Rapid Internal Audit
National Report
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Julian Edbrooke-Childs*, Ana Calderon*, Miranda Wolpert*, Peter Fonagy**

*Evidence-Based Practice Unit, the Anna Freud Centre and UCL, 21 Maresfield Gardens, London, NW3 5SD

**Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT), NHS England, Skipton House, 80 London Road, London SE1 6LH
AUDIT FOREWORD

First and foremost, I would like to extend my utmost thanks and appreciation for all of the hard work and dedication colleagues in each of the partnerships have shown to drive forward the CYP IAPT service transformation programme. We know that the scope and speed of the programme brought with it a number of challenges. Without your commitment to improving service provision for children, young people, and families, in the face of working on complex cases amidst a number of other organisational changes, I am sure that CYP IAPT would not have achieved the success it has. The continued rollout is testament to your dedication and achievement of service transformation.

As we come to the end of the initial four-year programme and stand on the verge of its next phase, now is an opportune moment to stand back and reflect not only on our successes but also on areas for continued development. We must not be complacent in our achievements but challenge ourselves to set the highest possible standards. It is within this context that we instituted the rapid internal audit. I am eternally grateful to colleagues who went above and beyond the call of duty by providing rich data and learning. Not only do these data allow us to see the challenges that we face, but they have also been instrumental in setting the future direction of the programme. In reflecting on the previous four years and the learning from the audit, I have set out below five areas that I see as key priorities for the future of CYP IAPT.

In doing so, I would ask you to reflect on the findings presented in this report as a piece of information about your service that should be considered in the context of your and your team’s experiences, and discussed with your colleagues to consider a) how the findings fit with your views, b) your interpretations, and c) any necessary actions you may wish to take.

In general, the findings presented for each partnership are based on a small cross-section of data and may not be representative of all those in your partnership. Therefore, conclusions drawn from the data should be tentative and based on local contextual knowledge. We have provided information for you to interpret the findings but have avoided over-interpretations ourselves, given these limitations. In particular, we chose to present descriptive statistics and funnel plots and not use significance testing.

Whole-team training

Findings from staff surveys and interviews suggest that team relationships are one of the areas most in need of further development. The audit identified the crucial importance of senior management commitment, providing strong leadership particularly when facing a number of contextual barriers to service transformation. To sustain and spread the CYP IAPT principles going forward, we recommend you consider maintaining whole-team training, particularly focused on overcoming local contextual challenges and other service changes.

Service access and self-referral

There are a number of means of accessing services and the number of self-referrals is increasing. Still, young people and parents reported that self-referral to CAMHS was not yet universally available, visible, or simple.
A plea for better engagement on first contact

A number of changes to service delivery and design have been made to improve engagement with services and there was an increase in the percentage of closed cases by mutual agreement to end treatment. Nevertheless, young people reported that, although they felt involved in care once treatment began, they did not always feel involved upon first contact or assessment. We have included examples of initiatives to improve engagement reported by sites and hope that these provide a useful springboard for future work to improve engagement on first contact.

A plea for better data on CAMHS

Staff and services are working incredibly hard to collect, enter, and feed back routinely collected data. Even so, there is more work to be done because without better, more complete data – particularly on matched outcome measures from time 1 to time 2 – we are very limited in what we can say about treatment outcome in CAMHS. Without these data, we simply cannot be confident in the conclusions we can draw about how children, young people, and families are benefiting from the invaluable care you provide. These data are desperately needed for staff and services to reflect on the care that you provide and for people to be able to make informed, convincing arguments when fighting the case for CAMHS funding.

Supervision

As you will see from this report, CAMH services aim to provide high-quality supervision. This supervision is somewhat hit and miss, and needs to be more systematic to ensure that all therapists have a space to discuss and reflect on the challenging work of providing therapy to children, young people, and families – crucial to providing effective care to our service users and also to our therapists.

All CAMHS therapists and practitioners should receive regular supervision where they can discuss their cases. By including a discussion of outcome measures and feedback in supervision, I am confident that we will help to provide a different piece of information about families in the supervision-space and develop the evidence we urgently need to show the benefits of the important work you do with children, young people, and families every day.

Peter Fonagy
National Clinical Advisor, CYP IAPT
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We would like to thank all the young people, parents, and clinicians who participated in the rapid internal audit. We would also like to thank the Collaboratives who participated and helped support the audit. Thanks also go to the Research Assistants who supported in data collection and the Child Outcomes Research Consortium (CORC) who supported in the conduct of the audit.
Overview

Between October 2014 and March 2015, the Evidence-Based Practice Unit at the Anna Freud Centre and UCL, and NHS England undertook a rapid internal audit of CYP IAPT. Case studies were conducted with 12 partnerships, involving analysis of routinely collected data, staff surveys and interviews, and interviews and focus groups with young people and parents involved in CYP IAPT participation groups. The aim of the audit was to explore how far services were along their transformation journey to embedding the CYP IAPT principles. At the heart of CYP IAPT is a strong emphasis on creating a collaborative approach across services and with service users and improving the availability, efficiency, and effectiveness of mental health services for children and young people (CYP IAPT, n.d.). This briefing note summarises the findings of the audit with regard to how far services were along their transformation journey.

A transformed service is more efficient

Findings of the audit suggest that services have higher levels of efficiency. The average number of days between referral and assessment decreased from 239 in 2010 (n = 5 services) to 64 in 2014 (n = 10 services), and the proportion of average waiting time to total accepted referrals decreased from 0.18 in 2010 (n = 5 services) to 0.04 in 2014 (n = 10 services). The average number of days between assessment and discharge decreased from 299 days in 2010 (n = 5 services) to 235 days in 2014 (n = 8 services), and the proportion of discharge time to total accepted referrals decreased from 0.24 in 2010 (n = 5 services) to 0.17 in 2014 (n = 8 services). Staff reported in interviews that young people were being seen faster and more appropriately, and that there was more throughput through the service, for instance because of the use of routine outcome monitoring.

I suspect we’re getting a better throughput, so almost having been able to access more people because we’re able to close [cases], having said “well, these were your goals, your symptoms have improved…this is your relapse prevention plan, we’ll do it together and this is how you can come back. (Staff)

Self-referral (see p. 3), more open referral routes, a single point of access, outreach services, and evening and weekend appointments were described as improving service access. Parents reported being seen within one month (21% or 9 parents), between one to two months (38%, 16), between three to five months (24%, 10), or longer (20%, 8).

A transformed service is a learning organisation

Using a validated questionnaire (Glisson et al., 2007) it was found that, compared to a national sample of mental health services in the United States, teams in CYP IAPT had more proficient organisational cultures and more functional organisational climates. This may suggest that services are successful in supporting the development of a skilled and cooperative workforce with clearly defined roles and a focus on the needs of service users. However, teams in CYP IAPT had more rigid and resistant organisational cultures and less engaged and more stressful organisational climates than US counterparts. This may suggest that there are still challenges for clinicians in
embedding new ways for working and that concomitant service reorganisations, higher levels of need compared to service provision (The Centre for Economic Performance’s Mental Health Policy Group, 2012), and service cut-backs (Young Minds, 2014) present ongoing contextual challenges.

In line with these survey findings, the staff interviews revealed that team relationships were the area in most need of improvement. Senior management commitment was seen as crucial to strong leadership and service transformation, particularly when facing a number of contextual barriers to service transformation. Whole team training as part of CYP IAPT, particularly focused on overcoming local contextual challenges and other service changes, may be useful to sustain and spread CYP IAPT going forward.

Areas of continuing improvement suggested by young people were increased opening times, better IT systems to enable information sharing, and more information about CAMHS but also about mental health and wellbeing in the community to raise awareness.

**A transformed service is more evidence based**

Clinicians described CYP IAPT as having embedded evidence-based treatments in their service and improving young people’s access to evidence-based treatments. Clinicians described feeling more confident in delivering evidence-based treatments as a result of CYP IAPT and that evidence is used in conjunction with patient preferences and clinical judgment.

> In terms of treatment, [CYP IAPT] has had a significant impact because it has enabled young people to access evidence-based treatments, whereas before they would have never been able to access that and therefore they may not have received the right treatment and...have prolonged mental health issues. (Staff)

Of those clinicians trained in NICE-recommended therapies, 97% (38) were still offering the therapy. However, use of evidence-based treatments was less frequent in the routinely collected data. Of the 1,268 young people presenting with depression or anxiety (Jones et al., 2013) 27% (345) received CBT. The standardised effect size of closed cases, according to the Revised Children’s Anxiety and Depression Scales (RCADS) (Weiss & Chorpita, 2011), was between 0.16-0.58 (95% CI = 0.02-0.68). Of those young people whose cases were closed and were above clinical cut off according to the RCADS at time 1, 28-57% (21-75) achieved recovery at time 2 (or 11-39% [4-14] according to parent report).

The differences between self-reports of embedding evidence-based treatments and use in the routinely collected data may be due to data quality and under-reporting or because those trained were unable to deliver the therapy. On the one hand, of those clinicians trained in NICE-recommended therapies, 83% (33) were still receiving supervision in the corresponding therapy. On the other hand, in the staff interviews, clinicians reported a need for the high-quality support received during training to continue after training. Contextual factors were also reported as a barrier to delivering evidence-based treatments: “staff ready and trained who can’t deliver, through service cuts” (Staff).

**A transformed service is outcomes focused**

Most staff reported that CYP IAPT had increased the use of outcome monitoring. Session-by-session monitoring was described as supporting shared decision making and improving the ability to review treatment progress. Young people and parents echoed this, reporting that it helped to “keep things focused” (Young person).
I always fill in the questionnaire before I start and look at the progress. It’s good to see how much you’ve progressed; it means that you can actually realise what you have progressed to ‘cos, s’pose if you don’t really write it down or say it out loud, you don’t really realise how much you’ve progressed until it’s kinda spoken to you. (Young person)

Young people and parents reported mixed experiences of outcome monitoring and that it was less helpful if not clearly explained or discussed. All groups reported that there was still more work to be done to embed monitoring, particularly around IT, discussing measures with service users, and using measures to review treatment progress or in supervision. This was mirrored in the routinely collected data. Of the total sample of 6,803 young people\(^1\), 83% (5,633) of CYP had an assessment measure recorded. Of those 3,939 CYP who had at least two sessions recorded\(^2\), 42% (1,639) had matched T1-T2 scores on an outcome measure. Of those 2,690 CYP who had at least three sessions recorded\(^3\), 49% (1,322) of children had any sessional measure used in at least two sessions and 44% (1,184) of children had any sessional measure used in at least three sessions.

A transformed service prioritises service user involvement

CYP IAPT and the participation groups were described by clinicians as having given children and young people “a voice in a massive way” (Staff). Young people described involvement as giving them a personal sense of worth and empowerment. Although young people felt listened to during participation activities, they were less aware of changes to the service that had been made as a result of feedback. Young people were involved in service design and delivery in a variety of ways, including: recruitment and interview panels, staff appraisal and training, website and information design, planning and delivery of a mental health awareness day for the wider population, “Mystery shopped” service evaluation, environmental changes, speaking to directors, new feedback systems (e.g., traffic light system), “You said, we did” board, discussions of more frequent appointments and extended opening hours, finding different locations to hold sessions where young feel more comfortable, and the “Y Factor” where young people have the opportunity to talk to other young people about mental health.

These changes to service delivery and design may have improved engagement with services, and the percentage of closed cases by mutual agreement to end treatment (vs. all other reasons) increased from 34% in 2010 (\(n = 5\) services) to 55% in 2014 (\(n = 10\) services). There was also a decrease in the proportion of DNAs to total accepted referrals from 1.17 in 2010 (\(n = 7\) services) to 0.99 in 2014 (\(n = 11\) services).

Young people reported feeling involved in treatment once treatment begins but not necessarily during the assessment process. This may suggest that further work to engage young people and parents at the initial stages of contact is needed or alternatively, that changes already made to services have not had sufficient time to make a difference to early engagement.

A transformed service supports self-referral

The percentage of accepted self-referrals out of all accepted referrals increased from 1.21% in 2010 (\(n = 7\) services) to 2.65% in 2014 (\(n = 11\) services) in the service-level data reported by partnerships. Young people reported having been able to self-refer and that there was information available in their service about self-referral, however they also thought that the process of self-referral could be simplified. The majority of parents reported wanting to be able to self-refer but currently not being able to.

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1 With complete age, gender, and at least one Current View Tool item recorded.
2 For the possibility of two measures having been administered.
3 Assuming the first session was assessment and the last session was discharge or case closure, there would be at least one treatment session in which a sessional measure could have been used (Law & Wolpert, 2014).
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OVERVIEW OF CYP IAPT

The Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) service transformation programme was introduced in 2011 and has a target to work with Child and Adolescent Mental Health Services (CAMHS) that cover 60% of the 0-19 population by 2015. CYP IAPT involves partnerships between CAMHS and higher education institutions across five Collaboratives: London and the South East, the North West, Oxford/Reading, the North East, and the South West. The aim of CYP IAPT is to transform existing services for children and young people by adopting those elements of the IAPT programme that will help improve outcomes for children and young people, and by providing treatment which is based on best evidence, outcomes focused, and client informed (CYP IAPT, 2013b; Department of Health, 2011, 2012). At the heart of CYP IAPT is a strong emphasis on creating a collaborative approach across services and with service users, and improving the availability, efficiency, and effectiveness of mental health services for children and young people (CYP IAPT, n.d.).

To achieve this aim, the programme works with partnerships to embed seven principles for working with children, young people, and families:

1. To support whole service transformation through leadership
2. To improve access through self-referral
3. To work in partnership with the young person and their parent/carer in service delivery and design
4. To deliver evidence-based psychological treatments
5. To deliver outcomes-focused psychological treatments
6. To work in partnership with the young person and their parent/carer throughout treatment
7. To provide supervision to support the delivery of evidence-based, service user-informed, and outcomes-informed practice

To embed these principles, the programmes is (CYP IAPT, 2013b) (p.5):

- working in partnership with children and young people to shape their local services and supporting local services participating in the programme to do likewise
- supporting services to develop a culture of reflective practice and accountability
- improving the workforce through training in best evidence-based practice
- developing mechanisms to deliver frequent/session-by-session outcome monitoring to help the therapist and service user work together in their session, and to help supervisors support therapists in improving outcomes
- supporting local areas in improving the infrastructure they use to collect and analyse data to see if children and young people are getting better.

Part of the CYP IAPT service transformation programme includes funding for a range of training and service-based continual professional development (e.g., service-based training in the use of outcome and feedback measures). Training in evidence-based therapies refers to:

- Cognitive behavioural-therapy (CBT) for depression and anxiety
- Parent training for conduct problems for 3-10 year olds
- Systemic family practice for depression and self-harm, conduct problems (over 10s), and eating disorders
- Interpersonal psychotherapy for adolescents experiencing depression
A recent survey found that 70% of CAMHS questioned reported that they were working to CYP IAPT principles (NHS Benchmarking Network, 2013). According to the annual refresh of data submitted for CYP IAPT, data completeness of matched time 1 and time 2 cases was 63.2% (Wolpert, Fleming, Jacob, Napoleone, & Whale, 2014). The five CYP IAPT Collaboratives may be undertaking their own evaluation and audit activity. However, to the best of our knowledge, there is no published evidence of the extent to which CYP IAPT has proceeded as intended and met its aim, or about the barriers and facilitators to implementing and sustaining CYP IAPT.
AIMS OF THE RAPID INTERNAL AUDIT

The aim of the audit was to explore how far services were along their transformation journey to embedding the CYP IAPT principles. In particular, to examine data relating to the implementation and impact of the CYP IAPT work streams of improving access to evidence-based therapies, creating a collaborative service culture by using regular feedback from session-by-session outcome monitoring, promoting service user participation in service design and delivery, and improving service access.
METHOD

AUDIT DESIGN

Multiple case studies were conducted with a sample of N=12 partnerships comprising two partnerships from each of the five Collaboratives, except for the London Collaborative where four partnerships were included as the area has a larger proportion of partnerships. Partnerships were purposively sampled to recruit services with the richest experience of CYP IAPT, balancing between earlier and later adopters. Selection criteria included:

1. Amount of routinely collected CYP IAPT data submitted
2. Number of trainees who have completed CYP IAPT training
3. Engagement with review and monitoring activity, including site visits from the central team
4. Ability to identify service leads, data managers, and informatics leads within case study sites and sites’ ability to upload and flow data from their locally held electronic patient record system
5. Ability to agree and commit to rapid internal audit requirements
6. Existing service user involvement activity, which could be drawn on to feed into interviews and focus groups with young people and parents

A mixed-method case study design was employed (Yin, 2009). The approach involved instrumental, multiple case studies to gather exemplars of more general phenomena, so learning from the implementation of CYP IAPT could be generalised beyond case study sites. Case studies were also pragmatic and explanatory to ensure that answers to the above audit questions were obtained. Embedded case studies were developed by obtaining data at multiple levels of analysis within case study sites.

Case studies involved five strands of data collection:
1. Routinely collected data
2. Clinician surveys
3. Clinician interviews
4. Focus groups with young people as part of ongoing CYP IAPT participation activities conducted by GIFT
5. Interviews with parents as part of ongoing CYP IAPT participation activities conducted by YoungMinds

PARTICIPANTS AND PROCEDURE

Routinely collected data

All routinely collected data since 2010 were requested from services. Routinely collected data were submitted and collated focusing primarily on data around activity and efficiency of services from electronic patient record systems that may not currently be collected as part of CYP IAPT routine data collection. Service-level data were submitted from 11 of the participating partnerships. Patient-level data were collated from all of the participating partnerships.

To minimise burden on sites, patient-level data were submitted and collated according to the CYP IAPT data specification (CYP IAPT, 2013a) and the CAMHS secondary uses dataset specification (Information Standards Board for Health and Social Care, 2012).

