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# Pragmatic implementation of low-intensity psychological treatment for children and young people: the reality

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## Abstract

**Background and aims:** Low-intensity psychological interventions are effective for children and young people (CYP) with mental health difficulties and can help bridge the demand–capacity gap. Despite increasing awareness, training and use of low-intensity psychological interventions, it is not yet understood what is being implemented in clinical practice in the UK and the associated evidence base.

**Method:** This paper presents two studies; first, a national survey ( $n = 102$ ) of practitioners to identify low-intensity psychological interventions currently delivered in practice and second, an exploration of the availability and the strength of empirical support (characterised as ‘gold’, ‘silver’ and ‘bronze’) of low-intensity CBT interventions for CYP.

**Results:** The first study found a wide variety of interventions being used across different services; 101/102 respondents reported using routine outcome measures. The second study identified 44 different low-intensity interventions, 28 of which were rated as having gold empirical support. However, only 13 of the gold interventions were considered accessible for practitioners and only two were reported being used in routine practice.

**Conclusion:** These findings highlight that these interventions have been developed and empirically tested, but many are not easily accessible, highlighting the ‘research–practice’ gap in the provision of low-intensity interventions. There is a need for an increase in standardisation of care and accessibility of gold interventions. This paper hopes to begin the process of creating a hub of low-intensity interventions that are accessible and empirically supported to improve equity of access and outcomes of low-intensity psychological interventions for CYP.

**Keywords:** anxiety; behavioural difficulties; depression; guided self-help; implementation; low-intensity; routine outcome measures

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## Introduction

Half of mental health disorders develop by the age of 14 years old (Kessler *et al.*, 2005) and around 18% of children and 22% of young people are living with a mental health condition in the UK (Newlove-Delgado *et al.*, 2022). This said, only a small percentage of children and young people in need receive evidence-based psychological interventions (Reardon *et al.*, 2020). Low-intensity CBT can help to bridge the demand–capacity gap. Low-intensity CBT has been defined as utilising self-help materials, with six hours or less of contact time, with each contact typically 30 minutes or less, where input can be provided by trained practitioners or supporters (Shafran *et al.*, 2021). It is recommended by the National Institute for Health and Clinical Excellence (NICE) as a first-line treatment for common mental health disorders in adults and young people.

In 2007, the UK government launched Improving Access to Psychological Therapies (IAPT) (now known as Talking Therapies) in line with recommendations from NICE (Department of Health, 2018). A new workforce of practitioners was trained to deliver low-intensity CBT interventions to adults, and specific training was later launched for practitioners working with children and young people in 2017. Low-intensity psychological interventions are a central part of Talking Therapies and practitioners follow a national curriculum that is taught by university courses, which includes techniques that are contained within NICE-recommended treatments such as graded exposure for anxiety disorders and behavioural activation for low mood (e.g. Higher Education England, *n.d.*; NHS England, 2023). Some materials are freely available, whereas others are not (e.g. cost money, require passwords or only available in specific locations). Talking Therapies training courses have also developed and taught interventions for areas where there are evidence gaps. Together, this has resulted in variation in the interventions and materials used by the low-intensity workforce in the UK and lack of standardisation.

A recent special issue of *tCBT* (2023) raised important questions about the use of low-intensity CBT in routine clinical practice (Lockhart, 2021) as well as the need to ensure that free to use and accessible guided self-help materials are available and evidence-based (Farrand *et al.*, 2022). Frameworks have been developed to help provide guidance to practitioners on the use of certain materials (e.g. Baguley *et al.*, 2010; Farrand *et al.*, 2022). However, at present, these only include interventions for adults delivered by Psychological Wellbeing Practitioners (PWP). Children's Wellbeing Practitioner (CWP) and Education Mental Health Practitioner (EMHP) roles were created at a later date to deliver low-intensity CBT interventions for children and young people with mental health difficulties (Fonagy *et al.*, 2017). To our knowledge, no framework yet exists to guide this workforce and it is currently not known which low-intensity psychological interventions are provided in routine clinical practice or the empirical support underlying them. Such information is essential to ensure optimal quality of care and equality of access to empirically supported interventions.

