Therapeutic Relationships in Child and Adolescent Mental Health Services (CAMHS): The TRIC studies

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology (ClinPsyD) in the Faculty of Biology, Medicine and Health

2020

Rachael Ryan

Division of Psychology and Mental Health
School of Health Science

Table of Contents

Thesis abstract 5
Declaration 7
Copyright statement 8
Acknowledgements 9
Paper 1: 10
Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review 10
Abstract 11
Keywords..11
Introduction 12
Methods 14
Results..27
Discussion..36
References..44
Paper 2: 50
Therapeutic relationships in Child and Adolescent Mental Health Services: a Delphi study with young people, carers and healthcare professionals.............................50
Abstract 51
Introduction 53
Methods 55
Results..60
Discussion..75
Funding 81
Acknowledgements 81
References..82
Paper 3 86
Critical appraisal 86
Overview 87
Review topic selection 89
Search term generation 89

Inclusion and exclusion criteria 91
Analysis and write up 93
Inter-rater reliability 93
Summary 94
Topic selection 95
Methodology selection 95
Capacity and consent 96
Recruitment 98
Patient and public involvement 100
Round one statement development 101
Round two statement development 103
Summary 103
Dissemination 104
Personal reflections 104
References 106
Appendix A: Author Guidelines for Clinical Child and Family Psychology Review 115
Appendix B: Table of excluded review papers and reasons 136
Appendix C: Adapted Effective Public Health Practice Project (EPHPP) tool 142
Appendix D: Author Guidelines for Child and Adolescent Mental Health Journal 158
Appendix E: Letter of ethical approval 166
Appendix F: Participant Information Sheet 171
Appendix G: Participant consent form (screenshot) 179
Appendix H: Demographic questionnaire (example of young person screen shot) 181
Appendix I: BAME social media post 182
Appendix J: Fathers social media post 183
Appendix K: Feedback from young people and staff on study image 184
Appendix L: Social media post (Delphi statement) 189
Appendix M: Delphi questionnaire (example of page one, round three screen shot) 190
Appendix N: List of excluded Delphi statements 191
Appendix O: Statements suggested by participants and rationale for inclusion/ exclusion 193

List of figures and tables

Figure 1. *PRISMA flow chart* 17
Figure 2. *Overview of statement inclusion or exclusion* **64**

Table 1. *Study characteristics* **18**
Table 2. *Quality assessment of studies* **29**
Table 3. *Participant demographics* **61**
Table 4. *Statements to define therapeutic alliance* **65**
Table 5. *Statements to define what builds good therapeutic alliance* **66**
Table 6. *Statements to define what hinders good therapeutic alliance* **72**
Table 7. *Statements that reached consensus disagreement* **73**
Table 8. *Round one statement themes* **102**

Word count:

(excluding title pages, references, appendices but including tables and figures)

Paper 1: 10,961

Paper 2: 7,732

Paper 3: 5,983

Total word count (all three papers): 24,676

Thesis abstract

Therapeutic Relationships in Child and Adolescent Mental Health Services (CAMHS):

The TRIC studies

Rachael Elizabeth Ryan

A thesis submitted to the University of Manchester for the Degree of Doctor of Clinical Psychology, May 2020

The aim of this thesis was to understand more about therapeutic relationships within child and adolescent mental health services (CAMHS). The thesis is presented as three separate papers. Paper 1 is a systematic review assessing the impact of therapist characteristics on therapeutic alliance or outcomes for children within mental health services. The search strategy is outlined and a narrative synthesis of the findings of the 15 included studies is presented. The strengths, limitations, quality appraisal of the studies are discussed. The review concludes by outlining the research and clinical implications from the available literature.

Paper 2 is an empirical investigation of the meaning of the concept of therapeutic alliance for young people, parent and staff who access CAMHS. These three participant groups, completed a Delphi method survey outlining what therapeutic alliance is, how good alliance can be build and what hinders good alliance formation. Findings suggest that the definition of therapeutic alliance in child and adolescent services is different from the widely recognised adult definitions. Furthermore, staff characteristics are considered the most important factor impacting on the quality of alliance.

Finally, paper 3 is a critical reflection of the processes involved in conducting the project. This paper provides further detail on the methodology and decision making

processes which took place within the research, alongside considering the strengths, limitations, and suggestions for future research. This paper concludes with personal reflections on the thesis project.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright statement

i. The author of this thesis (including any appendices and/or schedules to this thesis) owns certain copyright or related rights in it (the "Copyright") and s/he has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made only in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trademarks and other intellectual property (the "Intellectual Property") and any reproductions of copyright works in the thesis, for example graphs and tables ("Reproductions"), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property University IP Policy (see http://documents.manchester.ac.uk/display.aspx?DocID=24420), in any relevant Thesis restriction declarations deposited in the University Library, The University Library's regulations (see http://www.library.manchester.ac.uk/about/regulations/) and in The University's policy on Presentation of Theses.

Acknowledgements

Firstly, I would like to thank all of the young people, parents and staff that participated in the study, and kindly shared their expertise. Your knowledge and opinions have been instrumental to this project, and we literally couldn't have done it without you!
Thank you also to those staff and young people at the Hope and Horizon Unit, who shared their invaluable opinion on study advertising materials, statements and accessibility of the study. Additionally, thanks to the Community Liaison Group at the University of Manchester for the initial thought provoking discussions and feedback about the project.
I would also like to thank my clinical tutor, Linda Steen. Your kindness and compassion throughout my training journey has not only supported me, but also inspired me as a psychologist.

Undoubtedly, I would like to thank my research supervisors Professor Katherine Berry and Dr Samantha Hartley. Your patience and encouragement throughout this whole project has been incredible and I don't feel 'thank you' quite covers how much I have appreciated it.

To my D Clin Psyc cohort, thank you for all the fun, laughter and hugs. You have been such an amazing bunch to share this journey with! Thank you also to my wonderful friends and family who have always encouraged me.

To my Mum and dad; your unconditional love and belief in me has been unwavering. I am so proud to share this with you, as you've been with me every step of the way. Last but not least, to my husband Chris. Thank you for incredible pep talks and for sharing the highs and lows of this journey. You really are my cheerleader.

Paper 1:

Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review

Ryan, R. [1], Berry, K.[1], &Hartley, S.[1, 2]

[1] School of Health Sciences, University of Manchester, UK
[2]Pennine Care NHS Foundation Trust

Word count: 11,004 (complete text), 207 (abstract), 6,742 (main text excluding title, table, figure and references).

The following paper has been formatted according to the publication guidelines of Clinical Child and Family Psychology Review. Journal guidelines found in Appendix A.

Abstract

Young people's mental health is a significant concern globally. The evidence base suggests that there is a strong relationship between therapeutic alliance and children's reported outcomes such as symptoms and drop out of services. There are indications that therapist characteristics - including static qualities and dynamic behaviours - can be associated with both alliance and outcomes.

The aim of this review was to systematically collate, summarise and critique studies reporting on therapist characteristics that might influence the therapeutic alliance or outcome for young people accessing child and adolescent mental health services. Four databases were searched for 'therapist' and 'characteristic' combined with 'alliance' or 'outcome' and related terms associated with these topics.

A review of 15 papers showed that therapists' in-session behaviours and interpersonal style have a significant impact on alliance or outcome. One study also indicated important associations with attachment style. Findings related to ethnicity, gender and level of experience were complex, highlighting differences between sub-groups, ages, outcome measurement and diagnostic categories. Methodological issues such as secondary analysis on administrative data confounded the interpretation of results. Future research needs to adopt a prospective design and measure therapist characteristics and their relationship to alliance or outcome over time.

Keywords

Adolescent, alliance, outcome, therapist, practitioner, clinician, mental health

Introduction

The mental health of children and adolescents is a significant problem globally with 10-20% of children having a diagnosable mental health problem (World Health Organization, 2018). A robust evidence base exists to show that effective mental health support for children improves both their individual wellbeing, an addition to conferring an economic benefit for services (McDaid, 2011). The evidence base for supporting children and young people's mental health considers multiple measurements of progress or outcome. Outcome has broadly been defined within the literature as symptom change, global functioning, service use (Shirk, Gudmundsen, McMakin, Dent, & Karver, 2003), alongside engagement with or dropout from treatment (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). Meta analyses suggest that a key indicator and predictor of positive outcomes, is the relationship the young person and family has with their therapist (S. R. Shirk, M. S. Karver, & R. Brown, 2011). Specifically, research indicates that this therapeutic alliance predicts symptom improvement for young people, both when interventions are individually carried out with the young person (Hawley & Weisz, 2005), or as part of a family intervention (Shelef, Diamond, Diamond, & Liddle, 2005).

Therapeutic alliance has been an area of interest within adult psychotherapy for many years, where it is seen as crucial in the delivery of effective care and good outcomes in therapy (Fluckiger, Del Re, Wampold, & Horvath, 2018). Bordin (1979) argued therapeutic alliance had three essential components; (a) therapist and client agreement on the goals of therapy; (b) therapist and client agreement on the tasks of therapy; and (c) emotional bond between the therapist and client.

Green (2009), suggests that working with children and adolescents is complex, especially in terms of therapeutic relationships. For example, a young person might see a psychologist for therapy, a nurse for care coordination and risk management and a social worker for group intervention. Whilst this may also be true of adult services, parents are also often involved. This creates multiple relationships and opinions to be considered (Green, 2009). Therefore, therapeutic alliance and related

outcomes in child and adolescent services, is a complicated picture and might require more nuanced and focused investigation.

Research has started to try to define factors that impact alliance or outcome for young people receiving mental health support. This is due to the wide span of evidence demonstrating better outcomes for children's mental health is essential for their mental health as an adult (Department of Heath, 2017). Most of the research has focused on child contributors to the alliance or outcome (Shirk & Karver, 2003b). Green (2006) found that the child's diagnosis and whether their difficulty is of an internalizing or externalizing nature can have an impact on alliance. There is also evidence that how much contact young people have with deviant peers has a medium to large effect size on children dropping out of treatment (de Haan et al., 2013).

A recent meta-analysis highlighted the strength of the association between alliance and outcomes for young people in mental health treatment, although cast some doubt on previous hypotheses regarding the level that therapists variability contributes to this relationship (Murphy & Hutton, 2018). Previous research has shown that therapist factors, including in-session behaviours have been shown to have medium to large effect sizes when predicting alliance (de Haan et al., 2013). Manso, Rauktis, and Boyd (2008) asked young people what qualities they thought were essential for their therapists to have. Youth reported that therapists needed to be caring and trustworthy, be open to listening to the young person and show respect. Reviews within the adult literature have found similar therapist qualities to be essential to good alliance and outcome (Ackerman & Hilsenroth, 2001; Ackerman & Hilsenroth, 2003). However, there is currently no critical synthesis of therapist factors that might impact on alliance and outcomes in the context of child mental health services.

Aim

To systematically collate, summarise and critique studies reporting on therapist characteristics that influence the therapeutic alliance or outcome with young people

accessing child and adolescent mental health services. In order to capture the outcomes most relevant to services, the review sought to incorporate studies focused on therapeutic alliance or outcomes measured using definitions such as symptom change, engagement in services and global functioning (Shirk et al., 2003).

Methods

The review was conducted in accordance with guidelines from the Preferred Reporting Items for Systematic Review and Meta-Analysis PRISMA (Moher, Liberati, Tetzlaff, & Altman, 2009). The review was registered on Prosopero: ID CRD42020165770.

Search strategy

Papers were identified through searching the following databases: PsycINFO, PsycARTICLES, MEDLINE and CINAHL. Search terms were 'staff' OR 'therapist' OR 'counsellor' OR 'practitioner' OR 'clinician' OR 'counselor' AND 'mental' OR 'psychiatr*' OR 'counsel*' OR 'therapy' OR 'psychotherapy' AND 'youth' OR 'young' OR 'adolescen*' OR 'child*' AND 'alliance' OR 'outcome' OR 'therapeutic relationship' OR 'working relationship' OR 'helping relationship' OR 'drop*out'. Searches were limited to the title and abstract field. Related reviews and their reference lists were used to develop search terms and to identify additional relevant papers (Karver, Handelsman, Fields, & Bickman, 2006; Murphy & Hutton, 2018; Sánchez-Bahíllo, Aragón-Alonso, Sánchez-Bahíllo, & Birtle, 2014; Shirk & Karver, 2003b; S. R. Shirk et al., 2011). The reference lists of included papers were also hand searched for further potentially eligible studies.

Eligibility criteria

Studies were included in the review if they met the following criteria: (1) reported data on children or adolescents (maximum age 18) who were accessing a service to support their mental health; (2) used a validated therapist variables scale or defined demographics or an objective measurement of behaviour; (3) used a validated

therapeutic alliance scale OR a well operationalized or validated outcome measurement; (4) therapeutic alliance was assessed between client and mental health provider in the context of an individual relationship, even if the treatment was not individual therapy per se, for example, psychosocial interventions, group interventions, medication management, psychotherapy, care coordination, behaviour management; (5) a peer reviewed journal article; and (6) published in English.

Studies were excluded if the research was measuring a group alliance or outcome. Studies were also excluded if the alliance/outcome was reported for participants over the ages of 18 only or if the data for under 18s was not reported separately.

Study selection

Figure 1 depicts the flow of records through the study selection process. The database search and reviewing of key texts retrieved 8,806 records. After removing duplicates, the lead reviewer screened 7,200 titles and abstracts for relevance (stage 1). The full texts of potentially eligible papers (k = 120) were read in full, and reviewed against the inclusion and exclusion criteria (stage 2). A second reviewer independently screened a randomly selected 10 percent of the titles and abstract and the full text journals. Agreement was fair to substantial (Cohen's k=. 36 and k=. 66) between the two reviewers for stage one and two, respectfully. Discrepancies were discussed and resolved within the research team. Fifteen final papers were included in the review.

Quality assessment

The lead author assessed all eligible studies for quality using an adapted version of the Effective Public Health Practice (EPHPP) tool (Thomas, Ciliska, Dobbins, & Micucci, 2004). An adapted version of the tool was used due to the largely observational design of the reviewed studies and the consequent irrelevance of items related to blinding and intervention. The subcategory of the analysis item, 'are the statistical methods appropriate for the study design' was retained with the other three sections removed due to intention to treat and allocation status not being

deemed relevant to the study designs. An assessment of the use of a valid or reliable therapist characteristic was added to the tool, in line with the review inclusion criteria. As alliance or outcome was assessed, the quality of these specific analyses was also appraised separately. Therefore, the adapted EPHPP had eight components: (1) selection bias; (2) study design; (3) confounders; (4) data collection–therapist characteristic; (5) data collection–alliance; (6) data collection–outcome; (7) withdrawals and dropouts; and (8) analysis. Each section was rated as 'strong', 'moderate' or weak'. The EPHPP has been found to be a reliable tool in healthcare reviews of relationships within services, even when adapted (Degnan et al., 2018; Hartley, Raphael, Lovell, & Berry, 2020; Lavin, Bucci, Varese, & Berry, 2020). For the purposes of this review, a second reviewer assessed 50% of eligible journal articles for quality. A strong inter-rater agreement was reached (k= .90).

Data extraction

The data extracted from the papers included study setting; design; therapist demographics (including how this was measured if it was the therapist characteristic of interest); child demographics; measure of outcome or alliance; analysis and key findings. The lead author completed data extraction, with a second reviewer checking a third of papers with full (k=1.0) agreement.

Analysis

A meta-analysis was not performed due to the heterogeneity of studies. Therefore, a narrative synthesis (Mays, Roberts, & Popay, 2001) was conducted, reporting effect sizes of individual studies where available. This approach involved describing and critically appraising the reviewed studies and combining the evidence into a narrative within a coherent framework. The studies were collated and grouped based on therapist characteristic for ease of interpretation. The impact on alliance or outcome is then outlined.

Figure 1. *PRISMA flow chart*

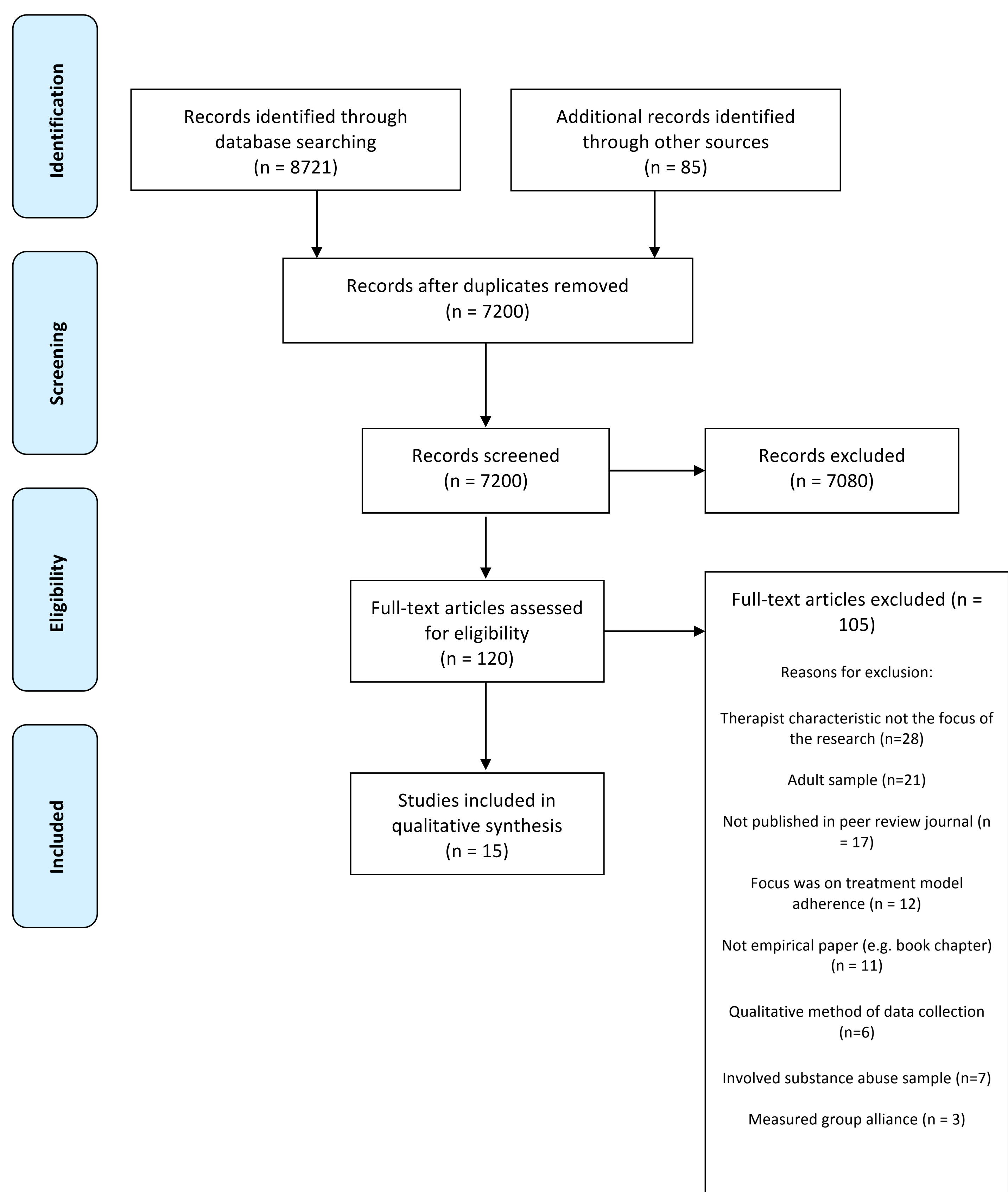


Table 1. *Study characteristics*

Study setting, Country, author and year	Study design	Therapist characteristics (how measured)	Child/adolescent characteristics	Measure of alliance	Measure of outcome	Analysis	Key findings
Outpatient, North America Yeh et al. (1994)	Cohort, retrospective	*No therapist demographics reported in paper* Ethnicity Language spoken (Service data)	4616 youth total 1517 (aged 6-11) 3099 (aged 12-17) **Race** African Americans 26.4% Asian Americans 19.6 % Caucasian Americans 21.5% Mexican Americans 32.5%	N/A	Dropout Length of treatment Global Assessment Scale (GAS)	Regression analysis	Ethnic matching significantly associated with outcome for groups of adolescents, but not children. When Asian youth were ethnically matched, this reduced dropout, increased number of sessions attended. It did not matter if they were language matched. When African youth were ethnically matched, this reduced dropout only
Outpatient, North America Hall et al. (2002)	Cohort, retrospective	*No therapist demographics reported in paper* Ethnic match Gender match Language spoken match (Service data)	4,616 youth 6 to 17 years **Ethnicity** Black 26.4% Asian 19.6% Mexican 32.5% White 21.5%	N/A	(GAS) discharge score Dropout Number of sessions attended Number of days in treatment	Multiple regression	**Ethnic match** Ethnic matching reduced reported drop out for all groups except White compared to unmatched therapists/youth **Gender match** Gender match was not a significant variable in determining dropout for any of the ethnic groups **Language match** Mexican Americans only attended more sessions if language was matched

Outpatient, North America Gamst et al. (2004)	Cohort, retrospective		1946 total youth 6–10 years; M = 8.38 30.1% 11–13 years; M = 12.06, 24.9% 14–18 years; M = 16.01 45% - named *middle adolescent**	N/A	Global Assessment of Functioning (GAF) discharge score Number of intervention sessions attended	ANCOVA- adjusting for a range of covariates	No impact of ethnic matching on GAF scores Ethnic matching was associated with fewer visits but only for African American children **Specific diagnoses** Ethnic matching of middle adolescent Latino and African American clients with mood disorders resulted in better clinical outcomes Ethnically matched Latino American clients with schizophrenia- had significantly more mental health visits No significant findings for anxiety disorder
Outpatient, North America Creed et al. (2005)	Cohort	*No therapist demographics reported in paper* Therapist Alliance-Building Behavior Scale (TABBS)	56 children (7-13 years, M9.53, SD=1.83) **Gender** Male 60.7% Female 39.3% **Race** Caucasian 92.9% African American 5.4%	Therapeutic Alliance Scales for Children (TASC) for Child and Therapist	N/A	Linear regression	**Early alliance influencers (session 3)** Positive impact on alliance: “collaboration” between therapist and child was predictive of higher child ratings of alliance at session 3. **Negative impact on alliance:** therapists “finding common ground” “Pushing the child to talk” about anxiety

			Other 1.7% All had a principle diagnosis of anxiety				beyond his or her comfort level was predictive of lower child ratings of an alliance both early on and later sessions (session 7).
Accident and Emergency or admitted onto an inpatient unit, North America Karver et al. (2008)	Cohort	6 therapists **Gender** Female 83.3% Male 16.7% **Ethnicity** Caucasian 100% **Education level** Doctorate in clinical psychology 83.3% Master's 16.7% (Engagement behaviours using the Adolescent Alliance Building Behavior Scale)	23 youth Mean age was 14.6 years (SD = 1.8) **Gender** Female 85% Male 15% **Ethnicity** Unknown 78% Hispanic 22% **Socioeconomic status** High 17% Low 57% **Diagnosis** Depressive symptoms and a suicide attempt	Working Alliance Inventory (WAI) The short version (Tracey & Kokotovitc, 1989)	Youth involvement in sessions measured by Vanderbilt Psychotherapy Process Scale	Correlation	**Positive behaviours:** Therapist rapport behaviors (exploring subjective experience of feelings, thoughts, or wishes; support) were strongly positively related (and statistically significant) to teen perception of the therapeutic alliance in CBT but not in NST in Session 1, despite being equally present and comparably variable in both treatments **Negative behaviours:** From session two - distorting or misunderstanding information, failing to acknowledge emotion, being criticizing to the youth, eliciting too much information about an event or situation, and too much recalling of prior information by client Other alliance observations Socialization behaviours (presents model, presents collaborative approach, and goal setting) created positive alliance in CBT where this happened more frequently, but negative alliance in NST Therapeutic alliance accounted for significant variance in subsequent youth

							treatment involvement
Outpatient, North America Russell et al. (2008)	Cohort	8 therapists **Gender** Female 100% **Education** Doctoral level psychologists 100% (Adolescent Alliance Building Scale; AABS)	54 youth Age 14 -18 years Mean age 15.8 **Gender** Female 66.7% Male 33.3% **Ethnicity** The sample was European American 57% Hispanic 22% African American 17% **Diagnosis** Depressive disorder	Therapeutic Alliance Scale for Adolescents (TASA)	N/A	Multivariate p-technique analysis	**Positive behaviours:** experiential socialization (r.26, pB.07), therapist responsiveness (r (32)=. 38, pB.02), including provides support, humor. Remoralization (r (32)=. 34, pB.03) including setting positive expectations, explores adolescent's motivation, praises adolescent, challenges pessimism **Negative behaviours:** elicits objective information, elicits/ explores subjective information, not recalling information, criticising the adolescent, fails to acknowledge adolescent's emotion
Community, North America, Greeson et al. (2009)	Cohort, retrosp ective	412 therapists **Race** Caucasian 74.5% African American 20.9% Other 0.5% **Gender** Male 18.2% Female 79.1% **Age in Years on Hire Date** 29.6 (7.9) **Therapist Experience in Months** 7.7 (9.6) **Level of Education**	1,416 youth Mean age 13.1 (SD=3.2) **Gender** Male 66.7% Female 33.3%	N/A	1-year post-discharge data: Youths' educational attainment Legal problems Living arrangements Level of care/service involvement	Estimated Ordered Logistic Regression Model	Likelihood of having an undesirable youth outcome for a female therapist was 87% lower than that for a male therapist (p < .01) Therapists race, age, level of education and experience did not significantly affect outcome

		Bachelor’s 48.5% Master’s 43.7% **Major** Counseling 17.0% Criminal Justice 3.9% Education 6.6% Psychology 27.4% Religion 4.4% Social Work 19.7% Sociology/Anthropology 6.1% Other 6.6%" (service use data)					
Outpatient, North America Jungbluth et al. (2009)	Cohort	8 therapists **Gender** Female 100% **Level of education** Doctoral psychologists 100% (Adolescent Alliance Building Scale; AABS, were coded from audiotapes of the first session of therapy)	42 adolescents 18-18 years old (M = 15.7) **Gender** Female 64.2% Male 35.8% **Ethnicity** Caucasian 45% Hispanic 26% African American 19% Mixed 14%***data reported incorrectly in paper* **Diagnosis** Depression	N/A	Assessed client involvement during Sessions 2, 4, and 8 using the five-item Patient Participation subscale of the Vanderbilt Psychotherapy Process Scale	Partial correlation	**Significantly positive behaviours at session 2:** Therapists attending to the client experience (elicits information about events, situations, thoughts, feelings, internal states; summarizes elicited content), exploring motivation (Therapist elicits teen’s reasons for working in therapy) and structuring (high level of therapist activity and direction) **Non-significant, but positive behaviours:** Therapist being supportive (provides warmth, concern, validation)

Outpatient, North America Garland et al. (2012)	Cohort	78 therapists Gender Female 86% Male 14% Ethnicity Caucasian 65% Unknown 35% Discipline Marriage & Family Therapy 57.7% Psychology 20.5% Social Work 21.8% Experience Mean 2.6 years (therapist level of experience)	181 children age 4–13 years (M=9) **Gender** Female 33.1% Male 66.9% **Ethnicity** Caucasian 49.2% Latino/Hispanic 29.8% African American 8.8% Other/Mixed 12.2% **Diagnosis** Disruptive behavior problem	N/A	Total number of treatment sessions attended	Unadjusted correlations	Therapists with greater experience had youth who were more engaged in attending sessions
Outpatient, Spain de La Peña et al. (2012)	Cohort	6 therapists **Gender** Female 66.7% Male 33.3% **Ethnicity** White Spanish **Education** Masters 100% **Clinical experience** Range 2-23 years (Therapist/ youth interactions)	10 youth Aged between 13-17 (M = 15) **Ethnicity** White Spanish **Diagnosis** Conduct disorder or antisocial behaviour	SOFTA-o The System for Observing Family Therapy Alliances	N/A	Mann–Whitney U	Youth and therapist interaction style affects the alliance When interactions are competitive, this negatively impacts the alliance When interactions are complimentary from both parties, this has little effect on the alliance Too much therapist dominance negatively impacts alliance Therapists need to hold the equal or more power in the conversation to have a good alliance. If youth hold this role, this has a negative impact on alliance

							Therapists need to adapt their style if the youth is passive to ask open ended questions rather than frequent, close ended questions
Residential facility, North America Duppong Hurley et al. (2013)	Cohort	124 therapists **Gender** Male 50% Female 50% (gender collected by service data)	145 youth Aged 10+ years **Diagnosis** Disruptive behavior 100% Service use First admission to agency	Therapeutic Alliance Quality Scale (TAQS)	N/A	Correlation	Strong positive alliance formed with both male and female therapists Male therapists had greater improvement in alliance scores compared to females
Outpatient, North America, Podell et al. (2013)	Cohort	38 therapists Age in years (M ± SD) 30.08 (4.40) **Gender** Female 84.2% Male 15.8% **Race** Caucasian 92.1% Asian 2% Other 1% **Professional Degree** PhD 57.9% PsyD 2.6% Masters 36.8% Social Work 2.6% **Prior clinical experience in**	279 youth Mean youth age 10.76 (SD=2.79) **Race** Caucasian 79.6% Hispanic 13.3% African American 9% Asian 2.5% Pacific Islander 0.4% American Indian 1.4%	N/A	Clinical Global Impression-Severity and Improvement Scales (CGI-S) Global Assessment Scale for Children (CGAS) Pediatric Anxiety Rating Scale (PARS) Child Behavior Checklist (CBCL) Multidimensional Anxiety Scale for Children (MASC)	Bivariate Correlations	Collaborative “coach” style predicted fewer child-reported symptoms Higher ratings of a therapist “coach” style were significantly correlated with higher levels of clinical experience, higher study caseload, therapists with a master’s degree, and older therapist age More years of prior clinical experience predicted better outcome whereas more anxiety-specific experience was linked to less optimal outcomes

		years (M ± SD) 5.59 (2.42) **Prior # of anxious youth cases treated** (M ± SD) 14.71 (8.39) (Therapist Information Form: TIF & Therapist style measured rated on CBT Checklist (CBTC) from video tapes of sessions)					
School health clinics, North America Mufson et al. (2014)	Cohort, retrospective	13 therapists **Gender** Female 84.6% Male 15.4% **Ethnicity** Caucasian 46.2% Latino 46.2% African American 7.6% **Discipline** Social workers 84.6% Clinical psychologists 15.4% (ethnic matching, service use data)	63 adolescents Range: 12 - 18 years Mean age 15.9 years (SD 1.9) **Gender** Female 86% Male 14% **Ethnicity** Latino 74.6% African American 14.3% Other 9.5% Asian 1.6%	N/A	Hamilton Rating Scale for Depression (HRSD) Beck Depression Inventory (BDI) Global Functioning Children's Global Assessment Scale (CGAS). Clinical Global Impression (CGI)	Multiple regression	Ethnic matching improved treatment outcome
Residential Care, North America Duppong Hurley et al. (2017)	Cohort	*No therapist demographics reported in paper* (Token economy - 4:1 ratio of positive to negative interactions from staff to youth recorded on youth review cards)	112 youth 10 to 17 years **Gender** Female 42.9% Male 57.1% **Ethnicity** White 39.3% Mixed 24.1% African American/ Black 23.2% Hispanic or Latino 10.7%	The Therapeutic Alliance Quality Scale (TAQS; Bickman	Child Behavior Checklist (CBCL)	Multiple regression	When interactions were 80% positive, there is a statistically significant improvement in therapeutic alliance and reduced CBCL scores at 6 months.

			Native American 1.8% Asian 0.9% **Diagnosis** Disruptive behavior First admission to the program				
Community hospital, Italy Muratori et al. (2017)	Cohort	6 therapists (Attachment Style Questionnaire; ASQ & level of experience)	80 children 8–12 years **Diagnosis** Oppositional defiant disorder 68% Conduct Disorder 32% Comorbid ADHD 32% Comorbid mood disorder 10%	N/A	Children's Global Assessment Scale (C-GAS) (Shaffer et al. 1983) Child Behavior Checklist (CBCL) (Achenbach and Rescorla 2001)	Multilevel modelling	**Secure attachment style** Positive child outcomes **Anxious attachment style** Increase in aggression score Create anxious and dependent relationships **Avoidant attachment style** Does not influence outcome **Overall finding** Therapists preoccupation with relationships may affect the outcomes of an intervention for children with a diagnosis of DBD

Results

An overview of included studies can be found in Table 1. The majority of studies were conducted in North America (n= 13) using data collected from free public health services or funded trials by the National Institute for Mental health research. Two studies were conducted in Europe (Italy, n=1; Spain n=1) with children who have also accessed free community services.

Two studies used data from the same database (Hall, Guterman, Lee, & Little, 2002; Yeh, Eastman, & Cheung, 1994) and two further studies used data from the same trial (N. J. Jungbluth & S. R. Shirk, 2009; Russell, Shirk, & Jungbluth, 2008). The diagnosis of the youth sample was varied; including anxiety, depression and conduct disorder. The reported age range of children and adolescents was between four and 18 years of age. Participants were recruited from both outpatient (k=13) and inpatient (k=2) settings. The number of therapists included in each study ranged from two to 421.