Data for a total of 20,181 young people were provided by all the sites. Young people from this dataset were included in the final sample if they had complete basic demographic information on
age, gender, and at least one presenting problem, complexity factor, or contextual factor recorded in the ‘Current View’ tool (Jones et al., 2013). This resulted in a final sample of \( N = 6,803 \) young people from 11 services, which corresponds to 34% of the total sample. Out of the 6,803 young people, 56% were female, with a mean age of 12.96 years (SD \(_{\text{AGE}} = 3.77\)). In total, 60% (4,045) of children were White, 2% (145) Asian, 5% (304) Mixed, 6% (408) Black, with 24% (1,648) not stating their ethnicity and 4% (253) recording another ethnicity; this is in line with research showing that children from black and minority ethnic groups may be under-represented in CAMHS (Malek & Joughin, 2004).

The overarching presenting problems recorded were internalising problems (70%, 4,672), externalising problems (41%, 2,795), interpersonal problems (60%, 4,096), and developmental problems (15%, 1,034) (multiple responses permitted). A breakdown of all presenting problems is shown in Figure 1 overleaf. Low mood and family relationship problems were the most frequent presenting problems (45-46%), followed by peer relationships, general anxiety, and social anxiety (37-39%). Separation anxiety, self-harm, attention deficit hyperactivity disorder (ADHD), conduct disorder, carer management, attachment, and panic were the next most frequent (20-28%), followed by obsessive compulsive disorder (OCD), agoraphobia, specific phobia, habit disorder, risk, post-traumatic stress disorder (PTSD), eating disorder, and emerging personality disorder (12-16%). The least frequent presenting problems were bipolar disorder, psychosis, drug or alcohol problems, elimination, selective mutism, gender discomfort, unexplained physical symptoms, unexplained developmental problems, self-care problems, or adjustment to health problems (1-7%).

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4 The ‘Current View’ tool is completed by clinicians and includes 30 presenting problems, 14 complexity factors and 4 contextual factors. If at least one presenting problem, complexity factor, or contextual factor was recorded, other presenting problems, complexity factors or contextual factors were treated as absent if recorded as missing.

5 Data for two of the partnerships are submitted using the same service identifier and hence are collapsed to represent one service.
Note. N = 6,803. Multiple responses permitted. ns reported in parentheses. No presenting problems were reported for 18% (1,208).

Figure 1:
Frequencies of presenting problems
The complexity factors recorded were social care problems (16%, 1,064), experience of trauma/abuse (24%, 1,634), and other problems (73%, 4,957) [multiple responses permitted]. The breakdown of complexity factors is shown in Figure 2. Parent health problems were the most frequent complexity factor (21%), followed by abuse (15%), child in need (9%), pervasive developmental disorder (PDD) (8%), financial difficulties (7%), looked after child (LAC) (5%), physical health problem (5%), young carer (4%), learning difficulty or disability (LDD) (4%), child protection plan (3%), youth justice system involvement (3%), neurological problems (2%), refugee (1%), and experience of war or trauma (1%).

![Figure 2: Frequencies of complexity factors.](image)

**Note.** $N = 6,803$. Multiple responses permitted. Frequencies reported in parentheses. No complexity factors were reported for 55% (3,713).

The frequencies of contextual factors are shown in Figure 3. Home issues were the most frequent contextual factor (39%), followed closely by school issues (36%), and employment, education, or training (EET) attainment issues (33%). Less frequent contextual factors were (EET) attendance issues (26%), community issues (20%), and engagement issues (14%).

CYP IAPT: Rapid internal audit report for Oxleas NHS Foundation Trust
Note. N = 6,803. Multiple responses permitted. Frequencies reported in parentheses. No complexity factors were reported for 34% (2,297).

Overall, 42% (2,883) of cases were closed, of which young people had an average of 5.71 events recorded (SD\textsubscript{events} = 8.64) with an average of 162 days (SD\textsubscript{days} = 195.28, n = 181 not specified) between period of contact start and case closure.

Clinician survey

The Tailored Design Method (Dillman, Smyth, & Christian, 2008) was used to develop and administer a clinician survey capturing demographic characteristics and experience of embedding the principles of CYP IAPT. Existing measures were used to design a bespoke survey, which captured: attitude to shared decision making (SDM), attitude to evidence-based treatments (EBT), and attitudes to providing young people and parents with feedback from routine outcome measures (ROM). In addition, organisational social context was assessed to capture team culture and climate (see Measures, below). To capture a representative perspective on culture and climate, the administration guidelines for the measure of organisational social context requires that non-senior managers who work at least 50% full-time equivalent, have direct clinical contact, and work in the same team are eligible. A minimum of one to two teams per partnership was recruited to complete the measure of organisational social context, with a team being defined as “a distinguishable set of two or more people who interact dynamically, interdependently, and adaptively toward a common and valued goal/objective/mission” (Salas, Dickinson, Converse, & Tannenbaum, 1998, p. 4) who work closely together and have the same team manager/leader. In general, participants who completed the measure of organisational social context also completed the other measures. Research assistants attended team meetings where no senior managers were present, to ensure confidentiality when recruiting team members. Clinicians completed the staff survey during the team meeting or via email, with follow-up visits and emails administered as necessary.

Partnerships were asked to recruit at least one to two teams to complete the Organisational Social Context (OSC) questionnaire and bespoke survey to achieve the required response rate for the
OSC; other staff in the partnership were able to complete the bespoke survey if they wished.

The mean response rate for the OSC was 71%. This resulted in a final sample of N = 361 (70% female, 17% male, 13% not specified) (\(M_{\text{age}} = 43, SD_{\text{age}} = 10.30, 6\% \text{ not specified}\)) from 43 teams.Clinicians were primarily a provider of direct services to children, young people, and families (69%, 249), primarily a supervisor of those who provide direct services (6%, 21), upper management (3%, 9), and other roles (10%, 36) with 13% (46) not specified. The most frequent level of education was Master’s degree (33%, 120), followed by Bachelor’s degree (25%, 90), doctoral degree (22%, 80), A-levels or equivalent (4%, 15), and NVQ or equivalent (2%, 7) with 14% (49) not specified. These qualifications were in psychology (26%, 93), nursing (14%, 50), social work (11%, 38), medicine (8%, 30), education (2%, 6), and other disciplines (25%, 91), with 15% (53) not specified. Clinicians had an average of 10 years of experience (SD = 7.74, 4% not specified) and had been in their current position for an average of 6.3 years (SD = 6.02, 1% not specified). The therapeutic approaches used were psychodynamically oriented treatment methods (72%, 259; 7% missing), cognitive and/or behavioural treatment methods (88%, 316; 1% missing), humanistic (61%, 219; 2% missing), systemic (89%, 320; 1% missing), and other (45%, 164, 32% missing) (multiple responses permitted).

Interviews

Clinicians were recruited to take part in an interview either during a team meeting when they completed the clinician survey or via email. Interviews were conducted one-to-one, either in person or by telephone. Most interviews were transcribed verbatim and then analysed, with a minority concurrently transcribed and analysed where notes from interviews were written up from audio records. A heterogeneous mix of clinicians was recruited to capture experiences of embedding the CYP IAPT principles. In total, N = 92 staff were interviewed, consisting of 66 clinicians, 22 team leads, and 4 commissioners from the 12 partnerships. Structured interview schedules were developed for each group (see Appendix 135); for the team lead interviews, the Children and Young People - Resources, Evaluation and Systems Schedule (CYPRESS) (Gaffney, 2012) was administered. CYPRESS describes the service characteristics, team operation, and delivery of interventions provided by services to children and young people with complex needs. It comprises 20 items, each scored from 1 to 5 with a maximum total score of 100; the maximum score for each section is 30 for service characteristics, 30 for team operation, and 40 for delivery of interventions.

Young person focus groups and parent interviews

CYP were recruited following a purposive sampling approach. Researchers liaised with existing participation groups and asked if they could run workshops with their members, including those who have experience of accessing CAMHS. Focus groups were conducted with N = 45 young people from 11 partnerships. Young people were aged 16 years (SD = 1.9; 71% female), and the majority (88%, 40) were White British; the majority of young people (78%, 35) were current CAMHS service users (within the past 12 months) and 22% (10) left the service before CYP IAPT was implemented. Topic guides were developed for the focus groups with young people (see Appendix C).

Parents were recruited for interview following a purposive sampling approach. Interviews were conducted with N = 42 parents from 10 partnerships. Overall, 81% (34) were still using the service and the children of 17% (7) had terminated treatment in the last 12 months, with the child of one parent having terminated treatment more than one year ago. Topic guides were developed for the interviews with parents (see Appendix D). To ensure consistency between the topic guides for the clinician interviews, young people focus groups, and parent interviews, all guides were designed and reviewed to capture the seven CYP IAPT principles and the service user participation pledges (see Appendix C and D).
ETHICS AND GOVERNANCE APPROVALS

For the parts of the audit led by the Evidence-Based Practice Unit (i.e., routinely collected data, clinician surveys, and interviews), University College London Research Ethics committee (project ID: 6087/001) gave ethical approval and the project was registered with local Trusts. All participants gave informed consent before taking part in the surveys, interviews, or focus groups. The focus groups with young people and the interviews with parents were conducted as part of ongoing CYP IAPT participation work, following GIFT’s and YoungMind’s protocols for ethics and governance.

MEASURES

Organisational social context

To measure organisational social context, the 105-item Organisational Social Context (OSC) (Glisson, et al., 2007) was used. The OSC measures three domains of the social context of mental health services: organisational culture, organisational climate, and work attitudes. Organisational culture refers to the expectations governing performance in the organisation, and is comprised of three second-order dimensions: rigidity, proficiency, and resistance. A rigid organisational culture is characterised by expectations that clinicians have little control and flexibility over how they carry out their work (e.g., “I have to ask a supervisor or coordinator before I do almost anything”). A proficient organisational culture is characterised by expectations that clinicians are responsive to the needs of service users and have up-to-date knowledge (e.g., “members of my organisational unit are expected to be responsive to the needs of each client”). A resistant organisational culture is characterised by expectations that clinicians are averse to change and new ways of working (e.g., “members of my organisational unit are expected to not make waves”).

Organisational climate refers to clinicians’ perceptions of the impact of the work environment on their well-being and ability to function, and comprises three second-order factors: engagement, functionality, and stress. An engaged climate is characterised by perceptions that clinicians are personally invested in their work and feel personal accomplishment (e.g., “I have accomplished many worthwhile things in this job”). A functional climate is characterised by perceptions that clinicians have role clarity, team cohesion, and opportunities for professional development (e.g., “my job responsibilities are clearly defined”). A stressful climate is characterised by perceptions of role conflict and overload, and that clinicians are emotionally exhausted (e.g., “interests of the clients are often replaced by bureaucratic concerns, e.g., paperwork”).

Work attitudes refers to clinicians’ perceptions of their morale, including job satisfaction and organisational commitment (e.g., “I am proud to tell others that I am part of this organisation”). Clinicians responded on a six-point scale from 0 (never) to 5 (always). The OSC has been widely used and has demonstrated reliability and validity in numerous studies (Aarons et al., 2012; Glisson, et al., 2007).

Attitude to SDM

To measure attitude to SDM, the 12-item Leeds Attitude Towards Concordance (LATCon) (Raynor, Thistlethwaite, & Knapp, 2001) was used (e.g., “The consultation between the professional and service user should be viewed as a negotiation between equals”). Clinicians responded on a four-point scale from 0 (strongly disagree) to 3 (strongly agree). The LATCon has been used in previous studies and demonstrated acceptable reliability (De las Cuevas, Rivero-Santana, Perestelo-Perez, Perez-Ramos, & Serrano-Aguilar, 2012; Raynor, et al., 2001).

\[6\] No widely used measure of attitude to shared decision making in CAMHS was found (Right Care, 2012; Scholl et al., 2011). As the LATCon was developed to measure pharmacists’ attitudes to shared decision making regarding medication adherence, items were modified to make them applicable to clinicians in CAMHS in England.
Attitude to EBT

To measure attitude to EBT, the 8-item Modified Practice Attitudes Scale (MPAS) (Borntrager, Chorpita, Higa-McMillan, & Weisz, 2009) was used (e.g., “I am willing to use new and different types of treatments if they have evidence of being effective”). Clinicians responded on a five-point scale from 0 (not at all) to 4 (to a very great extent). The MPAS has been used in a previous study and demonstrated acceptable reliability (Borntrager, et al., 2009).

Attitude to feedback

To measure attitude to feedback, the 8-item attitude to feedback scale was used from the attitudes to Routine Outcome Assessment (ROA) (Willis, Deane, & Coombs, 2009) questionnaire (e.g., “Providing feedback from outcome measures will help the clinician and service user work more collaboratively in treatment”). Clinicians responded on a six-point scale from 1 (strongly disagree) to 6 (strongly agree). The ROA has been used in previous studies and demonstrated acceptable reliability (Edbrooke-Childs, Wolpert, & Deighton, 2014; Willis, et al., 2009).

ANALYTIC STRATEGY

The results are presented and discussed in the next section. To explore the experience of embedding the CYP IAPT principles, each of the seven principles are presented with corresponding data. In general, service-level data are presented first, then patient-level data, clinician surveys, clinician interviews, parent interviews, and young person focus groups. Results are summarised for each of the data collection strands, along with associated implications. Each set of analysis will be preceded with a snapshot to outline the particular results that will be presented.

Overview of routinely collected data and clinician surveys

Service-level data were analysed using descriptive statistics and are presented graphically using run charts and bar charts. Service-level data were reported for calendar or financial year and have therefore been reported by year to include both sets of data. Patient-level data and clinician surveys were analysed using descriptive statistics in STATA 12 (StataCorp, 2011) and are presented graphically and in tables.

Overview of interviews and focus groups

Qualitative data were analysed using framework analysis, which has been extensively used for exploring policy implementation (Ritchie & Spencer, 1993). Framework analysis involves five stages, outlined below.

1. Familiarisation: embedding and immersion within the whole interview using audio recordings, transcripts, and field notes
2. Identifying a thematic framework: to ensure consistency across sites, the substantive thematic framework was developed a priori with emergent themes also then captured
3. Indexing: all items in transcripts are coded with multiple codes permitted

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7 As the measure was developed with clinicians in adult services, the word “client” was changed to “young person” to make the items more applicable to clinicians in CAMHS in England, without changing the meaning of the items.
8 As the measure was developed in Australia, the word “consumer” was changed to “service user” to make the items more applicable to clinicians in mental health services in England, without changing the meaning of the items.
9 Data were reported up until last time point available, meaning some services reported data with different end dates. All data were standardised; e.g., if data were provided until November 20014, data were divided by 11 and multiplied by 12.
4. Charting: summarising and synthesising all the data for each theme, with frequencies
5. Mapping and interpretation: to explain and understand findings by exploring consistent, contrasting, and unique occurrences

**Synthesis of findings**

To synthesise data across and within case study sites, a quantitatively driven multilevel mixed-methods analytic strategy was used with a qualitative component to triangulate the quantitative data (Teddle & Tashakkori, 2008). A meta-matrix was used to summarise findings, including a cross-case analysis using the constant comparative method (Mays & Pope, 2000) to explore similarities and differences within and between data strands. Data are summarised in a matrix reporting findings for each data strand (see Table 5).
SERVICE TRANSFORMATION SNAPSHOT

**Principle:** To support whole service transformation through leadership

**Clinician survey:** Compared to a national sample of mental health services in the United States, teams in CYP IAPT had more proficient organisational cultures and more functional organisational climates.

**Clinician interviews:** Senior management commitment was seen as crucial to strong leadership, particularly when facing a number of contextual barriers to service transformation. Overall, team relationships were described as being the area most in need of improvement.
ST: SERVICE TRANSFORMATION

ST 1. CLINICIAN SURVEY

Of the clinicians who responded to the survey (N = 361), 11% (n = 30/280) received leadership training (of whom 80% [n = 19/24] were satisfied with the training) and 56% (n = 185/331) of clinicians agreed with that their service was working toward whole service transformation through leadership. Also, 79% (n = 226/285) felt at least quite well able to meet the needs of CYP and families in their service, and 51% (n = 147/289) of clinicians agreed that CYP IAPT has improved the mental health outcome of CYP and families.

Using a validated questionnaire (Glisson, et al., 2007) it was found that, compared to a national sample of mental health services in the United States, the 30 teams in CYP IAPT who met inclusion criteria felt more overloaded by workload or unable to get the necessary things done (i.e., stress, M = 63.2, SD = 6.82) and reported less interest in change or in new ways of providing services (i.e., resistance, M = 67.5, SD = 7.25). They also felt less personal accomplishment and investment in their work (i.e., engagement, M = 48.2, SD = 7.12) and less discretion or flexibility in carrying out their jobs (i.e., rigidity, M = 56.7, SD = 7.61). However, clinicians reported higher levels of responsiveness to the needs of service users (i.e., proficiency, M = 55.2, SD = 6.13) and higher levels of role clarity, team cohesion, and professional development opportunities (i.e., functionality, M = 56.7, SD = 7.61).

ST 2. CLINICIAN INTERVIEWS

Leadership

Many participants reported that there was strong leadership in their partnership, which facilitated the embedding of the CYP IAPT principles: “I think there is huge amounts of buy-in at a senior level within the service, which I think helps in terms of then being able to look at how that could be implemented across the whole, and how the principles and learning from IAPT can be used across the whole service” (Site 2). Commitment from senior management was seen as crucial and as having improved: “[leadership] has not been historic…the service has had a review and identified areas for service improvement, and it’s got some good strong leadership now” (Site 1).

One site had notably less positive comments about leadership: “I don’t think our manager has ever been to one of [the CYP IAPT groups]...how can they implement CYP IAPT service [transformation] if they’re not attending the CYP IAPT training and having discussions around it” (Site 12). Contextual challenges were reported as a barrier to leadership and transformation; e.g., “under extreme pressure with massive numbers of increasing referrals, increasing expectations, and actually maintaining the focus, both in terms of [CYP] IAPT but also looking at different ways of providing, different ways of delivering, increasing productivity, absolutely is where the service is at, at the moment” (Site 2) (sub-themes italicised).

Relatedly, some sites reported room for improvement in leadership to support transformation, including more time and consideration for implementing changes which can feel “knee-jerk” (Site 8). Other areas for improvement were a concern that pressure was putting the numbers ahead of the patients and the need for some senior staff to have a stronger commitment to embedding the CYP IAPT principles.