The aims of this paper are (1) to explore the current implementation of low-intensity psychological interventions used in routine practice for children and young people across the UK and (2) to support the implementation of evidence-based low-intensity CBT in clinical practice by providing information on (a) the availability and (b) strength of empirical support for low-intensity CBT interventions for children and young people with anxiety, depression and behavioural difficulties.

## Study 1

Given there are a wide range of potential treatments and guided self-help materials that can be used as low-intensity psychological interventions for children and young people (Lewis and Simons, 2011), it is helpful to understand which ones are being used in routine clinical practice. The study aimed to understand and characterise the low-intensity psychological interventions for children and young people that are currently being delivered by practitioners across the UK.

## Study 1: Method

### Participants

Practitioners delivering low-intensity psychological interventions and guided self-help to children, young people and families in the UK were invited to complete an online questionnaire.

A questionnaire based on a previous survey of interventions given by psychological services in a paediatric hospital during the pandemic (Ching *et al.*, 2022) was developed by the research team and clinical team leads through iterative discussion. The anonymous online questionnaire included structured and open-ended questions that were used to gather rich insight into respondents' diverse perspectives and experiences of providing low-intensity interventions to children and young people. The final version was hosted on Redcap (see Appendix A in the Supplementary material).

The questionnaire collected demographic information about where participants worked, their profession and speciality. The next section used a branching structure where respondents were first asked whether they delivered any brief or low-intensity interventions (and were given the example of guided self-help books or a single psychoeducation session) and then given space to describe the intervention in an open text box. Prompts were included, asking respondents who the intervention(s) are for, their aim, who delivers them, if they are based on any manual or protocol, and how often they are delivered. There were then tick boxes for respondents to indicate who the intervention was for, what the intervention was for, who delivered the intervention, how the sessions were delivered, how many sessions in total, how often the intervention was delivered and the length of sessions. For all questions, more information could be provided in open text boxes and there was space to describe multiple interventions. The final section of the survey asked about outcome measures. Participants were asked whether they used standardised outcomes measures, to list the measures commonly used, when they were administered and space was given to provide more information in an open-text box.

### Procedure

A flyer was designed and sent out to promote the study which linked potential participants to the online questionnaire. The flyer and questionnaire were shared between 1 February and 31 March 2023 with relevant online networks and newsletters (The Psychological Professions Network, BABCP Low-Intensity Special Interest Group, British Psychological Society, Paediatric Psychology Network) and shared on social media (Facebook Groups, LinkedIn, Twitter).

### Data analysis

Descriptive and frequency statistics were calculated for the responses.

## Study 1: Results

### Participant characteristics

The questionnaire was completed by 102 participants and the characteristics of the respondents are shown in Table 1; 55.8% of respondents were EMHPs and CWP. Roles categorised as 'other' included: Associate Psychological Practitioner, CWP Managers and Systemic Practitioners, High-Intensity CBT Therapist (HICBT) for children and young people and CWP Supervisor, Child and Adolescent Psychotherapist, Trainee Family Therapist and EMHP Supervisor. The majority of respondents left their specialty blank or indicated their speciality to be 'low-intensity CBT' or 'early intervention' which is denoted by the 'other' category. The majority of respondents worked in schools or CAMHS.

**Table 1.** Participant characteristics

Categories	Frequency	Percentage
<b>Role (<i>n</i> = 102)</b>		
Education Mental Health Practitioner	57	55.8
Children's Wellbeing Practitioner	30	29.4
Clinical Psychologist	2	1.9
Assistant Psychologist	5	4.9
Other	8	7.8
<b>Location (<i>n</i> = 102)</b>		
Southwest England	21	20.6
Greater London	16	15.7
Northwest England	16	15.7
Southeast England	15	14.7
East of England	12	11.8
Yorkshire and Humber	11	10.8
East Midlands	6	5.9
Northeast England	3	2.9
West Midlands	2	2.0
<b>Specialty (<i>n</i> = 102)</b>		
School-based	25	24.5
CAMHS	13	12.7
Social care	3	2.9
Community paediatrics	2	2.0
Other	23	22.5
No response – unknown	36	35.2

### *Intervention delivery and use of routine outcome measures*

Respondents reported on the interventions they delivered and the use of routine outcome measures. Data are presented in Table 2 on the recipient of the intervention and which mental health difficulty the intervention targets.

