Northumbria University
NEWCASTLE

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Protocol

(Version 3)

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Table of Contents

1.Background and Study Rationale

This research study firstly aims to evaluate the delivery of Northumbria University's clinical training in Parent-led Cognitive Behavioural Therapy, a psychological intervention designed to help parents/carers to support their child with their fears and worries. The training in this intervention is delivered through selected Higher Education Institutes (HEI's) and forms part of a 'recruit to train' initiative funded by the UK Government (Health Education England) to educate a new workforce of Low Intensity Psychological Practitioners, Children's Wellbeing Practitioners and Education Mental Health Practitioners.

Secondly, the study would like to explore how this training may affect low intensity psychological practitioners' confidence and competence in delivering this clinical intervention within clinical practice and if these factors may affect or translate into better clinical outcomes for children, young people, and their families. The following background and contextual information relating to the Children and Young People's Increasing Access to Psychological Therapies Initiative (CYP-IAPT) and Parent-led CBT interventions will be explored further here with a clear rationale provided for the focus of this study.

Access to Child and Adolescent Mental Health Services (CAMHS) and specialist support for CYP has over the years fallen short of expectations. In 2007 the UK government launched the Improving Access to Psychological Therapies (IAPT) initiative which comprised of a large-scale attempt to improve access to evidence-based psychological therapies for adults with depression and anxiety disorders (DoH, 2012). It was later extended (2011) to cover the CYP-IAPT programme which aimed to improve services delivering mental health care to CYP and their families, as an extension to the adult initiative. As a government funded agenda CYP-IAPT aimed to improve this access to evidence-based psychological therapies by 'transforming' the existing workforce through an initiative of up-skilling and training as well as effectively monitoring and enhancing clinical outcomes and capturing service user experiences. This initiative however was not without its criticisms, (Timimi, 2015) suggested that this led to reduced patient choice (with a focus favourably on approaches such as depression and anxiety or parenting management). CYP-IAPT also created issues with staffing, with clinicians attending university courses and having to step out of clinical practice, leaving a gap in their role and need for funding to back-fill their post. Furthermore, Timimi (2015) reported increased waiting times and reduced access to CYP mental health services particularly for those most in need.

In 2017, seeking to address such difficulties, the DoH and DfE's Green Paper 'Transforming Children and Young People's Mental Health Provision' pledged further resources to continue improving access and the availability of first-line treatments such as Cognitive Behavioural Therapy (CBT) interventions for CYP by recruiting and training (up to 8,000) new staff and offering brief low intensity (LI) evidence-based interventions in a timely way (Ludlow *et al.,* 2020). These ambitious extension plans outlined by the Government aimed to increase not only the existing Child and Adolescent Mental Health (CAMHS) workforce but to create a new schools-based mental health workforce with a suggested rollout to reach 20,000 schools and colleges by 2023 (DoH, 2017).

As part of this policy, new specialist roles consisting of Children's Wellbeing Practitioners (CWPs) were initially created (2017) and later (2019) Education Mental Health Practitioners (EMHPs) were established to deliver LI interventions within settings such as existing CAMHS, schools and colleges. The rationale and focus on Services being further 'transformed' by this 'recruit to train' initiative with selected Higher Education Institutes (HEIs) delivering high quality training in routine outcome monitoring, service user participation, and evidence-based psychological therapies including therapist guided self-help principles (GSH), thus freeing up existing high intensity specialist clinicians who were struggling to work through the volume of more complex cases within specialist CAMHS (Fonagy 2019).

As the training of LI practitioners within CYP-IAPT is still in its infancy there is limited research available to determine the effectiveness of both the role of the LI practitioner and the effectiveness of LI interventions within these settings. Currently evaluative data in this field is considered to be sparce (Fuggle and Hepburn 2019). There have been calls too for a greater scrutiny of the CYP-IAPT models to avoid the mistakes made from the implementation of the adult IAPT model which was criticised for focusing too much on cognitive behavioural therapies and short-term treatments (Timimi 2015). Additional criticism was drawn for not considering staff stress levels which can lead to staff burn out (Westwood et al., 2017) and low patient recovery rates (Scott 2018). Furthermore Ludlow et al., 2020 suggests that LI CYP-IAPT interventions do show promise however it is imperative that robust evaluation of the CWP and EMHP programs is implemented.

1.1 CBT and Parent-led CBT interventions

CBT is a NICE recognised evidence-based treatment often used in the treatment of anxiety disorders in children. It is one of the most commonly evaluated treatments for anxiety disorders in CYP (Thirlwall *et al*., 2013) with many programmes now being offered to CYP and their families. James (2015) completed a systematic review assessing the effectiveness of CBT in treating anxiety disorders in CYP with findings indicating that CBT delivered individually or as a group were both significantly effective in reducing anxiety symptoms. To date there have been numerous studies that have investigated high intensity treatment programmes for children with anxiety disorders (Esbjørn *et al*., 2019) which have shown that CBT is effective in treating childhood anxiety when delivered by trained therapists on a weekly basis (James *et al*., 2013).

A relatively new LI treatment approach adopted within the CYP-IAPT core training programmes within HEIs is Parent-led CBT (Creswell, 2019) which utilises guided self-help (GSH) principles which aims to work collaboratively with parents to develop skills and confidence to support their children to overcome difficulties with anxiety. This approach requires less therapist contact time and fewer resources than standard forms of CBT (Lyneham & Rapee 2006). Positive outcomes have been reported in a number of studies for example, Cartwright-Hatton et al., (2011) reported 32% of children were free from all anxiety disorders post treatment with Evans et al., (2018) reporting 70% of children did not require any further treatment.

A recent study by Evans *et al.,* (2019) which evaluated Group Parent-Led CBT programmes in routine clinical practice found approximately 70% of children receiving this intervention did not require further treatment for anxiety difficulties post-group suggesting that this intervention in a group format can be a helpful low intensity treatment. Notably Group Parent-Led CBT was viewed by clinicians as acceptable and helpful with group process factors seen as providing additional benefits. The clinicians involved in this particular study were however predominately experienced staff with diverse training backgrounds and not LI 'recruit to train' practitioners.

There have been documented challenges with general data collection and reporting (within CYP-IAPT) as reported by Timimi (2015) particularly with return rates for second scores of patient related outcome measures (PROMS) with return/collection rates being low. This makes it difficult to determine the overall effectiveness of clinical interventions such as for example Parent-led CBT which in turn can hinder the evaluation process needed to support clinical improvements (Wolpert, 2014). Collecting outcome data will be an integral part of this study with LI practitioners being asked to collect Routine Outcome Measures such as the Revised Children's Anxiety and Depression Scale (RCADS: 47) Parent Report Version, Parents Goal Based Outcomes (GBOs) as well as End of Service questionnaires to help with the evaluation process of this LI intervention.

1.2 Training in Brief Parent-led CBT

At Northumbria University this is provided as part of the CYP IAPT course curriculum and is delivered over a 4-day period for CWPs and EMHPs. The training follows the manualised treatment approach devised by Creswell & Willetts *et al.*, (2019). Recruit to train trainee CWPs and EMHPs are taught how to work directly with parents on a 1-1 basis using this manualised protocol. Sessions with parents/carers are facilitated over 8 treatment sessions which include a combination of face-to-face sessions and telephone sessions. Parents/carers are supported to work through the guided self-help book implementing strategies and CBT techniques with their child at home (children do not attend the sessions along with their parents/carers). Parent-led CBT training aims to provide education in the development and maintenance of anxiety disorders in children and specifically how parents can be supported by practitioners to independently help their child overcome anxiety difficulties. Examples of the specific content include understanding CYPs fears, worries, and anxieties, setting realistic goals, encouraging brave and independent behaviour by using a step-by-step approach to overcoming fears and worries, managing physical symptoms of anxiety, problem solving and how to keep it all going.

1.3 Study Rationale

As literature suggests LI programmes such as Parent-led CBT which use a GSH focus are beneficial to parents (Creswell *et al.*, 2017, Evans *et al.*, 2019) however very little research has been carried out to date involving clinical interventions which are facilitated by LI trained practitioners such as CWPs and EMHPs. The main focus of this study will be on evaluating the quality and delivery of university training in the Parent-Led CBT manualised approach to determine how university training may affect self-perceived confidence and competence of LI practitioners and how this experience of training and supervision support may then translate into better clinical outcomes for families.

2. Theoretical Approach

The researcher will consider both the ontological and epistemological positions relating to research (i.e., how reality is viewed and how knowledge is created, respectively) and will align closely with an interpretivist/constructivist paradigm. Cohen and Manion (1994, pg. 36) refer to the interpretivist/constructivist stance as 'understanding the world of human experiences' with Mertens (2005 pg. 12) suggesting that 'reality is socially constructed'. The focus for the researcher will be on obtaining the 'participants' views' (Creswell, 2003, pg. 8) to support the analysis by means of qualitative data collection or in some situations through collation of quantitative data.

This study will primarily be a practitioner-based action research project which allows the researcher to be 'at the centre of the project' (Lees, 2001, p. 135), an advantageous position allowing the researcher to use her knowledge of psychological clinical interventions gained from professional training in CBT as well as drawing upon her academic qualifications gained through post graduate study to support the research process. Practitioner based research or practitioner action research are terms often used interchangeably within the literature (Kemmis 2006, 2009 and Bartlett & Burton 2006). Indeed, a key component of both practitioner research and action research are reflective practice and reflexivity. Reflective practice is concerned with the practitioner or researcher understanding and analysing an element of practice occurring in a particular moment (usually self-reflection), which is useful in supporting change and improving practice. However, reflexivity is more of an ongoing process where there is a deeper level of exploration by the practitioner or researcher particularly not only on their own experiences, their assumptions, and beliefs but how this may influence or affect the research process. Braun and Clark (2022 pg.5) note that 'reflexivity involves a disciplined practice of critically interrogating what we do, how and why we do it and the impacts and influences of this on our own research'.

The researcher in the present study aims to carry out further analysis of reflective and reflexive practice which may include taking a radical stance. Radical reflexivity described by Cuncliffe (2003, pg. 983) is a process in which researchers question differences made between fact and fiction, perceptions of knowledge and 'our purpose and practice as researchers'. Theoretical perspectives pertaining to pedagogical theories (for example cognitive learning theory, constructivism and experiential learning) as well as social learning theories (for example drawing upon the work of Bandura (1963), observational learning/modelling) will also be explored to support a deep analysis of the research which can assist in informing, analysing, and improving training and practice.

3. Research Project Aims/Objectives

This research project will include observations within the natural environment and will be a cross-sectional study.

The aims of this study are:

1. To explore LI practitioner views and experiences of how Northumbria University's 4-day training programme utilising the manualised Parent-Led CBT treatment approach is delivered. Does the programme delivery meet its learning aims and objectives and does the training effectively 'equip' practitioners in competently delivering this evidence-based intervention with parents?
2. To explore what factors may influence self-perceived practitioner confidence and competence in delivering a Parent-led CBT intervention within the community setting and to determine how these factors may influence or affect programme delivery.
3. To examine the usefulness of using a Parent-led CBT competency rating tool within clinical supervision. How does the tool affect confidence and competence of LI practitioners, and does it result in improved outcomes for parents?
4. To evaluate if Parent-led CBT interventions facilitated by LI practitioners are effective. This will be achieved by obtaining the views of participants (parents/carers) via a questionnaire

and by examining clinical outcome data to determine whether treatment goals have been achieved.

