London and South East CYP-IAPT Collaborative Children's Wellbeing Practitioner (CWP Programme)

Audit Report for Cohort 1 2017-2018

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Audit Foreword

In their ground-breaking report on child and young people's mental health, *Future in Mind* (Department of Health, 2015) the government has recognised the need to increase access to evidence based mental health provision for CYP. This report acknowledged a significant treatment gap in the provision of care, citing evidence that less than 25% – 35% of those with a diagnosable mental health condition accessed support (Green et al, 2005). This resulted in several initiatives to improve provision of mental health services for CYP and plans to increase the workforce which were further outlined in *Implementing the Five Year Forward View for Mental Health* (NHS England, 2016). An important pillar of this policy has been the creation of a totally new profession groups and service structures with bespoke training based on up to date evidence-based practice designed to tackle this shortfall.

The new professional group at the centre of this initiative are the Child Well-being Practitioners (CWP), supported by their Supervisors/Service Development Leads (SSDLs). The design of the CWP services have been the modelled by local services and their commissioners with the support of the SSDLs. These new and innovative services are likely to path the way for future services; therefore, it was felt vital that they should be closely evaluated in the first year. This report details the outcome of that evaluation, including a description of the diversity of service models and how they were implemented; the outcomes of the interventions and service user views; the views on the stakeholders and information on sustainability from the first year.

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The CWP cohort 1 participating sites; Barking & Dagenham (NELFT), Barnet (BEH/PHPH/CCG), Bromley Y (Bromley Y/CCG), Cambridge & Peterborough (CPFT), CHUMs (CHUM CIC/ELFT), Hammersmith & Fulham (WLMHT/CCG), Hertfordshire (HCC/HPFT/HCT/CCG (ENH/HV), Hounslow (WLMHT/HYCS/CCG), Islington (Whittington/CCG/FF), Lambeth (SLAM/CCG), Lewisham (SLAM/CCG), Norfolk (NSFT/OPO/CCG), South West London and St Georges (SWLSTG/CCG), Tower Hamlets (ELFT/DO/YJFIS/CCG) and Westminster (CNWL/CCG).

Executive Summary

The Children's Wellbeing Practitioner initiative has been designed in line with the *Five Year Forward View for Mental Health* (NHS England, 2016) to provide an additional resource offering low intensity interventions, including guided self-help, for children and young people experiencing mild to moderate mental health difficulties. This report concerns cases seen by CWPs in cohort one for London and the South East during the period 02/05/2017 to 24/07/2018.

Aims

The aims of this audit were:

1. Has it been possible to train new clinicians to provide low intensity interventions/guided self-help to children and young people with mild/moderate mental health difficulties who were otherwise not accessing mental health services?
2. Has the introduction of CWP's increased access to mental health services for children and young people?
3. Do the interventions provided fit within the principles of guided self-help; namely, brief, goal focused and collaboratively developed with young people and parents?
4. Are the interventions effective?

Methodology

A multimodal methodology was designed to address these aims by:

1. describing the implementation of the CWP model;
2. measuring outcomes in terms of improvement to symptomatology, service user goals and service user feedback of experience of service;
3. capturing the evolving views of stakeholders on the year's training, and
4. collecting information on the sustainability of the model in the services.

Outcomes data was drawn from an online outcome monitoring system used by most of the partnership organizations called POD, sampling a total of 1136 cases. The rest of the data is drawn from data completed on behalf of all the services, covering a total of 1427 CYP. Both sets of data are sampled from the first year to the CWP program but differ as the outcomes data only applies to CYP who have received an intervention, whereas the rest of the data includes all referrals to the CWP services. Furthermore, the outcomes data covers the period from the beginning of the program to the 24th July 2018, whereas the rest of the data covers up to the 1st April 2018.

Results

The implementation of the CWP model

The results found that the CWPs had been implemented in a variety of settings, including being placed in schools, specialist and community CAMHS and from a Single Point of Access, employed by voluntary sector, Local Authority and NHS organizations. All used criteria in line with providing low intensity work through a variety of referral pathways adapted to local service provision The Supervisors/Service Development Leads (SSDLs) were crucial to the development of the model within the various settings. CWP's development from within the services was supported by opportunities to observe clinical work, formal and informal supervision as well as some on-site training. There were a variety of challenges the SSDLs had to overcome in order to implement the CWP initiative within their organizations.

The demographics of referrals described the age, gender and ethnicity of the sample. Referrals were received for children aged 2-18 years old, the largest proportion of referrals were made for young people between the ages of 11-15 years, with the peak in referrals for boys between 8 and 9 years old and for girls between 11 and 15 years old. Ethnicity data found that majority of referrals were made in relation to children for a white back ground with a lot of diversity within the sample perhaps reflecting the diversity of areas covered by the audit from inner London to more rural areas such as Norfolk and Cambridgeshire and Peterborough. Data supported the view that on the whole services were adherent to the related Self-Help Model. That is, services saw children with problems consistent with the evidence based guided self-help model for an average of eight sessions, with the majority falling between 6-10 sessions. Ninety percent of cases were discharged without requiring referral on to further support.

Outcome Data

Primary outcome measures used for the CWP programme were: Goal Based Outcomes (GBOs), the Strengths and Difficulties Questionnaire (SDQ), and the Revised Anxiety and Depression Scale (RCADS). In this dataset there are 958 cases with Time 1 outcome data. Of these, 590 had completed intervention (discharged). The remainder were mostly in treatment or had no recorded outcomes. The following analysis concerns the discharged cases only. The sample for London and the South East CWP Programme includes outcomes data on GBOs (T1=430, T2= 385), SDQ (T1=227, T2=155) and RCADS (T1=385, T2=287), which came from completed intervention cases. The percentage for completion of Time 2 data was 89.5% for GBOs, 68.3% for SDQ and 74.5% for RCADS. All available session feedback data was included, including the Session Feedback Questionnaire (SFQ), completed a total of 2922 times by 709 clients, and the Session Rating Scale (SRS), completed a total of 345 times by 86 clients. Ninety Six percent of sessions were rated in the top 25% of the satisfaction scale for SFQ (16 or above) and 78% for the SRS (36 or above). The results for the outcome measures are:

- **For GBOs:** The average score for goals at Time 1 was 2.58 which increased at Time 2 to 7.00. This was a highly significant increase with an effect size of 2.10. A substantial proportion of those who specified goals made a reliable improvement in scores at Time 2 (77%).
- **For parent SDQs:** At Time 1, 79% of cases were in the clinical range on any subscale. Post treatment this was reduced to 50%. This was highly statistically significant ($\chi2(1) = 24.20$, $p < .001$). Of the 89 cases above the cut off on any scale at Time 1, 44% were no longer above cut off on any scale at Time 2 (recovered). The number of cases showing reliable improvement on SDQ Impact subscale was 38%.
- **For Young People's RCADS:** At Time 1, 67% of cases were in the clinical range on any subscale. Post treatment this was reduced to 38%. This was highly statistically significant ($\chi2(1) = 53.49$, $p < .001$). The proportion recovered on all scales was 49.7%. The number of cases showing reliable improvement is 33% for Total Anxiety and Depression. At post treatment the proportion of clinical cases was only 0.18 (SD=0.38) indicating a recovery rate of 45%.

Stakeholder views

The audit surveyed views of CWPs and SSDLs at two time points.

SSDLs rated the course highly in terms of understanding their role, meeting their training needs, innovation, and how the CWP model fitted within their sites existing model. They reported that they could identify appropriate cases, the training would enhance local CAMHs provision and that there was a good level of communication with the Health Education Institute. They also reported the training supported the work they

did in local settings to support the CWPs. Improvements in SSDL's ratings were shown within the first year in terms of appropriateness of cases identified and the embedding of the CWP service.

CWP's felt the course was supportive, understood their role and enjoyed theory practice links at the university and this also improved over time. Overall, they reported they enjoyed their training and overtime their experience of clinical skills sessions increased and they were more able to self-direct their learning. CWPs felt supported by their supervisors increasingly over time and felt confident in knowing the make-up of their local teams. Roughly 75% of CWPs reported that they would recommend the role to another.

This quantitative feedback was supported by the qualitative feedback, in which SSDLs and CWPs reported that they enjoyed their role and the training experience as whole. The main themes that emerged for consideration from the HEI in the future were the structure of the teaching day and length of course. Job retention and sustainability issues were also key themes in both the CWP and SSDL's feedback for future consideration. CWPs self-rating of competencies showed reported increases and improvement in knowledge and skills.

Sustainability

CWP and SSDL employment in the training year was subsidised by Higher Education England (HEE). The percentage of CWPs offered work into the second year was 87%, all of whom were employed at band 5 or equivalent. Of those who were offered posts, five out of 44 left to take up doctoral training (three Clinical Psychology, one Educational Psychology). Four out of 5 of these posts were planned to be filled, however, only one was.

Conclusions

The aims of the audit were reviewed in relation to results. The data demonstrated that a new workforce could be trained to provide effective low intensity interventions/guided self-help to children and young people with mild/moderate mental health difficulties who were otherwise not accessing mental health services. The number of CYP seen reflected a training caseload, so it will not be until the second year when qualified CWPs are offering services that the true capacity of the services can be assessed. The limitations of the audit included: the absence of two partnerships in the POD data; some missing data; data entry problems with demarcation of the specific intervention groups; and not all cases reaching clinical thresholds.

The implications of the study were considered in relation to clinical work, future research and policy implications.

Overview of Children's Wellbeing Practitioner (CWP) Programme

The Children's Wellbeing Practitioner (CWP) Programme

The Children's Wellbeing Practitioner (CWP) Programme has been developed in response to *Implementing the Five Year Forward View for Mental Health* (NHS England, 2016), which outlines the target of offering evidence-based intervention to at least 70,000 more children and young people annually from 2020, by training up 1700 new staff. The *Five Year Forward View for Mental Health* provides a blue print for NHS community services and NHS England partner organisations (health, education, youth justice, children's services, the voluntary and independent sectors) to provide a whole system approach to an accessible service for at least 35% of those with a diagnosable condition.

The new CWP training is part of the overarching Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) programme and has been designed, in line with the *Five Year Forward View for Mental Health,* to provide an additional resource to support and intervene with children and young people experiencing common mild to moderate mental health difficulties. It is specifically targeted at meeting the needs of those who do not currently receive a service. The CWP is a new role aimed at providing early intervention to better address emerging mental health needs. To deliver maximum impact quickly they should be integrated into an existing locality-based provision. The CWP programme contributes to the overarching CYP-IAPT local service transformation plans, which aim to transform existing services for children and young people through increasing access, improving outcomes and creating a collaborative approach to service development (CYP IAPT, 2013).

The London and South East Collaborative

The London and South East CYP-IAPT collaborative, comprised of 15 implementer sites, set out to employ 60 Child Well Being Practitioners (CWP) with Supervisor and Service Development Leads (SSDL's) and Service Managers at the time of this audit. In collaboration with the CWP CYP-IAPT team, and through local CWP steering groups, the CWP posts were overseen by the local partnerships, who decided how to create the CWP service and where best to place the service within existing local community structures to have the most impact and greatest accessibility of provision. National guidance is clear; regardless of the employing agency, CWPs can be deployed from any relevant organisation working with children and young people. Therefore, it was vital to consider where CWPs would gain the best clinical experiences to augment their learning at the Higher Education Institution (HEI) and how to support the on-site CWP training experience to avoid role dilution and/or the role substituting for existing services.

The National Curriculum for the HEIs was developed with a view of enabling greater access to and service through put of psychological therapy via a low intensity modality, namely Guided Self-Help (GSH). The principles of GSH were utilised in teaching and developing the CWP service model. GSH provides evidence-based low intensity interventions, to children and young people with mild to moderate mental health difficulties of depression, anxiety, or behavioural difficulties. The principles of GSH focus on fostering a sense of agency in children, young people or parents accessing the service, in order to maximise their ability to cope and manage their current difficulties (Fuggle, 2018). The aim was to target interventions to those children and young people who are not currently accessing mental health services.

Brief overview of CWP training for cohort one

Training programmes were established nationally across HEI sites with a core curriculum for all programmes, determined and monitored by the national curriculum group. This core curriculum was then implemented locally at individual HEI's. In the CYP-IAPT London and South-East Learning Collaborative the 15 implementer sites were allocated to HEI's, either King's College London and University College London in association with the Anna Freud Centre.

Cohort One training began in April 2017 and was completed in May 2018. In term one (April 2017-July 2017), CWPs were provided with intensive academic and clinical practice training at the HEI sites for three days a week. The remaining two days were allocated to the respective site with opportunities to develop clinical skills with SSDL's. In term two (October 2017-December 2017), CWPs attended HEI sites for clinical skills practice and training for one day a week and spent four days working in a service. During Term three (January 2018-April 2018), CWPs were placed within their service for five days a week except for four contact days with the HEI for clinical skills problem solving.

The CWPs were supervised by experienced specialist Supervisors who also had the vital function of developing services locally in order to create space for the new CWP workforce to practice. These Supervisors/Service Development Leads (SSDLs) attended separate training sessions facilitated by the Course Lead for the SSDL component of the programme. This involved opportunities for supervisors to network, problem solve and discuss service developments across the collaborative, with a combination of taught sessions, Action Learning Sets and group discussions. SSDLs also had the opportunity to attend lectures with the CWP's and were invited to participate and co-develop clinical skills teaching. This involved supporting small group discussions with CWPs, facilitating role plays and reviewing and supporting with video assessments. SSDL's have formed an integral role in ensuring that CWP skills developed during training are implemented correctly within a local mental health setting. They have also played a vital role in ensuring that local teams and professionals are familiar with the work that CWPs do, by promoting this new service and engaging local partners.

Overview of the interventions

In London and the South-East, the CWPs were trained to offer brief, focused evidence-based interventions in the form of low intensity support and guided self-help for children and young people who demonstrate mild/moderate:

- Anxiety
- Depression
- Common behavioural difficulties

CWPs offered around eight sessions of intervention to young people with mild/moderate anxiety or depression (aged 12-18 years old) and to parents of a child with anxiety (aged 7-12 years old) or behavioural difficulties (under eight years old). These sessions comprised of face to face and telephone sessions. Face to face sessions lasted between 30 minutes and one hour, with telephone sessions lasting around 20 minutes.

Details of all interventions have been manualised online: https://manuals.annafreud.org/cwp/index.html

Child Anxiety

In collaboration with Reading University, CWPs delivered a parent-delivered CBT approach using the guided self-help book 'Overcoming your child's fears and worries' by Cathy Creswell. A manual for therapists is available which includes a step by step guide to the exercises supplementing the self-help book. CWPs encourage parents to work through the manual, rehearse key skills with parents, and problem solve any difficulties which arise.

Parent led CBT for child anxiety disorders has been researched by Thirlwall et al (2013) who found that that there was a higher proportion (50%) of children free from primary diagnosis at the end of the intervention (n=64) compared to the proportion free from primary diagnosis (25%) after the same time on the waitlist (n=69). The intervention itself consisted of four one-hour sessions and four 20-minute telephone sessions.

Further research by Creswell et al (2017) has suggested that brief guided parent-delivered CBT interventions may be a cost-effective alternative to another intervention (solution focussed therapy).

Adolescent Anxiety

Self-help booklets developed by Camden and Islington NHS Foundation Trust for adult IAPT were adapted using participation groups. The adapted booklets contain information on 'Stress and Worry' and 'Panic and Phobias'. CWP's were trained in the core elements of these interventions including graded exposure, thought challenging and problem solving. CWP's worked through relevant sections of the booklet with young people, including exposure tasks and thought challenging. This intervention is in line with NICE guidance which recommends CBT for treatment of anxiety difficulties.

(https://www.nice.org.uk/guidance/qs53/chapter/Quality-statement-2-Psychological-interventions)

Depression

Behavioural Activation has a strong evidence for effectiveness in adult depression (Dimidjian et al., 2006) and is currently being adapted for young people (Ritschel, Ramirez, Jones, & Craighead, 2011). Reading University developed a Brief Behavioural Activation model including session plans and resources (Pass, 2018). CWP's were trained in the core components of this model, as well as cognitive interventions for low mood. Guided self-help based primarily on behavioural activation was used by CWPs in London and the South East to support young people experiencing low mood difficulties and mild depression accessing CWP services.

Behavioural Difficulties

CWPs invited parents to read 'The Incredible Years' by Carolyn Webster-Stratton. The Incredible Years intervention is an empirically supported mental health intervention for children with conduct problems (Brestan & Eyberg, 1998) The intervention teaches common parenting techniques focusing on attending and praise. CWP's were trained in the core elements of these parenting techniques and supported parents in implementing parenting strategies and in problem solving difficulties.

Aims

The aim of the audit was to assess the progress of the cohort one training programme in London and the South East and its implementation at a local level across a range of services. This is the first year of a Children's Wellbeing Practitioner (CWP) programme and its service implementation at local sites.

The audit is intended to demonstrate what is working well and areas for development. It also aims to describe the localisation of the CWP service model and explore areas of innovative practice. The audit aims to answer the following key questions;

1. Has it been possible to train new clinicians to provide low intensity interventions/guided self-help to children and young people with mild/moderate mental health difficulties who were otherwise not accessing mental health services?
2. Has the introduction of CWP's increased access to mental health services for children and young people?
3. Do the interventions provided fit within the principles of guided self-help; namely, brief, goal focused and collaboratively developed with young people and parents?
4. Are the interventions effective?

In due course the data may be shared with the Collaborative, implementing sites, local clinical commissioners and Health Education England (HEE).

Method

Design

All partnerships involved in the programme were asked to take part in the audit. This comprised Service Managers, Supervisors/Service Development Leads and CWPs, in addition to anonymous data collected by young people and parents/carers who had received an intervention.

The audit utilised a mixed method approach comprising qualitative and quantitative data collection.

Overview of Audit sections

The audit report is divided into the following sections:

Section 1: Implementation of the CWP service model
Section 2: Outcomes of assessed and treated cases and service user experience
Section 3: Evolving views of stakeholders over the training year
Section 4: Sustainability

As the methodology, data collection and procedure vary for each section, these are described separately below.

Section 1: Implementation of the CWP service model

This section explores local implementation models and describes ways in which this new service was set up and operationalised on the ground. Demographic information for the programme is also presented.

Participants and Procedure

This data was collected from the following participants;

- CWP's and SSDL's involved in the first year of the CWP programme
- Service users who were referred to and received interventions from CWP's attending the training programme.

Each site was visited by the programme manager and clinical lead over the course of the training and CWP's and supervisors were asked for information regarding service development, context and set up of the locality service. CWP's and SSDL's at each site were also asked to complete a record of demographic information for each case referred to their service.

Measures

During the site visits, the programme team worked with services to review a site visit checklist (Appendix A), exploring the following areas;

a. The name of CWP trainees employing organisation
b. The service context in which the CWP trainees worked and the training year
c. The referral criteria of the service context

d. The criteria used to identify suitable cases for the CWPs
e. How the service context relates to other local CAMHS provision
f. The Professional backgrounds of Supervisors/Service Development Lead in the service context
g. Links with local partners
h. Observational/shadowing opportunities within the service
i. Formal/ informal supervision structure and frequency
j. Opportunities for case discussions
k. Feedback arrangements for CWPs
l. Any improvements to on-site training made through the year (based on CWP feedback)

The Site Visit information was in qualitative format when collected onto a word document. Further qualitative information was also gathered from presentations and posters at the end of year learning event (London and South East CYP IAPT Learning Collaborative, 2016).

In addition, SSDL's at each site completed an excel spreadsheet that collected information on the following areas;

m. The demographic profile of the CWP cases
n. Referral sources
o. Transition information
p. Cases referred to CWPs but signposted elsewhere

Demographic and referral information was collected for all cases from the beginning of the course (April 2017) up until 1st April 2018.

Analysis

Qualitative data outlined above was collated and emerging themes are presented in Section 1 of the results section.

Quantitative data on demographic and referral details were also analysed. These are also presented in section 1 of the results section.

Section 2: Outcomes of assessed and treated cases and service user experience

This section explores the impact and outcomes of the CWP programme.

Participants and Procedure

Participants for this section of the audit were service users accessing CWP services (demographic details of these participants can be found in Section 1 of the Results section). This is the first programme to collect real time data based on CWP clinical activity through the first year of training. Routine Outcome Measures (ROMs) explored in this section were collected using an online data collection tool called 'POD' and the Experience of Service Questionnaire was designed to capture the CYP experience of GSH. These measures were completed in sessions with clients on a web-enabled device (e.g. phone, tablet, laptop). This enabled measures to be scored live within the session, providing instant feedback to the young person in the form of graphs and gauges

produced by POD. Visual feedback such as this can be used to guide discussions in terms of progress and areas for improvement. CWPs were introduced to POD at the beginning of the course in May 2017 and asked to use it to monitor their clients' outcomes.

As the data entered into POD is continuously updating the sample for section two of the audit includes cases up to 24/07/2018. This was to allow the most data as possible be included in the audit and allow time for CWPs to complete cases they began before qualification. Further, The POD database, for the first cohort, did not collect data on demographics, therefore, demographic details along with referral information were collected via a specifically designed Excel spreadsheet (see Section 1).

Measures

Quantitative data was gathered on the following areas;

a. Goals set during assessment (using the GBO)
b. Progress towards goals over time
c. Improvements in symptom outcomes over time (RCADS or SDQ)
d. Session feedback (SFQ or SRS)
e. Experiences of using the CWP service (ESQ)
f. Did young people's outcomes represent a reliable change/improvement?

The full outcomes framework is described below:

Table 1: Outcomes framework for cohort one

Intervention	Outcome Measure
Young person-Low Mood	Revised Child Anxiety and Depression Scale (RCADS) (session 1 and session 8) Revised Child Anxiety and Depression Scale (RCADS) depression subscale (session 2-7)
Young Person -Anxiety	Revised Child Anxiety and Depression Scale (RCADS) (session 1 and session 8) Relevant RCADS subscale (e.g. generalised anxiety) (session 2-7)
Parents-Anxiety	Strengths and Difficulties Questionnaire (SDQ) (session 1) Strengths and Difficulties Questionnaire (SDQ) impact supplement (session 2-7) Strengths and Difficulties Questionnaire (SDQ) follow up version (session 8)
Parents-Behaviour	Strengths and Difficulties Questionnaire (SDQ) (session 1) Strengths and Difficulties Questionnaire (SDQ) Impact (session 2-7) Strengths and Difficulties Questionnaire (SDQ) (session 8)
All interventions	Goal Based Outcomes (GBOs) (session 1-8) Session Feedback Questionnaire (SFQ) or Session Rating Scale (SRS) (session 1-8) Experience of service (ESQ) (session 6,7 or 8)

Revised Child Anxiety and Depression Scale

The Revised Child Anxiety and Depression Scale (RCADS) (Chorpita et al, 2000) is a 47-item scale with five subscales: separation anxiety, social phobia, generalised anxiety disorder, panic disorder, obsessive compulsive disorder and depressive disorder. A Total Internalising score is created from the sum of all 6 subscales, and a Total Anxiety score from the sum of the five anxiety subscales. Items are rated on a 4-point Likert-scale from 0 (Never) to 3 (Always).

The youth self-report RCADS questionnaire was used with adolescents being seen by CWPs for low mood or anxiety. Following a full RCADS at Session 1, CWPs would complete the relevant subscale with a client at each session (session 2-7) with a full RCADS being completed again at session 8.

Strength and Difficulties Questionnaire

The Strengths and Difficulties questionnaire (SDQ) (Goodman, 2001) is a brief behavioral screening questionnaire. It includes 25 items of psychological attributes such as emotional symptoms, conduct problems, hyperactivity/inattention, peer problems and pro-social behaviour. The first four subscales are added together to generate a Total Difficulties score. The SDQ also includes an Impact supplement which asks the rater to score the impact of difficulties in the following areas: distress, friendship, home life, learning, and leisure,

The parent version of the questionnaire was used with parents of children with anxiety or behavioral difficulties. The Full SDQ was used in Sessions 1 and 8 (follow up), and the SDQ Impact was used in Sessions 2-7.

Goal Based Outcomes

Goal Based Outcomes (GBOs) (Law & Jacob, 2013) were used in each session to evaluate progress towards the goals of clinical work. GBOs compare how far a child or young person feels they have moved towards reaching a goal that they have set for themselves at the beginning of an intervention. Items are rated on a 10-point scale from Zero (goal not at all met) to 10 (goal reached) with an anchor point of five (which is half way between the two). Goals were set collaboratively within the first two sessions and then reviewed at each session. CWPs were encouraged to develop three goals with their clients.

Session Feedback Questionnaire

The Session Feedback Questionnaire (SFQ) (CORC, 2012) is a simple, four-item scale designed to measure aspects of the therapeutic relationship: feeling listened to, discussion, understanding and future plans. It is a measure of engagement and provides feedback to the CWP about how the sessions have been experienced by the young person or the parent. Items are rated on a 5-point scale from 1 (Not at all) to 5 (Totally).

The SFQ is administered, scored and discussed at the end of each session to get real time feedback. This means that CWPs can identify and problem solve any difficulties as they arise.

Session Rating Scale

An alternative to the SFQ used by some services was the Session Rating Scale (SRS) (Millar, Duncan & Johnson, 2002). SRS is a simple, four-item visual analogue scale designed to assess key dimensions of effective therapeutic relationships. The SRS is administered, scored and discussed at the end of each session to get real time feedback from young people and parents so that alliance problems can be identified and addressed. The SRS is represented in four visual analogue scales each 10cm long to assess the client's perception of; feeling heard, respected and understood (Relationship), relevance of goals and topics, client-practitioner fit (Approach) and overall alliance.

Experience of Service Questionnaire

The Experience of Service Questionnaire (ESQ) (Attride-Stirling, 2002) formerly known as Chi-ESQ, was developed as a means of measuring service satisfaction in Child and Adolescent Mental Health Services. For the CWP programme, the ESQ is completed in a face to face session in the middle/end of the intervention (i.e. session 5-7). The ESQ consists of 12 items rated on a 3-point scale (1 being Certainly True and 3 being Not

True) and an option to provide qualitative feedback on areas which the client liked, and areas which needed improving.