Interventions for primary school aged children were often delivered to parents or carers in line with NICE recommendations (parent-led low-intensity CBT). Of the 'other' respondents, who specified that they did not deliver the intervention with children, young people or their parents directly, it was often indicated that interventions were delivered to school staff and/or the whole school.

Most interventions were delivered weekly, with only a small percentage of respondents using single-session interventions. Most sessions lasted between 31 and 59 minutes and interventions had an average of 7.6 sessions.

All respondents except one (101/102) indicated that they used routine outcome measures. These were used during the first and last session for 70% of respondents, and session-by-session measures used for 72% of the sample. The most commonly reported outcome measures were the Revised Children's Anxiety and Depression Scale (RCADS), which was used by 94% of respondents, the Strengths and Difficulties Questionnaire (SDQ) used by 62% of sample, goal-based outcomes (GBOs) used by 52% and the Child Outcome Rating Scale (CORS), used by 53%. Other examples included specific symptom trackers such as the Generalised Anxiety Disorder Questionnaire (GAD-7) and Patient Health Questionnaire (PHQ-9). The Experience of Service Questionnaire was used by 18% of respondents.

### *Materials used*

When asked to describe the intervention, respondents provided titles of 21 materials used (see Table 3).

**Table 2.** Intervention delivery and routine outcome measures

Intervention details	Frequency
<b>Delivered with</b>	
Children only	24
Parents only	1
Both children and parents	70
Other family members	15
Other	8
<b>Mental health difficulty</b>	
Anxiety	91
Depression	87
Behavioural difficulties	70
Sleep difficulties	65
Coping strategies	83
<b>How many sessions (<i>n</i> = 88)</b>	Mean = 7.6 SD = 1.4
<b>Frequency of sessions (<i>n</i> = 96)</b>	
Single session	2
Weekly	89
<i>Ad hoc</i> sessions	3
Other	2
<b>Length of sessions (<i>n</i> = 96)</b>	
30 minutes or less	2
31–59 minutes	89
More than 1 hour	5
<b>Routine outcome measures (<i>n</i> = 101)</b>	
Used at baseline and follow-up	71
Session-by-session measures	73
<b>Specific measures*</b>	
RCADs	96
SDQ	63
ORS	54
GBO	53
ESQ	18
SRS	12
GAD-7	4
BPSES	4
PHQ9	2

\*This table reports on routine outcome measures mentioned by one or more participant.

RCADs, Revised Children's Anxiety and Depression Scale; SDQ, Strengths and Difficulties Questionnaire; ORS, Outcome Rating Scale; GBO, goals-based outcomes; ESQ, Experience of Service Questionnaire; SRS, Session Rating Scale; GAD-7, Generalised Anxiety Disorder Questionnaire; BPSES, Brief Parental Self Efficacy Scale; PHQ-9, Patient Health Questionnaire.

The majority of interventions named were for behavioural difficulties ( $n = 9$ ), followed by anxiety ( $n = 8$ ), depression ( $n = 2$ ) and other ( $n = 2$ ). Some respondents also listed specific techniques used such as graded exposure, thought challenging and psychoeducation. Although 65 respondents indicated that they delivered interventions for sleep difficulties, no specific manuals or techniques were specified, and it is not known if the interventions specifically targeted sleep. Similarly, 83 respondents delivered interventions for 'coping difficulties', but it was not possible to ascertain which interventions were delivered and whether they were targeting coping.

## Study 1: Discussion

The survey highlights the wide variation of low-intensity psychological interventions and guided self-help materials that are currently being delivered in practice by low-intensity practitioners to children and young people with anxiety, depression and behavioural difficulties in the UK.