4. Study Design

The study will adopt a mixed methods approach using both quantitative and qualitative data collection and analysis. A thematic analysis of data (Braun and Clarke 2006) will be undertaken. Whilst this is not identified as a research paradigm this method of analysis is flexible and can be used with different theoretical perspectives. An inductive process will be adopted allowing patterns or themes to emerge from the collated data rather than from the theoretical data itself. This approach fits with a constructivist researcher stance where the focus fits more with qualitative data collection methods and analysis. It can however also be a feature of both qualitative and quantitative data analysis.

4.1 Qualitative Data

LI qualified practitioners/trainees/supervisors:

- Qualified LI practitioners and trainees will be invited to complete the researcher's evaluation of training form which will capture individual reflections of experiences of receiving training in Parent-led CBT with opportunities to add free text. *(Aligns with Primary obj.1)*

- Qualified LI practitioners, trainees and supervisors (post PLCBT session delivery) will also be invited to complete a questionnaire via JISCs commenting on the utility and usefulness of using a PLCBT competency rating scale/marking tool following 'live supervision' of practice. *(Aligns with Primary obj.3)*

4.2 Quantitative Data

LI qualified practitioners/trainees/supervisors:

- Pre-PLCBT intervention (and post university training), qualified LI practitioners and trainees will be invited to complete a pre-intervention PLCBT university competence tool incorporating a self-rating scale capturing self-perceived level of skill and confidence. The competence tool is based on the Dreyfus and Dreyfus model of Skill Acquisition (1986), a 5-point Likert scale which is used to assess and support progress in the development of skills or competencies. The self-rating tool asks practitioners to rate their self-perceived level of skills as being either; novice, advanced beginner, competent, proficient or expert. Additionally, a 5-Likert scale of confidence adapted from Joshi *et al* 2015, will be used to capture self-perceived levels of confidence. *(Aligns with Primary obj. 2)*

- Post-PLCBT intervention LI practitioners and trainees (following an observation of a clinical recording of practice in supervision) will be asked to re-rate their self-perceived level of skills and competence using the PLCBT university competence tool incorporating the Dreyfus and Dreyfus scale (1986) and the 5-Likert scale of confidence. Self-perceived post-competency scores will be generated. *(Aligns with Primary obj.2,3)*

- Supervisors will be asked to view the qualified practitioner or trainee's 'live session recording' and then use the university devised competency tool incorporating the Dreyfus and Dreyfus competency rating scale (1986) and the 5-Likert scale of confidence to generate both a competency rating score for skill and confidence. *(Aligns with Primary obj.2,3)*

Parents/Carers:

- Parents/Carers will be asked to complete the Revised Children's Anxiety and Depression Scale (RCADS: 47 P) Parent Report Version, (Chorpita, Moffitt & Gray, 2005). This is a 47 item self-report questionnaire which is routinely collected in clinical practice. This measures six subscales; major depressive disorder (MDD), generalised anxiety disorder (GAD), obsessive compulsive disorder (OCD), panic disorder (PD), separation anxiety disorder (SAD), social phobia (SP), as well as a total anxiety and total depression scores. Items are scored between 0-3 on a 4-point Likert scale which corresponds to responses of never, sometimes, often, or always. The RCADS has been shown to demonstrate good internal reliability in both clinical and non-clinical samples (Chorpita, Yim, Moffitt, Umemoto & Francis, 2000); Chorpita, Moffitt & Gray, 2005). Pre and post scores will be collected. *(Aligns with Primary obj.4)*
- Parental Goal Based Outcomes (Law & Jacob 2015) will be collated. Goal-Based Outcomes (GBOs) are a self-report measure of progress toward one or more identified idiosyncratic goals. Goals are rated pre- and post-intervention on a 10-point scale. Higher scores indicate progress toward meeting a specified goal. As a clinical tool, GBOs are described as having good face validity and correlate well with other tools measuring symptom change (Law, 2019). GBOs are routinely collected in clinical practice and can provide information about whether parents attending programmes have achieved their goals and may help to determine whether a Parent-led CBT intervention has successfully met needs. *(Aligns with Primary obj.4)*

- Parental evaluations of treatment sessions will be obtained through the Experience of Service Questionnaires (Law & Jacob 2015). These are also routinely collected in clinical practice and used by Services as a reflective tool to evaluate interventions. *(Aligns with Primary obj.4)*

5. Study Population

In 2011 Northumbria University was chosen as the North East's training provider by NHS England to help improve the outcomes for CYP experiencing mental health difficulties. Within this partnership arrangement health commissioners and providers (NHS Trusts and the community and voluntary sectors) have been established to provide training across a wide geographical area covering the North East & North Cumbria and Yorkshire & Humber. There are 20 partnerships involved within this Collaborative.

5.1 Sample Size and Recruitment

Since the commencement of LI practitioner training (CWPs, 2017 and EMHPs, 2019) approximately 310 practitioners within the Collaborative area have completed training in Parent-led CBT. There were 94 new trainees who commenced training in November 2021 who will receive Parent-Led CBT training in April and May 2022 with course completion in August 2022. Therefore, there is a potential to recruit from a total of 404 practitioner participants.

A priori sample size calculation has therefore been undertaken to estimate the number of participants required to enable a viable study. Using the Wilcoxon signed-rank test (matched pairs) and using a two tailed prediction a power calculation has been generated. This will enable comparison of scores on the RCADS: 47 Parent Report Version pre- and post- versions, (Chorpita, Moffitt & Gray, 2005) and Parental Goal Based Outcomes (Law & Jacob 2015). To detect a medium effect *(d=0.5) a minimum sample size* of 40 is required for 0.5 power with a medium effect, (Cohen, 1992). If a sample size of 80 is achieved with 0.5 power this will give a smaller effect size of 0.3 or if a sample size of 100 is achieved with a 0.5 power this will give a 0.2 effect size allowing for greater differences to be viewed.

Previous similar studies have been considered when completing this calculation for example, Kirk et al., (2022, in publication) which evaluated low-intensity interventions delivered by trainee CWPs for the treatment of anxiety and depression in a child and adolescent mental health service (CAMHS). This evaluation adopted a quantitative, within-subjects, cross-sectional design. The outcome measures of 98 service users aged 8-17 years were included in the evaluation. A repeated measures ANOVA (2x2 design) was conducted to identify any significant differences in RCADS-47 total anxiety and depression scores pre- and post- intervention. Presenting problem (anxiety or depression) was used as the between-subjects variable and time as the within-subjects variable. A priori power calculations conducted in this study for repeated measures ANOVA and t-tests (one-tailed prediction) specified a minimum sample of 98 and 27 participants required for 0.8 power with a medium effect size (Cohen, 1992). The data within this study was compared to normative data in the de Ross, Gullone & Chorpita, (2002) study in which pre- and post- intervention RCADS-47 scores were analysed and compared. Normative data included a sample of 405 children and adolescents aged 8 to 18 (mean age = 13.24 years, standard deviation = 2.52) from 18 primary and secondary schools in Victoria, Australia. The findings of the Kirk et al., (2022) study found that repeated measures ANOVA and Wilcoxon signed rank test showed a significant improvement in total anxiety and depression scores on the RCADS as well as GBO's post- CWP intervention.

6. Inclusion and Exclusion Criteria

6.1 Inclusion Criteria

- This study intends to recruit: 1) qualified LI practitioners (CWPs and EMHPs) currently working in clinical practice, and 2) LI practitioner trainees (CWPs and EMHPs) who have received PLCBT training as part of their course and are clinically active in practice.
- Only participants who have/or are currently attending a programme of study at Northumbria University and who are currently delivering either a Parent-led CBT group or an individual programme to parents.
- LI practitioners must be receiving regular clinical supervision as part of their role. (All LI qualified practitioners and current trainees currently working within Services should be receiving regular 'live' clinical supervision as this is a standard requirement).

- LI practitioners must be willing to and have obtained consent from families to record ‘live’ clinical practice sessions for supervision purposes and for their information to be included in the study.

6.2 Exclusion Criteria

LI Practitioners who

- Have not attended a Northumbria University training programme.
- Are not receiving ‘live’ clinical supervision as part of their role.
- Are unable to (i.e., have not obtained parental consent) or do not have access to record ‘live’ sessions as part of their supervision practices.

7. Strategies for Recruitment

The main recruitment strategy will be to email all Services who are either currently participating or who have participated previously in the ‘recruit-to-train initiative’ within the Collaborative. A poster advert will be sent via email to Service Leads asking for expressions of interest from their CWPs, EMHPs and clinical supervisors inviting them to participate.

To raise the study profile, it will also be discussed at the local mental health support team meetings (held monthly) which are attended by university staff and Service Leads from the Collaborative. The researcher will be available to answer any questions about the study and will encourage participation.

7.1 Participant Retention

LI practitioners who agree to participate in the first component of the study (feedback evaluations and questionnaires of university teaching) will then be invited to complete the further components (clinical competency and confidence self-rating tools collected pre- and post-PLCBT intervention, information will also be sought from clinical supervisors). If LI practitioners complete the first component but then do not complete the further components after 2 email reminders, then it will be assumed that they no longer wish to participate in the study. All data collected prior to this will be retained.

7.2. Participant withdrawal

Participants can choose to withdraw from the study and can request for their data which has already been collected to be removed. To do so they would need to contact the researcher. Although it will not be possible to remove data once data analysis has started as it will be anonymised. This will be explained in the Participant Information Sheet and relevant contact details provided.

8. Data Collection, Screening and Analysis

8.1 Screening Questions

At the beginning of the study potential participants will be asked screening questions to ensure they meet the inclusion criteria for the study. If they do not meet the criteria, then the survey will end at this point, and they will not then be included in the study. Participants will also be asked to consent to provide their email so that information can be sent and then collated at the appropriate timepoints.

8.2 Data Collection Surveys

Joint information systems committee surveys (JISC) are the preferred choice for collecting questionnaire/survey data. In addition to the survey data outlined in this protocol, it will also be necessary to collect name, e-mail addresses and work telephone numbers to ensure practitioners/trainees have access to the questionnaires. This data will be stored on a password protected Microsoft Excel spreadsheet held on the researcher's Secure OneDrive account which is password protected and will be separate to the survey data and only accessible by the researcher.

8.3 Collection of Data from Services

The researcher will send the participating Service a data collection sheet using an excel word format. Anonymised outcome data will be populated onto the excel sheet by the Service/Practitioner and will be sent to the researcher via a secure University OneDrive link. Anonymised 'End of Service' questionnaires completed by parents/carers (with the Practitioners ID clearly written at the top) will be sent to the researcher again via a Secure OneDrive link. All data will be held on the researcher's secure university OneDrive account which is password protected and accessible only to the researcher.