Analysis

POD collected ROMs throughout an intervention and provided real time feedback for CYP in the form of graphs and gauges. In addition, and for the purposes of the audit, programme data was also exported from POD into a CSV file for analysis. Data was extracted from POD on the 24/07/2018 and the data for clients who had completed intervention (marked as 'Discharged' on POD) was analysed for all clients with paired data (at time 1 and time 2 completion).

The key dimensions used in the analysis are as follows;

- **Reliable change** refers to the amount of change in scores on a scale which reflects more than the fluctuations of an imprecise measuring instrument (Jacobson & Truax, 1991). Reliable change index (RCI) is calculated using the Cronbach's alpha from a normative sample. For RCADS and SDQ the alphas from CYP IAPT data were used (Chorpita et al, 2015; Goodman et al. 2001; Ebesutani et al. 2001). For GBO, the RCI is a change in score of 2.45 (Edbrooke-Childs et al., 2015).
- **Hedges g** is a measure of effect size which is used to understand how much difference is observable between Time 1 and Time 2. A g of 1 indicates a difference of 1 standard deviation, a g of 2 indicates a difference of 2 standard deviations. This can be further broken down to: 0.2 being a small effect, 0.5 a medium effect and 0.8 a large effect. (ref: http://www.statisticshowto.com/hedges-g/)
- **McNemer's Chi-squared** is a statistical test used on paired sample. It is used to test the difference between those above clinical threshold at Time 1 compared to Time 2.
- **Proportional distributions** use means and standard deviations to represent the proportion of participants with complete data who scored above the clinical cutoff at Time 1. The best way to understand this is that these numbers represent percentages. For example, 0.67 indicates that 67% of clients scored above the clinical cut off at Time 1.
- **Data from completed ESQ's was extracted from POD**. Quantitative data was collated and the percentage ratings on each point of the Likert scale are presented for each questionnaire item. The ESQ also includes three free text sections looking at what the respondent liked about the service, what they felt needed improving and any other comments. NVivo was used to identify common themes for each of these questions.
- **Descriptive Means** were used to describe SRS and SFQ.

Section 3: Evolving views of stakeholders on the training year

The aim for this section of the audit was to explore the evolving views and feedback from key stakeholders involved in the first year of the programme.

For this section participants were stakeholders, namely:

1. Supervisors/Service Leads (SSDLs)
2. CWPs

CWPs and SSDLs were invited to complete a survey to capture the experience of the programme at the start of term in September 2017 (time point 1) and at the end in December 2017 (time point 2). CWP's were invited to complete their surveys through POD and supervisors completed a paper version. As part of the survey,

CWPs and SSDLs were asked for feedback on the HEI training experience and their experiences of working in-service.

CWP's also completed regular feedback on teaching sessions by completing the Teaching Feedback Questionnaire on POD after each teaching session.

CWPs were also asked to monitor their own learning outcomes on POD throughout the programme. The aim of this was to integrate outcomes into the CWPs' own learning, so that they could understand the benefits of embedding outcomes into their clinical practice, as well as measuring the impact of the training programme.

Measures

Stakeholder Survey

Two surveys were developed to explore feedback from CWPs and SSDLs (Appendix C). The survey for the CWP's contained 17-items, with 15-items on a 5-point likert-scale ranging from 5= very much to 1= not at all, and two free text questions relating to sources of support and any other comments. The survey developed for supervisors contained 16-items, including 15-items on a 5-point likert scale ranging from 5= very much to 1= not at all and one free text question for any other comments.

Teaching Feedback Questionnaire

This questionnaire consists of four questions relating to the quality of teaching (Appendix D). CWPs rate each question on a 7-point Likert scale ranging from 7= highly relevant to my learning goals, to 1= not relevant to my learning goals.

The Knowledge and Skills Questionnaire

This consists of 25 items and two sub scales: 12 items measure Knowledge and 13 items measure Skills. The questionnaire was completed by CWP students at the beginning of Term 1 (time point 1) and again at the end of Term 2 (time point 2). CWPs rate Knowledge and Skills from 1 (Not True) to 7 (Certainly True) (see Appendix H).

The Goal Rating Scale

This contains five goals; three goals were defined by the course and two goals defined by CWPs themselves. Goals are rated on a scale from 0-10 (zero being goal not at all met and 10 being goal reached). The goal rating scale was completed by CWP students at the end of Term 1 (time point 1) and again at the end of Term 2 (time point 2).

Analysis

The Likert scale from the evolving views of stakeholder's survey was converted to a numerical score that can be analysed quantitatively. Qualitative findings were entered into Nvivo 12 and themes explored.

All data from the Teaching Feedback forms was extracted from POD and collated for Term 1 and Term 2 and the average ratings for each of the questions presented.

The data from the Knowledge and Skills Questionnaire and Goal Rating Scale was extracted from POD and analysed using Paired data from the beginning of term 1 (Time point 1) and the end of term 2 (Time point 2). CWPs completed these measures at 3 time points throughout the training year.

Section 4: Sustainability

This section of the Audit sought to gather information on the sustainability plans of implementer sites.

Participants and Procedure

Service managers, SSDLs and commissioners were asked about their sustainability plans.

Measures

A questionnaire was devised for relevant participants to complete. Ongoing conversations regarding sustainability were also used to gather feedback from services.

Analysis

Data for this section was taken from the sustainability questionnaire and ongoing discussions and was collated on excel for descriptive analysis.

Results

Section 1: Implementation of CWP Service model – Service design, on-site training, demographics and referral information

Partnerships and service context

Fifteen partnerships were involved in the first year of the programme, 11 of which are NHS organisations, two are local authority and two are third sector organisations including a social enterprise and a charity. The 15 participating partnerships are described in Table 2 below. The CWPs were employed by each service, as part of a pilot, for one year. Each site allocated a Supervisor/Service Development Lead (SSDL) to a group of four CWPs to comprise a CWP team.

Table 2: Participating Partnerships of the CWP Programme

Partnership	HEI	Type of service	Base of service	Location of CWP's and session delivery
Bromley	KCL	Third Sector charity	Community (single point of access service	Service base
Hammersmith and Fulham	KCL	NHS	Tier 2 CAMHS)	Service base and schools 1 day a week
Lambeth	KCL	NHS	CAMHS	Service base
Lewisham	KCL	NHS	CAMHS	Service base
Richmond	KCL	NHS	CAMHS (single point of access)	Service base and schools 2 days a week
Tower Hamlets	KCL	NHS	CAMHS	Service base and school visits

Westminster	KCL	NHS	Tier 2 and Tier 3 CAMHS	Service base and schools 2 days a week
Barking and Dagenham	KCL	NHS	Tier 2 CAMHS	Service base and schools 2 days a week
Barnet	UCL	LA	Family Support Team	Service base and home/school/community visits
Cambridge and Peterborough	UCL	NHS	CAMHS Early Help	Service base
CHUMs (Bedford)	UCL	Social Enterprise	Community	Service base and schools 2 days a week
Hertfordshire	UCL	Local authority	Families First Team	Service base, community and home visits 3 days a week
Hounslow	UCL	NHS	Tier 2 and Tier 3 CAMHS	Service base and schools 2.5 days a week
Islington	UCL	NHS	CAMHS	Service base
Norfolk	UCL	NHS	Emotional Wellbeing Service	Service base

Local embedding of CWP services

Local partners and stakeholders

The CWP team were responsible for developing the CWP service and reported various strategies to do this. The SSDLs reported that they received various levels of support from the wider service in which they were co-located and that they had opportunities, to differing degrees, to attend and contribute to various local and national steering groups.

Partnerships have embedded their services and developed relationships with partners and stakeholders within the local settings in various ways. Those within CAMHS services have developed clear referral pathways and understanding of how the CWP service will fit within existing CAMHS provision. Those services external to CAMHS have developed links with these services through attending meetings and discussion. Many reported making external organisations aware of their service through, attending meetings, liaising with professionals such as visiting GP practices and schools, developing and sending out information leaflets and giving presentations at community events. Overall, SSDLs and CWPs made links with local partners including churches, youth groups, scouts, local authority and community organisations, police, drug and alcohol services, schools and GP practices.

The CWP work was carried out with children and young people and their families at a range of locations: the clinic base or school base, GP practice or at a home visit. There was a variety of ways in which the CWP's have been working; some spent all their time based in their own service, however, many split their time across clinic settings, schools, community settings and home visits (see Table 1 for individual partnership details).

Supervisor and Service Development Lead (SSDL) Role

Each site had a CWP team comprising four CWP's and a SSDL. The clinical role of the SSDL was described by sites as 'full time CWP supervisor/ Service Development Lead', as well as descriptors of professional background e.g. 'family therapist', 'clinical psychologist', 'senior CAMHS practitioner'. The SSDL's professional backgrounds are described below in Table 3.

A really important part of the SSDL role was to create a space for the new CWP workforce to practice. This often meant creating new referral criteria and referral pathways and processes. They also spoke of a role in 're-educating' the system to accept new ways of working, and to protect the time and service model of the CWPs. This often required the application of change management and quality improvement methodology and interactions with many stakeholders in the system to create the space for the new workforce including; commissioners, service managers, schools as well as parents and young people.

The SSDLs had a range of previous trainings in supervision. They worked four days a week, two partnerships employed two SSDLs who split the role, the remaining partnerships had one per site. SSDLs have spent 28% of their time on service development, 32% on supervision and 40% on co-production.

Table 3: The number and percentage of SSDL's professional background

Professional background	N	%
Clinical Psychologist	6	35
Mental Health Nurse	4	24
Psychological Well-being Practitioner	3	18
Social Worker	2	12
Art Psychotherapist	1	6
Other	1	6

All CWPs received weekly supervision on an individual basis with SSDLs closely monitoring case work from both the management and clinical perspective, whilst also holding in mind the broader GSH model and various tensions within their respective organisations. All CWPs at the site visits reported that they had the opportunity to discuss case work in supervision but that SSDLs also had an open-door policy so that immediate concerns or discussions around cases or service development could be discussed as soon as practically possible. There was also an opportunity for CWPs to be supervised or de-briefed on co-worked or shadowed cases.

CWPs reported that they were able to feedback to SSDLs through informal processes for example on an ad hoc basis using the open-door policy, e-mail or phone but also more formally during supervision or in CWP team meetings. Some sites reported using the Supervisors Feedback Form to help CWPs feedback on the supervision process.

All SSDL's were provided with the opportunity to attend ALS with the Course Lead for CWP Supervisors and Service Development Leads. These sessions were seen as vital by the attendees and an excellent opportunity to share innovative ideas, problem solve and engage with various aspects of the CWP programme.

Language used to describe the CWP service

The majority of partnerships have referred to themselves as 'Children and Young People's Well-being Service' with a minority referring to themselves as 'The Well-being Service'. One site took on feedback from families and re-named their service the 'family well-being team'. Two sites decided not to create a sub-team name within their existing service but referred to themselves individually as child well-being practitioners (CWP's).

Most practitioners described themselves as CWP's with one site referring to themselves as practitioners who were part of the 'Wellbeing service'.

Sites described that they would be offering 'guided self-help' or 'brief support'. Some sites described the interventions they could offer as a course of guided self-help and referred to the referral forms as applications for courses of guided self-help. Some sites produced brochures and leaflets to describe the CWP offer and these were developed for different audiences, tailoring the language to each group e.g. CYP, parents, leaflets for primary schools and leaflets for secondary schools.

Operationalising suitability for low intensity intervention

As part of the development of the service, sites were required to define case suitability for low intensity/guided self-help intervention. In general sites used a combination of Trust specific criteria and HEI guidance found on the WIKI – an online guide. A guide to case selection was developed by the HEI to ensure low intensity intervention would be useful to the client, and to allow CWPs to develop skills in a graded way. Criteria for training cases included:

- Axis 1 Disorder i.e. straightforward depression/anxiety disorder as main presenting problem
- Clear current and predictable difficulties
- Access to thoughts and feelings
- Definable problems and goals
- Available for weekly short-term therapy

As CWPs became more experienced it was expected that the process and criteria for selection of cases would broaden. All sites were using forums to discuss what constitutes low intensity interventions with current services to be able to streamline appropriate cases.

Examples of how low intensity work was operationalised are as follows. One site was part of a service that did not have criteria for accessing the service but in terms of identifying suitable cases for the CWPs the cases would need to be 'low risk and low-level need for intervention'. Another site was being guided by the trust's definition of the types of cases to be accepted to low intensity work.

Other sites utilised established internal CAMHS processes to select cases and describe low intensity intervention. Sites reported that they presented the type of work they would be doing to the management and multidisciplinary teams and described what guided self-help was and who it was aimed at for CWP service purposes. All CWPs were supported by their SSDL and encouraged by the HEI to consider the evidence base for the interventions when operationalising suitability for LI interventions.

For those sites who created leaflets to schools and external agencies such as GP practices, the descriptors used to identify suitable cases for low intensity work were mild/ moderate low mood, anxiety and behaviour difficulties. Another site specified the age range and intervention that could be offered e.g. behaviour work 4-8 years old, anxiety 4-17 years old and low mood 11-17 years old.

Referral Pathways

The CWP teams at each of the participating sites were asked about the referral route to the new service. Overall, referral pathways varied across services and are summarised in Table 4 below. The most common pathway for referrals was through the single point of access within their existing CAMHS service, where the case may be suitable for guided self-help and would otherwise have been rejected from CAMHS. However, direct referral pathways from schools and self-referrals were also common.

Table 4: CWP service referral pathways

Partnership	Anticipated Referral Pathway
Bromley	Single Point of Access
Hammersmith and Fulham	Single Point of Access
Lambeth	Stepped down from CAMHS, self-referrals, schools/GP
Lewisham	GP, self-referral, schools, CAMHS
Richmond	Single Point of Access
Tower Hamlets	CAMHS Triage, schools, self-referral
Westminster	CAMHS, Single Point of Access
Barking and Dagenham	Self-referral through I-Thrive model
Barnet	Through Common Assessment Framework (CAF), Schools
Cambridge and Peterborough	Single Point of Access
CHUMs (Bedford)	Schools
Hertfordshire	Through Local authority services, self-referral
Hounslow	Schools
Islington	CAMHS, school, Families first
Norfolk	Through Early Help Pathway Team (Tier 2 and Tier 3 CAMHS)

Referral Criteria

The CWP teams had to work out a referral acceptance and rejection criteria based on the training material and also on site specific needs. Sites reported using HEI guidance found on the WIKI on inclusion and exclusion criteria as a guide to help them think about these criteria in relation to their service context.

Each site was asked about their inclusion and exclusion criteria and a summary of the main inclusion and exclusion criteria from all site qualitative data are listed below.

Inclusion criteria:

- Low mood, anxiety or challenging behaviour
- Willingness to engage
- Case not previously known to other psychological service
- Case redirected from CAMHS as not appropriate for their service
- Early signs of emotional well-being distress
- Elevated RCADS scores

Exclusion criteria:

- Extreme risk (e.g. self-harm) or safeguarding concerns
- High case complexity (Eating disorder, Obsessive Compulsive Disorder, Post Traumatic Disorder, Psychosis, cases currently in court)
- Learning disability
- Complex family circumstances or social concerns
- Receiving an intervention in CAMHS or engaged with private therapy or additional support

However, all sites adapted the inclusion and exclusion criteria based on the needs of the community and service expectations. Below is an example of one site's specific inclusion and exclusion criteria.

Table 5: A specific site inclusion and exclusion criteria example

Inclusion criteria	**Exclusion criteria**
Guided self -help for anxiety: primary school aged children with mild to moderate anxiety through sessions mainly with their carers'. For example, we can work with parents where the child is – afraid of the dark, scared of animals, generally nervous etc. Individually with older children, secondary school up to the age of 18, e.g. social anxiety, exam stress etc.	The initial presentation (complex/potentially significant mental health difficulties) suggests that multi-disciplinary mental health assessment and/or formulation is required, i.e. the child or the young person requires a CAMHS assessment or there is an intellectual disability without a co-existing mental health difficulty.
Guided self-help for behavioural difficulties: Parents of children up to the age of 8 with mild behavioural difficulties e.g. temper tantrums, stealing, lying, and aggression.	There is significant risk of self-harm or harm to others where multi-disciplinary engagement, assessment and stabilisation may be indicated.
Guided self-help for depression: secondary school aged children up to the age of 18 with mild to moderate depression e.g. low mood, sleep problems, lacking in energy or motivation etc.	Where there are safe guarding concerns that requires assessment and intervention by Children's Social Care.
	There is a high level of family dysfunction/family conflict or complicated environmental factors.

CWP training experiences provided on site

Through site-visits and questionnaires, feedback was sought regarding the on-site training opportunities available to CWP's across the different partnerships. They have been offered a range of on-site training and supervision opportunities to embed the theoretical knowledge gained at HEI's.

Observations of Clinical Staff

CWP's had multiple opportunities to observe other clinical staff within their respective teams. For those CWP's based in NHS services this provided opportunities to observe different staff within the multi-disciplinary team, including clinical psychologists, psychiatrists, family therapists, nurses and child psychotherapists. Many had the opportunity to observe CAMHS initial assessments, CAPA choice appointments and triage appointments. There were some limited opportunities to observe other staff conducting neurodevelopmental assessments and clinical sessions. Some sites utilised video to allow CWP's to observe other's clinical work. Some CWP's were also given the opportunity to carry out joint assessments and clinical work with their supervisors, such as systemic family therapy sessions.

Many CWP's were also given the opportunity to observe and participate in team meetings in their respective sites. These have included MDT, referral and business meetings, as well as meetings with outside agencies such as school and social services. Many CWP's took an active role in meeting with professionals from external services to promote their service, this included meeting with schools and GP's.

Formal Supervision

A majority of CWP supervisors are offering weekly individual supervision. This supervision includes overall case management, clinical risk management, reflection and treatment planning for current cases and on-going service and professional development issues. Every case seen by CWP's would be discussed in supervision regularly; suitability of the case for GSH would be considered, formulation of the main issues and a treatment plan would be discussed and on-going review of the case's progress and reflection on clinical dilemmas would be provided. Supervisors would also provide references to supporting research and literature and appropriate GSH material and resources.

Many CWP's were also offered group supervision session with colleagues in addition to their individual supervision, in which they discussed current cases and shared resources and knowledge.

Supervisors were encouraged to utilise the CWP competency framework to guide feedback and ensure progression in key CWP clinical skills. Some CWP's and supervisors have also utilised video of clinical cases within supervision to increase opportunities for direct observation of the CWP's clinical work and enhance learning.

Informal discussion of cases and related issues

All CWP's had ample opportunities for informal case discussion, peer supervision and service development planning. Many were based within the same building as their supervisors, peers and other clinical staff providing opportunities for informal observations, discussions and learning. All had opportunities to contact supervisors outside of formal supervision for advice and support, particularly around any risk management or urgent clinical concerns.

Many CWP's discussed and shared their individual skills and knowledge with their peers and pooled and shared GSH materials that were developed over the course of the programme.

On-site training

Many CWP's attended mandatory training e.g. clinical governance, safeguarding and health and safety as part of the induction process within their respective services. Many also had opportunities to attend various professional development trainings or workshops held within their services e.g. motivational interviewing, behavioural activation, attachment-based therapy and managing self-harm. They have had opportunities to attend a variety of different professional's meetings to widen their experience and be involved in MDT clinical case discussions and workshops.

Trainee feedback arrangements with SSDLs

CWP's have had many opportunities to provide feedback, some partnerships have operationalised this informally through ongoing discussions and others have more formal structures in place. Many CWP's have provided feedback directly to supervisors during supervision, this has included service issues that need addressing (such as access to phones, computers, clinical space) and feedback on the supervision process. Some supervisors have utilised questionnaires such as the HASQ (Helpful Aspects of Supervision Questionnaire) or Leeds feedback scale to formalise this.

CWPs have also been given opportunities to provide feedback in team meetings and service development discussions.

Challenges to service implementation

CWPs and their SSDLs reported a number of operational challenges such as start-up issues such as, having to create letter heads, gain access to desks, computers, phones and identify admin support. They also reported the need for the development of a number of protocols and pathways for example, receiving and transferring referrals, safeguarding, risk assessment, communication and marketing with internal and external agencies. In many cases, the SSDL anecdotally reported that they would have benefited from more integration with senior management from the early start of the programme to support this process.

The operational difficulties encountered by the CWPs and SSDLs occurred within the context of systems change and some resistance to this change by existing services. SSDLs were responsible for designing a new pilot service that would sit alongside existing services. SSDLs were mindful to balance the desire to create a new service while also taking an overview of multiple existing services to fully understanding where and how the 'new' service would fit alongside existing and established services. The SSDLs and CWPs were under added pressure to develop a new service while also understanding and assimilating the training curriculum into clinical practice to then effect systems change more broadly.

Given the tight remit of the training course, the SSDLs and CWP had to balance receiving enough appropriate referrals while also not overstretching the team who were still in the infancy of training. SSDLs and CWPs reported that existing services were sceptical of the impact the 'new' service would have and were concerned about funding for existing services and de-skilling of the existing CAMHS workforce. SSDLs worked with senior leaders across existing services to develop a CWP service that would enable CYP to access services that they would not otherwise get and that would not detract from the core business of existing services.

Overall, the SSDL's were responsible for managing the daily operational service development needs and the close supervision of CWP's within their working week. The achievement of the CWP teams was reliant on close, high quality and effective in-built supervision within an overall service framework that supported the development of the CWP team alongside existing services.

The implementation process of new services and the transformation of existing clinical structures can take a number of years. However, SSDLs were faced with having to demonstrate value for money in terms of case throughput and accessibility by the end of the pilot year. SSDLs reported that they networked heavily with schools and GP surgeries and the newly developing CWP services spent time mapping existing services and highlighting gaps in provision. SSDLs attended numerous meetings with locality teams for example, from health, education and charities to market the new service while being mindful of the training needs of the CWPs. SSDLs utilised their Action Learning Sets to think through overcoming barriers to service change and many CWP services produced leaflets to market the service as part of the wider embedding process within systems change.

Despite the struggles that are inherent within system change processes, many CWP teams reported that they felt welcomed by existing CAMHS colleagues. However, in two cases the existing teams were not aware of the arrival of the CWP team or their functioning within and alongside CAMHS. In these cases, the CWPs anecdotally reported feeling initially marginalised and later fully integrated and supported by the existing service through the various processes of service implementation, integration and transformation.

Demographics of referred service users

The demographic characteristics of children and young people who were referred to CWP services within the collaborative are described below, all completed data was included in data analysis. Data was collected from 15 sites, each site reported data on age, gender and ethnicity of children and young people referred in their locality up until 1st April 2018.

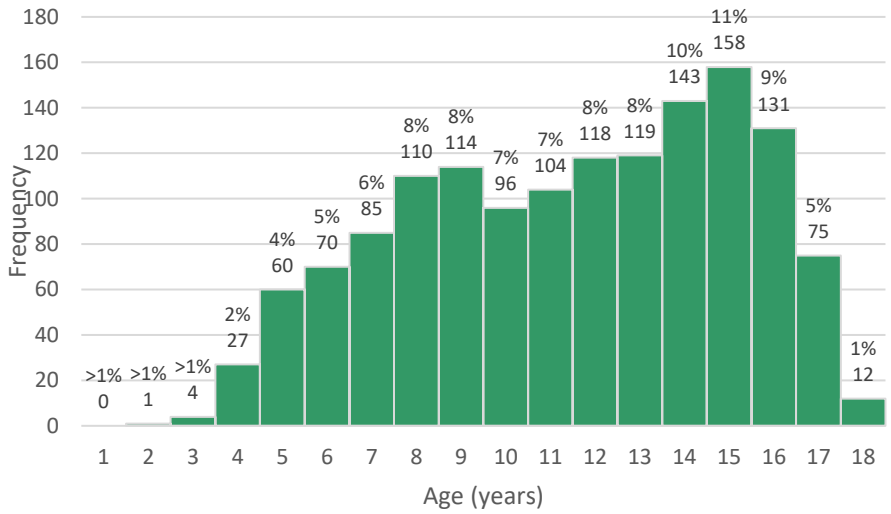

Figure 1: Histogram showing the distribution of age across the sample
n=7 not reported (1%) of the sample)

Figure 1 shows the ages of children and young people (n=1,427) referred to the CWP programme. The mean age was 11.47 years (SD= 3.66) and the most frequent age of the sample was 15 years old (11%), followed by 14-years old (10%) and 16-years olds (9%). The least frequent age was 1, 2 and 3 years old (>1%), followed by 18 years old (1%).

Of the sample (n=1,427) of children and young people, 54% were females and 45.8% were males, >1% of the sample self-disclosed and >1% did not wish to disclose their gender.