Table 3. Materials used

	Title	Authors/organisation	Format	Practitioner time	How many times intervention was cited
<b>Child anxiety</b>					
1	Helping Your Child with Fears and Worries: A Self-Help Guide for Parents	Creswell and Willets (2019)	Book	Four face-to-face and two telephone contacts with parents over an 8-week period	22
2	Pesky gNATS	McCashin <i>et al.</i> (2022)	Computer	Practitioner uses the Pesky gNATS computer game in sessions (approx. 7 sessions)	7
3	From Timid to Tiger: A Treatment Manual for Parenting the Anxious Child	Cartwright-Hatton (2010)	Book	Eight group sessions with practitioner	2
4	REACT Anxiety Group for Primary Aged Children	Liverpool CAMHS (n.d.)	Group	Five group sessions with practitioner	1
5	Coping Cat	Kendall and Hedtke (2006)	Paper	Practitioner guided sessions (16–20 sessions)	13
<b>Adolescent anxiety</b>					
6	Worry Management for GAD	Available in book ‘Low-intensity CBT Skills and Interventions: A Practitioner’s Manual’, Farrand (2020)	Paper	Practitioner guided sessions (approx. 5 sessions)	1
7	Getting to Grips with Anxiety: A Guided Self-Help Workbook	Kings College London CYP-IAPT, UCL/Anna Freud Centre, Richmond CWP Team, Lambeth CWP Team (n.d.)	Paper	Practitioner guided sessions (approx. 8 sessions)	1
8	The C.A.T. Project for Adolescents	Kendall (2002)	Paper	Practitioner guided sessions (approx. 16 sessions)	1
<b>Depression</b>					
9	Behavioural Activation for Young People with Low Mood: Guided Self-Help Manual	Maiden (n.d.)	Paper	Practitioner guided sessions (8–10 sessions)	1
10	Brief Behavioural Activation for Adolescent Depression	Reynolds and Pass (2020)	Book	Practitioner guided sessions (6–8 sessions)	17
<b>Behaviour</b>					
11	Guided Self Help for Common Behaviour Problems	Woolgar <i>et al.</i> (2022)	Paper	Practitioner guided sessions (8–10 sessions)	3
12	The Incredible Years: Trouble Shooting Guide for Parents of Children Aged 3-8 Years	Webster-Stratton <i>et al.</i> (2005)	Book	Self-help book with parenting strategies, but weekly practitioner involvement (via phone calls or face to face) are suggested	7

(Continued)

Table 3. (Continued)

	Title	Authors/organisation	Format	Practitioner time	How many times intervention was cited
13	Manchester Parenting Programme	EPEC Manchester Parenting Courses (2024)	Paper	Up to 14 group sessions with practitioner	2
14	CEDAR low intensity parenting book	CEDAR (n.d.)	Paper	Practitioner guided sessions (6 sessions)	1
15	What to Do When Your Temper Flares: A Kid's Guide to Overcoming Problems with Anger	Huebner (2021)	Paper	Self-help book with 12 chapters	1
16	The Solihull Approach	The Solihull Approach (n.d.)	Group	10 group sessions with practitioner	1
17	Watch Me Play! Manual for Parents	Wakelyn and Katz (2020)	Paper/online	Self-help manual	1
18	Communication and challenging behaviour intervention	The Challenging Behaviour Foundation (2020)	Paper/online	Self-help manual	1
19	Managing emotions	The Anna Freud & Mentally Healthy Schools (n.d.)	Website	Self-help website (focused on use in schools)	2
<b>Other</b>					
20	The Decider Skills	Ayres and Vivyan (2019)	Book	Self-help manual	1
21	FRIENDS Resilience	FRIENDS Resilience (n.d.)	Online	Practitioner guided sessions	2

There are likely to be several reasons why there is such a wide range of interventions being offered and variation between what practitioners deliver. This may be because the national curricula for the practitioners do not specify the use of specific manuals or materials. For example, the EMHP curriculum aims are general, focusing on ‘acquiring knowledge and skills in low-intensity interventions for children, young people and family systems experiencing anxiety, depression and behavioural difficulties, based on the most up to date evidence’ (p. 13, [Higher Education England, n.d.](#)), but do not dictate the use of specific guided self-help materials. This allows universities to choose different materials and manuals for each presenting difficulty, resulting in differences between what practitioners learn across the UK. Such differences allow for fidelity with flexibility to the local services which is central to successful implementation of interventions (Kendall *et al.*, 2008). This study focused on titled manuals and protocols, rather than specific skills or techniques used as it was not possible to ascertain how skills are being delivered amongst different professionals.