The table below outlines the proposed survey plans/data collection points and timescales:

	Baseline	2-3 months	12 months	18 months
Initial screening questions and consent form (via JISC) (Low Intensity Practitioners – EMHPs, CWPs). Collection of emails and contact details from participants.	X			
Demographics	X			
Initial questions about previous experiences and	X			

knowledge of low intensity CBT.				
Questionnaires about University training experiences and training evaluations		X		
Collection of LI Practitioners/Trainee's self-perceived competency rating Pre-scores based on the Dreyfus and Dreyfus model of Skill Acquisition (1986) and a 5-Likert scale of confidence. (Pre-scores collated).		x		
Collection of Service data from parents/carers including outcomes measures such as pre and post RCADS, Goal-based outcomes (GBO's) and End of service evaluations.			X	
Collection of LI Practitioners/Trainee's (and Supervisors) self-perceived competency rating Post-scores based on the Dreyfus and Dreyfus model of Skill Acquisition (1986) and a 5-Likert scale of confidence.			X	X
JISC Survey Practitioners/Trainees and Supervisors requesting feedback about the utility of using the scoring tool in supervision.			x	x

8.4 Data Analysis

Quantitative data analysis

Pre- and post- RCADS-47 P (Parent version) will be analysed using the statistical package (SPSS). Aggregated progress scores of up to three Parent/carer GBOs will also be compared using Wilcoxon signed rank tests. Both SPSS and descriptive statistics will be produced to summarise quantitative data collected from the Mental Health Services. Descriptive statistics is useful to organise and present data from a study in an informative way that best describes the basic features of the data and enables analysis (Martin & McFerran, 2008).

Qualitative data analysis

Thematic analysis of qualitative data (obtained via questionnaires and feedback forms) will be in accordance with the framework provided by Braun and Clarke (2022) which will support the identification of key emergent themes. For the data to be linked to the participants a unique study ID will be assigned to each participant, so they are anonymous for the data analysis. Data will be analysed using NVivo or Atlas. The data sets will not contain any personal identifiable information.

8.5 Missing data

If participants (practitioners/trainee's) do not complete the full surveys the data already collected may still be used in the analysis where applicable.

If a participant does not answer specific questions either by leaving the answer blank or selecting 'prefer not to answer' they will only be excluded from the specific analysis where data is required but will be included on other analysis for which they have completed all the necessary information.

9. Data Storage

Data (such as completed practitioner questionnaires, parent outcome measures, goal-based outcomes and end of service questionnaires) will be stored on the researcher's Northumbria University OneDrive system to ensure it is backed up in line with the University IT and Information Governance procedures. This is a secure system which is password protected which only the researcher has access to.

In line with the Northumbria University research data management policy the survey data will be retained for three years after the project completion as stipulated in the retention schedule for medium risk studies.

Identifiable data such as name and contact details of practitioners will be destroyed after the final survey data collection has been completed as it will no longer be required.

10. Ethical Considerations

Ethical considerations for this study will be in accordance with Northumbria University's Research Governance Framework (2020), the NHS Research Ethics Committee and the Health Research Authority (HRA). Ethical approval will be gained from Northumbria University Ethics Committee prior to recruitment. NHS research passport applications will be made which will allow research activity to be carried out within the Services who agreed to take part in this study. Once this is in place the completed passports will be forwarded to the NHS Trusts. All data will be handled in accordance with the Data Protection Act 1998 and GDPR 2018.

10.1 Informed Consent

Potential participants (practitioners/trainees) will be emailed an invitation (via Service Leads) to participate which will include an information sheet this will outline the study details including what they should expect if they agree to participate. The information sheet will include details of the researcher should they require any further information.

Parents/carers will be invited to participate in the research study and will be recruited by the participating Service. A parent/carer information sheet will provide information about the study for parents/carers. Should parents/carers wish to participate then the Service will complete the devised consent forms which include a video recording form and a data collection form, both consent forms will be held by the Service as these will include parent/carer identifiable information such as names. If parents/carers do not give consent for the session to be recorded, then the practitioner will not include the parent/carer in the study.

10.2 Confidentiality and Data Protection/Storage of Data

Details of (practitioner) participant email addresses and service data will need to be collated and stored securely on a password protected spreadsheet held within the Researcher's Secure OneDrive account. The researcher will be the only person who has access to this information. Participant and Service data will be allocated a unique study number so they cannot be identified, but their questionnaires can be linked. The study will be compliant with the requirements of the Data Protection Act 1998.

At the end of the research study and in line with the Northumbria University research data management policy the anonymised survey data will be retained for three years after the project completion as stipulated in the retention schedule for medium risk studies.

Any identifiable data such as name and contact details of practitioners/trainee's will be destroyed after the final survey data collection has been completed as it will no longer be required.

10.3 Video recordings

Video recordings of PLCBT sessions carried out with parents/s will be facilitated by the Service and stored on a Service encrypted laptop which is password protected and accessible only to the practitioner. The video will be watched by the practitioner and supervisor together as part of a supervision session which will form part of a supervisory discussion to support best practice. Parents/Carers and practitioners will give their consent for the video to be recorded and will sign consent forms. Consent forms will be retained by the Service only. Once the video has been watched it will be deleted from the Service's encrypted laptop or recording device in line with General Data Protection Regulations (GDPR). The researcher will not have any access to the LI practitioners clinical recordings. The video recording will not be viewed by any other person and will be stored safely by the practitioner as part of the Service's policies and in line with GDPR guidance.

10.4 Disclosures

It is possible that completion of the questionnaires may generate some anxieties for practitioners therefore the information sheet will include information of where to access support if required.

10.5 Definition end of study

The study will end following collection of the final data and materials, this will be in March 2025. This research study and its associated documents is consistent with other research studies of this nature/type.

11. Appendices

Appendix 1 – Draft e-mail to Services

Dear qualified low intensity practitioners (children's wellbeing practitioners and education wellbeing practitioners), current trainees and service supervisors.

The researcher would like to invite participants to join the research study exploring, 'How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?'

Qualified practitioners and current trainees who are delivering or are planning to deliver a Parent led-CBT intervention either in a 1-1 format with parent/s or a group format with parents and who are receiving clinical supervision as part of their clinical role are invited to participate.

The research study is voluntary if you wish to participate. I would like to direct you to the attached poster and accompanying information sheet before considering if you would like to take part.

The aims of this study are:

1. To explore LI practitioner views and experiences of how Northumbria University's 4-day training programme utilising the manualised Parent-led CBT treatment approach is delivered. Does the programme delivery meet its learning aims and objectives and does the training effectively 'equip' practitioners in competently delivering this evidence-based intervention with parents?
2. To explore what factors may influence self-perceived practitioner confidence and competence in delivering a Parent-led CBT intervention within the community setting and to determine how these factors may influence or affect programme delivery.
3. To examine the usefulness of using a Parent-led CBT competency rating tool within clinical supervision. How does the tool affect confidence and competence of LI practitioners, and does it result in improved outcomes for parents?
4. To evaluate if Parent-led CBT interventions facilitated by LI practitioners are effective. This will be achieved by obtaining the views of participants (parents/carers) via a questionnaire and by examining clinical outcome data to determine whether treatment goals have been achieved.

The study is being conducted by the researcher, Michealla Lincoln (Assistant Professor within the CYP-IAPT Team) as part of a PhD.

If you would like further details about the study, please contact the researcher on the following e-mail address m.lincoln@northumbria.ac.uk

Kind regards

Participant Information Sheet (Practitioners)

The purpose of this information sheet is to provide you with sufficient information so that you can decide if you wish to participate in this study. Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you are willing to take part.

Research Title

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln (PhD Student)

Research Aims:

1. ***To explore*** low intensity practitioner views and experiences of how Northumbria University's 4-day training programme utilising the manualised Parent-led CBT treatment approach is delivered. Does the programme delivery meet its learning aims and objectives and does the training effectively 'equip' practitioners in competently delivering this evidence-based intervention with parents/carers?
2. ***To identify*** what factors may influence self-perceived practitioner confidence and skill in delivering a Parent-led CBT intervention within the community setting and to determine how these factors may influence or affect programme delivery.
3. ***To examine*** the usefulness of using a Parent-led CBT competency rating tool within clinical supervision. How does the tool affect confidence and skill of LI practitioners, and does it result in improved outcomes for parents/carers?
4. ***To evaluate*** if Parent-led CBT interventions facilitated by LI practitioners are effective. This will be achieved by exploring the views of participants (parents/carers) and by examining clinical outcome data to determine whether treatment goals have been achieved.

Why have I been invited?

You have been selected to take part in the research study as you have attended or are currently attending a 'recruit to train' psychological therapy programme (either, Children's Wellbeing Practitioner or Education Mental Health Practitioner programme) at Northumbria University. As the study is examining the above components this places you in an ideal position to participate in this research project and the researcher would welcome your support to carry out this research. By listening to you, we can use your views to help shape education and training for the better.

Do I have to take part in the study?

No, participation in this study is completely voluntary. This information sheet is designed to help you make that decision. You are completely free to decide whether you would like to take part. If you decide to take part, then later decide to withdraw from the study you can do so at any time by contacting the researcher via email: m.lincoln@northumbria.ac.uk.

During the study if you do not complete the questionnaires two reminder prompts to complete the surveys/questionnaires and two reminder prompts to provide the following necessary data requested by the researcher will be sent to you. If after the prompts you do not complete these or they are not returned after the reminder then it will be assumed, you no longer wish to participate. Any data however already collected will still be used unless you email the researcher to ask for this to be removed.

What will I have to do?

- Complete an initial online screening questionnaire
- An online questionnaire giving feedback on your experiences of training at Northumbria University.
- Facilitate either a 1-1 Parent-led CBT session or small group session with parents.
- Using your Service's encrypted laptop or Service's recording device record a PLCBT clinical session for the purposes of clinical supervision.
- Complete a self-rating competency tool pre-and-post PLCBT delivery reflecting on your clinical skills and levels of confidence. You will then be asked to review this with your clinical supervisor and be willing to provide reflective feedback to the researcher via the feedback form.
- Collect parent/carer routine outcome data as part of the intervention, including asking parent/carers to complete an anonymous end of service questionnaire at the end of treatment.

Consent to Participate: Data Collection

If you agree to participate in the study, you will be giving us your consent by clicking on the on-line link and completing the consent 'to participate' box. You will then complete the first questionnaire. You will be asked to provide suitable contact details when you complete the first survey enabling the further survey questionnaires to be sent to you.

Consent to Participate: Video Recording

If you agree to participate in the study, you will also be invited to complete a consent form giving permission to record the clinical session between you and the parent/carer for the purposes of supportive in-Service clinical supervision. The consent form will remain within the Service and will not be sent to the researcher as the parent's name is also recorded on this form. The recording will capture either a one-to-one clinical session between you and the parent/carer, or a group session, if all participants agree to be recorded). The video recording will be via an encrypted Service laptop or Service recording device and will be held securely on that device for the purposes of in-Service clinical supervision only. *The recording will only be viewed by the practitioner and your in-Service Supervisor*. Once the recording has been viewed it will be deleted from the encrypted device. The purpose of this recording is so the practitioner can discuss with their in-Service supervisor how they have conducted the session using the parent led cognitive behaviour programme materials and discuss how confident and skilled they feel in delivering this treatment session with parents/carers. Supervision is a key component of practice and practitioners are regularly and closely supervised so they feel supported and can continue to grow in both confidence and skill during their professional role.