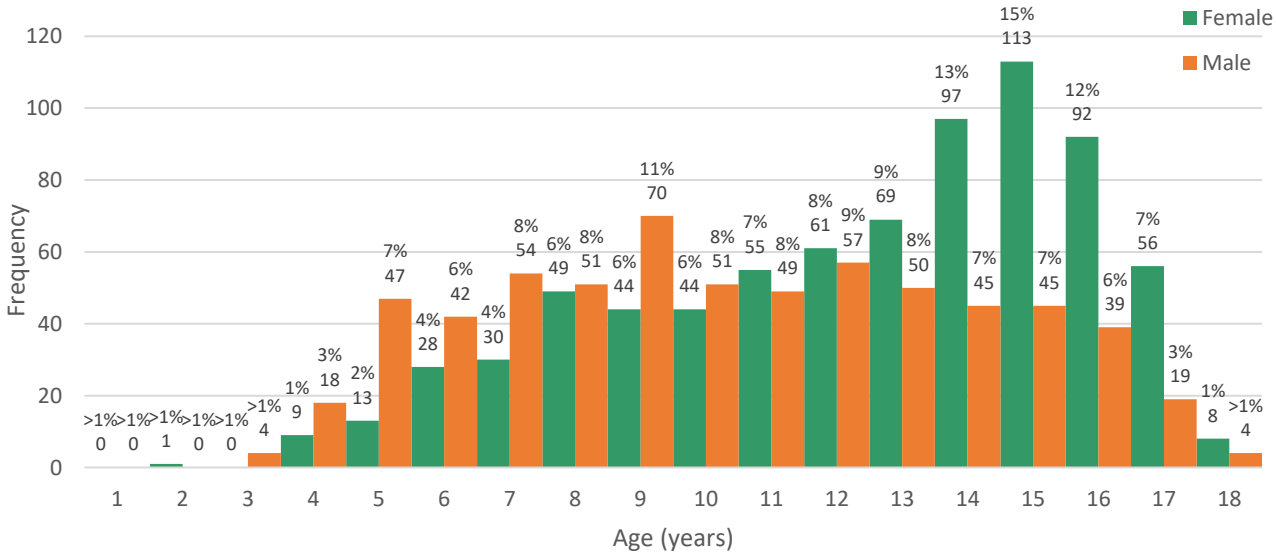

Figure 2. Histogram showing age distribution by gender
n=3 not reported (0.2%) of the sample

Figure 2 shows that the most frequent age of referral for females was 15 years (15%) whereas the most frequent age of referral for males was 9 years old (11%).

Table 6 below shows the spread of ethnicity of children and young people in the sample (n=1,434). In total, 54% (773) were White, 10% (141) were Mixed, 7% (105) were Asian, 7% (94) were Black, 5% (66) were recorded as other ethnicity and 18% (255) were unknown.

Table 6: Ethnicity distribution in the sample

White	Mixed	Asian	Black	Other	Unknown
773	141	105	94	66	255
54%	10%	7%	7%	5%	18%

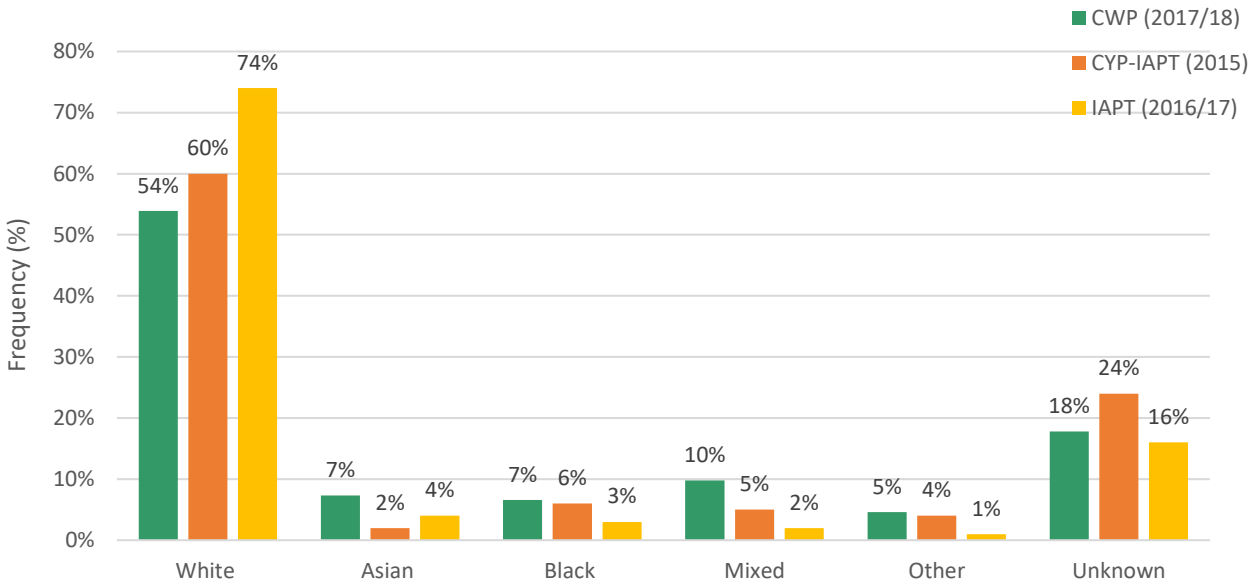

Figure 3. The ethnic breakdown of service users across the CWP and IAPT programmes
n=255 not reported (18%) of the sample

Figure 3 shows the CWP programme received a lower percentage of referrals for people from a White background (54%) as compared to the CYP-IAPT (60%) (CYP-IAPT, 2015) and National IAPT programme's (74%) (Baker, 2018) and a higher percentage of referrals from people from Asian (7%), Black (7%), Mixed (10%) and the Other (5%) category. The CWP programme had a lower percentage (18%) of unknown data recorded on ethnic background in comparison to CYP-IAPT (24%) and higher compared to National IAPT (16%) programmes.

Referrals received by CWP services

The total number of referrals to the CWP service across all 15 sites were 1,434. As shown in Figure 4 below, 78% (1,111) of referrals met referral criteria and were accepted for an assessment and/or intervention and 17% (243) did not meet referral criteria. The remaining 6% (80) were in progress, yet to be confirmed.

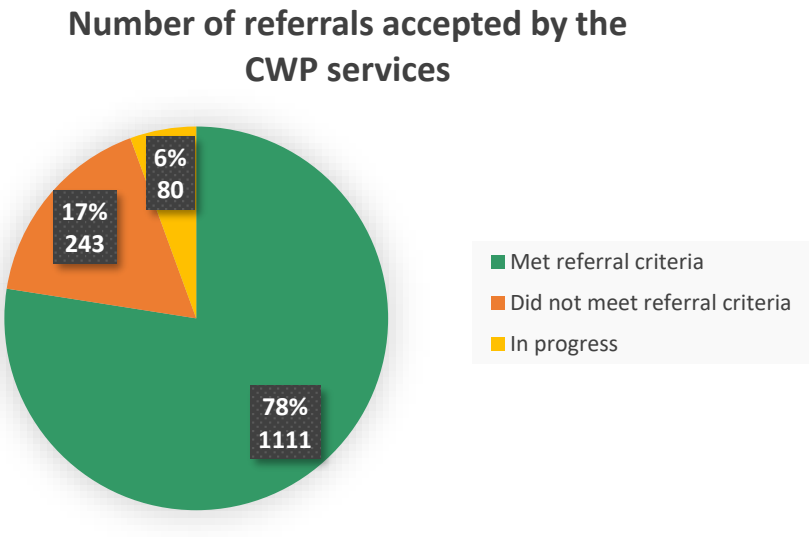

Figure 4. Pie-chart showing the number of referrals accepted onto the CWP services

Transition of referrals from the CWP services

Figure 5 shows the transition of those children and young people who were not seen by the CWP service. The proportion of children and young people who did not access the CWP service were referred to a Tier 3 service was 62% (150), followed by 21% (52) who were referred to their G.P, 5% (13) who were referred to a third sector organisation, 5% (12) who were unspecified, 3% (7) who were referred to a Tier 2 service, 3% (6) who were referred to another service and 1% (3) who were referred to a Tier 4 service.

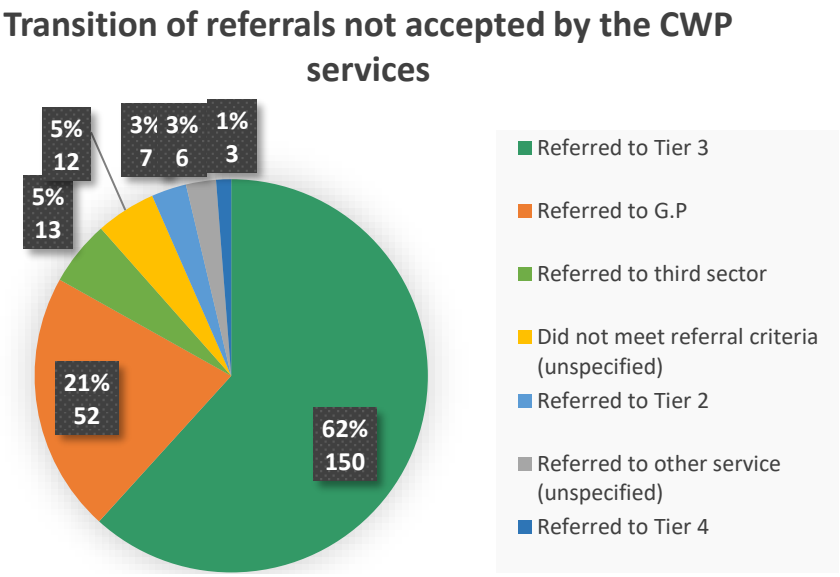

Figure 5. Pie-chart to show the transition of service users not seen by the CWP services
n= 12 not reported (16%) of the sample of cases that did not meet referral criteria

The number of assessments that took place across the CWP services were recorded as 1051 (73% of all referrals), however, there was some variation amongst sites in whether assessments were carried out and how these were operationalised. For example, some sites did not complete separate assessments but rather included a brief assessment within the first session of intervention. Other CWP services received referrals from other services where a generic mental health assessment had already been completed. Nine hundred and two children, young people and/or parents were reported to have attended the first session of intervention (63% of all referrals).

Source of referrals to CWP services

Figure 6 shows children and young people were most commonly referred from the education sector (37%), this mainly included schools. Following this a significant proportion of referrals came from CAMHS Tier 3 services (24%), including children and young people that didn't meet threshold for mainstream CAMHS. Thereafter the most common source of referral, was from self, parent and carers (8%). Referrals from G.P practices in primary care (7%), the local authority (5%), the voluntary and community sector (3%) were also received, as well as CAMHS Tier 2 (4%), CAMHS/triage (2%) and least frequently CAMHS tier 4 (>1%).

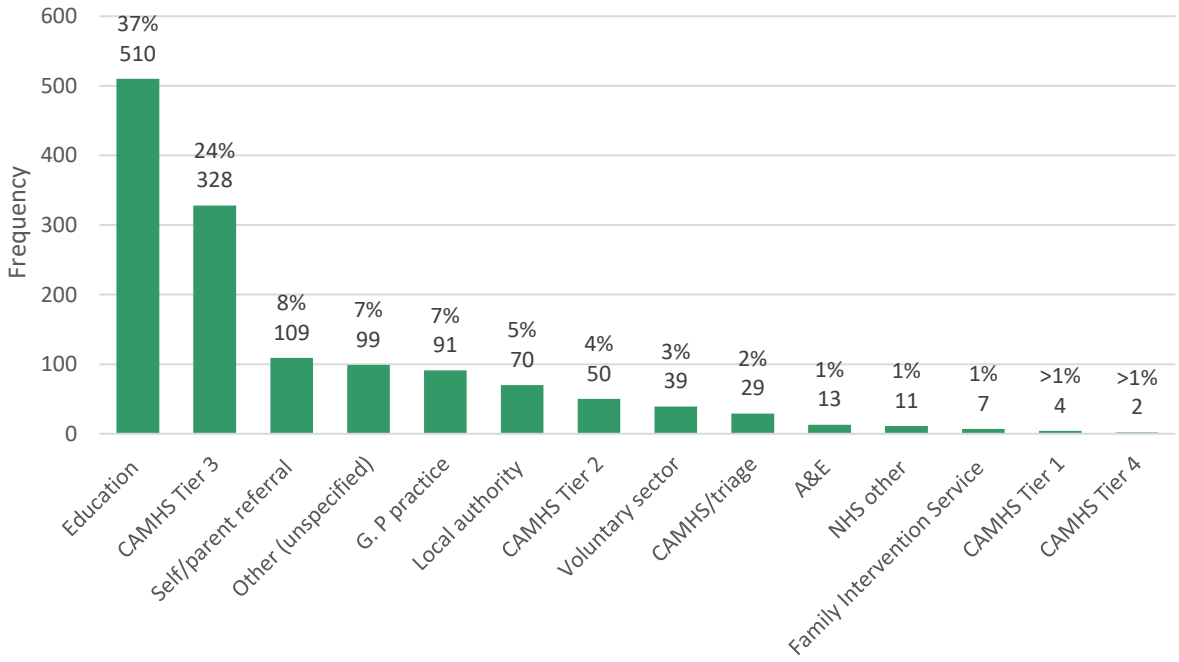

Figure 6. Bar graph to show referral source
n=72 not reported (5%) of the sample

Primary presenting problems at referral

Figure 7 shows a breakdown of the primary presenting problems of children and young people referred to CWP services. The most frequent primary presenting problems recorded at referral were anxiety (general), (50%), challenging behaviour (16%), low mood (15%), behavioural and emotional regulatory difficulties (5%), social phobia (4%), other (4%), separation anxiety (2%) and panic (2%). The least frequent presenting problems were phobia (1%) and a mixed presentation such as anxiety and low mood (1%).

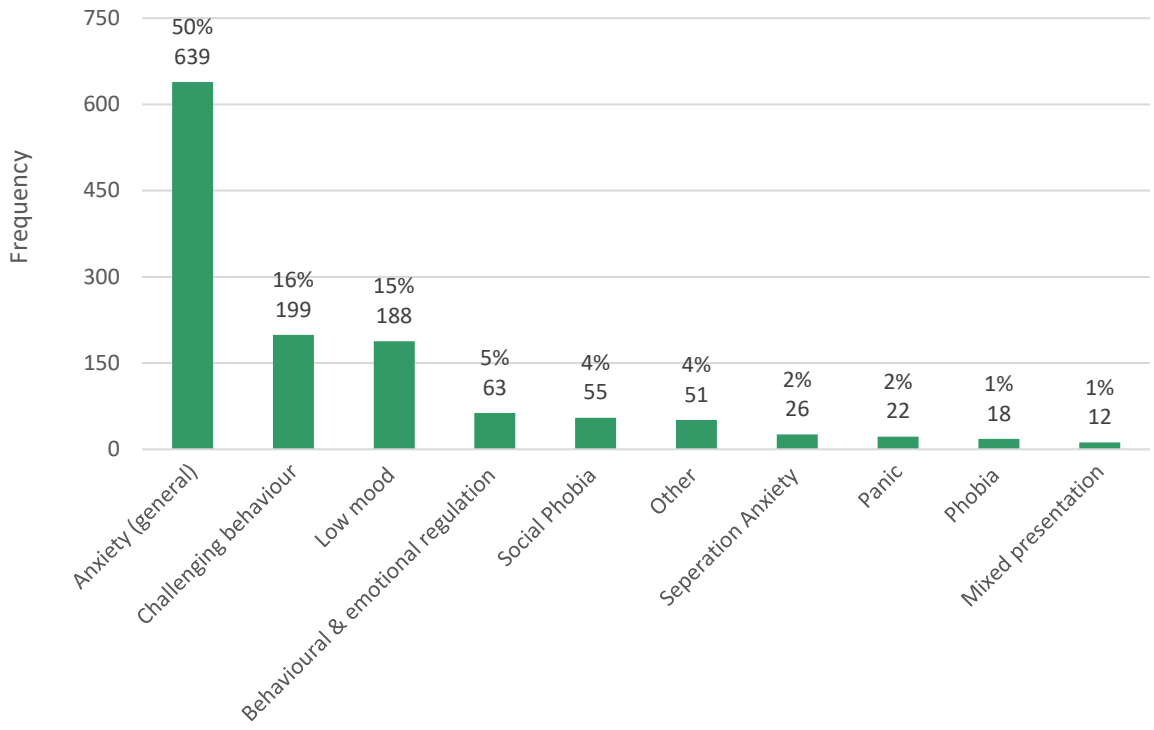

Figure 7. Bar graph showing the frequency of primary presenting problems
n=161 not reported (11%) of the sample

Guided self-help interventions

From site visits SSDL's reported that, when delivering guided self-help interventions in local services, anxiety case work appeared to be more easily identified as potential case work for the CWPs in the early stages of training. Many of the CWP teams developed their own Guided Self-Help Material based on the HEI teaching and used these manuals when working with parents, children and young people. Some services translated materials into various languages for their relevant community settings.

Figure 8 shows the most common intervention delivered was guided self-help (Child anxiety, Creswell) (25%), followed by guided self-help adolescent anxiety (24%), behavioural activation for low mood (Reading) (13%), guided self-help (Incredible Years) (13%), guided self-help (unspecified) (8%) The least common interventions were the other category (6%), workshops/groups (6%), computerised guided self-help (2%) and guided self-help for low mood (other) (>1%).

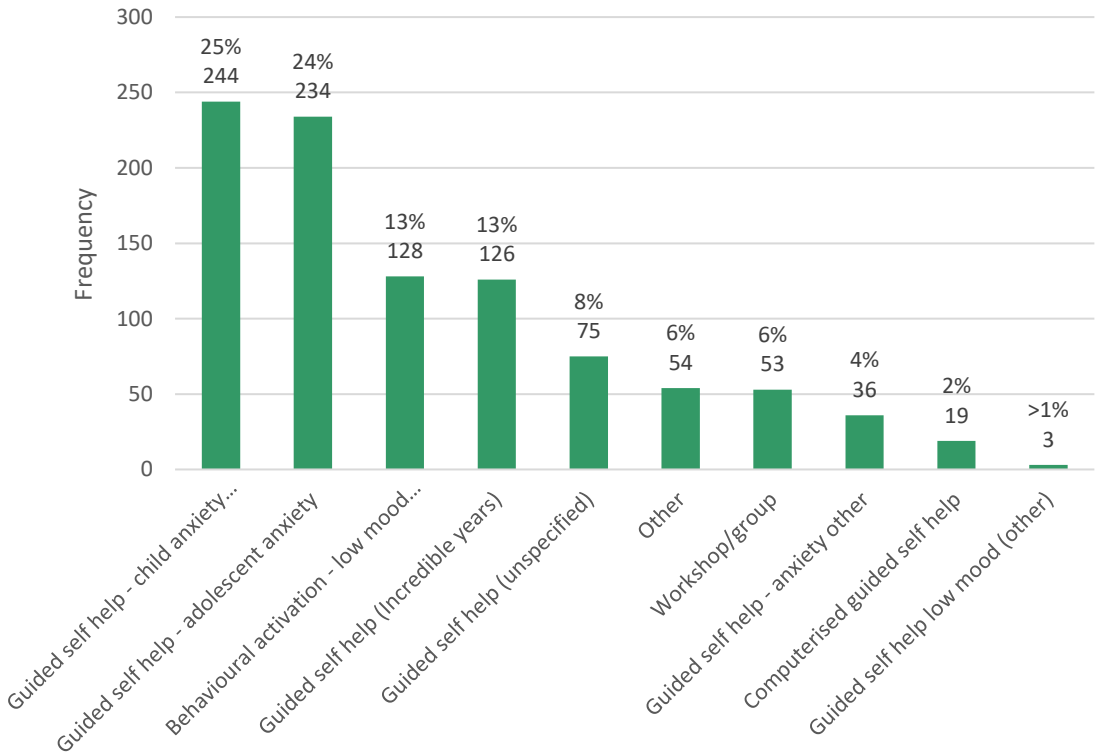

Figure 8. Bar-graph showing type of interventions delivered by the CWP programme n=139 not reported (10%) of accepted referrals

Sessions delivered across each CWP intervention

Figure 9 below shows the most common number of sessions for each intervention was 8 sessions (n=591), followed by 9 sessions, 6 sessions and thereafter 7 sessions, the least common number of sessions for each intervention was 14 sessions, 16 sessions, and lastly 23 sessions. The minimum number of sessions per intervention was 1 and the maximum number of sessions per intervention was 23. The average number of sessions that took place were 7.29, (SD=2.51) and overall the total number of sessions recorded across the CWP programme (n=1434) up till 1st April 2018 was 4260.

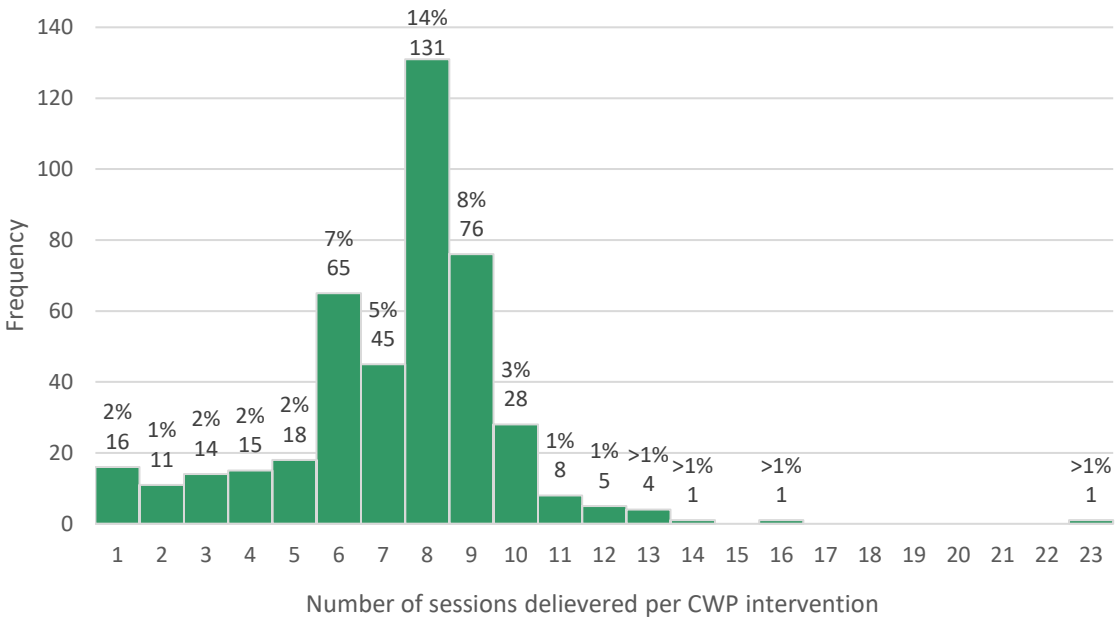

Figure 9. Histogram showing the number of sessions delivered per CWP intervention
n=152 not reported (26%) of cases which completed an intervention

Session Delivery

Figure 10 above shows the most common format of session delivery was face to face (75%), followed by a combination of face to face and telephone (23%) and a small proportion was delivered by telephone (1%). Data relating to the location of interventions across the CWP programme was also collected.

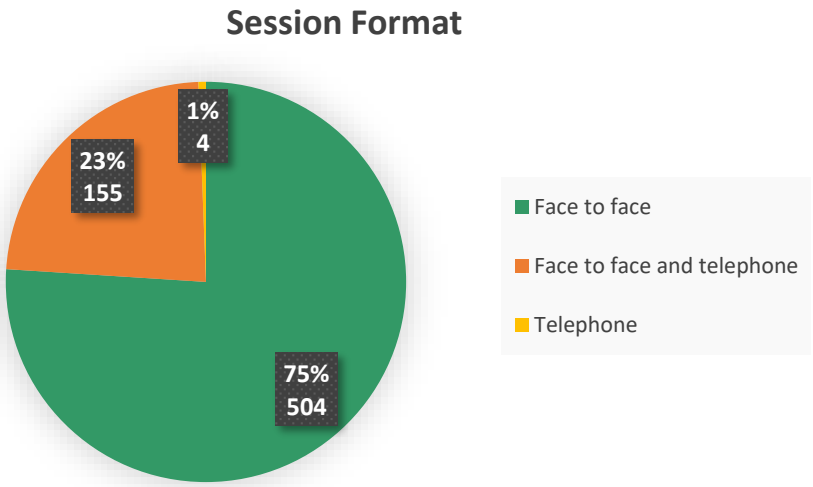

Figure 10. Pie-chart showing the breakdown of the format of session delivery
n= 448 not reported (40%) of the sample of accepted referrals

Session Locations

Figure 11 below shows that the most common session location was educational settings (41%), followed by CAMHS premises (30%), the voluntary and charity sector (13%), the child or young person's home (8%), at a youth centre (7%) or community centre (1%) and a small proportion of session took place in a primary care setting (>1%).

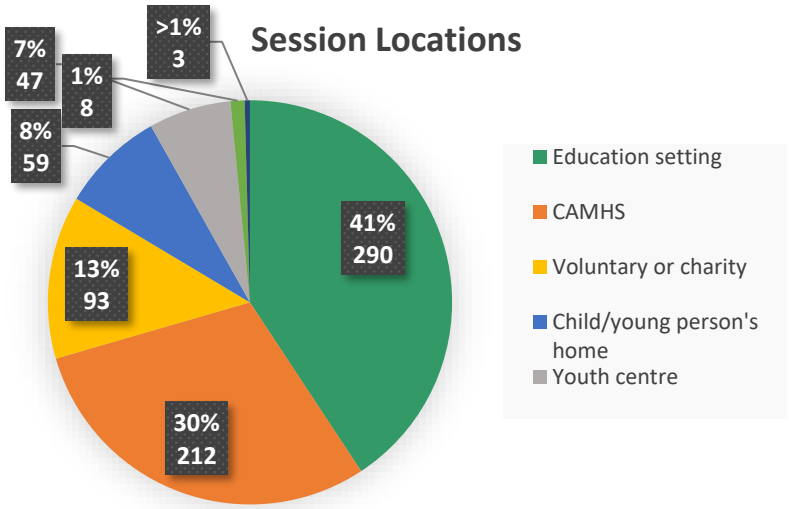

Figure 11. Pie-chart showing the breakdown of session locations
n=399 not reported (36%) of accepted cases

Transition of service users at the end of intervention

The number of children and young people that completed an intervention with a CWP at the time of data submission was 591. Figure 11 shows majority of service users who completed an intervention with a CWP (90%) weren't referred on for further support at the time of discharge. A proportion of those who completed an intervention were stepped up to a Tier 3 or other service (7%) and a smaller percentage were referred to a third sector organisation (2%) following an intervention with a CWP.