Quality assessment of studies

Table 2 provides a summary of the results of the quality appraisal for each paper. All studies were defined as cohort studies and so had a moderate study design rating. This classification was given as studies had a minimum of two data collection time points, either pre, during or post an intervention. For some studies, baseline therapist demographics were used as a measure of therapist characteristic. For other studies, therapist characteristics were captured as part of the intervention, for example within session behaviours.

The majority of studies recruited young people via professionals from schools, clinics and hospitals, reducing the representativeness sample of participants (Creed & Kendall, 2005; Duppong Hurley, Lambert, Van Ryzin, Sullivan, & Stevens, 2013; N. J. Jungbluth & S. R. Shirk, 2009; Karver et al., 2008; Muratori et al., 2017; Podell et al., 2013; Russell et al., 2008). On one occasion, information needed to assess the

quality of selection bias by Karver et al. (2008) was found in the original pilot study (Donaldson, Spirito, & Esposito-Smythers, 2005).

Five of the studies included service use data that was initially collected for administrative purposes, with analysis was then performed at a later date. Therefore, the information was collected without the primary aim of therapist characteristics being investigated. This potentially weakened the data collection or analysis options available for those studies (Gamst, Dana, Der-Karabetian, & Kramer, 2004; Garland, Haine-Schlagel, Accurso, Baker-Ericzen, & Brookman-Frazee, 2012; Hall et al., 2002; L. Mufson, P. Yanes-Lukin, M. Gunlicks-Stoessel, & P. Wickramaratne, 2014; Yeh et al., 1994). Only two studies specifically recruited participants to test the impact of therapists' interactions (de La Peña, Friedlander, Escudero, & Heatherington, 2012; Duppong Hurley, Lambert, Gross, Thompson, & Farmer, 2017). Whilst all analyses were appropriate for the design, some studies were weak in accounting for confounds (Duppong Hurley et al., 2013; Hall et al., 2002; Karver et al., 2008; Russell et al., 2008). When confounds such as child age, diagnosis, socio economic status were considered, this strengthened the quality of the results (Creed & Kendall, 2005).

Table 2. *Quality assessment of studies*

Author	Selection bias	Study design	Confounders	Therapist characteristics	Alliance measure	Outcome measure	Withdrawal/ Dropout	Analysis	Overall rating
Yeh et al, 1994	Moderate	Moderate	Moderate	Weak	N/A	Moderate	Weak	Moderate	Weak
Hall et al, 2002	Moderate	Moderate	Weak	Weak	N/A	Moderate	Moderate	Moderate	Weak
Gamst et al, 2004	Moderate	Moderate	Strong	Moderate	N/A	Moderate	N/A	Strong	Strong
Creed et al, 2005	Moderate	Moderate	Strong	Strong	Strong	N/A	N/A	Strong	Strong
Karver et al, 2008	Weak	Moderate	Strong	Strong	Strong	N/A	N/A	Strong	Moderate
Russell et al, 2008	Moderate	Moderate	Strong	Strong	Strong	N/A	N/A	Strong	Strong
Greeson et al, 2009	Moderate	Moderate	Moderate	Weak	N/A	Moderate	N/A	Strong	Moderate
Jungbluth et al, 2009	Moderate	Moderate	Strong	Strong	N/A	Strong	N/A	Strong	Strong
Garland et al, 2012	Strong	Moderate	Strong	Strong	N/A	Moderate	Weak	Strong	Moderate
de La Peña et al, 2012	Weak	Moderate	Strong	Strong	Strong	Strong	N/A	Strong	Moderate
Duppong Hurley et al, 2013	Weak	Moderate	Weak	Weak	Strong	N/A	N/A	Strong	Weak
Podell et al, 2013	Strong	Moderate	Strong	Weak	N/A	Strong	N/A	Strong	Strong
Mufson et al, 2014	Weak	Moderate	Strong	Weak	N/A	Strong	N/A	Strong	Weak
Duppong Hurley et al, 2017	Strong	Moderate	Strong	Moderate	Strong	Strong	N/A	Strong	Strong
Muratori et al, 2017	Moderate	Moderate	Weak	Strong	N/A	Strong	N/A	Strong	Moderate

In order to address the review aims and retain clarity, the main findings are organised by therapist characteristic. The therapist characteristics are broadly categorised as static characteristics (that are fixed or more stable): attachment style, ethnicity, gender and level of experience; or dynamic variables (that change): therapist alliance behaviours and interpersonal interactions. The impact on alliance or outcome is discussed within each characteristic category. Nine studies looked at

the impact of therapist characteristics on outcome alone (Gamst et al., 2004; Garland et al., 2012; Greeson, Guo, Barth, Hurley, & Sisson, 2009; Hall et al., 2002; N. J. Jungbluth & S. R. Shirk, 2009; L. Mufson et al., 2014; Muratori et al., 2017; Podell et al., 2013; Yeh et al., 1994), four looked at the impact on alliance alone (Creed & Kendall, 2005; Duppong Hurley et al., 2013; Russell et al., 2008) and two measured both (de La Peña et al., 2012; Duppong Hurley et al., 2017; Karver et al., 2008).

Therapist attachment style

One study assessed the influence of the therapist attachment style on children's outcomes in a hospital setting (Muratori et al., 2017). Six therapists completed the reliable and validated Attachment Style Questionnaire (ASQ) (Feeney, Noller, & Hanrahan, 1994). Children were systematically recruited for the study when accessing the service, reducing selection bias. Furthermore, the clinical outcomes of the 80 children who took part were measured using the valid and reliable Children's Global Assessment Scale (C-GAS) (Shaffer et al., 1983) and Child Behaviour Checklist (CBCL)(Achenbach & Rescorla, 2000). Results suggested that when therapists had a secure attachment style, children demonstrated positive outcomes in terms of reduction in symptoms. Interestingly, when therapists demonstrated an anxious attachment style, this increased children's level of aggression at the end of an evidence-based intervention compared to baseline scores. However, avoidant attachment styles in therapists did not statistically significantly predict outcomes. Moreover, multilevel modelling revealed that child diagnoses and the levels of the therapist preoccupation with relationships significantly predicted the change in aggressive behavior. However, this is only one study and as such, a possible association between therapist attachment and outcomes must be treated with caution until further corroborating evidence is available.

Therapist ethnicity

Four studies looked at the effect of matching youth and therapist ethnicity and the impact this had on outcomes in outpatient settings (Gamst et al., 2004; Hall et al., 2002; L. Mufson et al., 2014; Yeh et al., 1994). All studies took place in North

America, with a range of ethnicities included: Latino American, African American, Asian American and Caucasian American. Generally, studies found that when youth and therapist ethnicity was matched, it produced better outcomes. Examining the findings in more detail portrays a more complex picture. Gamst et al (2004) showed that there was no effect of ethnic matching on global functioning. However, there was a significant relationship between ethnic matching and number of service visits for African American children, although caution is required due to the relatively low number in this sub-group. Moreover, when analysing the results by diagnosis, age and ethnic group, ethnic matching was significantly associated with outcomes in some but not all cases. The study design allowed for control of potentially confounding variables and therefore adds to the confidence with which these detailed findings can be accepted. In addition, Hall et al. (2002) demonstrated a link between ethnic matching and reduced drop-out but this did not hold for those who identified as White Caucasian. The authors suggested that ethnic matching was less important to this group as the research took place in a context where this group were the majority and therefore might face fewer challenges related to cultural difference.

L. Mufson et al. (2014) completed a secondary analysis on data from a previous study (Mufson et al., 2004). Comprehensive youth outcome measures were used to measure symptom improvement when ethnicity was matched, across two intervention conditions. Whilst the sample size was small (n=63), key confounds including intervention type were accounted for in the analysis, with ethnic matching remaining significantly associated with better treatment outcome in terms of social functioning and depression.

Yeh et al. (1994) and Hall et al. (2002) both reviewed the same large data set of 4,616 children and young people,. This data was collected using an Automated Information System (AIS) from children who accessed Los Angeles County mental health system between 1982 and 1988. Yeh et al. (1994) separated the analysis by the age of the youth to see how this moderated the effect of ethnic matching on outcomes. They found that ethnic matching mattered for the outcome for

adolescents (aged 12-17), but not for younger children (aged 6-11). Yeh et al. (1994) and Hall et al. (2002) also examined language matching. Overall, language matching did not significantly impact outcome in either study, apart from in Mexican American adolescents (Hall et al., 2002) who attended more sessions if their language was matched with their therapist's.

Overall, there seems to be evidence to suggest that ethnic matching is an important factor for youth mental health outcomes. However, the picture is complex; significant associations vary by age group, diagnosis and ethnic group. Moreover, all data collected to assess the impact of ethnic matching were not collected with this primary research question in mind and was analysed retrospectively. Therefore, although confounds were controlled for in analysis, there will be inherent confounds in the poorer quality data, which cannot be controlled for. Consequently, caution needs to be taken when considering these findings, especially given that at the time of writing this review, this data is more than 30 years old.

Therapist gender

Three studies examined the impact of therapist gender. This comprised both investigations of gender matching between youth and therapist (Hall et al., 2002), and if having a male or female therapist *per se* affected outcome (Greeson et al., 2009) or alliance (Duppong Hurley et al., 2013).

Based on service use data (n=4,616), Hall et al. (2002) conducted a secondary analysis and found that gender match was not a significant variable in determining dropout from treatment for adolescents. This study was rated as moderate in terms of the quality of analysis and consideration of confounds, giving some confidence in the findings.

Interestingly, there were apparently conflicting findings regarding therapist gender, with Greeson et al. (2009) (n=1,416) showing less chance of undesirable outcomes for female therapists, while Duppong Hurley et al. (2013)(n=145) found that youth

who had male therapists showed more improvement in alliance scores over time, although both genders could cultivate strong alliances. Greeson et al. (2009) used database information was not collected for the primary focus of answering the research question. Therefore, there was less scope to account for other potentially unknown confounds such as nested data when therapists in this study worked with more than one youth. Duppong Hurley et al. (2013) used a prospective study design to measure alliance using the Therapeutic Alliance Quality Scale (Bickman et al., 2010) in both residential and outpatient settings. Again, the primary focus of the research was to validate the measure, rather than look at the effect of gender on outcome. Therefore, there is a risk of positive findings being more favourably reported when there is limited other data to discuss.

Overall, the impact of therapist gender on outcome or alliance for youth needs to be interpreted with careful consideration of the limitations of secondary analysis on pre-existing data and the complexity of the findings.

Therapist level of experience

The level of the therapist experience was considered across three papers in outpatient settings (Garland et al., 2012; Greeson et al., 2009; Podell et al., 2013). Podell et al. (2013) and Garland et al. (2012) found therapists who had higher levels of experience had significantly more positive outcomes at discharge and total number of treatment sessions attended in community clinics, respectively. The picture is complicated by its specificity though, with Podell et al. (2013) showing that although longer general therapeutic experience led to better outcomes, experience specifically related to working with anxiety disorders was associated with poorer outcomes. When Greeson et al. (2009) analysed a large service administration data set, there were no significant results found for therapist level of education or experience on child service use or post discharge outcomes. The sensitivity of this data for specifically exploring the relationship between experience and outcome as a secondary data analysis limits this finding (Greeson et al., 2009). Moreover, different measurements of outcome, such as session attendance (Garland et al., 2012) and

child symptoms (Garland et al., 2012; Podell et al., 2013) at different time points may not be easily comparable and could account for some of the differences.

Therapist alliance behaviours

Four papers explored the impact of therapist behaviours and reported on studies located across both outpatient (Creed & Kendall, 2005; N. J. Jungbluth & S. R. Shirk, 2009; Russell et al., 2008) and inpatient/hospital settings (Karver et al., 2008). Three out of the four papers were from the same research group (N. J. Jungbluth & S. R. Shirk, 2009; Karver et al., 2008; Russell et al., 2008) and used the validated and reliable Adolescent Alliance Building Behavior Scale (Shirk et al., 2003). Overall, all studies found that when therapists demonstrated behaviours including being responsive to the young person's feelings, facilitating collaboration, eliciting information about situations and internal states and providing a summary of discussions this had a positive significant impact on building alliance. When therapists were supportive, showed warmth, concern and validated the young person's feelings, this also had a positive, but non-significant impact on youth engagement. Conversely, when therapists engaged in behaviours such as pushing the child to talk, forgetting something the young person had previously said or not acknowledging their emotions, this negatively impacted the alliance (Creed & Kendall, 2005; Russell et al., 2008).

Overall, these studies were strong in their measurement of therapist behaviours, using double scored audio and videotapes using the Therapeutic Alliance Scale for Adolescents (TASA) or Therapist Alliance-Building Behavior Scale (TABBS). Moreover, Creed and Kendall (2005), N. J. Jungbluth and S. R. Shirk (2009) and Russell et al. (2008) accounted for key confounds such as economic status, adolescent initial resistance to therapy and baseline adolescent symptoms. Karver et al. (2008) also controlled for confounding variables using regression analysis and concluded that therapist behaviours significantly predicted observed but not self-reported therapeutic alliance. The majority of studies had moderate selection bias as school personnel, clinicians or parents referred young people into the studies. Whilst Karver

et al. (2008) attempted to reduce bias by inviting all adolescents attending the service to participate, only 52% took part, contributing to a weak selection bias rating. Finally, the positive alliance building behaviours previously outlined were measured in different treatment models, for example Cognitive Behavioural Therapy (CBT) and Nondirective Supportive Therapy (NST), with findings for the two models varying, highlighting the need to explore effects across therapeutic approaches. Overall, this body of research was strong and the findings about the impact of therapist behaviours on alliance are robust yet complex, with varied results depending on the nature of the intervention, specific type of therapist behaviour and method of alliance assessment.

Interpersonal interactions

Three studies examined the impact of interpersonal interactions between staff and young people on alliance (de La Peña et al., 2012), outcome (Podell et al., 2013) or both (Duppong Hurley et al., 2017). In outpatient clinics, higher ratings of therapist 'coach style', incorporating collaboration and flexibility, were associated with better anxiety outcomes (Podell et al., 2013). Duppong Hurley et al. (2017) identified that positive interactions in therapy improved therapeutic alliance and outcomes at six months.

de La Peña et al. (2012) demonstrated that the way therapists specifically respond to young people is paramount to successful interaction. Five families with good alliance, and five with poor alliance were selected to assess interactions during sessions using the Family Relational Communication Control Coding System (FRCCCS) (Friedlander & Heatherington, 1989). When adolescents and therapists (regardless of who initiates the conversation) both hold a dominant role within the relationship and interacted in a competitive way, this was shown to have a significant negative effect on the alliance. When youth show a passive communication style, therapists needed to adapt their communication style to be inquisitive and open-ended. When multiple closed questions were asked, adolescents perceived this as interrogative (de La Peña et al., 2012). On the other hand, when interactions were coded as complimentary (FRCCCS) and there was an underlying acceptance of

dominance/submissive roles within the interactions, then only small effects were evident. The authors argued that whilst it is not helpful for therapists to be dominant or interrogative, they need to hold more or equal control of dominance compared to youth to have a positive alliance (de La Peña et al., 2012). However, the families in this study were a small sample selected from a service based on alliance ratings, potentially limiting the generalizability of findings. On the other hand, Duppong Hurley et al. (2017) and Podell et al. (2013) had a larger sample sizes, 112 and 279 respectfully, with low selection bias. As all studies accounted for confounds- such child's age, diagnosis and sex- the results can be interpreted with more confidence. Overall, these three papers suggest that therapist interpersonal interactions are an important influencer on alliance or outcome and that considering these issues in their relational context, rather than in isolation, is important.

Discussion

This systematic review is the first to provide a synthesis of research appraising the impact of both static and dynamic therapist factors on therapeutic alliance or outcomes when working with children and young people accessing mental health services. In summary, 15 papers were identified, summarised and critically appraised, covering range of factors, populations, settings, and outcomes.

There are tentative indications from one paper that therapist attachment style can influence outcomes (Muratori et al., 2017), supporting the need for further work. In terms of demographic characteristics, the results are varied. Findings in relation to therapist ethnicity are particularly complex. Ethnic matching seems to positively influence outcomes for some groups of young people but not others, and the significance of findings varies according to the child's age and the nature of their mental health difficulties and the specific outcomes assessed (Gamst et al., 2004; Hall et al., 2002; L. Mufson et al., 2014; Yeh et al., 1994). Gender matching does not seem to affect outcome, and both male and female therapists can build positive alliances, although there is some indications that there might be differences in

outcomes and the progression of alliance over time (Hall et al., 2002).Therapist experience also showed a varied relationship with outcomes; generally more experience is related to better outcomes, but where experience concerns working with anxiety disorders, this seemed to confer poorer results (Garland et al., 2012; Greeson et al., 2009; Podell et al., 2013). Overall, the findings related to therapist demographics must be interpreted with caution as data were often collected without an a priori research question and as secondary analyses.

Evidence suggests that a range of therapist in-session behaviours and interaction styles with young people can influence the therapeutic alliance and outcome for young people (Creed & Kendall, 2005; N. J. Jungbluth & S. R. Shirk, 2009; Russell et al., 2008). These findings were based on careful analysis of session events and also controlled for confounding factors, adding weight to their validity and reliability. However, the results varied by specific behaviour, model of intervention and nature of outcome and therefore further work will be needed to tease apart which behaviours and interaction styles are important in which context.

The review highlights some convergence between findings from the adult and youth literature. The finding that therapist behaviours such as being collaborative, adapting sessions to the youths interests and having positive interactions increase alliance and positive outcomes for youth has parallels with the adult literature (Ackerman & Hilsenroth, 2003). Collaboration appears to be paramount to underpinning successful therapy outcomes or alliances. However, when children do not self refer to therapy, then their goals may be different to parents or other family members, and it may be harder for the therapist to establish a collaborative goal (Green, 2006). Moreover, being negative, dominant and not remembering what youth say can negatively impact the alliance or outcome, which is similarly evidenced when working with adults (Ackerman & Hilsenroth, 2001). Although only one study evaluated the impact of therapist attachment style upon the outcomes for the child, the findings from this paper broadly found a similar relationship established in the adult literature, supporting the idea that therapists' attachment style influences the way they behave in relationships (Degnan, Seymour-Hyde, Harris, & Berry, 2016).

However, no effects were found for therapist avoidant attachment style when working with children, but an impact in the adult literature is noted. It is also important to consider impact of youth's initial presentation and how this can impact on the behaviours and interactions therapists have as a response. The therapeutic relationship is a constant dynamic conversation with multiple influences (Green, 2006). Children who are considered to have secure attachments are shown to have positive social–emotional competence and cognitive functioning. On the other hand, when children have an insecure attachment, functioning well in these areas can be harder (Ranson & Urichuk, 2008). The papers in this review only look at behaviour from the therapist perspective. However, internalizing or externalizing child presentations and possible attachment style is known to impact alliance and outcome (B. D. McLeod, 2011). There is a need for further study in this area to corroborate or clarify these initial findings and also explore interactions between child and therapist attachment style and related in-session behaviours.

Findings related to ethnicity varied across groups, with clients from Black Minority and Ethnic (BAME) groups benefitting most from ethnic matching (Gamst et al., 2004). Research in the adult literature suggest a similarly complex pattern (O'Brien, Fahmy, & Singh, 2009) with adults sharing a preference for an ethnically similar therapist (Cabral & Smith, 2011). However, BAME groups are less likely to access or seek out mental health services both in the United States (Zhang, Snowden, & Sue, 1998), and in the United Kingdom (Memon et al., 2016). Therefore, being under represented in both services and in turn research. As identified in the current review, the methodological issues across all the studies complicate these findings. Large data sets were analysed in order to look for ethnic matching patterns. However, research in other healthcare settings suggests that ethnicity recording, especially for BAME groups, has a substantial and variable degree of misclassification error. Therefore, the secondary analysis of this data, which may be inherently incorrect, might not provide an accurate representation of how the ethnicity of the client, regardless of age, can impact on alliance or outcome. Furthermore, ethnic matching is only one facet of the relational complexities. In all papers included within this review that reported the ethnicity of therapists, they all had Caucasian therapists as the

majority. Moreover, (Burkett, 1991) highlighted that there is always an element of clinician to patient cultural difference, even if they are the same ethnicity. There are potentially many other cultural factors, which are not taken into consideration. Yeh et al. (1994) and Hall et al. (2002) tried to take into account wider cultural factors such as language. However, the inherent power imbalances and relationship to authority were not considered, but are known to be an important factor within the adult literature (Tsui & Schultz, 1988). In addition, Yeh et al. (1994) assessed the impact of the child's age on the outcome from the ethnic matching with the therapist. Exploration of the moderating effect of child age on ethnic matching in future research could help explain the impact of culture and other unknown variables further (Gopalkrishnan, 2018). Given the mixed findings and often poor uptake and accessibility of services for ethnic minority groups, further work in this area is both indicated and distinctly necessary.

Finally, the research suggests that both male and female therapists can have a positive impact on both outcome and alliance. However, more research needs to be completed, to examine potential differences in alliance development over time and desirable outcomes for male and female therapists (Duppong Hurley et al., 2013; Greeson et al., 2009). This finding is not consistent with previous adult literature, where Bhati (2014) found that having a female therapist could in fact result in higher average alliance ratings compared to male therapists.

Strengths and limitations

The current review offers a synthesis of a heterogonous set of information pertaining to alliance and outcomes for young people accessing mental health services. It is the first review of its kind to contribute to understanding the role of therapist characteristics in child and adolescent mental health, which has previously been under-studied. The review was completed in line with PRISMA guidelines,

ensuring the process was systematic and replicable and incorporated validated quality assessment.

All studies were written in English, or published in a peer review journal. Therefore, language and publication biases are possible. When reviewing the literature, there were a number of thesis publications that were not included, but may have added to the findings. As most papers included in this review were conducted in North America (k=13) it is important to consider how these services were financed and delivered in very different ways compared to other countries (Satcher, 2000). Services in North America can range from free public services, paid services on a sliding scale dependant on income and private services. Whilst this hybrid system aims to provide care for many people, it does not address the difficulty that those with the most complex need and least resources often find it difficult to access services. Therefore, the broad range of children and young people who were included in this review may have been the most socially disadvantaged and experienced additional complexities compared to children who access community services in other countries. Interestingly, no studies were completed in the United Kingdom. Whilst there is inequality in access to NHS service provision, it is not as large as in North America. Therefore, this may limit the generalizability of the review's findings to NHS settings.

When reviewing the inter-rater reliability, agreement was fair to substantial (Cohen's k=. 36 and k=. 66) between the two reviewers for stage one (screening titles and abstracts) and two (full texts), respectfully. A possible explanation for the discrepancies is due to the broad nature and definition of therapist characteristics, which rendered it difficult to discern whether papers met eligibility criteria based on titles alone. There were additional complexities when considering the reliability and quality assessment, as studies often reported on findings relevant to the current review that were not primary aims of the study. Despite these difficulties, there was adequate agreement, especially at full text level and in terms of quality assessment ratings, assisted by clear additional guidelines and discussion within the research team.

The review has referenced findings related to a broad range of therapist characteristics and a number of different outcome measures, which might be more nuanced than at first glance. Treatment engagement, when operationalised as attending more sessions, could be viewed in terms of being more engaged with therapist and a strong alliance, or treatment ineffectiveness and so needing more sessions. Outcomes reflected by the number of sessions attended might facilitate accurate measurement but may not capture the story in detail as to whether this is a good treatment outcome.

Clinical implications

Evidence regarding therapist behaviour and interpersonal interaction seems robust. The findings suggest that collaboration, careful management of conversations, praise for the young person and consideration of power dynamics are key to supporting good outcomes and alliance for children and young people. There are also indications that therapist attachment style (which might impact on relational behaviours) might be related to outcomes. Therefore, therapists should be supported to reflect on and manage their own attachment or interpersonal style in sessions. Supervision could be used to explore how their interpersonal style and specific behaviours can provide a safe and nurturing environment for the young person or family in the sessions, or not.

In the United Kingdom, despite significant populations of BAME groups, young people and families from these group often do not access services (Memon et al., 2016). Findings from this review suggest that ethnic matching might be beneficial to BAME groups when considering youth outcome. However, as previously highlighted, not all cultural elements of ethnicity were considered in the research and the implications differ in terms of subgroups. Cultural competence in CAMHS is a significant concern (Papadopoulos, Tilki, & Ayling, 2008) and focused research into allocation systems and therapist behaviours and qualities that could cultivate this have the potential to contribute to this conversation.

The impact of therapist's gender, or gender matching has widely mixed in findings across the literature. What is perhaps more important to consider, is giving young people choice in the person they see, regardless of their gender. Finally, this review suggests that therapist's level of experience has been found to be a good indicator of therapeutic alliance of outcome for young people. Therefore, it is important that services are able to retain staff their experience builds, to aid better service delivery outcomes (Beidas et al., 2016).

A key way for therapist's to aid positive outcomes for children is through monitoring their therapeutic alliance. A brief measurement tool, such as the Session Rating Scale (David, 2014) could be completed by the young person regularly throughout the therapy. This would help therapists identify any changes or decline in the therapeutic relationship, whatever factors these are driven by, so they could respond effectively. Moreover, monitoring could support therapists in tracking the likely outcome of therapy before discharge.

Future research

It will be important for future research to specifically aim to explore questions related to static and dynamic therapist factors (and the interplay between the two) as a priori research questions. It would be naïve to think that just an isolated characteristic highlighted by the research, is not influenced by other characteristics. A person as a whole is influenced by so many factors such as upbringing, access to personal therapy, or experience and more. Therefore, it is very difficult to specifically say how just one characteristic influences the outcome or alliance completely. It is important that future research is conducted in other countries, other than North America. This can help widen the understanding of different therapist characteristics across different service types and cultures. Moreover, a more robust measurement of multiple elements of characteristics needs to be included within research from the outset. This would enable analysis taking confounding factors into account and building in robust data collection from the start. Moreover, the same rich

complexities apply to what children and young people bring to therapy, which cannot be overlooked. Future research could therefore offer an opportunity to explore the mutual interactions between child and therapist factors and influencers thereof in a dynamic and connected manner in both the short and long term. This might involve network analysis, experience sampling methodology, longitudinal research or multi-method approaches. Finally, future research should consider the context of therapist characteristics in the way services are delivered. We have moved away from institutions to an increase in community services (Drake & Latimer, 2012). Now, in the wake of the COVID 19 pandemic, it is important to consider which therapist characteristics are important when children are accessing services online or via other technology and how the therapist can adjust and adapt to this change (Goldschmidt, 2020).

Conclusion

The current review provides a narrative synthesis and critical appraisal of therapist factors and their impact on outcomes and therapeutic alliance. The research suggests that therapist characteristics such as ethnicity, gender and attachment might be important to youth alliance and outcomes; however, the findings – although warranting further research - are complex and the factors not necessarily amenable to change. Therapist interactions and behaviours were also strongly related to youth outcome and alliance and have more scope to be amenable to change. It could be possible to train therapists in positive behaviours and interactions, across treatment models. However, the critical appraisal of the studies included within this review, highlights that despite their potential significance, research dedicated to understanding the impact of therapist factors is limited. Therefore, future studies incorporating specific focus on the robust and prospective measurement of therapist factors and the impact on alliance and outcome are needed to strengthen the field as it stands.

References

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms and profiles* (Vol. 30): Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 171. doi:https://doi.org/10.1037/0033-3204.38.2.171

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review, 23*(1), 1-33. doi:https://doi.org/10.1016/S0272-7358(02)00146-0

Beidas, R. S., Marcus, S., Wolk, C. B., Powell, B., Aarons, G. A., Evans, A. C., . . . Walsh, L. M. (2016). A prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-funded mental health system. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(5), 640-649. doi:https://doi.org/10.1007/s10488-015-0673-6

Bhati, K. S. (2014). Effect of client-therapist gender match on the therapeutic relationship: an exploratory analysis. *Psychological reports, 115*(2), 565-583. doi:https://doi.org/10.2466/21.02.PR0.115c23z1

Bickman, L., Athay, M., Riemer, M., Lambert, E., Kelley, S., Breda, C., & Vides de Andrade, A. (2010). Manual of the Peabody treatment progress battery. *Nashville: Vanderbilt University.* Retrieved from http://peabody.vanderbilt.edu/ptpb\.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice, 16*(3), 252. doi:10.1037/h0085885

Burkett, G. L. (1991). Culture, illness, and the biopsychosocial model. *Family medicine, 23*(4), 287-291.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537-554. doi:https://doi.org/10.1037/a0025266

Creed, T. A., & Kendall, P. C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of consulting and clinical psychology, 73*(3), 498. doi:https://doi.org/10.1037/0022-006X.73.3.498

David, C. (2014). Session Rating Scale (SRS) and Child Session Rating Scale (CSRS). *Guide to using outcomes and feedback tools*, 143.

de Haan, A. M., Boon, A. E., de Jong, J. T., Hoeve, M., & Vermeiren, R. R. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical psychology review, 33*(5), 698-711. doi:https://doi.org/10.1016/j.cpr.2013.04.005

de La Peña, C. M., Friedlander, M. L., Escudero, V., & Heatherington, L. (2012). How do therapists ally with adolescents in family therapy? An examination of relational control communication in early sessions.

Journal of Counseling Psychology, 59(3), 339. doi:https://doi.org/10.1037/a0028063

Degnan, A., Berry, K., Sweet, D., Abel, K., Crossley, N., & Edge, D. (2018). Social networks and symptomatic and functional outcomes in schizophrenia: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 53*(9), 873-888. doi:https://doi.org/10.1007/s00127-018-1552-8

Degnan, A., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). The Role of Therapist Attachment in Alliance and Outcome: A Systematic Literature Review. *Clinical Psychology and Psychotherapy, 23*(1), 47-65. doi:https://doi.org/10.1002/cpp.1937

Department of Heath. (2017). *Transforming children and young people's mental health provision: a green paper*. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Donaldson, D., Spirito, A., & Esposito-Smythers, C. (2005). Treatment for adolescents following a suicide attempt: results of a pilot trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(2), 113-120. doi:https://doi.org/10.1097/00004583-200502000-00003

Drake, R. E., & Latimer, E. (2012). Lessons learned in developing community mental health care in North America. *World Psychiatry, 11*(1), 47-51. doi: https://doi.org/10.1016/j.wpsyc.2012.01.007

Duppong Hurley, K., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care. *Journal of Emotional and Behavioral Disorders, 25*(1), 37-45. doi:https://doi.org/10.1177/1063426616686756

Duppong Hurley, K., Lambert, M. C., Van Ryzin, M., Sullivan, J., & Stevens, A. (2013). Therapeutic Alliance Between Youth and Staff in Residential Group Care: Psychometrics of the Therapeutic Alliance Quality Scale. *Children and Youth Services Review, 35*(1), 56-64. doi:https://doi.org/10.1016/j.childyouth.2012.10.009

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. S. W. H. Berman (Ed.), *Attachment in adults: Clinical and developmental perspectives* (pp. 128–152): Guilford Press.

Fluckiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340. doi:http://dx.doi.org/10.1037/pst0000172

Friedlander, M. L., & Heatherington, L. (1989). Analyzing relational control in family therapy interviews. *Journal of Counseling Psychology, 36*(2), 139. doi:https://doi.org/10.1037/0022-0167.36.2.139

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2004). Ethnic Match and Treatment Outcomes for Child and Adolescent Mental Health Center Clients. *Journal of Counseling and Development, 82*(4), 457-465. doi:https://doi.org/10.1002/j.1556-6678.2004.tb00334.x

Garland, A. F., Haine-Schlagel, R., Accurso, E. C., Baker-Ericzen, M. J., & Brookman-Frazee, L. (2012). Exploring the effect of therapists' treatment practices on client attendance in community-based care for children. *Psychological Services, 9*(1), 74-88. doi:https://doi.org/10.1037/a0027098

Goldschmidt, K. (2020). The COVID-19 pandemic: Technology use to support the wellbeing of children. *Journal of Pediatric Nursing*. doi: https://doi.org/10.1016/j.pedn.2020.04.013

Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in public health, 6*, 179. doi:https://doi.org/10.3389/fpubh.2018.00179

Green, J. (2006). Annotation: the therapeutic alliance--a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47*(5), 425-435. doi:https://doi.org/10.1111/j.1469-7610.2005.01516.x

Green, J. (2009). The therapeutic alliance. *Child: Care, Health and Development, 35*(3), 298-301. doi:https://doi.org/10.1111/j.1365-2214.2009.00970.x

Greeson, J. K., Guo, S., Barth, R. P., Hurley, S., & Sisson, J. (2009). Contributions of Therapist Characteristics and Stability to Intensive In-home Therapy Youth Outcomes. *Research on Social Work Practice, 19*(2), 239-250. doi:https://doi.org/10.1177/1049731508329422

Hall, J., Guterman, D. K., Lee, H. B., & Little, S. G. (2002). Counselor-Client Matching on Ethnicity, Gender, and Language: Implications for Counseling School-aged Children. *North American Journal of Psychology, 4*(3).