Senior staff mirrored these barriers, describing the implementation of CYP IAPT as occurring at “a difficult time where there’s big changes in the way the team work” (Site 4). However, the CYP IAPT
management training was noted as being useful in overcoming this. Concerns over sustainability after the end of formal training were raised by a small number of participants: “Roles seem to be alive [only] during the course...so I was left to get on with it” (Site 3). Finally, a small number of senior staff discussed the role of leadership externally in terms of ensuring that important relationships are maintained during internal transformation: for instance, with the local authority.

Team relationships

Views about the impact of CYP IAPT on team relationships were more mixed. On the one hand, many sites reported a number of positive changes to team relationships. Teams were described as being more structured and focused: “CYP IAPT has aligned everyone on to the same thing which pulls everyone along together” (Site 7), “people are thinking more in terms of evidence base, looking at what are the best pathways, understanding of care pathways has improved and the feedback I have on the clinics that are used is much better” (Site 7), “real structure to their practice and clinical work, which is hugely beneficial...and has reduced stress and burden for them as practitioners” (Site 2), “much more focused in terms of what they are delivering as treatments” (Site 1), “[staff] attitudes around working more collaboratively with children and families has changed” (Site 1), “Everyone has come somewhere along the road from where they started, with some being enthusiastic and some kind of grudgingly now...but they were people who wouldn’t have touched [evidence-based models] with a bargepole three years ago” (Site 11). One site particularly noted how the team’s relationship to outcome monitoring had changed from an externally improved “managerial thing” with the expectation that “people will be better within a certain number of weeks when actually with some longer-term cases that doesn’t happen” whereas now the team’s use of measures has improved and they use them in a more meaningful way (Site 12).

Improved team functioning in terms of communication, information sharing, and understanding of skills was described as fostering a better understanding of the internal referral systems, utilisation of multidisciplinary skills, and easier access to appropriate peer supervision with “better discussion in peer supervision” (Site 1), “The team works collaboratively to determine the most appropriate care pathway for CYPs; and as a result of CYP IAPT more interventions are available” (Site 10), “more whole services getting together kind of events...[we’ve] become stronger, and it feels more like we’re all part of one thing, as well as having our individual identities and roles and services” (Site 4), “Staff are now listened to more, and there is more collaborative working and discussions around ROMs. This has allowed the team to gain different perspectives on the issues shared by families” (Site 4). Other staff thought there was further work to be done to ensure there was support in meetings to ensure all staff were heard. More opportunities and resources were discussed by some participants: “CYP IAPT has brought an energy to the team, there is an idea that things are changing and it’s largely viewed positively. People are pleased that there are training opportunities and resources available to support training/trainees” (Site 8).

On the other hand, team relationships were described as being a “work in progress” (Site 1) by the majority of sites. The period of transformation was described as creating strain on the team – some of which was due to changes as a result of CYP IAPT – and the contextual changes were also key: “over the last 12 months there have been so many cuts to resources and we’re in a culture of ‘do more, do more, do more’ with less” (Site 3). Still, it was acknowledged that embedding the CYP IAPT principles seeks to overcome these challenges in the long-term. A downside of the structure and focus reported above was an increase in workload and stress (e.g., as a result of using ROM). Some staff completing training and others not was described by some as divisive, with staff leaving to go on training and, in turn, creating an increased workload for others as backfill was not always arranged. Consequently, some participants reported non-trained staff feeling isolated. In addition, “I think the leadership is there but...could do well to include some of the rest of us who are new coming through, who are really enthusiastic...If you don’t use that enthusiasm now it will just get dissipated” (Site 11). There were mixed views of whether inter-disciplinary tensions had increased or decreased. On the one hand: “The principles of CYP IAPT are food for further conflict...there is a
discrepancy between professionals whose training has involved...themes related to [CYP] IAPT and those who haven’t...Psychologists are scapegoated as being the element of the team that should be doing this” and “I wonder if [family therapists] sort of feel a bit like it’s been imposed by psychology on a model and doesn’t fit well.” On the other hand: “A coming together of psychologists and psychotherapists; it’s served to integrate disciplines and instil notions of a shared task” (Site 11).

However, some suggested these conflicting views were mitigated when the team saw the value of the training and this was filtered through to their colleagues: “There was initial hesitation during the first wave of [CYP] IAPT due to staff leaving to take part in training, this dissipated once the value of the training to the team became evident, increase in skills filtered from trainees into the rest of the team, awareness of clinicians’ skills and specialities increased” (Site 6). Others disagreed that there were rifts, commenting that “different disciplines and modalities are respected” and “we can have disagreement and get on with it” (Site 3). Participants recommended additional whole team CYP IAPT training, in addition to the ripple effect of trained staff feeding learning back to the team: “there needs to be more opportunities for the whole team, together, to train around [CYP] IAPT...and when I say the whole team I mean the whole clinical team, as well as the administration team, together, but not as it has been – just a few nominated people going out and coming back and hoping that the ripple effect is enough,” (Site 1).

Impact on CYP mental health

I’m completely sold by the whole model and I have seen the advantages from service supervision, the clinicians’ work with young people, and the whole model, when it comes together, works for them and their families (Site 5).

The majority of participants reported that CYP IAPT had had a range of positive impacts on CYP mental health: “standards overall of everyone have been raised, more uniformity across the service” (Site 5), “[we] have had good feedback from people who have gone through the service and are in the service” (Site 1). Participants described their service as becoming more transparent, focused, and child-centred, facilitated by the use of ROM, which was described as putting the young person in the centre of their treatment: “more questions being asked about how [clients are] finding things and reviewing and looking at their goals and looking at symptom measures and looking at session rating measures” (Site 4). Consequently, staff reported that young people were being seen faster and more appropriately and that there was more throughput through the service, for instance because of the use of routine outcome monitoring.

I suspect we’re getting a better throughput, so almost having been able to access more people because we’re able to close [cases], having said “well, these were your goals, your symptoms have improved...this is your relapse prevention plan, we’ll do it together and this is how you can come back”. (Clinician)

CYP were perceived to have felt a greater sense of ownership, which “facilitates important discussions that might not take place otherwise” (Site 4). Service changes, based on feedback from CYP, were described as valuable in making the service more accessible and useful, with the potential impact of “seeing more people, we’re seeing them more quickly” (Site 4).

There was a lot of good work that was being done beforehand. It’s more, ‘how did we know that was happening? So I think that that’s what [CYP] IAPT has contributed to...an open approach to take with people for them to actually physically see progress (Site 11).
Participation groups were seen as having a direct positive impact on CYP mental health:

From when we’ve first started working with them, and what the clinicians have seen, is they’ve grown: their self-esteem has grown; they’ve learnt skills; they’ve found friends; they’ve gained so much from that group and participating and being an important part of the service and how the service is designing itself; sitting on interview panels; all of those things. Their confidence and self-esteem has grown, has a massive impact, just from that bit (Site 1).

Some participants were keen to engage a wider range of CYP in service feedback, beyond existing mechanisms: “a ‘squawk box’ where anyone who comes into the service for an appointment, goes to the squawk box on their way out and gives their feedback of either the general style or the service or the building or whatever […] to get representative information from all the users” (Site 4). Care pathways were described as being more timely and time-limited, with the use of ROM and EBT commented on in particular: “There is evidence that use of ROMs improves mental health outcomes and patient experience” (Site 10); “Treatments have been made available that weren’t available previously, and there are more people able to provide these therapies” (Site 10); “I think that definitely with low mood and anxiety, the treatment is much more effective. It’s recognised better now, so they are immediately put into NICE evidence-based CBT therapy and so they get access quicker and the outcomes are better” (Site 9).

Increased practitioner confidence was noted by several sites; e.g., “I have seen in my personal work with people it has definitely benefited from me being more knowledgeable and experienced, and having had the opportunity to train to do something properly. I know that from my colleagues as well, from seeing them first come here and grow and go through the [CYP] IAPT as well” (Site 6).

Fewer participants commented that it was difficult to disentangle the impact of CYP IAPT from existing practice and contextual changes, such as funding and resource cuts. Some commented that changes were in ways limited to specific groups; for instance, older children or ones with specific presenting problems such as OCD: “Children with OCD are certainly benefiting and I think some of the principles of [CYP] IAPT are very helpful to the families during that. Families are often helped seeing symptom change on the tracker” (Site 3). A number of participants noted that additional investment in CYP IAPT would foster further impact, including additional long-term support after the end of formal training, further development to embed the CYP IAPT principles throughout the team, and training more staff: “unlike adult IAPT, very small numbers of therapists are receiving training, making it difficult to keep up when people leave or go on maternity leave” (Site 8).
SERVICE ACCESS AND SELF-REFERRAL SNAPSHOT

**Principle: To improve access through self-referral**

**Routinely collected data:** The percentage of accepted self-referrals out of all accepted referrals increased from 1.21% in 2010 (n = 7 services) to 2.65% in 2014 (n = 11 services) in the service-level data reported by partnerships.

**Clinician survey:** 54% (n=178) of clinicians agreed or strongly agreed that their service was working towards improving access through self-referral and 61% (n=84) thought that access to the service had improved for the local population over the last 12 months.

**Clinician interviews:** Improvements to self-referral were “on the agenda” and a number of mechanisms for self-referral were reported. Self-referral was seen as benefiting CYP engagement with treatment.

**CYP focus groups:** Young people reported having self-referred into the service and there being available information on self-referral, however the process could be simplified.

**Parent interviews:** The majority of parents reported wanting to self-refer but currently being unable to.
SR: SERVICE ACCESS AND SELF-REFERRAL

SR 1. ROUTINELY COLLECTED DATA

In terms of the service-level data, the percentage of accepted self-referrals out of all accepted referrals increased from 1.21% in 2010 (n = 7 services) to 2.65% in 2014 (n = 11 services) in the service-level data reported by partnerships.

In terms of patient-level data, over half of referrals with a recorded source were from the GP (54%, 2,405/4,435), with 2% (108/4,435) being from the CYP or parent. Other sources (13%, 577/4,435), education services (10%, 450/4,435), social services (7%, 308/4,435), transfer from CAMHS (5%, 237/4,435), and community paediatrics (4%, 156/4,435) were among the most frequent sources of referral.

![Figure 4: Percentage frequencies for source of referral.](image)

Note. N = 4,435. ns are reported in parentheses.
SR 2. CLINICIAN SURVEY

Of clinicians who responded (N = 361), 5% (n=14/276) had received training in service access (of whom 55% [n=6/11] were satisfied with the training), 54% [n=178/331] agreed or strongly agreed that their service was working towards improving access through self-referral, and 61% (n=84/138) of clinicians thought that access to the service had improved for the local population over the last 12 months. Clinicians who thought that access to the service had improved over the last 12 months agreed more strongly that their service was working toward the principle of self-referral (n=84, M=2.71, SD=1.22) than clinicians who did not think that access to the service had improved over the last 12 months (n=53, M=2.04, SD=1.37; t[135]=3.01, p<.01).

We asked clinicians whether any changes to the service had been made based on feedback from CYP and families and, if so, what these changes had been.

• 37% (n=92/251) reported changes to self-referral. Examples included implementing a self-referral process for closed cases in the last 12 months, increased publicity of the self-referral process, and increased choice for CYP over the extent to which their parents were involved.
• 65% (n=168/257) reported changes to information. Examples included redesigning information leaflets based on service user feedback or with direct involvement of service users, redesign of the service website, introduction of welcome packs, service user participation events, mobile phone applications, changes to appointment letters, provision of more information to parents about diagnosis and treatment management, and more information in the waiting area.

SR 3. CLINICIAN INTERVIEWS

Overall, interviewees had positive attitudes about self-referral, strengths being that it improves access, transparency, and patient experience; it was being described as the “lifeblood” of one service: “vital to the service...and it’s actually vital to young people” (Site 2). A variety of methods for self-referral were described (e.g., in person, telephone), with different mechanisms being used in different contexts—in particular, through a single point of access to the service, school or community outreach, being available to those over a certain age or those who have used the service previously, and a proposed web-based tool that would permit self-referral to adolescent clinics after screening. Self-referral was described as improving early engagement: “a lot of the work we do is engaging young people and helping them to think about their own mental health and take responsibility...so it’s a perfect message...when they do self-refer that’s incredible for us because it’s a big difference from the first time we saw them, so I think it’s definitely a positive thing” (Site 4).

Referral through the GP or school were still described as the predominant referral routes, with a strength being the ability to direct CYP into the appropriate service in the first instance. Some participants thought that CYP would not expect to self-refer, with the GP being the gatekeeper to specialist services and therefore, the ability to self-refer into specialist services being counter-intuitive. Concerns about self-referrals included whether the referral information would be of adequate quality, risk (e.g., when self-referrals are from primary school children), service capacity for “mushrooming of referral” (Site 1) given the “sorts of numbers” already accessing CAMHS (Site 2), and an increase in inappropriate referrals, although it was noted that this had not occurred and could be mitigated with appropriate signposting. Some participants commented that self-referral was not currently available and, in general, it was felt that improving self-referral was “on the agenda” (Site 1). Services could improve self-referrals, especially as some had only very recently implemented it: “also they’ve introduced a ‘no wrong door’ policy, so that wherever a referral comes into the system we work between our agencies and our disciplines, in order to ensure that the referral gets to the right place quickly and efficiently without having to be bounced back to the referrer” (Site 4).
SR 4. CYP FOCUS GROUPS

The CYP focus groups indicated that, in general, CYP felt a need for more information about CAMHS. For instance, CYP did not as yet fully understand the aims of their CAMHS service and this information was not readily available to them. In particular, 30% (14) reported knowing what CAMHS aims to do, and 35% (16) that the aims and values are in place for all CYP to see. CYP mentioned that better IT systems may enable information sharing and also that there should be more information about mental health and wellbeing in the community. Areas of continuing improvement suggested by young people were increased opening times, better IT systems to enable information sharing, and more information about CAMHS but also about mental health and wellbeing in the community to raise awareness.

Similarly, CYP described wanting further information about available services, with 37% (17) having received information about the CAMHS before attending, of whom 76% (13) thought the information answered all of their questions about the service. In particular, 30% (14) thought that CAMHS had information on a website or app that they could access.

Service availability was identified as one of the greatest obstacles for CYP accessing services, with 47% (21) thinking that CAMHS was open at the right times for them and 62% (28) reporting that they were able to change their appointment time. This was mainly because CAMHS appointments often coincided with school time and schools could be reluctant to let the student go to the appointment. It was also noted that CAMHS appointment times often proved an obstacle for parents, clashing with their working hours. These factors, along with the problems young people and parents faced when trying to reschedule, were described as possibly leading to a young person missing their appointment:

Mm, I think it's important to have access to support at the weekends in CAMHS because children and young people don't just have problems five days a week and in working hours. Nine to five, five days a week and I think it needs to be broader than that, wider. I think that was my problem, I couldn't phone then. When it was past five o'clock or whatever...it was like "ah there's no point now".

I had a really quite bad experience with CAMHS because I was referred by my doctor and they lost my notes so I had to ring CAMHS personally and they're like "right you have to go on another six-month waiting list" even though I'd already been on six months so I had to wait a year and then they finally got back to me, we had a meeting, they were like "yeah you need further help" and they were like "right, we'll rearrange another time, for you to come and see a counsellor" and they did and I said "well I've got an exam on that day and they were like "ok, we'll ring you back with another date" and they never rang me back. And then we rang them and they were just like "we don't know who you are".

A number of young people focused on the perceived lack of information about mental health in the community, especially in schools. Young people believed that CAMHS should focus on developing good relationships with institutions in the community, as a way to educate people on the importance of children and young people's mental health and to facilitate referrals. Comments like these may reflect the reported reluctance by schools to release students for appointments and the reported lack of knowledge or interest in mental health by school staff. All of these examples can make it very hard for a young person to acknowledge that they have a mental health problem and even harder to seek professional help:

I think it is the service's responsibility...to make sure the teachers and school nurses and pastoral support workers are more clued up on mental health and young people and to support them as well so, like, in turn there may end up being less referrals to CAMHS because they can deal with it at school.
Compared to the other data strands, self-referral rates were reported as being higher in the CYP focus groups, with 13% (6) reporting that they had referred themselves, although the process for self-referral was described as difficult by all those who had self-referred. Still, there appeared to be a high level of information about how to self-refer, with 45% (20) of CYP reporting that they were able to self-refer and 49% (22) reporting that there was information on self-referral that all CYP can find.

According to young people, the waiting times between referral and the first appointment with a clinician have improved and were typically between 1-3 weeks, although in some areas young people still have to wait up to 6 months for their first appointment.

SR 5. PARENT INTERVIEWS

In terms of service access, parents reported being seen within one month (21%, 9 parents), between one to two months (38%, 16), between three to five months (24%, 10), or longer (20%, 8) when they were only seen after reaching crisis point:

I then had to phone and say we were absolutely desperate, my daughter needed help, her condition was getting much worse. I had to do this through a carers support service. Also have to add that this was not the first time we had been to this service so referral should have been easier the second time.

Information about accessing CAMHS was described as coming from leaflets, professionals, and websites/apps (26% [11], 19% [8], and 7% [3], respectively). The majority of parents reported being unable to refer their child to CAMHS when they needed help (79%, 33), with a minority reporting that they were able to do so (7%, 3): “I telephoned as my child had previously been to them so they had their case notes already.” Mirroring the findings of the routinely collected data, the majority of parents reported accessing CAMHS through the GP (55%, 23), followed by other services (e.g., physical health services, A&E, the police) (33%, 14), a school (19%, 8), and self-referral (5%, 2). The majority of parents reported that they would like to have the option to self-refer (83%, 35) with only a minority reporting that they would not like this option (7%, 3). Some parents reported a lack of information about CAMHS being a barrier to access – “I didn’t know CAMHS existed until I spoke to my GP” – while others reported accessing CAMHS via gatekeepers to be a barrier – “I would like to be able to self-refer as going through a gatekeeping system can sometimes be a barrier for people seeking help”, “My child has been with CAMHS for a long period of time and when they close the case and need to reopen this still has to be done through a professional; it would be so much easier if I could self-refer”.

SERVICE DELIVERY SNAPSHOT

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SERVICE DELIVERY SNAPSHOT

Principle: To work in partnership with the young person and their parent/carer in service delivery and design.