In addition, some existing and widely used evidence-based materials do not meet the recent definition of low-intensity CBT (Shafran *et al.*, 2021). For example, ‘Coping Cat’ is a 16-session intervention lasting for 50 minutes (Kendall and Hedtke, 2006), and Webster-Stratton’s Incredible Years programme can last up to 22 sessions although variants of these interventions do exist which are briefer (e.g. Reedtz *et al.*, 2011) or computer-assisted (Khanna and Kendall, 2008; Khanna and Kendall, 2010) and may be the ones being used in practice to provide a low-intensity treatment.

Finally, it is highly encouraging that so many practitioners used outcome measures, although this paper does not focus on their frequency (e.g. session-by-session measurement). Using outcome measures has been shown to improve patient outcomes and described as ‘essential’ to implementing evidence-based practice (Boswell, 2015); session-by-session feedback is also strongly supported by empirical data from adult research (Delgadillo *et al.*, 2018). The finding that their use in this sample was nearly universal indicates that they are feasible and being implemented in routine low-intensity psychological treatment.

## Conclusion

This study identified and characterised the specific interventions and techniques currently delivered by practitioners across the UK. There are a number of reasons why this variation may exist, but further empirical support for some of the low-intensity psychological interventions and guided self-help materials currently in use is needed. It is also possible that practitioners are not clear on which interventions are easily available and have also been fully and rigorously evaluated in randomised controlled trials and which have not, since such information is lacking.

## Study 2:

The first study highlighted the wide range of low-intensity psychological interventions that are offered to children and young people with mental health difficulties. One reason for the wide range is the potential variation in resources among services as some interventions may have a cost implication and require technological resources. Another is that there is a lack of information for practitioners about the evidence base for the interventions. Some of the specific manuals taught on training courses are evidence-informed rather than evidence-based due to a gap in the current research.

This second study aims to establish (a) the availability and (b) strength of empirical support for low-intensity CBT for children and young people with anxiety, depression and behavioural difficulties. This study was restricted to CBT interventions rather than other low-intensity psychological interventions as CBT interventions are the ones with the strongest empirical support (Horrocks, 2023).



## Study 2: Method

### Materials

A comprehensive list of efficacious low-intensity CBT interventions for children and young people was compiled from a range of relevant sources. This included recent systemic reviews on guided self-help and low-intensity CBT interventions (Bennett *et al.*, 2019; Roach *et al.*, 2023) and updated searches, treatments described in a recently published book on brief and low-intensity interventions for children and young people (Bennett *et al.*, 2022), interventions described for anxiety, low mood or behaviour problems in the survey responses from Study 1, and interventions used as part of low-intensity practitioner programmes in London that are freely available to access online (<https://manuals.annafreud.org>).

### Procedure

Interventions were categorised by primary symptom (child anxiety, adolescent anxiety, adolescent depression or child behavioural difficulties), and whether there is randomised control trial (RCT) evidence available supporting the efficacy of the intervention.

It was also noted whether there were any restrictions to access the interventions: location, website or intervention defunct or insufficient information. Location refers to when the intervention was only available in a specific country or language and 'website or intervention defunct' is when the manual or website were no longer available. Insufficient information was denoted when only brief descriptions of the intervention were presented in research papers rather than a manual or session plan, and would not be sufficient for a practitioner to use. Interventions were considered inaccessible if they met one or more of these three conditions. In addition, the cost of the intervention has been presented (all information is available in Appendix B of the Supplementary material).

Following the principles of the hierarchy of evidence (Murad *et al.*, 2016), the interventions were provisionally rated using a scoring system of gold, silver or bronze to represent the evidence base of each low-intensity intervention (Table 4). Two researchers (A.R. and I.S.) independently ranked all interventions using the below definitions. Where this was unclear a discussion took place with a clinical supervisor (S.B.) and consensus was reached on the categorisation of all included interventions. When interventions were tested in multiple research studies (e.g. a feasibility study and then an RCT), the results from the study with the highest level of evidence (e.g. RCT) was used for the ranking. If RCT evidence suggested an intervention was not efficacious, it was not included in the table.