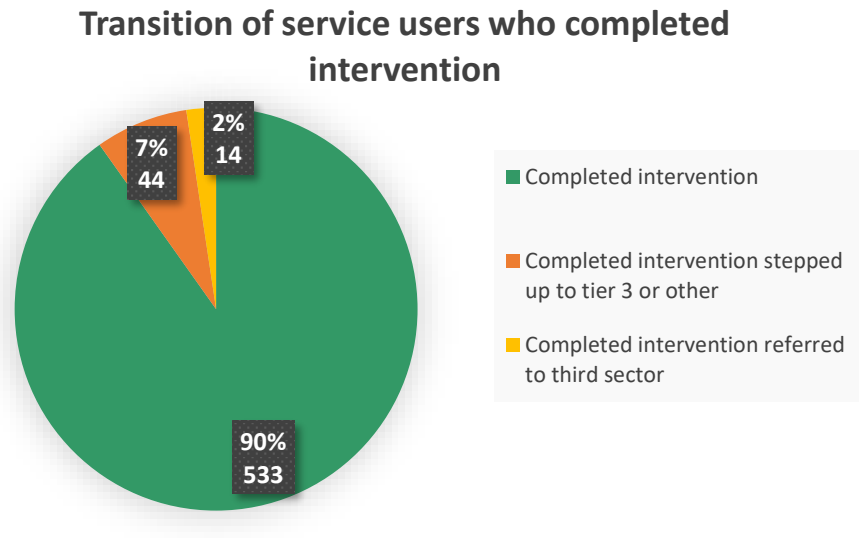

Figure 12. Pie-chart to show the transition of service users who completed intervention

Section 1 Summary

The qualitative data collected through site visits and the end of year learning event was extremely encouraging and overall demonstrated that sites were successful in their implementation of the CWP service model. As can be seen from the data presented, there was a wide variation in the service model design and a wealth of innovative practice that brought the aims of the CWP programme to fruition.

Service Implementation

The most popular service delivery model was placing CWP teams within an Education setting. Of the 15 sites, six based their service in schools for at least part of the working week and further teams offered appointments in school. Referral data also showed a high proportion (37%) of referrals were received from education services. This is a much higher proportion of referrals than those to CYP-IAPT services where only 10% of referrals were received from Education (CYP-IAPT, Rapid Internal Audit, 2015). The success of this service delivery model is very encouraging for the aims of the Government Green Paper on the transformation of children and young people's mental health provision and plans to place mental health support teams within all educational settings nationally. However, in light of the popularity of this service delivery model within

CWP teams, there is likely to be significant overlap between the CWP training and service delivery model and new Education Mental Health Worker programme. Careful consideration of how these two programmes can be integrated and work in unison will be particularly important moving forward.

The 15 sites were able to offer training opportunities for CWPS at the service base and of the 15 sites seven were able to offer training experiences within schools in addition to the service base. SSDLs were from a range of backgrounds and CWPs had access to a range of rich training experiences including shadowing core MDT staff in CAMHS and opportunities for formal and informal supervision within group and individual formats.

Challenges to Service Implementation

A number of services reported initial implementation difficulties, particularly in relation to basic service set up, e.g. where CWPs will be located and access to desks/computers/phones. Whilst these may appear minor issues they have a significant impact on the experience of new clinicians and the ability to start clinical work. In the second cohort it will be important for sites, particularly those who are new to the CWP programme, to learn from the experiences this year and attempt to resolve these issues as early as possible.

Many services also reported challenges relating to the need to draw up new service protocols e.g. in relation to referral pathways and risk management, as well as considerable work in promoting the service and communicating with internal and external agencies. These challenges are expected with all new service developments, but worth holding in mind when considering the impact of these services at such an early stage in their development. Understandably the requirement to implement these start up procedures will have an impact on the team's ability to start receiving referrals and providing interventions. In future years, for those services that are already established this process will hopefully be a faster.

Two services reported significant early difficulties in integrating with the existing CAMHS services. These problems seemed to primarily derive from a lack of understanding and communication about the CWP programme and the role they would play within CAMHS. Following service transformation and integration processes these initial difficulties were resolved, however, it highlights the need moving forward to ensure that there is clear communication and information shared across teams in an attempt to prevent these initial problems.

SSDLs were tasked with creating a new service and effecting a systems change. For example, the new CWP service needed to think strategically about the way the new and existing services would think about referrals and allocations to teams - the CWP service created an opportunity for greater access to mental health services. However, the SSDLs role involved shifting current thinking about services and building new relationships as well as developing a core purpose of the CWP model that would fit with the population needs. The SSDLs reported balancing their time to build up a skilled CWP workforce while also building relationships with existing teams to enable a culture of collaboration for systems change. SSDLs navigated the current system and its related financial and resource constraints with the opportunity for innovative practice based on a separate income stream. SSDLs also learnt to balance the relative tensions this new opportunity brought and how this may have played out in teams and with colleagues. SSDLs thus endeavoured to create a culture of system change that supported and complemented existing services. Shifts in system change were afforded through networking. For example, SSDLs were part of local and national steering groups and this provided opportunities to network with commissioners and managers. Networking with senior leadership groups enabled SSDLs to form a collective leadership group and gain greater 'credibility' and 'sponsorship' to be able to test out a new model for delivering mental health intervention against a backdrop of historic system constraints.

Access

The data revealed encouraging findings for one of the key aims of the CWP programme which was to increase access to mental health services for children and young people. While still fairly low there was nonetheless an encouraging number of self-referrals (8%) which is higher than rates reported by general CAMHS (5%, CSN Policy Briefing, 2015) and CYP-IAPT services (2.5%, CYP-IAPT Rapid Internal Audit, 2015). In contrast, referrals made from GPs were much lower (7%) in comparison to CAMHS data (44%. CSN Policy Briefing, 2015). This in combination with the high level of referrals from Education suggests that the services are successfully accessing referrals from different sources and increasing the breadth of mental health service provision for children and young people.

Furthermore, the location of sessions was also predominantly away from clinic bases (70%), with 40% of sessions being held in educational settings, 13% in voluntary or charity settings and 15% in service user's homes or youth centres. This is again encouraging in relation to increased accessibility and flexibility in service delivery and in line with feedback from young people who report wanting services to be in more welcoming environments, such as home, school or community settings and less clinical settings (Department of Health, 2015).

The total number of referrals recorded during the audit's time frame was 1,434 and 1,111 were accepted (78%). The acceptance rate is comparable to other CAMHS data (79%, CAMHS Benchmarking Report, 2013) and suggests that on the whole, the referrals that were made were appropriate.

Demographics of referrals

The mean age of children and young people referred to the service was 11.47 years old and the largest proportion of referrals were made for young people between the ages of 11-15 years old. This is comparable to the CYP-IAPT data where the mean age was found to be 12.96 years old (CYP-IAPT Internal Rapid Report, 2015) and general CAMHS data which reports the highest proportion of referrals to be between the ages of 11-15 years (Children's Commissioner Lightning Review, 2016).

Interestingly there was a peak in referrals for boys between the ages of 8 and 9 years old and girls between the ages of 14 and 15 years old. It's possible these differences relate to cognitive/developmental transitions that children go through at these ages or the difference in prevalence of particular disorders at different ages. For example, National statistics for mental health disorders in children and adolescents (2004) show that "children with emotional disorders were more likely than those without emotional disorders to be girls (54 % compared to 49%) and to be in the older age group, 11-16 (62% compared to 46%). In contrast, children with conduct and hyperkinetic disorders are predominantly boys (National statistics, 2004). The guided self-help (GSH) interventions provided by CWP services focused on interventions for challenging behaviour for children between the ages of 2 and 11 years old and there was a broader range of interventions for emotional disorders available for young people from 11-18 years old. It's possible that the referral data reflects these differences.

In regard to ethnicity data, the majority of referrals reported that they were from a White background (54%), with 10% Mixed, 7 % Black and 7% Asian. This data is relatively in line with other CAMHS data, although encouragingly found higher proportions of referrals from Black, Asian and Mixed backgrounds (7 % versus 6%, 7% versus 2% and 10% versus 5% respectively in comparison to CYP-IAPT data, 2015). This is again suggesting that CWP services are beginning to increase the accessibility and breadth of mental health service provision for children and young people.

Guided self-help

The data reported regarding presenting problems at referral encouragingly represents the presenting problems targeted by the GSH interventions taught on the course and demonstrates that appropriate referrals were being made to services. Furthermore, the average number of sessions offered was 8, with a majority falling between 6-9 sessions. This demonstrates that overall CWPs are providing short/focused interventions which fits with the aims of a low intensity model and is encouraging for the hopes of increasing service capacity over the following years.

It is also extremely encouraging to see that majority of cases (90%) were discharged without being referred for no further support. This suggests that the interventions provided were successful in helping children and young people overcoming the difficulties they sought help for and this is further supported by the outcomes data presented in the following section of the report.

Section 2: Interventions - CWP assessed/treated cases

This section of the audit focuses on the outcomes for children and young people who have received guided self-help interventions from Children Wellbeing Practitioners (CWPs). These outcomes were collected using an online outcome monitoring system called POD and CWPs followed an outcomes framework developed by the London and South East collaborative, including measures of symptoms, goals and experiences (see method section for data collection process, procedure and analysis pg. x).

Sample

On the 24/07/2018, a total of 1136 clients were registered on POD, of which 958 clients had outcomes data which met the inclusion criteria. 368 of these cases were current and 590 had completed intervention with a CWP.

Table 7: The cases break down into the following groups for clients registered on POD (n=1136)

Group	Current	%	Complete Intervention	%
General Pathway	214	18%	301	26%
Anxiety-Adolescent	81	7%	166	15%
Anxiety-Child	64	6%	124	11%
Behaviour Difficulties	32	3%	72	6%
Low Mood	30	3%	52	5%

Table 8: The cases break down into the following groups for clients with outcome data (n=958)

Group	Current	%	Complete Intervention	%
General Pathway	193	20%	235	24%
Anxiety-Adolescent	67	7%	140	14%
Anxiety-Child	53	5%	105	11%
Behaviour Difficulties	29	3%	65	6%
Low Mood	26	3%	45	4%

Goal Based Outcomes (GBOs)

Data for GBOs was available for 430 clients at Time 1 and 385 clients at Time 2, creating a percentage completion for Time 2 data of 89.5%.

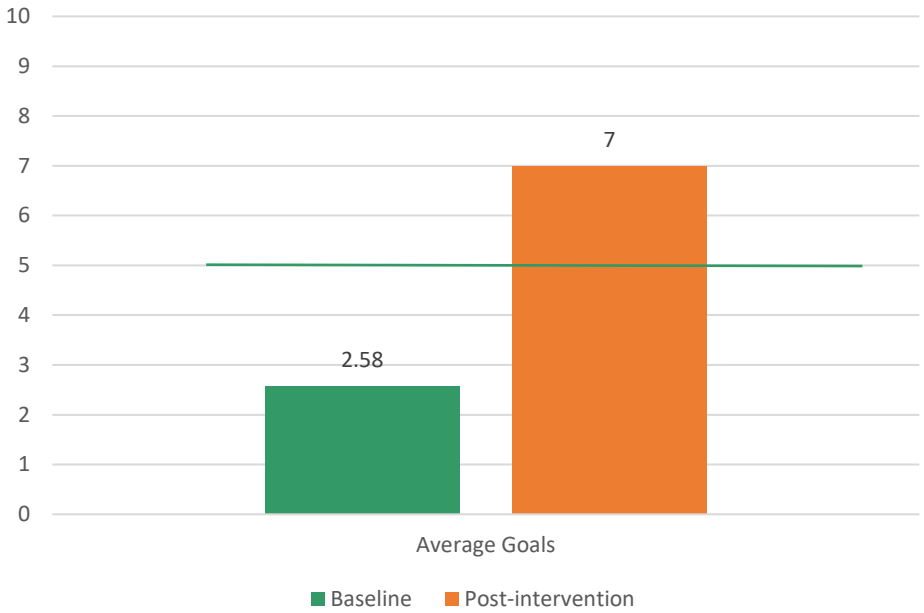

Figure 13. The average goal ratings at baseline and post-intervention.

The line represents the level of reliable change, which is a point change of 2.45 (Edbrooke-Childs et al, 2015). Graph 5 shows that overall for GBO clients exceed the level of reliable change at post-intervention.

Reliable change refers to whether the change in scores between measurements on a psychological scale is enough that the change is unlikely to be due to simple measurement error (Jacobson & Truax, 1991). The reliable change index (RCI) estimates the amount of change a client must show on a specific psychological measure between measurement time-points for that change to be reliable, this is calculated using the pre-treatment and post treatment scores and the internal consistency of the measure. Service users can be classified into the categories of the proportion that showed reliable improvement, deterioration or not changed (Edrooke-Childs et al, (2015).

Table 9: Score Descriptives of Goals

Subscale		**Baseline**		**Post-treatment**			
	N	***M (SD)***	**95% CI**	***M (SD)***	**95% CI**	***t***	***g* (95% CI)**
Goal 1	381	2.57 (2.06)	2.36-2.78	6.96 (2.67)	6.69-7.22	t(380) = 28.81, p < .001	1.82 (1.62-2.02)
Goal 2	314	2.45 (1.92)	2.23-2.66	7.11 (2.56)	6.83-7.40	t(313) = 29.83, p < .001	2.04 (1.81-2.28)
Goal 3	199	2.56 (1.84)	2.31-2.82	6.95 (2.74)	6.57-7.33	t(198) = 20.99, p < .001	1.85 (1.57-2.14)
Average Goals	385	2.58 (1.79)	2.41-2.76	7.00 (2.35)	6.76-7.23	t(384) = 33.65, p < .001	2.10 (1.88-2.31)

The mean GBO score significantly increased from baseline (M= 2.58, SD= 1.79) to discharge (M=7.00, SD=2.35; t (384) =33.65, p<.001, g=2.10, 95% CI [1.88-2.31]).

Table 10: Reliable Change for Goals

Subscale	N	N (%) Improvement	N (%) Deterioration	N (%) No Change
Goal 1	381	277 (73%)	3 (1%)	101 (27%)
Goal 2	314	249 (79%)	2 (1%)	63 (20%)
Goal 3	199	147 (74%)	3 (2%)	49 (25%)
Average Goals	385	297 (77%)	1 (1%)	86 (22%)

On average, 77% of clients showed a reliable improvement in GBO scores between Time 1 and Time 2. Few clients (1%) showed reliable deterioration, and 22% showed no reliable change.

SDQ

Data for the SDQ was available for 227 clients at Time 1 and 155 clients at Time 2, creating a percentage completion for Time 2 data of 68.3%.

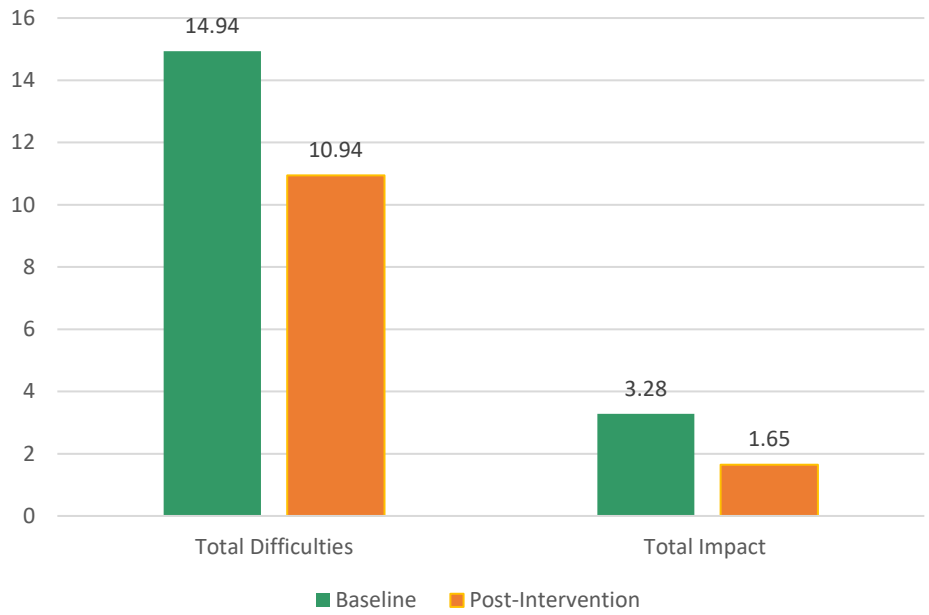

Figure 14: Mean SDQ Subscale Scores at Time 1 and Time 2

Table 11: SDQ Subscale Difference Time 1 and Time 2

		Baseline		Post-treatment			
Subscale	***N***	***M (SD)***	**95% CI**	***M (SD)***	**95% CI**	***t***	***g* (95% CI)**
IMPACT Total	128	3.28 (2.49)	2.85-3.71	1.65 (2.05)	1.29-2.00	t(127) = 8.89, p<.001	0.82 (0.61-1.02)
Total Difficulties	112	14.94 (6.27)	13.78-16.10	10.94 (5.82)	9.86-12.02	t(111) = 7.40, p < .001	0.66 (0.46-0.85)

Table 11 shows that the mean Total Difficulties score significantly declined from baseline (M = 14.94, SD = 6.27) to post treatment (M = 10.94, SD = 5.82; t(111) = 7.40, p < .001, g = 0.66, 95% CI [0.46-0.85]).

The mean Total IMPACT score significantly declined from baseline (M = 3.28, SD = 2.49) to post treatment (M = 1.65, SD = 2.05; t(127) = 8.89, p < .001, g = 0.82, 95% CI [0.61-1.02]).

The Total Difficulties mean scores moved from the 'Slightly Raised' clinical range at Time 1 (Score of 14-16) to the 'Close to Average' clinical range at Time 2 (Score of 0-13). The IMPACT supplement of the SDQ scores moved from the clinical range 'Very High' at Time 1 (Score of 3-10) to 'Slightly Raised' at Time 2 (Score of 1).

Table 12: McNemar Chi Square analysis for SDQ

		Baseline			Post-intervention				
Subscale	***Total N***	***N > Cutoff***	***M (SD)***	**95% CI**	***N > Cutoff***	***M (SD)***	**95% CI**	***χ2***	***OR* (95% CI)**
Total Difficulties	112	89	0.79 (0.40)	0.72-0.87	56	0.50 (0.50)	0.41-0.59	χ2(1) = 24.20, p < .001	6.50 (2.75-15.35)
Impact	128	66	0.52 (0.50)	0.43-0.60	23	0.18 (0.38)	0.11-0.25	χ2(1) = 34.89, p < .001	9.60 (3.83-24.11)

Table 12 shows the number of people scoring above the high clinical cut off (>17 Total Difficulties; >2 IMPACT) at baseline and post-intervention. The number of people scoring in the high range for the Total Difficulties and IMPACT subscales both reduced post intervention compared to baseline. These differences were found to be statistically significant (p<0.001). These results are represented in the below graph x.

Total Difficulties

For Total Difficulties at baseline, 79% of 112 individuals met the SDQ clinical threshold. At post intervention, this was significantly reduced to 50% (χ2(1) = 24.20, p < .001, OR = 6.50, 95% CI [2.75-15.35]). The Odds Ratio demonstrates that the outcomes were due to the intervention rather than occurring in the absence of the intervention.

Of the 89 cases who met the clinical threshold on the SDQ Total Difficulties at baseline, 44% were no longer in the clinical range following intervention. 56% of the 89 cases who showed caseness on any SDQ scale (no impact) maintained caseness on at least one scale at post intervention.

Total IMPACT

For Total IMPACT at baseline, 52% of 128 individuals met the SDQ clinical threshold. At post intervention, this was significantly reduced to 18% (χ2(1) = 34.89, p < .001, OR = 9.60, 95% CI [3.83-24.11]).

Of the 66 cases who met the clinical threshold on the SDQ IMPACT total at baseline, 73% were no longer in the clinical range following intervention. 27% of the 66 cases who showed caseness on any IMPACT scale maintained caseness on at least one scale at post intervention.

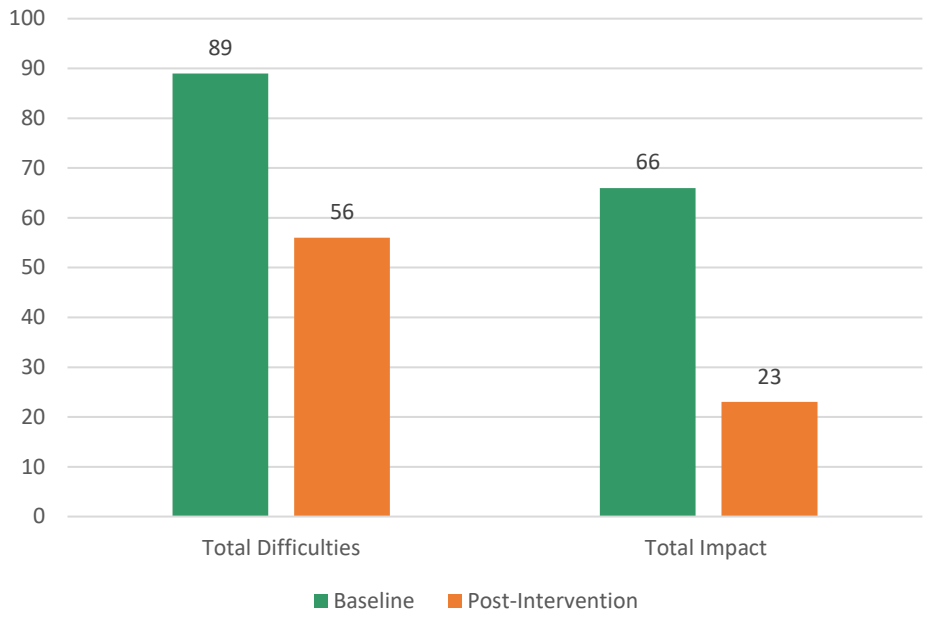

Figure 15: The number of clients above clinical cut off at Time 1 decreased at Time 2 for Total Difficulties and the IMPACT subscales

Table 13: Reliable Change Analysis for SDQ

Subscale	N	N (%) Improvement	N (%) Deterioration	N (%) No Change
IMPACT	128	48 (37.5%)	2 (2.3%)	77 (60.2%)
Total Difficulties	112	22 (19.6%)	0 (0%)	90 (80.4%)

Table 13 shows the percentage of client SDQ scores which reached reliable change for Total Difficulties and IMPACT. For SDQ IMPACT, the reliable change index was calculated as a change in score of 2.47. For SDQ Total Difficulties RCI was 8.69. A higher proportion of IMPACT scores reliably improved (38%) compared to Total Difficulties (20%).

RCADS

Data for the RCADS was available for 385 clients at Time 1 and 287 clients at Time 2, therefore the percentage of completion at Time 2 was 74.5%.

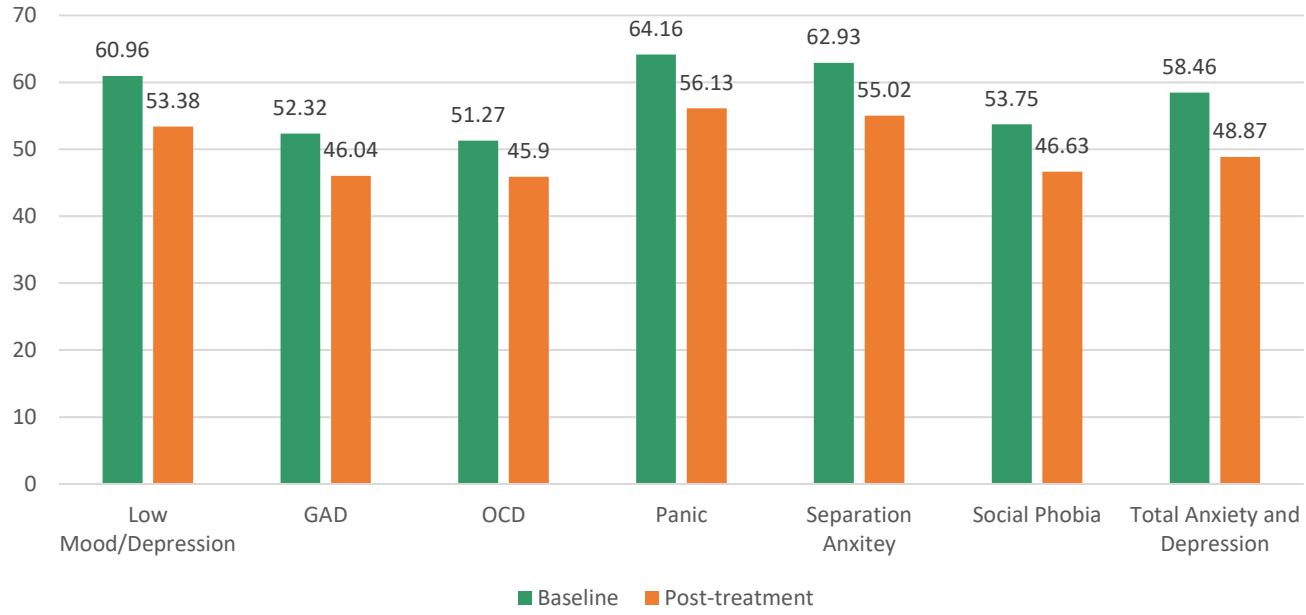

Figure 16: Mean RCADS Subscale Scores at Time 1 and Time 2

Table 14: RCADS Subscale Means at Time 1 and Time 2

Subscale		**Baseline**			**Post-Intervention**			
	N	***M (SD)***	**95% CI**	***M (SD)***	**95% CI**	***t***	***g* (95% CI)**
Low Mood/Depression	259	60.96 (16.03)	59.01-62.91	53.38 (16.69)	51.35-55.41	t(258) = 8.81, p < .001	0.46 (0.35-0.57)
GAD	255	52.32 (12.27)	50.81-53.82	46.04 (12.49)	44.51-47.58	t(254) = 8.47, p < .001	0.51 (0.38-0.63)
OCD	245	51.27 (12.72)	49.67-52.86	45.90 (12.47)	44.34-47.46	t(244) = 7.93, p < .001	0.42 (0.31-0.53)
Panic	253	64.16 (17.15)	62.04-66.27	56.13 (16.42)	54.10-58.15	t(252) = 9.19, p < .001	0.48 (0.37-0.58)
Separation anxiety	243	62.93 (16.48)	60.85-65.00	55.02 (15.20)	53.11-56.93	t(242) = 8.08, p < .001	0.50 (0.37-0.62)
Social Phobia	247	53.75 (12.90)	52.14-55.36	46.63 (12.87)	45.02-48.23	t(246) = 9.65, p < .001	0.55 (0.43-0.67)
Total Anxiety and Depression	236	58.46 (13.87)	56.69-60.23	48.87 (13.67)	47.12-50.61	t(235) = 11.49, p < .001	0.69 (0.56-0.83)

Table 14 shows that mean scores on subscales at Time 1 (Baseline) ranged from 51-64. The range at Time 2 (Post -Intervention) is 45-56. The differences in group means at Time 1 and Time 2 were all found to be statistically significant (p=<0.001). Further analysis on the effect sizes was conducted using Hedges g. The effect sizes for GAD, Separation Anxiety and Social Phobia was found to be moderate (0.5-0.8), while Low Mood, OCD and Panic were found to be low (0.2-0.5).