What are the benefits of taking part?

Taking part in the study can be beneficial as you move towards applying for professional accreditation with a governing body such as the British Psychological Society (BPS). One of the requirements of accreditation is that you continue to receive supervision of your 'live practice' with children, young people, and their families. Maintaining your professional/work-based supervision logs within your professional portfolio can provide rich evidence of your ongoing supervised therapeutic work.

Providing feedback to the University about your training experiences can help shape education and training for future trainees.

Will my participation involve any physical or psychological discomfort?

Answering questions about your self-perceived clinical skills and confidence in using PLCBT approaches/interventions with parents/carers for some individuals may feel uncomfortable and may trigger emotions such as self-doubt or worry. This is usually a normal experience and forms part of personal development/growth, speaking with your Service supervisor can often help to explore any of these feelings.

If completing the study brings up feelings of emotional distress, please consider seeking help either though your work-based departments, GP or other health agencies. The NHS website 'Every Mind Matters' has a range of resources which can be utilised to support mental health. https://www.nhs.uk/oneyou/every-mind-matters/

How will confidentiality be assured and who will have access to the information that I provide?

Only the researcher and the researcher's supervision team will have access to the information provided. Your year of birth and initials will be used to identify your data and enable us to link up your responses across the questionnaires/surveys and to the anonymised data provided by the parents/carers. Your personal data will not be identifiable in any analysis or published results. Your name will not be written on any of the data collected. Any direct quotes you provide regarding your experiences of training or following your supervision with your in-Service Supervisor may be quoted directly in the researcher's final write up. This will be fully anonymised so any information you provide cannot be linked directly to you.

What will you do with the study results?

The results will be used as part of a PhD study. In addition, the results may be published in professional journals and may be presented at professional forums.

Will I receive any financial reward?

There are no financial rewards for taking part in this study.

Will the use of my data meet GDPR rules?

GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules. Universities, NHS organisations and companies may use patient data to do research to make health and care better. When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data. Universities and the NHS are funded from taxes, and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'. Researchers' must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

What happens to my data at the end of the research study?

At the end of the research study and in line with the Northumbria University research data management policy the anonymised survey data will be retained for three years after the project completion as stipulated in the retention schedule for medium risk studies.

Any identifiable data such as name and contact details of practitioners/trainee's will be destroyed after the final survey data collection has been completed as it will no longer be required.

Who is organising and funding the study?

The study has been organised and funded by Northumbria University.

Will I receive a copy of the findings?

You will be asked when you complete the final survey if you would like to receive a summary of the findings. These will be e-mailed to you when they are available.

If I require any further information, who should I contact?

If you would like more information about the study, please contact the researcher Michealla Lincoln at: m.lincoln@northumbria.ac.uk

Contact details should you require any further information:

Researcher email: m.lincoln@northumbria.ac.uk
Researcher's supervisor: emily6.henderson@northumbria.ac.uk, markku.wood@northumbria.ac.uk

Ethics concerns or complaints: vikki.smith@northumbria.ac.uk

Name and contact details of the Records and Information Officer at Northumbria University: Duncan James (dp.officer@northumbria.ac.uk).

You can find out more about how we use your information at: www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/ or by contacting a member of the research team

Participant Information Sheet (Parent/Carers)

The purpose of this information sheet is to provide you with sufficient information so that you can decide if you wish to participate in this study. Reading this leaflet, discussing it with others or asking any questions you might have will help you decide whether you are willing to take part.

Research Title

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln

Research Aims:

- ***To evaluate the delivery*** of Northumbria University's clinical training in Parent-led Cognitive Behavioural Therapy (PLCBT). A brief, effective treatment for childhood anxiety disorders offered to parents to help them support their children with fears and worries.

- ***To measure levels of practitioner confidence and skill*** in delivering this clinical intervention to families following university training.

- ***To explore supportive 'clinical supervision'*** that practitioners receive within Services and if it may help to improve or enhance practitioners' confidence and skills and if by doing so, can this better help and support parents to achieve their therapy goals.

Why have I been invited and what is Parent Led Cognitive Behaviour Therapy?

You have been invited to take part in the research study as you have been offered support from a low intensity practitioner (either a Children's Wellbeing Practitioner or an Education Mental Health Practitioner) who would like to provide a parent-led cognitive behavioural therapy intervention to help you and your child with their fears and worries. Low intensity practitioners are employed within schools/colleges or within child and adolescent mental health services and form part of a new workforce to support children and young people with their mental health and emotional wellbeing.

The Parent Led Cognitive Behaviour Therapy programme utilises guided self-help principles which aims to support you by further developing your skills and confidence to support your child to overcome their difficulties with anxiety. Specific sessions include understanding your child's fears, worries, and anxieties, setting realistic goals, encouraging brave and independent behaviour by using a step-by-step approach to overcoming fears and worries, recognising, and managing physical symptoms of anxiety, problem solving and then how to keep it all going.

Do I have to take part in the research study?

No, participation in this study is completely voluntary. This information sheet is designed to help you make that decision. You are completely free to decide if you would like to take part. If you decide to take part, then later decide to withdraw from the study you can do so at any time by letting your practitioner know.

What will I have to do?

Complete 2 routine outcome measure questionnaires (revised child and depression scale – parent version)  	*Identify 1 or more individual parent goals* (goal-based outcomes) 
Complete an 'End of Service Questionnaire' (ESQ)  	*Give your consent for the clinical session to be recorded by the practitioner* (this is a compulsory component within the study) 

What are the possible benefits of taking part?

By taking part in this research study, you can help us to further evaluate how university training and in-Service clinical supervision may help to shape and support low intensity practitioners in delivering the treatment approach you have received. We are keen to hear about your individual experiences of how the intervention was delivered so we can further support practitioners in practice.

Will my information be kept confidential?

Yes. The outcome measure data collected from you will not contain any identifiable information such as your name or child's name. The Service will be asked to send the anonymised data to the researcher via a secure Microsoft Office University OneDrive link.

A video recording of your clinical session will be made by the practitioner on the Service's encrypted laptop or recording device. The purpose of this recording is so the practitioner can discuss with their in-Service supervisor how they have conducted the session using the parent led cognitive behaviour programme materials. The video is not to assess you, but to capture the session delivery so both the supervisor and practitioner can talk about the level of practitioner perceived skill and confidence.

How will my data be stored and who will have access to the information that I provide?

Data collected will be fully anonymised and kept by the researcher in the researcher's secure Microsoft Office University OneDrive account which is accessible only to the researcher and is password protected. No patient names or any identifiable information will be kept. Any feedback comments or direct quotes you provide about your experiences of treatment may be used in the researcher's final project write up and may be used in a research journal or presented at a research conference. If used this will not contain any identifiable information.

Only the researcher and the researcher's supervision team will have access to the information provided. The consent forms you complete will be kept by the Service only. Your personal data will not be identifiable in any analysis or published results. Your name will not be written on any of the data collected.

Will the use of my data meet GDPR rules?

Yes. GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules. Universities, NHS organisations and companies may use patient data to do research to make health and care better. When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data. Universities and the NHS are funded from taxes, and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'. Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

Consent to Participate: Data Collection

If you agree to participate in the research study, you will be invited to complete a consent form for data collection. This will be signed by you and will be witnessed/signed by the Service Practitioner. This will remain with the Service and will **not be** sent to the researcher.

Consent to Participate: Video Recording

If you agree to participate in the study, you will need to complete a consent form giving permission for the practitioner to record your clinical session for the purposes of supportive in-Service clinical supervision (this is a compulsory component within the study). The recording will capture a clinical session between you and the practitioner (or if you are receiving your intervention as part of a group, and if all participants agree to be recorded). The focus of the video recording is to gather information about the practitioner's level of skill and confidence in delivering the intervention *it is not to carry out further assessment or observe you as a parent*.

The video recording will be via an encrypted Service laptop or recording device and will be held securely for the purposes of in-Service clinical supervision only. The recording will only be viewed by the practitioner and the in-Service Supervisor only. Once the recording has been viewed it will be deleted from the encrypted device. The completed consent form will remain with the Service and will **not be** sent to the researcher.

Supervision is a key component of practice and practitioners are regularly and closely supervised so they feel supported and can continue to grow in both confidence and skill during their professional role. If during your clinical session any concerns arose such as those of a safeguarding nature the practitioner would carry out their usual professional duties by; discussing any concerns raised with you in the session; discussing these with their in-Service supervisor; and following their Service policy with regard to safeguarding procedures in their organisation.

What will you do with the study results?

The general findings will be written up in the researcher's final project. These findings may be reported in a research journal or presented at a conference. The data will never include any names or identifiable information. We can provide you with a summary of the findings from the study if you email the researcher at the address listed below.

What happens to my data at the end of the study?

At the end of the research study and in line with the Northumbria University research data management policy the anonymised survey data (outcome measures and end of Service questionnaires) will be retained for three years after the project completion so, if necessary, the researcher's work can be verified/checked. The video recording will be deleted by the practitioner as soon as it has been viewed in supervision and will not be kept or retained for three years after the study.

Who is organising and funding the study?

The study has been organised and funded by Northumbria University.

Who has reviewed the study?

Before the study could begin, permissions were obtained from Northumbria University and the Research Ethics Committee.