## Study 2: Results

In total, 44 low-intensity CBT interventions for child and adolescent anxiety, adolescent depression and child behavioural difficulties were identified and ranked gold, silver or bronze. Results are displayed in Table 5 and a full table with more information on each intervention is available in Appendix B of the Supplementary material. Behavioural difficulties had the most 'gold' and total interventions.

Of the 44 interventions identified, 28 had been evaluated in an RCT, deemed effective and rated 'gold'. Of the 28 gold-rated interventions, 13 were accessible to practitioners. This included four child anxiety treatments (Creswell and Willetts, 2019; Kendall and Khanna, 2008; Morgan *et al.*, 2016; Rapee *et al.*, 2000), two adolescent depression interventions (Burns and Beck, 1999; Grudin *et al.*, 2022) and seven child behavioural difficulties interventions (Forehand *et al.*, 2010; Irvine *et al.*, 2015; Markie-Dadds and Sanders, 2006; Morawska *et al.*, 2014; PCIT, 2023; PCIT, *n.d.*; Turner and Sanders, 2013). There were no gold-rated accessible interventions for adolescent anxiety.

**Table 4.** Ranking criteria for LICBT interventions

Gold	Evidence-based	Intervention has been tested using at least one randomised controlled trial (RCT) and shown to reduce clinical symptoms
Silver	Evidence-informed	Intervention shown to reduce symptoms but not tested in an RCT (e.g. open trial, case study)
Bronze	Clinician-recommended	May use components of evidence-based treatment and used and/or recommended by practitioners, but no published evidence of efficacy in any trial or research study

**Table 5.** Intervention ranking and accessibility

	Child anxiety	Adolescent anxiety	Adolescent depression	Child behaviour	Other (combined)	Total
<b>Overall ranking</b>						
Gold	9	3	5	10	1	<b>28</b>
Silver	0	0	2	0	1	<b>3</b>
Bronze	0	4	2	7	0	<b>13</b>
<b>Total</b>	<b>9</b>	<b>7</b>	<b>9</b>	<b>17</b>	<b>2</b>	<b>44</b>
<b>Accessibility (n/total)</b>						
Gold	4/9	0/3	2/5	7/10	0/1	<b>13/28</b>
Silver	0	0	1/2	0	0/1	<b>1/3</b>
Bronze	0	3/4	1/2	7/7	0	<b>11/13</b>
<b>Total</b>	<b>4/9</b>	<b>3/7</b>	<b>4/9</b>	<b>14/17</b>	<b>0/2</b>	<b>25/44</b>
<b>Interventions used in routine practice* (n/total)</b>						
Gold	1/9	0/3	1/5	0/10	0/1	<b>2/28</b>
Silver	0	0	0/2	0	0/1	<b>0/3</b>
Bronze	0	3/4	1/2	6/7	0	<b>10/13</b>
<b>Total</b>	<b>1/9</b>	<b>3/7</b>	<b>2/9</b>	<b>6/17</b>	<b>0/2</b>	<b>12/44</b>

\*Named in survey from Study 1.

Only two out of the 28 gold-rated interventions were named as being used in routine practice by practitioners in the survey from Study 1. This included one of the accessible child anxiety interventions (Creswell and Willetts, 2019) and one for adolescent depression (Grudin *et al.*, 2022). There were no gold-rated adolescent anxiety or child behaviour difficulties interventions identified as being used in routine practice. Most interventions used by practitioners in routine practice were deemed 'bronze' ( $n = 10$ ).

Of the 44 total interventions, only 25 were accessible to practitioners to use with children, young people and families with interventions not accessible due to location restrictions ( $n = 8$ ), website or intervention now defunct ( $n = 6$ ), or insufficient information available to deliver the intervention ( $n = 8$ ). Some interventions were inaccessible for multiple reasons and this is noted in Appendix B of the Supplementary material.

