, face-to-face, video facility, email, texts, or online support/the internet</td>
<td></td>
</tr>
<tr>
<td><strong>When is it delivered?</strong></td>
<td>Can be first treatment intervention or, in countries with 'stepped care', provided after insufficient response to first treatment intervention and/or full therapy is indicated due to complexity such as suicidality</td>
</tr>
<tr>
<td>Typically as first treatment intervention</td>
<td></td>
</tr>
<tr>
<td><strong>Why is it delivered?</strong></td>
<td>Improving cost-effectiveness and aiming to provide appropriate 'dose' of intervention</td>
</tr>
<tr>
<td>To deliver least burdensome intervention, have high-volume caseloads with rapid turnover and meet demand; based on principles of clinical and cost-effectiveness and appropriate 'dose' of intervention</td>
<td></td>
</tr>
<tr>
<td><strong>How is it delivered?</strong></td>
<td>Between-session materials and exercises are advocated</td>
</tr>
<tr>
<td>A health technology such as self-help books or technology-based intervention is used</td>
<td></td>
</tr>
<tr>
<td><strong>How long is therapy?</strong></td>
<td>Therapy contact time is typically 50% or less than the full CBT intervention, usually delivered in 50–60-minute sessions</td>
</tr>
<tr>
<td>Any input is typically 6 hours or less of contact, often delivered in 20–30-minute sessions</td>
<td></td>
</tr>
<tr>
<td><strong>If not recovered, then what?</strong></td>
<td>Referral to full therapy or specialist service</td>
</tr>
<tr>
<td>Referral to brief or full high intensity therapy</td>
<td></td>
</tr>
</tbody>
</table>
Proposed definition of LICBT

Based on Table 1.1, Shafran et al (2022) proposed a definition of LICBT that (1) utilizes self-help materials, (2) is 6 hours or less of contact time with each contact being typically 30 minutes or less, and (3) any input (support or guidance) can be provided by trained practitioners or supporters. They suggested that brief high intensity CBT (1) be based on the standard evidence-based CBT treatment, with therapy contact time 50% or less than the full CBT intervention; and (2) is usually delivered by someone with a core mental health professional qualification or equivalent. Consequently, brief CBT can refer to either LICBT and/or brief high intensity CBT with therapy contact time 50% or less than the full CBT intervention but we recommend that a distinction is drawn between the different forms for clarity.

Chapter summary

Children and young people’s mental health services are being revolutionized in England. As with adult IAPT, it is hoped that many other countries will follow. Resources are not infinite but there is increasing global recognition of the evidence base for LI interventions that can significantly improve the mental well-being of children and young people at scale. LICBT provides the opportunity to improve access to mental health services, and to intervene early in an attempt to pre-empt mental health difficulties continuing into adulthood. As readers will find as they work their way through the book, many of these evidence-based interventions and new technologies offer an opportunity to widen access to counter anxiety, depression, and conduct problems in children and young people. Readers may be drawn to chapters that are immediately relevant to their area of work and may be inspired by other chapters with a focus on new developments in LICBT approaches. There is still no international agreement on what constitutes LICBT and some chapters may seem to fit more under the term brief CBT.

References


Low intensity therapy: a parent’s perspective

Lauran O’Neill

Learning objectives

• To understand what receiving a low intensity intervention may be like for a parent.
• To understand a parent’s view of the importance of providing low intensity interventions.
• To highlight the importance of clear goals and session-by-session measurement.

Introduction

My daughter is 8 years old, the eldest of two siblings, and has a physical illness for which she needed a procedure. She didn’t sleep very well because of anxiety, was picking her skin, and was very anxious about going into hospital. She was in social skills classes at school because she could be quite controlling with friends and she needed quite a lot of preparation for things. We were becoming increasingly frustrated with her because we didn’t know what was wrong and so she would get in trouble quite a lot. From our perspective, we gave her every opportunity and she was making a choice not to enjoy herself. We thought that she was being spoiled and rude. I felt constantly frustrated with her and disappointed that she wasn’t taking up opportunities or just having fun as a child, the way that a child should.