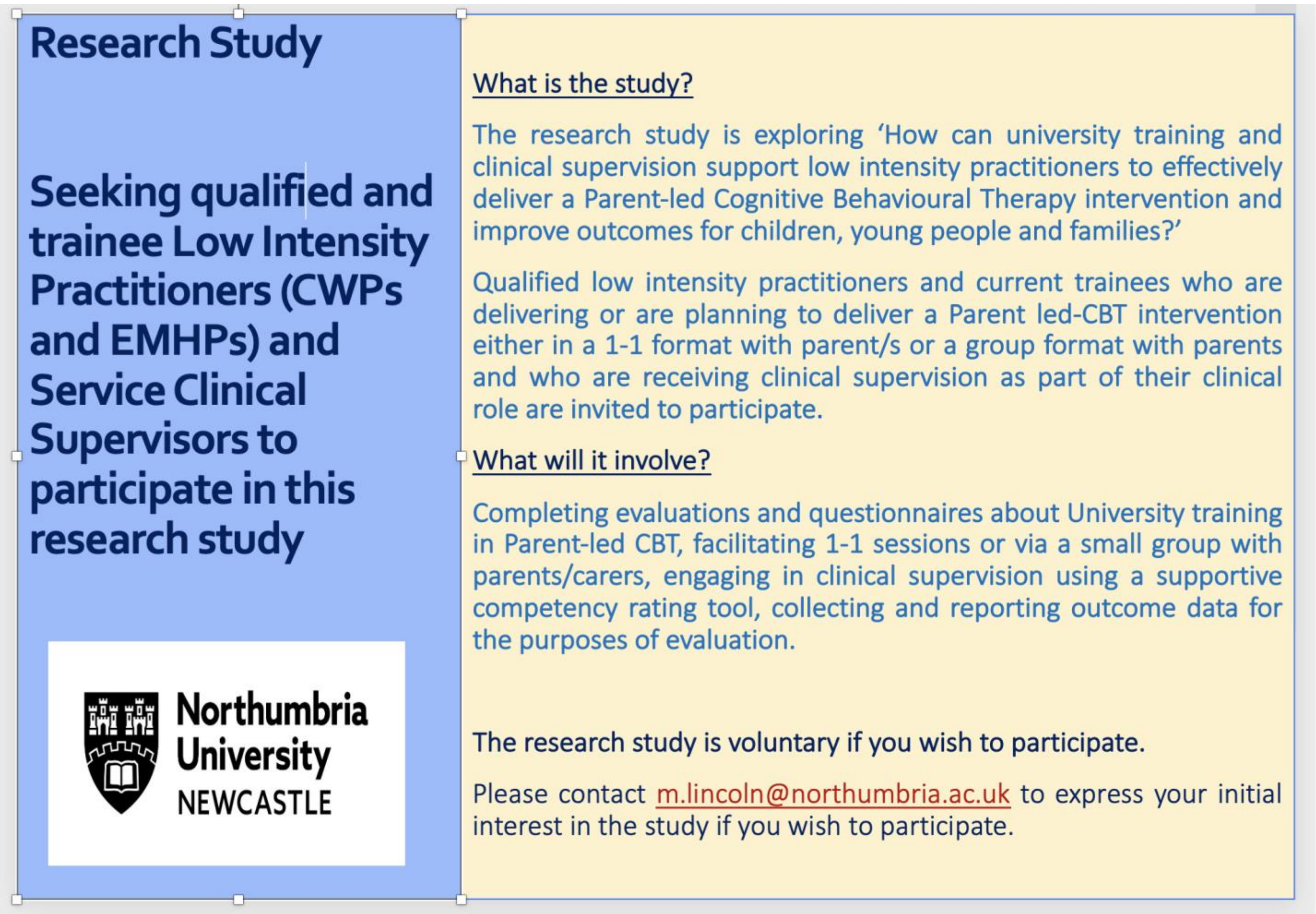
Contact details if you require further information about the study, including if you have any concerns or wish to make a complaint.

Researcher email: m.lincoln@northumbria.ac.uk
Researcher's supervisors: emily6.henderson@northumbria.ac.uk, markku.wood@northumbria.ac.uk

Name of another person who can provide independent information or advice about this project
jane.davies@northumbria.ac.uk

The Patient Advice and Liaison Service (PALS) provide a point of contact for patients, their families and their carers offering confidential advice, support and information on health-related matters including how to make a complaint. https://www.nhs.uk/

Appendix 4 – Poster (v3)



Research Study

Seeking qualified and trainee Low Intensity Practitioners (CWPs and EMHPs) and Service Clinical Supervisors to participate in this research study

Northumbria University
NEWCASTLE

What is the study?

The research study is exploring ‘How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?’

Qualified low intensity practitioners and current trainees who are delivering or are planning to deliver a Parent led-CBT intervention either in a 1-1 format with parent/s or a group format with parents and who are receiving clinical supervision as part of their clinical role are invited to participate.

What will it involve?

Completing evaluations and questionnaires about University training in Parent-led CBT, facilitating 1-1 sessions or via a small group with parents/carers, engaging in clinical supervision using a supportive competency rating tool, collecting and reporting outcome data for the purposes of evaluation.

The research study is voluntary if you wish to participate.

Please contact m.lincoln@northumbria.ac.uk to express your initial interest in the study if you wish to participate.

Appendix 5 – Screening Survey

Screening Questions (Low Intensity Practitioners - EMHPs, CWPs)

Question	Possible Answers
Are you a trainee/qualified EMHP or CWP?	Yes No*
Please circle	Trainee EMHP Qualified EMHP Trainee CWP Qualified CWP
Are you receiving clinical supervision as part of your role?	Yes No*
Have you studied at Northumbria University?	Yes No*
Have you received the PLCBT training at Northumbria University	Yes No*
When did you qualify as an EMHP?	Date options
If still in training, when are you due to finish your course?	Date options
Do you consent to be contacted by email to participate in the follow up surveys	Yes No*
Have you read the accompanying participant information sheet	Yes No*
I am aware that taking part in this research is voluntary and that I have the right to withdraw at any time without giving a reason	Yes No*
I consent to allow the researcher to use/publish any direct quotes I have given when completing questionnaires. I understand this information will be fully anonymised and I will not be identified in any way	Yes No*
I would like to consent to take part in the study?	Yes No*

*Will be re-directed to screen-out page as do not meet inclusion criteria

Demographics (Personal Factors)

Question	**Possible Answers**
What is your Gender?	Female Male Other Prefer not to answer
What is your age?	18-25 26-40 40- 50 50+

	Prefer not to answer
What is your marital status?	Single Married Co-habiting In a relationship, but not living together Widowed Prefer not to answer
Do you have caring responsibilities?	Yes If Yes – How many children?....Adults?...... No Prefer not to answer
What is your ethnic group?	**White** 1. English/Welsh/Scottish/Northern Irish/British 2. Irish 3. Gypsy or Irish Traveller 4. Any other White background, please describe **Mixed/Multiple ethnic groups** 5. White and Black Caribbean 6. White and Black African 7. White and Asian 8. Any other Mixed/Multiple ethnic background, please describe **Asian/Asian British** 9. Indian 10. Pakistani 11. Bangladeshi 12. Chinese 13. Any other Asian background, please describe **Black/ African/Caribbean/Black British** 14. African 15. Caribbean 16. Any other Black/African/Caribbean background, please describe **Other ethnic group** 17. Arab 18. Any other ethnic group, please describe Prefer not to answer
Do you consider yourself to have a disability?	Yes – physical impairment Yes – mental impairment Yes – learning impairment No Prefer not to answer

Question	
Prior to your EMHP training did you already have a professional registration/qualification i.e., in health care, social care or education?	Yes No If Yes, please specify. e.g., Teacher, Social Worker, Nurse, Other, please specify ….
If yes. How many years have you worked in this profession?	Date options
Did you have any previous training in cognitive behavioural therapy interventions?	Yes No
If yes, what training have you attended	Free Text
Have you had previous experience of co-delivering a PLCBT programme prior to receiving the training at Northumbria University?	Yes No
If yes, please provide date	Date/Month
If yes, did you receive any supervision?	Yes No
Who are you currently employed by?	NHS Trust Private Healthcare Provider Independent Other______
Are you currently working for the same employer post qualification as either a CWP or EMHP?	Yes No N/A – Current student Prefer not to answer
Current work email address	Free Text
Thank you for your screening responses. The researcher will arrange to send out the 1st questionnaire to the email address provided above.	

Appendix 6 – Pre intervention PLCBT Scoring tool

Research Study Title:

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln

Pre- Intervention Parent-Led CBT Competency Scoring Tool

(To be completed by Practitioner or Trainee)

University devised competency tool incorporating a self-rating scoring tool based on the Dreyfus Model of Skill Acquisition (1989).

(5-Likert Scale 'Novice to Expert')

1. **Novice** - Has an incomplete understanding, may approach tasks mechanistically and needs supervision to complete them.
2. **Advanced Beginner** - Has a working understanding, tends to see actions as a series of steps, can complete simpler tasks without supervision.
3. **Competent** - Has a good working and background understanding, sees actions at least partly in context, able to complete work independently to a standard that is acceptable though it may lack refinement.
4. **Proficient** - Has a deep understanding, sees actions holistically, can achieve a high standard routinely.
5. **Expert** - Has an authoritative or deep holistic understanding, deals with routine matters intuitively, able to go beyond existing interpretations, achieves excellence with ease.

(Dreyfus, H. L. (1989). The Dreyfus model of skill acquisition. *In* J. Burke (ed.) *Competency based education and training.* London: Falmer Press).

5- Likert Confidence Rating scale (Based on work by Joshi *et al* 2015).

1	2	3	4	5
Not at all confident	Slightly confident	Somewhat confident	Quite confident	Extremely Confident

Joshi, A. Kale, S. Chandel, S. Pal, D.K. (2015) Likert scale: explored and explained. *British Journal of Applied Science and Technology* 7(4): 396.

Practitioner ID:	
Date of Training in PLCBT	
Date of Completing form	
Agenda and Session structure	**Predicted Reflective Comments:** please record your thoughts here about your perceived level of skill and confidence in being able to complete and carry out the following tasks.
Was an appropriate collaborative agenda set? **Did it include any of the following? -** • Brief review of previous session • Homework review • Goals for session • LI guided self-help • Setting of new homework • End of session summary **Did the therapist follow the agenda and manage their time effectively? Consider the following: -**	

Was the pacing of the session appropriate to the client/s needs? Did the therapist address all items on the agenda within the time frame (40-60 minutes)? Did the therapist and client/s achieve the stated session goals? Did the session have discrete beginning middle and end phases? Was there an appropriate end of session summary and new homework task/s set?	**PRACTITIONER or TRAINEE** pre - intervention '**Novice to Expert'** perceived score **PRACTITIONER or TRAINEE** pre-intervention perceived '**Confidence Score'**
Interpersonal Effectiveness	**Predicted Reflective Comments:** please record your thoughts here about your perceived level of skill and confidence in being able to complete and carry out the following tasks.
Does the therapist demonstrate the core skills and values necessary to develop an effective therapeutic alliance? Consider the following: - Does the therapist use effective non-verbal cues (e.g., eye contact, posture, nods, and facial expression)? Does the therapist display empathy using verbal communication skills (e.g., using emotionally validating statements)? Does the therapist demonstrate warmth and genuineness? Does the therapist use language and engagement strategies appropriate for client/s developmental level?	

Does the therapist support the client/s to reflect upon their difficulties during the parenting intervention, group work treatment or consultation? Does the therapist adopt patient centred interviewing techniques to include the use of open questions, summarising and clarification? Does the therapist give and elicit regular feedback from the client/s?	**PRACTITIONER or TRAINEE** pre-intervention **‘Novice to Expert’** perceived Score **PRACTITIONER or TRAINEE** pre-intervention **‘Confidence Score’**
Evidence Based Low Intensity Intervention (Parent Led CBT)	**Predicted Reflective Comments:** please record your thoughts here about your perceived level of skill and confidence in being able to complete and carry out the following tasks.
Has the therapist prepared effectively for the session? Consider the following: - Does the therapist have a clear plan for the session, informed by theoretical knowledge and practice? Does the therapist have the materials required to conduct the required treatment session? This might include diagrams, models, handouts, leaflets, information and materials. **Does the therapist demonstrate an understanding of the principles of low intensity interventions for the delivery of:**	

• **1-1 session with parent** **or** • **Group work intervention** **(Consider the following): -** Does the therapist appear to have a clear understanding of the theory and practice of PLCBT? Does the therapist provide a clear rationale to the parent or group about the treatment approaches for the chosen interventions? Is it understood by them and the therapist? **Helpful guidance for a PLCBT intervention** (1-1 or group session) does the session follow the correct suggested protocol (during the chosen session recording are the following tasks conducted)? For example: • **Session 1 – Face to face (40-60 mins)** Brief philosophy of program re-visited Why CBT and why parental approach? Psychoeducation How anxiety develops and is maintained Treatment goals • **Session 2 – Face to face (40-60 mins)**	

What is my child thinking? What does my child need to learn? Promoting independence and ‘having a go’ Rewards • **Session 3 – Face to face (40-60 mins)** Including Step-by-step plan • **Sessions 4,5,6 – see below (15/20 mins)** • **Session 7 – Face to face 40-60 mins)** Checking in & reviewing homework Problem solving approach **(Sessions 4, 5 + 6 are not ideal clinical sessions for recording as they are shorter sessions/check ins of 15/20 mins in duration).** **Does the therapist demonstrate technical skill in managing in-session discussions/tasks? Please consider the following:-** Does the therapist offer to provide a clear rationale to the client/s about why they are undertaking particular tasks? Does the therapist demonstrate fidelity to the low intensity approaches by remaining focused on the task in hand (achieving model fidelity)?	