## Conclusion

In summary, 44 low-intensity CBT interventions for child and adolescent anxiety, adolescent depression and child behavioural difficulties were identified. Of these, 28 (64%) were rated as gold. This suggests that high-quality empirically tested low-intensity CBT interventions do exist. However, there is a research–practice gap. Of these 28 interventions, 13 are accessible to practitioners to use (46%). Furthermore, taken together with the results of the survey in Study 1, only two gold-rated interventions were reported as being used in routine practice (one child anxiety, and one child behaviour intervention). Instead, the majority of interventions named as used in practice by practitioners were rated bronze. This highlights a gap between research and

evidence-based practice that could be addressed relatively speedily by researchers, increasing the accessibility and reducing the cost of the interventions rated as gold.

## Study 2: Discussion

The first study found a wide variability in the low-intensity psychological interventions and guided self-help materials offered to children, young people and families by practitioners across the UK. The second study reported that ‘gold’ standard low-intensity CBT interventions for children and young people with anxiety, depression and behavioural difficulties do exist, but many are difficult to access resulting in a research–practice gap. Furthermore, although they are drawn from longer evidence-based CBT treatments, none of the accessible anxiety interventions was found to be empirically tested with adolescents despite adolescent anxiety being one of the most common referrals to child and adolescent mental health services (Gibbons *et al.*, 2021; Hansen *et al.*, 2021) and evidence that adolescents respond favourably to CBT (Kendall and Peterman, 2015).

There are multiple reasons practitioners may not be using interventions that have ‘gold’ rated empirical support, including researchers often failing to follow rigorous RCTs with implementation studies to optimise their use in clinical practice. In addition, lack of access to funding and resources within children’s mental health services means that there are not excess resources for organisations to pay for intervention manuals or specific training programmes (Peters-Corbett *et al.*, 2023). It is well documented that mental health services have not been well invested in, and increases in funding have often been attached to specific interventions or trialling new programmes, which has left core frontline services without necessary investment (The King’s Fund, 2019). Within the UK, prior to the pandemic, less than 1% of national funding went to children’s mental health services (Lennon, 2021). Cost to services remains one of the largest barriers to the implementation of interventions across healthcare settings (Peters-Corbett *et al.*, 2023).

This study found variation in costs of interventions from free to over £1700 for training. There are expectations that physical healthcare costs are not free of charge, and positive attitudes towards the principle of paying towards prescriptions more generally for physical health conditions (Schafheutle, 2008). It is unclear if there is an expectation that mental health treatment should be free, despite general acceptance for means tested prescription fees, and the principle of parity of esteem between physical and mental health care (Mitchell *et al.*, 2017). Furthermore, inequalities in access to health care occur for a huge variety of reasons of which economic ones are only part of the issue.

There were also accessibility issues due to location restrictions, for example interventions that were only available in certain countries or languages. Seven gold-rated interventions are not freely available in the UK. Many low-intensity interventions with ‘gold standard’ RCT evidence have been developed and tested in Australia and New Zealand, where low-intensity CBT has long since been recognised, delivered and evaluated (e.g. New Access, MindStep and Orygen Research Institute). The reasons for such geographical disparity in access is unclear. As well as language, it is important to highlight the paucity of research with CYP and families from different cultures and communities, meaning it is not clear the extent to which these ‘evidence-based’ interventions are culturally relevant or sensitive to many of the UK population. As these interventions are developed for children and young people with mental health difficulties, potential risk must be acknowledged about having the materials freely available on a website without sufficient accompanying training or monitoring that they will be implemented with fidelity. Therefore, researchers may not want their intervention to be used without closer control. Furthermore, research evidence may sometimes be solely available in academic journals, which practitioners may find challenging to access.

A large proportion of interventions used in routine practice by practitioners were rated 'bronze'. It may be that bronze-rated interventions are easier to access than some of the gold ones, due to gold interventions often taking a longer time to develop, using more sophisticated technology such as websites which can require regular maintenance, having had more initial investment in their development and facing issues of intellectual property. Conversely, clinicians may be creating their own manuals, quickly, without significant investment in a randomised controlled trial with the primary purpose of sharing expertise and without significant concerns about intellectual property. It would be useful to empirically test these interventions to understand the clinical effectiveness and to provide 'practice-based' evidence, especially as there is sparse research into the clinical outcomes of low-intensity practitioner teams (Lockhart, 2021). However, it is important to highlight both the difficulty, and time commitment, in obtaining funding for such research, in particular large-scale randomised control trials of mental health interventions.