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies, 102*, 103490. doi:https://doi.org/10.1016/j.ijnurstu.2019.103490

Hawley, K. M., & Weisz, J. R. (2005). Youth versus parent working alliance in usual clinical care: distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 117-128. doi:https://doi.org/10.1207/s15374424jccp3401_11

Jungbluth, N. J., & Shirk, S. R. (2009). Therapist strategies for building involvement in cognitive-behavioral therapy for adolescent depression. *Journal of consulting and clinical psychology, 77*(6), 1179-1184. doi:https://doi.org/10.1037/a0017325

Karver, M., Shirk, S., Handelsman, J. B., Fields, S., Crisp, H., Gudmundsen, G., & McMakin, D. (2008). Relationship Processes in Youth Psychotherapy. *Journal of Emotional and Behavioral Disorders, 16*(1), 15-28. doi:https://doi.org/10.1177/1063426607312536

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: the evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clin Psychol Rev, 26*(1), 50-65. doi:10.1016/j.cpr.2005.09.001

Lavin, R., Bucci, S., Varese, F., & Berry, K. (2020). The relationship between insecure attachment and paranoia in psychosis: A systematic literature review. *British Journal of Clinical Psychology, 59*(1), 39-65. doi:https://doi.org/10.1111/bjc.12231

Manso, A., Rauktis, M. E., & Boyd, A. S. (2008). Youth expectations about therapeutic alliance in a residential setting. *Residential Treatment for*

Children and Youth, 25(1), 55-72. doi:https://doi.org/10.1080/08865710802209826
Mays, N., Roberts, E., & Popay, J. (2001). Synthesising research evidence. In N. Fulop, P. Allen, A. Clarke, & N. Black, (Ed.), *Studying the organisation and delivery of health services* (Vol. 220): Routledge.
McDaid, D. (2011). *Making the long-term economic case for investing in mental health to contribute to sustainability*.
McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: a meta-analysis. *Clinical psychology review, 31(4), 603–616, 31*(4), 603-616. doi:https://doi.org/10.1016/j.cpr.2011.02.001
Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open, 6*(11), e012337. doi:http://dx.doi.org/10.1136/bmjopen-2016-012337
Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Annals of Internal Medicine, 151*(4), 264-269. doi:https://doi.org/10.7326/0003-4819-151-4-200908180-00135
Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy fordepressed adolescents. *Archives of General Psychiatry, 61*(6), 577-584. doi:10.1001/archpsyc.61.6.577
Mufson, L., Yanes-Lukin, P., Gunlicks-Stoessel, M., & Wickramaratne, P. (2014). Cultural Competency and Its Effect on Treatment Outcome of IPT-A in School-Based Health Clinics. *American journal of psychotherapy, 68*(4), 417-442. doi:https://doi.org/10.1176/appi.psychotherapy.2014.68.4.417
Muratori, P., Polidori, L., Chiodo, S., Dovigo, V., Mascarucci, M., Milone, A., . . . Lambruschi, F. (2017). A pilot study implementing coping power in Italian community hospitals: Effect of therapist attachment style on outcomes in children. *Journal of child and family studies, 26*(11), 3093-3101. doi:https://doi.org/10.1007/s10826-017-0820-7
Murphy, R., & Hutton, P. (2018). Practitioner Review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment - a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry, 59*(1), 5-19. doi:https://doi.org/10.1111/jcpp.12767
O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. A literature review. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 558-568. doi:https://doi.org/10.1007/s00127-008-0476-0
Papadopoulos, I., Tilki, M., & Ayling, S. (2008). Cultural competence in action for CAMHS: Development of a cultural competence assessment tool and training programme. *Contemporary Nurse, 28*(1-2), 129-140. doi:https://doi.org/10.5172/conu.673.28.1-2.129
Podell, J. L., Kendall, P. C., Gosch, E. A., Compton, S. N., March, J. S., Albano, A. M., . . . Piacentini, J. C. (2013). Therapist Factors and Outcomes in CBT for Anxiety in Youth. *Professional Psychology: Research and Practice, 44*(2), 89-98. doi:https://doi.org/10.1037/a0031700

Ranson, K. E., & Urichuk, L. J. (2008). The effect of parent–child attachment relationships on child biopsychosocial outcomes: a review. *Early Child Development and Care, 178*(2), 129-152. doi:https://doi.org/10.1080/03004430600685282

Russell, R., Shirk, S., & Jungbluth, N. (2008). First-session pathways to the working alliance in cognitive-behavioral therapy for adolescent depression. *Psychotherapy Research with Children and Adolescents, 18*(1), 15-27. doi:https://doi.org/10.1080/10503300701697513

Sánchez-Bahíllo, Á., Aragón-Alonso, A., Sánchez-Bahíllo, M., & Birtle, J. (2014). Therapist characteristics that predict the outcome of multipatient psychotherapy: Systematic review of empirical studies. *Journal of psychiatric research, 53*, 149-156. doi:https://doi.org/10.1016/j.jpsychires.2014.01.016

Satcher, D. (2000). Mental health: A report of the Surgeon General--Executive summary. *Professional Psychology: Research and Practice, 31*(1), 5. doi:https://doi.org/10.1037/0735-7028.31.1.5

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry, 40*(11), 1228-1231. doi:10.1001/archpsyc.1983.01790100074010

Shelef, K., Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of consulting and clinical psychology, 73*(4), 689-698. doi:https://doi.org/10.1037/0022-006X.73.4.689

Shirk, S., Gudmundsen, G., McMakin, D., Dent, H., & Karver, M. (2003). *Rater's manual for the Alliance Building Behaviors Scale*. Unpublished manual, University of Denver, Denver, CO.

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of consulting and clinical psychology, 71*(3), 452-464. doi:https://doi.org/10.1037/0022-006X.71.3.452

Shirk, S. R., Karver, M. S., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy (Chicago, Ill.), 48*(1), 17-24. doi:https://doi.org/10.1037/a0022181

Thomas, B. H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing, 1*(3), 176-184. doi:https://doi.org/10.1111/j.1524-475X.2004.04006.x

Tsui, P., & Schultz, G. L. (1988). Ethnic factors in group process: cultural dynamics in multi-ethnic therapy groups. *Am J Orthopsychiatry, 58*(1), 136-142. doi:10.1111/j.1939-0025.1988.tb01573.x

World Health Organization. (2018). Child and adolescent mental health. Retrieved from https://www.who.int/mental_health/maternal-child/child_adolescent/en/

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22*(2), 153-163.

doi:https://doi.org/10.1002/1520-6629(199404)22:2<153::AID-JCOP2290220210>3.0.CO;2-R

Zhang, A. Y., Snowden, L. R., & Sue, S. (1998). Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology, 26*(4), 317-326. doi:https://doi.org/10.1002/(SICI)1520-6629(199807)26:4<317::AID-JCOP2>3.0.CO;2-Q

Paper 2:

Therapeutic relationships in Child and Adolescent Mental Health Services: a Delphi study with young people, carers and healthcare professionals

Ryan, R. [1], Hartley, S.[1, 2], & Berry, K.[1]

[1] School of Health Sciences, University of Manchester, UK

[2] Pennine Care NHS Foundation Trust

Word count: 9,729 (complete text), 250 (abstract), 5,845 (main text excluding tables, figure and references).

The following paper has been formatted according to the publication guidelines of *Child and Adolescent Mental Health.* Submission guidelines found in Appendix D. However, additional words above the requested 5,500 (total) have been included in this thesis for clarity.

Ethical approval letter found in appendix E

Abstract

Background: Therapeutic alliance has been a construct widely recognised as crucial in the adult psychotherapy literature. Bordin (1979) argued that therapeutic alliance consists of bond, tasks and goals. However, there is comparatively little research on what constitutes and impacts therapeutic alliance in the context of child and adolescent mental health services (CAMHS). Relationships within CAMHS are inherently complex, with multiple relationships taking place between children, parents and staff members.

Method: The Delphi method was used to gain consensus regarding the definition of therapeutic relationship, what helps to build and what hinders the formation of a good relationship in the context of CAMHS. Three expert groups (young people, carers and staff) were invited to complete an online Delphi survey across three rounds.

Results: Consensus was reached to define the therapeutic relationship as trust, reliability and lack of judgement (n=19 statements). Factors that help build good relationships predominantly refer to staff behaviours of setting up open communication channels, showing acceptance of the young person’s difficulties and being consistent (n=88 consensus agreement statements). Factors that hindered a good relationship were inconsistencies and lack of clear communication between all groups (n=22 consensus agreement statements).

Conclusions: Therapeutic alliance is complex when working with children. It is essential that staff are open and honest in facilitating discussions about parental involvement within the relationship and that staff provide consistent and trusting support to young people. A key clinical implication is that based on the new understanding of alliance within CAMHS, a new therapeutic alliance warrants development.

Key Practitioner Message

What is known?

- Therapeutic alliance is important for alliance and outcomes in children
- Definitions and understanding of alliance lies in the adult literature

What is new?

The word alliance is not a helpful definition for children, but working relationship defined by trust and partnership is

There is key agreement between young people, parents and staff about what builds and hinders good relationships

What is significant for clinical practice?

Staff behaviours are key to building good alliance

Parental involvement (or not) in therapeutic work should be set out with clear expectations at the start

Keywords:
Child, adolescent, therapeutic alliance, therapeutic relationship, Delphi

Introduction

According to the World Health Organization (2018), 10-20% of children worldwide experience mental health difficulties. Approximately half of these difficulties start before the age of 14, which has the potential to have a negative impact on children's education, development, ability to live fulfilling lives, and even their brain development (Romeo, 2017). Furthermore, young people can experience additional social adversity due to stigma and isolation associated with mental health difficulties (World Health Organization, 2018).

Access to Child and Adolescent Mental Health Services (CAMHS) is essential for children's future development (Department of Health, 2015). However, only 25-35% of children and adolescents access the mental health support they need (Armbruster & Kazdin, 1994; Green, McGinnity, Meltzer, Ford, & Goodman, 2005). Moreover, when children do access treatment, they often drop out early and this can often happen when the therapeutic relationship, otherwise known as the therapeutic alliance, is not prioritised and monitored by the professional (O'Keeffe, Martin, & Midgley, 2020). Arguments within the adult literature suggest that the therapeutic alliance consists of three components; tasks, goals, and bond (Bordin, 1979)

Previous meta-analyses have shown that youth reported therapeutic alliance is an important factor in relation to mental health outcomes (S. Shirk, M. Karver, & R. Brown, 2011; Shirk & Karver, 2003a). Additionally, parent and therapist alliance is predictive of attendance and engagement within services, and agreement about discharge (Hawley & Weisz, 2005). Although therapist-reported alliance has also been identified as important, it is often rated lower than parent- or child- reported (Accurso & Garland, 2015). Furthermore, when there are therapeutic relationship problems, such as the therapist not seeming to do the right things, or when the therapist doesn't seem to understand the child's difficultly, parents have expressed these as reasons why they want their child to stop therapy (Garcia & Weisz, 2002).

Efforts have been made to understand what elements might predict positive alliance in youth mental health contexts, given its importance. The focus has tended to be on the variables such as child diagnosis (Shirk & Karver, 2003a), therapist behaviours (Creed & Kendall, 2005; Karver et al., 2008) and the helpful or unhelpful interaction styles between young people and their therapist (de La Peña et al., 2012). However, constructs of alliance are founded within the adult literature and do not always fully capture the conceptualisation of the relationship as situated within a systemic, family context, as is often relevant for CAMHS (Bryce D McLeod, 2011). Family alliances are complex, as there are multiple alliances within one unit accessing the service (Green, 2009). Therefore, it is important that we explore the definition and predictors of therapeutic alliance specifically within therapeutic relationships that encompass children and their family members.

Existing evidence suggests that there can be significant ruptures and hindrances to alliance formation and maintenance (S. Shirk et al., 2011). In order to develop an understanding of therapeutic alliance in CAMHS, a consensus needs to be reached about what it is, as well as what helps to build a good alliance, or hinder its formation. This needs to be done specifically by those who are included within the relationship; young people, their family members and staff. The Delphi consensus method, originally used to develop consensus from experts of a hypothetical Russian attack on the USA (Dalkey & Helmer, 1963) is useful technique in gathering information, where there is limited previous research. Delphi designs have evolved to incorporate view points from multiple expert groups, and have previously used to inform CAMHS service design (Howarth et al., 2019) and quality standards (Sayal et al., 2012). A particular strength of the Delphi method is that feedback is provided separately by survey, so each member is not influenced by group dynamics when making their decision. This is important strength when considering its utility with children and young people, who may be susceptible to power dynamics from parents or staff members. Therefore, a multiple expert group Delphi methodology has been selected, with the aim to achieve an overall consensus and explore between group differences of alliance definition, factors that help form a good alliance and those

that hinder it within three key expert groups: young people, parent/carers and staff members.

Methods

Design

The Delphi method followed the three rounds as suggested by Langlands, Jorm, Kelly, and Kitchener (2008) and used in previous NHS research recruiting service users (Law & Morrison, 2014) . There are no universally-accepted guidelines on how to complete a Delphi study, and so this project has been based on the most commonly used practice of having three rounds (Langlands et al., 2008). In round one, key statements were generated from the literature and feedback from stakeholders. In subsequent rounds, these statements were rated for consensus agreement. There can be unlimited rounds to the Delphi method of rating statements, however, traditionally they stop after three to minimise burden to participants (Okoli & Pawlowski, 2004), which was the case here. Participants who were considered 'experts' due to their experience of accessing or working within a CAMHS service (Law & Morrison, 2014).

Ethical approval and considerations

The Central Manchester National Research Ethics Service (NRES) Committee approved the study. Previous research was utilised to inform the procedures regarding consent for under 18s (Parry, 2018) and in line with Health Research Authority (HRA) guidelines for Clinical Trials of Investigational Medicinal Products CTIMPS (Health Research Authority). Young people were deemed to have capacity to consent, if they were able to navigate through the Participant Information Sheet and provide online consent. Furthermore, Parry (2018) found that anonymity was important to increase participation. Therefore, identifiable information such as email addresses were not linked with Delphi answers. However, participant safety was paramount and as it would not be possible to identify participants if they disclosed risk, signposting information was presented on each page of the survey.

Recruitment

Participants were included in the study if they were a young person (13-19 years), a parent/carer of a child, or a staff member who is either currently or previously accessed or worked in child therapeutic services i.e. community/ inpatient Child and Adolescent Mental Health Services (CAMHS)/charitable organisations, in the past year. All staff disciplines were eligible to participate, including but not limited to: nurse, nursing assistant, psychologist, psychiatrist, family therapist, dietician and occupational therapist. Participants were recruited via convenience sampling through social media, posters, email networks and sharing information in waiting areas. Recruitment took place within a North West of England Foundation Trust and across the country online. Whilst participants were offered the opportunity to complete a paper-based version when approached in CAMHS waiting rooms, no participants chose this option. All responses were completed electronically.

When participants consented, they were asked to provide demographic information and free text boxes were included for gender and ethnicity so participants were not restricted in their answers. Participants were invited to provide an email address for future contact. Participants were then directed to a separate website which hosted the Delphi statements to disconnect identifiable information from Delphi responses. Both young people and carers were invited in free text boxes to outline which additional services they have accessed that were not listed. Additional services included specialist eating disorder, private practice, school practitioners and Improved Access to Psychological Therapies (IAPT).

Procedure

Round one

Key to the Delphi design is generating statements from the literature or key stakeholders, in order to provide data for participants to rate. Initially, the literature was reviewed which was relevant to therapeutic alliance in child mental health services. Key papers were reviewed (Green, 2006; Shirk & Karver, 2003a) and concepts around what builds good relationships were developed. It then seemed

important to include what could damage therapeutic relationships, as it is not necessarily the opposite of what helps build them. From knowing what helps build and hinder good therapeutic relationships, it also seemed important to define what the therapeutic relationship is like, rather than use definitions from the adult literature. Therefore, the research question comprised of three components; what is alliance, what helps build good alliance, what hinders good alliance formation?

When looking to define the different aspects of therapeutic alliance, information from the adult literature was incorporated to determine their relevance to alliance in child services. Rogers (1951) described the therapeutic relationship as an agreement and basic acceptance and Bordin (1979) argued that the alliance is a bond, with tasks to meet goals were included. Whilst these explanations are based on adult relationships, it was important to see how they were rated by children, parents and staff members, as they are often used in the child literature (Green, 2006).

Concepts of building good alliance were highlighted to be; the importance of a treatment plan and having non-problem talk (Garcia & Weisz, 2002) and understanding the culture of a family and who is considered the person with power within the family relationship (Funakoshi, Tanaka, Hattori, & Arima, 2016).

Statements were also generated based on preliminary emerging themes from qualitative interviews conducted as part of a separate study regarding therapeutic alliance (Hartley, Redmond, & Berry, 2020). Themes included, the importance of humour, the young persons interests being included in the work and staff managing their own emotions and also echoed themes previously identified from the literature.

Young people who were accessing CAMHS general adolescent inpatient services were consulted on the relevance and accessibility of the preliminary statement list. Items aiming to define therapeutic alliance such as 'mutuality (i.e. common ground)' and 'alliance' were removed as young people reported that they did not understand what these terms meant. Therapeutic alliance was relabelled as 'therapeutic

relationship' and mutuality was renamed to 'mutually agreed goals'.

The research team, including clinicians currently practicing in CAMHS, also reviewed the initial statement list for relevance and accessibility. Items which referred to 'therapy' were changed to refer to 'the work' to make it more representative of multiple disciplinary relationships i.e. nursing relationships, which may be therapeutic, but not viewed traditionally as 'therapy'.

The statements were then coded into themes by two researchers. Statements coded as capturing the relational aspects of the therapeutic relationship were considered key in attempting to define and understanding non-specific factors, and potentially a key contribution to the evidence base. The second theme was related to the therapeutic technique/outcome goals as this is a concept that would potentially guide therapeutic relationships from the start. The third theme followed on with items relating to therapeutic technique, for when processes of the work were outlined. The theme of the therapeutic technique and practicalities of session followed and then how staff members respond in the relationship was next. Finally, characteristic-related statements were considered. Family characteristics i.e. young person or parent/carer were placed first, and then staff competence and then staff characteristics.

The research team decided to present statements that considered the precise interpersonal elements of the relationship first and practical about where sessions should take place later. This decision was made so that if participants dropped out of completing the survey, then data about interpersonal relationships between the expert groups was more likely to be captured, as this was deemed more of a priority, compared to where sessions took place. An example of themes within what helps build good relationships were, but not limited to, included: relational/ therapeutic technique/ practicalities of sessions.

Round two

A list of statements was generated and formatted into an online and paper-based questionnaire and sent to participants. Participants were asked to rate statements based on how much they agree or disagree with the statement as being important to the definition of alliance, or whether the statement helps or hinder good relationships. Options of agreement were presented on a five point Likert scale (1: strongly disagree, 2: disagree, 3: neither agree/disagree, 4: agree, 5: strongly agree). In order to include additional information and perspectives generated from 'experts' in this context, participants were invited to suggest any additional statements they did not feel were already captured.

There is a range of ways to define consensus with no absolute guidance. For the purposes of this study, percentage of participant consensus of agreement or disagreement was established as a combined score on strongly agree and agree, or strongly disagree and disagree. A minimum agreement of ≥70% was needed between participants to reach consensus agreements. This level of agreement was based on discussions within the research team. Statements rated between 60-69% in agreement were included round three. Items that did not reach these criteria were excluded.

Round three

Two members of the research team reviewed additional statements suggested by participants. Suggestions that the team felt were already included in the original statements were excluded. Additional statements that seemed to capture similar themes were combined. Suggestions that added a new perspective to the statements were formatted into a Delphi statement.

Participants were contacted and presented with items that had previously reached 60-69% agreement in the previous round, as well as new participant suggested items. When participants were presented with items that they were re-rating, the

overall agreement or disagreement percentage from the prior round was shared. Participants were asked to rerate this statement again, with an opportunity to explain in a free text box if they had changed their rating from last time and if so, why. Again, a consensus agreement or disagreement of ≥70% needed to be met for items to be included. Items below this were excluded and the three Delphi rounds were complete.

Results

Table 3 demonstrates participant characteristics in round two and three. The majority of participants identified themselves as White British and female across all three expert groups.

Table 3. *Participant demographics*

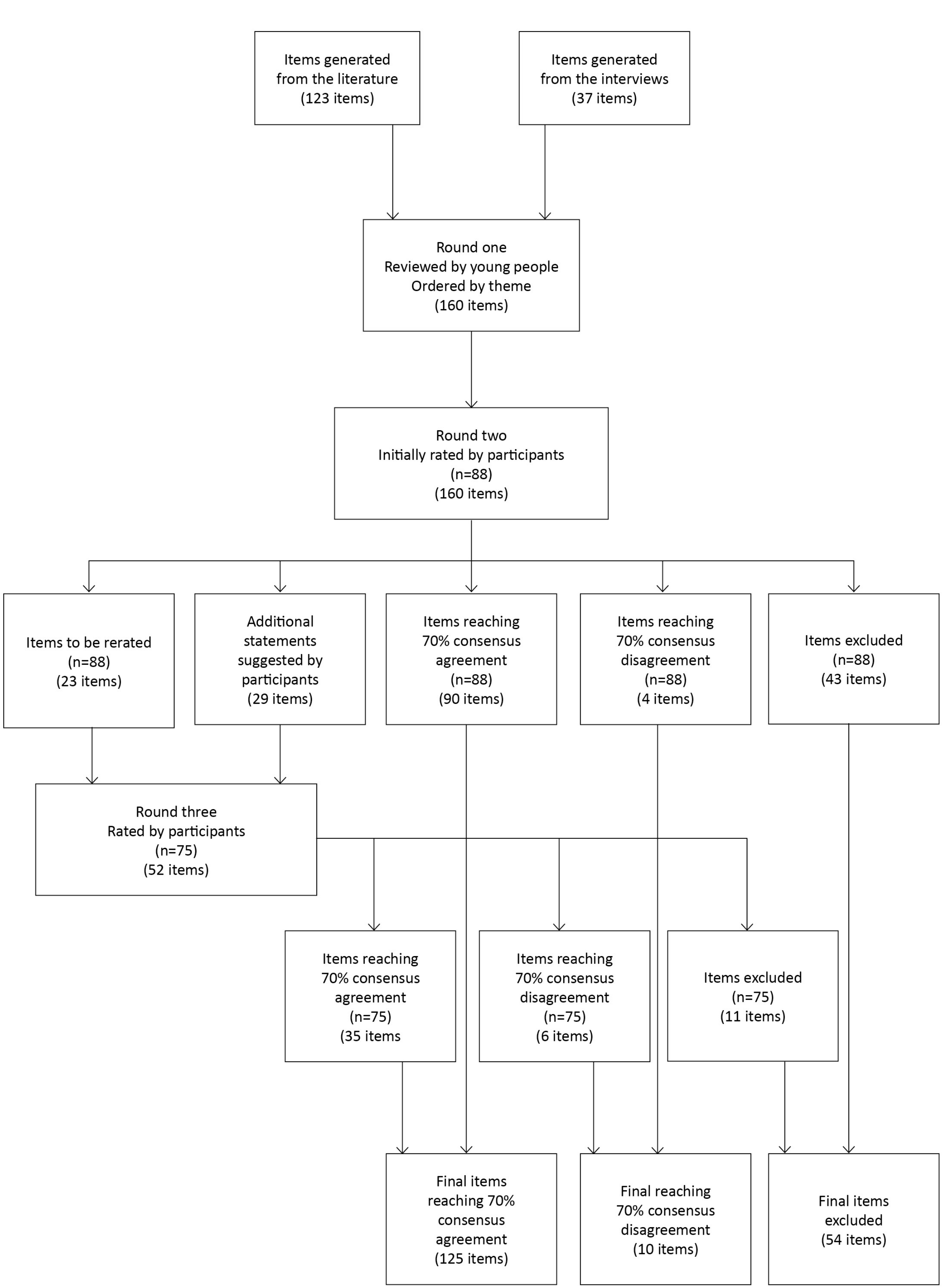
Participant type	Variable	Round 2	Round 3
Young people	N	29	17
Age	N		
	13-14	4	0
	15-16	10	2
	17-18	13	13
	19-20	2	2
Gender	N		
	Female	24	17
	Male	3	0
	Prefer not to say	2	0
Ethnicity	N		
	White British/White/British	24	15
	Mixed	2	1
	White Other	3	1
Time accessing service	N		
	Less than 1 month	1	0
	1-2 months	2	0
	3-6 months	6	2
	6 months -1 year	2	1
	1-2 years	4	3
	2+ years	14	11
Type of service accessed	N		
	Community CAMHS	28	16
	Inpatient CAMHS	9	8
	Charity Organisation	10	8
	Other	4	2
Carer	N	21	11
Gender	N		
	Female	17	11
	Male	3	0
	Unknown	1	0
Relationship to child	N		
	Biological mother	17	11
	Biological father	3	0
	Other caregiver	1	0
Ethnicity	N		
	White British/White/British	18	11
	Caribbean	1	0
	Unknown	2	0

Time accessing service	N		
	Less than 1 month	1	1
	1-2 months	1	0
	3-6 months	3	0
	6 months -1 year	4	1
	1-2 years	2	3
	2+ years	10	6
Type of service accessed	N		
	Community CAMHS	18	11
	Inpatient CAMHS	6	1
	Charity Organisation	6	3
	Other	3	1
Staff	N	38	27
Profession			
	Mental Health Nurse	10	7
	Psychologist	8	10
	Social worker	3	1
	Support worker/nursing assistant	2	0
	Psychiatrist	1	1
	Psychotherapist	1	1
	Other	13	7
Gender	N		
	Female	36	25
	Male	2	2
Ethnicity	N		
	White British/White/British	35	23
	Mixed other	3	4
Time working in service	N		
	1-6 months	4	0
	6 Months - 2 years	8	9
	2 - 4 years	9	2
	4 - 8 years	9	6
	8 - 15 years	2	4
	15+ years	6	6

The flow of statements through the study is outlined in Figure 2. A total of 160 statements were generated in round one. Eighty-eight participants rated their

agreement and disagreement for each statement in round two. A total of 94 statements reached consensus. There were 23 statements that reached between 60-69% in agreement. Participant's also suggested 29 new statements that they did not feel were captured in the previous lists of statements. Therefore, a total of 52 statements were sent out to participants who provided their email address for further contact. A total of 75 participants clicked onto the link to the Delphi study for round three, however, only 55 participants (17 young people, 11 parents/carers and 27 staff) completed the questionnaire. A further 36 statements reached consensus. Figure 2 below illustrates the number of items that were included, rerated, and excluded at each round of the study.

Figure 2. *Overview of statement inclusion or exclusion*



Tables 4-6 show the final statements in their respective categories: What is therapeutic alliance (n=19), what helps build good therapeutic alliance (n=88) and what hinders good therapeutic alliance (n=22). Statements that include an *, are additional statements generated from participants in round two. Table 6 includes statements where participants reached consensus disagreement (n=10). A grey highlight demonstrates where overall consensus was reached, but a specific participant group did not reach within group consensus.

Table 4. *Statements to define therapeutic alliance*

Statement	Overall agreement	Young person agreement	Parent agreement	Staff agreement	Round consensus reached
A sense of reliability*	96	86	100	100	3
A sense of trust*	96	93	91	100	3
A partnership	94	93	82	100	3
Non-judgmental*	94	86	100	96	3
A relationship with boundaries*	92	79	91	100	3
A sense of safety*	92	93	100	88	3
A sense of consistency*	92	86	91	96	3
A relationship	88	79	82	96	3
A genuine sense of connection	87	92	74	89	3
A collaborative effort	87	88	79	89	3
Has mutually agreed goals	86	81	74	95	3
An understanding of what another person is experiencing	86	85	79	89	3
An open, honest conversation*	84	86	82	83	3
An agreement between people	84	79	82	88	2
Joint cooperation	82	77	68	92	2
A bond	80	93	64	79	2
Showing respect for each other*	80	86	91	71	2
A basic acceptance and support of a person regardless of what the person says or does	75	85	63	74	2
A sense of empowerment*	73	57	73	83	2

1.1 What is a therapeutic relationship?

When defining therapeutic relationship, all three expert groups highly endorsed participant's recommended statements such as having 'a sense of reliability', 'sense

of trust' and being 'non- judgemental'. The group considered the relationship to be 'a partnership', with 'boundaries' and 'consistency'.

1.2 Within group consensus

1.2.1 Parents

Interestingly, whilst overall consensus was reached, there were three statements that parents/carers did not fully agree with young people and staff. This disagreement related to statements defining the therapeutic relationship as a joint co-operation, a bond and a basic acceptance of the person regardless of what they say or do. Within free text, a parent explained that they disagreed with the relationship being described as a bond, saying, "It is not a bond. It is a helping partnership. We would not miss the therapist when they have finished". Another parent shared that they neither agreed nor disagreed, but "bond feels too strong a word to use". Staff also provided reasoning with the statement that they neither agreed or disagreed that the relationship was 'an agreement between people', by explaining "How can you agree on something which is an experience within a relationship before it has began" and "Isn't always (an agreement) e.g. some young people don't want therapy".

Table 5. *Statements to define what builds good therapeutic alliance*

Statement	Overall agreement	Young person agreement	Parent agreement	Staff agreement	Round consensus reached
If a staff member is willing to allow, and encourage, open channels of communication*	100	100	100	100	3
If the staff member follows through on what they say they're going to do in a timely manner *	100	100	100	100	3
If the staff member shows acceptance of the person's difficulties*	100	100	100	100	3
If the staff member is non-judgmental	100	100	100	100	2
If the staff member is empathetic/ empathic	100	100	100	100	2
If the staff member is caring	100	100	100	100	2
If the staff member is consistent	100	100	100	100	2
If the staff member is supportive	100	100	100	100	2

If the staff member listens to the young person or parent/carer	100	100	100	100	2
If the staff member is compassionate	100	100	100	100	2
If the staff member understands the young person's or parent/carers point of view	100	100	100	100	2
If the staff member is genuine	100	100	100	100	2
If the young person has a choice to say something (or not)	99	100	94	100	2
If the staff member is relaxed	98	93	100	100	2
If the staff member can give honest feedback about how the work is going	97	94	94	100	2
If the staff member explores feelings with the young person	97	100	89	100	2
If the staff member treats each person as an individual	97	100	89	100	2
If the staff member picks up on body language if families do/don't want to talk about something.	97	93	100	97	2
If everyone gets a chance to say what they think when the young person/parent and staff member meet	97	93	100	97	2
If the young person can give honest feedback about how the work is going	96	94	89	100	2
If the parent/carer can give honest feedback about how the work is going	96	89	94	100	2
If everyone can be honest and discuss things they might not want to hear	96	94	94	97	2
If there is a clear discussion about what is expected from each other e.g. lateness, completing tasks etc.*	96	92	90	100	3
If the staff member is flexible in terms of re-arranging missed appointments, returning calls*	96	100	100	91	3
If a staff member explains the best ways to communicate with them about appointments, e.g. email, and advises of a likely timescale for response*	96	92	100	96	3
If humour is sometimes used (when appropriate)*	96	92	100	96	3
If the staff member is able to address disagreements in the session *	96	100	90	96	3
If the staff member isn't shocked by what the young person says	95	87	100	97	2
If the staff member/young person can talk one to one	95	100	93	94	2
If the staff member has boundaries	95	87	93	100	2
If the staff member does not shy away from asking about difficult things	94	94	83	100	2
If the staff member creates a safe environment for families	94	89	89	100	2
If the staff member is friendly	94	100	93	91	2
If there is trust between the family members and staff*	93	92	90	96	3

If the staff member has responsibility for their own behaviour	93	94	89	94	2
If the young person can stop the session if they want to	92	87	80	100	2
If the young person likes the staff member	91	100	89	88	2
If the treatment plan is clearly explained	91	94	83	94	2
If the goal of "the work" is the young person's	91	94	83	94	2
If the staff member explores feelings with the parent/carers	91	78	89	100	2
If non-problem things are talked about	91	100	72	97	2
If the staff member is active in the work	91	100	83	91	2
If the staff member does not tell the young person what to think	91	94	83	94	2
If the young person listens to the staff member	90	93	93	88	2
If the staff member is nurturing	90	80	93	94	2
If the staff member is positive	90	80	93	94	2
If the young person is active in the work	90	94	83	91	2
If the staff member is willing to take part in helping parents/young people test things out in the work	90	94	83	91	2
If the staff member adapts work to include a young person's interests/hobbies*	89	83	90	91	3
If the staff member can soothe parent/young person if they are upset	89	93	100	81	2
If the parent/carer listens to the staff member	89	87	93	88	2
If the parent/carer has a choice to say something (or not)	88	78	89	94	2
If the young person is willing to try out behaviours or thinking about things which relate to the work	88	89	83	91	2
If the staff member does not show if they are angry	87	85	100	83	3
If the staff member is seen as capable of making mistakes or being wrong	87	80	87	91	2
If the staff member tells a family if they have crossed boundaries	87	87	87	88	2
If staff members smile at the young person or parent/carer	86	83	78	91	2
If there is a treatment plan	86	89	72	91	2
If the parent is willing to try out behaviours or thinking about things which relate to the work	86	72	83	94	2
If the staff member does not tell the parent/carer what to think	86	83	83	88	2
If the staff member isn't shocked by what the parent/carer says	85	67	100	88	2
If the young person is able to express their emotions	85	93	87	81	2
If there are times when everyone meets together (young person, parent/carer and staff)	85	67	100	88	2
If the staff member is confident at their job	85	100	80	81	2

If the staff member is able to address the unspoken feelings between them and the young person/parent in the session*	84	75	70	96	3
If the staff member asks about the person's hobbies	84	89	72	88	2
If the staff member has a choice to say something (or not)	84	89	94	76	2
If session can happen outside school/college hours	84	93	80	81	2
If the staff member uses trial and error to guide discussions rather than their own plan	84	86	73	88	3
If the parent has responsibility for their own behaviour	83	94	78	79	2
If the staff member understands the family's culture	83	72	78	91	2
If the young person is able to express their thoughts	82	93	87	75	2
If the staff member has had specific training in the treatment type	82	93	100	69	2
If the young person has responsibility for their own behaviour	81	94	67	82	2
If the staff member starts sessions with a "clean slate" without expectations	81	69	91	83	3
Staff modelling (acting in the desired way as an example) roles	80	78	72	85	2
If the work has a focus/goal	78	83	78	76	2
If the staff and family members are talking about the right problems	78	94	89	64	2
If the staff member asks about the family's culture	78	67	72	88	2
If the parent/carer likes the staff member	78	50	82	92	3
If the staff member gets back to the young person/parent the same day if they have called	77	87	87	69	2
If things talked about by the young person and staff member is kept private from parents (unless harm is imminent)	76	100	53	75	2
If eye contact is made between the young person or parent/carer and staff member	75	78	72	76	2
If the staff member can stop the session if they want to	74	69	82	74	3
If the staff member is not seen as perfect	72	83	50	79	2
If the parent/carer is active in the work	72	50	83	79	2
If the young person, parent/carer and staff feel equal in the relationship	71	67	83	67	2
If the staff member is seen as important by the young person	71	94	72	58	2

2.1 What helps to build a good therapeutic relationship?

The top rating statements related to factors that build a good relationship and alliance are all related to staff behaviours, rather than the young person or parent. Important considerations were that the staff member is ‘non-judgemental’, ‘empathic’, ‘listens’ and is ‘genuine’. These statements reached agreement in round

two, suggesting they are highly important without need for further consideration. Secondly, relational themes of honesty, giving feedback and everyone having their say were also highly rated.