We completed a questionnaire about her emotions and behaviours when we came to the hospital for another appointment. The results said that she scored highly for anxiety. We always thought she wasn’t a particularly happy child but to actually have those concrete results was really interesting for us. We were offered six sessions of low intensity (LI) therapy, and I was over the moon with this. If someone had offered me two sessions with some helpful tips, I probably would have taken it too because private therapy is so expensive. For a National Health Service referral, the general practitioner needs to know so much detail and I don’t think my daughter would have met the thresholds for child and adolescent mental health services. There are such long waiting lists too. So being offered six sessions straight away felt like a luxury. We probably wouldn’t have done anything about the difficulties had it not been for this.
For me, six sessions were better than nothing and, at that point, we weren’t in the mental health system and we didn’t know whether six sessions was a short or long amount of therapy time.

**My experiences of LI intervention**

We had six face-to-face sessions of guided self-help in the hospital. One of the first things to change was my daughter’s sleep. At the start of therapy, all the lights had to be on and the doors open. I had to sit on my bed where she could see me from her bedroom and sometimes it would take her 4 hours to go off to sleep. That changed almost overnight, which changed our whole household. She talked about the fear she had and built a ladder with the scariest point at the top, which for her was to sleep in the dark in her room with the door closed. She was so motivated that she went faster than the therapist suggested. At points she was jumping three steps up and she was so excited by it. It was amazing. Within the space of 7 days, she went to sleep in a dark room, with the door closed, and was asleep within about 20 minutes. I think because we had such clear goals at the beginning, we knew what we were working towards and it was obvious that she had achieved the three targets. Having that final endpoint to work towards really helped.

**What is LI therapy like to experience as a parent?**

Even though it is called LI therapy, I still found it intensive because you dig deeply into things quite quickly. Within the first week we were talking about our family and the ways that we communicate with each other. For us, a family that’s normally quite private, it was very intimate and so it felt intense. You have to get behind it fully and you do have to invest fully in it—no one is there to fix your problems for you. There were tasks that were set each session and, particularly at the beginning, we were doing them every single night.

The fact that you’ve taken a step to talk to someone about your child means that you think about things more consciously. Rather than getting through every day and then just going to sleep and then getting through the next day, by stopping and appraising where you are and working out where you want to be, you can make a big change.

**What are the benefits of stepped care?**

My daughter had more therapy after the LI therapy, focused specifically on anxiety about a specific procedure in hospital. Having the LI therapy first helped because my daughter and I got used to talking about the difficulties and our family. It gives you
practice and you learn what to expect from therapy. You learn that you have very limited time in those meetings so it is really important to prepare beforehand. You also learn what the therapist wants you to talk about and that helps you to be more structured with what you are saying. Suddenly, when you stop and you explain your life to someone, you can actually do a lot of therapy yourself. You take a step back and see things you didn’t see before.

What would be helpful for LI therapists to know when they’re working with young people and families?

It is quite daunting to go into these situations and meet with people you’ve never met before. It’s a short space of time where you have to trust each other so quickly. I think it is important that families know they won’t be judged and the therapists know that parenting and life are stressful and that it’s okay that everything is not okay. Not loving every aspect of mothering doesn't mean you don’t love to be a mother.

It is also really important that therapists are clear at the beginning about what this therapy might be like. For example, that it will be 2 months of hard work and it will involve lots of you looking into how things are, which might be upsetting.

One of the most helpful things for us was setting really concrete goals, like sleeping with the door closed with the lights off. It meant my daughter always knew what she was aiming for.

Chapter summary

I think the mindset of many schools and mental health services is that children have to be very poorly before they get any input for emotional or behavioural problems. If they don't meet a certain threshold for symptoms, you’re told from the offset there's nothing for you. It’s crazy that you have to reach such a damaging level before you can access help. Having LI therapy as a preventative or first step is really important. We heard all the time that our daughter was ‘good as gold, just quiet in the corner’. Six weeks of LI therapy gave us the strategies to help her anxiety, and through this we learnt that she had symptoms of autism. She then had an autism assessment and now she’ll get more resources and help. It all started with 6 weeks of LI therapy and that's brought our family so many benefits.
Efficacy of low intensity interventions for mental health problems in children and young people

The evidence

Sophie D. Bennett

Learning objectives

• To understand the current state of the evidence for low intensity interventions in children and young people.
• To be aware of the limitations of the current evidence base.
• To consider who low intensity interventions may be suitable for according to research evidence.