Clinician survey: Clinicians reported a number of service changes based on feedback from CYP and families and a number of mechanisms for participation, including a You Said, We Did board, welcome packs, a message tree, and the Y Factor.

Clinician interviews: CYP IAPT and the participation groups have given CYP “a voice in a massive way.”

CYP focus groups: Involvement gave CYP a personal sense of worth and empowerment; although CYP felt listened to during participation activities, they were less aware of changes to the service that had been made as a result of feedback.

Parent interviews: Involvement of parents in service design and delivery was described as being less frequent than involvement of CYP.
SD: CYP AND PARENT INVOLVEMENT IN SERVICE DELIVERY

SD 1. CLINICIAN SURVEY

Of the clinicians who responded to the survey (N = 361), 18% (n = 50/277) received training in participation (of whom 64% [n = 26/41] were satisfied with the training). Overall, 70% (n = 230/332) of clinicians agreed that their service was moving toward working in partnership with CYP and their parent/carer in service design and delivery.

At the start of CYP IAPT, participation groups affiliated to each partnership made a number of participation pledges regarding young people’s (and parents’) involvement in service delivery. We asked clinicians the extent to which they agreed that their service had achieved each of these participation pledges and of those who responded:

• 30% (n = 79/262) agreed that their service was working toward delivering a training programme led by young people for all staff (19% [n = 49/260] for the parent version)
• 40% (n = 102/259) reported that young people were invited to attend management meetings (25% [n = 61/245] for the parent version)
• 84% (n = 268/319) reported that young people were encouraged to participate in their treatment and reviews (85% [n = 267/315] for the parent version)
• 58% (n = 175/301) reported that young people’s participation was an everyday part of the service (52% [n = 148/287] for the parent version)

We asked clinicians whether any changes to the service had been made based on feedback from CYP and families and, if so, what these changes had been.

• 65% (n = 172/265) reported changes to the service environment. Examples included redecorating the waiting room and also adding images, radio, or magazines; improved building access; increased methods for feedback and involvement of CYP and families, such as a “You Said, We Did” board and a message tree
• 48% (n = 125/261) reported changes to appointment times and location. Examples included extended open hours, flexible appointment times to fit in with the school schedule, and regular appointments in schools, GPs, homes, and other locations
• 37% (n = 92/247) reported changes to social media. Examples included more utilisation of social media since CYP IAPT, redesign of the service website with service user involvement, Twitter, mobile phone Buddy App, and CAMHSWeb
• 61% (n = 152/251) reported changes to delivery of care. Examples included more information about different therapies to young people, treatments adjusted to service users’ needs, more extensive use of ROM, participation groups and focus groups to inform service design and delivery, FaceTime available for internet contact, and more choice of treatments
• 43% (n = 86/201) reported changes to choice of therapy. Examples included a broader selection of therapies, service users and parents being able to choose the therapy they think will fit their treatment goals, information sheets on the range of interventions offered to facilitate choice, new CBT groups, and more CBT and family treatments offered
• 40% (n = 98/248) reported changes to staff training. Examples included more staff trained in psychological therapies, training in outcome measures, and training in service user involvement
• 55% (n = 139/255) reported changes to staff recruitment. Examples included CYP and/or parents being involved in recruitment panels and CYP being invited to interview staff

SD 2. CLINICIAN INTERVIEWS

The involvement of CYP and families in service design and delivery was discussed positively by the majority of sites, with CYP IAPT and the participation groups helping to give CYP “a voice in a massive way” (Site 2), “[service users] know that their feedback is being used, or if it hasn’t the
reasons why it hasn’t and how we might overcome these barriers” (Site 4). In addition to positive changes to the service, involvement was described as having a positive impact on CYP, with participants commenting on the expertise the participation groups bring and that involvement is empowering for CYP in helping to develop skills and confidence. Fewer participants identified the extra work around involvement as stressful, noting that although there are structured systems for obtaining feedback, implementing changes is less structured, with some staff not adopting it or changes only being “tokenistic” (Site 7). Still, a range of examples of mechanisms for involving CYP and families and of changes made to the service as a result of feedback, were discussed:

- Recruitment and interview panels
- Staff appraisals
- Training delivery and service-wide continual professional development days
- Planning and delivery of a mental health awareness day for the wider population
- Shadow boards
- Website design
- Logo design
- “Mystery shopped” service evaluation (Site 1)
- Walk-through of the centre’s facilities with CYP to understand the facilities and access from the service users’ point of view
- Feedback fair
- Opportunities for service users to speak to directors
- Leaflets
- Name change
- Regular focus groups with patients and families
- Family fun days
- Traffic light system for feedback
- Positive thoughts tree
- Environmental changes, including waiting room layout, decorations, water cooler, and radio stations
- Family forum
- “You Said, We Did” board in the waiting room
- Cultural changes whereby therapists no longer present themselves as experts and instead focus on patients’ experience and needs
- Discussions of more frequent appointments and extended opening hours
- Finding different locations to hold sessions where CYP feel more comfortable
- Changes to the self-referral process
- Producing videos for other CYP about what to expect from the service
- Producing videos for Black History month
- Trainees interviewing CYP to gain feedback
- “Y Factor” (Site 1) where CYP talk to other young people about mental health
- More age-appropriate magazines
- Storage of toys
- Pictorial representation of CYP’s experience of CAMHS
CYP reported high levels of participation, with 61% (27) reporting that their CAMHS has regular participation groups for CYP and 58% (26) reporting that there is information about the participation group available in their CAMHS. At 45% (20), fewer reported that there had been changes to their CAMHS as a result of participation groups. CYP were positive about participation groups, in terms of being able to meet other young people and discuss relevant issues, but also in terms of meeting commissioners and service management.

Well the participation groups have given us lots of chances to get involved in different ways - meetings and things… We have a lot of people coming in for different reasons. We’ve had commissioners, we have people that are advocates for young people, people that run local campaigns and with whom we’re doing a workshop next week to do with, you know, educating young people and stigma. It gives us a chance to have a say in things, meeting with like, director of CAMHS, people like that so it does give us a chance.

Overall, 41% (18) reported being involved in the design and/or delivery of staff training and 25% (11) reported that CYP have a say in the content of training. CYP who were involved in staff training were very positive about the experience and they believed that it made an improvement to their therapeutic work:

CYP 1: We did a training video. There were set questions [that we needed to address in the video] but I got to choose my answers and I could be as broad as I liked.

CYP 2: I drew a picture and did some writing. I wasn’t too keen to be in the video but I still gave my feedback and was able to project what I wanted to say.

Involvement of CYP in staff recruitment appeared to be more challenging to implement, with partnerships that had previously involved CYP in recruitment continuing to do so, but partnerships that had not involved CYP not having implemented this: 48% (22) of CYP had been involved in recruiting staff and 37% (17) reported that training for involvement in recruitment was available. Examples of good practice reported by CYP included: having young people representatives on interviewing panels, having a dedicated youth panel which interviews prospective employees, making recruitment videos, writing job specifications, and giving feedback on prospective employees. In these areas, young people were very positive about the personal sense of worth and empowerment that being involved in recruitment and selection gave them:

YP 1: We had two panels didn’t we? One adult panel and one young people. We met at the end and got all candidates in exactly the same [ranking] order.

Int: So do you feel like your opinions and your voice is heard when it’s improvement of staff or what staff training should be involved in?

YP 2: You’re always listened to!

The majority of CYP had been able to feedback about how the service is working for them: 83% (37). Fewer, at 48% (22), had done this directly in commissioning meetings. In a few partnerships, young people were satisfied with the level and quality of contact that they have had with commissioners and CYP felt that their opinions were taken on board the most. In particular, the changes proposed by young people that were taken on board by commissioners included improving ROM questionnaires (e.g., avoiding duplication and more open-ended questions.
for CYP to say in their own words what they feel) and improving communication pathways in CAMHS: “[Things that changed are] the questionnaires, the surveys about the service. Oh yeah, the complaints changed too.”

Well we met with a board of commissioners. We were actively involved, we did like, ice-breaking exercises and they actually like took our, I feel, I definitely feel like they took our views into account and they’d already started acting on it like sending emails in that session.

The experience of influencing senior managers was described as mixed by CYP, with 47% (21) having met with managers, of whom 61% (13) felt listened to and 71% (15) thought that managers acted on their views. Still, CYP often felt that senior managers were unaware of young people’s needs and circumstances, and were overly focused on pushing their own agenda. In particular, professional jargon used by managers was reported as being difficult to understand and leaving little room for an informed discussion:

I personally think that if you’re going to be a manager, and obviously that’s a key important role, but if you’re going to have that role, you can’t just be a guy who’s good at being a manager, you have to actually understand what you’re going into, such as mental health, you actually have to understand the mental health system and how it influences people and the main thing there is that it influences people because without the service, God knows where we would all be now. And he doesn’t understand and everything that we said, he didn’t understand, so it’s like we’re talking in two completely different languages.

Having a regular opportunity to meet with senior management and discuss not only treatment choices, but also recruitment of new staff and the day-to-day running of the service, was discussed as an example of good practice, which should be considered as part of any continuing CYP IAPT programme.

We met with managers regularly through Have Your Say. We met with the CAMHS practice manager, we talked about interviews, volunteering (peer mentoring/buddy system), she asked for our help with job descriptions.

Managers usually acted on what we say. Not always, but they told us when they couldn’t and why.

Still, some CYP felt that their involvement was mostly a “box-ticking” exercise and that their opinions were not taken on board:

YP 1: [A senior person in the Trust] […] came to ’listen’ to us, he was appalling. Ok, yeah, he was nice, then, the next week we met him, he completely just contradicted himself for a start…But also, we got some younger people from the youth group and they actually didn’t know what he was on about […] It wasn’t exactly like jargon, it just wasn’t your normal, usual… He heard what, well actually he didn’t hear what we were saying at all, he just disregarded us and didn’t listen to us at all - just said what he wanted to say.

YP 2: Yeah he was trying to, like he was saying, ‘oh I’m the big boss here, you guys are just in the service that I’m providing you’ and you just think, ‘hold on a minute, woah.’
Mirroring the findings of the clinician survey and interviews, involvement of parents and carers in service design and delivery was described as occurring less often than involvement of CYP. The majority of parents (55%, 23) reported that their CAMHS does not have a regular participation group for parents and carers, while 26% (11) said that their CAMHS did, which they were encouraged to contribute to:

I’ve said things which need updating; they need to improve the location and findings of the building; it was too hard to find, they need clearer instructions to find the CAMHS building when sending information for appointments. When you go into the building the rooms are not clearly marked and to be made more child friendly ask the children to design the rooms.

In terms of participation activities, a minority of parents (12%, 5) reported being involved in designing information available to young people and parents; e.g., “keeping it plain and simple language”. More parents (36%, 15) reported being asked to have a say about the environment of their service; e.g., “there are posters asking us for our views and help”, “I was in a waiting room which had just had a makeover and they asked for our thoughts and I said that they needed to change the makeup of the other rooms as the rooms are quite scary. The new waiting area was bright and airy,” and “we did at first as it was appalling and then we were asked and since there has been lots of improvement.”

Few parents (7%, 3) said they had – or knew of parents who had – been involved in staff recruitment, and few parents (5%, 2) reported being invited to be involved in the design and delivery of staff training: “I work in training some of the staff and have given talks”. Similarly, none of the parents reported being invited to commissioning meetings. Parents were generally unsure whether or not management listened to the views of parents: 26% (11) said they did not feel that managers act on parents’ views and ideas (“if they did they would give opportunities to hear the views, they don’t even give you an email address to feed back on”), whereas 17% (7) said they did feel that managers act on the views and ideas of parents (“at a meeting I attended as a service user representative, I talked about the language used in the letters saying that they need it clearer and plainer and that was acted upon”).

A minority of parents (17%, 7) reported awareness of changes in the service as a result of participation activities: “They did not want to include parents with kids who have special needs on their course and I spoke about this and as a result they allowed me to attend the group, meaning we were more welcomed”, “clearer and plain language is used. The building is less clinical, there is service user art work about the place – again all came from service users”, “we got new seating and the writing room has been developed.”

Half of parents (50%, 21) reported that that they were offered a choice in appointment times that were convenient, however 45% (19) said that they were not, which was described as challenging by some parents; e.g., “That was a sticking point - I said it needed to be after school as it would increase her anxiety if she was having appointments in her GSCE year, we were initially told that after-school appointments were very difficult to get”. Still, most parents (69%, 29) reported being able to change appointment times to fit with other commitments, while fewer (23%, 9) reported that they could not. Flexibility in appointment times was described as useful by some parents (43%, 18). Choice of appointment location was less frequent, with 24% (10) of parents reporting that this was offered; again, this flexibility was described as useful by some parents (31%, 13).

In terms of information about complaints procedures, 33% (14) of parents reported receiving information about how to access the CAMHS complaints procedure, but 64% (7) said that they had not received information; there were mixed views about whether or not the complaints procedure was easy to follow; e.g., “I am going through this now and it’s not an easy process”.

SERVICE DELIVERY SNAPSHOT
EVIDENCE-BASED TREATMENT SNAPSHOT

Principle: To deliver evidence-based psychological treatments.

Routinely collected data: 27% (n=345) of CYP presenting with depression or anxiety received CBT.

Clinician survey: 97% (n=38) of clinicians trained in NICE-recommended therapies were still offering the therapy.

Clinician interviews: Clinicians described CYP IAPT as having embedded evidence-based treatment in their service and improving children and young people’s access to evidence-based treatments.

CYP focus groups: the overall experience of CAMHS by CYP was 3.20 (SD=1.4) or neutral.
**EVIDENCE-BASED TREATMENTS**

EBT 1. ROUTINELY COLLECTED DATA

The frequencies for treatment type received are shown in Figure 5. The most frequent treatment type recorded was other (25%, 762/3,034) closely followed by CBT (20%, 595/3,034). Less frequent treatment types recorded were parent training (6%, 187/3,034), family work (5%, 142/3,034), counselling (5%, 151/3,034), parent other (4%, 122/3,034), multimodal (3%, 84/3,034), family systemic (3%, 93/3,034), group therapy (3%, 96/3,034), solution-focused (2%, 73/3,034), pharmacotherapy advice (2%, 55/3,034), creative (1%, 17/3,034), and interpersonal therapy (IPT), psychodynamic, psychoanalytic, dialectical, multi-systemic therapy (MST), eye movement desensitisation and reprocessing (EMDR), neuropsychology, and child psychotherapy (each <1%).

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**Note.** N =3,034. Frequencies are reported in parentheses. Multiple responses permitted.

Figure 5: Frequencies of treatment type.
Of the $n = 1,268$ CYP presenting with depression or anxiety and with information on treatment type received, 27% ($345/1,268$) received CBT, 34% ($426/1,268$) received other treatments, and the remaining CYP received any other treatment, as shown in Figure 6.

Note. $N = 1,268$. Frequencies are reported in parentheses. Multiple responses permitted.

EBT 2. CLINICIAN SURVEY

Of the clinicians who responded to the survey ($N = 361$), 8% ($n = 22/280$) received CBT training (of whom 69% [$n = 15/22$] were satisfied with the training), 4% ($n = 11/275$) parent training (82% [$n = 9/11$] satisfied), 9% ($n = 25/271$) systemic family practice (64% [$n = 16/20$] satisfied), and 3% ($n = 9/278$) received interpersonal psychotherapy training for adolescents (85% [$n = 6/7$] satisfied). Of those trained in NICE-recommended therapies, 83% ($n = 33/40$) were still receiving supervision in the corresponding therapy and 97% ($n = 38/39$) were still offering the therapy.

Overall, 86% ($n = 189/281$) reported that they used the NICE-recommended treatment in 70% of their cases or more and 89% ($299/335$) agreed that their service was working toward the delivery of evidence-based psychological treatments. Finally, 46% ($n = 134/291$) of respondents indicated that they were interested in attending the formal training offered as part of CYP IAPT. The average attitude to EBT was 2.52 ($n = 321$, $SD = 0.67$, range $= 0.63-4$), meaning that clinicians agreed in general with EBTS to a moderate extent.

11 Using the Current View Form (Jones et al., 2014).
There was a consensus across sites that CYP IAPT had embedded EBT within services: “evidence-based treatment is embedded in the service”, “we are very good at looking at the evidence and following through the guidelines and recommendations” (Site 2), “I think the discussions have become more about evidence-based interventions, so what is the evidence, what are the NICE guidelines” (Site 4). Clinicians noted that CYP now consequently had greater access to EBTs: “In terms of treatment, [CYP IAPT] has had a significant impact because it has enabled young people to access evidence-based treatments, whereas before they would have never been able to access that and therefore they may not have received the right treatment and…have prolonged mental health issues” (Site 1), “[we] match [staff] skills with what is needed, as well as matching our workforce to reflect the evidence base that is out there” (Site 1).

Still, the majority of participants noted that NICE guidelines were complemented with individual preferences and clinical judgement; for instance, one participant noted that “we’re adapting to meet the need of the patient as an individual, and I think NICE guidance is great, and it is the predominant driver in our treatment processes, but we don’t want to lose sight of the individual either” (Site 1) while another commented that “everything [they] do is based on NICE” and they make a “conscientious effort to stick with NICE guidelines” but there has to be “flexibility if it’s to meet the needs of the clients and family” (Site 4). Many participants described increased confidence in the delivery of treatments either at a service-level or in their own work; for instance, one participant noted that they now “confidently offer CBT” (Site 1) and another remarked that CBT training had improved her confidence in using CBT for OCD, noting that previously she did not feel effective in this.