Does the therapist explain and plan homework tasks adequately with client/s? Does the session content and interventions used lead to the client/s developing a new level of understanding about their difficulties?	**PRACTITIONER or TRAINEE** pre-intervention ‘**Novice to Expert’** Score **PRACTITIONER or TRAINEE** pre-intervention ‘**Confidence Score’**
Collaboration and Shared decision making	**Predicted Reflective Comments:** please record your thoughts here about your perceived level of skill and confidence in being able to complete and carry out the following tasks.
Do the therapist and client/s work effectively as a team? Does the therapist achieve a balance between task and bond (not becoming too focussed on either the relationship/s or the tasks of therapy)? Do the therapist and client/s think together about the client/’s difficulties? Is there a shared written formulation of their difficulties referred to during the session or group? Are the client/s active participants in the session? Is the workload shared? Was the therapist overly directive or too controlling?	**PRACTITIONER or TRAINEE** pre-intervention ‘**Novice to Expert’** Score **PRACTITIONER or TRAINEE** pre-intervention ‘**Confidence Score’**

Did the therapist give the client/s sufficient space and time to think?	

Summary of Rating Scores	**PRACTITIONER or TRAINEE** Pre-intervention '**Novice to Expert'** Score	**PRACTITIONER or TRAINEE** pre-intervention '**Confidence Score'**
Agenda and Session structure		
Interpersonal Effectiveness		
Evidence Based Low Intensity Intervention (Parent Led CBT)		
Collaboration and Shared decision making		

Additional Comments (Practitioner/Trainee)

Thank you for your support and co-operation in completing this scoring tool.

Appendix 7– Post- intervention PLCBT Scoring tool

Research Study Title:

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln

Post Intervention Parent-Led CBT Competency Scoring Tool

(To be completed by Practitioner or Trainee and Supervisor)

University devised competency tool incorporating a self-rating scoring tool based on the Dreyfus Model of Skill Acquisition (1989).

(5-Likert Scale 'Novice to Expert')

1. **Novice** - Has an incomplete understanding, may approach tasks mechanistically and needs supervision to complete them.
2. **Advanced Beginner** - Has a working understanding, tends to see actions as a series of steps, can complete simpler tasks without supervision.
3. **Competent** - Has a good working and background understanding, sees actions at least partly in context, able to complete work independently to a standard that is acceptable though it may lack refinement.
4. **Proficient** - Has a deep understanding, sees actions holistically, can achieve a high standard routinely.
5. **Expert** - Has an authoritative or deep holistic understanding, deals with routine matters intuitively, able to go beyond existing interpretations, achieves excellence with ease.

(Dreyfus, H. L. (1989). The Dreyfus model of skill acquisition. *In* J. Burke (ed.) *Competency based education and training.* London: Falmer Press).

5- Likert Confidence Rating scale (Based on work by Joshi *et al* 2015).

1	2	3	4	5
Not at all confident	Slightly confident	Somewhat confident	Quite confident	Extremely Confident

Joshi, A. Kale, S. Chandel, S. Pal, D.K. (2015) Likert scale: explored and explained. *British Journal of Applied Science and Technology* 7(4): 396.

Parent-Led Cognitive Behaviour (PLCBT)	1-1 Session delivery or Group session delivery *(Please circle)* *(Please circle)*
Practitioner ID:	
Date of PLCBT session delivery:	
Number of 1-1 PLCBT interventions delivered since training: (1 intervention = 5hrs 20 mins)	**1 intervention** **2 interventions** **3-5 interventions** **6+ interventions** *(Please circle)*
Number of Group PLCBT interventions delivered since training: (1 intervention = 10hrs)	**1 intervention** **2 interventions** **3-5 interventions** **6 + interventions** *(Please circle)*
Supervisor Information: Professional qualifications held Please also specify your CBT and supervision-based qualifications if held.	
Length of experience as a supervisor	
Supervisor level of self-perceived skill/competency in PLCBT interventions using the 5-Likert scale Dreyfus model of Skill Acquisition (1989). 'Novice – Expert'	1. Novice 2. Advanced Beginner 3. Competent 4. Proficient 5. Expert *(Please circle)*
Agenda and Session structure	**Reflective Comments**

Was an appropriate collaborative agenda set? **Did it include any of the following? -** - Brief review of previous session - Homework review - Goals for session - LI guided self-help - Setting of new homework - End of session summary **Did the therapist follow the agenda and manage their time effectively? Consider the following: -** Was the pacing of the session appropriate to the client/s needs? Did the therapist address all items on the agenda within the time frame (40-60 minutes)? Did the therapist and client/s achieve the stated session goals? Did the session have discrete beginning middle and end phases? Was there an appropriate end of session summary and new homework task/s set?	**PRACTITIONER or TRAINEE** Post-intervention ‘**Novice to Expert’** Score **SUPERVISOR** Post-intervention ‘**Novice to Expert’** Score **PRACTITIONER** or TRAINEE post Intervention ‘**Confidence Score’** ☐ **SUPERVISOR** post intervention ‘**Confidence Score’** ☐
Interpersonal Effectiveness	**Reflective Comments**
Does the therapist demonstrate the core skills and values necessary to develop an effective therapeutic alliance? Consider the following: -	**PRACTITIONER or TRAINEE** Post-intervention ‘**Novice to Expert’** Score **SUPERVISOR** Post-intervention ‘**Novice to Expert’** Score

Does the therapist use effective non-verbal cues (e.g., eye contact, posture, nods, and facial expression)? Does the therapist display empathy using verbal communication skills (e.g., using emotionally validating statements)? Does the therapist demonstrate warmth and genuineness? Does the therapist use language and engagement strategies appropriate for client/s developmental level? Does the therapist support the client/s to reflect upon their difficulties during the parenting intervention, group work treatment or consultation? Does the therapist adopt patient centred interviewing techniques to include the use of open questions, summarising and clarification? Does the therapist give and elicit regular feedback from the client/s?	☐ ☐ **PRACTITIONER or TRAINEE** post intervention '**<u>Confidence Score</u>**' ☐ **SUPERVISOR** post intervention '**<u>Confidence Score</u>**' ☐
Evidence Based Low Intensity Intervention (Parent Led CBT)	**Reflective Comments**

Has the therapist prepared effectively for the session? Consider the following: - Does the therapist have a clear plan for the session, informed by theoretical knowledge and practice? Does the therapist have the materials required to conduct the required treatment session? This might include diagrams, models, handouts, leaflets, information and materials. **Does the therapist demonstrate an understanding of the principles of low intensity interventions for the delivery of:** • **1-1 session with parent** **or** • **Group work intervention** **(Consider the following): -** Does the therapist appear to have a clear understanding of the theory and practice of PLCBT? Does the therapist provide a clear rationale to the parent or group about the treatment approaches for the chosen interventions? Is it understood by them and the therapist? **Helpful guidance for a PLCBT intervention** (1-1 or group session) does the session follow the correct	

suggested protocol (during the chosen session recording are the following tasks conducted)? For example: • **Session 1 – Face to face (40-60 mins)** Brief philosophy of program re-visited Why CBT and why parental approach? Psychoeducation How anxiety develops and is maintained Treatment goals • **Session 2 – Face to face (40-60 mins)** What is my child thinking? What does my child need to learn? Promoting independence and 'having a go' Rewards • **Session 3 – Face to face (40-60 mins)** Including Step-by-step plan • **Sessions 4,5,6 – see below (15/20 mins)** • **Session 7 – Face to face 40-60 mins)** Checking in & reviewing homework Problem solving approach	

PRACTITIONER or TRAINEE Post-Intervention '**Novice to Expert'** Score	**SUPERVISOR** Post-intervention '**Novice to Expert'** Score

(Sessions 4,5 + 6 are not ideal clinical sessions for recording as they are shorter sessions/check ins of 15/20 mins in duration). **Does the therapist demonstrate technical skill in managing in-session discussions/tasks? Please consider the following:-** Does the therapist offer to provide a clear rationale to the client/s about why they are undertaking particular tasks? Does the therapist demonstrate fidelity to the low intensity approaches by remaining focused on the task in hand (achieving model fidelity)? Does the therapist explain and plan homework tasks adequately with client/s? Does the session content and interventions used lead to the client/s developing a new level of understanding about their difficulties?	☐ ☐ **PRACTITIONER or TRAINEE** post Intervention '**Confidence Score'** ☐ **SUPERVISOR** post intervention '**Confidence Score'** ☐
Collaboration and Shared decision making	**Reflective Comments**

Do the therapist and client/s work effectively as a team? Does the therapist achieve a balance between task and bond (not becoming too focussed on either the relationship/s or the tasks of therapy)? Do the therapist and client/s think together about the client/'s difficulties? Is there a shared written formulation of their difficulties referred to during the session or group? Are the client/s active participants in the session? Is the workload shared? Was the therapist overly directive or too controlling? Did the therapist give the client/s sufficient space and time to think?	**PRACTITIONER or TRAINEE** Post-Intervention '**Novice to Expert'** Score **SUPERVISOR** Post-Intervention '**Novice to Expert'** Score **PRACTITIONER or TRAINEE** post Intervention '**Confidence Score'** **SUPERVISOR** post Intervention '**Confidence Score'**

Summary of Rating Scores	**PRACTITIONER or TRAINEE** Post-Intervention '**Novice to Expert'** Score	**SUPERVISOR** Post-Intervention '**Novice to Expert'** Score	**PRACTITIONER or TRAINEE** post Intervention '**Confidence Score'**	**SUPERVISOR** post Intervention '**Confidence Score'**
Agenda and Session structure				