The mean total anxiety and depression score significantly declined from baseline (M = 58.46, SD = 13.87) to discharge (M = 48.87, SD = 13.67; t(235) = 11.49, p < .001, g = 0.69, 95% CI [0.56-0.83]).

Table 15: McNemar Chi Square analysis for RCADS

Subscale		**Baseline**			**Post-treatment**			
	Total N	***N > Cutoff***	***M (SD)***	**95% CI**	***N > Cutoff***	***M (SD)***	**95% CI**	***χ2***
Low Mood/Depression	259	102	0.39 (0.49)	0.33-0.45	58	0.22 (0.42)	0.17-0.27	$\chi2(1) = 30.25$, $p < .001$
GAD	255	46	0.18 (0.38)	0.13-0.23	25	0.10 (0.30)	0.06-0.13	$\chi2(1) = 12.60$, $p < .001$
OCD	245	40	0.16 (0.37)	0.12-0.21	23	0.09 (0.29)	0.06-0.13	$\chi2(1) = 8.76$, $p = 0.003$
Panic	253	114	0.45 (0.50)	0.39-0.51	72	0.28 (0.45)	0.23-0.34	$\chi2(1) = 27.56$, $p < .001$
Separation anxiety	243	102	0.42 (0.49)	0.36-0.48	50	0.21 (0.40)	0.15-0.26	$\chi2(1) = 37.56$, $p < .001$
Social Phobia	247	58	0.23 (0.42)	0.18-0.29	29	0.12 (0.32)	0.08-0.16	$\chi2(1) = 16.49$, $p < .001$
All Scales	236	159	0.67 (0.47)	0.61-0.73	90	0.38 (0.49)	0.32-0.44	$\chi2(1) = 53.49$, $p < .001$

Table 15 shows an analysis on the clinical ranges in the RCADS measured by clients who scored above the clinical cut off (>65 t scores) at Time 1 compared to Time 2. There was a reduction in the number of people scoring above the clinical threshold in all sub scales post treatment. All of these differences were found to be statistically significant (p=<0.001).

At Time 1 the proportion of cases who were in the clinical range on any subscale was 0.67 (0.47). Post treatment this was reduced to 0.38 (0.49). This was highly statistically significant ($\chi2(1) = 53.49$, $p < .001$). The proportion recovered on all scales was 49.7%. At post treatment the proportion of clinical cases was only 0.18 (0.38) indicating a recovery rate of 45%.

At baseline, 39% of 259 individuals met the RCADS clinical threshold for depression. At discharge, this was significantly reduced to 22% ($\chi2(1) = 30.25$, $p < .001$, OR = 5.40, 95% CI [2.75-10.6]).

Of the 102 cases who met the clinical threshold on the RCADS depression scale at baseline, 53% were no longer in the clinical range following treatment.

50% of the 159 cases who showed a clinically significant score on at least one RCADS scale at baseline recovered on all scales.

50% of the 159 cases who showed caseness on any RCADS scale maintained caseness on at least one scale at discharge.

Of those completing all the RCADS scales at both time-points (n = 236), 67% (95% CI: 61%-73%) met caseness criteria on one or more RCADS scales. This dropped to 38% (95% CI: 32%-44%) at discharge.

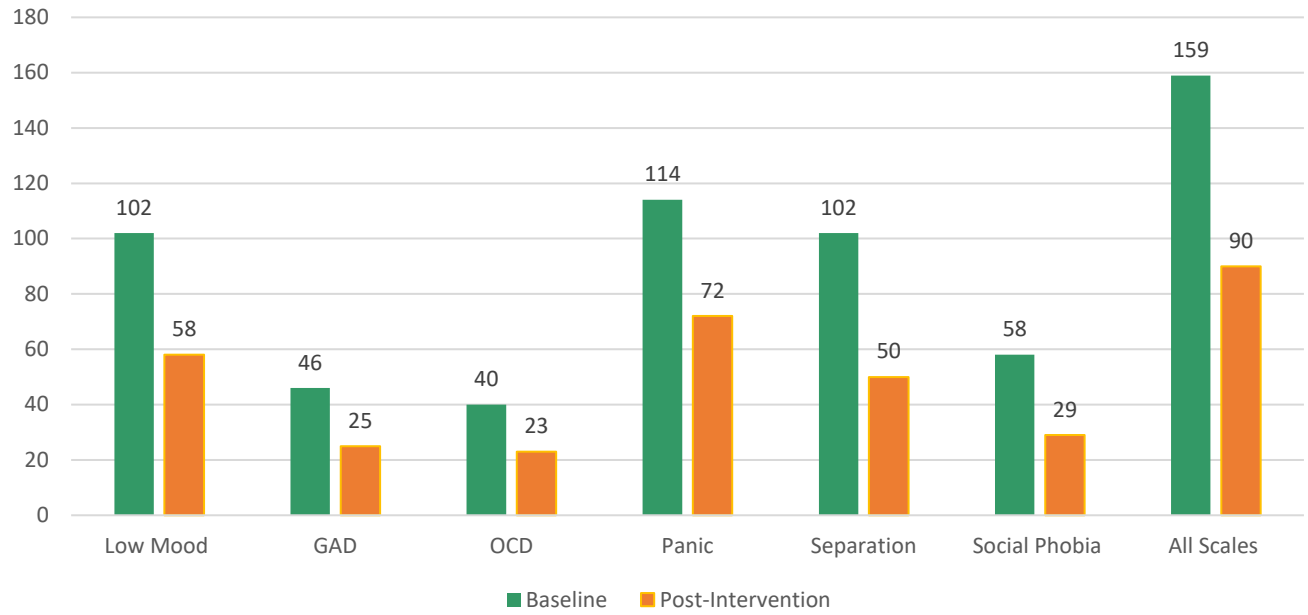

Figure 17: The number of clients above clinical cut off at Time 1 decreased at Time 2 for all subscales

All scores represent a binary variable indicating whether participants scored above threshold on *any* of the RCADS subscales at each time-point. Data in all scales contains all subscales including Total Anxiety and Total Anxiety and Depression scores.

Table 16: CWP reliable Change for RCADS Subscales

Subscale	**N**	***N* (%) Improvement**	***N* (%) Deterioration**	***N* (%) No Change**
Low Mood/Depression	259	54 (21%)	10 (4%)	195 (75%)
GAD	255	61 (24%)	6 (2%)	188 (74%)
OCD	245	39 (16%)	8 (3%)	198 (81%)
Panic	253	60 (24%)	7 (3%)	186 (74%)
Separation anxiety	243	41 (17%)	3 (1%)	204 (84%)
Social Phobia	247	69 (28%)	7 (3%)	171 (69%)
Total Anxiety	243	69 (28%)	5 (2%)	169 (70%)
Total Anxiety and Depression	236	77 (33%)	5 (2%)	154 (65%)

For Total Anxiety and Depression, the level of reliable change was calculated at 14.89.

Almost one in three (33%) of 236 cases showed a reliable improvement in RCADS total anxiety and depression scores between Time 1 and Time 2.

Few patients (2%) showed reliable deterioration in their RCADS depression and anxiety scores, and 65% showed no reliable change.

Experience Measures

SFQ

The SFQ was completed a total of **2922 times** on POD. The SFQ was used by 13 sites.

Table 17: Mean SFQ Score per item

Item	Mean (SD)
Listened to	4.88 (.4)
Discussed topics client wanted	4.75 (.5)
Understanding content	4.77 (.5)
Ideas for what to do	4.60 (.7)

96% (n=2812) of sessions were rated the top 25% of the satisfaction scale or above (>16).

SRS

The SRS was completed a total of **345 times** on POD. The SRS was used by 8 sites.

Table 18: Mean SRS Score per Item

Item	Mean (SD)	% scores less than 9
Goals	9.39 (1.2)	12%
Approach	9.46 (1.3)	9%
Overall	9.46 (1.3)	10%

Table 18 shows the mean SRS scores. A score of lower than 36, overall, or 9 on any scale, could be a source of concern and therefore prudent to invite the client to comment.

78% (n=269) of sessions were rated the top 25% of the satisfaction scale or above (>36).

ESQ

Young Person ESQ

257 young people completed the **self-rated ESQ.**

Tables 19 highlights child-reported responses about their experience of being offered a CWP service. Overall, most items were related Certainly True, with "comfortable facilities" scoring low but most young people reported that 'they felt listened to', 'had received good help', and were 'treated well'.

Table 19: Experience of service child-reported responses

Item	Certainly true		Partly true		Not true		Don't know	
Listened to	245	95%	10.00	4%	0.00	0%	2.00	8%
Easy to talk to	215	84%	40.00	16%	1.00	1%	1.00	1%
Treated well	254	99%	3.00	1%	0.00	0%	0.00	0%

Views and worries	246	96%	10.00	4%	0.00	0%	1.00	1%
Know how to help	214	83%	39.00	15%	1.00	1%	3.00	1%
Given enough explanation	216	84%	39.00	15%	0.00	0%	2.00	1%
Working together	219	85%	27.00	11%	1.00	1%	10.00	4%
Comfortable facilities	162	63%	61.00	24%	4.00	2%	27.00	11%
Convenient appointments	170	66%	74.00	28%	11.00	4%	2.00	1%
convenient location	216	84%	33.00	13%	2.00	2%	6.00	2%
Recommend to a friend	215	84%	26.00	10%	3.00	1%	13.00	5%
Good help	242	94%	14.00	5%	0.00	0%	1.00	1%

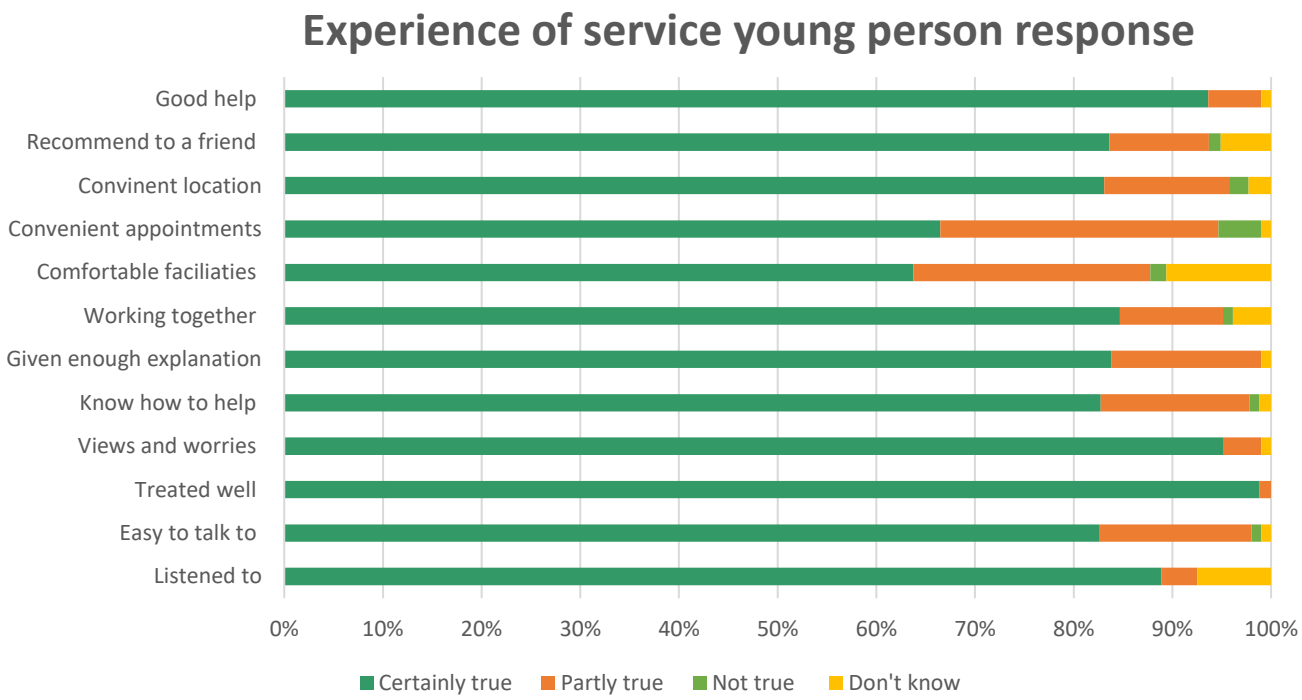

Figure 18: Experience of service (ESQ) questionnaire: young people's responses

The ESQ also includes three free text sections looking at what the respondent liked about the service, what they felt needed improving and any other comments. NVivo was used to identify common themes for each of these questions.

When asked what was good about their care, the main theme young people discussed was feeling listened to. This theme was found to be linked with feeling comfortable with CWPs, feeling that CWPs were understanding, and feeling that CWPs took them seriously:

> ***"I felt as if I was listened to at all times and I felt comfortable about saying anything personal"; "I liked how they listened to me and understood how to deal with the problems I had."***

Young people discussed how they found it useful to talk about their feelings and how they have learnt skills during their time with a CWP:

> ***"Good practical skills on coping was also given which I will use life long and pass on to whomever needs it."***

When asked was there anything they disliked or needed improving, the main theme young people spoke about was the length of sessions. Young people discussed having longer interventions, or having a longer first session due to the amount of information discussed:

> ***"The first session felt rushed, but this was due to having to share so much information all in one go- maybe a longer initial meeting would be helpful."***

The second most common theme involved improvements to the rooms where young people saw a CWP. Young people reported finding the waiting room patronizing and uncomfortable and thought the session rooms could have better decoration or could be bigger. Other themes included finding the paperwork long, not having time to complete handouts or models being too general.

The final question of the ESQ provides a space for the respondent to enter any other comments about the service they received. Young people used this question to recommend the service to others:

> ***"I would definitely recommend to anyone who felt the same way that I did; anxious and shy. Because I felt so cared for, but also that I was very comfortable with everything."***

Young people also commented on the 'Convenience' of appointments, how they found the 'Resources' and 'Improvement' they have seen specifically in terms of 'Confidence.' Overall young people used this question to thank CWPs and discuss positives of the service:

> ***"The people who work there are very supportive, and I appreciate that. I think that the questionnaire was very helpful and proved to me that CAMHS would go the extra mile for their clients."***

Parent ESQ

170 parents completed the **self-rated ESQ**.

Table 20 shows parent-reported responses about their experience of service.

For Sites, most items were scored Certainly True with "Convenient Appointment" and "Convenient Location" being the lowest rated.

Table 20: Experience of service parent-reported responses

Item	Certainly true		Partly true		Not true		Don't know	
Listened to	164	97%	1	1%	0	0%	5	3%
Easy to talk to	165	97%	2	1%	1	1%	2	1%

Treated well	166	97%	0	0%	0	0%	4	2%
Views and worries	165	97%	5	3%	0	0%	0	0%
Know how to help	156	92%	14	8%	0	0%	0	0%
Given enough explanation	158	93%	10	6%	0	0%	2	1%
Working together	159	94%	5	3%	0	0%	6	4%
Comfortable facilities	142	84%	13	8%	0	0%	15	9%
Convenient appointments	142	84%	25	15%	2	2%	0	0%
convenient location	153	90%	11	7%	1	1%	5	3%
Recommend to a friend	165	97%	3	2%	1	1%	1	1%
Good help	166	98%	4	2%	0	0%	0	0%

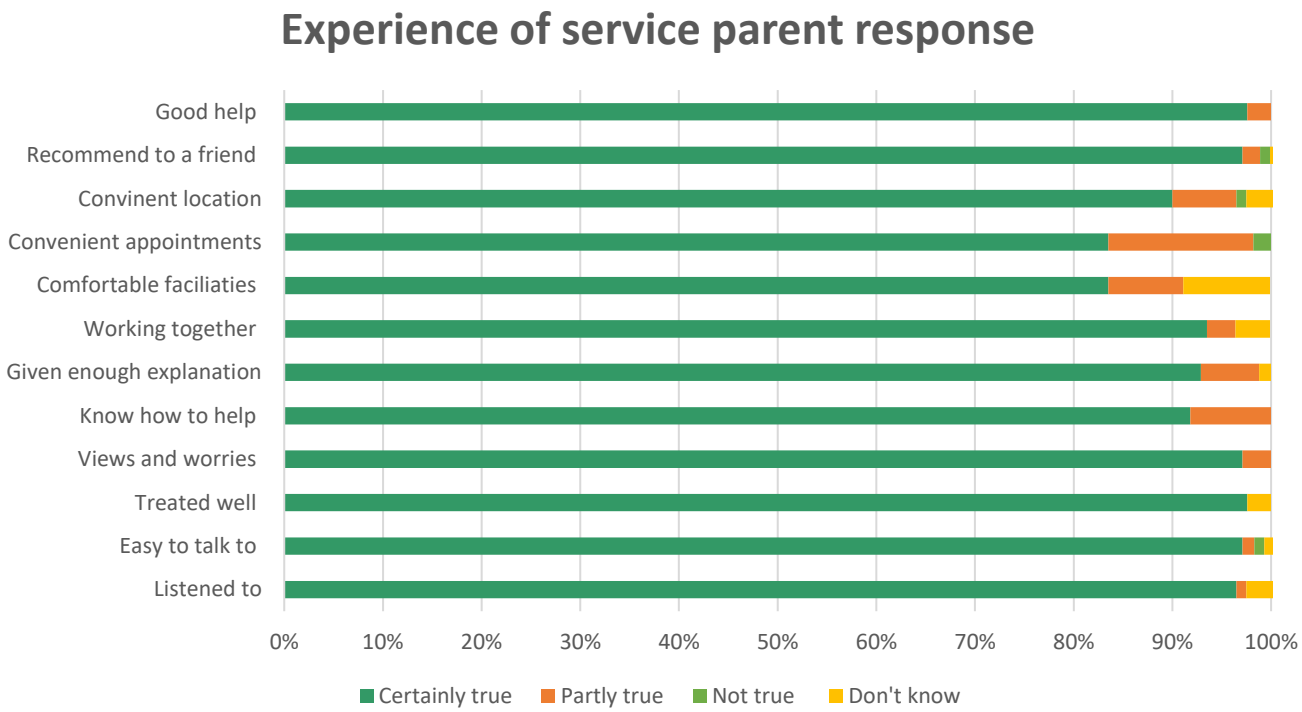

Figure 19: Experience of service questionnaire (ESQ) parent responses

When asked what was good about the care received, the main theme parents spoke about was feeling listened to and discussed the benefit of having someone to talk to. Parents discussed various aspects of the intervention which they found helpful including how the sessions were individually tailored:

> ***"The balance between following the ideas in the book systematically whilst also tailoring them to my child's specific experiences."***

Parents spoke about the usefulness of the resources provided by CWPS:

"The book also helps a great deal with ways to help that I would never have thought about myself."

Parents also used this section to discuss qualities of the CWPs which facilitated the sessions including being patient, personable, non-judgmental, and explaining things well.

When asked was there anything they disliked or needed improving, the main theme was regarding sessions. Parents discussed wanting more sessions, more face to face work, or having appointments after work. Parents also discussed that they found the homework in between sessions a challenging and that handouts should always be given to explain key concepts. Parents suggested improvements to the service such as involving children in the interventions.

Parents used the final question of the ESQ to thank CWPs for the intervention they received and to express positive feedback about the service:

"It has made such a difference to my son's life as well as our family life. I will always be grateful for the advice and help I was given."

"It has been a life changing experience for me and my family, I have learnt so many new tools to use with my family and for us to work better as a family unit."

The most common theme parents discussed was recommending the service to others. Parents also used this question to request further support, or to suggest improvements for the service such as involving the child in sessions.

Section 2 Summary

The data reported in section two has extracted from POD over a number of months, demonstrates that 84% of clients met inclusion criteria. This is comparable to the 83% of young people who completed the CYP-IAPT data set (CYP IAPT, 2015).

GBOs

The goal-based outcomes score significantly increased in a positive direction, from time point one to time point two with 77% of young people showing a reliable improvement overtime. The reliable change and effect size reported here was in line with the data set from the rapid audit. Previous research has shown that goal setting is vital to helping young people and clinicians move effectively through the therapeutic process and provides a rational for closing cases once goals are met (CYP IAPT, 2015).

SDQ

The SDQ devised by Goodman has been used to capture strengths and difficulties in routine CAMHS work and in some NHS trusts a Key Performance Indicator. The SDQ Impact Total and Total Difficulties scores demonstrated a change over time such that both scores reduced. The reduction in scores was statistically significant and was of a medium effect size range. Of those cases who met clinical threshold at the start of GSH 50% no longer met caseness at discharge. The Total Impact score over time demonstrated that 73% of young people no longer met clinical threshold. The reduction in SDQ Total IMPACT score and TOTAL DIFFICULTIES suggests that GSH is a useful tool for reducing levels of psychological distress in children and young people.

RCADS

The RCADS scores demonstrated a change over time that was significant and reliable with effect sizes ranging from 0.42 to 0.69, which are in the medium effect size range. The data from the RCADS for the CWP pilot is in line with or higher than the RCADS data from the main CYP-IAPT data set reported in the rapid audit where effect sizes ranged from 0.38 to 0.58 (low to medium effect sizes).

The proportion of clients scoring below clinical threshold at time point two (post intervention) reduced significantly from time point one (baseline) from 0.67 to 0.38 with a recovery rate of 45%. Fifty percent of young people met caseness for at least one subscale of the RCADS at both baseline and at discharge. This is in line with previous CYP-IAPT data (Woolpert, 2016) and a recent day study of GSH for depression (Pass et al, 2018).

SFQ, SRS and ESQ

It is encouraging that SFQ and SRS were rated as satisfactory by 96% and 78% of young people respectively. This is in line with satisfaction ratings found in the CYP-IAPT rapid audit and with the CORC report (Woolpert, 2016) in which 80% young people and 90% parents endorsed receiving 'good help'.

Previous data collected from the CYP-IAPT main programmes demonstrate that 97% of clinicians trained in CBT were still able to deliver this 5 years post training. It will be interesting to see in further how many CWPs are able to continue practicing GSH for anxiety and depression in the future.

Section 3: Evolving views of stakeholders on the training year

The Audit sought to review the views of CWP's and SSDL's on their experience of training over the course of the training year. SSDLs were asked to complete a questionnaire about their experiences at the start of the training for cohort 1 and at the end of the cohort one teaching in December. SSDLs reported on their experience of the course, change in their knowledge and skills and learning goals and direct feedback on teaching.

Stakeholders Survey

The percentage of supervisors that completed the survey at both time points were 100% (n=15) and the percentage of CWP'S who completed the survey at both time points was 80% (n=48).

Supervisor/Service Development Lead feedback on training year

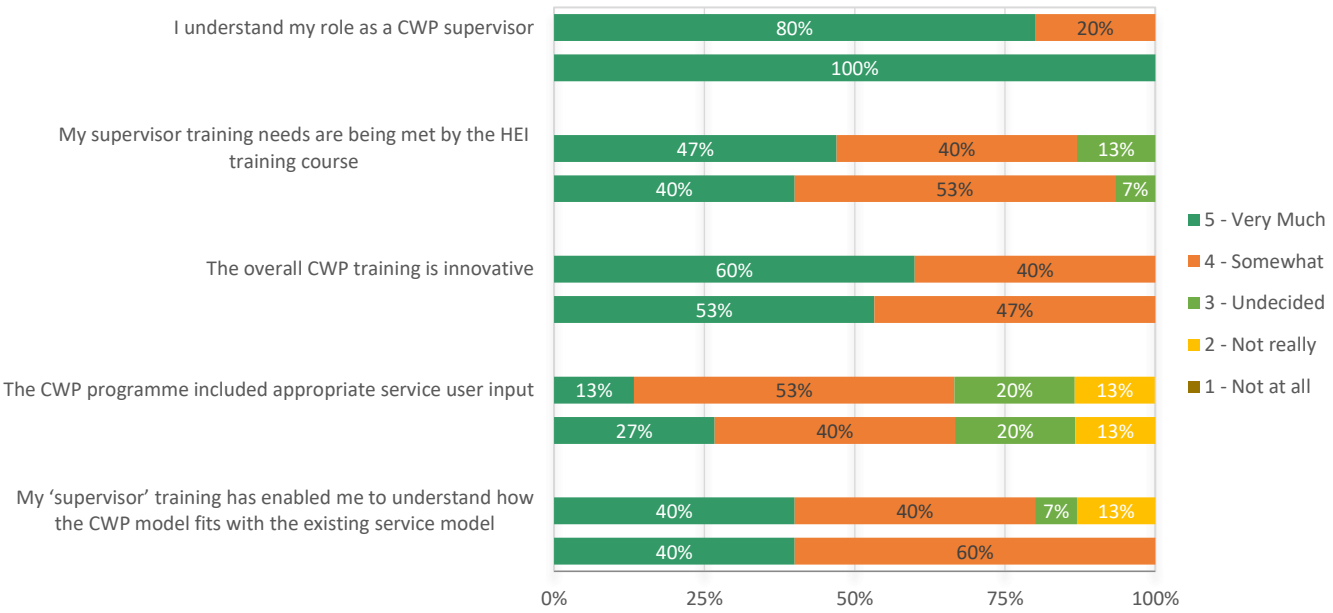

Figure 20: Bar-graph showing percentage of survey responses for SSDLs

Overall, Figure 10 shows the responses from supervisors at time point one and two in relation to perception of the training course and supervisor training. At time point one and two, supervisors rated highly that they understood their role of a supervisor for CWPs, felt their own training needs were being met by the course, that the course was innovative, and that they had an understanding of how the CWP model fitted within their sites existing model.