Interestingly, two suggestions from participants which had not been highlighted in the literature, included staff explaining ‘what is expected of families in terms of lateness’, and ‘sharing the best way to communicate’ as highly important for a good relationship. Specific therapeutic techniques were agreed as important, such as staff ‘modelling behaviour’ that is discussed in sessions, there being a clear treatment plan and the goal of treatment being the young persons, rather than carer or therapist. As well as staff characteristics being important, family characteristics were also highly rated. All agreed that young people and carers ‘listening to a staff member’ and ‘choosing whether to say something or not’ helped build a good relationship.

The practicalities of where sessions were held also generated much discussion from participants when providing a rationale for their answer. Overall (84%), agreed ‘that a session can happen outside school or college’ was good for the therapeutic relationship. However, two young people provided feedback in the comments that they strongly disagreed with this statement because “I would find it stressful to partake in anything therapeutic in college because people would ask questions and I would miss lesson time which would stress me out” and “I prefer having boundaries between mental health work and school to keep my feelings separate. For example if therapy makes me upset I don't want to be at school immediately afterwards”. Staff echoed this through not agreeing or disagreeing by suggesting it “…completely depends on the young person and their preferences” and “some young people might feel comfortable with this, some might not”.

2.2 Within group consensus

2.2.1 Young people

Whilst there was a high agreement overall between the three expert groups, as to what helps build good relationships, there were 7% of statements where young people did not reach 70% within group consensus, but carers and staff did. Interestingly, these statements were mainly focused on the amount of involvement parents had in the work. Only 50% of young people thought it would help build a good working relationship 'if the parent was active in the work' or 'if the parent liked the staff member'. Young people shared that they disagreed with the importance of the parents liking the staff member "as long as the client (young person) likes the member of staff it doesn't matter", that a "therapeutic relationship should be purely between the therapist and the service user. Parents/carers should not have an influence on how the relationship is built" and "parental approval of the staff member should not affect it". Staff had different views of disagreement with the statement because "it is important but can be worked around as key person is the young person". However, another staff member noted, "we all prefer to spend time and engage with people we like".

2.2.2 Parent/carer

Parents on the other hand, had disagreements compared to young people and staff in relation to the young person's behaviour. Parents also had lower agreement (53%) in relation to the statement that they do not need to know the content of work between the young person and staff, unless harm is imminent.

2.2.3 Staff

Staff members did not reach consensus on four items compared to young people and staff. When discussing relational issues, staff agreed that it is important they are seen as important by the young person, and that they need to be talking about the 'right problems' with families 58% and 64% respectively. Finally, a relational statement of young people, parents and staff feeling equal in the relationship had an overall consensus of 71%, however, both young people and staff only agreed 67%, and so just shy of consensus.

Table 6. *Statements to define what hinders good therapeutic alliance*

Statement	Overall agreement	Young person agreement	Parent agreement	Staff agreement	Round consensus reached
If appointments are cancelled regularly*	100	100	100	100	3
If information is shared, which is not risk related, without permission*	93	100	80	96	3
If the staff member acts in a mistrustful way when working together	93	100	86	93	2
If the staff member is acting bored in sessions	91	100	86	89	2
If there is not a clear trend or theme during the work together	91	83	100	91	3
If the staff member does not acknowledge or answer questions*	91	100	100	83	3
If parent/carer's and staff members make decisions and don't include the young person	88	100	71	89	2
If the young person acts in a mistrustful way when working together	87	100	90	78	3
If someone holds a grudge about something another person has done (young person, parent/carer or staff member)	82	93	57	89	2
If the staff member acts in a defensive way during the work together	82	73	79	89	2
If the staff members is showing a lot of anxiety during the work	81	73	86	82	2
If meetings take place somewhere that is too busy	81	93	79	75	2
If the young person is acting bored in sessions	80	92	80	74	3
If the young person has a lack of power in the relationship	79	80	50	93	2
If the parent/carer acts in a mistrustful way when working together	77	87	71	75	2
If the young person is told what to do by staff members	77	67	71	86	2
If the parent/carer is acting bored in sessions	74	80	79	68	2
If parent/carer's are told what to do by staff members	72	60	64	82	2

3.1 What hinders good therapeutic relationships?

All expert groups (100%) agreed that regular cancelled appointments hindered a good relationship forming, which was suggested by a participant. Also, a further participant suggested statement of information being shared that is not risk related reached high overall consensus (93%), with 100% of young people agreeing. Relational interpersonal themes that hinder relationships related to staff behaviour. These include acting bored, mistrustful or not acknowledging or answering questions. Interestingly, young people also 100% agreed that when they too were acting in a mistrustful way, this hinders the relationship. Staff members'

interpretation of young people acting bored though did not mean that they agreed or disagreed that this hindered the relationship. Staff suggested this is because it "depends upon the therapeutic approach" and "some young people do not trust, this can be worked on but is a challenge". A staff member who disagreed with this statement explained further "although this can make things difficult, we should not expect trust from young people and this may take time to build".

Table 7. *Statements that reached consensus disagreement*

Statement	Overall disagreement	Young person disagreement	Parent disagreement	Staff disagreement	Round consensus reached
What builds a good therapeutic relationship?					
If the staff member is seen as a friend by the young person or parent/carer	86	71	82	96	3
If the staff member/parent or carer/young person are the same ethnicity	80	79	82	79	3
If staff only have contact with the young person or parent/carer over text message	77	60	87	81	2
If staff only have contact with the young person or parent/carer over the telephone	77	67	87	78	2
If the staff member/young person is the same gender	71	57	73	79	3
If no eye contact is made between the young person or parent/carer and staff member	71	71	82	67	3
What hinders a good therapeutic relationship?					
If the young person initiates (starts) the discussion	87	75	90	91	3
If the young person, parent/carer or staff member is honest about how they feel	74	80	43	86	2
If the staff member initiates (starts) the discussion	73	58	80	78	3
If there are times when everyone meets together (young person, parent/carer and staff)	72	67	57	82	2

4.1 Consensus disagreement

4.1.1. Building a good relationship

Consensus disagreement occurred when between the three groups, over 70% of participants agreed that a statement was not important. For example, that overall, 86% agreed that it is not important '*If the staff member is seen as a friend by the young person or parent/carer*'. Therefore, they have reached overall consensus disagreement. This is important as statements were generated because they have been considered important in the literature, but have specifically shown not to be

through the Delphi process. These are different from statements that reached less than 60% agreement, as their importance remains ambiguous.

There were six statements where overall consensus was disagreement with the statements, when asked about what builds good alliance. When discussing if staff and young people need to be the same gender, three staff elaborated that they neither agreed or disagreed due to it "sometimes" mattering, "depending on what they are discussing" and that "while gender of therapist may matter for some young people, for others it may not make a difference". A parent strongly disagreed that they needed to be the same gender, suggesting it "shouldn't make a difference" and a young person sharing "my therapist was not the same gender. As long as they work well together it shouldn't matter". In addition, overall, and within groups disagreement was reached that contact should only be over text or telephone.

When participants were asked about not giving eye contact, overall disagreement was reached. However, a young person shared the opposite feedback, describing, "as an autistic teenager, I do not often make eye contact. Being forced to make eye contact would make me very uncomfortable". A staff member who neither agreed nor disagreed with the statement explained that it "depends on the young person. Sometimes eye contact can be intimidating e.g. if a young person has autism, so sometimes too much eye contact can be the opposite of therapeutic" suggesting this is not clear-cut.

4.1.2. Hindering a good relationship

Seventeen percent of the items reached overall *disagreement* consensus when asked about what hinders a therapeutic relationship. Overall, young people, parents and staff disagreed that if it is just a young person or a staff member always 'initiating discussions', then this would hinder the therapeutic relationship. Implying that just one member of the group regularly starting the conversation is ok. However, a staff member shared in the free text section that they "…feel sessions should also be lead by the young person".

A point of note was when participants were asked if ‘meeting with young people, parents and staff’ hindered the relationship, neither young people nor parents reached a participant consensus (70%). However, staff felt strongly that this did not hinder the therapeutic relationship (82%). A further item where overall agreement was reached, but young people and parents did not reach consensus, whereas staff did, was on the statement ‘if parents/carers are told what to do by staff members’.

Discussion

To the authors’ knowledge this is the first paper of its kind, presenting a group consensus on elements of therapeutic alliance in CAMHS, with the involvement of young people, parents and staff members. The study aimed to define what a therapeutic relationship is, how to build a good relationship and factors that hinder a good alliance formation. Items that reached consensus represent endorsement by young people and parents whom have accessed and staff members who have worked in CAMHS and therefore have high validity when working with families who identify themselves as White British. Whilst there were a large proportion of statements where overall consensus was reached, there were many areas where group consensus could not be obtained. Therefore, it is important to include all three expert groups as key stakeholders, when answering questions about relationships in CAMHS. Moreover, it is important to consider how other expert groups, such as Black Minority and Ethnic (BAME) groups, may not value these statements in the same way.

Young people did not understand the word “alliance” during the initial accessibility checks stage of the study and therefore this term was not used in the Delphi study. This supports the proposition that child-specific alliance research is needed, as their understanding is likely to be different from adults. Interestingly, whilst Bordin (1979) argued within the adult literature that the therapeutic alliance consists of a ‘bond’, this was not endorsed in this population. Similarly, Rogers (1951) client-centred premise that there needs to be a basic acceptance between people, also shared less

agreement. Participants suggested ideas of being reliable and trustworthy and spoke much more specifically about the nature of the relationship.

Intriguingly, the highest rated statements in terms of building a good alliance were related to staff behaviours and characteristics (Ryan, Berry, & Hartley, 2020). Staff characteristics have been found to be an important contributor to alliance (Bryce D McLeod, 2011). Whilst staff and young person ethnicity was not described as important within the context of this study; ethnic matching has sometimes been shown to improve youth mental health outcomes within the literature (Hall et al., 2002; Laura Mufson, Paula Yanes-Lukin, Meredith Gunlicks-Stoessel, & Priya Wickramaratne, 2014; Yeh et al., 1994). However, previous research has shown that when white participants are matched within a Western society, this does not significantly improve outcome. However, if youth and therapists are from a Black and Minority and Ethnic group (BAME) in a Western society, then this does have a significant positive effect on youth outcome (Hall et al., 2002). Therefore, as this sample was predominantly white, the views from young people, parents and staff where ethnicity may be more important, were not captured. Additionally, as the majority of CAMHS therapists and families who access CAMHS are white, ethnicity differences may not have previously been highlighted or considered (Memon et al., 2016). Moreover, the interpersonal nature of therapists such as being empathic, listening and being honest about emotions, has been reinforced as important from previous studies (Creed & Kendall, 2005; Nathaniel J Jungbluth & Stephen R Shirk, 2009; Karver et al., 2008; Russell et al., 2008).

When considering what hinders a good relationship, having ‘mistrust’ in the relationship seemed to be a key detriment. Qualitative interviews with young people reinforce this premise, that trust is needed in order to be open about difficulties (Harper, Dickson, & Bramwell, 2014). Moreover, this finding correlates with the definition of the working relationship being a ‘sense of trust’.

It is important to note the individual differences even within each expert group. In particular, young people disagreed with each other about what they wanted when

considering the practicalities of sessions, and the environment in which sessions take place. There have been key benefits in terms of identification of young people's difficulties through accessing mental health services through schools (Wolpert, Humphrey, Belsky, & Deighton, 2013), this was not found in the current study. Whilst it is important to find common ground of consensus, it is also important to plan with the young person what they individually want and need from therapeutic sessions (VanDenBerg, 1993).

This paper is the first Delphi to explore if participants reach consensus, but through disagreeing with a statement, rather than agreeing. Interestingly, gender is not seen as an important factor to build good alliance. However, the literature suggests that male therapists can potentially build higher alliance compared to female therapists (Duppong Hurley et al., 2013). Moreover, in relation to eye contact, the subjective nature of whether eye contact is seen as engaging or intrusive needs to be considered (Browne, 2006). It reinforces the point that while group consensus is important, individual differences need to be taken into consideration to build a good working relationship (VanDenBerg, 1993).

Strengths and limitations

A key strength to this Delphi study is that succeeded at synthesising the understanding of complex relationships in the context of mental health care at a critical time for families. By having multiple expert groups, it ensured that all key stakeholder views are heard in an unbiased way. Often, young people are not included in research due to concerns of vulnerability, or issues with capacity and consent. However, this study specifically sought consultation from experts in the field about how to include young people in research, so their invaluable voices could be heard (Parry, 2018). Furthermore, there was a wide range of professional discipline views collected, not just psychology and psychotherapy, where most previous alliance literature is considered. This is in line with the nature of CAMHS, where multiple professional groups are allocated to provide individual and systemic support for young people.

Moreover, recruitment took place online with no geographical restrictions, ensuring that these results are representative of experts across the country. In turn, these findings can be used to inform services across the country, and inform services of key expectations and desires from a family accessing CAMHS. However, whilst efforts were made to recruit within services to include participants who would prefer not to participate online, no participants decided to up take this offer and so their views may have been missed.

Whilst specific efforts were taken to try and recruit members from BAME communities across all expert groups, there is still a smaller sample compared to the White British sample. This is representative of current take up of services from BAME groups and qualitative research has highlighted a narrative that there are language barriers, poor communication between service users and providers, inadequate recognition or response to mental health needs and an imbalance of power and authority between service users and providers embedded within cultural naivety (Memon et al., 2016). Therefore, BAME voices are often not heard and included in service improvement or research, which potentially reinforces the cycle that CAMHS services are inaccessible. It is important to think about these findings as useful for White British families, but these cannot be assumed to be accurate for BAME families. Furthermore, specific focus was given to aim to increase father-figure voices in CAMHS as they are often under represented (Davison, Charles, Khandpur, & Nelson, 2017). Recruitment took place on dad specific social media forums, with a specific call out for fathers. However, there were still a small number of fathers who took part and so this study potentially missed out on their views. Therefore, dads may not have the same perceptions about what is important in therapeutic relationships as mums. It is important to consider how to include views from fathers in the future, so that they are involved in their child's care. Davison et al. (2017) recommended that father-focused community events could be a good avenue to increase male father figure participation in research, which is a consideration for the future.

Finally, whilst the original statement generation was aimed to capture definitions of therapeutic relationships from the literature and qualitative interviews, there are

multiple ways items could have been generated. Other Delphi studies have included items generated from focus groups or service user panel discussions (Sayal et al., 2012). In turn, the authors could have increased bias in the statements included. However, the utility of interviews from young people, parents and staff about therapeutic relationships, and allowing participants to add statements they did not feel were already included, helped to reduce this potential bias.

Clinical implications

Scales aiming to measure child alliance have been developed, such as the Therapeutic Alliance Scales for Children (TASC) for Child and Therapist (Accurso, Hawley, & Garland, 2013), Therapeutic Alliance Scale for Adolescents (TASA) (Russell et al., 2008) or tools are used from the adult literature such as the ubiquitous Working Alliance Inventory (Tracey & Kokotovic, 1989). However, these have not been developed with young person and family definitions of involvement. Moreover, they focus on a therapy-based relationship, rather than capturing the 'therapeutic mileu' (Sergeant, 2009) of CAMHS therapeutic work. Therefore, a therapeutic alliance tool, based on collaborative joint understanding of the therapeutic alliance established within this study, would be beneficial to the clinical measurement in CAMHS, as well as the scientific literature. It would be important to include families in the development of this tool, especially from BAME backgrounds. Likewise, a complete definition of a therapeutic relationship could help inform clinical practice in the form of therapeutic alliance session measurement and future training of therapists in clinic skills. A key finding from this Delphi suggests that is it important to have an explicit negotiation with young people, parents and staff about expectations of the working relationship at the start. It would be useful to hear from all members of the family, including dads and to specifically seek this out. This finding echoes previous literature which considers who is involved in the session and how they can share their views, in particular with involvement, or not, of parents (Harper et al., 2014).

Conclusions

In conclusion, this is the first study of its kind to explore the definition and dynamics of therapeutic relationships in CAMHS. As suggested by Green (2009), relationships are complex. Therefore, it is essential to hear from young people and families accessing services, about their expectations and needs (Fonagy, Pugh, & O'Herlihy, 2017) in order to create better working relationships and outcomes. Moreover, as the research suggests additional effort needs to be made so that voices from under represented families or family members are heard. Overall, the therapeutic relationship is bound by trust, reliability and consistency. Staff members have a key influence when considering how good working relationships are built, or hindered. Young people want to take an active role in their own care. It is important to hear parent's views, but also discuss clear expectations of their active involvement, based on the views of their child. Further research is warranted when exploring the multifaceted and rich relationships within CAMHS settings.

Funding

No external funding was received.

Acknowledgements

The authors would like to thank the families and staff members who contributed their valuable time and effort. The authors confirm that there is no funding to report for this study and that it was undertaken as part of a Doctorate in Clinical Psychology at The University of Manchester by R.R., the lead author. The authors have declared that they have no competing or potential conflicts of interest.

References

Accurso, E. C., & Garland, A. F. (2015). Child, caregiver, and therapist perspectives on therapeutic alliance in usual care child psychotherapy. *Psychological assessment, 27*(1), 347-352. doi:https://doi.org/10.1037/pas0000031

Accurso, E. C., Hawley, K. M., & Garland, A. F. (2013). Psychometric properties of the Therapeutic Alliance Scale for Caregivers and Parents. *Psychological assessment, 25*(1), 244-252. doi:https://doi.org/10.1037/a0030551

Armbruster, P., & Kazdin, A. E. (1994). Attrition in Child-Psychotherapy. In T. H. Ollendick, R.J., Prinz, (Ed.), *Advances in Clinical Child Psychology, Vol 16* (Vol. 16, pp. 81-108). Boston, MA: Springer, .

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260. doi:10.1037/h0085885

Browne, M. E. (2006). Communicating with the child who has autistic spectrum disorder: a practical introduction. *Paediatric Nursing, 18*(1), 14-18.

Creed, T. A., & Kendall, P. C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of Consulting and Clinical Psychology, 73*(3), 498. doi:https://doi.org/10.1037/0022-006X.73.3.498

Dalkey, N., & Helmer, O. (1963). An Experimental Application of the DELPHI Method to the Use of Experts. *Management Science, 9*(3), 458-467. doi:https://doi.org/10.1287/mnsc.9.3.458

Davison, K. K., Charles, J. N., Khandpur, N., & Nelson, T. J. (2017). Fathers' perceived reasons for their underrepresentation in child health research and strategies to increase their involvement. *Maternal and child health journal, 21*(2), 267-274. doi:https://doi.org/10.1007/s10995-016-2157-z

de La Peña, C. M., Friedlander, M. L., Escudero, V., & Heatherington, L. (2012). How do therapists ally with adolescents in family therapy? An examination of relational control communication in early sessions. *Journal of counseling psychology, 59*(3), 339. doi:https://doi.org/10.1037/a0028063

Department of Health. (2015). Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing. *Mental health service reform,* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf *[date accessed 31st March. 2020]*.

Duppong Hurley, K., Lambert, M. C., Van Ryzin, M., Sullivan, J., & Stevens, A. (2013). Therapeutic Alliance Between Youth and Staff in Residential Group Care: Psychometrics of the Therapeutic Alliance Quality Scale. *Children and Youth Services Review, 35*(1), 56-64. doi:https://doi.org/10.1016/j.childyouth.2012.10.009

Fonagy, P., Pugh, K., & O'Herlihy, A. (2017). The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) Programme in England. *Child psychology and psychiatry: Frameworks for clinical training and practice*, 429-435. doi:https://doi.org/10.1002/9781119170235.ch48

Funakoshi, A., Tanaka, A., Hattori, K., & Arima, M. (2016). Process of Building Patient-Nurse Relationships in Child and Adolescent Psychiatric Inpatient

Care: A Grounded Theory Approach in Japan. *Journal of Nursing and Patient Care, 2*, 2. doi:10.4172/2573-4571.1000106
Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70*(2), 439-443. doi:https://doi.org/10.1037/0022-006X.70.2.439
Green, H., McGinnity, Á., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain, 2004*. (1403986371). Palgrave Macmillan Basingstoke
Green, J. (2006). Annotation: the therapeutic alliance--a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47*(5), 425-435. doi:https://doi.org/10.1111/j.1469-7610.2005.01516.x
Green, J. (2009). The therapeutic alliance. *Child: Care, Health and Development, 35*(3), 298-301. doi:https://doi.org/10.1111/j.1365-2214.2009.00970.x
Hall, J., Guterman, D. K., Lee, H. B., & Little, S. G. (2002). Counselor-Client Matching on Ethnicity, Gender, and Language: Implications for Counseling School-aged Children. *North American Journal of Psychology, 4*(3).
Harper, B., Dickson, J. M., & Bramwell, R. (2014). Experiences of young people in a 16–18 Mental Health Service. *Child and Adolescent Mental Health, 19*(2), 90-96. doi:https://doi.org/10.1177/2158244017719113
Hartley, S., Redmond, T., & Berry, K. (2020). *Therapeutic relationships within adolescent mental health inpatient wards: a qualitative investigation of the experiences of young people, family members and nursing staff*. In prep.
Hawley, K. M., & Weisz, J. R. (2005). Youth versus parent working alliance in usual clinical care: distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 117-128. doi:1https://doi.org/10.1207/s15374424jccp3401_11
Health Research Authority, H. (5th February 2020). Clinical Trials of Investigational Medicinal Products (CTIMPS). Retrieved from https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/clinical-trials-investigational-medicinal-products-ctimps/
Howarth, E., Vainre, M., Humphrey, A., Lombardo, C., Hanafiah, A. N., Anderson, J. K., & Jones, P. B. (2019). Delphi study to identify key features of community-based child and adolescent mental health services in the East of England. *BMJ open, 9*(6), e022936. doi:http://dx.doi.org/10.1136/bmjopen-2018-022936
Jungbluth, N. J., & Shirk, S. R. (2009). Therapist strategies for building involvement in cognitive–behavioral therapy for adolescent depression. *Journal of Consulting and Clinical Psychology, 77*(6), 1179. doi:https://doi.org/10.1037/a0017325
Karver, M., Shirk, S., Handelsman, J. B., Fields, S., Crisp, H., Gudmundsen, G., & McMakin, D. (2008). Relationship Processes in Youth Psychotherapy. *Journal of Emotional and Behavioral Disorders, 16*(1), 15-28. doi:https://doi.org/10.1177/1063426607312536
Langlands, R. L., Jorm, A. F., Kelly, C. M., & Kitchener, B. A. (2008). First Aid Recommendations for Psychosis: Using the Delphi Method to Gain

Consensus Between Mental Health Consumers, Carers, and Clinicians. *Schizophrenia Bulletin, 34*(3), 435-443. doi:https://doi.org/10.1093/schbul/sbm099

Law, H., & Morrison, A. P. (2014). Recovery in Psychosis: A Delphi Study With Experts by Experience. *Schizophrenia Bulletin, 40*(6), 1347-1355. doi:https://doi.org/10.1093/schbul/sbu047

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603-616. doi:https://doi.org/10.1016/j.cpr.2011.02.001

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open, 6*(11), e012337. doi:http://dx.doi.org/10.1136/bmjopen-2016-012337

Mufson, L., Yanes-Lukin, P., Gunlicks-Stoessel, M., & Wickramaratne, P. (2014). Cultural competency and its effect on treatment outcome of IPT-A in school-based health clinics. *American journal of psychotherapy, 68*(4), 417-442. doi:https://doi.org/10.1176/appi.psychotherapy.2014.68.4.417

O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture–repair in the therapeutic alliance and association with therapy ending. *Psychotherapy*. doi:10.1037/pst0000279

Okoli, C., & Pawlowski, S. D. (2004). The Delphi method as a research tool: an example, design considerations and applications. *Information & Management, 42*(1), 15-29. doi:https://doi.org/10.1016/j.im.2003.11.002

Parry, S., Djabaeva, R., & Varese, F. . (2018). *Engaging Young People Who Hear Voices in Online Mixed-Methods Research*. doi:https://dx.doi.org/10.4135/9781526457783

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*: Houghton Mifflin Boston.

Romeo, R. D. (2017). The impact of stress on the structure of the adolescent brain: Implications for adolescent mental health. *Brain Research, 1654*, 185-191. doi:https://doi.org/10.1016/j.brainres.2016.03.021

Russell, R., Shirk, S., & Jungbluth, N. (2008). First-session pathways to the working alliance in cognitive-behavioral therapy for adolescent depression. *Psychotherapy Research with Children and Adolescents, 18*(1), 15-27. doi:https://doi.org/10.1080/10503300701697513

Ryan, R., Berry, K., & Hartley, S. (2020). *Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review* In prep.

Sayal, K., Amarasinghe, M., Robotham, S., Coope, C., Ashworth, M., Day, C., . . . Simonoff, E. (2012). Quality standards for child and adolescent mental health in primary care. *BMC family practice, 13*(1), 51. doi:https://doi.org/10.1186/1471-2296-13-51

Sergeant, A. (2009). Working within child and adolescent mental health inpatient services: a practitioner's handbook.

Shirk, S., Karver, M., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy (Chicago, Ill.), 48*(1), 17-24. doi:https://doi.org/10.1037/a0022181

Shirk, S. R., & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464. doi:https://doi.org/10.1037/0022-006X.71.3.452

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A journal of consulting and clinical psychology, 1*(3), 207. doi:https://doi.org/10.1037/1040-3590.1.3.207

VanDenBerg, J. E. (1993). *Integration of individualized mental health services into the system of care for children and adolescents* (Vol. 20).

Wolpert, M., Humphrey, N., Belsky, J., & Deighton, J. (2013). Embedding mental health support in schools: learning from the Targeted Mental Health in Schools (TaMHS) national evaluation. *Emotional and Behavioural Difficulties, 18*(3), 270-283. doi:https://doi.org/10.1080/13632752.2013.819253

World Health Organization. (2018). Child and adolescent mental health. Retrieved from https://www.who.int/mental_health/maternal-child/child_adolescent/en/

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22*(2), 153-163. doi:https://doi.org/10.1002/1520-6629(199404)22:2<153::AID-JCOP2290220210>3.0.CO;2-R

Paper 3

Critical appraisal

Word count: 6,986 (complete text), 5,884 (main text excluding tables, figures and references).

The following paper has been written as a reflective piece and is not intended for publication.

Overview

The following paper provides a critical appraisal of the research process whilst completing the systematic literature review and empirical study, alongside reflecting on the programme of work as a whole and experience of that as a trainee. The strengths and limitations of the work and its contributions to the field of research will be discussed, with the aim of informing future research. The trainee's personal reflections on the process will be discussed.

The overall body of work aimed to investigate the concept of therapeutic alliance, in the context of child and adolescent mental health services (CAMHS). This interest has developed from the fact that the majority of the trainee's pre-course employment was with children and young people. A post as a participation coordinator within the Children and Young People's Improved Access to Psychological Therapist (CYP IAPT) programme particularly instilled the passion of working with children and their families. The trainee found that the raw, honest and insightful opinions of families to be refreshing, and highlighted the importance of an open dialogue.

Therapeutic alliance has been a focus of research efforts for many years, especially within adult mental health literature. Bordin (1979) argued that therapeutic alliance is (a) therapist and client agreement on the goals of therapy; (b) therapist and client agreement on the tasks of therapy; (c) emotional bond between the therapist and client. There is strong evidence to suggest that therapeutic alliance is a strong predictor of the outcome of therapy in adults (Horvath, Del Re, Fluckiger, & Symonds, 2011). Moreover, a similar relationship has been found in the child literature (S. R. Shirk et al., 2011). Therefore, it is important to consider what can impact and influence this alliance and then outcome (Green, 2006). Paper 1 systematically reviews the literature to explore how therapist characteristics can influence the alliance or outcome. Paper 2, looks more closely at the definition of therapeutic alliance, what helps build it, as well as what hinders it. In particular, this research aims to gain a group consensus via the Delphi method, about alliance within the child and family relationship.

The findings from both this review and empirical research will support the growing understanding of factors that influence outcomes for children and their families in mental health provision. The trainee is passionate that the “evidence base” translates into the “evidence-based practice” when working with families both in their own practice, and through disseminating findings.

Paper 1: Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review

Review topic selection

Through discussion in supervision, the review focus was developed while considering literature that would be informative for the empirical study and to contribute to the broader field as a whole. The ultimate aim was to add to our understanding of what assists with the development and maintenance of therapeutic alliance in CAMHS in order that services could foster more positive outcomes for young people who use services. The trainee used “therapeutic alliance”, “adolescence” in a search database, and used truncation to expand search words. The trainee considered what factors influence alliance. Previous reviews that had explored child factors (Shirk & Karver, 2003b), the parent/professional relationship (de Greef, Pijnenburg, van Hattum, McLeod, & Scholte, 2016) and factors that influencing length of treatment for adolescents (Bettmann & Jasperson, 2009). These reviews were interesting and already synthesized key parts of the literature. The impact of therapist’s had been recently highlighted as a key contributor to alliance variance (Murphy & Hutton, 2018). The trainee checked Prospero to ensure the review had not already been registered.

Search term generation

The search strategy took several months and iterations for the trainee to develop. The trainee was aware of a number of key, relevant papers as a result of initial scoping and the presence of these in search results was used as a validity check on the search process, alongside appraising the number and general relevance of papers produced. The trainee experimented with several search strings and terms. Initially, a key word search of terms related to 1) therapist factors 2) alliance and outcome were used in multidisciplinary databases (SAGE Journals, Medline PsycINFO, Web of Science: pubmed, CINAHL*).* The rationale for having numerous databases was to capture research conducted across different disciplines to reflect the multi disciplinary team set up often found in child and adolescent mental health

teams. However, there were too few results. Therefore, the trainee discussed in supervision adding in terms such as therapist behaviour and empathy/ warmth (as these common characteristics found to predict alliance in adult literature) as well as profession type. Therefore, the search string, with various iterations, was recategorised to include 1) profession type AND 2) characteristics AND 3) alliance or outcome. However, results from searching (ESCBO) Medline database initially produced 249, 688 results. Therefore, the results were not being filtered systematically enough. The trainee tried to reduce the results by adding the following topic filters (age) 0-18, (topic) mental disorder, however, this still yielded large results and irrelevant papers being included (for example about HIV). The trainee consulted with the University of Manchester librarian to develop search terms. Following this discussion, the trainee added the term psychiatric (or study setting) as a new search string. The trainee was concerned that the process of adding topic filters to search terms across different databases was unsystematic. Following a discussion with the supervisor, the trainee conducted searches using OVID platform, which could systematically search a number of databases within it. Furthermore, the term characteristic/factor was no longer included as it yielded too many results. Therefore, following several iterations of searching results now included 1 – alliance/outcome, 2- staff type, 3- youth, 4- psychiatric. However, this now produced too few results (3116). Finally, and through further extensive discussion with supervisors, titles and abstracts were reviewed of papers identified through scoping. The search strategy was updated to include key words that were found in the titles or abstracts (such as drop out which was a specific outcome variant), as well as previous iterations of search terms. These terms generated a more manageable number of titles and abstracts to screen (7,400), when searching in titles and abstract. Therefore, this gave the trainee confidence that relevant papers to the research question were likely to be included. This enabled a clear research protocol to be developed following this lengthy process.