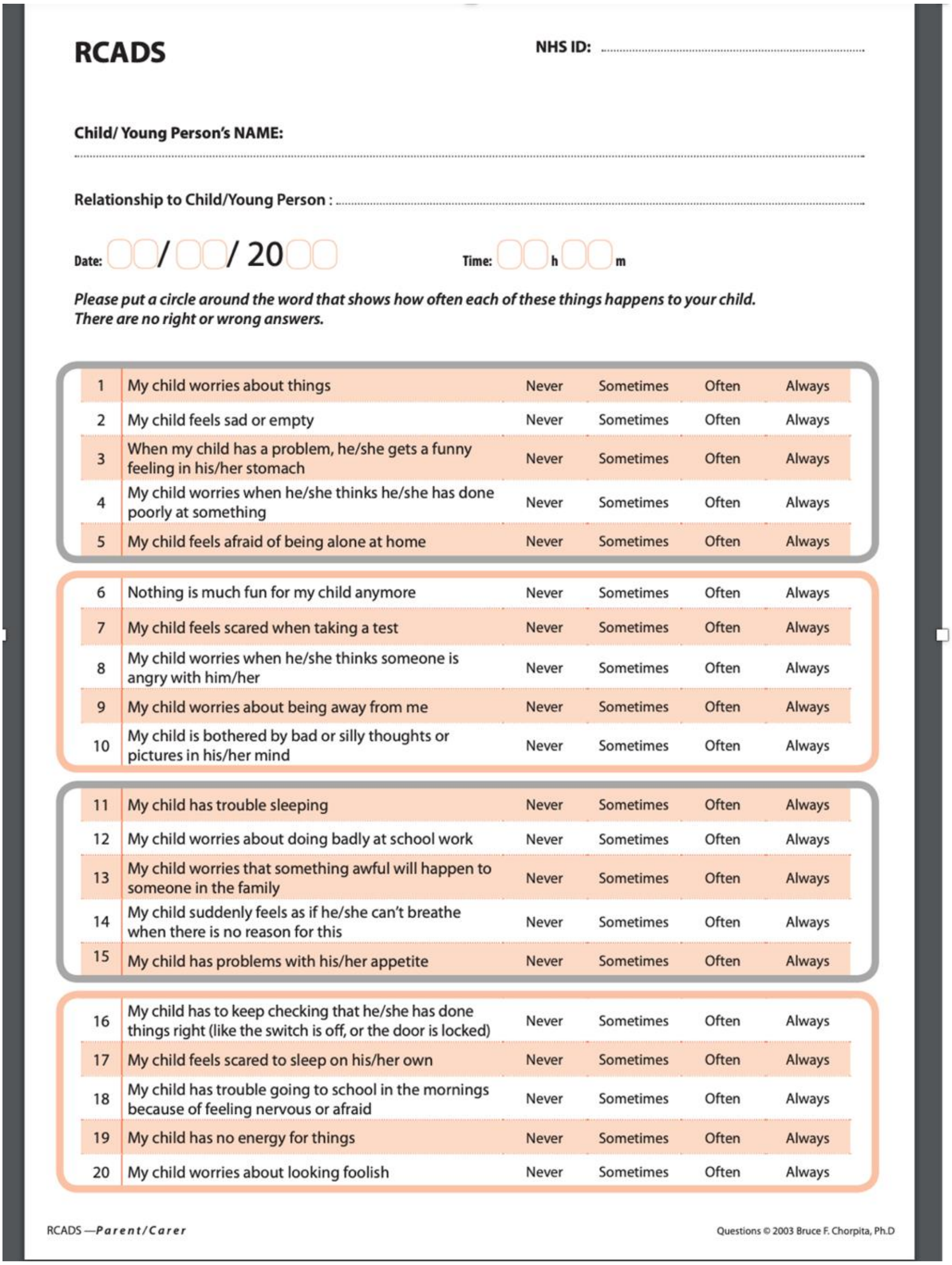
Interpersonal Effectiveness				
Evidence Based Low Intensity Intervention (Parent Led CBT)				
Collaboration and Shared decision making				

Additional Comments (Practitioner/Trainee)
Additional Comments (Supervisor)

Thank you for your support and co-operation in completing this scoring tool.

Appendix 8

Revised Children’s Anxiety and Depression Scale (RCADS: 47) Parent Report Version, (Chorpita, Moffitt & Gray, 2005)



RCADS

NHS ID: ……………………………………

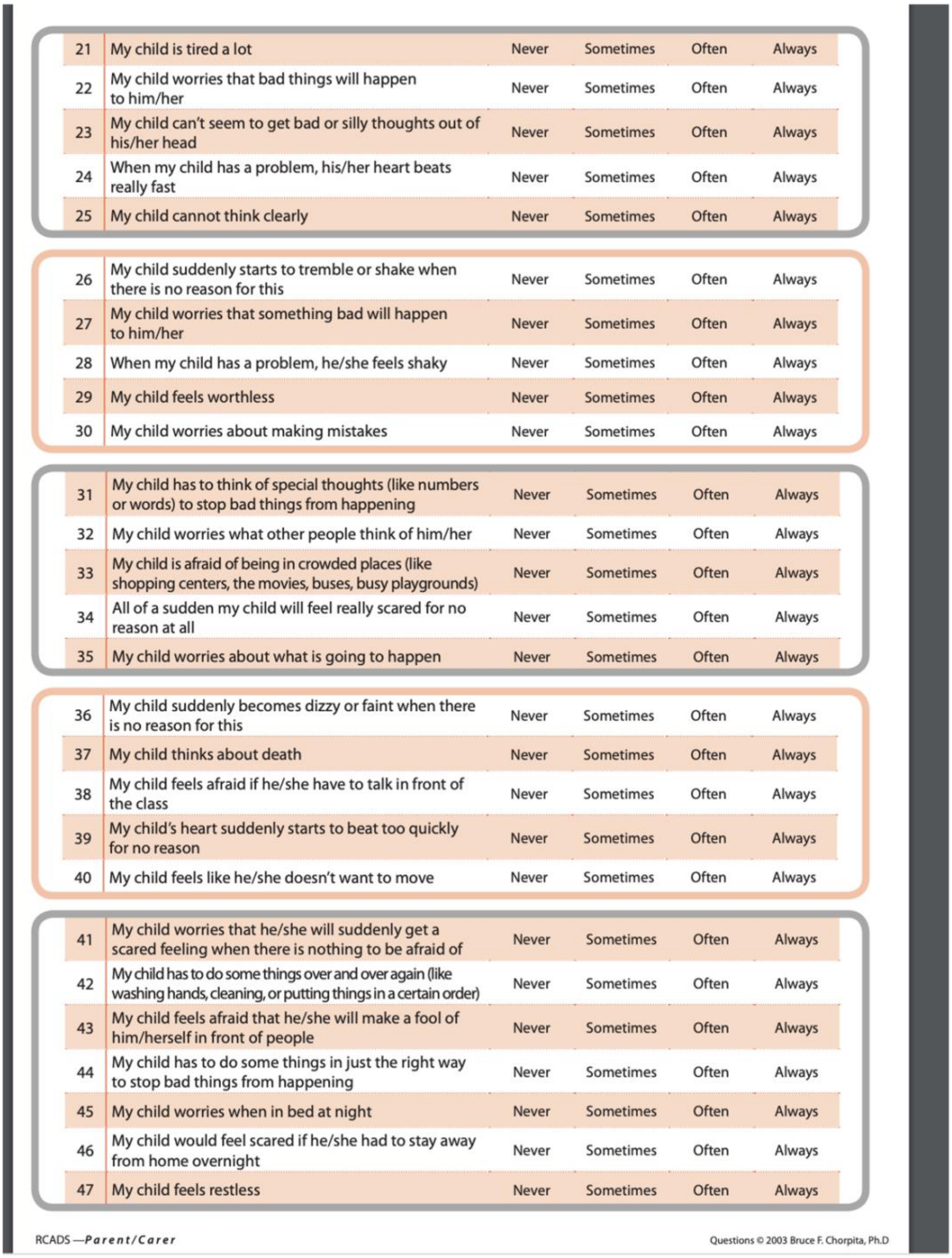
Child/ Young Person’s NAME: ……………………………………

Relationship to Child/Young Person : ……………………………………

Date: ☐☐/ ☐☐/ 20☐☐ **Time:** ☐☐h ☐☐m

Please put a circle around the word that shows how often each of these things happens to your child. There are no right or wrong answers.

1	My child worries about things	Never	Sometimes	Often	Always
2	My child feels sad or empty	Never	Sometimes	Often	Always
3	When my child has a problem, he/she gets a funny feeling in his/her stomach	Never	Sometimes	Often	Always
4	My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
5	My child feels afraid of being alone at home	Never	Sometimes	Often	Always
6	Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
7	My child feels scared when taking a test	Never	Sometimes	Often	Always
8	My child worries when he/she thinks someone is angry with him/her	Never	Sometimes	Often	Always
9	My child worries about being away from me	Never	Sometimes	Often	Always
10	My child is bothered by bad or silly thoughts or pictures in his/her mind	Never	Sometimes	Often	Always
11	My child has trouble sleeping	Never	Sometimes	Often	Always
12	My child worries about doing badly at school work	Never	Sometimes	Often	Always
13	My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
14	My child suddenly feels as if he/she can’t breathe when there is no reason for this	Never	Sometimes	Often	Always
15	My child has problems with his/her appetite	Never	Sometimes	Often	Always
16	My child has to keep checking that he/she has done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17	My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
18	My child has trouble going to school in the mornings because of feeling nervous or afraid	Never	Sometimes	Often	Always
19	My child has no energy for things	Never	Sometimes	Often	Always
20	My child worries about looking foolish	Never	Sometimes	Often	Always