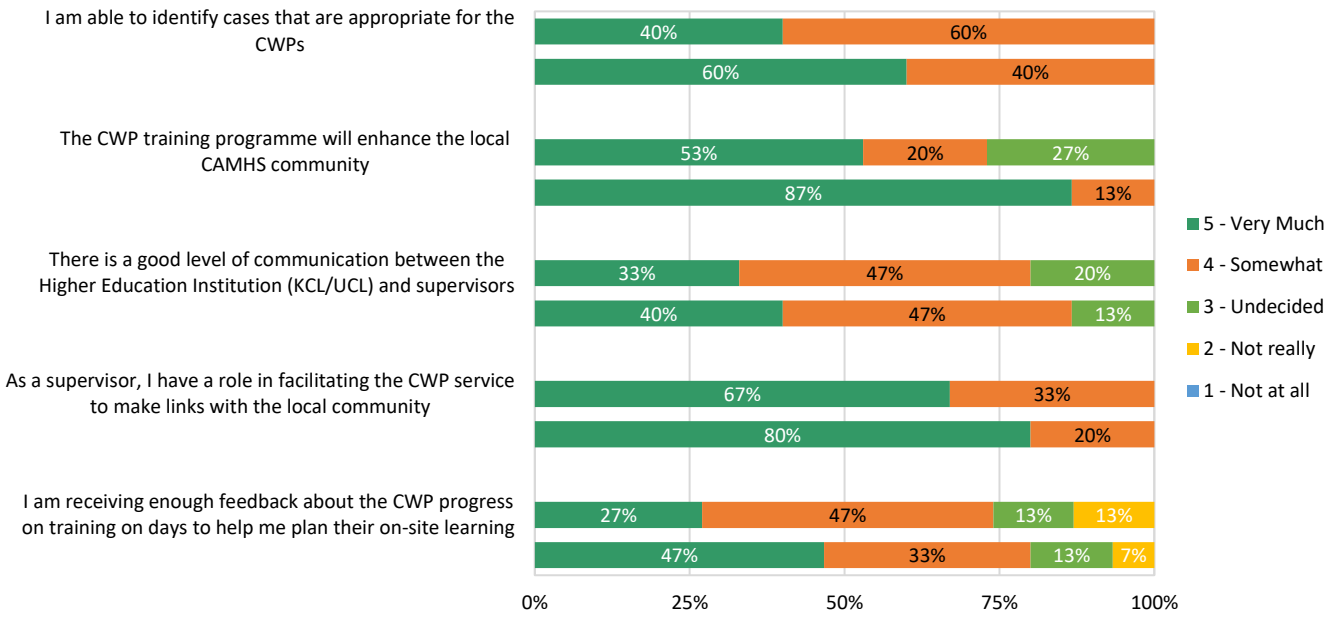

Figure 21: Bar-graph showing percentage of survey responses for SSDLs

From Figure 11, the SSDLs also reported at both time point one and two that they were able to identify appropriate cases, that the training would enhance local CAMHS provision, that there was a good level of communication between the HEI and supervisors. They also reported that they had a role in their local community CAMHS or child setting to facilitate and develop the CWP service and that the HEI feedback enabled SSDLs to plan their onsite CWP learning opportunities.

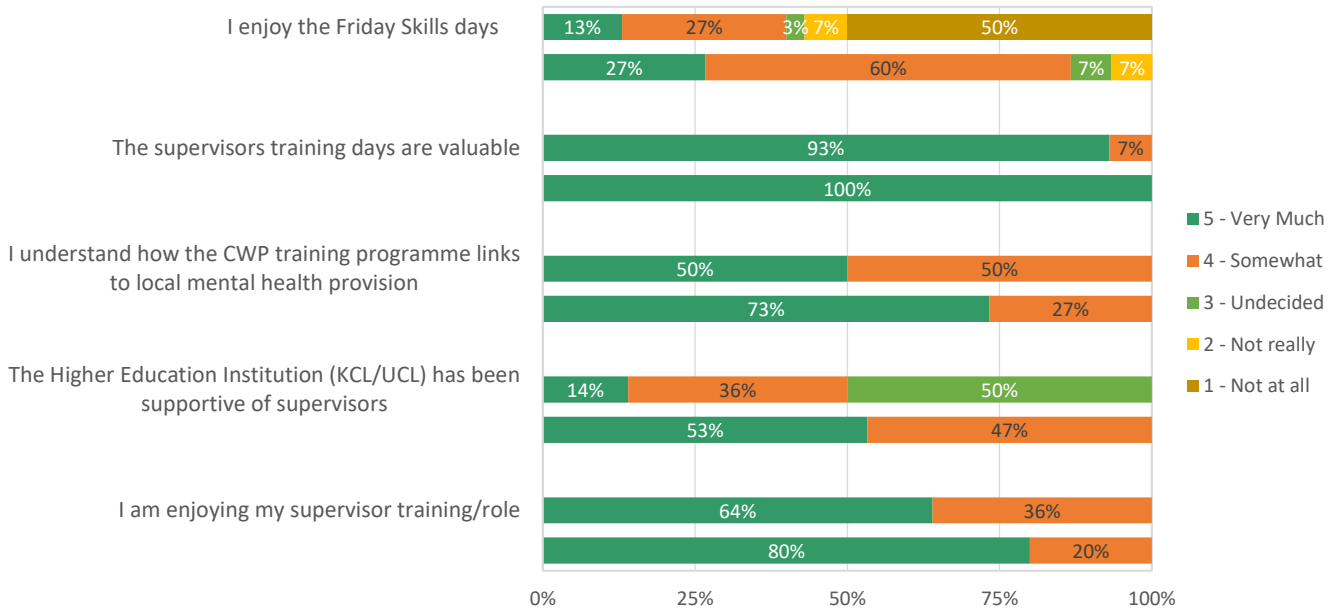

Figure 22:Bar-graph showing percentage of survey responses for SSDLs

From Figure 12, half of the supervisors enjoyed the Friday Skills days, almost all enjoyed the supervisor training days, all supervisors reported that they understood how the CWP programme linked to the local mental health provision and enjoyed their supervisor role. At time point two, supervisors reported that the HEI had been supportive and this was an increase from time point 1.

Qualitatively the supervisors reported that there were aspects of the overall CWP programme that were going well and aspects that needed clarifying and these are summarised in the Table 21. Table 21 shows a summary of comments from supervisors however, there were too few comments to qualitatively analyse with NVIVO 12. In addition, SSDLs comments are for time point two only as there were no comments reported at time point one. Only seven out of 17 supervisors provided qualitative feedback.

SSDLs reported that they felt familiar with their role and enjoyed it and that they thought the HEI training was innovative and would help enhance the mental health provision of service at a local level. Supervisors commented that the CWP model of working within the wider service context needed clarifying as did their role as part of the Friday skills day at the HEI. See Table 21 below for overall supervisor comments:

Table 21: Qualitative Supervisor/Service development leads Feedback

Aspects going well	**Aspects in need of clarifying / more work**
Familiar with supervisor role	
Training needs being met	Understanding how CWP model fits with service model
Innovative training and enhancing provision to the local community identifying appropriate cases	Friday skills day
good level of communication between the HEI and supervisors	Support to supervisors from HEI
Value supervisor training days	Understanding how the CWP training links to the local mental health context
Enjoying the training	Vague resources
Demanding but enjoyable role	No consultation with supervisors about university attendance
Feel extremely positive about the role	Friday skills day is not useful for supervisors
	More support on how to supervisor CWPs
	Teach risk earlier on
	Feel pressurised with amount of time I have as a supervisor
	Would be good to know that supervisors need to have level of CBT skill

Some direct quotes from SSDLs include:

'In principle this is a great new development. However, barriers include not knowing what is happening to the posts in the future, and that the expectations of the supervisors was not clear from the outset'.

'Quite a demanding role, although enjoyable'.

'For the most part I don't think the Friday study days were a good use of supervisor time'.

'I would have liked having more time for learning the intervention the CWPS were being taught'.

'I would have liked more support about the nature of supervision with CWPS'.

'I have enjoyed the role; however, it is very challenging at times and within my service 3 days does not feel sufficient as supervisor.
I feel extremely positive about the programme and have enjoyed being part of the pilot year….'

'I can honestly say that I love the job. Sustainability seems to be the most pressing issue'.

'I feel this pressure less as I do have the time and am grateful for it'.

'….my concern for next year is that with some new partnerships being given 2 CWP's,
I'm not sure how the job can be done with only 2 days of supervisor time.
Providing adequate supervision, doing the service development, attending Friday skills days and the supervisor training days is a big ask for such a part-time supervisor….'

CWP feedback on training year

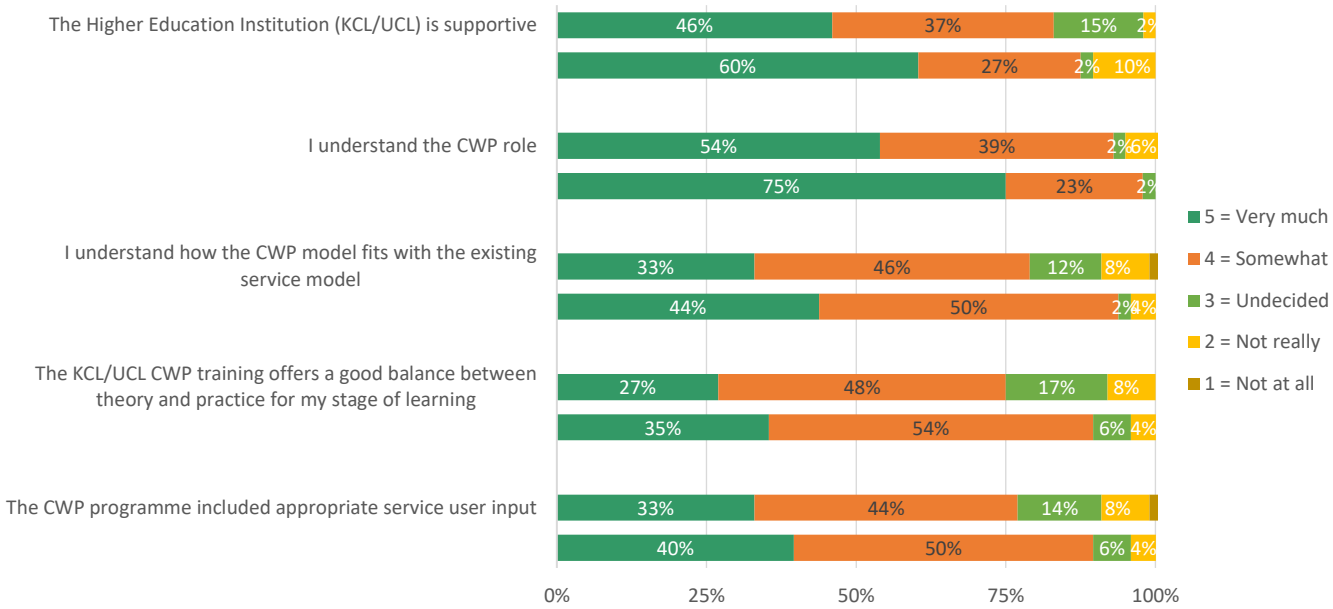

Figure 23: Bar-graph showing percentage of survey responses for CWPs

From Figure 22, a majority of CWPs reported that they mainly felt supported by the HEI, understood their role and the CWP service model within their locality and that training had a balance of theory and practice links and included service user input. Around 20% of CWPs reported at time point 1 however, that they were undecided or did not really think that they had a good understanding of the CWP model in their service, nor felt there was enough service user involvement or that they were supported by the HEI or had a good balance in teaching between theory and practice. This reduced to around 10% at time point 2.

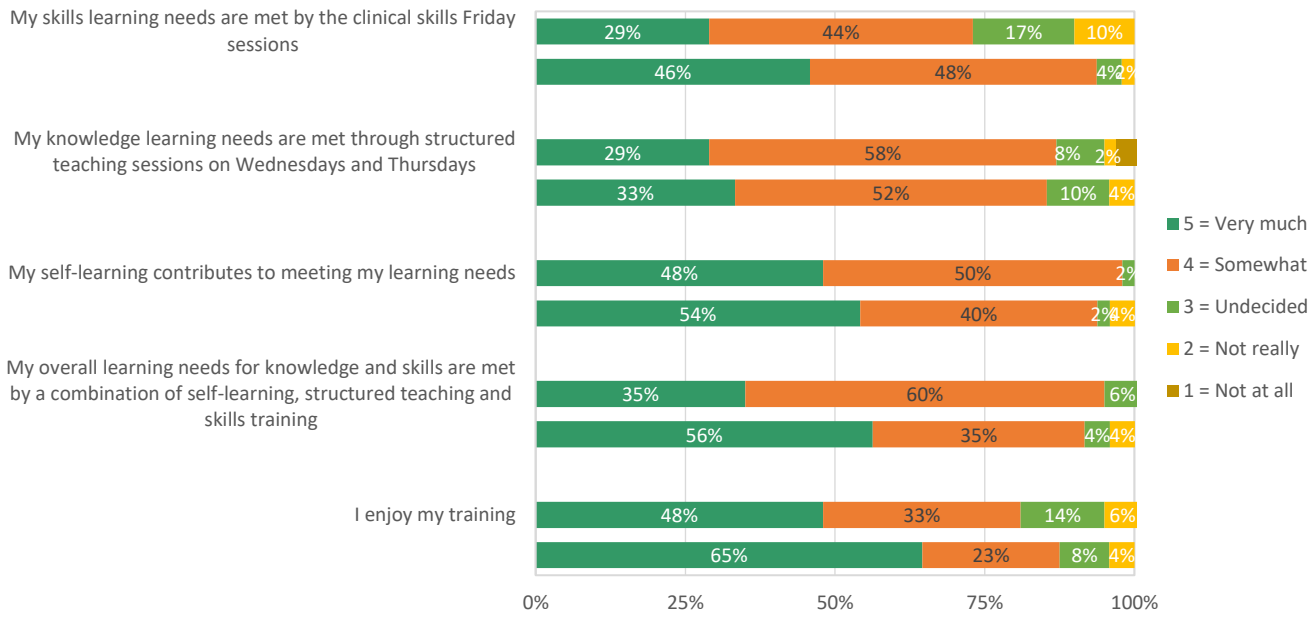

Figure 24: Bar-graph showing percentage of survey responses for CWPs

From Figure 23, a majority CWPS reported that they were mainly having their learning needs met through clinical skills days, structured teaching and that they enjoyed their training. There was a small proportion who reported that they were undecided or that the course did not really meet their learning needs though either clinical skills or structured teaching days, but this decreased at time point 2.

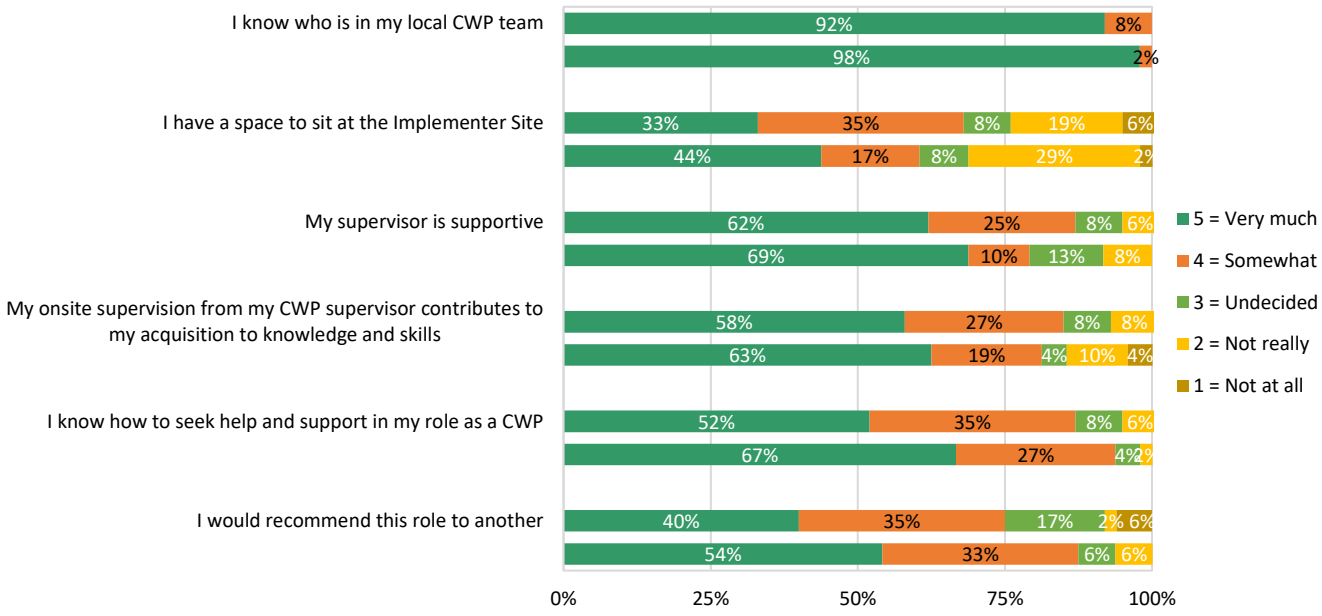

Figure 25: Bar-graph showing percentage of survey responses for CWPs

From Figure 24, a majority of CWPs reported that they knew who was in their team. Some CWPs had space to sit at their site but around 30% reported at the start of the audit that they did not. Most CWPs felt that the

site supervisors contributed to knowledge and skill acquisition and that the CWP knew how to access support with their role. About 80% increasing to 90% of CWPs at time point two would recommend their role to another.

Thematic analysis was applied to the qualitative survey data using NVivo 12. There was four key dimensions that emerged from the data, relating to the experience of the CWP programme namely:

- Perceptions of the CWP programme experience
- Perceptions of the course
- Perceptions of placements within sites
- Sustainability and funding

The key dimensions are presented below:

Key dimension 1: Perceptions of the CWP programme experience

Overall the CWP's described that they 'enjoyed the training' experience. CWP's described that there was a 'supportive learning environment' where learning from across the sites was viewed as valuable, one respondent felt the differences between service provision across sites affected the ability of the CWP's to support each other with their clinical work. It was described that staff have been 'positive role models and supportive' 'throughout the learning process' and there was an appreciation from the CWPs of being part of the first wave of CWP's. There was an acknowledgement of the CWP programme being an 'evolving' programme and CWP's felt they were a part of the development of the programme.

> ***'Overall the whole experience has been amazing, and it's been great to be a part of the first wave of CWP practitioners'***
>
> ***'This experience has been thoroughly enjoyable despite it being a new programme. Staff have been incredibly positive role models and supportive people throughout this learning process'.***
>
> ***'It's also great to hear about what's happening in other services and to share resources'***
> ***It feels great to be part of something that is evolving and I really feel a part of contributing to the development of the service, I.e. I really feel that my voice is heard!***

Key dimension 2: Perceptions of the course

The quality of the teaching was described as 'very good' and the teaching team were described as 'outstanding' 'approachable and supportive'. Suggestions for improvements to the course from CWP's included changing the timing of the start of the course. It was felt that it would have been more beneficial to start the course earlier in the year, due to initial difficulties with building up caseloads in preparation for the completion of assignments. CWPs described how the course was flexible to any challenges and reported that they were helped to face of any initial difficulties. Other feedback in relation to the structure of the course included; the content could have been covered in a shorter space of time and more detailed training in risk management would have been useful. The availability of more resources tailored to the needs of children and young people would have also been helpful. The ability of the programme team to be 'responsive to feedback' across various parts of the programme was a key facilitator, it was felt the course listened and responded to feedback and ideas for improvement throughout the pilot year.

> ***'The teaching has been of very good quality, everyone on the course has been approachable and supportive '***

'The academic teaching has been thorough'
'Would have been beneficial to have started training sooner'

'I thought the taught aspects of the course was intelligently modelled and our skills practice days certainly consolidated my learning. Skills practice teacher was outstanding, and our skills session s were and brilliant forum of support. I have sincerely valued the whole course and met some very genuine peers along the way'
'…has been responsive to feedback and adjusted the curriculum to meet our needs which has been greatly appreciated'

Key dimension 3: Perceptions of placement within sites

The initial struggle to build up a caseload, while services were established, led to a gap in learning which created anxiety for some CWP's. The importance of supervision was highlighted, one person stated the 'majority of their learning relevant to the job came from supervision' and another said they felt lucky to have had a supervisor with experience as they were able to provide them with additional learning in their area of specialism. Whereas, another described having the support of other CWP in situations where their supervisor was not available as helpful.

'*We have struggled to find referrals, this will mean that in practice our learning needs are not being met. This has created anxiety for our group and we feel there is a disconnect between theory and practice'.*

'The majority of my practical learning that is most relevant to the job has come from supervision'.

'My service has been lucky because our supervisor is a clinical psychologist who has worked in CAMHS for 15 years and who specialises in CBT for anxiety and who runs parent group for challenging behaviour. She has therefore been able to provide lots of additional clinical training'.

Key dimension 4: Sustainability and funding

The main reason for reservations in recommending the CWP role to others was found to be 'uncertainty of job retention'. This was a primary concern for CWP's as they did not know whether they would have a job in the future. They felt there needs to be a further exploration of the CWP role to ensure the retention of a skilled workforce.

'The only reason I may not recommend this role to another is due to the uncertainty of job retention after the course. I think sites should have to commit to retaining CWPs for 2 years when they apply for the funding'.

'I know how or CWP service fits in but the unawareness of how it will be funded and implemented in the future has been a huge concern as we a are unsure whether we will have jobs in that future and if we do have jobs in the future where and what they will be doing.'

'I think the value of post graduate low intensity CYP-IAPT practitioners requires further exploration to retain a skilled future workforce for the much-needed service! I think the need suggests that Low intensity has equal value to that of high intensity and this should be considered in the current banding decision to ensure retention and skilled practitioners'. 'Only if they're guaranteed a permanent full-time job after they complete training, unlike us'

Appendix F shows the emerging primary/secondary themes and facilitators/barriers from the CWP's perspective across two time points during the CWP programme.

Teaching Feedback from CWPs

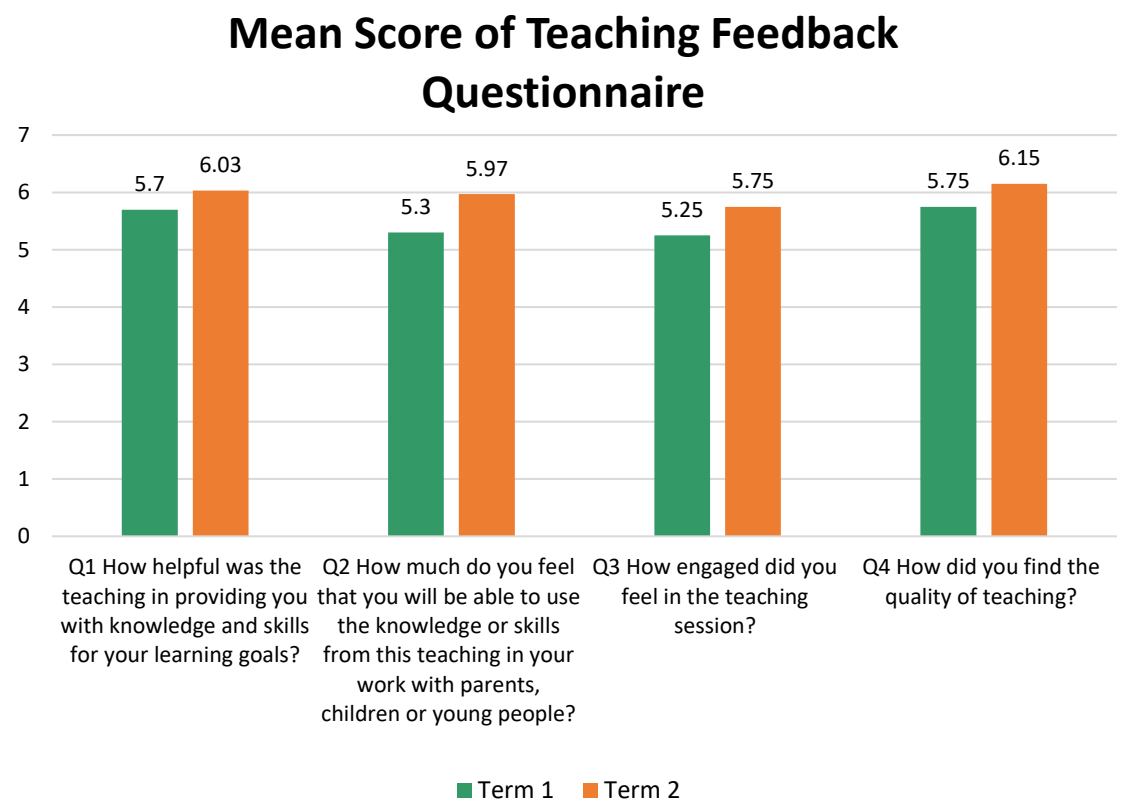

Figure 26: The average feedback for each question on the Teaching feedback questionnaire at end of Term 1 and Term 2

As shown in Figure 26 scores for questions 1, 2, 3 and 4 at the end of Term 2 (6.03, 5.97, 5.75, 6.15) remain similar to scores at the end of Term 1 (5.7, 5.3, 5.25 and 5.75), suggesting that there is good consistency between teaching sessions in term 1 and 2.