The formal training in EBT was described as good and supportive, however staff commented that more training opportunities were needed in other approaches (e.g., psychoanalytical approaches) and to ensure more staff can deliver EBTs to avoid those trained becoming pigeon-holed: “I’m ‘Lady CBT’: it’s good but I really miss doing some of the other things I used to do but there’s such a demand for CBT” (Site 3). Similarly, some noted that there was too much focus on CBT in the CYP IAPT programme. Moreover, participants commented that the evidence-base needed development for certain treatments, conditions, and complexity factors: “sometimes you get such co-morbidity and just awful things – in the middle, someone will get excluded from school or kicked out of home or attacked on the street – and those kinds of things just aren’t written up in NICE guidance” (Site 3), “there are gaps in what the NICE guidelines can offer us in terms of younger children” (Site 11). Embedding EBT was described by some as requiring a culture change that was “easier for some disciplines than others” but some staff had “given up some old ways of working that weren’t particularly evidence-based and replaced them with evidence-based interventions” (Site 1); “Lots more interest in doing systematic, proper intervention and thinking about the theoretical model as to; ‘What can I do with this child?’” (Site 12). Finally, contextual barriers were again raised as impeding delivery of EBT as part of CYP IAPT: “staff ready and trained who can’t deliver, through service cuts” (Site 4).

EBT 4. CYP FOCUS GROUP

The average response to the overall experience of CAMHS by CYP was 3.20 (SD=1.4) or neutral.
SESSION-BY-SESSION MONITORING SNAPSHOT

Principle: To deliver outcomes-focused psychological treatments.

Routinely collected data: Of the total sample of $N = 6,803$ young people, $83\%$ ($n=5,633$) of CYP had an assessment measure recorded. Of those $3,939$ CYP who had at least two sessions recorded$^{12}$, $42\%$ ($1,639$) had matched T1-T2 scores on an outcome measure. Of those $2,690$ CYP who had at least three sessions recorded$^{13}$, $49\%$ ($1,322$) of children had any sessional measure used in at least two sessions and $44\%$ ($1,184$) of children had any sessional measures used in at least three sessions.

Clinician survey: $56-57\%$ ($n=177-181$) of clinicians reported often or always using outcome data to review treatment progress or to inform therapy, while $51-53\%$, $n=160-170$ reported often or always discussing outcome data with CYP and families in sessions and comparing change in an individual’s scores.

Clinician interviews: Session-by-session monitoring was described as supporting shared decision making, however there is still more work to be done to embed monitoring, particularly around IT.

CYP focus groups: CYP mirrored reports from clinicians and also thought that monitoring helped to “keep things focused.”

Parent interviews: Parents’ experience of SBS was mixed, finding it positive if measures were explained and if they were involved in decisions about completing measures, but not if there was a lack of explanation or consultation.

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$^{12}$ For the possibility of two measures having been administered.

$^{13}$ Assuming the first session was assessment and the last session was discharge or case closure, there would be at least one treatment session in which a sessional measure could have been used (Law & Wolpert, 2014).
SBS: SESSION-BY-SESSION OUTCOME MONITORING

SBS 1. ROUTINELY COLLECTED DATA

Of the total sample of \( N = 6,803 \) young people, 83\% (5,633) of CYP had an assessment measure recorded. Of those 3,939 CYP who had at least two sessions recorded\(^{14}\), 42\% (1,639) had matched T1-T2 scores on an outcome measure. Of those 2,690 CYP who had at least three sessions recorded\(^{15}\), 49\% (1,322) of children had any sessional measure used in at least two sessions, 44\% (1,184) of children had any sessional measures used in at least three sessions, and 51\% (1,368) had no sessional measures recorded (e.g., the Revised Children’s Anxiety and Depression Scale (Weiss & Chorpita, 2011), the Goal Based Outcomes tool (Law, 2011), the Session Rating Scale (Duncan & Miller, 2003)).

SBS 2. CLINICIAN SURVEY

Of the clinicians who responded to the survey (\( N = 361 \)), 44\% (\( n = 124/283 \)) received training in the use of outcome measures (of whom 60\% (\( n = 68/115 \)) were satisfied with the training). Overall, 89\% (\( n = 298/335 \)) of clinicians agreed that their service was working towards the delivery of outcomes-focused psychological treatments, 76\% (\( n = 209/277 \)) used outcome measures at assessment with at least 70\% of cases, 43\% (\( n = 119/276 \)) used outcome measures on a SBS basis with at least 70\% of cases, and 71\% (\( n = 195/274 \)) used outcome measures at review or case closure with at least 70\% of cases.

The average attitude to feedback was 4.51 (\( n = 318, SD = 0.93, range = 1.13-6 \)), meaning that clinicians slightly agreed in general with providing feedback based on outcome measures to CYP and parents. Figure 7 shows the ways in which clinicians use outcome data in direct clinical work with CYP and families. Outcome data are most frequently used to review treatment progress or to inform therapy, with 56-57\% of clinicians reporting that they often or always use outcome data in these ways. Discussing outcome data with CYP and families in sessions and comparing change in an individual’s scores was less frequent, with 51-53\% of clinicians often or always using outcome data in these ways. Using outcome data in supervision or comparing change in a group of service users’ scores were the least frequent, with 25-30\% of clinicians often or always using outcome data in these ways.

\(^{14}\) For the possibility of two measures having been administered.

\(^{15}\) Assuming the first session was assessment and the last session was discharge or case closure, there would be at least one treatment session in which a sessional measure could have been used (Law & Wolpert, 2014).
Figure 8 shows the ways in which clinicians reported that their service uses outcome data. Fewer clinicians completed these questions, perhaps suggesting that clinicians are less aware of how outcome data are used more broadly within their service. Still, the majority of respondents (70%) reported that their service often or always reports outcome data to commissioners. Most respondents reported outcome data being discussed within the organisation at board level or it being used to benchmark their service against other similar service (59%). Somewhat fewer agreed that management uses outcome data to inform service planning (55%) and a minority of respondents agreed that outcome data were discussed with service user participation groups (32%).
The majority of participants reported that CYP IAPT had increased the use of ROM “in a massive way” (Site 11), with reports of increased understanding of how ROMs can benefit treatment, the importance of collecting outcome data to monitor the efficacy of the service and improve collaboration and session monitoring, and that it gives clarity and focus to treatment. Training and software development was reported as supporting this increased use. One participant noted that staff were “encouraged all the time” to use ROM with “quite a lot of emphasis on getting the 90% compliance” (Site 2). In addition to increased use, participants reported a change in how ROM is used, with measures being used in a more clinically relevant fashion. One participant noted that their use had changed “every day” and that although their service already used the Goal Based Outcome (GBO) measure before CYP IAPT, the programme had resulted in “real cultural change” in the integration of the GBO into clinical practice and the sharing of data, as opposed to a “tickboxy” approach (Site 3). Similarly, another commented that CYP IAPT had helped to “explain why [ROMs are] useful and why we’re being asked to use them - for clinical reasons and, for the good of the work and for the service, and for families, not just as a tickbox exercise” (Site 4).

Use of ROM was described by some participants as requiring a culture change as they did not like using ROMs at first, finding it “clunky” and a “challenge”, but gradually their opinions changed and most now find them “helpful” having “become embedded and more fluent” within their practice: “initially I didn’t like it, but now I’m used to it and I think the team is getting used to it and using it more confidently” (Site 2). Another participant noted “it’s skilled-up staff that don’t have a therapy qualification...and has in another way got even experienced practitioners maybe to look at the way to actually deliver interventions and... how much they can gain from looking at the outcome measures” (Site 12).

The young people that don’t want to use them...we’ve had to be quite flexible and imaginative about how we can do that but we’re still trying to hold on to the idea that we’re checking in each session and checking the variety of different places we need to check about the relationships, about the symptoms, about the goals and even if it’s not on the paper, we’re still trying to do it in a helpful way (Site 4).

The main benefits of ROM were monitoring treatment progress – “it’s also a good way to actually monitor progress, or no progress, so people have got a clearer idea of what we are trying to achieve” (Site 1), “I think certainly it’s helped tracking improvement” (Site 4) – and promote SDM – “it means that young people and families are more involved in their care” (Site 1), “it’s helped young people get more of a buy-in from the start. It’s helped them track improvement” (Site 4). In terms of sharing data with the young person, this could be done directly via iPads or print outs, but this depends on clinical assessment; for instance, discussion of deterioration might discourage patients from engaging in more intensive forms of therapy, but could be discussed at a later point.

Still, there appeared to be a tension between recognising the clinical utility of ROM whilst also seeing it as an imposition in the context of the prescriptive nature of their introduction and associated “heightened anxieties” (Site 3). In particular, a number of areas were discussed for improving the use of ROM in the future. Some participants noted that ROM was less appropriate for some patient groups, including women in the perinatal period, those receiving short-term interventions, and those with co-morbid conditions: “the impossibility having patients complete four or five measures in a session, so ends up having to ask which the patient prefers, which limits clinical usefulness and for very ill patients” (Site 4). Some noted that ROM was less appropriate for some cases:

Sometimes it is not appropriate to use ROMs, and need to find a way to capture this, I mean you aim to do them, with CBT you want to do them every session, but sometimes it’s not always clinically the best thing to do, you know there might be a situation where somebody just comes in and ‘Ah!’ and you don’t wanna be saying ‘oh hang on a minute, just park that, we’ve got to do our forms’ (Site 1).
Improvement to *information technology* was consistently raised as a particular barrier: “I think the paper work and the amount of administration are massive barriers, we still haven’t worked out an easy and quick way...our IT system is the biggest barrier at the moment, it’s meant to be facilitating it and actually it’s more prohibitive than it is useful.” (Site 1), “I think what is underestimated is the workload on practitioners sometimes, because we’re still not able to get young people to input them directly. We have to do everything in paper and then we have to input it, so it is really difficult” (Site 2).

Most participants agreed that while they have “come a long way” and made “quite a lot of progress” with ROM, “*more work* needed to done” “to make it absolutely part and parcel of every single young person’s experience” (Site 4), with some remarking that staff were not using measures and a minority remarking that they were still “only paying lip-service” to ROM (Site 7). High caseloads and time constraints were mentioned as additional barriers, with variations in use between those who had and had not completed training and between disciplines, with one participant noting that ROM was more easily adopted by psychologists and “the more analytical you get the harder it is” (Site 3).

**SBS 4. CYP FOCUS GROUPS**

Mirroring the themes from the clinician interviews, the focus groups with young people indicated that there was *more work to be done* in the use of ROM: 50% (22) reported being involved in ROM and 50% (22) in goal setting. Overall, 29% (4) reported that outcome measures had been explained to them and 62% (28) that treatment progress had been discussed. Young people reported a degree of confusion with regards to ROM, with some respondents stating that it is not always clear to them what the questions are asking. Furthermore, a number of respondents stated that the questionnaires did not give the *whole picture* about the client, with little emphasis on the young person’s thoughts and feelings. Often, they were deemed to be too linear and incapable of capturing the complexity of the situations in which young people often find themselves:

> I remember like I used to do a lot of questionnaires, like every other day it was so it got to the point where... I almost felt like I had to get paid minimum wage to do them. Cause there wasn’t like a ‘right, [these are] my exact thoughts and feelings’. It was like categories, do you know what I mean. And obviously, you know, you can’t go by every individual’s thing as there’s quite a lot of us but makes it difficult [to convey what you are feeling].

Still, young people agreed that having ROMs in place is a very good idea, as they help to “*keep things focused*”. They were said to give a young person a sense of empowerment through making their own decisions and having a say in their choice of treatment.

> I always fill in the questionnaire before I start and look at the progress. It’s good to see how much you’ve progressed; it means that you can actually realise what you have progressed to ‘cos, s’pose if you don’t really write it down or say it out loud, you don’t really realise how much you’ve progressed until it’s kinda spoken to you.

In some areas however, CYP reported that ROMs were still not shared with young people and that the staff can often be unsympathetic and exclusive of young people, or failed to acknowledge that young people may need additional help to fill out their ROMs: “we were told what they are for, but not shown or helped with how to fill them out. I told the therapist more than once that I am dyslexic, but I still didn’t get any help and it was confusing”. Such examples were few, but they did highlight the need for culture change as a key component of the CYP IAPT programme. *Improving IT* was reported as key to improving information sharing with young people and therefore, their experience of CAMHS (also see Appendix C).
Less than half of parents (48%, 20) reported completing outcome measures about their child’s progress whilst at CAMHS. Experience of outcome monitoring was reported as mixed. On the one hand, some parents described it as helpful to monitor treatment progress or give feedback: “at the start of the referral I completed them, and then my daughter completed them at the end and start of each session so we could get a clear picture of how she was progressing”, “from time to time we did have a survey to say what was going on or not happy so we had an opportunity to say something”, “after every session; it’s to the point, nice, short and sweet and very helpful”, “they explained it to me in a way I could understand and know what they were about”, “the diary and journals were good, the surveys also helped her reflect upon her experiences and growth throughout the sessions”, “they showed me stress levels and anxiety levels and we compare them, and now they show us the results so that is has been a change which is really helpful”, “it helps me reflect and look at his behaviour patterns; e.g., that is happening him so I can articulate it better, as a result I was able to monitor at home and a referral has been made for paediatric assessment to check for [autism spectrum disorder]”. On the other hand, parents reported outcomes measures were less helpful if they were not explained or they and their children were not consulted about completing measures: e.g., “my daughter has just been given one to answer on her moods, but that is after four years”, “they were not helpful, not explained”, “we were not given information and the questions came off a survey she didn’t learn anything about my child and the environment was not helpful she introduced as a mental health worker but my child was frightened and the questions were not age appropriate - my child was 8. I have to say the worker was nice but those questions were not helpful and so he was not forthcoming”, “no I don’t feel clear about what they are and could be explained in a better way”. Overall, 62% (26) of parents reported that outcome measures had not been explained to them and, even if the measures are explained, feedback from the measures may still not be given.
SHARED DECISION MAKING SNAPSHOT

**Principle:** To work in partnership with the young person and their parent/carer throughout treatment.

**Routinely collected data:** The percentage of closed cases by mutual agreement to end treatment (vs. all other reasons) increased from 34% in 2010 (n = 5 services) to 55% in 2014 (n = 10 services).

**Clinician survey:** 83-96% (n=265-308) of clinicians reported having usually or always engaged in shared decision-making activities in the last two weeks.

**Clinician interviews:** Clinicians described CYP IAPT as having increased shared decisionmaking, and routine outcome-monitoring was described as supporting and systematising shared decision making and the involvement of CYP and families in treatment.

**CYP focus groups:** CYP commented that, although shared decision making was not always immediate in assessment, it increases once treatment begins.

**Parent interviews:** Parents’ described their experience of shared decision making as mixed, commenting on the need to balance the tension of the extent to which parents should be involved in their child’s treatment as particularly important.
SDM: SHARED DECISION MAKING

SDM 1. ROUTINELY COLLECTED DATA

The percentage of closed cases by mutual agreement to end treatment (vs. all other reasons) increased from 34% in 2010 (n = 5 services) to 55% in 2014 (n = 10 services).

SDM 2. CLINICIAN SURVEY

Of the clinicians who responded to the survey (N = 361), 27% (n=74/278) received SDM training (of whom 62% [n=36/59] were satisfied with the training). Overall, 91% (n=305/334) of the clinicians who responded to the survey agreed that their service is moving toward working in partnership with CYP and their parent/carer throughout treatment. The average attitude to SDM was 2.55 (n=326, SD=0.34, range=0-3), meaning that clinicians agreed in general with SDM. Clinicians were asked how often, in the last two weeks, they had engaged in SDM:

- 83% (n=265/319) reported having usually or always discussed the range of treatment options available with service users
- 93% (n=301/323) reported having usually or always encouraged service users to raise or ask concerns
- 96% (n=308/322) reported having usually or always made it easy for service users to raise concerns
- 89% (n=286/321) reported having usually or always considered and respected the healthcare and treatment choices that service users thought would be best

SDM 3. CLINICIAN INTERVIEWS

Most participants commented that SDM had increased since CYP IAPT: “the moment people come through the door” (Site 1), “the staff are more aware and more patient focused...they’re more aware of children and young people and that engagement of keeping them more involved in the treatment programme” (Site 1), “there’s a bit more awareness...of family involvement. I think because we have been a bit young people focused we’ve almost excluded parents, in a way, as part of our kind of ethos, and I think maybe we are a bit more attuned to the fact that actually sometimes it’s really good to involve parents.” (Site 2), “the drive to introduce [CYP] IAPT measures...to make them much more an element of the treatment [and] the measures have helped to make a shift and allowed people to work more on the areas the young people identify that they want help” (Site 1).

Some noted that the role of the service and clients’ rights had been made more explicit as a result of CYP IAPT. In particular, structuring discussions of treatment options was one of the values of ROM, which was consistently described as facilitating and systematising SDM, and the involvement of CYP and families in treatment. ROM was described as making therapy more transparent through reviewing progress, giving CYP and families a voice, and enabling the demonstration of achievements. “The review paperwork has made it possible, I think, for families and children to be able to have their views regularly monitored and fed back, and acted upon, on a session-by-session basis” (Site 1).

When you sit down with a form, 47-question RCADS that we do every 6 sessions in CBT, and you’ll look at their initial scores and it might be 103 or something and they’re circling ‘often’ and ‘always’ for most things and six or twelve weeks later you’ll say ‘hmmm...103 last time – how do you think you’ve scored this time?’ and they’ll say ‘oh, maybe it’s down a bit, maybe it’s seventy’ and you’ll say ‘37!’ and their jaw drops...because they don’t grasp that moment, they’ve lost that moment of 12 weeks ago how dreadful or distressed they were feeling and you know it really does motivate and further drive their success and change (Site 1).
I think particularly with the use of goals, young people are very clear about it’s both of us working together on something that they have identified. So that means how it’s changed is that young people can own it more, and when we’ve completed, we review much more, so we have a session where we review it, how’s it gone, has it been helpful. They’re much more in control of saying ‘yes, that’s fine, actually I would like more of…’ so I think it’s empowered them and families (Site 4).