Inclusion and exclusion criteria

When considering the inclusion and exclusion criteria, the trainee valued discussion with her supervisors. When reviewing what type of services and interventions should be included as part of the review, it was decided to focus on generic services that are related to common mental health problems. Whist substance abuse is a relatively well-researched area in terms of alliance or outcome, this type of service was considered a specialist service. Moreover, the presenting difficulty for accessing the service was substance abuse and not a mental health problem specifically. Whilst the trainee and her supervisors acknowledge that this population is likely to have comorbid mental health difficulties, this is not the primary focus of the intervention in substance abuse services.

In order to answer the specific question about the impact of therapist characteristics on children or young people's alliance or outcomes, it was decided that group ratings would not be included. However, if a young person is participating in a group intervention or family therapy, then if there was an individual rating between the young person and therapist then this could be included. However, overall group alliance was excluded as it did not specifically answer the research question (Johnson, Ketring, Rohacs, & Brewer, 2006).

When defining a therapist characteristic, the trainee found that this also came with its own caveats. Due to the lack of research within the child literature on alliance, a broad definition of a characteristic needed to be included, in order to encompass different types of characteristics. The trainee examined the adult literature for similar review topics of positive behaviours (Ackerman & Hilsenroth, 2003) , negative behaviours (Ackerman & Hilsenroth, 2003) and therapist attachment (Degnan et al., 2016); however, the same focused review of a specific characteristic was not possible in the child literature due to lack of research on just one trait . Therefore, there is a wide body of literature to scope. Moreover, the broad range of literature and study designs also impact on the quality of therapist characteristic measurement accepted within the review. In particular, when the characteristic of interest was a

demographic variable such as experience, the research is relying on self-report administrative data, which is considered a weak data collection method for quality appraisal using the Effective Public Health Practice Project tool (Thomas et al., 2004).

The review aimed to focus on therapist characteristics. The trainee and the supervisory team agreed a theoretical distinction between these general factors and more specific considerations in relation to model compliance, competence or adherence. These aspects of therapeutic process have an evidence base of their own and so are arguably separate from therapist characteristics. However, there remained ambiguities as to what could be classed as a model specific behaviour and what was a therapist factor impacting on the alliance, both of which could be assessed by valid and reliable tools. Moreover, therapist competence in a therapeutic model often overlapped with basic therapeutic skills that could influence alliance or outcome. However, as adherence to a model is often measured using a reliable and valid measurement tool, this presented issues in where to draw the line about what is a model specific behaviour, and what is a therapist alliance building behaviour. The research team discussed papers when this occurred. For example, research by Boyer, MacKay, McLeod, and van der Oord (2018) measured therapist in-session skills using a valid motivational interviewing scale across two forms of a Cognitive Behavioural Therapy (CBT) intervention. However, the write up and interpretation of the results focused on adherence to the model as the therapist skill, rather than any in session behaviours captured by the scale. This paper was discussed and excluded due to the focus of the paper not being on a therapist characteristic specifically. Therefore, a group decision was made based on the focus of the paper. However, the trainee is aware of the potential bias associated with this exclusion.

Outcome is defined in many ways throughout the literature. Symptom change, engagement in service, sessions attended and dropout were considered key outcomes of measurement that could be operationalized. However, through discussion with supervisors, the trainee did not include client satisfaction as an

outcome as this is measuring a different variable and not significantly related to other outcomes discussed (Solberg, Larsson, & Jozefiak, 2015).

The trainee discussed with supervisors about the inclusion of dissertations which were found as part of the systematic search and which were relevant to the research question (Brull, 2008; Hirokawa, 1993; Yasin, 2016). However, due to the time limits of the doctoral training, it was not possible to fully and systematically review the “grey literature”. Furthermore, due to these papers not being peer reviewed, the quality of the findings could not be verified.

Analysis and write up

The trainee grouped the therapist characteristic behaviours, interactions, attachment, ethnicity, gender and experience. The trainee felt this was a logical way of discussing the strengths, limitations and conclusions of the papers, with the aim of highlighting which characteristics were influential and why. This approach was taken, rather than categorising findings in relation to alliance or outcome, which the trainee felt would have been less coherent. However, whilst the trainee has discussed the categories and implications for synthesising the data with the research team, the trainee is aware that inherent cultural or societal bias could have influenced her interpretation of the results, given that characteristics such as gender and ethnicity were discussed.

Inter-rater reliability

The trainee has previously discussed the important complexities regarding screening and quality appraisal, and its impact on inter-rater reliability within paper 1 discussion. In particular, for stage one, papers that were not included by reviewer two had potentially more ambiguous titles; for example ‘During Therapeutic Residential Care and How Do Therapists Ally With Adolescents in Family Therapy? An Examination of Relational Control Communication in Early Sessions’ (de La Peña et al., 2012). However, reviewer one was familiar with the literature due to previous

scoping searches. Therefore, increasing the chances of screening in more papers that had more imprecise titles. However, once stage two screening was completed where full texts were reviewed, reliable ratings increased considerably.

The trainee reflects that whilst there are challenges associated with completing a systematic review for the first time, there are unique challenges specific to this review. This was demonstrated throughout the lengthy process of developing search terms, and fair agreement (k=0.36) at screening. Due to the trainee familiarising herself with the literature through scoping, she adopted a systematic and inclusive approach to screening titles. This meant that when papers had more ambiguous titles with regards to the research question, such as 'The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care' (Duppong Hurley et al., 2017), did not always refer to therapist characteristics. Therefore, rater two screened out this title, even though it was an eligible paper. The trainee discussed discrepancies with the second rater and the research team, and papers the trainee had identified were confirmed as meeting the inclusion criteria for the review.

Furthermore, due to the complex measurement of therapist characteristics, and then having multiple outcomes such as alliance, symptom change, drop out or engagement this was a challenging review to complete. In turn, the trainee reflects that the multifaceted nature highlights the complexities of researching within the child alliance and outcome literature.

Summary

In summary, this systematic literature review was the first comprehensive review of the quantitative literature of therapist characteristics and the impact on alliance or outcomes within child mental health services. The steps taken to ensure the review was undertaken rigorously enhance the credibility of its findings. The aims of the review were successfully met, and findings revealed key recommendations for policy development and service delivery. Moreover, the review highlighted therapist

characteristics are an important variable in alliance and outcome, which warrant future rigorous research.

Paper 2: Therapeutic relationships in Child and Adolescent Mental Health Services: a Delphi study with young people, carers and healthcare professionals.

Topic selection

The empirical study involved in this thesis was part of a wider body of research lead by one of the supervisors (Hartley, 2020). When the trainee started working on the project, the broad aim was to understand more about therapeutic relationships in CAMHS. Therefore, discussions in supervision took place about the current evidence base and possible use of a consensus method. Ideas included what the public understand about staff and family relationships in CAMHS and young people’s experience of inpatient CAMHS admission and how relationships with nursing staff are managed. Alongside these discussions, the trainee was reviewing the literature, to identify any gaps in the literature to inform understanding about therapeutic relationships. The trainee noted that when therapeutic relationships were discussed in CAMHS, the literature referred to adult understandings of therapeutic relationships (Bordin, 1979; Rogers, 1951). Therefore, through discussion in supervision, it was considered important to find out more about what young people, parents and staff think are key components of building effective relationships. What is it about people that help relationships build, for example, their ‘warmth’, ‘reliability’, ‘capacity to make others laugh’, or ‘reflective nature’? Finally, what helps or hinders staff-family working relationships.

Methodology selection

There are a number of methodologies in developing a consensus, however there are two which are commonly used in healthcare research (Jones & Hunter, 1995). These

are the nominal group technique (Delbecq & Van de Ven, 1971)and the Delphi method (Dalkey & Helmer, 1963). The nominal group technique involves inviting between nine to 12 experts to a highly structured meeting to discuss a consensus topic. The Delphi method involves collecting feedback anonymously from experts, and sharing the group opinion. In addition, the Delphi method has previously been adapted to allow for multiple expert groups, to consider overall consensus and within each group consensus (Bond, Chalmers, Jorm, Kitchener, & Reavley, 2015). The trainee felt it was essential to include young people in the consensus development about therapeutic relationships in CAMHS. However, the literature suggests that participants in group consensus exercises can feel power imbalances from other stakeholders (Murphy et al., 1998). A key strength of the Delphi method for this research was that young people could be involved, and share their opinion anonymously, rather than feeling potentially influenced by group power dynamics. Furthermore, a discussion took place about the involvement of carers, and whether they are 'service users' or experts of the therapeutic relationship in CAMHS. As parents are often involved in the referral process and sometimes intervention, it was felt important that they were also included (Haine-Schlagel & Walsh, 2015). Finally, young people, parents and carers often have therapeutic relationships with a number of professionals who are not directly delivering a specific therapeutic intervention i.e. care coordinators, mental health practitioners or nurses on an inpatient ward. It is typical for young people on inpatient wards to benefit from the 'therapeutic milieu' and interactions with non-therapy staff, in addition to those offering formal therapy (Sergeant, 2009). Therefore, all staff members were included who work in CAMHS, not solely those who deliver formal therapy. The trainee was aware that whilst the Delphi method has previously been criticised for potentially having an inadequate way of reliably selecting experts compared to the nominal group technique (Rowe, Wright, & Bolger, 1991), intense focus was given to the recruitment of participants.

Capacity and consent

When considering the appropriate recruitment of young people, extensive consultation took place with other researchers who had recruited 13 year olds and above on line (Parry, 2018). Careful consideration was given to whether parents would need to consent on behalf of young people, if they were below the age of 16. However, the trainee was aware this could increase barriers to young people participating online if there are more steps needed for them to take part. Therefore, it was essential that the trainee could make the research as accessible to young people as possible, without parental consent. Moreover, it was also a consideration that possibly children younger than 13, or over 19 might take part, even though they were not eligible. Whilst this is difficult to manage online, the benefits of increasing accessibility to eligible teenagers outweighed the chance that young people who were not eligible may take part. The study advertising clearly stated that young people 13 -19 were being asked to participate. Additionally, participants were asked to self select which participant group they were in and confirm "are you a young person between 13-19" and a radio button response of "yes" or "no" at the start of the demographics form. Parry (2018) had sought ethical approval from Central Manchester NHS Committee, which was paediatric led and so the research team decided to apply here also, due to the committee's familiarity with recruiting adolescents.

Moreover, the ability to provide informed consent was an issue for online research of minors (Parry, 2018). In face-to-face research, when consenting a young person you can assess if they have Gillick Competence i.e. understand and weigh up risks to medical treatment and consent. Parry (2018) has initial devised an online consent form whereby the young people needed to navigate and choose from multiple choices the correct response to consent. However, feedback
from the ethics committee was that if young people were able to access the link, information sheet and complete a single tick consent form then they are deemed to have implicit capacity to complete their survey (appendix F, G, H). This bypassed the issue of Gillick competence and so was used in the Delphi study. Likewise, discussion took place how the survey was appropriately incentivized to under 18's. Parry (2018) advertised that there was a £50 voucher prize draw for participants who completed

the survey. Participants could leave their email address to be contacted if they won and if they wanted a summary of information from the survey. They just needed to select and option or both. Therefore, advertising a ‘chance’ of winning a prize draw which children could opt into, rather than children feeling obliged to take part. Therefore, the same method was applied in this study, due to the robust considerations.

Recruitment

The trainee and supervisors gave considerable thought to the recruitment strategy. Often participants from Black Minority Ethnic (BAME) groups and fathers are underrepresented in CAMHS research (Davison et al., 2017; Memon et al., 2016). BAME social media sites were specifically invited (appendix I), with the trainee contacting the admin member for permission to post. The trainee also liaised with admin members, about other sites to post on. Due to the time constraints of the study, it was not possible to build links with community groups in person. The same approach was taken with fathers, by recruiting via Reddit and Facebook (appendix J). It was important to highlight in the advert that the trainee was not implying that these specific groups had mental health difficulties. Instead, the approach was to highlight their ‘expert’ statuses as a member of the BAME community or a father (or father figure). Unfortunately, the study recruited only small numbers of participants from BAME groups and fathers. This disappointed the trainee due to the targeted efforts used with the aim to get a range of under represented voices heard. In future, it would be important to build face-to-face links with targeted community groups also, to allow multiple ways for participants to be invited into research.

In order to cover a range of study social media platforms, multiple accounts were set up. A study image was created, in order to attract participants to the social media accounts. Feedback was sought from young people and staff as to which study image they preferred, and found friendly and engaging (appendix K). The trainee and research team felt it was important to have a separate study social media presence, rather than purely through and NHS social media account. Moreover, whilst ethical

approval was gained to recruit within Pennine Care NHS Foundation Trust, the trainee wanted participants to know that they were able to participate from anywhere in the country. Therefore, not affiliating with this specific NHS Trust. However, the trainee appreciated the endorsement from the Trust Healthy Young Mind's social media accounts. Moreover, having a separate social media identity allowed the trainee to manage the accounts personally. A key aim was to build discussion and conversation about the importance of hearing from young people and parents in particular, through an engaging study presence. Key campaigns were used to highlight the importance of mental health and to generate traffic to the accounts. Sample questions from the Delphi statements were shared as a picture, to generate interest and discussion in the post (appendix I). Instagram was mainly targeted at young people, Facebook and twitter for staff, parents, dads specialist groups and BAME groups. Furthermore, Reddit was used in order to recruit targeted BAME and fathers groups, where there are multiple discussion forums already. Finally, LinkedIn was used in order to target staff members, which had a strong response rate. Links were made with mental health charities such as 42ndStreet, in order to invite all three groups who accessed or worked there, which were not accessing NHS provision.

The trainee was also keen to include families or staff members who were not online. Therefore, posters were places in Pennine Care CAMHS and charity organisations waiting areas, with contact information. Furthermore, the trainee visited waiting rooms on a handful of occasions, with printed versions of the participant information pack and Delphi survey. Whilst they were provided with the opportunity to participate at the time, freepost envelopes were also provided for participants to post responses back to the University of Manchester. Two parents decided to take the information away with them, however no postal responses were returned. The trainee found that many young people and parents had strong ideas about what they thought relationships in CAMHS looked like. The trainee had opportunities to speak with parents in the waiting room whilst they were waiting for their child to have a session. The trainee aimed to focus the conversation on the research project; conversations diverged onto mental health difficulties and relationships within the

family. Whilst it felt important that the parent (s) felt listened to, alongside building engagement into the research, the content of the conversations was of a deeply private nature, which was not appropriate for a waiting room. Therefore, the trainee made the decision with the research team to stop being present to disseminate advertising materials in waiting areas, at the risk of losing out on non-online participants.

Patient and public involvement

The trainee has reflected that a key strength of this research is the multiple time points in which feedback was sought from 'service users', staff or public. During the initial planning stages of this project, the trainee liaised with The University of Manchester Community Liaison Group (CLG). This group is made up of adults who have accessed services in relation to their mental health. Through informal contact with the group, the trainee was aware that some members are also parents, or accessed CAMHS. Two members of the group had reviewed the project for interest and confirmed its relevance to services. Based on feedback, the option of having paper versions of the Delphi in services was devised. As part of the wider research project, the trainee's supervisor had met with young people in a focus group, who had identified that relationships are important in CAMHS.

Two young people who were accessing a Pennine Care inpatient ward provided feedback on the layperson summary for the ethics application. Young people and staff also provided feedback on the study-advertising image as well as provide feedback on the accessibility of round one statements. Based on feedback, a statement about what hinders relationships was, "staff holding grudges about what a young person/parent has said or done" was removed as it was considered unclear. The trainee thought about expanding it to include a version for young people or parents i.e. "parent/carer holding grudges about what a young person/ staff has said or done" or "young person holding grudges about what a parent/carer / staff member has done". However, the trainee decided to remove this as comments about "being open and honest" were still included as well as 'giving feedback about

how the work' is going and more specific ideas about "mistrust/ defensiveness" are explored in other statements. Furthermore, a statement about "a family member being bored in sessions" was expanded to capture specific traits, as being bored is difficult to monitor or change. However, it is about the expression of boredom, which may impact the other person. Therefore the statements were expanded to, 'young people acting bored in sessions", "parents/carers acting bored in sessions" and "staff members acting bored in sessions". The aim of statement development was for them to be accessible to 13 year olds, with the idea that they would then be accessible for the rest of the expert groups. Finally, members of the public (the trainee's friends and family) gave feedback on the usability of the Delphi website, both on web and mobile. For statements regarding what builds alliance, feedback was given that this needs to be separated out further, to make it more user friendly. This was incorporated in the website design, by the university of Manchester IT technician.

Round one statement development

As discussed in paper 2, statements generated in round one from the literature and interviews, were coded and ordered. The trainee and supervisor received consultation from a fellow researcher who had completed a Delphi study (Law & Morrison, 2014). Advice received was that whilst you would hope participants are engaged enough to complete the Delphi, if they have decided to take part in the research, it is preferable to ask participants to rate statements the trainee would like to prioritise an answer to, appear in the order first. Therefore, the trainee and a second trainee clinical psychologist developed themes. The second trainee was working on a different project; however had experience of working in CAMHS and building therapeutic relationships. The definition of the therapeutic relationship was kept in the same order, as this was considered a theme of its own. For statements regarding building a good relationship and what hinders it, themes were developed through a discussion about grouping similar constructs together. The themes were developed and adjusted throughout discussion of the process. Each statement was coded under one of the following themes:

Table 8. *Round one statement themes*

Theme	Description
Relational	Statement regarding the interpersonal element of the relationship
Therapeutic technique/goals	Statement regarding outcome/goals
Therapeutic technique	Statement regarding the type of therapy or therapeutic process
Therapeutic technique/practical	Statement regarding practical aspects of work i.e. location
Therapeutic technique/staff response	Statement regarding staff reaction
Family characteristic	Statement regarding a young person or parent/carer presentation
Therapeutic technique/competence	Statement regarding staff experience
Staff characteristic	Statement regarding a staff members presentation

Statements were then grouped together in excel, and reordered according to what helps build good relationships and what hinders good relationships.

Statements coded as capturing the relational aspects of the therapeutic relationship were considered key in attempting to define and understanding non-specific factors, and potentially a key contribution to the evidence base. The second theme was related to the therapeutic technique/outcome goals as this is a concept that would potentially guide therapeutic relationships from the start. The third theme followed on with items relating to therapeutic technique, for when processes of the work were outlined. The theme of the therapeutic technique and practicalities of session followed and then how staff members respond in the relationship was next. Finally, characteristic-related statements were considered. Family characteristics i.e. young person or parent/carer were placed first, and then staff competence and then staff characteristics.

The same rationale was given to items about what hinders relationships. When statements related to all three perspectives of the experts e.g. ‘young person initiates (starts) the conversation’, or the same statement replaced with parent/carer or staff member, then the statements were always presented in that expert group order, to highlight the importance of feedback from young people.

The trainee is aware that the ordering of statements may have been biased by their own perceptions of good working relationships. Therefore, a second trainee was asked to rate and theme the statements as part of a collaborative process, to reduce this bias. Through the discussion, an agreement of the order was reached.

Round two statement development

As highlighted in paper 2 methods, items were included at this stage if they had reached a minimum of 70% overall group agreement. This level of agreement was recommended in the literature (Powell, 2003). Statements that reached 60-69% agreement were carried forward to round 3 (appendix M) and statements with lower than 60% agreement were excluded (appendix N). At this stage, participants were invited to add any statements that they did not feel were already included in each category of what is a therapeutic relationship, what helps build it and what hinders it. Statement generation from experts is central to the Delphi process, which was included through data from expert interviews(Hartley, Redmond, & Berry, In prep). However, the opportunity to add interactive feedback and information is an additional strength to this project. The trainee reviewed all suggested statements and cross-referenced them to statements already included in round 2. Any additional ideas were generated into new statements for round 3. Ideas where information had already been included in other statements were not included. The trainee is aware of this risk of bias due to their interpretation of information included or not, and so these decisions were also discussed within the research team. Suggested data and rationale can be found in appendix O.

Summary

In summary, this empirical research was the first time a consensus of therapeutic relationships and its components has been undertaken within child mental health literature. The trainee is aware that there were multiple opportunities where the trainee may have subjectively influenced this project. In particular through statement generation initially, with the trainee finding statements that appeared

important throughout the literature, as well as considering which participant suggested statements should be included or not. This is a caveat of the Delphi methodology. However, active discussion and participation from other colleagues or service users was sought as much as possible. The steps taken to ensure this research was undertaken rigorously enhance the credibility of its findings. The aims of the Delphi were successfully met. The findings revealed key recommendations for service delivery and the foundation of information to develop a therapeutic alliance measure, to help monitor and inform successful relationships in CAMHS.

Dissemination

Paper 1 will be submitted to for Clinical Child and Family Psychology Review for publication. Paper 2 will be submitted to the journal *Child and Adolescent Mental Health* for publication. A lay summary of the findings will be circulated to participants who provided their email address and indicated that they would like to be informed of study findings. This will be written in plain English, and presented in a colourful, engaging format. Moreover, the trainee is planning on creating brief animation of overall findings, which will be shared on social media platforms. Furthermore, a summary will be sent to teams who supported recruitment, such as Pennine Care NHS Foundation Trust CAMHS, and charitable organisations such as 42ndStreet. This will be done via an email circulating an easy read of findings. The study's social media accounts (Twitter, Facebook, Reddit, LinkedIn) will also share a summary. Once the papers are published, a link to the published articles will be shared via these platforms discussed. The trainee will consider further opportunities to disseminate the findings within the child and adolescent mental health field, including the CAMHS research unit, with the hope that the findings will inform clinical practice across CAMHS. The trainee will also seek out relevant conferences to disseminate findings.

Personal reflections

The trainee's increased understanding and awareness of therapeutic alliance, and the importance of staff behaviours, has influenced her clinical practice. For example,

using collaboration and praise was a therapeutic skill she already used, but now an emphasis is made on working together and acknowledging strengths. Moreover, the trainee noted how the therapeutic relationship has parallels within the supervisory relationship. What young people need within therapeutic work are honesty, collaboration and understanding. The trainee exceptionally valued these qualities in her supervisors throughout the research process.

Moreover, the research process and findings has reinforced the trainee's passion to work within child and adolescent mental health services and embed service user feedback channels to make sure families' voices are heard. The trainee reflects that the empirical paper adds a new level of understanding to therapeutic relationships, which has not been highlighted before. The trainee is proud to be able to contribute to this essential field of research.

The trainee has found the research project exciting and challenging at times, highlighting areas of strength and areas for development. The trainee has a great sense of achievement of being able to complete this thesis process, especially in the context of deeply difficult personal circumstances. It has allowed the trainee to reflect on her role within her own personal network as well as her role as a psychologist. Moreover, the thesis has allowed the trainee to develop further self awareness, which will support the transition into a qualified clinical psychology post. This has been especially important during the recent COVID-19 pandemic, which has necessitated managing work demands whilst maintaining a good the balance of self-care.

References

Accurso, E. C., & Garland, A. F. (2015). Child, caregiver, and therapist perspectives on therapeutic alliance in usual care child psychotherapy. *Psychological assessment, 27*(1), 347-352. doi:https://doi.org/10.1037/pas0000031

Accurso, E. C., Hawley, K. M., & Garland, A. F. (2013). Psychometric properties of the Therapeutic Alliance Scale for Caregivers and Parents. *Psychological assessment, 25*(1), 244-252. doi:https://doi.org/10.1037/a0030551

Achenbach, T. M., & Rescorla, L. A. (2000). *Manual for the ASEBA preschool forms and profiles* (Vol. 30): Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(2), 171. doi:https://doi.org/10.1037/0033-3204.38.2.171

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical psychology review, 23*(1), 1-33. doi:https://doi.org/10.1016/S0272-7358(02)00146-0

Armbruster, P., & Kazdin, A. E. (1994). Attrition in Child-Psychotherapy. In T. H. Ollendick, R.J., Prinz, (Ed.), *Advances in Clinical Child Psychology, Vol 16* (Vol. 16, pp. 81-108). Boston, MA: Springer, .

Beidas, R. S., Marcus, S., Wolk, C. B., Powell, B., Aarons, G. A., Evans, A. C., . . . Walsh, L. M. (2016). A prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-funded mental health system. *Administration and Policy in Mental Health and Mental Health Services Research, 43*(5), 640-649. doi:https://doi.org/10.1007/s10488-015-0673-6

Bettmann, J. E., & Jasperson, R. A. (2009). *Adolescents in residential and inpatient treatment: A review of the outcome literature.* Paper presented at the Child & Youth Care Forum.

Bhati, K. S. (2014). Effect of client-therapist gender match on the therapeutic relationship: an exploratory analysis. *Psychological reports, 115*(2), 565-583. doi:https://doi.org/10.2466/21.02.PR0.115c23z1

Bickman, L., Athay, M., Riemer, M., Lambert, E., Kelley, S., Breda, C., & Vides de Andrade, A. (2010). Manual of the Peabody treatment progress battery. *Nashville: Vanderbilt University.* Retrieved from http://peabody.vanderbilt.edu/ptpb\.

Bond, K. S., Chalmers, K. J., Jorm, A. F., Kitchener, B. A., & Reavley, N. J. (2015). Assisting Australians with mental health problems and financial difficulties: a Delphi study to develop guidelines for financial counsellors, financial institution staff, mental health professionals and carers. *Bmc Health Services Research, 15*. doi:https://doi.org/10.1186/s12913-015-0868-2

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260. doi:10.1037/h0085885

Boyer, B., MacKay, K. J., McLeod, B. D., & van der Oord, S. (2018). Comparing Alliance in two cognitive-behavioural therapies for adolescents with ADHD using a randomized controlled trial. *Behavior therapy, 49*(5), 781-795. doi:https://doi.org/10.1016/j.beth.2018.01.003

Browne, M. E. (2006). Communicating with the child who has autistic spectrum disorder: a practical introduction. *Paediatric Nursing, 18*(1), 14-18.

Brull, J. V. (2008). *Therapist Verbal Response Modes, the Therapeutic Alliance, and In-session Client Good Moments*: ProQuest.

Burkett, G. L. (1991). Culture, illness, and the biopsychosocial model. *Family medicine, 23*(4), 287-291.

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537-554. doi:https://doi.org/10.1037/a0025266

Creed, T. A., & Kendall, P. C. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of consulting and clinical psychology, 73*(3), 498. doi:https://doi.org/10.1037/0022-006X.73.3.498

Dalkey, N., & Helmer, O. (1963). An Experimental Application of the DELPHI Method to the Use of Experts. *Management Science, 9*(3), 458-467. doi:https://doi.org/10.1287/mnsc.9.3.458

David, C. (2014). Session Rating Scale (SRS) and Child Session Rating Scale (CSRS). *Guide to using outcomes and feedback tools*, 143.

Davison, K. K., Charles, J. N., Khandpur, N., & Nelson, T. J. (2017). Fathers' perceived reasons for their underrepresentation in child health research and strategies to increase their involvement. *Maternal and child health journal, 21*(2), 267-274. doi:https://doi.org/10.1007/s10995-016-2157-z

de Greef, M., Pijnenburg, H. M., van Hattum, M. J. C., McLeod, B. D., & Scholte, R. H. J. (2016). Parent-Professional Alliance and Outcomes of Child, Parent, and Family Treatment: A Systematic Review. *Journal of Child and Family Studies, 26*(4), 961-976. doi:https://doi.org/10.1007/s10826-016-0620-5

de Haan, A. M., Boon, A. E., de Jong, J. T., Hoeve, M., & Vermeiren, R. R. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical psychology review, 33*(5), 698-711. doi:https://doi.org/10.1016/j.cpr.2013.04.005

de La Peña, C. M., Friedlander, M. L., Escudero, V., & Heatherington, L. (2012). How do therapists ally with adolescents in family therapy? An examination of relational control communication in early sessions. *Journal of counseling psychology, 59*(3), 339. doi:https://doi.org/10.1037/a0028063

Degnan, A., Berry, K., Sweet, D., Abel, K., Crossley, N., & Edge, D. (2018). Social networks and symptomatic and functional outcomes in schizophrenia: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 53*(9), 873-888. doi:https://doi.org/10.1007/s00127-018-1552-8

Degnan, A., Seymour-Hyde, A., Harris, A., & Berry, K. (2016). The Role of Therapist Attachment in Alliance and Outcome: A Systematic Literature Review. *Clinical Psychology and Psychotherapy, 23*(1), 47-65. doi:https://doi.org/10.1002/cpp.1937

Delbecq, A. L., & Van de Ven, A. H. (1971). A group process model for problem identification and program planning. *The Journal of Applied Behavioral Science, 7*(4), 466-492. doi:https://doi.org/10.1177/002188637100700404

Department of Health. (2015). Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing. *Mental health service reform,* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf *[date accessed 31st March. 2020]*.

Department of Heath. (2017). *Transforming children and young people's mental health provision: a green paper*. https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Donaldson, D., Spirito, A., & Esposito-Smythers, C. (2005). Treatment for adolescents following a suicide attempt: results of a pilot trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(2), 113-120. doi:https://doi.org/10.1097/00004583-200502000-00003

Drake, R. E., & Latimer, E. (2012). Lessons learned in developing community mental health care in North America. *World Psychiatry, 11*(1), 47-51. doi: https://doi.org/10.1016/j.wpsyc.2012.01.007

Duppong Hurley, K., Lambert, M. C., Gross, T. J., Thompson, R. W., & Farmer, E. M. (2017). The role of therapeutic alliance and fidelity in predicting youth outcomes during therapeutic residential care. *Journal of Emotional and Behavioral Disorders, 25*(1), 37-45. doi:https://doi.org/10.1177/1063426616686756

Duppong Hurley, K., Lambert, M. C., Van Ryzin, M., Sullivan, J., & Stevens, A. (2013). Therapeutic Alliance Between Youth and Staff in Residential Group Care: Psychometrics of the Therapeutic Alliance Quality Scale. *Children and Youth Services Review, 35*(1), 56-64. doi:https://doi.org/10.1016/j.childyouth.2012.10.009

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. S. W. H. Berman (Ed.), *Attachment in adults: Clinical and developmental perspectives* (pp. 128–152): Guilford Press.

Fluckiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340. doi:http://dx.doi.org/10.1037/pst0000172

Fonagy, P., Pugh, K., & O'Herlihy, A. (2017). The Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) Programme in England. *Child psychology and psychiatry: Frameworks for clinical training and practice*, 429-435. doi:https://doi.org/10.1002/9781119170235.ch48

Friedlander, M. L., & Heatherington, L. (1989). Analyzing relational control in family therapy interviews. *Journal of Counseling Psychology, 36*(2), 139. doi:https://doi.org/10.1037/0022-0167.36.2.139

Funakoshi, A., Tanaka, A., Hattori, K., & Arima, M. (2016). Process of Building Patient-Nurse Relationships in Child and Adolescent Psychiatric Inpatient Care: A Grounded Theory Approach in Japan. *Journal of Nursing and Patient Care, 2*, 2. doi:10.4172/2573-4571.1000106

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2004). Ethnic Match and Treatment Outcomes for Child and Adolescent Mental Health Center Clients. *Journal of Counseling and Development, 82*(4), 457-465. doi:https://doi.org/10.1002/j.1556-6678.2004.tb00334.x

Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70*(2), 439-443. doi:https://doi.org/10.1037/0022-006X.70.2.439

Garland, A. F., Haine-Schlagel, R., Accurso, E. C., Baker-Ericzen, M. J., & Brookman-Frazee, L. (2012). Exploring the effect of therapists' treatment practices on client attendance in community-based care for children. *Psychological Services, 9*(1), 74-88. doi:https://doi.org/10.1037/a0027098

Goldschmidt, K. (2020). The COVID-19 pandemic: Technology use to support the wellbeing of children. *Journal of Pediatric Nursing*. doi: https://doi.org/10.1016/j.pedn.2020.04.013

Gopalkrishnan, N. (2018). Cultural Diversity and Mental Health: Considerations for Policy and Practice. *Frontiers in public health, 6*, 179. doi:https://doi.org/10.3389/fpubh.2018.00179

Green, H., McGinnity, Á., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in Great Britain, 2004*. (1403986371). Palgrave Macmillan Basingstoke

Green, J. (2006). Annotation: the therapeutic alliance--a significant but neglected variable in child mental health treatment studies. *Journal of Child Psychology and Psychiatry, 47*(5), 425-435. doi:https://doi.org/10.1111/j.1469-7610.2005.01516.x

Green, J. (2009). The therapeutic alliance. *Child: Care, Health and Development, 35*(3), 298-301. doi:https://doi.org/10.1111/j.1365-2214.2009.00970.x

Greeson, J. K., Guo, S., Barth, R. P., Hurley, S., & Sisson, J. (2009). Contributions of Therapist Characteristics and Stability to Intensive In-home Therapy Youth Outcomes. *Research on Social Work Practice, 19*(2), 239-250. doi:https://doi.org/10.1177/1049731508329422

Haine-Schlagel, R., & Walsh, N. E. (2015). A review of parent participation engagement in child and family mental health treatment. *Clinical child and family psychology review, 18*(2), 133-150. doi:https://doi.org/10.1007/s10567-015-0182-x

Hall, J., Guterman, D. K., Lee, H. B., & Little, S. G. (2002). Counselor-Client Matching on Ethnicity, Gender, and Language: Implications for Counseling School-aged Children. *North American Journal of Psychology, 4*(3).