CWP learning outcomes

The paired data in this report for the Knowledge and Skills questionnaire and Goal Rating Scale came from 66% of CWPs. In an attempt to increase responses time was allocated in practice tutor groups and two follow up emails were sent to work addresses.

Knowledge and Skills Questionnaire

Table 22 shows the mean scores for the Knowledge and Skills subscale at time points 1 and 3, the standard deviation from the mean and the number of completers. The percentage change has also been calculated.

These scores are represented in Figure 27

Table 22: Mean scores from the Knowledge and Skills Questionnaire at Time Points 1 and 2

		Knowledge	Skills
Time point 1	Mean	*36.68*	*35.78*
	N	41	41
	Std. Deviation	11.81	14.81
Time point 2	Mean	*70.85*	*74.82*
	N	41	41
	Std. Deviation	6.19	7.68
Percentage change		**93%**	**105%**

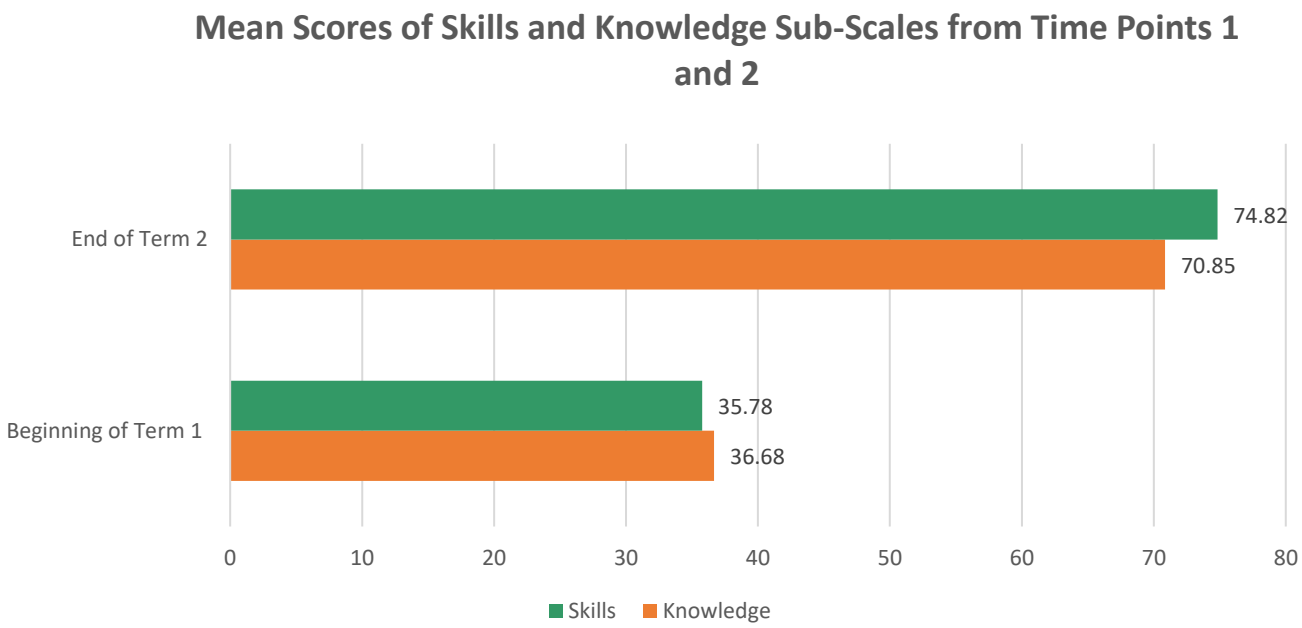

Figure 27: Mean Scores of Skills and Knowledge Sub-Scales from Time Points 1 and 2

As demonstrated in Figure 27, CWPs rated Skills lower than Knowledge at the beginning of term 1. At the end of term 2 however, Skills ratings have increased further than knowledge.

The mean scores for individual items on the questionnaire at time point 1 and time point 2 were also calculated) and presented in Graph form (see

Appendix G). The percentage change between these scores are presented below in Table 23.

Table 23: 'Knowledge' and the corresponding percentage change from time point 1 to time point 2 (12 questions)

Knowledge Based Questions	***Increased %***
I know about the theory, research and implementation of social support (the importance of the backup team) in addressing the mental health needs of children and young people.	211
I know how low mood typically presents in children/young people.	155
I know the self-help materials for parents, children and young people in detail and am fluent in their use	149
I know how anxiety typically presents in children/young people.	135
I know about problem solving methods in helping parents, children and young people to overcome barriers to change.	117
I know the mandatory CWP outcome framework and can apply it to specific problems as needed	94
I know how to identify clients whose problems lie outside the scope of low intensity interventions.	93
I know and communicate a clear description of what the intervention may involve using self-help materials as appropriate.	91
I know how to develop a shared understanding of how the young person's problem may have developed and factors contributing towards maintenance.	75
I know how behaviour problems typically present in children/young people.	70
I know the range of roles that parents/carers can play in relation to low intensity interventions, (from non-involvement through to a co-clinician offering active support outside of sessions)	56
I know about CAMHS, multi-agency services and the CYP-IAPT programme.	53

Table 24: 'Skills' and the corresponding percentage change from time point 1 to time point 2 (13 questions)

Skills Based Questions	***Increased %***
I can include multiple perspectives in understanding a problem particularly from the parent, child or young person.	184
I know how to carry out psycho-education in a collaborative way with parents, young people and children.	143
I have specific skills in providing low intensity help for behaviour problems in children/young people.	135
I have specific skills to provide effective low intensity help for children and young people with anxiety.	135
I can develop a set of options as to how a parent or young person may like to address their difficulties including non-professional help and self-management.	131
I can model an active problem-solving approach to difficulties that arise in the intervention.	131
I know how to provide information to the parent/carer about the nature and course of the child or young person's difficulty.	114
I can support the parent and young person in making a choice about how they would like to address their difficulties.	107
I can work collaboratively to produce a future support plan that actively involves the available interpersonal and professional networks.	98
I use outcome measures in all face to face contacts with parents, children and young people to inform the collaborative work together.	85
I actively notice and promote self-helping behaviours by parents and young people.	63
I can help focus the young person and the parent to develop realistic and achievable goals.	61
I have specific skills to provide effective low intensity help for children/young people with low mood.	51

Key

%	**150-200 + % increase**
%	**100-150 % increase**
%	**50-100 % increase**

Goal Rating Scale

The goal rating scale was completed by CWP students at the end of Term 1 (time point 1) and again at the end of Term 2 (time point 2).

Graph 2 shows the mean scores from goals 1, 2 and 3 at time points 1 and 2.

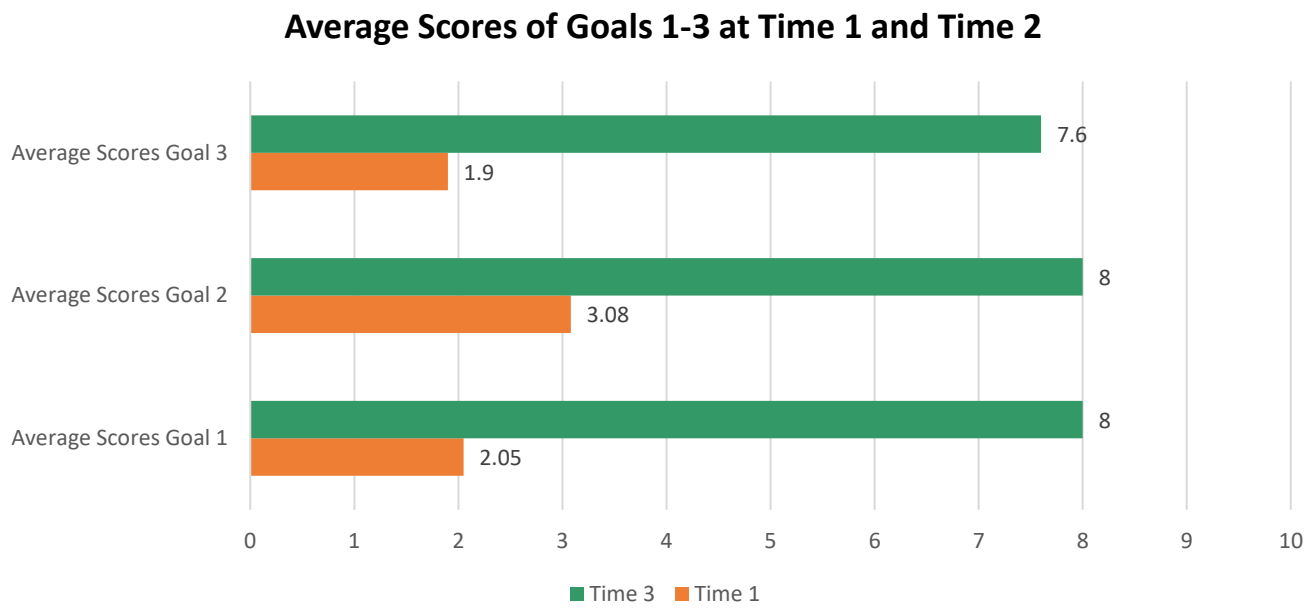

Figure 28: Average Scores of Goals 1-3 at Time 1 and Time 2

Table 25: The percentage increase in the mean scores from time points 1 and 2.

Mean scores from the Goal Rating Scale at Time Points 1 and 2 (N=39)	
Goal 1: I feel that I know how to deliver low intensity interventions with parents, children and young people.	290% Increase in mean score
Goal 2: I feel that I have sufficient knowledge of low mood, anxiety and behaviour problems for my work with children, young people and parents.	160% Increase in mean score
Goal 3: I feel sufficiently confident in effectively delivering low intensity interventions to parents, children and young people.	300% Increase in mean score

Section 3 summary

Summary of SSDL's learning outcomes and experience of teaching

Overall, SSDLs reported enjoying their role. It appears that there needs to have been a greater clarification and understanding of the SSDLs role at the HEI. This is unsurprising given the pilot nature of this project.

SSDL's survey results showed, overall, they were very satisfied with certain aspects of the training experience including opportunity to innovate, supervisor ALS and understanding the CWP and their own role and this improved over time. This is extremely positive given that this was the first year of the running of the course.

While sites struggled to identify cases initially this improved over time, as did the supervisors ability to embed the CWP service. SSDLs also reported improved feedback mechanisms from the HEI over time.

CWP's felt the course was supportive, understood their role and enjoyed theory practice links at the university and this also improved over time. Overall, they reported they enjoyed their training and overtime their experience of clinical skills sessions increased and they were more able to self-direct their learning. CWPs felt supported by their supervisors increasingly over time and felt confident in knowing the make-up of their local teams. Roughly 75% of CWPs reported that they would recommend the role to another. Again, these findings are positive given the pilot nature of the programme course.

This quantitative feedback was supported by the qualitative feedback, in which SSDLs and CWPs reported that they enjoyed their role and the training experience as whole. The main themes that emerged for consideration from the HEI in the future were the structure of the teaching day and length of course. Job retention and sustainability issues were also key themes in both the CWP and SSDL's feedback for future consideration.

Summary for CWP Learning outcomes and experience of teaching

At the end of term two, skills ratings increased further than knowledge which may be explained by CWPs practicing skills within their services and practice tutor groups.

There appeared to be a balance of skills and knowledge gained by CWPs on the training course. Not all competencies improved equally, which may have something to do with the taught curriculum. However, Appendix H shows that this may also be down to CWPs scoring more highly on some questions at time 1, therefore leaving less scope for percentage increase.

We have received a high level of teaching feedback this year, which may be down to CWPs being given time in sessions to complete this. However, looking at the paired data for the Knowledge and Skills questionnaire and Goal Rating Scale, there is still 34% missing data, which means that 20 CWPs either missed entry at Time 1 or Time 3. This needs to be given more thought for the next cohort.

Section 4 - Sustainability

During the CWP application process, each partnership was asked to describe ways in which the CWP programme would align with Local Transformation Plans (LTPs), to ensure that the posts created would be sustained beyond the training year. Responses from individual partnerships varied, however, there were some key themes in line with LTPs. These included:

- Promote resilience, prevention and early intervention
- Working towards a THRIVE model that offers greater choice and shared decision-making principles aimed at providing improved services for children and young people with learning disabilities and mental health difficulties to build resilience

- Commissioning a dedicated 'Early Intervention' team who will work primarily with GPs and education establishments, acting as a named point of contact providing a rapid response to prevent issues from escalating and reduce the number of inappropriate referrals to structured treatment
- Ensure CAHMS services are better embedded within local communities and within multi-disciplinary teams
- Achieve an overall reduction in the number of children and young people referred to CAHMS for treatment

To achieve this, successful partnerships were asked to work with commissioners to build sustainability models for CWP's which would see them progress from a Band 4 post during training to a Band 5 post once qualified.

In July 2018, following the end of the first year of training, all partnerships were asked to provide feedback on their sustainability plans for the following year. The following information was collected.

Table 26: Partnership feedback on funding for CWP posts

Partnership	**Number of posts funded**	**Band**	**Length of Contract**
Bromley Y	3	Band 5	Until September 2019
Hammersmith and Fulham	1	Band 5	Until May 2019
Lambeth	0	N/A	N/A
Lewisham	2	Band 5	Until September 2020
Richmond	4	Band 5	Ongoing contracting with schools and other stakeholders
Tower Hamlets	2	Band 5	Permanent posts
Westminster	4	Band 5	Permanent posts
Barking and Dagenham	0	N/A	N/A
Barnet	4	Band 5	Permanent posts
Cambridge and Peterborough	2	Band 5	Permanent posts
CHUMS	4	Band 5	Until September 2019
Hertfordshire	4	Band 5	Permanent posts
Hounslow	0.5	Band 5	Until March 2020
Islington	3	Band 5	Until March 2019
Norfolk	4	Band 5	Permanent posts
Ealing	1.5	Band 5	Until March 2020
Total	**39**		

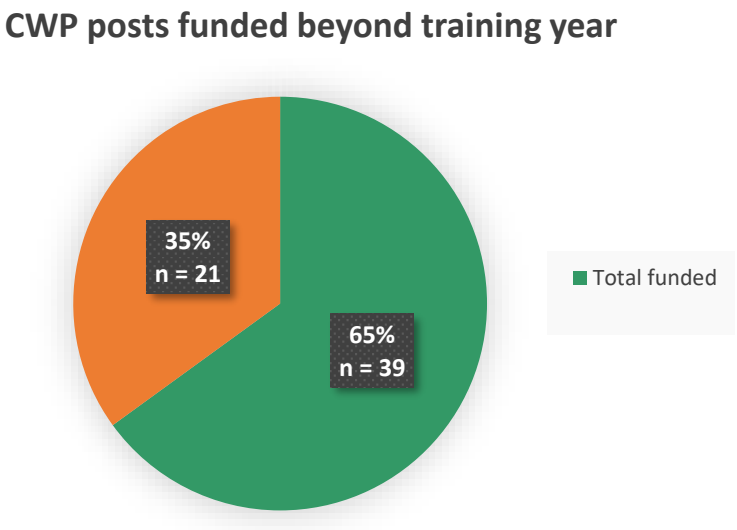

Figure 27. Pie-chart to show CWP posts funded beyond training year

All the posts sustained beyond the training year were funded at band 5 (or equivalent for non-NHS organisations).

Majority of posts were created due to early agreement with Commissioners and ongoing feedback drawing on outcomes data collected throughout the programme. Other creative sustainability models were also put in place to ensure posts were sustained. For example, in one area the Partnership seconded all 4 CWPs from their Families First team and trained them to deliver the guided self-help model as a CWP. At the end of the training, these CWPs then returned to their previous roles but continues to embed their learning from the pilot year into their role. Other Partnerships reduced the number of Assistant Psychologist posts to allow funding from these posts to be used to support the sustainability of the CWP role. Similarly, other areas also looked at creative ways of incorporating aspects of other posts, for example participation workers, into the CWP role. This enabled additional funding for the posts and encouraged the CWPs to adopt new, relevant skills in other areas, providing roles that are appropriate to local context and promote skill mix within the new workforce.

Additional work was carried out to determine how many of the CWPs who were offered one of the 44 sustained band 5 posts stayed in post.

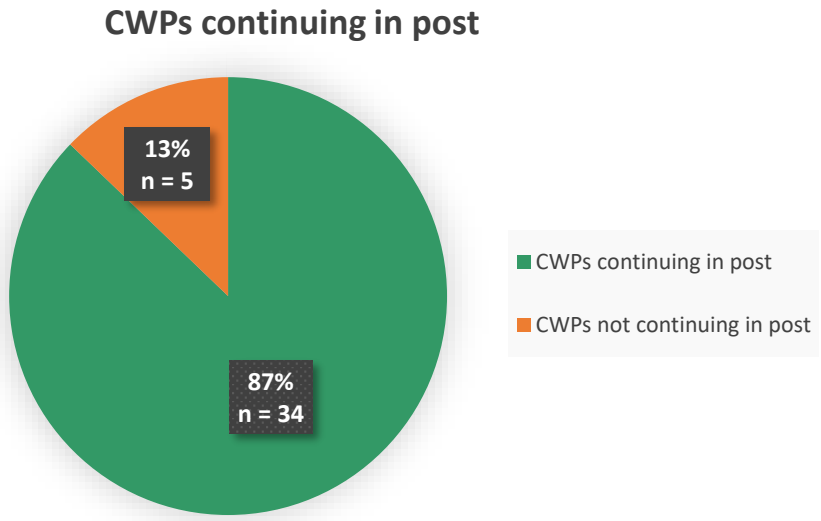

Figure 28. Pie-chart to show the number of CWP's in post

Of the five CWPs who did not remain in the band 5 post created, three went onto study a Clinical Psychology Doctorate and one went onto study an Education Psychology Doctorate. However, it was anticipated that four out of five of these posts would be filled drawing on the network of CWPs whose original posts were not retained. The CYP IAPT Learning Collaborative has a record of all CWPs, both in post and looking for opportunities, and will provide the link for recruiting Partnerships.

Section 4 Summary

Overall, the partnerships have worked hard in the first year to set up new services in response to the new CWP training initiative. The services have created models of working within the local communities and with partner agencies. Over the duration of the pilot, each site creatively explored ways of continuing to resource the newly formed teams and, encouragingly, 87% of CWPs at the end of training were able to continue in post. Wiggins et

al. (DofE, 2010), notes that good implementation science involves several stages of which Sustainability is one. The CWP sites may have begun to think about the key stages of sustainability (assessing suitability for sustainability, providing evidence of fidelity, assessing levels of resource required, consideration of the political support and long-term funding opportunities) as part of the implementation process but may have to embed the implementation process further in order for the service to be sustainable in the long term. Therefore, while the CWP programme offers trainees a training in 'fidelity to the model' – in this instance Guided Self Help- financial and resource (admin, supervisory and practitioner) constraints locally may result in regular CWP staff turnover if CWP retention pathways are not established or maintained.

Conclusion

This audit for the year one CWP training programme and service implementation set out to examine whether:

1. It has been possible to train new clinicians to provide low intensity interventions/guided self-help to children and young people with mild/moderate mental health difficulties who were otherwise not accessing mental health services?
2. The introduction of CWP's increased access to mental health services for children and young people?
3. The interventions provided fit within the principles of guided self-help; namely, brief, goal focused and collaboratively developed with young people and parents?
4. The interventions are effective?

Overall, the data demonstrate that CWPs are able to train in the guided self-help models of anxiety, depression and challenging behavior and that referrals to the CWP teams were for children, young people and their families who would not otherwise have met either Tier 2 or 3 CAMHS inclusion criteria. Those cases that were referred from schools to CWPs in school settings also highlight that CWPs are able to provide early access and intervention to CYP who may not otherwise have a CAMHS type service. While the training caseloads were within reasonable limits, it is anticipated that the qualified caseloads of CWPs will be similar to PWP work, therefore affording greater access to mental health services to the CYP in local communities, this would be in line with the vision of the Five Year forward View and NHSE commissioning objectives.

The data also highlights that GSH was deliverable within an 8-week timeframe and that the outcomes for cases showed reliable change over time. The use of GSH, incorporating CYP-IAPT principles, led to high service user satisfaction. It will be interesting to examine longer term outcomes for the CYP who received the CWP service.

The audit for the CWP training has demonstrated that it is possible to train health care professionals to deliver GSH to children young people and their families in a way that is time limited, goal based collaborative and for which progress can be routinely monitored. The results have shown that the changes over time are reliable, improvements in psychological distress are significant and that GSH, delivered over eight sessions is clinically effective.

The demographics of the CYP in this pilot year were largely representative and that psychological distress peaked around the ages of common cognitive, social and emotional transitions. Hence, future work may wish to screen these age ranges in particular for early intervention.

The CYP reported being satisfied with the GSH process and would recommend this to a friend. Therefore, the sustainability of GSH in services may be dependent on communities providing positive feedback on the service received, which may in turn reduce the stigma of seeking psychological services early and empower young people to support one another in gaining access to locally based cwp services such as those in schools. This would contribute to the "social solidarity" needed for "successful and sustainability health care systems" (Crisp, 2017).

The CWP trainees and SSDLs reported enjoying their training and have been able to either find employment as qualified CWPs or in roles within the mental health care or associated with these. CCGs, commissioners and supervisor / service leads were all keen to support the sustainability aspects of the CWP programme. As the CWP initiative has taken place at a great pace within a system that frequently changes it was challenging for localities to plan forward for the ongoing needs of the CWPs post training. Crisp (2017) highlights that sustainability of services relies on key factors: "money, staffing, computer systems, trust (in the system)". Recently, the CYP

Sustainability and Transformation Plans (STPs) aimed to ensure the health and social care needs of the local population could be met. Localities are likely to need to revisit these STPs to further consider the sustainability of the CWP workforce. One way to achieve sustainability may be to, as Crisp suggests, develop "cross sectional partnerships of private and public organisations, to fulfil critical roles in .....[healthy communities]'. This is the premise of the recent green paper which further re-iterates that whole school and community approaches to mental health are needed to be able to offer prevention and early intervention in mental and physical health domains to enable "human security – [to live] a decent life" (Crisp, 2017).

Limitations

Absence of two partnerships in the POD data

For cohort one, two out of the 15 partnerships did not use POD. This resulted in the collaborative not having the same instant access to the data as services using POD. Although measures were taken to access data from services not using POD, limitations in the exporting functionality meant useable data was not sent to the collaborative. Because of this, the two services not using POD were unable to be included in the audit outcomes analysis. For cohort 2, measures have been put in place to ensure any services not using POD can flow data to the collaborative. The two services not using POD in cohort one have decided to use POD in cohort 2.

Missing data

During the analysis of the sample it was found that clients (n=178) had been registered on POD but had no completed outcomes. The collaborative plan to look into the reason behind this during cohort 2 and 3 of the CWP programme, in addition to the lowest percentage of completion which was found for SDQ at 68%.

General pathway

On POD for cohort one intervention groups were added with measures corresponding to the outcomes framework. A general pathway group, containing all measures, needed to be added as CWPs found using additional measures to the outcomes framework clinically useful. It was found that the majority of CWPs would use the general pathway group rather than selecting a specific intervention group. This resulted in the outcomes framework not being followed correctly, making identification of the intervention group difficult.

For cohort 2 the collaborative has made changes to improve the aforementioned limitation by removing the option of the general pathway on POD. In cohort 2 CWPs are required to select an intervention group. However, within these groups the outcome framework measures are clearly listed on POD with additional measures available if needed.

Caseness and entry criteria

One of the limitations of the outcome analysis was that both reliable improvement and reliable change were seen as key outcomes for the progress. For services who were more focused on prevention of problems escalating above clinical thresholds the outcomes for such a service are not best assessed using reliable change. For services which are more focused on treating mild problems above clinical thresholds the measure of reliable change makes more sense/is more appropriate. The CWP programme currently fulfils both prevention and treatment function and therefore the outcomes framework may need to be more sensitive to assessing its success on these two functions.

Implications

Clinical Implications

Clearly the results of this study are promising, suggesting that it is possible to offer effective low intensity interventions for children and young people with mild to moderate mental health problems. It is important to emphasise some important aspects of the intervention that were in place. The workforce consisted of CWPs who trained in evidence-based approaches, drawing on the evidence base to meet specific needs. They worked, under close supervision of highly trained and experienced clinicians. In order to ensure that the right cases were seen during the pilot year, Supervisors/Service Development Leads (SSDLs) were pivotal; for providing clinical and management support to the trainees and for ensuring that local networks were formed, referral pathways established and boundaries around caseloads and roles and responsibilities were defined.

This intervention was designed for mild to moderate mental health problems for CYP and their families who are able to access Guided Self-help. There is no evidence of the effectiveness of this approach for CYP with more complex or severe presentations, or whose social circumstances are such that they are unable to use GSH.

It is also very heartening that the CWPs have shown that, with the right tools, they are able to collect T1 and T2 data for 89.5% of GBOs, 68.3% of SDQ and 74.5% of RCADS outcomes, hence there is a meaningful and large enough dataset to demonstrate effectiveness. It is interesting that the CWPs were more successful than previous CAMHS clinicians at collecting data as shown by the recent CYP IAPT rapid internal audit with only 42% matched T1 and T2 scores. There are several possible reasons for this success. The use of outcome measures was incorporated in the CWP training from the start, both as clinical tools to be shared with CYP and as outcome measures able to act as a proxy to measure the effectiveness of the intervention. The CWP trainees had access to POD from the start of training and were supported in the use of POD by the POD team, the training schemes and their SSDLs. Furthermore, CWPs were required to use POD to measure their own learning outcomes and training goals, allowing them to mirror the use of the tool on themselves and integrate it as a natural part of their day to day activity.

Implications for future research

For the CWP programme to be truly successful it will be important to demonstrate that it is possible for them to offer low intensity interventions with a higher turnover than was demonstrated in training. It will therefore be important to continue the audit into year 2, including a health economics aspect to the audit. The costs of mental health needs not being met in CYP has been evaluated in a number of ways. Knapp et al (2016) estimated the average cost of mental health related interventions totalled £1778 per annum over a three-year period. Colleagues in the Midlands CYP IAPT collaborative have used this to calculate how many cases need to be seen by CWP to be cost effective (Associate Development Solutions Limited, Midlands CYP IAPT Collaborative, 2018). It would be useful to benchmark any future evaluation of the CWP initiative using such a cost benefit analysis.