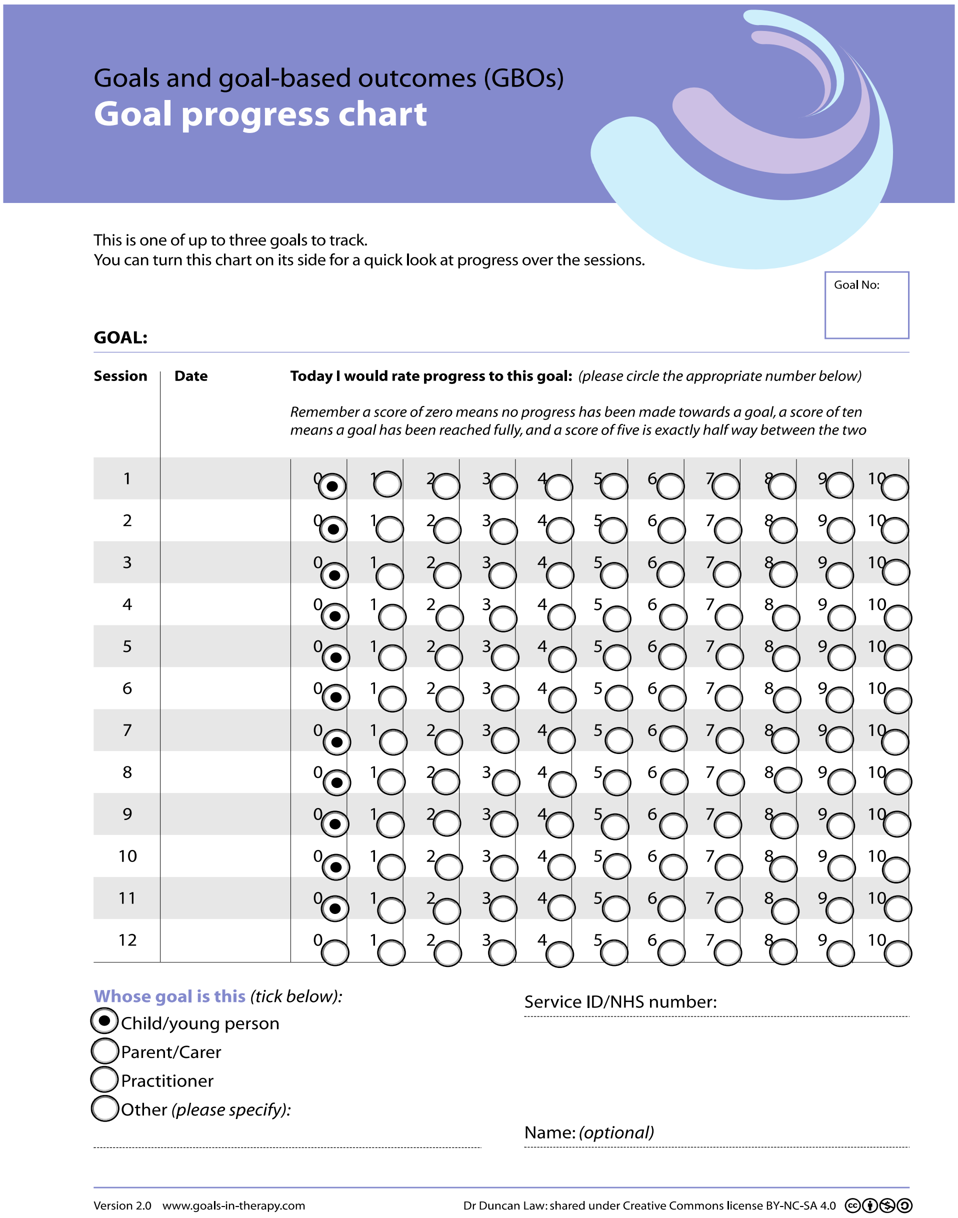


21	My child is tired a lot	Never	Sometimes	Often	Always
22	My child worries that bad things will happen to him/her	Never	Sometimes	Often	Always
23	My child can't seem to get bad or silly thoughts out of his/her head	Never	Sometimes	Often	Always
24	When my child has a problem, his/her heart beats really fast	Never	Sometimes	Often	Always
25	My child cannot think clearly	Never	Sometimes	Often	Always
26	My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27	My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always
28	When my child has a problem, he/she feels shaky	Never	Sometimes	Often	Always
29	My child feels worthless	Never	Sometimes	Often	Always
30	My child worries about making mistakes	Never	Sometimes	Often	Always
31	My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
32	My child worries what other people think of him/her	Never	Sometimes	Often	Always
33	My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34	All of a sudden my child will feel really scared for no reason at all	Never	Sometimes	Often	Always
35	My child worries about what is going to happen	Never	Sometimes	Often	Always
36	My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37	My child thinks about death	Never	Sometimes	Often	Always
38	My child feels afraid if he/she have to talk in front of the class	Never	Sometimes	Often	Always
39	My child's heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
40	My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
41	My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
42	My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
43	My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
44	My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
45	My child worries when in bed at night	Never	Sometimes	Often	Always
46	My child would feel scared if he/she had to stay away from home overnight	Never	Sometimes	Often	Always
47	My child feels restless	Never	Sometimes	Often	Always

RCADS —*Parent/Carer*

Appendix 9

Parental Goal Based Outcomes (Law, D., & Jacob, J. (2015). Goals and Goal Based Outcomes (GBOs). Third Edition. London, UK: CAMHS Press. https://www.corc.uk.net/



Goals and goal-based outcomes (GBOs)

Goal progress chart

This is one of up to three goals to track.
You can turn this chart on its side for a quick look at progress over the sessions.

Goal No:

GOAL:

Session	**Date**	**Today I would rate progress to this goal:** *(please circle the appropriate number below)* *Remember a score of zero means no progress has been made towards a goal, a score of ten means a goal has been reached fully, and a score of five is exactly half way between the two*										
1		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
2		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
3		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
4		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
5		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
6		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
7		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
8		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
9		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
10		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
11		0 ●	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○
12		0 ○	1 ○	2 ○	3 ○	4 ○	5 ○	6 ○	7 ○	8 ○	9 ○	10 ○

Whose goal is this *(tick below):*

● Child/young person
○ Parent/Carer
○ Practitioner
○ Other *(please specify):* ....

Service ID/NHS number: ....

Name: *(optional)* ....

Version 2.0 www.goals-in-therapy.com

Appendix 10

Experience of Service Questionnaires. (Law, D., & Jacob, J. (2015). Third Edition. London, UK: CAMHS Press. https://www.corc.uk.net/

Child Outcomes Research Consortium

CORC ADAPTED PARENT EXPERIENCE OF SERVICE QUESTIONNAIRE

Please think about the appointments you, your child and/or your family have had at this service or clinic.

For each item, please tick the box that best describes what **you** think or feel about the service (e.g. ☑).

	Certainly True	**Partly True**	**Not True**	**Don't know**	
I feel that the people here listened to me	☐	☐	☐	☐	1
It was easy to talk to the people here	☐	☐	☐	☐	2
I was treated well by the people here	☐	☐	☐	☐	3
My views and worries were taken seriously	☐	☐	☐	☐	4
I feel the people here know how to help with the Problem(s) I came for	☐	☐	☐	☐	5
I have been given enough explanation about the help available here	☐	☐	☐	☐	6
I feel that the people here are working together to help with the problem(s)	☐	☐	☐	☐	7
The facilities here are comfortable (e.g. waiting area)	☐	☐	☐	☐	8
The appointments are usually at a convenient time (e.g. don't interfere with work, school)	☐	☐	☐	☐	9
It is quite easy to get to the place where the appointments are	☐	☐	☐	☐	10
If a friend needed similar help, I would recommend that he or she come here.	☐	☐	☐	☐	11
Overall, the help I have received here is good	☐	☐	☐	☐	12

PLEASE TURN OVER...

What was really good about your care? 13

Was there anything you didn't like or anything that needs improving? 14

Is there anything else you want to tell us about the service you received? 15

THANK YOU FOR YOUR HELP

Consent Form Data Collection
Parents/Carers

Research Title

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln

Research Aims:

- ***To evaluate the delivery*** of Northumbria University's clinical training in Parent-led Cognitive Behavioural Therapy (PLCBT). A brief, effective treatment for childhood anxiety disorders offered to parents to help them support their children with fears and worries.
- ***To measure levels of practitioner confidence and skill*** in delivering this clinical intervention to families following university training.
- ***To explore supportive 'clinical supervision'*** that practitioners receive within Services and if it may help to improve or enhance practitioners' confidence and skills and if by doing so, can this better help and support parents to achieve their therapy goals.

I understand that the purpose of this consent form is to give my permission to (insert Service name) and Northumbria University who would like to use my data for research purposes.

All data obtained will be anonymised and no individual parent or child will be identified. Data collected will include:

- Goals and Goal Based Outcomes (GBO's)
    - Parent/Carer version
- CORC Adapted Parent Experience of Service Questionnaires (ESQ)
- Revised Child and Anxiety Depression Scale (RCADS- P, Parent Version)

This information will enable the University of Northumbria to carry out an analysis of a Parent-led Cognitive Behavioural Therapy intervention either delivered in a small group format or on a 1-1 basis with parents/carers. The research will assist in evaluating this delivered intervention by Low Intensity Practitioners such as Children's Wellbeing Practitioners and/or Education Mental Health Practitioners.

Will the use of my data meet GDPR rules?

GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules. Universities, NHS organisations and companies may use patient data to do research to make health and care better. When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data. Universities and the NHS are funded from taxes, and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'. Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

- I am aware that taking part in this research is voluntary and that I have the right to withdraw at any time without giving a reason. ***(Please circle)***

  Yes/No

- I can confirm that I have read the information sheet V3 22.03.23 for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ***(Please circle)***

  Yes/No

- I confirm that I have read and understand this consent form and I have had sufficient time to decide whether to take part. ***(Please circle)***

Yes/No

- I consent to allow the researcher to use/publish any direct quotes I have given when completing the anonymised end of service questionnaire. ***(Please circle)***

Yes/No

- I have been given a copy of the consent form. ***(Please circle)***

Yes/No

(Completed form to be retained by the Service)

I agree to take part in allowing (insert Service name) and Northumbria University to use my anonymised data:

Signed (Parent/Carer)………………………………………………………………. Date………………………………………..

Name………..

Person taking Informed consent:

Signed (Practitioner)………………………………………………………………. Date………………………………………..

Name………..

Appendix 12

(Consent form Parents and Carers/Practitioners: Video Recording)

Consent Form Video Recording

Parents/Carers

Research Title

How can university training and clinical supervision support low intensity practitioners to effectively deliver a Parent-led Cognitive Behavioural Therapy intervention and improve outcomes for children, young people and families?

Research Investigator: Michealla Lincoln

Research Aims:

- ***To evaluate the delivery*** of Northumbria University's clinical training in Parent-led Cognitive Behavioural Therapy (PLCBT*)*. A brief, effective treatment for childhood anxiety disorders offered to parents to help them support their children with fears and worries.
- ***To measure levels of practitioner confidence and skill*** in delivering this clinical intervention to families following university training.
- ***To explore supportive 'clinical supervision'*** that practitioners receive within Services and if it may help to improve or enhance practitioners' confidence and skills and if by doing so, can this better help and support parents to achieve their therapy goals.

I understand that the purpose of this consent form is to give my permission for the (insert name of Service) to record this clinical session for the purposes of in-Service practitioner clinical supervision.

Giving my consent for the clinical session to be recorded is on the understanding that this video will only be used for the purposes of in-Service supervision and will only be watched by the practitioner and the practitioner's supervisor of practice. The clinical session will be recorded using a Service encrypted laptop which only the practitioner will have access to. The video will be watched by the practitioner and supervisor together as part of a clinical supervision session which will form part of a supervisory discussion to support best practice.

Once the video has been watched it will be deleted as per (insert Trust's name) policy and in line with General Data Protection Regulations (GDPR).

GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules. Universities, NHS organisations and companies may use patient data to do research to make health and care better. When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data. Universities and the NHS are funded from taxes, and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'. Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

As part of an analysis of a Parent-led Cognitive Behavioural Therapy intervention either delivered in a small group format or on a 1-1 basis with parents/carers the University of Northumbria and (insert service name) are working together to carry out research to examine practitioners' confidence and skill in delivering this low intensity clinical intervention. Supervisors and practitioners will be discussing the video recording and using a competency scoring tool (post session) to rate the practitioner's skill and confidence in delivering this intervention. The focus of the video recording is to gather information about the practitioner's level of skill and confidence in delivering the intervention *it is not to carry out further assessment or observe you as a parent*.

- I am aware that taking part in this research is voluntary and that I have the right to withdraw at any time without giving a reason. ***(Please circle)***

Yes/No

- I can confirm that I have read the information sheet V3 22.02.23 for the above research study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ***(Please circle)***

  Yes/No

- I confirm that I have read and understand this consent form and I have had sufficient time to decide whether to take part. ***(Please circle)***

  Yes/No

- I have been given a copy of the consent form. ***(Please circle)***

  Yes/No

(Completed form to be retained by the Service)

I agree to take part and give my consent for the practitioner to record a Parent Led Cognitive Behavioural Therapy session.

Signed (Parent/Carer)………………………………………………………………. Date……………………………………….

Name………..

Person taking Informed consent:

Signed………………………………………………………………….. Date……………………………………….

Name………..

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