Harper, B., Dickson, J. M., & Bramwell, R. (2014). Experiences of young people in a 16–18 Mental Health Service. *Child and Adolescent Mental Health, 19*(2), 90-96. doi:https://doi.org/10.1177/2158244017719113

Hartley, S. (2020). NIHR Funding and Awards Search Website. *Funding and Awards.* Retrieved from https://www.fundingawards.nihr.ac.uk/award/ICA-CL-2017-03-008

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies, 102*, 103490. doi:https://doi.org/10.1016/j.ijnurstu.2019.103490

Hartley, S., Redmond, T., & Berry, K. (2020). *Therapeutic relationships within adolescent mental health inpatient wards: a qualitative investigation of the experiences of young people, family members and nursing staff*. In prep.

Hartley, S., Redmond, T., & Berry, K. (In prep). *Therapeutic relationships within adolescent mental health inpatient wards: a qualitative investigation of the experiences of young people, family members and nursing staff*.

Hawley, K. M., & Weisz, J. R. (2005). Youth versus parent working alliance in usual clinical care: distinctive associations with retention, satisfaction, and treatment outcome. *Journal of Clinical Child and Adolescent Psychology, 34*(1), 117-128. doi:https://doi.org/10.1207/s15374424jccp3401_11

Health Research Authority, H. (5th February 2020). Clinical Trials of Investigational Medicinal Products (CTIMPS). Retrieved from https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/clinical-trials-investigational-medicinal-products-ctimps/

Hirokawa, G. M. (1993). *The relationship of ethnic and sex match between client and therapist on treatment outcome and premature termination among Asian American adolescents.*

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy (Chic), 48*(1), 9-16. doi:10.1037/a0022186

Howarth, E., Vainre, M., Humphrey, A., Lombardo, C., Hanafiah, A. N., Anderson, J. K., & Jones, P. B. (2019). Delphi study to identify key features of community-based child and adolescent mental health services in the East of England. *BMJ open, 9*(6), e022936. doi:http://dx.doi.org/10.1136/bmjopen-2018-022936

Johnson, L. N., Ketring, S. A., Rohacs, J., & Brewer, A. L. (2006). Attachment and the therapeutic alliance in family therapy. *The American Journal of Family Therapy, 34*(3), 205-218. doi:https://doi.org/10.1080/01926180500358022

Jones, J., & Hunter, D. (1995). Qualitative research: consensus methods for medical and health services research. *Bmj, 311*(7001), 376-380. doi:https://doi.org/10.1136/bmj.311.7001.376

Jungbluth, N. J., & Shirk, S. R. (2009). Therapist strategies for building involvement in cognitive-behavioral therapy for adolescent depression. *Journal of consulting and clinical psychology, 77*(6), 1179-1184. doi:https://doi.org/10.1037/a0017325

Jungbluth, N. J., & Shirk, S. R. (2009). Therapist strategies for building involvement in cognitive–behavioral therapy for adolescent depression. *Journal of Consulting and Clinical Psychology, 77*(6), 1179. doi:https://doi.org/10.1037/a0017325

Karver, M., Shirk, S., Handelsman, J. B., Fields, S., Crisp, H., Gudmundsen, G., & McMakin, D. (2008). Relationship Processes in Youth Psychotherapy. *Journal of Emotional and Behavioral Disorders, 16*(1), 15-28. doi:https://doi.org/10.1177/1063426607312536

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: the evidence for different relationship variables in the child and adolescent

treatment outcome literature. *Clin Psychol Rev, 26*(1), 50-65. doi:10.1016/j.cpr.2005.09.001
Langlands, R. L., Jorm, A. F., Kelly, C. M., & Kitchener, B. A. (2008). First Aid Recommendations for Psychosis: Using the Delphi Method to Gain Consensus Between Mental Health Consumers, Carers, and Clinicians. *Schizophrenia Bulletin, 34*(3), 435-443. doi:https://doi.org/10.1093/schbul/sbm099
Lavin, R., Bucci, S., Varese, F., & Berry, K. (2020). The relationship between insecure attachment and paranoia in psychosis: A systematic literature review. *British Journal of Clinical Psychology, 59*(1), 39-65. doi:https://doi.org/10.1111/bjc.12231

Law, H., & Morrison, A. P. (2014). Recovery in Psychosis: A Delphi Study With Experts by Experience. *Schizophrenia Bulletin, 40*(6), 1347-1355. doi:https://doi.org/10.1093/schbul/sbu047
Manso, A., Rauktis, M. E., & Boyd, A. S. (2008). Youth expectations about therapeutic alliance in a residential setting. *Residential Treatment for Children and Youth, 25*(1), 55-72. doi:https://doi.org/10.1080/08865710802209826
Mays, N., Roberts, E., & Popay, J. (2001). Synthesising research evidence. In N. Fulop, P. Allen, A. Clarke, & N. Black, (Ed.), *Studying the organisation and delivery of health services* (Vol. 220): Routledge.
McDaid, D. (2011). *Making the long-term economic case for investing in mental health to contribute to sustainability*.
McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603-616. doi:https://doi.org/10.1016/j.cpr.2011.02.001
McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: a meta-analysis. *Clinical psychology review, 31(4), 603–616, 31*(4), 603-616. doi:https://doi.org/10.1016/j.cpr.2011.02.001
Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *BMJ open, 6*(11), e012337. doi:http://dx.doi.org/10.1136/bmjopen-2016-012337
Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Annals of Internal Medicine, 151*(4), 264-269. doi:https://doi.org/10.7326/0003-4819-151-4-200908180-00135
Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy fordepressed adolescents. *Archives of General Psychiatry, 61*(6), 577-584. doi:10.1001/archpsyc.61.6.577
Mufson, L., Yanes-Lukin, P., Gunlicks-Stoessel, M., & Wickramaratne, P. (2014). Cultural competency and its effect on treatment outcome of IPT-A in school-based health clinics. *American journal of psychotherapy, 68*(4), 417-442. doi:https://doi.org/10.1176/appi.psychotherapy.2014.68.4.417
Mufson, L., Yanes-Lukin, P., Gunlicks-Stoessel, M., & Wickramaratne, P. (2014). Cultural Competency and Its Effect on Treatment Outcome of IPT-A in

School-Based Health Clinics. *American journal of psychotherapy, 68*(4), 417-442. doi:https://doi.org/10.1176/appi.psychotherapy.2014.68.4.417
Muratori, P., Polidori, L., Chiodo, S., Dovigo, V., Mascarucci, M., Milone, A., . . . Lambruschi, F. (2017). A pilot study implementing coping power in Italian community hospitals: Effect of therapist attachment style on outcomes in children. *Journal of child and family studies, 26*(11), 3093-3101. doi:https://doi.org/10.1007/s10826-017-0820-7
Murphy, M., Black, N., Lamping, D., McKee, C., Sanderson, C., Askham, J., & Marteau, T. (1998). Consensus development methods, and their use in clinical guideline development. *Health technology assessment (Winchester, England), 2*(3), i-88.
Murphy, R., & Hutton, P. (2018). Practitioner Review: Therapist variability, patient-reported therapeutic alliance, and clinical outcomes in adolescents undergoing mental health treatment - a systematic review and meta-analysis. *Journal of Child Psychology and Psychiatry, 59*(1), 5-19. doi:https://doi.org/10.1111/jcpp.12767
O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. A literature review. *Social Psychiatry and Psychiatric Epidemiology, 44*(7), 558-568. doi:https://doi.org/10.1007/s00127-008-0476-0
O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture–repair in the therapeutic alliance and association with therapy ending. *Psychotherapy*. doi:10.1037/pst0000279
Okoli, C., & Pawlowski, S. D. (2004). The Delphi method as a research tool: an example, design considerations and applications. *Information & Management, 42*(1), 15-29. doi:https://doi.org/10.1016/j.im.2003.11.002
Papadopoulos, I., Tilki, M., & Ayling, S. (2008). Cultural competence in action for CAMHS: Development of a cultural competence assessment tool and training programme. *Contemporary Nurse, 28*(1-2), 129-140. doi:https://doi.org/10.5172/conu.673.28.1-2.129
Parry, S., Djabaeva, R., & Varese, F. . (2018). *Engaging Young People Who Hear Voices in Online Mixed-Methods Research*. doi:https://dx.doi.org/10.4135/9781526457783
Podell, J. L., Kendall, P. C., Gosch, E. A., Compton, S. N., March, J. S., Albano, A. M., . . . Piacentini, J. C. (2013). Therapist Factors and Outcomes in CBT for Anxiety in Youth. *Professional Psychology: Research and Practice, 44*(2), 89-98. doi:https://doi.org/10.1037/a0031700
Powell, C. (2003). The Delphi technique: myths and realities. *Journal of Advanced Nursing, 41*(4), 376-382. doi:https://doi.org/10.1046/j.1365-2648.2003.02537.x

Ranson, K. E., & Urichuk, L. J. (2008). The effect of parent–child attachment relationships on child biopsychosocial outcomes: a review. *Early Child Development and Care, 178*(2), 129-152. doi:https://doi.org/10.1080/03004430600685282
Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*: Houghton Mifflin Boston.

Romeo, R. D. (2017). The impact of stress on the structure of the adolescent brain: Implications for adolescent mental health. *Brain Research, 1654*, 185-191. doi:https://doi.org/10.1016/j.brainres.2016.03.021

Rowe, G., Wright, G., & Bolger, F. (1991). Delphi: a reevaluation of research and theory. *Technological forecasting and social change, 39*(3), 235-251. doi:https://doi.org/10.1016/0040-1625(91)90039-I

Russell, R., Shirk, S., & Jungbluth, N. (2008). First-session pathways to the working alliance in cognitive-behavioral therapy for adolescent depression. *Psychotherapy Research with Children and Adolescents, 18*(1), 15-27. doi:https://doi.org/10.1080/10503300701697513

Ryan, R., Berry, K., & Hartley, S. (2020). *Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review* In prep.

Sánchez-Bahíllo, Á., Aragón-Alonso, A., Sánchez-Bahíllo, M., & Birtle, J. (2014). Therapist characteristics that predict the outcome of multipatient psychotherapy: Systematic review of empirical studies. *Journal of psychiatric research, 53*, 149-156. doi:https://doi.org/10.1016/j.jpsychires.2014.01.016

Satcher, D. (2000). Mental health: A report of the Surgeon General--Executive summary. *Professional Psychology: Research and Practice, 31*(1), 5. doi:https://doi.org/10.1037/0735-7028.31.1.5

Sayal, K., Amarasinghe, M., Robotham, S., Coope, C., Ashworth, M., Day, C., . . . Simonoff, E. (2012). Quality standards for child and adolescent mental health in primary care. *BMC family practice, 13*(1), 51. doi:https://doi.org/10.1186/1471-2296-13-51

Sergeant, A. (2009). Working within child and adolescent mental health inpatient services: a practitioner's handbook.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry, 40*(11), 1228-1231. doi:10.1001/archpsyc.1983.01790100074010

Shelef, K., Diamond, G. M., Diamond, G. S., & Liddle, H. A. (2005). Adolescent and parent alliance and treatment outcome in multidimensional family therapy. *Journal of consulting and clinical psychology, 73*(4), 689-698. doi:https://doi.org/10.1037/0022-006X.73.4.689

Shirk, S., Gudmundsen, G., McMakin, D., Dent, H., & Karver, M. (2003). *Rater's manual for the Alliance Building Behaviors Scale*. Unpublished manual, University of Denver, Denver, CO.

Shirk, S., Karver, M., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy (Chicago, Ill.), 48*(1), 17-24. doi:https://doi.org/10.1037/a0022181

Shirk, S. R., & Karver, M. (2003a). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464. doi:https://doi.org/10.1037/0022-006X.71.3.452

Shirk, S. R., & Karver, M. (2003b). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 71*(3), 452-464. doi:https://doi.org/10.1037/0022-006X.71.3.452

Shirk, S. R., Karver, M. S., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy (Chicago, Ill.), 48*(1), 17-24. doi:https://doi.org/10.1037/a0022181

Solberg, C., Larsson, B., & Jozefiak, T. (2015). Consumer satisfaction with the Child and Adolescent Mental Health Service and its association with treatment outcome: a 3-4-year follow-up study. *Nordic Journal of Psychiatry 69*(3), 224-232. doi:https://doi.org/10.3109/08039488.2014.971869

Thomas, B. H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing, 1*(3), 176-184. doi:https://doi.org/10.1111/j.1524-475X.2004.04006.x

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A journal of consulting and clinical psychology, 1*(3), 207. doi:https://doi.org/10.1037/1040-3590.1.3.207

Tsui, P., & Schultz, G. L. (1988). Ethnic factors in group process: cultural dynamics in multi-ethnic therapy groups. *Am J Orthopsychiatry, 58*(1), 136-142. doi:10.1111/j.1939-0025.1988.tb01573.x

VanDenBerg, J. E. (1993). *Integration of individualized mental health services into the system of care for children and adolescents* (Vol. 20).

Wolpert, M., Humphrey, N., Belsky, J., & Deighton, J. (2013). Embedding mental health support in schools: learning from the Targeted Mental Health in Schools (TaMHS) national evaluation. *Emotional and Behavioural Difficulties, 18*(3), 270-283. doi:https://doi.org/10.1080/13632752.2013.819253

World Health Organization. (2018). Child and adolescent mental health. Retrieved from https://www.who.int/mental_health/maternal-child/child_adolescent/en/

Yasin, A. R. (2016). What Works for Successful In-Home Family Therapists Working at Community-Based Agencies.

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22*(2), 153-163. doi:https://doi.org/10.1002/1520-6629(199404)22:2<153::AID-JCOP2290220210>3.0.CO;2-R

Zhang, A. Y., Snowden, L. R., & Sue, S. (1998). Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology, 26*(4), 317-326. doi:https://doi.org/10.1002/(SICI)1520-6629(199807)26:4<317::AID-JCOP2>3.0.CO;2-Q

Appendix A: Author Guidelines for Clinical Child and Family Psychology Review

Instructions for Authors
Types of papers
Review Papers, Conceptual/Theoretical Papers, Issue-Focused Papers.
Back to top

Submission
Submissions are by editor invitation only.
Back to top

Peer Review
All manuscripts undergo peer review
Back to top

Invitation
All submissions are by invitation only
Back to top

Manuscript submission
Invited authors will receive instructions from the editor about how to submit their manuscript online. Electronic submission substantially really reduces the editorial processing and reviewing times and shortens overall publication time.
Back to top

Editorial procedure
Single-blind peer review
This journal follows a single-blind reviewing procedure.
Back to top

Title page
Title Page
Please use this **template title page** for providing the following information.
The title page should include:

- The name(s) of the author(s)
- A concise and informative title
- The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
- A clear indication and an active e-mail address of the corresponding author
- If available, the 16-digit ORCID of the author(s)

If address information is provided with the affiliation(s) it will also be published.
For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.
Abstract
Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.

For life science journals only (when applicable)
Trial registration number and date of registration
Trial registration number, date of registration followed by “retrospectively registered”

Keywords

Please provide 4 to 6 keywords which can be used for indexing purposes.

Declarations

All manuscripts must contain the following sections under the heading 'Declarations'.
If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

To be used for non-life science journals

Funding (information that explains whether and by whom the research was supported)
Conflicts of interest/Competing interests (include appropriate disclosures)
Availability of data and material (data transparency)
Code availability (software application or custom code)
Authors' contributions (optional: please review the submission guidelines from the journal whether statements are mandatory)

To be used for life science journals + articles with biological applications

Funding (information that explains whether and by whom the research was supported)
Conflicts of interest/Competing interests (include appropriate disclosures)
Ethics approval (include appropriate approvals or waivers)
Consent to participate (include appropriate statements)
Consent for publication (include appropriate statements)
Availability of data and material (data transparency)
Code availability (software application or custom code)
Authors' contributions (optional: please review the submission guidelines from the journal whether statements are mandatory)

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

Back to top

Text

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Manuscripts with mathematical content can also be submitted in LaTeX.
LaTeX macro package (Download zip, 188 kB)

Headings

Please use no more than three levels of displayed headings.

Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.

Footnotes

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.
Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.
Always use footnotes instead of endnotes.

Acknowledgments

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.
Back to top

Terminology

- Please always use internationally accepted signs and symbols for units (SI units).

Back to top

Scientific style

- Generic names of drugs and pesticides are preferred; if trade names are used, the generic name should be given at first mention.
- Please use the standard mathematical notation for formulae, symbols etc.:Italic for single letters that denote mathematical constants, variables, and unknown quantities Roman/upright for numerals, operators, and punctuation, and commonly defined functions or abbreviations, e.g., cos, det, e or exp, lim, log, max, min, sin, tan, d (for derivative) Bold for vectors, tensors, and matrices.

Back to top

References

Citation

Cite references in the text by name and year in parentheses. Some examples:

- Negotiation research spans many disciplines (Thompson 1990).
- This result was later contradicted by Becker and Seligman (1996).
- This effect has been widely studied (Abbott 1991; Barakat et al. 1995; Kelso and Smith 1998; Medvec et al. 1999).

Ideally, the names of six authors should be given before et al. (assuming there are six or more), but names will not be deleted if more than six have been provided.

Reference list

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text. Do not use footnotes or endnotes as a substitute for a reference list.

Reference list entries should be alphabetized by the last names of the first author of each work.

Journal names and book titles should be *italicized*.

- Journal article Harris, M., Karper, E., Stacks, G., Hoffman, D., DeNiro, R., Cruz, P., et al. (2001). Writing labs and the Hollywood connection. *Journal of Film Writing*, 44(3), 213–245.
- Article by DOI Slifka, M. K., & Whitton, J. L. (2000) Clinical implications of dysregulated cytokine production. *Journal of Molecular Medicine*, https://doi.org/10.1007/s001090000086
- Book Calfee, R. C., & Valencia, R. R. (1991). *APA guide to preparing manuscripts for journal publication.* Washington, DC: American Psychological Association.
- Book chapter O'Neil, J. M., & Egan, J. (1992). Men's and women's gender role journeys: Metaphor for healing, transition, and transformation. In B. R. Wainrib (Ed.), *Gender issues across the life cycle* (pp. 107–123). New York: Springer.
- Online document Abou-Allaban, Y., Dell, M. L., Greenberg, W., Lomax, J., Peteet, J., Torres, M., & Cowell, V. (2006). Religious/spiritual commitments and psychiatric practice. Resource document. American Psychiatric Association. http://www.psych.org/edu/other_res/lib_archives/archives/200604.pdf. Accessed 25 June 2007.

For authors using EndNote, Springer provides an output style that supports the formatting of in-text citations and reference list.

EndNote style (Download zip, 4 kB)

Back to top

Tables

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.
- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

Back to top

Artwork and Illustrations Guidelines

Electronic Figure Submission

- Supply all figures electronically.

- Indicate what graphics program was used to create the artwork.
- For vector graphics, the preferred format is EPS; for halftones, please use TIFF format. MSOffice files are also acceptable.
- Vector graphics containing fonts must have the fonts embedded in the files.
- Name your figure files with "Fig" and the figure number, e.g., Fig1.eps.

Line Art

- Definition: Black and white graphic with no shading.
- Do not use faint lines and/or lettering and check that all lines and lettering within the figures are legible at final size.
- All lines should be at least 0.1 mm (0.3 pt) wide.
- Scanned line drawings and line drawings in bitmap format should have a minimum resolution of 1200 dpi.
- Vector graphics containing fonts must have the fonts embedded in the files.

Halftone Art

- Definition: Photographs, drawings, or paintings with fine shading, etc.
- If any magnification is used in the photographs, indicate this by using scale bars within the figures themselves.
- Halftones should have a minimum resolution of 300 dpi.

Combination Art

- Definition: a combination of halftone and line art, e.g., halftones containing line drawing, extensive lettering, color diagrams, etc.
- Combination artwork should have a minimum resolution of 600 dpi.

Color Art

- Color art is free of charge for online publication.
- If black and white will be shown in the print version, make sure that the main information will still be visible. Many colors are not distinguishable from one another when converted to black and white. A simple way to check this is to make a xerographic copy to see if the necessary distinctions between the different colors are still apparent.
- If the figures will be printed in black and white, do not refer to color in the captions.
- Color illustrations should be submitted as RGB (8 bits per channel).

Figure Lettering

- To add lettering, it is best to use Helvetica or Arial (sans serif fonts).
- Keep lettering consistently sized throughout your final-sized artwork, usually about 2–3 mm (8–12 pt).
- Variance of type size within an illustration should be minimal, e.g., do not use 8-pt type on an axis and 20-pt type for the axis label.
- Avoid effects such as shading, outline letters, etc.
- Do not include titles or captions within your illustrations.

Figure Numbering

- All figures are to be numbered using Arabic numerals.
- Figures should always be cited in text in consecutive numerical order.
- Figure parts should be denoted by lowercase letters (a, b, c, etc.).

- If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc." Figures in online appendices (Electronic Supplementary Material) should, however, be numbered separately.

Figure Captions

- Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
- Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
- No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
- Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
- Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

Figure Placement and Size

- Figures should be submitted separately from the text, if possible.
- When preparing your figures, size figures to fit in the column width.
- For large-sized journals the figures should be 84 mm (for double-column text areas), or 174 mm (for single-column text areas) wide and not higher than 234 mm.
- For small-sized journals, the figures should be 119 mm wide and not higher than 195 mm.

Permissions

If you include figures that have already been published elsewhere, you must obtain permission from the copyright owner(s) for both the print and online format. Please be aware that some publishers do not grant electronic rights for free and that Springer will not be able to refund any costs that may have occurred to receive these permissions. In such cases, material from other sources should be used.

Accessibility

In order to give people of all abilities and disabilities access to the content of your figures, please make sure that

- All figures have descriptive captions (blind users could then use a text-to-speech software or a text-to-Braille hardware)
- Patterns are used instead of or in addition to colors for conveying information (colorblind users would then be able to distinguish the visual elements)
- Any figure lettering has a contrast ratio of at least 4.5:1

Back to top

Electronic Supplementary Material

Springer accepts electronic multimedia files (animations, movies, audio, etc.) and other supplementary files to be published online along with an article or a book chapter. This feature can add dimension to the author's article, as certain information cannot be printed or is more convenient in electronic form.

Before submitting research datasets as electronic supplementary material, authors should read the journal’s Research data policy. We encourage research data to be

archived in data repositories wherever possible.

Submission

- Supply all supplementary material in standard file formats.
- Please include in each file the following information: article title, journal name, author names; affiliation and e-mail address of the corresponding author.
- To accommodate user downloads, please keep in mind that larger-sized files may require very long download times and that some users may experience other problems during downloading.

Audio, Video, and Animations

- Aspect ratio: 16:9 or 4:3
- Maximum file size: 25 GB
- Minimum video duration: 1 sec
- Supported file formats: avi, wmv, mp4, mov, m2p, mp2, mpg, mpeg, flv, mxf, mts, m4v, 3gp

Text and Presentations

- Submit your material in PDF format; .doc or .ppt files are not suitable for long-term viability.
- A collection of figures may also be combined in a PDF file.

Spreadsheets

- Spreadsheets should be submitted as .csv or .xlsx files (MS Excel).

Specialized Formats

- Specialized format such as .pdb (chemical), .wrl (VRML), .nb (Mathematica notebook), and .tex can also be supplied.

Collecting Multiple Files

- It is possible to collect multiple files in a .zip or .gz file.

Numbering

- If supplying any supplementary material, the text must make specific mention of the material as a citation, similar to that of figures and tables.
- Refer to the supplementary files as “Online Resource”, e.g., "... as shown in the animation (Online Resource 3)", “... additional data are given in Online Resource 4”.
- Name the files consecutively, e.g. “ESM_3.mpg”, “ESM_4.pdf”.

Captions

- For each supplementary material, please supply a concise caption describing the content of the file.

Processing of supplementary files

- Electronic supplementary material will be published as received from the author without any conversion, editing, or reformatting.

Accessibility

In order to give people of all abilities and disabilities access to the content of your supplementary files, please make sure that

- The manuscript contains a descriptive caption for each supplementary material
- Video files do not contain anything that flashes more than three times per second (so that users prone to seizures caused by such effects are not put at risk)

Back to top

English Language Editing

For editors and reviewers to accurately assess the work presented in your manuscript you need to ensure the English language is of sufficient quality to be understood. If you need help with writing in English you should consider:

-
- Asking a colleague who is a native English speaker to review your manuscript for clarity.
-
- Visiting the English language tutorial which covers the common mistakes when writing in English.
-
- Using a professional language editing service where editors will improve the English to ensure that your meaning is clear and identify problems that require your review. Two such services are provided by our affiliates Nature Research Editing Service and American Journal Experts. Springer authors are entitled to a 10% discount on their first submission to either of these services, simply follow the links below.

English language tutorial
Nature Research Editing Service
American Journal Experts

Please note that the use of a language editing service is not a requirement for publication in this journal and does not imply or guarantee that the article will be selected for peer review or accepted.
If your manuscript is accepted it will be checked by our copyeditors for spelling and formal style before publication.

.
Nature Research Editing Service
American Journal Experts
Nature Research Editing Service
American Journal Experts
Nature Research Editing Service
American Journal Experts

Back to top

Ethical Responsibilities of Authors
This journal is committed to upholding the integrity of the scientific record. As a member of the Committee on Publication Ethics (COPE) the journal will follow the COPE guidelines on how to deal with potential acts of misconduct.
Authors should refrain from misrepresenting research results which could damage the trust in the journal, the professionalism of scientific authorship, and ultimately the entire scientific endeavour. Maintaining integrity of the research and its presentation is helped by following the rules of good scientific practice, which include*:

-
- The manuscript should not be submitted to more than one journal for simultaneous consideration.

- The submitted work should be original and should not have been published elsewhere in any form or language (partially or in full), unless the new work concerns an expansion of previous work. (Please provide transparency on the re-use of material to avoid the concerns about text-recycling ('self-plagiarism').
- A single study should not be split up into several parts to increase the quantity of submissions and submitted to various journals or to one journal over time (i.e. 'salami-slicing/publishing').
- Concurrent or secondary publication is sometimes justifiable, provided certain conditions are met. Examples include: translations or a manuscript that is intended for a different group of readers.
- Results should be presented clearly, honestly, and without fabrication, falsification or inappropriate data manipulation (including image based manipulation). Authors should adhere to discipline-specific rules for acquiring, selecting and processing data.
- No data, text, or theories by others are presented as if they were the author's own ('plagiarism'). Proper acknowledgements to other works must be given (this includes material that is closely copied (near verbatim), summarized and/or paraphrased), quotation marks (to indicate words taken from another source) are used for verbatim copying of material, and permissions secured for material that is copyrighted.

Important note: the journal may use software to screen for plagiarism.

- Authors should make sure they have permissions for the use of software, questionnaires/(web) surveys and scales in their studies (if appropriate).
- Research articles and non-research articles (e.g. Opinion, Review, and Commentary articles) must cite appropriate and relevant literature in support of the claims made. Excessive and inappropriate self-citation or coordinated efforts among several authors to collectively self-cite is strongly discouraged.
- Authors should avoid untrue statements about an entity (who can be an individual person or a company) or descriptions of their behavior or actions that could potentially be seen as personal attacks or allegations about that person.
- Research that may be misapplied to pose a threat to public health or national security should be clearly identified in the manuscript (e.g. dual use of research). Examples include creation of harmful consequences of biological agents or toxins, disruption of immunity of vaccines, unusual hazards in the use of chemicals, weaponization of research/technology (amongst others).
- Authors are strongly advised to ensure the author group, the Corresponding

Author, and the order of authors are all correct at submission. Adding and/or deleting authors during the revision stages is generally not permitted, but in some cases may be warranted. Reasons for changes in authorship should be explained in detail. Please note that changes to authorship cannot be made after acceptance of a manuscript.

*All of the above are guidelines and authors need to make sure to respect third parties rights such as copyright and/or moral rights.
Upon request authors should be prepared to send relevant documentation or data in order to verify the validity of the results presented. This could be in the form of raw data, samples, records, etc. Sensitive information in the form of confidential or proprietary data is excluded.
If there is suspicion of misbehavior or alleged fraud the Journal and/or Publisher will carry out an investigation following COPE guidelines. If, after investigation, there are valid concerns, the author(s) concerned will be contacted under their given e-mail address and given an opportunity to address the issue. Depending on the situation, this may result in the Journal's and/or Publisher's implementation of the following measures, including, but not limited to:

-
- If the manuscript is still under consideration, it may be rejected and returned to the author.
-
- If the article has already been published online, depending on the nature and severity of the infraction: - an erratum/correction may be placed with the article - an expression of concern may be placed with the article - or in severe cases retraction of the article may occur.

The reason will be given in the published erratum/correction, expression of concern or retraction note. Please note that retraction means that the article is **maintained on the platform**, watermarked "retracted" and the explanation for the retraction is provided in a note linked to the watermarked article.

-
- The author's institution may be informed
-
- A notice of suspected transgression of ethical standards in the peer review system may be included as part of the author's and article's bibliographic record.

Fundamental errors

Authors have an obligation to correct mistakes once they discover a significant error or inaccuracy in their published article. The author(s) is/are requested to contact the journal and explain in what sense the error is impacting the article. A decision on how to correct the literature will depend on the nature of the error. This may be a correction or retraction. The retraction note should provide transparency which parts of the article are impacted by the error.

Suggesting / excluding reviewers

Authors are welcome to suggest suitable reviewers and/or request the exclusion of certain individuals when they submit their manuscripts. When suggesting reviewers, authors should make sure they are totally independent and not connected to the work in any way. It is strongly recommended to suggest a mix of reviewers from

different countries and different institutions. When suggesting reviewers, the Corresponding Author must provide an institutional email address for each suggested reviewer, or, if this is not possible to include other means of verifying the identity such as a link to a personal homepage, a link to the publication record or a researcher or author ID in the submission letter. Please note that the Journal may not use the suggestions, but suggestions are appreciated and may help facilitate the peer review process.
Back to top

Authorship principles
These guidelines describe authorship principles and good authorship practices to which prospective authors should adhere to.

Authorship clarified

The Journal and Publisher assume all authors agreed with the content and that all gave explicit consent to submit and that they obtained consent from the responsible authorities at the institute/organization where the work has been carried out, **before** the work is submitted.

The Publisher does not prescribe the kinds of contributions that warrant authorship. It is recommended that authors adhere to the guidelines for authorship that are applicable in their specific research field. In absence of specific guidelines it is recommended to adhere to the following guidelines*:

All authors whose names appear on the submission

1) made substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data; or the creation of new software used in the work;
2) drafted the work or revised it critically for important intellectual content;
3) approved the version to be published; and
4) agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

* Based on/adapted from:
ICMJE, Defining the Role of Authors and Contributors,
Transparency in authors' contributions and responsibilities to promote integrity in scientific publication, McNutt at all, PNAS February 27, 2018

Disclosures and declarations

All authors are requested to include information regarding sources of funding, financial or non-financial interests, study-specific approval by the appropriate ethics committee for research involving humans and/or animals, informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals (as appropriate).

The decision whether such information should be included is not only dependent on the scope of the journal, but also the scope of the article. Work submitted for publication may have implications for public health or general welfare and in those cases it is the responsibility of all authors to include the appropriate disclosures and declarations.

Data transparency

All authors are requested to make sure that all data and materials as well as

software application or custom code support their published claims and comply with field standards. Please note that journals may have individual policies on (sharing) research data in concordance with disciplinary norms and expectations. Please check the Instructions for Authors of the Journal that you are submitting to for specific instructions.

Role of the Corresponding Author

One author is assigned as Corresponding Author and acts on behalf of all co-authors and ensures that questions related to the accuracy or integrity of any part of the work are appropriately addressed.

The Corresponding Author is responsible for the following requirements:

-
- ensuring that all listed authors have approved the manuscript before submission, including the names and order of authors;
-
- managing all communication between the Journal and all co-authors, before and after publication;*
-
- providing transparency on re-use of material and mention any unpublished material (for example manuscripts in press) included in the manuscript in a cover letter to the Editor;
-
- making sure disclosures, declarations and transparency on data statements from all authors are included in the manuscript as appropriate (see above).

* The requirement of managing all communication between the journal and all co-authors during submission and proofing may be delegated to a Contact or Submitting Author. In this case please make sure the Corresponding Author is clearly indicated in the manuscript.

Author contributions

In absence of specific instructions and in research fields where it is possible to describe discrete efforts, the Publisher recommends authors to include contribution statements in the work that specifies the contribution of every author in order to promote transparency. These contributions should be listed at the separate title page.

Examples of such statement(s) are shown below:

• Free text:

All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by [full name], [full name] and [full name]. The first draft of the manuscript was written by [full name] and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Example: CRediT taxonomy:

• Conceptualization: [full name], …; Methodology: [full name], …; Formal analysis and investigation: [full name], …; Writing - original draft preparation: [full name, …]; Writing - review and editing: [full name], …; Funding acquisition: [full name], …; Resources: [full name], …; Supervision: [full name],….

For **review articles** where discrete statements are less applicable a statement should

be included who had the idea for the article, who performed the literature search and data analysis, and who drafted and/or critically revised the work.
For articles that are based primarily on the **student's dissertation or thesis**, it is recommended that the student is usually listed as principal author:
A Graduate Student's Guide to Determining Authorship Credit and Authorship Order, APA Science Student Council 2006

Affiliation

The primary affiliation for each author should be the institution where the majority of their work was done. If an author has subsequently moved, the current address may additionally be stated. Addresses will not be updated or changed after publication of the article.