Increased SDM was described as having a positive impact on CYP mental health: “one of the things that has happened is, certainly with that is, families are getting a more aerodynamic service, appear to be getting it quickly, and are happier, so complaints are less” (Site 2). Several participants noted that feedback was being used to “build and shape” (Site 2) the treatment and treatment provision. Examples discussed included:

• Trying to put more counselling slots during out of hours sessions
• User-friendly environments
• More web access or internet communications
• Information leaflets about certain therapies
• Orientation session for group therapies to reduce anxiety when starting treatment
• Letters/leaflets about what will happen next
• Greater continuity of care: “They fed back a lot about wanting the same clinician and finding it difficult when you’re passed between different clinicians and that’s something that we move, so we’re going into a new pathway model, starting in January, that is something we’re trying to make sure that there’s more continuity” (Site 4).
• More out-of-hours clinics
• Text reminders, which were reported as having reduced the DNA rates for first appointment
• More skills-based groups
• Voluntary support scheme so young people can get experience of working within CAMHS
• Increasing choice in appointments and treatments
• Using CYP and family feedback in reports
• More explanation of outcome measures and treatment progress with service users

Some noted that SDM was a work in progress with attitudes to SDM in some teams posing a barrier and the tension between trying to encourage parents’ involvement, with some CYP not wanting their parent to be involved. Finally, contextual challenges again emerged as a barrier to SDM, with some noting that staff shortages meant clinicians had less time to support SDM, which was seen as dependent upon clinicians and services.

SDM 4. CYP FOCUS GROUPS

In terms of assessment, 63% (28) of CYP reported that they felt CAMHS staff had explained how their assessment would be carried out and 59% (27) that CAMHS staff had explained what treatment or help they needed. Still, 30% (14) felt they were given enough information to make a choice about the treatment they received. Young people reported a number of unanswered questions as to what the assessment entailed, and it was felt that the assessment process was more suited to parents than young people and that they often felt left out at the start of treatment. Nevertheless, in time, several young people managed to develop a good working relationship with their clinician: “I felt so uncomfortable in my assessment. I didn’t like the person that was doing my assessment ‘cos I didn’t think that there was something wrong with me so I weren’t going to admit it… She sort of just dismissed everything I said.” Many CYP felt that staff were good at explaining clearly what they did once a young person was actually attending the service but it would be helpful to have more things written down and to receive more information before the first appointment.
CYP reported a number of **service changes that increased SDM**: appointment times are now longer and the clinicians are more accommodating of young people’s opinions and attitudes towards their problem or illness. Furthermore, young people stated that they are more often consulted on certain aspects of their care, including whether they want their parents involved in the process. Being part of the process was deemed a particularly important development.

*But I kind of felt that the sessions I wanted to go there on my own… ‘cos I thought if I was with somebody else like my parents, I maybe would have thought the session wouldn’t have gone so well. I am glad that my therapist realised this and asked me straight away if I wanted my parents there…*

Overall, 42% (19) of CYP reported that their CAMHS has a **complaints procedure** but 16% (7) were given information on how to access it. Likewise, 19% (9) were clear about what advocacy in their CAMHS means and 27% (12) were given information on how to access it. CYP reported that the complaints procedure was still largely viewed as negative by staff and the process was often left unexplained or vague. As a result, young people were not always able to report what advocacy entailed for them:

*I know there’s a way to complain ‘cos I’ve seen the leaflets but it’s not advertised and it’s not explained to young people, it’s not explained to service users, well it wasn’t explained to me. I think complaints are seen as negative when really they’re a way, if you complain it’s a way the service can improve. I think there needs to be a different view on complaints.*

[Advocacy] we’re still not sure what it means, have heard of it, but….. The word itself is just awful. If we needed to get our voice heard where would we go? Dunno. Maybe GP…

Some partnerships were a notable exception to this and had worked with young people extensively to make improvements to the service – both the therapeutic work as well as the interior of the CAMHS offices. They typically used comment trees and suggestion boxes, as well as young people’s participation groups, to discuss matters on a regular basis: “we have worked on this a lot in our group. We’ve all been very involved in creating and installing the comment tree and suggestions box in CAMHS reception.”

Young people discussed CAMHS’ efforts to set up **interactive IT** systems and their role in helping to improve the service. In some areas, young people were involved in helping to reshape the websites, by providing feedback on the content, writing their own information, and editing information written by CAMHS workers:

*We re-designed the CAMHS website. The old one was cringe-worthy. We consulted children and young people on the content and voted on stuff like colours and pictures. We assessed other websites to work out what is good and bad in web design. Then we made videos for the site about: What is CAMHS; How to get there; What to expect; Early signs and symptoms (CAMHS wrote this and we edited).*

SDM 5. PARENT INTERVIEWS

Overall, parents’ experience of involvement in their child’s treatment was described as mixed. Over half of parents (66%, 28) reported that **staff had explained** how their child’s assessment would be carried out or what help their child needed; e.g., “I turned up on the day and she saw us separately and then together. They sent us a letter which further explained how they understood what they could do and what my daughter could do it was all there in front us that was useful it was a guided plan”, “my son had an assessment by himself and then I joined and was given feedback just outlines not too much detail and then I saw the therapist privately and this worked as I could
talk about how I was feeling”, “he explained how he was going to achieve what my daughter needed and that was the route we took”. Fewer parents (36%, 15) reported that they felt that staff had not explained how their child’s assessment would be carried out or what help their child needed: “the clinician kept using jargon with my daughter – e.g., CBT – and I would have to say you need to explain this to my daughter”, “nothing was explained. The letter also gave no outline as to what would be discussed and that would have been helpful”.

Although the majority of parents reported being involved in assessments, this involvement was described as mixed, ranging from perceptions of appropriate involvement: “they asked my husband and my daughter to fill in a questionnaire. They used this then as prompts to ask my child;” partial or under-involvement: “they did speak to me and I relayed information to them but I was not asked about options I was told this is what needs to happen and that was it;” to over-involvement: “they involved me a bit too much asking me the parent and not my child in a way I wish I just directed all questions to my daughter”.

Again, half of parents (50%, 21) felt that they and their child were given enough information to make a choice about the treatment they received: “he told us what they were going to do and gave us the option of saying if not right for them to be told – it’s very well communicated as to what is the way forward”. While just under half did not (43%, 18): “this was not a good situation, the practitioner offered a talking therapy and we couldn’t get a service for a while along – we were told they only see young people for a set number of sessions but they did extend this for her.”

Again, half of parents (50%, 21) reported that their child’s progress had been explained to them at regular intervals; e.g., “we had a discussion with the therapist and that was useful, she was encouraged to keep a mood journal on eat, sleep and moods, which we could also discuss if my daughter wanted us to”. Still, just under half (45%, 19) reported that their child’s progress had not been explained to them at regular intervals; e.g., “I didn’t feel I was at all part of the treatment”, “I am also unsure as to what progress they are aiming for as they have not discussed this with me”.

Balancing the tension of the extent to which parents should be involved in their child’s treatment was particularly important. “Sometimes I had a one-to-one and I could discuss issues about my daughter and sometimes me and my daughter would have a session with the therapist”, “yes they have been very good about that and they have listened to what I have to say and given credence to that I was given space to talk on my own about my child’s difficulties”, “I would have liked to have someone to one time with the therapist. At one time I asked if I could see the therapist by myself which then upset my daughter as she worried about what was being said - so I could have had more private one-to-one time”, “I was asked lots of questions about my daughter when she was in the room and I did indicate that this was difficult so they did give me time to talk separately when my daughter was not there.”

I would take her (my daughter) every week and I was never told anything I was just kept in the dark. At a first review with a psychiatrist, they told me what had been happening with my daughter with the assumption that I knew this. I found this meeting frustrating as I was being told new information, for which no one had told me about in the actual sessions or at the end of the sessions. This was quite difficult. I didn’t need to know what my daughter was discussing but I would have liked to have been told what the plan was and certainly the direction of any treatment.
SUPERVISION SNAPSHOT

**Principle:** To provide supervision to support the delivery of evidence-based, service user-informed and outcomes-informed practice.

**Clinician survey:** 66% \((n=187)\) of all respondents were satisfied or extremely satisfied with their current levels of supervision and 83% \((n=33)\) of those who trained in NICE-recommended therapies were still receiving supervision in that therapy.

**Clinician interviews:** Clinicians generally described supervision as being a work in progress, with a number of practical and contextual barriers, although some commented that CYP IAPT had standardised the supervision process; use of outcome measures in supervision was described as being “hit and miss”.

**CYP focus groups:** CYP also commented that there were “blockages” regarding this aspect of feedback, suggesting that more means for anonymous feedback about how they feel the work with their therapist is going would be useful.

**Parent interviews:** Parents’ experience of being able to feedback about the therapy their child is receiving was also described as mixed, with some feeling listened to and others struggling to give feedback.
SU: SUPERVISION

SU 1. CLINICIAN SURVEY

Of the clinicians who responded to the survey (N = 361), 22% (n=61/282) received training in supervision (of whom 64% [n=32/50] were satisfied with the training). Overall, 75% (n=248/331) agreed that their service was working toward providing supervision to support the delivery of evidence-based, service user-informed and outcomes-informed practice, and 66% (n=187/283) were satisfied or extremely satisfied with their current levels of supervision. Of those trained in NICE-recommended therapies, 83% (n=33/40) were still receiving supervision in the corresponding therapy.

SU 2. CLINICIAN INTERVIEWS

Generally, experiences and processes of supervision were reported as mixed and it was described as something of a “work in progress” (Site 6), with some reporting that “supervision tends to be a tickbox exercise and there’s not enough time... spent on... reflecting and thinking” (Site 12). Some commented that CYP IAPT had standardised the supervision process and helped to determine how much supervision therapists needed. One site noted that their service had a comprehensive system of supervision, which had changed considerably since the introduction of CYP IAPT, although it was difficult to attribute these changes directly to CYP IAPT, rather than to CQC requirements. Here, supervision took a number of forms including within-discipline peer supervision, small group meetings, and informal supervision, with frequency influenced by the Trust’s clear supervision policy and clinician experience.

Another site noted that they make a point of reviewing the involvement of CYP: “in case-management supervision, we’re discussing the interventions being offered and we’re discussing where the clients are with that, what progress has been made on the goals that have been set, and has this case been reviewed with the clients, and what are they saying, so we do that” (Site 4). One site noted that all supervisors had “been on the CYP IAPT supervision training, and what has changed is that [the service has] up-skilled those staff that haven’t necessarily had supervision training” (Site 1).

The discussion of outcome data in supervision was generally described as “hit and miss” (Site 1). Some participants stated that outcome data was either discussed or starting to be discussed during supervision, but not as often as was done in formal training; those not currently discussing it in supervision were aware of the potential benefits of doing so. Those who used outcome data noted that it “has aided us to work towards the same goals and follow a clear structure through regular management and support” (Site 5) with others reporting that they used it to discuss patients whose treatment is not progressing as anticipated and to explore what else is going on in the CYP’s life. One participant noted that supervision had reduced fear and hostility to outcome measures, which had been previously seen as “an attack or attempt to trip them up” and that there is more discussion about NICE guidelines and practice-theory links (Site 11). One participant routinely discussed ROM with supervisees, commenting that CYP IAPT had “made a huge difference” in terms of ROM discussion within teams and feedback to patients and commissioners.

Some participants discussed the need to overcome cultural barriers to discussing ROM in supervision, which was mirrored across other sites, where participants noted that it is easier to discuss things verbally than present outcome data:

The initial thing was ‘ugh! I got to bring all this stuff again, we gotta go through it again…’ but the feedback has been really useful because it allows conversations to happen in supervision about how things are going and just to share our hypotheses and have a think about what could be happening and ways that that can be spoken about with the young person, so the feedback has been that it’s been useful, even if it’s a little bit cumbersome (Site 4).

CYP IAPT: Rapid internal audit National Report
Clinicians reported receiving regular specialist training and supervision during the formal training, and some commented that this left a gap that was difficult to accommodate after training, especially for the newer interventions or modalities in which supervision is more regular. Similarly, contextual factors such as staff shortages were mentioned as a barrier to comprehensive supervision.

SU 3. CYP FOCUS GROUPS

As mentioned above, this principle refers to the provision of supervision to support service-user informed treatments. When CYP were asked if they were asked to feedback about how the work they do with the therapist is going, 32% (14) reported that they were asked for feedback and 51% (23) reported that they had given feedback about the service so improvements can be made to their treatment. Young people identified the existence of a “blockage” when it came to providing feedback on the quality of a service and, in particular, being able to give anonymous feedback was described as important to increasing the amount of feedback from CYP. “We don’t want to say anything bad or to be mean about someone. But we do want to be truthful. Maybe we could give anonymous feedback. Or maybe we could write our feedback rather than say it.”

SU 4. PARENT INTERVIEWS

In the same line of enquiry related to the delivery of service-user informed treatments, 33% (14) of parents reported that they were asked to feedback about how the work with their child was going with their therapist by other people: “At the end of every session I give feedback as to what works well and what does not work well”, “if things were not going well I could phone and we could change direction”, “there is a box for us to put comments or coins with slots 1-10 and you pop your coin in as to what you think is relevant for that day”. Parents who reported that they were able to give feedback about the therapy their child is receiving thought that this seemed to be listened to; e.g., “If I wasn’t happy with the therapy they would find an alternative route”, “they have an iPad in the waiting room which they encourage you to use as they welcome service user feedback”, “I have suggested some things and they seem to have been taken on board by the nurse”.

However, the majority of parents (62%, 26) reported that they were not asked for feedback: “I have started to offer it in frustration but never asked for it.” Moreover, a number of parents (40%, 17) reported struggling to give feedback or find information: “I have done when it hits crisis points and it’s not proactively asked, in fact I didn’t know that was a part of the process”, “I struggle to even find out treatments are available, they told me that they discuss it; e.g., the CAMHS teams”.

54 CONSIDERING IMPACT OF SERVICES
CONSIDERING IMPACT OF SERVICES

Additional indicators of practice from the routinely collected data, not covered above in relation to indications of overall impact of services that are using the seven CYP IAPT principles, are considered below.

INDICATORS OF ACCESS, TAKE-UP, AND CONTACT

The average number of days between referral and assessment decreased from 239 in 2010 (n = 5 services) to 64 in 2014 (n = 10 services), and the proportion of average waiting time to total accepted referrals decreased from 0.18 in 2010 (n = 5 services) to 0.04 in 2014 (n = 10 services). The average number of days between assessment and discharge decreased from 299 days in 2010 (n = 5 services) to 235 days in 2014 (n = 8 services), and the proportion of discharge time to total accepted referrals decreased from 0.24 in 2010 (n = 5 services) to 0.17 in 2014 (n = 8 services). The total number of accepted referrals increased from 12,608 in 2010 (n = 7 services) to 31,942 in 2014 (n = 11 services).

There was a decrease in the proportion of DNAs to total accepted referrals from 1.17 in 2010 (n = 7 services) to 0.99 in 2014 (n = 11 services). This may suggest that further work to engage young people and parents at the initial stages of contact is needed or alternatively, that changes already made to services have not had sufficient time to make a difference to early engagement.

![Figure 9: Percentage of appointments seen of appointments offered, percentage of cases closed on mutual agreement out of all closed cases, percentage of cases closed by other reasons than mutual agreement out of all closed cases, and percentage of closed cases out of all cases in 2010 and 2014.](image-url)
INDICATORS OF CYP TREATMENT OUTCOME

In Tables 1-4 below, treatment outcome for closed cases are shown for the Revised Children’s Anxiety and Depression Scales (RCADS)\textsuperscript{16} based on child- and parent- reports, including: 1) the standardised effect size\textsuperscript{17}, 2) the proportions of CYP showing reliable change\textsuperscript{18}, 3) the proportions of CYP showing clinically significant change, and 4) the proportions of CYP at caseness at T1 showing reliable and clinically significant change; here, recovery indicates reliable change where the CYP was at caseness at T1 but not at T2, improvement indicates reliable change where the CYP was at caseness at T1 and still at caseness at T2, no change indicates neither reliable nor clinical change, and worsening indicates reliable change in the direction of increased symptomatology, where the CYP was at caseness at T1 and still at caseness at T2.

\textsuperscript{16} The RCADS captures five domains of anxiety and depression: separation anxiety (7 items; e.g., “I would feel afraid of being on my own at home alone”), social phobia (9 items; e.g., “I worry when I think I have done poorly at something”), GAD (6 items; e.g., “I worry about things”), panic disorder (9 items; e.g., “I suddenly feel as if I can’t breathe when there is no reason for this”), OCD (6 items; e.g., “I get bothered by bad or silly thoughts or pictures in my mind”), and major depression (10 items; e.g., “I feel sad or empty”). Young people responded to each item on a 4-point scale from never (0) to always (3). The RCADS is a widely used measure of anxiety and depression and has demonstrated reliability and validity in numerous studies (de Ross, Gullone, & Chorpita, 2002; Esbjorn, Somhovd, Turnstedt, & Reinholdt-Dunne, 2012).

\textsuperscript{17} Standardised effect size = (pre-score – post-score)/ SD\textsubscript{T1}

\textsuperscript{18} The reliable change index estimates the amount of change required in a measure to conclude that the change observed is not solely attributable to measurement error. The Jacobson-Truax method was used, taking the Cronbach’s alpha and SD of scores at T1 (Jacobson & Truax, 1991). Clinical cut-off scores were taken from the RCADS user manual (Weiss & Chorpita, 2011).
Table 1. Standardised effect size M (95% CI).

<table>
<thead>
<tr>
<th>RCADS</th>
<th>Social phobia</th>
<th>Panic</th>
<th>Depression</th>
<th>GAD</th>
<th>Separation anxiety</th>
<th>OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child report</td>
<td>0.48 (0.39-0.57)</td>
<td>0.38 (0.29-0.47)</td>
<td>0.58 (0.49-0.68)</td>
<td>0.41 (0.29-0.57)</td>
<td>0.55 (0.45-0.66)</td>
<td>0.23 (0.10-0.40)</td>
</tr>
<tr>
<td>Parent report</td>
<td>0.25 (0.10-0.40)</td>
<td>0.19 (0.02-0.37)</td>
<td>0.55 (0.45-0.66)</td>
<td>0.23 (0.10-0.40)</td>
<td>0.38 (0.29-0.48)</td>
<td>0.16 (0.02-0.30)</td>
</tr>
</tbody>
</table>

N 356 128 358 123 392 131 353 133 348 130 355 128

Table 2. Proportions of CYP showing reliable change with n in parentheses.