Finally, it is important to highlight the wider debate in mental health services and research regarding manualised interventions. Typically, research trials that form the evidence base have manuals or protocols. NICE guidance suggests that '*psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention*' (National Institute for Health and Care Excellence, 2022; p. 113). A multi-level meta-analysis of 52 studies found that evidence-based youth psychotherapies, based on manuals, outperform usual care which is less likely to utilise manuals (Weisz *et al.*, 2013) although the question of the benefit of manuals is still debated (e.g. Truijens *et al.*, 2019). The provision of manuals, however, facilitates standardisation of care and therefore can reduce inequalities in the provision and access to care.

## Study 2: Limitations

Although there was an encouraging response to the national survey ( $n = 102$ ), the responses may not be a representative sample of the thousands of low-intensity CBT practitioners that have been trained and are working in the UK; thus this was a convenience sample. Responses were largely from the South of England and over-represented by EMHPs. This may have been reflected by the way the survey was shared with specific groups. Additionally, it may be that individuals did not complete the survey as they do not recognise or acknowledge that they deliver low-intensity interventions.

A full systematic review of the literature on low-intensity interventions for common mental health disorders was not conducted, but instead the study relied on previous reviews (e.g. Bennett *et al.*, 2019) and other sources. It is possible that some interventions were therefore overlooked, for example those designed for specific phobias (Wright *et al.*, 2023). It is also likely that there are low-intensity interventions that children's mental health services and practitioners have developed themselves that are not available to access via the internet. Additionally, it is noteworthy that the interventions did not include those that are aimed at non-clinical samples such as those of Schleider and colleagues (Schleider *et al.*, 2020).

We acknowledge that the system used for determining the 'gold', 'silver' and 'bronze' categories were somewhat arbitrary and other systems have developed for the classification of high-intensity interventions (Anna Freud Centre, 2023) or practice elements (Blue Menu of Evidence-Based Interventions, 2015). However, the classification was based on the hierarchy of evidence (Murad *et al.*, 2016) and the relative lack of research in the area of low-intensity interventions. This meant that the threshold for interventions to be ranked silver was low: studies only had to be shown to reduce symptoms in any research study. This meant that interventions from a single case study which showed a positive impact, were categorised as silver (e.g. Borschuk *et al.*, 2015). Furthermore, such categorisation did not allow for nuances in the literature. For example, a recent RCT found that Pesky gNATs (an intervention indicated in Survey 1 that is used in practice), was not effective in providing clinically significant levels of change when compared with a waitlist

control group (McCashin *et al.*, 2022), despite the initial feasibility study suggesting potential effectiveness (Chapman *et al.*, 2016). This intervention was therefore not included in the list of interventions in Appendix B of the Supplementary material. Other interventions, in particular group interventions, were difficult to categorise at times. This was particularly true for the Incredible Years programmes; however, given that these interventions were typically not led by the materials and did not involve paraprofessionals, they were not deemed to be low-intensity but instead considered as brief interventions (Shafran *et al.*, 2021).

## Overall conclusion

This study has highlighted the research–practice gap for low-intensity psychological interventions for children and young people. It is hoped that by identifying the interventions with the strongest evidence base and their accessibility, that practitioners and educators will be in a better position to provide interventions and focus on training practitioners to implement them effectively. However, it is also clear that there are many barriers to the implementation of the interventions and a need to fill evidence gaps. In addition, there is a paucity of research on the use of these low-intensity interventions with the different cultures and communities that live in the UK. We hope this paper is a first step in identifying available low-intensity, evidence-based resources for children and young people that practitioners and young people akin to the available resource for high-intensity interventions (Anna Freud Centre, 2023) and classification of evidence for specific techniques (Blue Menu of Evidence-Based Interventions, 2015). Such resources will hopefully serve to genuinely improve access to evidence-based psychological therapies delivered by the low-intensity workforce and improve clinical outcomes.

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