Changes to authorship

Authors are strongly advised to ensure the correct author group, the Corresponding Author, and the order of authors at submission. Changes of authorship by adding or deleting authors, and/or changes in Corresponding Author, and/or changes in the sequence of authors are **not** accepted **after acceptance** of a manuscript.

-
- **Please note that author names will be published exactly as they appear on the accepted submission!**

Please make sure that the names of all authors are present and correctly spelled, and that addresses and affiliations are current.
Adding and/or deleting authors at revision stage are generally not permitted, but in some cases it may be warranted. Reasons for these changes in authorship should be explained. Approval of the change during revision is at the discretion of the Editor-in-Chief. Please note that journals may have individual policies on adding and/or deleting authors during revision stage.

Author identification

Authors are recommended to use their ORCID ID when submitting an article for consideration or acquire an ORCID ID via the submission process.

Deceased or incapacitated authors

For cases in which a co-author dies or is incapacitated during the writing, submission, or peer-review process, and the co-authors feel it is appropriate to include the author, co-authors should obtain approval from a (legal) representative which could be a direct relative.

Authorship issues or disputes

In the case of an authorship dispute during peer review or after acceptance and publication, the Journal will not be in a position to investigate or adjudicate. Authors will be asked to resolve the dispute themselves. If they are unable the Journal reserves the right to withdraw a manuscript from the editorial process or in case of a published paper raise the issue with the authors' institution(s) and abide by its guidelines.

Confidentiality

Authors should treat all communication with the Journal as confidential which includes correspondence with direct representatives from the Journal such as Editors-in-Chief and/or Handling Editors and reviewers' reports unless explicit consent has been received to share information.

Back to top

Compliance with Ethical Standards

To ensure objectivity and transparency in research and to ensure that accepted principles of ethical and professional conduct have been followed, authors should include information regarding sources of funding, potential conflicts of interest (financial or non-financial), informed consent if the research involved human participants, and a statement on welfare of animals if the research involved animals.

Authors should include the following statements (if applicable) in a separate section entitled "Compliance with Ethical Standards" when submitting a paper:

- Disclosure of potential conflicts of interest
- Research involving Human Participants and/or Animals
- Informed consent

Please note that standards could vary slightly per journal dependent on their peer review policies (i.e. single or double blind peer review) as well as per journal subject discipline. Before submitting your article check the instructions following this section carefully.

The corresponding author should be prepared to collect documentation of compliance with ethical standards and send if requested during peer review or after publication.

The Editors reserve the right to reject manuscripts that do not comply with the above-mentioned guidelines. The author will be held responsible for false statements or failure to fulfill the above-mentioned guidelines.

Back to top

Disclosure of potential conflicts of interest

Authors must disclose all relationships or interests that could have direct or potential influence or impart bias on the work. Although an author may not feel there is any conflict, disclosure of relationships and interests provides a more complete and transparent process, leading to an accurate and objective assessment of the work. Awareness of a real or perceived conflicts of interest is a perspective to which the readers are entitled. This is not meant to imply that a financial relationship with an organization that sponsored the research or compensation received for consultancy work is inappropriate. Examples of potential conflicts of interests **that are directly or indirectly related to the research** may include but are not limited to the following:

- Research grants from funding agencies (please give the research funder and the grant number)
- Honoraria for speaking at symposia
- Financial support for attending symposia
- Financial support for educational programs

- Employment or consultation
-
- Support from a project sponsor
-
- Position on advisory board or board of directors or other type of management relationships
-
- Multiple affiliations
-
- Financial relationships, for example equity ownership or investment interest
-
- Intellectual property rights (e.g. patents, copyrights and royalties from such rights)
-
- Holdings of spouse and/or children that may have financial interest in the work

In addition, interests that go beyond financial interests and compensation (non-financial interests) that may be important to readers should be disclosed. These may include but are not limited to personal relationships or competing interests directly or indirectly tied to this research, or professional interests or personal beliefs that may influence your research.

The corresponding author collects the conflict of interest disclosure forms from all authors. In author collaborations where formal agreements for representation allow it, it is sufficient for the corresponding author to sign the disclosure form on behalf of all authors. Examples of forms can be found
here:

The corresponding author will include a summary statement in the text of the manuscript in a separate section before the reference list, that reflects what is recorded in the potential conflict of interest disclosure form(s).

See below examples of disclosures:

Funding: This study was funded by X (grant number X).

Conflict of Interest: Author A has received research grants from Company A. Author B has received a speaker honorarium from Company X and owns stock in Company Y. Author C is a member of committee Z.

If no conflict exists, the authors should state:

Conflict of Interest: The authors declare that they have no conflict of interest.

Back to top

Research involving human participants, their data or biological material

Ethics approval

When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the

reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

Retrospective ethics approval

If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval usually cannot be obtained and it may not be possible to consider the manuscript for peer review. The decision on whether to proceed to peer review in such cases is at the Editor's discretion.

Ethics approval for retrospective studies

Although retrospective studies are conducted on already available data or biological material (for which formal consent may not be needed or is difficult to obtain) ethics approval may be required dependent on the law and the national ethical guidelines of a country. Authors should check with their institution to make sure they are complying with the specific requirements of their country.

Ethics approval for case studies

Case reports require ethics approval. Most institutions will have specific policies on this subject. Authors should check with their institution to make sure they are complying with the specific requirements of their institution and seek ethics approval where needed. Authors should be aware to secure informed consent from the individual (or parent or guardian if the participant is a minor or incapable) See also section on **Informed Consent**.

Cell lines

If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

It is recommended that authors check the NCBI database for misidentification and contamination of human cell lines. This step will alert authors to possible problems with the cell line and may save considerable time and effort.

Further information is available from the International Cell Line Authentication Committee (ICLAC).

Authors should include a statement that confirms that an institutional or independent ethics committee (including the name of the ethics committee) approved the study and that informed consent was obtained from the donor or next of kin.

Research Resource Identifiers (RRID)

Research Resource Identifiers (RRID) are persistent unique identifiers (effectively similar to a DOI) for research resources. This journal encourages authors to adopt RRIDs when reporting key biological resources (antibodies, cell lines, model organisms and tools) in their manuscripts.

Examples:

Organism: *Filip1tm1a(KOMP)Wtsi* **RRID:MMRRC_055641-UCD**

Cell Line: RST307 cell line **RRID:CVCL_C321**

Antibody: Luciferase antibody DSHB Cat# LUC-3, **RRID:AB_2722109**

Plasmid: mRuby3 plasmid **RRID:Addgene_104005**
Software: ImageJ Version 1.2.4 **RRID:SCR_003070**
RRIDs are provided by the Resource Identification Portal. Many commonly used research resources already have designated RRIDs. The portal also provides authors links so that they can quickly register a new resource and obtain an RRID.

Clinical Trial Registration

The World Health Organization (WHO) definition of a clinical trial is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes". The WHO defines health interventions as “A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions” and a health-related outcome is generally defined as a change in the health of a person or population as a result of an intervention.

To ensure the integrity of the reporting of patient-centered trials, authors must register prospective clinical trials (phase II to IV trials) in suitable publicly available repositories. For example www.clinicaltrials.gov or any of the primary registries that participate in the WHO International Clinical Trials Registry Platform.

The trial registration number (TRN) and date of registration should be included as the last line of the manuscript abstract.

For clinical trials that have not been registered prospectively, authors are encouraged to register retrospectively to ensure the complete publication of all results. The trial registration number (TRN), date of registration and the words 'retrospectively registered’ should be included as the last line of the manuscript abstract.

Purely observational trials will not require registration.

Standards of reporting

Springer Nature advocates complete and transparent reporting of biomedical and biological research and research with biological applications. Authors are recommended to adhere to the minimum reporting guidelines hosted by the EQUATOR Network when preparing their manuscript.

Exact requirements may vary depending on the journal; please refer to the journal’s Instructions for Authors.

Checklists are available for a number of study designs, including:

Randomised trials (CONSORT) and Study protocols (SPIRIT)
Observational studies (STROBE)
Systematic reviews and meta-analyses (PRISMA) and protocols (Prisma-P)
Diagnostic/prognostic studies (STARD) and (TRIPOD)
Case reports (CARE)
Clinical practice guidelines (AGREE) and (RIGHT)
Qualitative research (SRQR) and (COREQ)
Animal pre-clinical studies (ARRIVE)
Quality improvement studies (SQUIRE)
Economic evaluations (CHEERS)

Summary of requirements

The above should be summarized in a statement and included on **a title page that is separate from the manuscript** with a section entitled **“Declarations”** when

submitting a paper. Having all statements in one place allows for a consistent and unified review of the information by the Editor-in-Chief and/or peer reviewers and may speed up the handling of the paper. Declarations include Funding, Conflicts of interest/competing interests, Ethics approval, Consent, Data and/or Code availability and Authors' contribution statements. **Please use the following template title page for providing the statements.**
Once and if the paper is accepted for publication, the production department will put the respective statements in a distinctly identified section clearly visible for readers.
Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

- Provide **"Ethics approval"** as a heading (see template)

Examples of ethics approval obtained:

- All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).
- This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).
- Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.
- The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of C (Ethics approval number: ...).

Examples of a retrospective study:

- Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.
- This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.
- This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

Examples no ethical approval required/exemption granted:

- This is an observational study. The XYZ Research Ethics Committee has confirmed that no ethical approval is required.
- The data reproduced from Article X utilized human tissue that was procured via our Biobank AB, which provides de-identified samples. This study was reviewed and deemed exempt by our XYZ Institutional Review Board. The BioBank protocols are in accordance with the ethical standards of our institution and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.

Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.
Back to top

Informed consent
All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.
Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scholarly purposes and the participant (or parent or guardian if the participant is incapable) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases. Detailed descriptions of individual participants, whether of their whole bodies or of body sections, may lead to disclosure of their identity. Under certain circumstances consent is not required as long as information is anonymized and the submission does not include images that may identify the person.
Informed consent for publication should be obtained if there is any doubt. For example, masking the eye region in photographs of participants is inadequate protection of anonymity. If identifying characteristics are altered to protect anonymity, such as in genetic profiles, authors should provide assurance that alterations do not distort scientific meaning.
Exceptions where it is not necessary to obtain consent:
• Images such as x rays, laparoscopic images, ultrasound images, brain scans, pathology slides unless there is a concern about identifying information in which case, authors should ensure that consent is obtained.
• Reuse of images: If images are being reused from prior publications, the Publisher will assume that the prior publication obtained the relevant information regarding consent. Authors should provide the appropriate attribution for republished images.
Consent and already available data and/or biologic material
Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.
Data protection, confidentiality and privacy
When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made what kind of (personal) data will be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to

a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered "informed". However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

Consent to Participate

For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found here. (Download docx, 36 kB)

Summary of requirements

The above should be summarized in a statement and included on **a title page that is separate from the manuscript** with a section entitled **"Declarations"** when submitting a paper. Having all statements in one place allows for a consistent and unified review of the information by the Editor-in-Chief and/or peer reviewers and may speed up the handling of the paper. Declarations include Funding, Conflicts of interest/competing interests, Ethics approval, Consent, Data and/or Code availability and Authors' contribution statements. **Please use the template Title Page for providing the statements**.

Once and if the paper is accepted for publication, the production department will put the respective statements in a distinctly identified section clearly visible for readers.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Provide **"Consent to participate"** as a heading

Sample statements consent to participate:

Informed consent was obtained from all individual participants included in the study.

Informed consent was obtained from legal guardians.

Written informed consent was obtained from the parents.

Verbal informed consent was obtained prior tothe interview.

The patient has consented to the submission of the case report for submission to the journal.

Provide **"Consent to publish"** as a heading

The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.

The participant has consented to the submission of the case report to the journal.
Patients signed informed consent regarding publishing their data and photographs.
Sample statements if identifying information about participants is available in the article:
Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.
Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.
If any of the sections are not relevant to your manuscript, please include the heading and write 'Not applicable' for that section.
Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.
Images will be removed from publication if authors have not obtained informed consent or the paper may be removed and replaced with a notice explaining the reason for removal.
Back to top

Appendix B: Table of excluded review papers and reasons

Reference	Reason for exclusion
Bar-Kalifa, E., Prinz, J. N., Atzil-Slonim, D., Rubel, J. A., Lutz, W., & Rafaeli, E. (2019). Physiological synchrony and therapeutic alliance in an imagery-based treatment. *Journal of counseling psychology*, *66*(4), 508.	Adult sample
Calderon, A., Schneider, C., Target, M., & Midgley, N. (2019). 'Interaction structures' between depressed adolescents and their therapists in short-term psychoanalytic psychotherapy and cognitive behavioural therapy. *Clinical child psychology and psychiatry*, *24*(3), 446-461.	Model adherence
Izmirian, S. C., Chang, J. P., & Nakamura, B. J. (2019). Predicting youth improvement in community-based residential settings with practices derived from the evidence-base. *Administration and Policy in Mental Health and Mental Health Services Research*, *46*(4), 458-473.	Model adherence
Lee, P., Zehgeer, A., Ginsburg, G. S., McCracken, J., Keeton, C., Kendall, P. C., ... & Albano, A. M. (2019). Child and adolescent adherence with cognitive behavioral therapy for anxiety: Predictors and associations with outcomes. *Journal of Clinical Child & Adolescent Psychology*, *48*(sup1), S215-S226.	No therapist measure included
Boyer, B., MacKay, K. J., McLeod, B. D., & van der Oord, S. (2018). Comparing Alliance in two cognitive-behavioural therapies for adolescents with ADHD using a randomized controlled trial. *Behavior therapy*, *49*(5), 781-795.	Model adherence
Behn, A., Davanzo, A., & Errázuriz, P. (2018). Client and therapist match on gender, age, and income: Does match within the therapeutic dyad predict early growth in the therapeutic alliance?. *Journal of clinical psychology*, *74*(9), 1403-1421.	Adult sample
Crawford, E. A., Frank, H. E., Palitz, S. A., Davis, J. P., & Kendall, P. C. (2018). Process factors associated with improved outcomes in CBT for anxious youth: Therapeutic content, alliance, and therapist actions. *Cognitive Therapy and Research*, *42*(2), 172-183.	No therapist measure included
Fauskanger Bjaastad, J., Henningsen Wergeland, G. J., Mowatt Haugland, B. S., Gjestad, R., Havik, O. E., Heiervang, E. R., & Öst, L. G. (2018). Do clinical experience, formal cognitive behavioural therapy training, adherence, and competence predict outcome in cognitive behavioural therapy for anxiety disorders in youth?. *Clinical psychology & psychotherapy*, *25*(6), 865-877.	Model adherence
Kluft genannt Jans, A. (2018). Child Involvement and Therapist Alliance-Building Behavior: In-session Behavior during Alliance Ruptures within Cognitive-Behaveriol Therapy for Anxious Children.	Dissertation
Arnold, K., Loos, S., Mayer, B., Clarke, E., Slade, M., Fiorillo, A., ... & Bording, M. K. (2017). Helping alliance and unmet needs in routine care of people with severe mental illness across Europe: a prospective longitudinal multicenter study. *The Journal of nervous and mental disease*, *205*(4), 329-333.	Adult sample
Bullock, M. M. (2017). Rates and Predictors of Adolescent Premature Termination: Applying Clinically Significant Change.	Dissertation
Labouliere, C. D., Reyes, J. P., Shirk, S., & Karver, M. (2017). Therapeutic alliance with depressed adolescents: Predictor or outcome? Disentangling temporal confounds to understand early improvement. *Journal of Clinical Child & Adolescent Psychology*, *46*(4), 600-610.	No therapist measure included
Bjaastad, J. F., Haugland, B. S. M., Fjermestad, K. W., Torsheim, T., Havik, O. E., Heiervang, E. R., & Öst, L. G. (2016). Competence and Adherence Scale for Cognitive Behavioral Therapy (CAS-CBT) for anxiety disorders in youth: Psychometric properties. *Psychological Assessment*, *28*(8), 908.	No therapist measure included
McLeod, B. D., Jensen-Doss, A., Tully, C. B., Southam-Gerow, M. A., Weisz, J. R., & Kendall, P. C. (2016). The role of setting versus treatment type in alliance within youth therapy. *Journal of consulting and clinical psychology*, *84*(5), 453.	Model adherence
Ormhaug, S. M. (2016). The Therapeutic Alliance in the Treatment of Traumatized Youths. Relationship to Outcome and Dropout Across Rater Perspectives and Therapeutic Interventions.	Dissertation
Staehlin, T. M. (2016). Identifying Therapeutic Alliance Patterns Among a Feasible Clinical Measure to Improve Treatment Outcome.	Dissertation
Yasin, A. R. (2016). What Works for Successful In-Home Family Therapists Working at Community-Based Agencies.	Dissertation
Accurso, E. C., & Garland, A. F. (2015). Child, caregiver, and therapist perspectives on therapeutic alliance in usual care child psychotherapy. *Psychological Assessment*, *27*(1), 347.	No therapist measure included

Byers, A. N., & Lutz, D. J. (2015). Therapeutic alliance with youth in residential care: Challenges and recommendations. *Residential Treatment for Children & Youth*, *32*(1), 1-18.	Not an empirical paper
Feldstein Ewing, S. W., Gaume, J., Ernst, D. B., Rivera, L., & Houck, J. M. (2015). Do therapist behaviors differ with Hispanic youth? A brief look at within-session therapist behaviors and youth treatment response. *Psychology of Addictive Behaviors*, *29*(3), 779.	Substance abuse
Gutermann, J., Schreiber, F., Matulis, S., Stangier, U., Rosner, R., & Steil, R. (2015). Therapeutic adherence and competence scales for Developmentally Adapted Cognitive Processing Therapy for adolescents with PTSD. *European journal of psychotraumatology*, *6*(1), 26632.	Model adherence
Higa-McMillan, C. K., Nakamura, B. J., Morris, A., Jackson, D. S., & Slavin, L. (2015). Predictors of use of evidence-based practices for children and adolescents in usual care. Administration and Policy in Mental Health and Mental Health Services Research, 42(4), 373-383.	Model adherence
Stirman, S. W., Gutner, C. A., Crits-Christoph, P., Edmunds, J., Evans, A. C., & Beidas, R. S. (2015). Relationships between clinician-level attributes and fidelity-consistent and fidelity-inconsistent modifications to an evidence-based psychotherapy. *Implementation Science*, *10*(1), 115.	No therapist measure included
Zandberg, L. J., Skriner, L. C., & Chu, B. C. (2015). Client-therapist alliance discrepancies and outcome in cognitive-behavioral therapy for youth anxiety. *Journal of Clinical Psychology*, *71*(4), 313-322.	No therapist measure included
Chu, B. C., Skriner, L. C., & Zandberg, L. J. (2014). Trajectory and predictors of alliance in cognitive behavioral therapy for youth anxiety. *Journal of Clinical Child & Adolescent Psychology*, *43*(5), 721-734.	No therapist measure included
Conway, F. (2014). The use of empathy and transference as interventions in psychotherapy with attention deficit hyperactive disorder latency-aged boys. *Psychotherapy*, *51*(1), 104.	Model adherence
La Valle, W. (2014). The Therapeutic Relationship and Alliance-Building Behaviors: Treatment Implications for Childhood Social Phobia.	Dissertation
Nakamura, B. J., Selbo-Bruns, A., Okamura, K., Chang, J., Slavin, L., & Shimabukuro, S. (2014). Developing a systematic evaluation approach for training programs within a train-the-trainer model for youth cognitive behavior therapy. *Behaviour Research and Therapy*, *53*, 10-19.	No therapist measure included
Nemeth, J. M. (2014). Essential Music Therapist Attributes for Relationship-Building with Children: Does our Profession Train Personal Abilities?.	Dissertation
Talley, P. F. (2014). Foundations of clinical work with children: The therapeutic relationship. In *Handbook for the treatment of abused and neglected children* (pp. 149-170). Routledge.	Not an empirical paper
Abrishami, G. F., & Warren, J. S. (2013). Therapeutic alliance and outcomes in children and adolescents served in a community mental health system. *Journal of Child and Adolescent Behavior*, *1*(2), 1-7.	No therapist measure included
Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical psychology & psychotherapy*, *20*(2), 118-135.	Adult sample
Bhola, P., & Kapur, M. (2013). The development and role of the therapeutic alliance in supportive psychotherapy with adolescents. Psychological Studies, 58(3), 207-215. Chicago	No therapist measure included
Cummings, C. M., Caporino, N. E., Settipani, C. A., Read, K. L., Compton, S. N., March, J., ... & Ginsburg, G. (2013). The therapeutic relationship in cognitive-behavioral therapy and pharmacotherapy for anxious youth. *Journal of consulting and clinical psychology*, *81*(5), 859.	No therapist measure included
Ellis, M. L., Lindsey, M. A., Barker, E. D., Boxmeyer, C. L., & Lochman, J. E. (2013). Predictors of engagement in a school-based family preventive intervention for youth experiencing behavioral difficulties. *Prevention Science*, *14*(5), 457-467.	No therapist measure included
Friedberg, R. D., Tabbarah, S., & Poggesi, R. M. (2013). Therapeutic presence, immediacy, and transparency in CBT with youth: carpe the moment!. *The Cognitive Behaviour Therapist*, *6*.	Not an empirical paper
Langberg, J. M., Becker, S. P., Epstein, J. N., Vaughn, A. J., & Girio-Herrera, E. (2013). Predictors of response and mechanisms of change in an organizational skills intervention for students with ADHD. *Journal of child and family studies*, *22*(7), 1000-1012.	No therapist measure included
Reyes, J. P. M. (2013). Examining the Alliance-Outcome Relationship: Reverse Causation, Third Variables, and Treatment Phase Artifacts.	Dissertation
Fjermestad, K. W. (2012). The therapeutic alliance in cognitive behavioral therapy for youth anxiety disorders (Doctoral dissertation, Doctoral dissertation). University of Bergen, Bergen).	Dissertation

Fjermestad, K. W., McLeod, B. D., Heiervang, E. R., Havik, O. E., Öst, L. G., & Haugland, B. S. (2012). Factor structure and validity of the therapy process observational coding system for Child Psychotherapy–Alliance Scale. Journal of Clinical Child & Adolescent Psychology, 41(2), 246-254.	No therapist measure included
Higham, J. E., Friedlander, M. L., Escudero, V., & Diamond, G. (2012). Engaging reluctant adolescents in family therapy: An exploratory study of in-session processes of change. *Journal of Family Therapy*, *34*(1), 24-52.	Qualitative method
Levin, L., Henderson, H. A., & Ehrenreich-May, J. (2012). Interpersonal predictors of early therapeutic alliance in a transdiagnostic cognitive-behavioral treatment for adolescents with anxiety and depression. *Psychotherapy*, *49*(2), 218.	No therapist measure included
Orimoto, T. E., Higa-McMillan, C. K., Mueller, C. W., & Daleiden, E. L. (2012). Assessment of therapy practices in community treatment for children and adolescents. *Psychiatric Services*, *63*(4), 343-350.	No therapist measure included
Williams, C. (2012). *The System of Care Mental Health Service Experience: Differences in Perceptions between African American and Caucasian Youth and its Impact on Service Use and the Relationship between Receipt of Services and Emotional and Behavioral Symptoms* (Doctoral dissertation).	Dissertation
Campbell, A. F., & Simmonds, J. G. (2011). Therapist perspectives on the therapeutic alliance with children and adolescents. *Counselling Psychology Quarterly*, *24*(3), 195-209.	Qualitative method
Langer, D. A., McLeod, B. D., & Weisz, J. R. (2011). Do treatment manuals undermine youth–therapist alliance in community clinical practice?. *Journal of consulting and clinical psychology*, *79*(4), 427.	No therapist measure included
Sburlati, E. S., Schniering, C. A., Lyneham, H. J., & Rapee, R. M. (2011). A model of therapist competencies for the empirically supported cognitive behavioral treatment of child and adolescent anxiety and depressive disorders. Clinical Child and Family Psychology Review, 14(1), 89-109.	No therapist measure included
Seay, J. (2011). The relationship between client-counselor race and counselor use of reflective listening skills.	Substance abuse
Slater, H. M., Mitschke, D. B., & Douthit, P. (2011). Understanding qualities of positive relationship dynamics between adolescent parents and their school-based counselors. *Journal of Family Social Work*, *14*(4), 354-368.	Qualitative method
Spirito, A., Simon, V., Cancilliere, M. K., Stein, R., Norcott, C., Loranger, K., & Prinstein, M. J. (2011). Outpatient psychotherapy practice with adolescents following psychiatric hospitalization for suicide ideation or a suicide attempt. *Clinical child psychology and psychiatry*, *16*(1), 53-64.	Model adherence
Constantino, M. J., Castonguay, L. G., Zack, S. E., & DeGeorge, J. (2010). Engagement in psychotherapy: Factors contributing to the facilitation, demise, and restoration of the therapeutic alliance.	Not an empirical paper
Karver, M. S., & Caporino, N. (2010). The use of empirically supported strategies for building a therapeutic relationship with an adolescent with oppositional-defiant disorder. *Cognitive and Behavioral Practice*, *17*(2), 222-232.	Model adherence
Liber, J. M., McLeod, B. D., Van Widenfelt, B. M., Goedhart, A. W., van der Leeden, A. J., Utens, E. M., & Treffers, P. D. (2010). Examining the relation between the therapeutic alliance, treatment adherence, and outcome of cognitive behavioral therapy for children with anxiety disorders. *Behavior Therapy*, *41*(2), 172-186.	No therapist measure included
MacDonald, M. (2010). Promoting parent-therapist collaboration in intensive behavioural intervention programs: exploring estrategies to improve teamwork.	Qualitative method
Naidu, T., & Behari, S. (2010). The parent-child-therapist alliance: A case study using a strategic approach. *Journal of child and adolescent mental health*, *22*(1), 41-50.	Qualitative method
Christensen, M., & Skogstad, R. S. (2009). *What predicts quality of the therapeutic alliance in a cognitive behavioural treatment for children with anxiety disorders? Therapeutic alliance measured from the patient, therapist and observer perspective* (Master's thesis, The University of Bergen).	Dissertation
Chu, B. C., & Kendall, P. C. (2009). Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology*, *65*(7), 736-754.	Model adherence
Friedberg, R. D., Gorman, A. A., & Beidel, D. C. (2009). Training psychologists for cognitive-behavioral therapy in the raw world: A rubric for supervisors. Behavior Modification, 33(1), 104-123.	No therapist measure included
Brull, J. V. (2008). *Therapist Verbal Response Modes, the Therapeutic Alliance, and In-session Client Good Moments*. ProQuest.	Dissertation
Handwerk, M. L., Huefner, J. C., Ringle, J. L., Howard, B. K., Soper, S. H., Almquist, J. K., ... & Father Flanagan's Boys' Home. (2008). The role of therapeutic alliance in therapy outcomes for youth in	No therapist measure included

residential care. Residential Treatment for Children & Youth, 25(2), 145-165.

Robbins, M. S., Mayorga, C. C., Mitrani, V. B., Szapocznik, J., Turner, C. W., & Alexander, J. F. (2008). Adolescent and Parent Alliances With Therapists in Brief Strategic Family TherapyTM With Drug-Using Hispanic Adolescents. *Journal of Marital and Family Therapy*, *34*(3), 316-328.	Substance abuse
Shirk, S., & McMakin, D. (2008). Client, therapist, and treatment characteristics in EBTs for children and adolescents. In Handbook of evidence-based therapies for children and adolescents (pp. 471-486). Springer, Boston, MA.	Not an empirical paper
Simpson, T. P. (2008). Factors Predicting Therapeutic Alliance in Antisocial Adolescents.	Dissertation
Bernard, A. (2007). *Therapeutic Techniques that Predict Clinical Improvement in a Schizoid Patient in Long-term Intensive Psychoanalytic Treatment* (Doctoral dissertation, Adelphi University).	Dissertation
Corning, A. F., Malofeeva, E. V., & Bucchianeri, M. M. (2007). Predicting termination type from client-therapist agreement on the severity of the presenting problem. Psychotherapy: Theory, Research, Practice, Training, 44(2), 193.	No therapist measure included
Farsimadan, F., Draghi-Lorenz, R., & Ellis, J. (2007). Process and outcome of therapy in ethnically similar and dissimilar therapeutic dyads. *Psychotherapy Research*, *17*(5), 567-575.	Adult sample
McWey, L. M. (2007). In-home family therapy as a prevention of foster care placement: Clients' opinions about therapeutic services. *The American Journal of Family Therapy*, *36*(1), 48-59.	Group outcome/allaince
Zack, S. E., Castonguay, L. G., & Boswell, J. F. (2007). Youth working alliance: A core clinical construct in need of empirical maturity. Harvard review of psychiatry, 15(6), 278-288.	Not an empirical paper
Handelsman, J. B. (2006). Linking pretreatment therapist characteristics to the therapeutic alliance in youth treatment: An examination of professional burnout, counseling self-efficacy and gender role orientation.	Dissertation
Johnson, L. N., Ketring, S. A., Rohacs, J., & Brewer, A. L. (2006). Attachment and the therapeutic alliance in family therapy. *The American Journal of Family Therapy*, *34*(3), 205-218.	Group outcome/allaince
Meier, P. S., & Donmall, M. C. (2006). Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use*, *11*(1), 73-80.	Substance abuse
Hill, C. E. (2005). Therapist techniques, client involvement, and the therapeutic relationship: Inextricably intertwined in the therapy process. *Psychotherapy: theory, research, practice, training*, *42*(4), 431.	No therapist measure included
Kazdin, A. E., Marciano, P. L., & Whitley, M. K. (2005). The therapeutic alliance in cognitive-behavioral treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of consulting and clinical psychology*, *73*(4), 726.	No therapist measure included
Watson, J. C., & McMullen, E. J. (2005). An Examination of Therapist and Client Behavior in High-and Low-Alliance Sessions In Cognitive-Behavioral Therapy and Process Experiential Therapy. *Psychotherapy: Theory, Research, Practice, Training*, *42*(3), 297.	Adult sample
Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents?. *Professional Psychology: Research and Practice*, *36*(4), 400.	Substance abuse
Bickman, L., De Andrade, A. R. V., Lambert, E. W., Doucette, A., Sapyta, J., Boyd, A. S., ... & Rauktis, M. B. (2004). Youth therapeutic alliance in intensive treatment settings. *The Journal of Behavioral Health Services & Research*, *31*(2), 134-148.	Model adherence
Flicker, S. M. (2004). *The relationship between ethnic matching, therapeutic alliance, and treatment outcome with Hispanic and Anglo adolescents in family therapy* (Doctoral dissertation, The University of New Mexico).	Dissertation
Harwood, M. D., & Eyberg, S. M. (2004). Therapist verbal behavior early in treatment: Relation to successful completion of parent–child interaction therapy. *Journal of Clinical Child and Adolescent Psychology*, *33*(3), 601-612.	Group outcome/allaince
Vocisano, C., Klein, D. N., Arnow, B., Rivera, C., Blalock, J. A., Rothbaum, B., ... & Castonguay, L. (2004). Therapist Variables That Predict Symptom Change in Psychotherapy With Chronically Depressed Outpatients. *Psychotherapy: Theory, Research, Practice, Training*, *41*(3), 255.	Adult sample
Heckenberg, L. J. (2003). An exploration of the therapeutic alliance between children and school counselors.	No therapist measure included

McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal of Child and Family Studies*, *11*(3), 347-359.	Qualitative method
Bell, C. K., Goebert, D. A., Andrade, N. N., Johnson, R. C., McDermott, J. F., Hishinuma, E. S., ... & Miyamoto, R. H. (2001). Sociocultural factors influencing adolescent preference and use of native Hawaiian healers. *Complementary therapies in medicine*, *9*(4), 224-231.	No therapist measure included
Hersoug, A. G., Høglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *The Journal of psychotherapy practice and research*, *10*(4), 205.	Adult sample
Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapists, therapist variables, and cognitive-behavioral therapy outcome in a multicenter trial for panic disorder. *Journal of consulting and clinical psychology*, *69*(5), 747.	Adult sample
McLeod, B. D. (2001). The therapy process observational coding system for child psychotherapy. *Los Angeles: University of California*.	No therapist measure included
Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2000). Ethnic match and client ethnicity effects on global assessment and visitation. *Journal of Community Psychology*, *28*(5), 547-564.	Adult sample
Bänninger-Huber, E., & Widmer, C. (1999). Affective relationship patterns and psychotherapeutic change. *Psychotherapy Research*, *9*(1), 74-87.	Adult sample
Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, Training*, *36*(4), 355.	Substance abuse
Shaw, B. F., Elkin, I., Yamaguchi, J., Olmsted, M., Vallis, T. M., Dobson, K. S., ... & Imber, S. D. (1999). Therapist competence ratings in relation to clinical outcome in cognitive therapy of depression. *Journal of Consulting and Clinical Psychology*, *67*(6), 837.	Adult sample
Jerrell, J. M. (1998). Effect of ethnic matching of young clients and mental health staff. *Cultural Diversity and Mental Health*, *4*(4), 297.	Adult sample
Zlotnick, C., Elkin, I., & Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression?. *Journal of Consulting and Clinical Psychology*, *66*(4), 655.	Adult sample
Blatt, S. J., Sanislow III, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical psychology*, *64*(6), 1276.	Adult sample
Eltz, M. J., Shirk, S. R., & Sarlin, N. (1995). Alliance formation and treatment outcome among maltreated adolescents. *Child Abuse & Neglect*, *19*(4), 419-431.	No therapist measure included
Goerge, R. M. (1994). The effect of public child welfare workforce characteristics and turnover on discharge from foster care. In R. P. Barth, J. Duerr Berrick, & N. Gilbert (Eds.), Child welfare research review, Vol. 1. (pp. 205-217). New York: Columbia University Press.	Not an empirical paper
Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. The working alliance: Theory, research, and practice, 173, 51-84.	Not an empirical paper
Hirokawa, G. M. (1993). The relationship of ethnic and sex match between client and therapist on treatment outcome and premature termination among Asian American adolescents.	Dissertation
Gaston, L., Marmar, C., Gallagher, D., & Thompson, L. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy processes. *Psychotherapy Research*, *1*(2), 104-112.	Adult sample
Hagborg, W. J. (1991). Adolescent clients and perceived counselor characteristics: A study of background characteristics, therapeutic progress, psychological distress, and social desirability. *Journal of clinical psychology*, *47*(1), 107-113.	Adult sample
Mallinckrodt, B., & Nelson, M. L. (1991). Counselor training level and the formation of the psychotherapeutic working alliance. *Journal of Counseling Psychology*, *38*(2), 133.	Adult sample
Fullerton, C. S., Yates, B. T., & Goodrich, W. (1990). The sex and experience of the therapist and their effects on intensive psychotherapy of the adolescent inpatient. *Adolescent psychiatry*, *17*, 272.	Not an empirical paper
Williams, K. E., & Chambless, D. L. (1990). The relationship between therapist characteristics and outcome of in vivo exposure treatment for agoraphobia. *Behavior Therapy*, *21*(1), 111-116.	Adult sample

Marcos, L. R. (1988). Understanding ethnicity in psychotherapy with Hispanic patients. American Journal of Psychoanalysis, 48(1), 35-42.	Not an empirical paper
Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, *22*(2), 127-141.	Adult sample
Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry*, *39*(4), 397-402.	Adult sample
Rosenheim, E. (1974). Humor in psychotherapy: An interactive experience. American Journal of Psychotherapy, 28(4), 584-591.	Not an empirical paper

Appendix C: Adapted Effective Public Health Practice Project (EPHPP) tool

Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health: a systematic review

Author: Rachael Ryan

Effective Public Health Practice Project (EPHPP)

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES (ADAPTED*)

Common types of design include: (A) randomised controlled trial (B) non-randomized controlled trials, and (C-D-E) observational analytic study or component where the intervention/exposure is defined/assessed, but not assigned by researchers.