Introduction

There is an increasing evidence base for the use of low intensity (LI) interventions in children and young people. A meta-analysis, pulling together the results of existing studies of self-help for children and young people (Bennett et al., 2019), found that self-help (both guided and unguided) was associated with significant medium-to-large effects on symptoms of anxiety, depression, and disruptive behaviour in children and young people. Larger effect sizes indicate bigger differences between groups, so a medium-to-large effect size suggests that there is a ‘medium-to-large sized’ difference between scores for the LI intervention groups and the control groups. This suggests that the LI intervention works better than the control intervention. This chapter considers the results of the 50 studies included in this meta-analysis. ‘Self-help’ is used to mean both clinician-guided and self-guided (or ‘unguided’) interventions.

Results from meta-analysis of self-help

LI therapies were significantly more effective than no intervention and slightly less effective than traditional higher intensity treatments such as standard face-to-face
treatment. In addition, the overall effect size for self-help in comparison to alternative treatments was very small and corresponded to a 'number needed to treat' of ten. This means that ten patients would have to be treated with standard higher intensity face-to-face treatments for one patient to have better outcomes from higher intensity treatments compared to a LI self-help treatment. This difference is very small, especially when the costs of each intervention are considered; many more patients can feasibly be treated with LI treatments compared to standard treatments. The review also found that families were happy with the content and outcomes of the LI treatments.

These potential findings of near equivalence for LI therapies compared to higher intensity interventions are in agreement with a number of previous reviews across mental health disorders in adults. Some have found that the interventions have comparable effect sizes (Cuijpers, Donker, van Straten, Li, & Andersson, 2010; Perkins, Murphy, Schmidt, & Williams, 2009; Priemer & Talbot, 2013). Other reviews have found that although LI interventions are more effective than no intervention, they may be less effective than traditional higher intensity face-to-face therapy (Hirai & Clum, 2006; Mayo-Wilson & Montgomery, 2013).

Considering the different diagnoses or difficulties, an overall medium effect size was found for the 12 depression studies that compared self-help against an inactive control group such as a waiting list. There was a medium-to-large overall effect size for 13 anxiety studies comparing against an inactive control group; all but one of the anxiety studies included children who met full diagnostic criteria and all but one included guidance. The 16 interventions focused on disruptive behaviour demonstrated an overall medium effect size, although the effect was not significant when only studies with low risk of bias (i.e. studies conducted in a way that minimized bias and increased the validity of the results) were considered.

These findings, coupled with ease of accessibility, particularly for communities living a distance from a clinic, suggest that self-help could be a viable option for treatment for common childhood mental health disorders. Given the review found that LI interventions were statistically slightly less efficacious than higher intensity interventions, self-help may be particularly useful if used in a stepped care model where those who do not respond are then offered face-to-face treatment. This could (1) prevent overtreatment for children and young people who might benefit from LI support and (2) reduce waiting times for others by reserving high intensity interventions for those who do not benefit from LI interventions (see Chapter 21).

What characteristics of interventions might work best?