The other area of research that would be useful in terms of cost effectiveness would be to see the impact of CWP initiatives on the broader CAMHS landscape. In particular, it would be useful to see the impact on specialist CAMHS: do referral rates decrease or increase for these services when CWP services are provided in their area?

Policy implications

January 2019 will see the start of the Educational Mental Health Practitioner (EMHP) training which will skill up a new workforce to deliver low intensity, guided self-help to children and young people with mild to moderate difficulties within an education setting. Whilst this is an important step in widening the support that CYP receive, consideration needs to be given to the similarities and differences between these roles to ensure that these two professional groups are working alongside each other to meet the needs of CYP in different settings.

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Acronyms

ALS	Action Learning Sets
CAMHS	Child and Adolescent Mental Health Service
CAPA	Choice and Partnership Approach
CWP	Children's Well-being Practioner
CYP-IAPT	Children and Young People's Improving Access to Psychological Therapies
DEP	Depressive Disorder
ESQ	Experience of Service Questionnaire
GAD	Generalised Anxiety Disorder
GBO	Goal Based Outcomes
GSH	Guided Self-Help
HEI	Higher Education Institution
HEE	Health Education England
IAPT	Increased Access to Psychological Therapy
NHSE	National Health Service England
OCD	Obsessive Compulsive Disorder
OR	Odds ratio
PD	Panic Disorder
RCADS	Revised Child Anxiety and Depression Scale
RCADS-P	Revised Child Anxiety and Depression Scale Parent Version
RCI	Reliable Change Index
ROM's	Routine Outcome Measures
SSDL	Supervisor and Service Development Lead
T1	Time 1
T2	Time 2
T3	Time 3
SA	Separation Anxiety
SDQ	Strengths and Difficulties Questionnaire
SFQ	Session Feedback Questionnaire

SP	Social Phobia
SRS	Session Rating Scale

Definitions

Caseness	The degree to which the accepted standardized diagnostic criteria for a given condition are applicable to a given service user
Effect size	The magnitude of the difference between groups
Odds Ratio	An odds ratio is a relative measure of effect, which allows the comparison of the intervention group of a study relative to the comparison or placebo group
Recovery	The number of service user's completing treatment who move from above to below caseness on the SDQ or RACDS from first to last appointment
Referral	The number of service users entering into the CWP service/system with a unique pathway
Reliable change	Reliable change refers to the amount of change in scores on a scale which reflects more than the fluctuations of an imprecise measuring instrument
Wiki	A wiki is a website or database developed collaboratively by a community of users, allowing users to be able to modify content and structure, allowing the structure to emerge according to the needs of the users.

Appendices

Appendix A

Site Visit Checklist

Partnership Checklist – CWP Site Visits

1) **Employer and Service Context**
    a. Service context in which CWP trainees will work in their training year
    b. Referral criteria of the service context – where do referrals come from? How are CWPs involved in the referral process?
    c. Criteria for access to CWPs
        i. How has suitability for low intensity treatment been operationalised?
        ii. How do other areas of the service refer to CWPs? What language is used?
        iii. How do external organisations refer to CWPs? How have they been made aware of this new sub-service?
    d. How does the service context relate to other local CAMHS provision? (e.g. tier 1-3, community or other)
    e. Clinical role of supervisor in the service context
    f. Local partners/stakeholders… (NHS, 3rd Sector, LA, Commissioners…) – how closely are CWPs linked with local partners?

2) **CWP training provided on site**
    a. Observations of clinical staff working: in assessments, therapy, team meetings, consultation (type, frequency, at what stage in training?)
    b. Formal supervision (type, frequency)
    c. Informal discussion of cases and related issues (type, frequency)
    d. Trainee feedback arrangements
    e. Improvements to on-site training through the year (resulting from experience/feedback)

3) **Technology**
    - Do all CWPs have access to a tablet or laptop?
    - Do all CWPs have access to WiFi within the service?
    - Are they able to access POD, the Wiki and Google Drive docs without restrictions?
    - Do they all have access to cameras and recording equipment? USBs?

4) **POD**

    If using POD:

    - Do CWPs have a POD account?
    - Do supervisors have a POD account?
    - Have they received guidance documents? and do they know how to use it?

- Has their service signed off on the use of POD (check with supervisor re contract?)
- Do they need to export data from POD into patient record? How are they managing this?
- Does POD improve or hinder normal processes of collecting data?

If not using POD:

- If not using POD, what system are they using?
- How will data be exported from system onto POD?

5) Practical arrangements

- Do all CWPs have a desk?
- Do they have phones? Mobiles?
- Are they near to their supervisor if they need them? Are they able to get in touch with them easily if they need them?
- Are CWPs working with/near each other regularly? Do they have time to catch up?

6) Supporting course learn within the local context

- Are supervisors prepared to offer advice on CWP assignments
- Whole session videos (October and November)

7) Any pastoral issues they would like to discuss?

Appendix B

List of measures used by services

	Title of full measure	Acronym	Subscales	Child version	Parent version	Website
1	Goal Based Outcomes	GBO	-	Y	Y	https://goalsintherapycom.files.wordpress.com/2018/03/gbo-version-2-march-2018-final.pdf
2	Experience of Service Questionnaire	ESQ	-	Y	Y	https://drive.google.com/drive/folders/1Hub2gtgS4x2rPeMomKGl8nKxEq-SYGSC
3	Revised Child Anxiety and Depression Scale	RCADS	Generalised anxiety Separation anxiety Depression Social anxiety Panic Obsessive compulsive disorder (OCD) Total anxiety	Y	Y	https://drive.google.com/drive/folders/1fdyylA-F0PvIDGaluyrMZaEuKIyZBtR9
4	Session Feedback Questionnaire	SFQ	-	Y	Y	https://drive.google.com/file/d/0B1hDLHd8syMsSGVsRWpoVi0wVmc/view
5	Session Rating Scale	SRS	-	Y		http://integratedrecovery.org/wp-content/uploads/2015/07/Session-Rating-Scale.pdf
6	Strengths and Difficulties Questionnaire	SDQ	Emotional problems Hyperactivity Conduct problems Peer problems Prosocial behaviour Impact on life	Y	Y	https://drive.google.com/drive/folders/19sKzlbAUJp_NjjPW32M93Ei_7Q9uwb8d

Appendix C

Stakeholders Survey

Evolving views of stakeholders on the training year –Survey

Stakeholder: CWP trainee

Instructions to CWP trainee: Thinking about the first part of your training, please answer the questions below. **(Please answer with the first response that comes to mind. There are no right or wrong answers. All data will be anonymised).**

ID no. ……

Partnership: …….

Date: ……

Role: ……CWP……

	Please circle the most appropriate response	Very Much 5	Somewhat 4	Undecided 3	Not really 2	Not at all 1
Q1	The Higher Education Institution (KCL/UCL) is supportive					
Q2	I understand the CWP role					
Q3	I understand how the CWP model fits with the existing service model					
Q4	The KCL/UCL CWP training offers a good balance between theory and practice for my stage of learning					
Q5	The CWP programme included appropriate service user input					
Q6	My 'skills' learning needs are met by the clinical skills Friday sessions					
Q7	My 'knowledge' learning needs are met through structured teaching sessions on Wednesdays and Thursdays					
Q8	My self-learning contributes to meeting my learning needs					
Q9	My overall learning needs for 'knowledge and skills' are met by a					

	combination of self-learning, structured teaching and skills training					
Q10	I enjoy my training					
Q11	I know who is in my local CWP team					
Q12	I have a space to sit at the Implementer Site					
Q13	My supervisor is supportive					
Q14	My onsite supervision from my CWP supervisor contributes to my acquisition to knowledge and skills					
Q15a	I know how to seek help and support in my role as a CWP					
Q15b	Please specify who your main sources of help and support are.					
Q16	I would recommend this role to another					
Q17	Any other comments?					

Evolving views of stakeholders on the training year –Survey

Stakeholder: CWP Supervisor

Instructions to CWP Supervisor: Thinking about the first part of your training, please answer the questions below: **(Please answer with the first response that comes to mind. There are no right or wrong answers. All data will be anonymised).**

ID no. ……

Partnership: …….

Date: ……

Role: ……CWP Supervisor……

	Please circle the most appropriate response	**Very Much 5**	**Somewhat 4**	**Undecided 3**	**Not really 2**	**Not at all 1**
Q1	I understand my role as a CWP supervisor					
Q2	My supervisor training needs are being met by the HEI training course					
Q3	The overall CWP training is innovative					
Q4	The CWP programme included appropriate service user input					
Q5	My 'supervisor' training has enabled me to understand how the CWP model fits with the existing service model					
Q6	I am able to identify cases that are appropriate for the CWPs					
Q7	The CWP training programme will enhance the local CAMHS community					
Q8	There is a good level of communication between the Higher Education Institution (KCL/UCL) and supervisors					
Q9	As a supervisor, I have a role in facilitating the CWP service to make links with the local community					

Q10	I am receiving enough feedback about the CWP progress on training on days to help me plan their on-site learning					
Q11	I enjoy the Friday Skills days					
Q12	The supervisors training days are valuable					
Q13	I understand how the CWP training programme links to local mental health provision					
Q14	The Higher Education Institution (KCL/UCL) has been supportive of supervisors					
Q15	I am enjoying my supervisor training/role					
Q16	Any other comments?					

Appendix D

Teaching Feedback Questionnaire

CWP-a completed the questionnaire below in morning and afternoon sessions where relevant during Term 1 lectures. CWP-a only completed one Teaching Feedback Questionnaire in Term 2 and rated all items (maximum score of 7). For Term 1 ratings from CWP-a are lower than the average from the whole cohort.

	Question		**Rating**							
			1	2	3	4	5	6	7	
		Descriptor	Not at all			Some of it			Nearly all of it	Descriptor
1.	How helpful was the teaching in providing you with knowledge and skills for your learning goals?	Not relevant to my learning goals								highly relevant to my learning goals
2.	How much do you feel that you will be able to use the knowledge or skills from this teaching in your work with parents, children or young people?	Hardly at all								Nearly all cases
3.	How engaged did you feel in the teaching session?	Not engaged								Very engaged
4.	How did you find the quality of teaching?	teaching content poorly presented								teaching content well presented

Appendix E

Knowledge and Skills Questionnaire

Number	Knowledge or skills	Domain	Question	Rating						
				1	2	3	4	5	6	7
Please rate the following statements as to how true they are of you over the last week				Not true			Somewhat true			Certainly True
1	knowledge	service context	I know about CAMHS, multi-agency services and the CYP-IAPT programme.							
2	knowledge	making sense of things	I know how to develop a shared understanding of how the young person's problem may have developed and factors contributing towards maintenance.							
3	skills	making sense of things	I can include multiple perspectives in understanding a problem particularly from the parent, child or young person.							
4	knowledge	making sense of things	I know the range of roles that parents/carers can play in relation to low intensity interventions, (from non-involvement through to a co-clinician offering active support outside of sessions)							
5	skills	making sense of things	I know how to provide information to the parent/carer about the nature and course of the child or young person's difficulty.							
6	knowledge	psycho-education	I know and communicate a clear description of what the intervention may involve using self-help materials as appropriate.							
7	skills	shared decision making	I can develop a set of options as to how a parent or young person may like to address their difficulties including non-professional help and self-management.							
8	skills	shared decision making	I can support the parent and young person in making a choice about how they would like to address their difficulties.							
9	knowledge	outcome monitoring	I know the mandatory CWP outcome framework and can apply it to specific problems as needed							

10	skills	outcome monitoring	I use outcome measures in all face to face contacts with parents, children and young people to inform the collaborative work together.							
11	skills	setting goals	I can help focus the young person and the parent to develop realistic and achievable goals.							
12	knowledge	guided self help	I know the self-help materials for parents, children and young people in detail and am fluent in their use							
13	skills	guided self help	I know how to carry out psycho-education in a collaborative way with parents, young people and children.							
14	skills	guided self help	I actively notice and promote self-helping behaviours by parents and young people.							
15	knowledge	problem solving	I know about problem solving methods in helping parents, children and young people to overcome barriers to change.							
16	skills	problem solving	I can model an active problem-solving approach to difficulties that arise in the intervention.							
17	knowledge	supervision	I know how to identify clients whose problems lie outside the scope of low intensity interventions.							
18	knowledge	low mood	I know how low mood typically presents in children/young people.							
19	skills	low mood	I have specific skills to provide effective low intensity help for children/young people with low mood.							
20	knowledge	anxiety	I know how anxiety typically presents in children/young people.							
21	skills	anxiety	I have specific skills to provide effective low intensity help for children and young people with anxiety.							
22	knowledge	behaviour	I know how behaviour problems typically present in children/young people.							
23	skills	behaviour	I have specific skills in providing low intensity help for behaviour problems in children/young people.							
24	knowledge	ending help	I know about the theory, research and implementation of social support (the importance of the backup team) in addressing the mental health							

			needs of children and young people.							
25	skills	ending help	I can work collaboratively to produce a future support plan that actively involves the available interpersonal and professional networks.							

Appendix F

Stakeholder Survey Feedback

Facilitators and barriers at time point one

Primary theme	Secondary theme	Facilitator	Illustrative quote	Barrier	Illustrative quote
Perceptions of the CWP programme experience	Experience and support	Enthusiasm and collaboration	'have enjoyed the training so far and have learnt a lot'. 'The Friday practice tutor groups are so helpful and therapeutic for CWP's - Give CWP's a chance to ask for advice, support, and ideas from others who are not from their sites'.	Differences across clinical services	'I feel that as the services across London/SE are so varied so at points I have felt unsupported by the CWPs from other services as there is such a vast difference between the work we are doing - e.g. Working with under 8yrs and working with 14yrs plus etc'
Perceptions of the course	Structure, organisation and timings	Development	'I think once it is set up properly, it will be great'.	Timing of the course and duration of teaching days	'Would have been beneficial to either have started training sooner' 'Sometimes the days can be longer than necessary (too many group exercises, discussions, role plays etc). - I believe a lot of the content could be taught in a shorter time-period more effectively and this would increase student engagement'
	Assignment deadlines			Assignment deadline times	'…or moved back assignment dates as some sights have struggled with cases'.
	Additional useful teaching content			Confidence in risk management	'More detailed risk training'
Perceptions of placement within sites	Experience	Satisfaction	'Really enjoying the job' I am enjoying this role	Recruitment /skills mismatch	'I do feel this role would be better suited to someone with perhaps less skills and would be better if the role was situated within a clinical setting.
	Supervision			Selection of CWP cases	'Progress through training programme has been hindered by supervisor restricting our access to clients'.

	Caseload	Time required to generate referrals	'We have struggled to find referrals, this will mean that in practice our learning needs are not being met. This has created anxiety for our group and we feel there is a disconnect between theory and practice'.
Sustainability and funding	Job retention	Uncertainty about funding	'I think the value of post graduate low intensity CYP-IAPT practitioners requires further exploration to retain a skilled future workforce for the much-needed service! I think the need suggests that Low intensity has equal value to that of high intensity and this should be considered in the current banding decision to ensure retention and skilled practitioners'. 'Only if they're guaranteed a permanent full-time job after they complete training, unlike us'

Stakeholder Survey Feedback

Facilitators and barriers at time point two

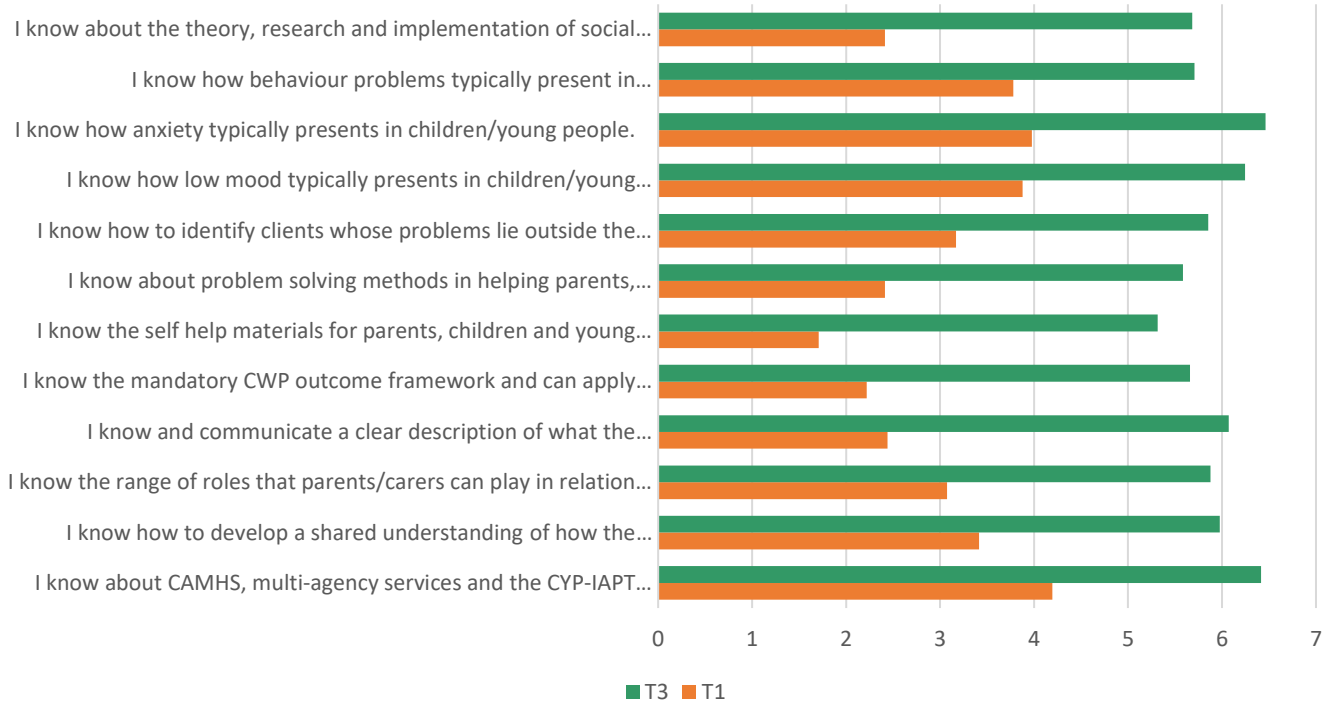
Primary theme	Secondary theme	Facilitator	Illustrative quote	Barrier	Illustrative quote
Perceptions of the CWP programme experience	Experience and support	Enthusiasm and collaboration	'Overall the whole experience has been amazing, and it's been great to be a part of the first wave of CWP practitioners' 'This experience has been thoroughly enjoyable despite it being a new programme. Staff have been incredibly positive role models and supportive people throughout this learning process'. Very well done!! Amazing teaching and support on the course and in our roles at our sites. It's also great to hear about what's happening in other services and to share resources		
Perceptions of course	Structure, organisation and timings	Space during teaching to discuss and support	'I have gained most from Friday afternoon sessions, fantastic space to discuss and support each other'.	Lack of structure and self-help materials	Lack of self-help materials and structure at the beginning of the course has been frustrating! This needs to be in place from the beginning of next year, so teaching can be structured accordingly!
	Quality of teaching	'Intelligently modelled'	'The teaching has been of very good quality, everyone on the course has been approachable and supportive 'the academic teaching has been thorough'		

			'I thought the taught aspects of the course was intelligently modelled and our skills practice days certainly consolidated my learning. Skills practice teacher was outstanding, and our skills session s were and brilliant forum of support. I have sincerely valued the whole course and met some very genuine peers along the way		
	Assignment deadlines	Flexibility with deadlines	'They have also been flexible over assignment deadlines which was great for me as my service was slow to start seeing clients and I did not have the cases to be able to meet the assignment deadlines'.	Gaining consent from service users	'The only feedback I would give would be that in regard to deadlines and gaining video consent for videos has been stressful at times with many trainees having to apply for extensions'.
	Additional useful teaching content			Challenging clinical scenarios	'We haven't really done much on problem solving, endings, future plans, conversations if ROMs show no change etc'
	Responsiveness to feedback	Flexibility of teaching	It feels great to be part of something that is evolving and I really feel a part of contributing to the development of the service, I.e. I really feel that my voice is heard! '…has been responsive to feedback and adjusted the curriculum to meet our needs which has been greatly appreciated. '…and the course have been great at listening to and responding to feedback'.		
	Resources			Lack of tailored resources	'Some more young people friendly booklets and videos would be helpful'.
Perceptions of placements within sites	Supervision	Consolidation of learning in supervision	'The majority of my practical learning that is most relevant to the job has come from supervision'. 'my service has been lucky because our supervisor is a clinical psychologist who has worked in CAMHS for 15 years and who specialises in CBT for anxiety and who runs parent group for challenging behaviour. She has therefore been able to provide lots of additional clinical training'.	Selection of supervisors and location of team	'I think it's essential more thought goes into where the team sits and who supervises them. We were lucky as between the four of us we had clinical knowledge to support each other when the clinical supervisor is not available'.
	Flexibility			Little flexible working at placement	Would be good to be more flexible with where we work - especially if based more in schools. Working

				from home would be useful when there is no need to come into the office on certain days.
Sustainability and funding	Job retention		Uncertainty about funding	'The only reason I may not recommend this role to another is due to the uncertainty of job retention after the course. I think sites should have to commit to retaining CWPs for 2 years when they apply for the funding'. 'I know how or CWP service fits in but the unawareness of how it will be funded and implemented in the future has been a huge concern as we a are unsure whether we will have jobs in that future and if we do have jobs in the future where and what they will be doing.'

Appendix G

Graphs of Mean Scores of Items on Knowledge Subscale



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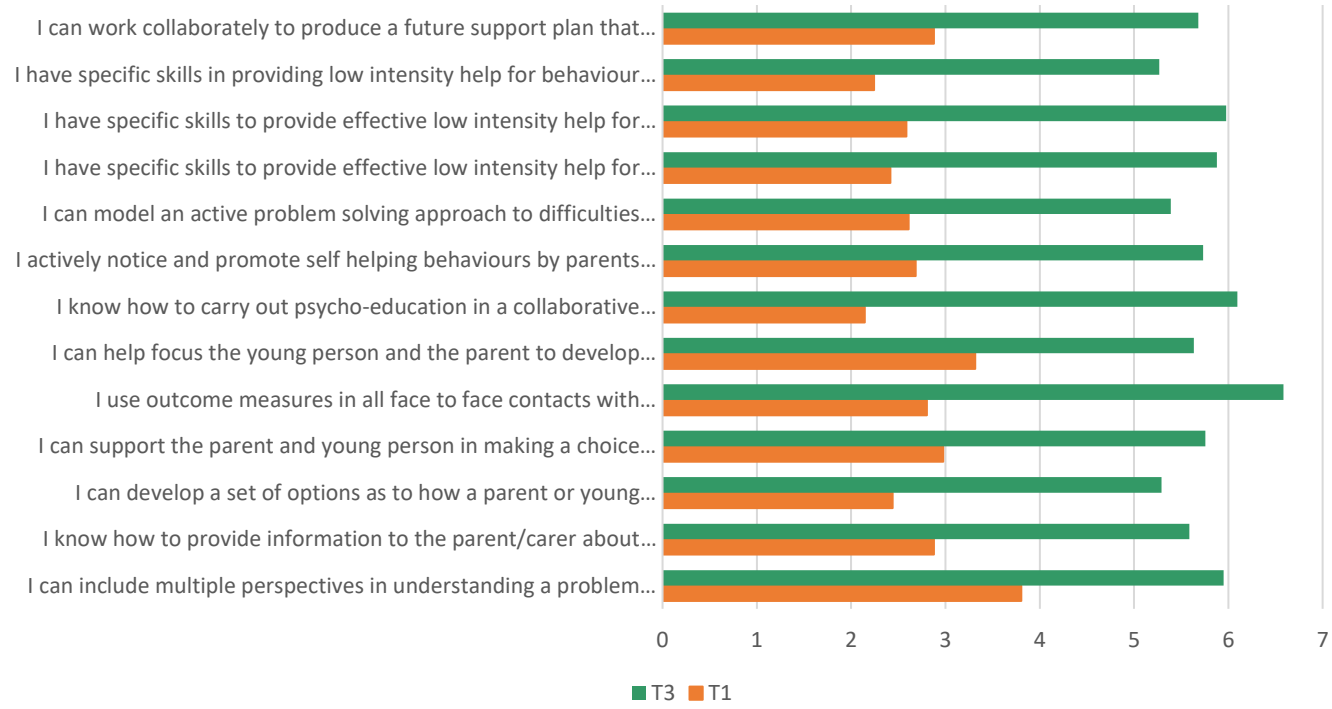

Appendix H

Knowledge and Skills Questionnaire Percentage Change

Percentage Change between means at Time Point 1 and Time point 3

Time point 1	**4.20**	**3.41**	**3.80**	**3.07**	**2.87**	**2.44**	**2.44**	**2.98**	**2.22**	**2.80**	**3.32**	**1.71**
Time point 3	6.41	5.98	5.95	5.88	5.58	6.07	5.29	5.76	5.66	6.59	5.63	5.32
% Change	53	75	56	91	94	149	117	93	155	135	70	211

Percentage Change between means at Time Point 1 and Time point 3

Time point 1	**2.15**	**2.68**	**2.41**	**2.61**	**3.17**	**3.88**	**2.24**	**3.98**	**2.59**	**3.78**	**2.24**	**2.41**	**2.88**
Time point 3	6.09	5.73	5.59	5.39	5.85	6.24	5.88	6.46	5.98	5.71	5.26	5.68	5.68
% Change	185	114	131	107	85	61	143	63	131	51	135	135	97

Key

%	**150-200 + % increase**
%	**100-150 % increase**
%	**50-100 % increase**

End of Report