<table>
<thead>
<tr>
<th>RCADS</th>
<th>Social phobia</th>
<th>Panic</th>
<th>Depression</th>
<th>GAD</th>
<th>Separation anxiety</th>
<th>OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child report</td>
<td>26% (94)</td>
<td>25% (90)</td>
<td>31% (123)</td>
<td>28% (100)</td>
<td>13% (17)</td>
<td>10% (36)</td>
</tr>
<tr>
<td>Parent report</td>
<td>20% (26)</td>
<td>13% (16)</td>
<td>8% (10)</td>
<td>28% (100)</td>
<td>13% (17)</td>
<td>10% (36)</td>
</tr>
<tr>
<td>No change</td>
<td>70% (249)</td>
<td>68% (243)</td>
<td>64% (249)</td>
<td>92% (120)</td>
<td>78% (104)</td>
<td>87% (304)</td>
</tr>
<tr>
<td>Deterioration</td>
<td>4% (13)</td>
<td>7% (25)</td>
<td>5% (20)</td>
<td>1% (1)</td>
<td>5% (16)</td>
<td>9% (12)</td>
</tr>
</tbody>
</table>

N 356 128 358 123 392 131 353 133 348 130 355 128
Table 3. Proportions of CYP showing clinical change with n in parentheses.

<table>
<thead>
<tr>
<th>RCADS</th>
<th>Social phobia</th>
<th>Panic</th>
<th>Depression</th>
<th>GAD</th>
<th>Separation anxiety</th>
<th>OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement</td>
<td>10% (35)</td>
<td>14% (18)</td>
<td>23% (82)</td>
<td>18% (22)</td>
<td>26% (100)</td>
<td>24% (32)</td>
</tr>
<tr>
<td>No change</td>
<td>87% (309)</td>
<td>81% (103)</td>
<td>70% (252)</td>
<td>71% (87)</td>
<td>68% (268)</td>
<td>70% (92)</td>
</tr>
<tr>
<td>Deterioration</td>
<td>3% (12)</td>
<td>6% (7)</td>
<td>7% (24)</td>
<td>11% (14)</td>
<td>6% (24)</td>
<td>5% (7)</td>
</tr>
<tr>
<td>N</td>
<td>356</td>
<td>128</td>
<td>358</td>
<td>123</td>
<td>392</td>
<td>131</td>
</tr>
</tbody>
</table>

Table 4. Proportions of CYP at caseness at T1 showing reliable and clinical change with n in parentheses.

<table>
<thead>
<tr>
<th>RCADS</th>
<th>Social phobia</th>
<th>Panic</th>
<th>Depression</th>
<th>GAD</th>
<th>Separation anxiety</th>
<th>OCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery</td>
<td>39% (21)</td>
<td>39% (14)</td>
<td>46% (55)</td>
<td>11% (4)</td>
<td>42% (75)</td>
<td>11% (8)</td>
</tr>
<tr>
<td>Improvement</td>
<td>-</td>
<td>11% (4)</td>
<td>8% (9)</td>
<td>9% (5)</td>
<td>4% (7)</td>
<td>-</td>
</tr>
<tr>
<td>No change</td>
<td>61% (33)</td>
<td>44% (16)</td>
<td>42% (50)</td>
<td>65% (34)</td>
<td>52% (92)</td>
<td>89% (63)</td>
</tr>
<tr>
<td>Worsening</td>
<td>-</td>
<td>6% (20)</td>
<td>4% (5)</td>
<td>4% (2)</td>
<td>2% (4)</td>
<td>-</td>
</tr>
<tr>
<td>N</td>
<td>54</td>
<td>36</td>
<td>119</td>
<td>52</td>
<td>178</td>
<td>71</td>
</tr>
</tbody>
</table>
Table 5. Overview of audit findings by data source.

<table>
<thead>
<tr>
<th>ROUTINELY COLLECTED DATA</th>
<th>CLINICIAN SURVEY</th>
<th>CLINICIAN INTERVIEWS</th>
<th>CYP FOCUS GROUP</th>
<th>PARENT INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The average number of days between referral and assessment decreased from 239 in 2010 (n = 5 services) to 64 in 2014 (n = 10 services), and the proportion of average waiting time to total accepted referrals decreased from 0.18 in 2010 (n = 5 services) to 0.04 in 2014 (n = 10 services). The average number of days between assessment and discharge decreased from 299 days in 2010 (n = 5 services) to 235 days in 2014 (n = 8 services), and the proportion of discharge time to total accepted referrals decreased from 0.24 in 2010 (n = 5 services) to 0.17 in 2014 (n = 8 services).</td>
<td>Compared to a national sample of mental health services in the United States, teams in CYP IAPT had more proficient organisational cultures and more functional organisational climates.</td>
<td>Senior management commitment was seen as crucial to strong leadership, particularly when facing a number of contextual barriers to service transformation. Overall, team relationships were described as being the area most in need of improvement.</td>
<td>Areas of continuing improvement suggested by young people were increased opening times, better IT systems to enable information sharing, and more information about CAMHS but also about mental health and wellbeing in the community to raise awareness.</td>
<td>Parents reported being seen within one month (21% or 9 parents), between one to two months (38%, 16), between three to five months (24%, 10), or longer (20%, 8).</td>
</tr>
<tr>
<td>The percentage of closed cases by mutual agreement to end treatment (vs. all other reasons) increased from 34% in 2010 (n = 5 services) to 55% in 2014 (n = 10 services).</td>
<td>Clinicians reported a number of service changes based on feedback from CYP and families and a number of mechanisms for participation, including a You Said, We Did board, welcome packs, a message tree, and the Y Factor.</td>
<td>CYP IAPT and the participation groups have given CYP “a voice in a massive way.”</td>
<td>Involvement gave CYP a personal sense of worth and empowerment; although CYP felt listened to during participation activities, they were less aware of changes to the service that had been made as a result of feedback.</td>
<td>Involvement of parents in service design and delivery was described as being less frequent than involvement of CYP.</td>
</tr>
<tr>
<td>The percentage of accepted self-referrals out of all accepted referrals increased from 1.21% in 2010 (n = 7 services) to 2.65% in 2014 (n = 11 services) in the service-level data reported by partnerships.</td>
<td>54% (n=178) of clinicians agreed or strongly agreed that their service was working towards improving access through self-referral and 61% (n=84) thought that access to the service had improved for the local population over the last 12 months.</td>
<td>Improvements to self-referral were “on the agenda” and a number of mechanisms for self-referral were reported. Self-referral was seen as benefiting CYP engagement with treatment.</td>
<td>Young people reported having self-referred into the service and available information on self-referral, however the process could be simplified.</td>
<td>The majority of parents reported wanting to self-refer but currently being unable to.</td>
</tr>
</tbody>
</table>
### Routinely Collected Data

27% \((n=345)\) of CYP presenting with depression or anxiety received CBT, and 28-57% \((n=21-75)\) of CYP above cut-off on child-reported RCADS at T1 achieved recovery at T2 \((n=4-14)\) according to parent-report.

### Clinician Survey

97% \((n=38)\) of clinicians trained in NICE-recommended therapies were still offering the therapy.

### Clinician Interviews

Clinicians described CYP IAPT as having embedded evidence-based treatment in their service and improving CYP’s access to evidence-based treatments.

### CYP Focus Group

CYP mirrored reports from clinicians and also thought that monitoring helped to “keep things focused.”

### Parent Interviews

Parents’ experience of SBS was mixed, finding it positive if measures were explained and if they were involved in decisions about completing measures, but not if there was a lack of explanation or consultation.

---

Of the total sample of 6,803 young people, 83% \((5,633)\) of CYP had an assessment measure recorded. Of those 3,939 CYP who had at least two sessions recorded, 42% \((1,639)\) had matched T1-T2 scores on an outcome measure. Of those 2,690 CYP who had at least three sessions recorded, 49% \((1,322)\) of children had any sessional measure used in at least two sessions and 44% \((1,184)\) of children had any sessional measures used in at least three sessions.

Clinicians described CYP IAPT as having increased shared decision making, and routine outcome-monitoring was described as supporting and systematising shared decision making and the involvement of CYP and families in treatment.

Clinicians described CYP IAPT as having increased shared decision making, and routine outcome-monitoring was described as supporting and systematising shared decision making and the involvement of CYP and families in treatment.

CYP commented that, although shared decision making was not always immediate in assessment, it increases once treatment begins.

Experience of shared decision making was mixed, with comments on the need to balance the tension of the extent to which parents should be involved in their child’s treatment as particularly important.
<table>
<thead>
<tr>
<th>ROUTINELY COLLECTED DATA</th>
<th>CLINICIAN SURVEY</th>
<th>CLINICIAN INTERVIEWS</th>
<th>CYP FOCUS GROUP</th>
<th>PARENT INTERVIEWS</th>
</tr>
</thead>
<tbody>
<tr>
<td>66% (n=187) of all respondents were satisfied or extremely satisfied with their current levels of supervision and 83% (n=33) of those who trained in NICE-recommended therapies were still receiving supervision in that therapy.</td>
<td>Clinicians generally described supervision as being a work in progress, with a number of practical and contextual barriers, although some commented that CYP IAPT had standardised the supervision process; use of outcome measures in supervision was described as being &quot;hit and miss&quot;.</td>
<td>CYP also commented that there were &quot;blockages&quot; regarding this aspect of feedback, suggesting that more means for anonymous feedback about how they feel the work with their therapist is going would be useful.</td>
<td>Parents' experience of being able to feedback about how the therapy their child is receiving was also described as mixed, with some feeling listened to and others struggling to give feedback.</td>
<td></td>
</tr>
</tbody>
</table>

19 With complete age, gender, and at least one Current View Tool item recorded.
20 For the possibility of two measures having been administered.
21 Assuming the first session was assessment and the last session was discharge or case closure, there would be at least one treatment session in which a sessional measure could have been used (Law & Wolpert, 2014).
## DATA COMPLETENESS

Table 6. Data completeness for closed cases (N = 2,883).

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children attending at least three face-to-face sessions where treatment has ended</td>
<td>45% (1,308/2,883)</td>
</tr>
<tr>
<td>Number of children with outcome information(^{22})</td>
<td>50% (659/1,308)</td>
</tr>
<tr>
<td>Minimum % of cases sent with outcome information by individual site (out of children attending at least three face-to-face sessions where treatment has ended)</td>
<td>0%</td>
</tr>
<tr>
<td>Maximum % of cases sent with outcome information by individual site (out of children attending at least three face-to-face sessions where treatment has ended)</td>
<td>98% (115/117)</td>
</tr>
<tr>
<td></td>
<td>100% (4/4)</td>
</tr>
</tbody>
</table>

\(^{22}\) Refers to two or more “symptom or general outcome measurement time points” (this could be, for example RCADS, SDQ, CGAS, HoNOSCA, C/ORS, or Goals, as long as they are from the same perspective (Child or Parent) where case is closed but was seen on three or more occasions.
BARRIERS AND FACILITATORS, LIMITATIONS, AND CONCLUSION

BARRIERS AND FACILITATORS

Table 7 shows the themes emerging from the staff interviews about facilitators to implementing and sustaining CYP IAPT. Participants consistently reported local **CYP IAPT champions** as crucial to implementing and sustaining CYP IAPT. Champions were described as helping support CYP IAPT from the bottom up, complementing the top down implementation described below: “We certainly tried to integrate into the team and have some champions almost, so some people have kind of taken it on board within the team, so it doesn’t feel too top down.” (Staff). Similarly, **top down** support from **senior management, CYP IAPT project leaders**, and supervisors was described as vital for facilitating leadership of the CYP IAPT service transformation: “senior management telling us why, feedback and communication” (Staff).

*I think there is huge amounts of buy-in at a senior level within the service, which I think helps in terms of then being able to look at how that could be implemented across the whole, and how the principles and learning from [CYP] IAPT can be used across the whole service – not just within CAMHS but also within the organisation as a whole* (Staff).

The provision of **training and resources** was also frequently described as a key facilitator, with the **high quality of training** consistently noted; e.g., “the training and the research that’s been put out there to support it; the material that’s been put out is generally very good – very high quality” (Staff), “Training for me changed my practice completely” (Staff). When a greater number of staff attended formal training at higher education institutes or there was whole team training, staff reported this as facilitating the **spread and embedding** of CYP IAPT: “I think the fact that we have had quite a lot of people training helps because it creates a body of people within the service who help move it forward” (Staff). A minority of participants reported a desire for greater clarity of how staff were selected for training.

The **flexibility** of the programme was described as helping staff to adapt implementation in the face of challenges: “we’ll talk about it and if it doesn’t feel right with this particular client, that’s OK as well” (Staff), “helping people work through their reservations and talking about it regularly” (Staff). **Staff commitment and collaboration**, both **between organisations** (e.g., voluntary and statutory services, organisations within a collaborative) and **between staff** to support one another was described as a crucial facilitator. “The commitment from the clinicians, so really it’s all about them, and they’ve shown a great deal of commitment and collaboration” (Commissioner), “The way the collaborative has worked together to support each other and share ideas” (Staff), “I suppose because we’ve had some people on the training course…their enthusiasm helped us along, ‘cos they’ve been given new skills and they’ve felt sort of rejuvenated in their work” (Staff). The principles of CYP IAPT fitting with the aims of services and other policy drivers was described as a facilitator as it was **moving in the same direction** as the service was headed (Staff): “being an outreach team working in the community, it has mean that our focus has always been about engagement, and [CYP] IAPT suits us” (Staff), “many of the things [CYP] IAPT encapsulates are well overdue and so there are lots of drivers moving in the same direction” (Staff).

Clinicians reported **feedback** as facilitating implementation and sustainment of CYP IAPT. Feedback was described in terms of **using outcome measures in therapy**:

*The fact that you can see the results. When you’re actually working with somebody and you are doing your scores…you can see what’s improving and see where some of the weaknesses are as well and that helps you to move forwards* (Staff).
Feedback was also described in terms of the service’s implementation of CYP IAPT from the national team: “there are regular updates in the team meetings about what’s happening” (Staff) (also see the barrier, Lack of communication). Similarly, CYP IAPT being on the agenda was described as useful for continual discussion and feedback within the team; the involvement of CYP, particularly through participation groups, was highlighted as useful for obtaining feedback from young people and families: “Enthusiasm and motivation of people to make sure the young person’s voice is central to what we do” (Staff).

Other facilitators regarded the provision of resources and support, including funding, backfill, support particularly from Assistant Psychologists, and organisational support from the central team. When technology systems worked well, they were described as facilitating implementation and sustainment (also see the barrier, Technology).
Table 7. CYP IAPT facilitators.

<table>
<thead>
<tr>
<th>PRIMARY THEME</th>
<th>SECONDARY THEME</th>
<th>TERTIARY THEME</th>
<th>KEY POINTS</th>
<th>ILLUSTRATIVE QUOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYP IAPT champions</td>
<td>Bottom-up support</td>
<td>Champions help support bottom-up, which compliments top-down support</td>
<td>&quot;Having people on board, using the outcomes to see the evidence improving quality in terms of care, much more of a service now that looks outward and isn’t afraid of people looking in.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot;We certainly tried to integrate into the team and have some champions almost, so some people have kind of taken it on board within the team, so it doesn’t feel too top down.”</td>
</tr>
<tr>
<td>Training and resources</td>
<td>High quality of training</td>
<td>Spread and embedding</td>
<td>High quality of teaching was repeatedly mentioned When more staff were trained or there was whole team training it was easier to embed Fewer reported the training being stressful and of a lower quality Clarity over how trainees were selected</td>
<td>&quot;The training and the research that’s been put out there to support it; the material that’s been put out is generally very good – very high quality.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot;Training for me changed my practice completely.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot;I think the fact that we have had quite a lot of people training helps because it creates a body of people within the service who help move it forward.”</td>
</tr>
<tr>
<td>Flexibility</td>
<td>In the face of challenges</td>
<td></td>
<td>&quot;We’ll talk about it and if it doesn’t feel right with this particular client, that’s OK as well.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot;Helping people work through their reservations and talking about it regularly.”</td>
</tr>
<tr>
<td>“Commitment and collaboration”</td>
<td>Between staff to support one another</td>
<td>Between organisations (e.g., voluntary and statutory services, organisations within a collaborative)</td>
<td>Sharing learning within the team Staff enthusiasm, particularly after training</td>
<td>“The commitment from the clinicians, so really it’s all about them, and they’ve shown a great deal of commitment and collaboration”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Everybody doing it all together, adapted to it as a whole service, the team work and support and management has helped it sustain.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“The way the collaborative has worked together to support each other and share ideas”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I suppose because we’ve had some people on the training course...their enthusiasm helped us along, ‘cos they’ve been given new skills and they’ve felt sort of rejuvenated in their work”</td>
</tr>
<tr>
<td>Primary Theme</td>
<td>Secondary Theme</td>
<td>Tertiary Theme</td>
<td>Key Points</td>
<td>Illustrative Quote</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Fit</td>
<td>“moving in the same direction”</td>
<td></td>
<td></td>
<td>“Being an outreach team working in the community, it has meant that our focus has always been about engagement, and [CYP] IAPT suits us.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Many of the things [CYP] IAPT encapsulates are well overdue and so there are lots of drivers moving in the same direction.”</td>
</tr>
<tr>
<td>Top-down support</td>
<td>Senior management / CYP IAPT project leader, and supervision</td>
<td>Leadership</td>
<td></td>
<td>“Senior management telling us why, feedback and communication.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“I think there is huge amounts of buy-in at a senior level within the service, which I think helps in terms of then being able to look at how that could be implemented across the whole, and how the principles and learning from [CYP] IAPT can be used across the whole service – not just within CAMHS but also within the organisation as a whole”</td>
</tr>
<tr>
<td>Feedback</td>
<td>In therapy using outcome measures</td>
<td>About CYP IAPT implementation</td>
<td>From the national team</td>
<td>“The fact that you can see the results. When you’re actually working with somebody and you are doing your scores...you can see what’s improving and see where some of the weaknesses are as well and that helps you to move forwards.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“There are regular updates in the team meetings about what’s happening.”</td>
</tr>
<tr>
<td>Involvement of CYP</td>
<td>Participation groups</td>
<td></td>
<td></td>
<td>“Enthusiasm and motivation of people to make sure the young person’s voice is central to what we do.”</td>
</tr>
<tr>
<td>Backfill</td>
<td></td>
<td></td>
<td></td>
<td>“The backfill has been massive – without it, I don’t think the service could have trained anyone.”</td>
</tr>
<tr>
<td>Support, particularly from Assistant Psychologists</td>
<td></td>
<td></td>
<td></td>
<td>“I think, on the whole, there has been some really good ‘joined up’”</td>
</tr>
<tr>
<td>Organisational support from the central team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8 shows the themes emerging from the interviews about barriers to implementing and sustaining CYP IAPT. Participants reported a reluctance to change practice as a key barrier to CYP IAPT. “Some people have been set in working in a particular way for a long time, where they think they have the right amount of expertise to tell families what they need” (Staff). Some thought that this reluctance was in part driven but CYP IAPT perceived as an external imposition on the service. Many participants raised anxiety about outcome data being used for performance management and CYP not showing change in measures: “The concept of evaluating our own work is hugely unsettling for individuals and for teams.”