Overall, in studies comparing self-help against control groups, the presence of guidance was associated with better outcome. This finding was significant when disruptive behaviour interventions were considered alone. The same pattern was true in
depression studies but the result was not significant. As almost all anxiety studies included guidance, it is not possible to assess whether this is true for anxiety interventions. This overall result is consistent with findings of many reviews of self-help that demonstrate superior effect sizes for greater amounts of therapist contact (e.g. Gellatly et al., 2007—a review of self-help for depression; Lewis, Pearce, & Bisson, 2012—a review of self-help for anxiety disorders; O’Brien & Daley, 2011—self-help for childhood behaviour disorders; Pearcy, Anderson, Egan, & Rees, 2016—a review of self-help for obsessive–compulsive disorder; van Boeijen et al., 2005—self-help for anxiety). Previous research has indicated that increased therapist contact may also be associated with improved acceptability of the intervention (O’Brien & Daly, 2011) and there was some support for this from the 50 studies included in the review. The non-significant difference between studies of the treatment of depression with and without guidance may warrant further investigation. Previous reviews have suggested that the level of therapist contact required may vary according to diagnosis (Newman, Erickson, Przeworski, & Dzus, 2003). It may also vary according to the format of interventions; self-guided single-session treatments show promise (Schleider & Weisz, 2017; see Chapter 23).

Other reviews of the type, rather than amount, of therapist contact suggest that while some therapist contact is important, this does not need to be in the form of ‘guidance’; ‘non-guidance’ contact, such as emails to encourage treatment adherence, are also effective (Talbot, 2012). Many studies were not clear regarding the amount of therapeutic ‘guidance’ versus non-therapeutic ‘encouragement’ given and so this was not analysed within our review. However, the meta-analysis did not find any effect of the format of guidance given (i.e. telephone calls, face-to-face, email, or mixed guidance), or of the amount of training of the therapists. There was some evidence for greater effect sizes for computerized interventions compared to bibliotherapy or other types of self-help. However, heterogeneity was high for many of the comparisons. Heterogeneity is a measure of how varied the outcomes of different studies are; high heterogeneity means that the results of the different studies that have been analysed together are very different to each other. This means that the findings from some of these analyses may not be reliable.

Who is it suitable for?

Few patient characteristics appeared to make significant differences to the effect size of self-help. There was a significant effect of age on effect size for the studies comparing against face-to-face treatment, with studies of older children and young people demonstrating greater effect sizes than those of younger children (i.e. self-help appeared to be more effective in older children compared to younger children). Importantly, as in adult studies (Karyotaki et al., 2018), there was no evidence that interventions were only effective in those with mild–moderate difficulties, despite evidence-based guidance commonly only recommending them for this group.
What are the gaps in the literature?

There were relatively few studies with low risk of bias and most studies were relatively small. It is therefore possible that studies were simply not big enough to detect differences between self-help and face-to-face treatments. In addition, there was significant publication bias indicating that studies that did not find self-help worked better than an inactive control may not have been published. Publication bias is often found in studies of psychological interventions (Driessen, Hollon, Bockting, Cuijpers, & Turner, 2015) and may have led to an overestimation of the effect of self-help against control groups.

Overall, additional studies are needed to compare guided self-help treatments against standard face-to-face treatments across anxiety, depression, and disruptive behaviour. Direct comparisons of different methods of self-help (e.g. bibliotherapy compared to computerized treatments) would be helpful. Further research investigating the use of self-help and guided self-help interventions in young people who are under-represented by the current research, such as those with intellectual and developmental disabilities and those from low- and middle-income countries, is warranted. The question regarding who LI interventions are suitable for remains unanswered. Individual patient meta-analyses, whereby the results from individual participants in studies are analysed rather than groups of participants, would help us understand whether LI interventions are only suitable for mild–moderate difficulties, or whether they could be used for more severe symptoms. Research into personalization, investigating exactly which patients benefit from which intensity therapies would be particularly useful. To date, there have been very few trials of stepped care (see Chapter 21), despite many guidelines recommending this model. Stepped care approaches across disorders need further investigation.

Finally, additional research is needed to investigate uptake of, and engagement with, self-help materials. In adults, reviews have found that this can vary significantly between trials. Routine collection of data from practice would support research into how these interventions can be integrated into routine care (see Chapter 8).

Chapter summary

- Self-help can increase access to therapy to meet a growing unmet need.
- Self-help is efficacious in treating common childhood mental health disorders.
- Guided self-help may be more efficacious than self-guided self-help, but this needs further research.
- Self-help interventions for this population may be slightly less effective than traditional higher intensity face-to-face treatments.
Recommended reading


References