A lack of communication was also described as a key barrier, with some staff being unclear about what CYP IAPT is; at times, this lack of clarity lead to CYP IAPT being associated with adult IAPT and CBT. “It’s got a bad press: it’s equated with...the adult services, 70-80 people on your books doing CBT by manual bank...there’s been that confusion of IAPT with CYP IAPT” (Staff). Consequently, a lack of communication and clarity was described as making cultural change harder as misconceptions first had to be overcome. Mirroring this, some staff reported a lack of senior management buy-in and that senior management was also unclear about the CYP IAPT approach.

Technology was mentioned by most participants as a barrier, ranging from use of iPads, multiple different electronic record systems, a need for paper and electronic data entry, problems extracting data, and an inability to upload data from more than one source; “our IT system is the biggest barrier...it’s more prohibitive than it is useful.” (Staff). Similarly, information governance was described as a barrier, as was a lack of feedback from measures: “lack of feedback. We need it more often to make it more accessible” (Staff). The number of measures was described as overwhelming by some participants (also see the principle Session-by-session monitoring).

Contextual barriers were frequently mentioned as a barrier, with cost cutting and competing organisational changes resulting in increased pressures on staff. “I’ll say external pressures in terms of cuts, across the children and young people’s service and the impact that has had on the service. That puts an increasing demand on the service with a reduction of staff.” (Staff). Moreover, some participants noted that a lack of resources was a particular barrier to making changes based on feedback from CYP and families. Delays in backfill for staff attending training were described as increasing pressure on staff (also see Low staff morale), linked with the speed at which CYP IAPT was implemented. Under-staffing was mentioned as a general contextual barrier, compounded by the loss of staff to training in CYP IAPT; furthermore, some participants noted that some staff left the service after attending training.

Time both within and between therapeutic work to learn new systems and processes was a challenge, in terms of administration/paperwork for outcome measures or having “protected time” after training to embed new practices (Clinician).
The above barriers were described as culminating in low staff morale in some teams: providing therapy was described as an emotionally demanding profession, which is compounded by pressures related to transformation and change and pressure related to contextual challenges. “We are under a lot of pressure in terms of seeing people and our targets so having the time to take to train people and have the time to reflect on how we build and develop that.” (Staff). Participants described implementing and sustaining new work practices in the context of these pressures as particularly challenging.

The need to develop the evidence base for certain therapies (also see the principle, Evidence-based treatments) was mentioned or, as one participant put it, “Whose evidence is it anyway?”

A minority of participants described the training not be accessible to all (e.g., full-time staff only) and training issues (e.g., difficulties arranging placements) as a barrier (also see the facilitator, Training and resources).

Sustainability was raised as a future barrier, potentially confounded by the speed at which CYP IAPT was implemented. “The fact that budgets are not consistent, services are always on the edge of vanishing, it’s hard to build a future pathway and develop services when strategically you don’t know whether you are going to exist.”
Table 8. Barriers to CYP IAPT.

<table>
<thead>
<tr>
<th>PRIMARY THEME</th>
<th>SECONDARY THEME</th>
<th>TERTIARY THEME</th>
<th>KEY POINTS</th>
<th>ILLUSTRATIVE QUOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reluctance to change practice</td>
<td>Imposition</td>
<td></td>
<td>“Worrying that their expertise is somehow going to be eroded by working with clients in a new way”</td>
<td>“I think there are some challenges in terms of rolling that routine outcome monitoring out across the whole service, because obviously it’s a change and, you know, kind of getting everybody on board with that, there is always going to be some challenges in that.”</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Concern if CYP do not show change in outcome measures</td>
<td></td>
<td>“The concept of evaluating our own work is hugely unsettling for individuals and for teams.”</td>
<td>“Questionnaires don’t necessarily record the change from successful interventions.”</td>
</tr>
<tr>
<td>Lack of communication</td>
<td>What is CYP IAPT?</td>
<td>Harder to make cultural changes</td>
<td>Association with adult IAPT and delivering CBT; Feedback needed</td>
<td>“It’s got a bad press: it’s equated with…the adult services, 70-80 people on your books doing CBT by manual bank…there’s been that confusion of IAPT with CYP IAPT”</td>
</tr>
<tr>
<td>PRIMARY THEME</td>
<td>SECONDARY THEME</td>
<td>TERTIARY THEME</td>
<td>KEY POINTS</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Lack of senior management buy-in</td>
<td>Technology</td>
<td>Feedback</td>
<td>“I don’t think they understand the ethos and the approach”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information</td>
<td></td>
<td>“Our IT system is the biggest barrier…it’s more prohibitive than it is useful.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>governance</td>
<td></td>
<td>“Lack of feedback. We need it more often to make it more accessible.”</td>
<td></td>
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**Key Points**
- **Technological Issues**
  - **Information Governance**: iPads, Different systems, Paper and electronic, Data extraction, Uploaded scores for family, home and school.
  - **Feedback**: "Our IT system is the biggest barrier…it’s more prohibitive than it is useful.”
  - "Lack of feedback. We need it more often to make it more accessible.”
  - "We need changes to the way electronic records are kept and how that can facilitate the use of outcomes data.”
  - "Getting the measures into the system, getting them scored”
- **Number of Measures**: The number of measures was described by some as being overwhelming (see SBS).
- **Contextual Barriers**
  - "I’ll say external pressures in terms of cuts, across the children and young people’s service and the impact that has had on the service. That puts an increasing demand on the service with a reduction of staff.”
- **Resources to Make Changes**
  - "Lack of resource, in terms of facilitating better groups or being able to use the groups’ feedback more”
<table>
<thead>
<tr>
<th>PRIMARY THEME</th>
<th>SECONDARY THEME</th>
<th>TERTIARY THEME</th>
<th>KEY POINTS</th>
<th>ILLUSTRATIVE QUOTE</th>
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<tr>
<td>Backfill</td>
<td>Loss of staff to training</td>
<td>Loss of staff post-training</td>
<td>Delay in backfill when staff attend training</td>
<td>“So you get interviewed and then you’ve almost got to be freed up completely to go and do this course but then you’ve still got all the commitment and finding backfill and finding people that have the suitable skills because of your work”</td>
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<td>Under-staffed</td>
<td>Loss of staff to training</td>
<td>Loss of staff post-training</td>
<td>In general but compounded by CYP IAPT</td>
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<td>Time</td>
<td>Administration/ paperwork for outcome measures</td>
<td>“Protected time” after training to embed new practices</td>
<td>Time within and between sessions and to learn new systems and processes</td>
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<td>Low staff morale</td>
<td>Pressure related to change</td>
<td>Pressure related to contextual challenges</td>
<td>Both of these within an already difficult and pressurized job Makes it more difficult to implement and sustain new practices</td>
<td>“We are under a lot of pressure in terms of seeing people and our targets so having the time to take to train people and have the time to reflect on how we build and develop that.”</td>
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<td>“Whose evidence is it anyway?”</td>
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<td>Need to develop evidence for some treatments (see EBT)</td>
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<td>Training not accessible for all</td>
<td>Training issues (e.g., placements)</td>
<td>Training only for FT staff Issues arranging placements during training</td>
<td>“The fact that budgets are not consistent, services are always on the edge of vanishing, it’s hard to build a future pathway and develop services when strategically you don’t know whether you are going to exist.”</td>
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LIMITATIONS

Limitations should be considered when interpreting the findings of the present audit. Overall, this was an observational study of the implementation of CYP IAPT, not a controlled trial, therefore causal inferences should not be made and the audit may have less internal validity as it was not conducted in a controlled setting. Nevertheless, the audit may have increased ecological validity as it was conducted under naturalistic conditions. Moreover, the audit was conducted over six months and, with a longer timeframe, different methodological decisions may have been taken. A formal evaluation of CYP IAPT, over a longer timeframe with a greater number of partnerships, would help provide additional, more generalisable evidence about the experience of embedding the CYP IAPT principles.

There was a large amount of missing data in the routinely collected dataset and there may be differences in those with complete data and those without (Clark et al., 2009). Future research should continue to explore the pattern of missing data and different approaches to handling missing data. Moreover, it was not possible to assess adherence to the CYP IAPT data collection protocol.

In terms of the clinician survey, they may have been a response bias whereby clinicians with more extreme attitudes to or experiences of embedding the CYP IAPT principles may have been more likely to take part. However, response rates for both the OSC and bespoke surveys were monitored and reported. Both the clinician surveys and interviews may have the risk of social desirability bias, although this was mitigated by using recommended procedures (Dillman, Smyth, & Christian, 2008). Still, interviews were conducted by a number of different interviewers, given the time constraints and geographical spread of the interviews. To ensure consistency, a structured interview schedule was used and a framework analysis conducted.

The CYP focus groups and parent interviews were conducted as part of ongoing CYP IAPT participation groups. Hence, those with the richest experience of involvement may have been more represented in the sample, meaning the views and experiences expressed may not be representative of the young people and parents least engaged in CAMHS.

CONCLUSION

OVERVIEW

Between October 2014 and March 2015, the Evidence-Based Practice Unit at the Anna Freud Centre and UCL, and NHS England, undertook a rapid internal audit of CYP IAPT. Case studies were conducted with 12 partnerships, involving analysis of routinely collected data, staff surveys and interviews, and interviews and focus groups with young people and parents involved in CYP IAPT participation groups. The aim of the audit was to explore how far services were along their transformation journey to embedding the CYP IAPT principles. At the heart of CYP IAPT is a strong emphasis on creating a collaborative approach across services and with service users and improving the availability, efficiency, and effectiveness of mental health services for children and young people (CYP IAPT, n.d.). This briefing note summarises the findings of the audit with regard to how far services were along their transformation journey.

A TRANSFORMED SERVICE IS MORE EFFICIENT

Findings of the audit suggest that services have higher levels of efficiency. The average number of days between referral and assessment decreased from 239 in 2010 ($n=5$ services) to 64 in 2014 ($n=10$ services), and the proportion of average waiting time to total accepted referrals decreased from 0.18 in 2010 ($n=5$ services) to 0.04 in 2014 ($n=10$ services). The average number of days

This is taken from the Briefing Note (see p. 3).
between assessment and discharge decreased from 299 days in 2010 (n = 5 services) to 235 days in 2014 (n = 8 services), and the proportion of discharge time to total accepted referrals decreased from 0.24 in 2010 (n = 5 services) to 0.17 in 2014 (n = 8 services). Staff reported in interviews that young people were being seen faster and more appropriately, and that there was more throughput through the service, for instance because of the use of routine outcome monitoring.

I suspect we’re getting a better throughput, so almost having been able to access more people because we’re able to close [cases], having said “well, these were your goals, your symptoms have improved… this is your relapse prevention plan, we’ll do it together and this is how you can come back”’. (Staff)

Self-referral (see p. 4), more open referral routes, a single point of access, outreach services, and evening and weekend appointments were described as improving service access. Parents reported being seen within one month (21% or 9 parents), between one to two months (38%, 16), between three to five months (24%, 10), or longer (20%, 8).

A TRANSFORMED SERVICE IS A LEARNING ORGANISATION

Using a validated questionnaire (Glisson, et al., 2007) it was found that, compared to a national sample of mental health services in the United States, teams in CYP IAPT had more proficient organisational cultures and more functional organisational climates. This may suggest that services are successful in supporting the development of a skilled and cooperative workforce with clearly defined roles and a focus on the needs of service users. However, teams in CYP IAPT had more rigid and resistant organisational cultures and less engaged and more stressful organisational climates than US counterparts. This may suggest that there are still challenges for clinicians in embedding new ways for working and that concomitant service reorganisations, higher levels of need compared to service provision (The Centre for Economic Performance’s Mental Health Policy Group, 2012), and service cutbacks (Young Minds, 2014) present ongoing contextual challenges.

In line with these survey findings, the staff interviews revealed that team relationships were the area in most need of improvement. Senior management commitment was seen as crucial to strong leadership and service transformation, particularly when facing a number of contextual barriers to service transformation. Whole team training as part of CYP IAPT, particularly focused on overcoming local contextual challenges and other service changes, may be useful to sustain and spread CYP IAPT going forward.

Areas of continuing improvement suggested by young people were increased opening times, better IT systems to enable information sharing, and more information about CAMHS but also about mental health and wellbeing in the community to raise awareness.

A TRANSFORMED SERVICE IS MORE EVIDENCE BASED

Clinicians described CYP IAPT as having embedded evidence-based treatments in their service and improving young people’s access to evidence-based treatments. Clinicians described feeling more confident in delivering evidence-based treatments as a result of CYP IAPT and that evidence is used in conjunction with patient preferences and clinical judgment.

In terms of treatment, [CYP IAPT] has had a significant impact because it has enabled young people to access evidence-based treatments, whereas before they would have never been able to access that and therefore they may not have received the right treatment and…have prolonged mental health issues. (Staff)

Of those clinicians trained in NICE-recommended therapies, 97% (38) were still offering the therapy. However, use of evidence-based treatments was less frequent in the routinely collected
data. Of the 1,268 young people presenting with depression or anxiety (Jones, et al., 2013) 27% (345) received CBT. The standardised effect size of closed cases according to the Revised Children’s Anxiety and Depression Scales (RCADS) (Weiss & Chorpita, 2011) was between 0.16-0.58 (95% CI = 0.02-0.68). Of those young people whose cases were closed and were above clinical cut off according to the RCADS at time 1, 28-57% (21-75) achieved recovery at time 2 (or 11-39% [4-14] according to parent-report).

The differences between self-reports of embedding evidence-based treatments and use in the routinely collected data may be due to data quality and under-reporting or because those trained were unable to deliver the therapy. On the one hand, of those clinicians trained in NICE-recommended therapies, 83% (33) were still receiving supervision in the corresponding therapy. On the other hand, in the staff interviews, clinicians reported a need for the high-quality support received during training to continue after training. Contextual factors were also reported as a barrier to delivering evidence-based treatments: “staff ready and trained who can’t deliver, through service cuts” (Staff).

A TRANSFORMED SERVICE IS OUTCOMES-FOCUSED

Most staff reported that CYP IAPT had increased the use of outcome monitoring. Session-by-session monitoring was described as supporting shared decision making and improving the ability to review treatment progress. Young people and parents echoed this, reporting that it helps to “keep things focused” (Young person).

I always fill in the questionnaire before I start and look at the progress. It’s good to see how much you’ve progressed; it means that you can actually realise what you have progressed to ‘cos, s’pose if you don’t really write it down or say it out loud, you don’t really realise how much you’ve progressed until it’s kinda spoken to you. (Young person)

Young people and parents reported mixed experiences of outcome monitoring and that it was less helpful if not clearly explained or discussed. All groups reported that there was still more work to be done to embed monitoring, particularly around IT, discussing measures with service users, and using measures to review treatment progress or in supervision. This was mirrored in the routinely collected data. Of the total sample of 6,803 young people24, 83% (5,633) of CYP had an assessment measure recorded. Of those 3,939 CYP who had at least two sessions recorded25, 42% (1,639) had matched T1-T2 scores on an outcome measure. Of those 2,690 CYP who had at least three sessions recorded26, 49% (1,322) of children had any sessional measure used in at least two sessions and 44% (1,184) of children had any sessional measure used in at least three sessions.

A TRANSFORMED SERVICE PRIORITISES SERVICE USER INVOLVEMENT

CYP IAPT and the participation groups were described by clinicians as having given children and young people “a voice in a massive way” (Staff). Young people described involvement as giving them a personal sense of worth and empowerment. Although young people felt listened to during participation actives, they were less aware of changes to the service that had been made as a result of feedback. Young people were involved in service design and delivery in a variety of ways,

24 With complete age, gender, and at least one Current View Tool item recorded.
25 For the possibility of two measures having been administered.
26 Assuming the first session was assessment and the last session was discharge or case closure, there would be at least one treatment session in which a sessional measure could have been used (Law & Wolpert, 2014).
including: recruitment and interview panels, staff appraisal and training, website and information design, planning and delivery of a mental health awareness day for the wider population, “Mystery shopped” service evaluation, environmental changes, speaking to directors, new feedback systems (e.g., traffic light system), “You said, we did” board, discussions of more frequent appointments and extended opening hours, finding different locations to hold sessions where young feel more comfortable, and the “Y Factor” where young people have the opportunity to talk to other young people about mental health.

These changes to service delivery and design may have improved engagement with services, and the percentage of closed cases by mutual agreement to end treatment (vs. all other reasons) increased from 34% in 2010 (n = 5 services) to 55% in 2014 (n = 10 services). There was also a decrease in the proportion of DNAs to total accepted referrals from 1.17 in 2010 (n = 7 services) to 0.99 in 2014 (n = 11 services).

Young people reported feeling involved in treatment once treatment begins but not necessarily during the assessment process. This may suggest that further work to engage young people and parents at the initial stages of contact is needed or alternatively, that changes already made to services have not had sufficient time to make a difference to early engagement.

A TRANSFORMED SERVICE SUPPORTS SELF-REFERRAL

The percentage of accepted self-referrals out of all accepted referrals increased from 1.21% in 2010 (n = 7 services) to 2.65% in 2014 (n = 11 services) in the service-level data reported by partnerships. Young people reported having been able to self-refer and that there was information available in their service about self-referral, however they also thought that the process of self-referral could be simplified. The majority of parents reported wanting to be able to self-refer but currently not being able to.
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