- ***A.*** **Randomized Controlled Trial (RCT)** *An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and only use the words 'random' or 'randomly', the study is described as a controlled clinical trial.*
- ***B. Non-randomized controlled trials***
  The intervention is assigned by researchers, but there is no randomization, e.g., a pseudo-randomization. A non-random method of allocation is not reliable in producing alone similar groups.
- ***C. Cohort study***
  Subsets of a defined population are assessed as exposed, not exposed, or exposed at different degrees to factors of interest. Participants are followed over time to determine if an outcome occurs (prospective longitudinal).
- ***D. Case-control study***
  Cases, e.g., patients, associated with a certain outcome are selected, alongside a corresponding group of controls. Data is collected on whether cases and controls were exposed to the factor under study (retrospective).
- ***E. Cross-sectional analytic study***
  At one particular time, the relationship between health-related characteristics (outcome) and other factors (intervention/exposure) is examined. E.g., the frequency of outcomes is compared in different population sub-groups according to the presence/absence (or level) of the intervention/exposure.

***This measure has been adapted for use in a review of studies including randomised, non-randomised studies including cross-sectional and cohort (prospective, longitudinal) analytical designs.**

***The following subscales have been omitted:**

- C – CONFOUNDERS Q2
- D – BLINDING Q1 AND Q2
- G – INTERVENTION INTEGRITY Q1, Q2 AND Q3
- H – ANALYSES Q1, Q2, AND Q4

COMPONENT RATINGS

A) SELECTION BIAS

(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?*

Very likely
Somewhat likely
Not likely
Can't tell

(Q2) What percentage of selected individuals agreed to participate?

1. 80 – 100%
2. 60 – 79%
3. Less than 60% agreement
4. Not applicable
5. Can't tell

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

DICTIONARY: SELECTION BIAS

**please note, this is about the selection of participants into the study of therapist characteristics, rather than the way they were selected into the service*

(Q1) *Participants are more likely to be representative of the target population if they are randomly selected from a comprehensive list of individuals in the target population (score very likely). They may not be representative if they are referred from a source (e.g. clinic) in a systematic manner (score somewhat likely) or self-referred (score not likely).*

(Q2) *Refers to the % of subjects in the control and intervention groups that agreed to participate in the study before they were assigned to intervention or control groups.*

A: SELECTION BIAS SCORING

Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) and there is greater than 80% participation (Q2 is 1).
Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); and there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).
Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); or there is less than 60% participation (Q2 is 3) or selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B) STUDY DESIGN

Indicate the study design

Randomized controlled trial
Controlled clinical trial
Cohort analytic (two group pre + post)
Case-control
Cohort (one group pre + post (before and after))
Interrupted time series
Other specify ____________________________
Can't tell

Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)
No Yes

If Yes, was the method appropriate? (See dictionary)

No Yes **RATE THIS SECTION**	**STRONG**	**MODERATE**	**WEAK**
See dictionary	1	2	3

Dictionary: study design

An experimental design where investigators randomly allocate eligible people to an intervention or control group. A rater should describe a study as an RCT if the randomization sequence allows each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. If the investigators do not describe the allocation process and

only use the words ‘random’ or ‘randomly’, the study is described as a controlled clinical trial.*

In order to receive a strong rating for a RCT, the randomisation must apply to the therapist characteristic variable, not the RCT design of an intervention. The study design refers to the variable of therapist characteristic is measured in relation to the design or outcome.

More information:

Was the study described as randomized?

Score YES, if the authors used words such as random allocation, randomly assigned, and random assignment.

Score NO, if no mention of randomization is made.

Was the method of randomization described?

Score YES, if the authors describe any method used to generate a random allocation sequence.

Score NO, if the authors do not describe the allocation method or describe methods of allocation such as alternation, case record numbers, dates of birth, day of the week, and any allocation procedure that is entirely transparent before assignment, such as an open list of random numbers of assignments.
If NO is scored, then the study is a controlled clinical trial.

Study design additional notes:
Was the method appropriate?

Score YES, if the randomization sequence allowed each study participant to have the same chance of receiving each intervention and the investigators could not predict which intervention was next. Examples of appropriate approaches include assignment of subjects by a central office unaware of subject characteristics, or sequentially numbered, sealed, opaque envelopes.

Score NO, if the randomization sequence is open to the individuals responsible for recruiting and allocating participants or providing the intervention, since those individuals can influence the allocation process, either knowingly or unknowingly.

If NO is scored, then the study is a controlled clinical trial. Types outlined below:

Controlled Clinical Trial (CCT)

An experimental study design where the method of allocating study subjects to intervention or control groups is open to individuals responsible for recruiting subjects or providing the intervention. The method of allocation is transparent before assignment, e.g. an open list of random numbers or allocation by date of birth, etc.

Cohort analytic (two group pre and post)
An observational study design where groups are assembled according to whether or not exposure to the intervention has occurred. Exposure to the intervention is not under the control of the investigators. Study groups might be non-equivalent or not comparable on some feature that affects outcome.

Case control study
A retrospective study design where the investigators gather 'cases' of people who already have the outcome of interest and 'controls' who do not. Both groups are then questioned or their records examined about whether they received the intervention exposure of interest.

Cohort (one group pre + post (before and after)
The same group is pretested, given an intervention, and tested immediately after the intervention. The intervention group, by means of the pretest, act as their own control group.

Interrupted time series
A time series consists of multiple observations over time. Observations can be on the same units (e.g. individuals over time) or on different but similar units (e.g. student achievement scores for particular grade and school). Interrupted time series analysis requires knowing the specific point in the series when an intervention occurred.

C) CONFOUNDERS

(Q1) Were important differences between groups taken into account (controlled for) in the analysis?

Yes
No
Can't tell

STUDY SPECIFIC NOTES: CONFOUNDERS

The following are examples of confounders for the young person sample.
Diagnosis; Service (inpatient/outpatient, community care); Medication use; diagnosis of mental health problem (Green, 2006)

RATE THIS SECTION	STRONG	MODERATE	WEAK
See dictionary	1	2	3

DICTIONARY: CONFOUNDERS

By definition, a confounder is a variable that is associated with both the independent variable and the dependent variable. The authors should indicate if confounders were

controlled in the design [by stratification or matching] or in the analysis. There should be no obvious dissimilarities between groups that may account for differences in outcomes.

STUDY SPECIFIC NOTES: CONFOUNDERS

While specific definitions may vary, in essence a confounding variable fits the following four criteria, here given in a hypothetical situation with variable of interest "V", confounding variable "C" and outcome of interest "O":

1. *C is associated (inversely or directly) with O*
2. *C is associated with O, independent of V*
3. *C is associated (inversely or directly) with V*
4. *C is not in the causal pathway of V to O (C is not a direct consequence of V, not a way by which V produces O)*

Examples of controlling for confounders in analysis include comparing groups (e.g. t-test) to check for differences if one group not included in analysis; partial correlation; controlling for variables in regression; covariates in ANCOVAs

(Q1) *If some attempt to control for confounders in either analysis or design rate as 'yes' (NB., where there are more than two analyses in one paper, if control for confounders in only one (e.g. regression but not t-tests) still rate yes).*

C: CONFOUNDERS SCORING

Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2).
Moderate: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1).
Weak: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) or control of confounders was not described (Q1 is 3).

D) DATA COLLECTION METHODS

D1) Therapists characteristic's measure

(Q1) Were the data collection tools for therapist's characteristics shown to be valid?

Yes
No
Can't tell
Not applicable – service use data*

(Q2) Were the data collection tools for therapist's characteristic's shown to be reliable?

Yes
No
Can't tell
Not applicable – service use data*

**Therapist's characteristics may be measured using a demographic form which may not be psychometrically validated. Alternately, characteristics may be captured by using a specific measure of an observable characteristic i.e. using humour, which will need to measured using a validated tool.*

D2.1) Alliance measure

(Q1) Were the data collection tools for therapeutic alliance shown to be valid?

Yes
No
Can't tell
Not applicable

(Q2) Were the data collection tools for therapeutic alliance shown to be reliable?

Yes
No
Can't tell
Not applicable

D2.2) : OUTCOME MEASURE

(Q1) Were the data collection tools for outcome measure(s) shown to be valid?

Yes*
No
Can't tell
Not applicable – service use data**

(Q2) Were the data collection tools for outcome measure(s) shown to be reliable?

Yes

No
Can't tell
Not applicable – service use data**

* if outcome is dropout or engagement in services then use outcome measure

** Service use measures (e.g. hospital admission, length of stay, types of services used etc.) tend to be rated from medical case notes or other clinical records and assessment tools are not typically psychometrically validated. Service use assessment tools are therefore rated as 'not applicable' in the questions relating to their validity and reliability.

DICTIONARY: DATA COLLECTION METHODS

Tools for primary outcome measures must be described as reliable and valid. If 'face' validity or 'content' validity has been demonstrated, this is acceptable. Some sources from which data may be collected are described below:

Self- reported data includes data that is collected from participants in the study (e.g. completing a questionnaire, survey, answering questions during an interview, etc.).
Assessment/Screening includes objective data that is retrieved by the researchers. (e.g. observations by investigators).
Medical Records/Vital Statistics refers to the types of formal records used for the extraction of the data.

Reliability and validity can be reported in the study or in a separate study. For example, some standard assessment tools have known reliability and validity.

STUDY SPECIFIC NOTES: DATA COLLECTION METHODS

Data collection ratings will be made for measures relevant to the review question. For the purpose of this study, the component has been divided into two subcomponents: 1) therapists characteristics measure(s); and 2) alliance or outcome measure(s). Ratings will be conducted in relation to the therapist's characteristics measure(s) and the outcome(s) of interest only (and not in relation to other reported measures). If the outcome of interest is 'dropout', then the dropout quality assessment will be used.

For both subcomponents, if there is more than one measure and one is valid/ reliable and the other is not valid/ reliable, rate 'no'. All measures have to have some indication of validity/reliability to rate 'yes'.

If papers have used reliable and validated outcome measures but have translated these into another language or modified them, these modified versions would need to have demonstrable validity/reliability

For the therapist's characteristics, where studies have used a demographic form to capture the characteristic of interest, then this can still be rated as valid/ reliable based on theoretical literature relating to that form.

D1: DATA COLLECTION METHODS SCORING – Therapist Characteristic

Strong: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have been shown to be reliable (Q2 is 'yes').

> *For service use data, a strong rating is given when a validated or published rating scale has been used to extract data from clinical case notes or medical records.

Moderate: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have not been shown to be reliable (Q2 is 'no') **or** reliability is not described (Q2 is 'can't tell').

> *For service use data, a moderate rating given when data has been extracted from clinical case notes or medical records; **or** if more than one data source has been used (e.g. case notes and interview) but none of these meet criteria for a strong rating.

Weak: The data collection tools have not been shown to be valid (Q1 is no) **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell').

> *For service use data, a weak rating is given when data has been obtained through self-report assessment tools or interviews; **or** if the assessment tool has not been described.

D2.1: DATA COLLECTION METHODS SCORING – Alliance

Strong: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have been shown to be reliable (Q2 is 'yes').

> *For service use data, a strong rating is given when a validated or published rating scale has been used to extract data from clinical case notes or medical records.

Moderate: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have not been shown to be reliable (Q2 is 'no') **or** reliability is not described (Q2 is 'can't tell').

> *For service use data, a moderate rating given when data has been extracted from clinical case notes or medical records; **or** if more than one data source has been used (e.g. case notes and interview) but none of these meet criteria for a strong rating.

Weak: The data collection tools have not been shown to be valid (Q1 is no) **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell').

> *For service use data, a weak rating is given when data has been obtained through self-report assessment tools or interviews; **or** if the assessment tool has not been described.

D2.2: DATA COLLECTION METHODS SCORING – OUTCOME

Strong: The data collection tools have been shown to be valid (Q1 is ‘yes’); **and** the data collection tools have been shown to be reliable (Q2 is ‘yes’).

> *For service use data, a strong rating is given when a validated or published rating scale has been used to extract data from clinical case notes or medical records.

Moderate: The data collection tools have been shown to be valid (Q1 is ‘yes’); **and** the data collection tools have not been shown to be reliable (Q2 is ‘no’) **or** reliability is not described (Q2 is ‘can’t tell’).

> *For service use data, a moderate rating given when data has been extracted from clinical case notes or medical records; **or** if more than one data source has been used (e.g. case notes and interview) but none of these meet criteria for a strong rating.

Weak: The data collection tools have not been shown to be valid (Q1 is no) **or** both reliability and validity are not described (Q1 and Q2 is ‘can’t tell’).

> *For service use data, a weak rating is given when data has been obtained through self-report assessment tools or interviews; **or** if the assessment tool has not been described.

E) WITHDRAWALS AND DROP-OUTS (if applicable)

(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?

Yes
No
Can’t tell
Not Applicable (i.e. one time surveys or interviews)

(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).

80 -100%
60 - 79%
less than 60%
Can’t tell
Not Applicable (i.e. Retrospective case-control)

RATE THIS SECTION	STRONG	MODERATE	WEAK	
See dictionary	1	2	3	Not Applicable

DICTIONARY: WITHDRAWALS AND DROP-OUTS

(Q1) *Score **YES** if the authors describe BOTH the numbers and reasons for*

withdrawals and drop-outs.

*Score **NO** if either the numbers or reasons for withdrawals and drop-outs are not reported.*

***(Q2)** The percentage of participants completing the study refers to the % of subjects remaining in the study at the final data collection period.*

STUDY SPECIFIC NOTES: WITHDRAWALS AND DROP-OUTS

****Rating not applicable for one time point cross-sectional studies – only rate for longitudinal studies***

***(Q1)** If withdrawals are not referred to in the paper, and the 'n' included in the analysis is the same as the 'n' for the original sample, presume there are no drop outs.*

**Consider how many were included in the analysis. If the 'n' in the reported results (e.g. tables) is different to the original 'n' but the authors do not explicitly report the withdrawals/drop-outs/missing data in the text then rate as 'no'. If they report the numbers but do not give reasons then also report as 'no'. Must report both for a rating of 'yes'.*

E: WITHDRAWALS AND DROP-OUTS SCORING

Strong: will be assigned when the follow-up rate is 80% or greater (Q2 is 1).
Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q2 is 5 (N/A).
Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Not applicable = no follow up (not longitudinal)

F) ANALYSES

(Q1) Was the quantitative analysis appropriate to the research question and the statistical methods appropriate for the study design?

Yes

No

Can't tell

STUDY SPECIFIC NOTES: ANALYSES

** Consider this rating in terms of whether the analysis was appropriate and reported in a way that it is clear how it illuminates the research questions*
**Rate yes if some level of clarity. If score yes, can then score strong or moderate depending on extent to which appropriate and reported in such a way that it is clear how answers aims/ research questions (see scoring).*
**When assessing whether the analysis was appropriate for the question asked, consider sample size and power analyses, type of statistical test, correcting for Type I error (e.g. conservative p value, using Bonferroni adjustment where multiple comparisons) and handling of skewness (e.g. transformation) and missing data (e.g. listwise deletion, imputation).*

**Consider whether the authors report analysis clearly – Is the analysis clearly reported? (I.e. is there an analysis section in the methods or is the analysis sufficiently described in the results?) Are relevant statistics presented? Do the authors report and justify decisions (e.g. power analysis for sample size and p values)? Do the authors report the distribution of data and skewness statistics? Do the authors report missing data?*

F. ANALYSES SCORING

Strong: will be assigned when the analysis is appropriate and reported in a way that it is clear how it illuminates the research questions (Q1 is *yes*). *The authors provide a clear description of analysis and report relevant information, such as that relating to sample size estimates/power analysis, statistical test, choice of p value, skewness and missing data.*

Moderate: will be assigned when the analysis is appropriate but is not reported in a way that it is clear how it illuminates the research questions (*Q1 is yes or can't tell)*. *The analysis is appropriate but it is not reported clearly and/or is missing relevant information relating to sample size estimates/power analysis, statistical test, choice of p value, skewness and missing data.*

Weak: will be assigned when the analysis is not appropriate, or it is not clear (*Q1 is no or can't tell). The analysis is not appropriate or the analysis seems appropriate but it is reported in such a way that it is unclear how it relates to the research question and no relevant information relating to the analysis is provided.*

NB in the original version of the tool, the analysis section was omitted from the global scoring but it is included in our adapted version*

Additional guidance (italicised text) has been added to the anchor points to aid scoring

SCORING

COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A	**Selection bias**	**Strong**	**Moderate**	**Weak**
		1	**2**	**3**
B	**Study Design**	**Strong**	**Moderate**	**Weak**
		1	**2**	**3**
C	**Confounders**	**Strong**	**Moderate**	**Weak**
		1	**2**	**3**
D	**Data collection method**	**Strong**	**Moderate**	**Weak**
D1)	***Therapist Characteristic***	**1**	**2**	**3**
D2.1)	***Alliance***	**1**	**2**	**3**
D2.2)	***Outcome***	**1**	**2**	**3**
E	**Withdrawals and dropouts**	**Strong**	**Moderate**	**Weak**
		1	**2**	**3**
F	***Analysis***	**Strong**	**Moderate**	**Weak**
		1	**2**	**3**

GLOBAL RATING FOR THIS PAPER (circle one):

1 STRONG (no WEAK ratings)
2 MODERATE (one WEAK rating)
3 WEAK (two or more WEAK ratings)

With both reviewers discussing the ratings:

Is there a discrepancy between the two reviewers with respect to the component (A-E) ratings?

If yes, indicate the reason for the discrepancy

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

Final decision of both reviewers (circle one):

1 STRONG
2 MODERATE
3 WEAK

Component Ratings of Study:
For each of the six components A – F, use the following descriptions as a roadmap.

A: SELECTION BIAS SCORING

Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) and there is greater than 80% participation (Q2 is 1).
Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); and there is 60 - 79% participation (Q2 is 2). 'Moderate' may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell).
Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); or there is less than 60% participation (Q2 is 3) or selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).

B: STUDY DESIGN

Strong: will be assigned to those articles that described RCTs and CCTs.

Moderate: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series.

Weak: will be assigned to those that used any other method or did not state the method used.

C: CONFOUNDERS SCORING

Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); or (Q2 is 1).
Moderate: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) and (Q2 is 2).
Weak: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) and (Q2 is 3) or control of confounders was not described (Q1 is 3) and (Q2

is 4).

D1: DATA COLLECTION METHODS SCORING – Therapist characteristic

Strong: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have been shown to be reliable (Q2 is 'yes').

Moderate: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have not been shown to be reliable (Q2 is 'no') **or** reliability is not described (Q2 is 'can't tell').

Weak: The data collection tools have not been shown to be valid (Q1 is no) **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell').

D2.1: DATA COLLECTION METHODS SCORING – Alliance

Strong: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have been shown to be reliable (Q2 is 'yes'); **AND** the measure of size is adequate (Q3 is 'yes').

Moderate: The data collection tools have not been shown to be valid or reliable (Q1 and Q2 is 'yes'); **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell'); **OR** the measure of size is inadequate **or** not sufficiently described (Q3 is 'no' or 'can't tell).

Weak: The data collection tools have not been shown to be valid or reliable (Q1 and Q2 is 'yes'); **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell'); **AND** the measure of size is inadequate **or** not sufficiently described (Q3 is 'no' or 'can't tell).

D2.2: DATA COLLECTION METHODS SCORING – outcome

Strong: The data collection tools have been shown to be valid (Q1 is 'yes'); **and** the data collection tools have been shown to be reliable (Q2 is 'yes'); **AND** the measure of size is adequate (Q3 is 'yes').

Moderate: The data collection tools have not been shown to be valid or reliable (Q1 and Q2 is 'yes'); **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell'); **OR** the measure of size is inadequate **or** not sufficiently described (Q3 is 'no' or 'can't tell).

Weak: The data collection tools have not been shown to be valid or reliable (Q1 and Q2 is 'yes'); **or** both reliability and validity are not described (Q1 and Q2 is 'can't tell'); **AND** the measure of size is inadequate **or** not sufficiently described (Q3 is 'no' or 'can't tell).

E: WITHDRAWALS AND DROP-OUTS SCORING

Strong: will be assigned when the follow-up rate is 80% or greater (Q2 is 1).
Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) **OR** Q2 is 5

(N/A).
Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Not applicable = no follow up (not longitudinal)

F. ANALYSES SCORING

Strong: will be assigned when the analysis is appropriate and reported in a way that it is clear how it illuminates the research questions (Q1 is *yes*). *The authors provide a clear description of analysis and report relevant information, such as that relating to sample size estimates/power analysis, statistical test, choice of p value, skewness and missing data.*

Moderate: will be assigned when the analysis is appropriate but is not reported in a way that it is clear how it illuminates the research questions (*Q1 is yes or can't tell)*. *The analysis is appropriate but it is not reported clearly and/or is missing relevant information relating to sample size estimates/power analysis, statistical test, choice of p value, skewness and missing data.*

Weak: will be assigned when the analysis is not appropriate, or it is not clear (*Q1 is no or can't tell)*. *The analysis is not appropriate or the analysis seems appropriate but it is reported in such a way that it is unclear how it relates to the research question and no relevant information relating to the analysis is provided.*

****NB in the original version of the tool, the analysis section was omitted from the global scoring but it is included in our adapted version****

****Additional guidance (italicised text) has been added to the anchor points to aid scoring***

Appendix D: Author Guidelines for Child and Adolescent Mental Health Journal

Why submit to *Child and Adolescent Mental Health*?

- An international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health
- Ranked in ISI: 2018: 75/124 (Pediatrics); 109/146 (Psychiatry); 93/142 (Psychiatry, Social Science); 78/130 (Psychology, Clinical).
- 6,239 institutions with access to current content, and a further 7,939 institutions in the developing world
- High international readership - accessed by institutions globally, including North America (25%), Europe (39%) and Asia-Pacific (13%)
- Excellent service provided by editorial and production offices
- Opportunities to communicate your research directly to practitioners
- Every manuscript is assigned to one of the Joint Editors as decision-making editor; rejection rate is around 84%
- Acceptance to Early View publication averages 6 weeks
- Simple and efficient online submission – visit http://mc.manuscriptcentral.com/camh_journal
- Early View – articles appear online before the paper version is published. Click here to see the articles currently available
- Authors receive access to their article once published as well as a 25% discount on virtually all Wiley books
- All articles published in CAMH are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF)

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice; Narrative Matters; Debate Articles.

Original Articles: Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice.

Review Articles: These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health.

Measurement Issues: These papers aim to evaluate evidence-based measurement tools and issues in child mental health disorders and services.

Innovations in Practice: These papers report on any new and innovative development that could have a major impact on evidence-based practice, intervention and service models.

Narrative Matters: These papers describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences.

Debate Articles: These papers express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice

Clinical Conundrums: Clinical Conundrums provides an opportunity to publish educational articles that challenge mental health professionals in their clinical work.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original submission, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: **http://mc.manuscriptcentral.com/camh_journal** and c*heck for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal c*reate a new account.* Help with submitting online can be obtained from the Editorial Office at ACAMH (email: **publications@acamh.org**)

4. Authors' professional and ethical responsibilities

Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Preprints
CAMH will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article. Please find the Wiley preprint policy **here**.

Note to NIH Grantees
Pursuant to NIH mandate, Wiley-Blackwell will post the accepted version of contributions authored by NIH grant-holders to PubMed Central upon acceptance. This accepted

version will be made publicaly available 12 months after publication. For further information, see **www.wiley.com/go/nihmandate**.

Recommended guidelines and standards
The Journal requires authors to conform to CONSORT 2010 (see **CONSORT Statement**) in relation to the reporting of randomised controlled clinical trials; also recommended is the **Extensions of the CONSORT Statement** with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission. Trials must be registered in one of the ICJME-recognised trial registries:

Australian New Zealand Clinical Trials Registry
Clinical Trials
Netherlands Trial Register
ISRCTN Registry
UMIN Clinical Trials Registry

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis.

The **Equator Network** is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work **http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields** and on quasi-experimental **http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research** and mixed method designs **http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond**

CrossCheck
An initiative started by *CrossRef* to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s) and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Key Practitioner Message: Below the Abstract, please provide 1-2 bullet points answering each of the following questions:

- **What is known?** - What is the relevant background knowledge base to your study? This may also include areas of uncertainty or ignorance.
- **What is new?** - What does your study tell us that we didn't already know or is novel regarding its design?
- **What is significant for clinical practice?** - Based on your findings, what should practitioners do differently or, if your study is of a preliminary nature, why should more research be devoted to this particular study?

Keywords: Please provide 4-6 keywords use **MeSH Browser** for suggestions

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at **http://authorservices.wiley.com/bauthor/english_language.asp**. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributorships differ between author group. (All authors must share responsibility for the final version of the work submitted and published; if the study include original data, at least one author must confirm that he or she had full access to all the data in the study and takes responsibility for the integrity of the data in the study and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

10. For referencing, *CAMH* follows a slightly adapted version of APA Style **http:www.apastyle.org/**. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.
See **http://authorservices.wiley.com/bauthor/illustration.asp** for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

Data Sharing and Supporting Information

CAMH encourages authors to share the data and other artefacts supporting the results in the paper by archiving them by uploading it upon submission or in an appropriate public repository. Examples of possible supporting material include intervention manuals, statistical analysis syntax, and experimental materials and qualitative transcripts.

1. If uploading with your manuscript please call the file 'supporting information' and reference it in the manuscript.
2. Please note supporting files are uploaded with the final published manuscript as supplied, they are not typeset.
3. On publication your supporting information will be available alongside the final version of the manuscript online.
4. If uploading to a public repository please provide a link to supporting material and reference it in the manuscript. The materials must be original and not previously published. If previously published, please provide the necessary permissions. You may also display your supporting information on your own or institutional website. Such posting is not subject to the journal's embargo date as specified in the copyright agreement. Supporting information is made free to access on publication.

Full guidance on Supporting Information including file types, size and format is available on the **Wiley Author Service** website.

For information on Sharing and Citing your Research Data see the **Author Services website here**.

Original Articles

Original Articles make an original contribution to empirical knowledge, to the theoretical understanding of the subject, or to the development of clinical research and practice. Adult data is not usually accepted for publication unless it bears directly on developmental issues in childhood and adolescence.

Your Original Article should be no more than 5,500 words including tables, figures and references.

Review Articles

Research Articles offer our readers a critical perspective on a key body of current research relevant to child and adolescent mental health and maintain high standards of scientific practice by conforming to systematic guidelines as set out in the **PRISMA statement**. These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Your Review Article should be no more than 8,000 words excluding tables, figures and references and no more than 10,000 including tables, figures and references.

Measurement Issues

These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office **publications@acamh.org** with an outline proposal.

Your Measurement Issues article should be no more than 6,000 words excluding tables, figures and references and no more than 8,000 including tables, figures and references.

Innovations in Practice

Innovations in Practice promote knowledge of new and interesting developments that have an impact on evidence-based practice, intervention and service models. These might have arisen through the application of careful, systematic planning, a response to a particular need, through the continuing evolution of an existing practice or service, or because of changes in circumstances and/or technologies. Submissions should set out the aims and details of the innovation including any relevant mental health, service, social and cultural contextual factors, and give a close, critical analysis of the innovation and its potential significance for the practice of child and adolescent mental health.

Due to the short length of this article type, your Innovations in Practice article should be no more than 2,200 words including tables, figures and references and contain no more than 8 references.

Narrative Matters

Narrative Matters describe important topics and issues relevant to those working in child and adolescent mental health but considered from within the context and framework of the Humanities and Social Sciences. The topics can include aspects of child mental health service history; representations of abnormal mental states or mental illness in children and teenagers in film, literature or drama; depictions of child mental health clinicians within popular culture; ethical dilemmas in the specialty. Interest and originality are valued. If in doubt, please contact the section editor **Gordon.Bates@covwarkpt.nhs.uk**.

Due to the short length of this article type, your Narrative Matters article should be no more than 1,800 including tables, figures and references and contain no more than 8 references.

Debate Articles

Our debate articles express opposing points of view or opinions, highlighting current evidence-based issues, or discuss differences in clinical practice. Although discussion of evidence is welcome, these articles generally do not include primary data. The evidence on which your arguments are based and how that was sourced should be explicit and referenced, and the quality of your evidence made clear.

Due to the short length of this article type, your Debate article should be no more than 1,000 words and contain no more than 8 references. If in doubt, please contact the section editor **Rachel.Elvins@mft.nhs.uk**

Clinical Conundrums

Clinical Conundrums provides an opportunity to publish educational articles that challenge mental health professionals in their clinical work. The articles should be based on genuine clinical scenarios and might include consultations with experts. The clinical scenarios should be unusual, go beyond the established evidence base, be easily missed or have serious consequences. The goal of Clinical Conundrums is to provide CAMH readers with a new knowledge on assessment and management of challenging clinical scenarios. We welcome submissions from all specialities and we especially welcome submissions from teams of authors representing different specialities or working in different healthcare settings. Authors will need to submit written consent from every patient, parent, carer or next of kin, regardless of whether the patient can be identified.

Your Clinical Conundrums article should be no more than 2,500 words, contain no figures/tables in the main text but only as supplementary information for publication online, and contain no more than 8 references. If in doubt, please contact the CAMH editorial office at **Prabha.Choubina@acamh.org**.

Manuscript Processing

Peer Review Process: All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE **http://publicationethics.org/resources/guidelines** and ICMJE **http://icmje.org/** best practice.

Proofs

Authors will receive an e-mail notification with a link and instructions for accessing HTML page proofs online. Page proofs should be carefully proofread for any copyediting or typesetting errors. Online guidelines are provided within the system. No special software is required, all common browsers are supported. Authors should also make sure that any renumbered tables, figures, or references match text citations and that figure legends correspond with text citations and actual figures. Proofs must be returned within 48 hours of receipt of the email. Return of proofs via e-mail is possible in the event that the online system cannot be used or accessed.

Offprints: Free access to the final PDF offprint of your article will be available via Wiley's Author Services only. Please therefore sign up for Author Services if you would like to access your article PDF offprint and enjoy the many other benefits the service offers.

Should you wish to purchase additional copies of your article, please visit http://offprint.cosprinters.com/cos/bw/ and follow the instructions provided. If you have queries about offprints please email:offprint@cosprinters.com.

Copyright: If your paper is accepted, the author identified as the corresponding author for the paper will receive an email prompting them to log into Author Services where, via the Wiley Author Licensing Service (WALS), they will be able to complete a license agreement on behalf of all co-authors of the paper.

Article Preparation Support

Wiley Editing Services offers expert help with English Language Editing, as well as translation, manuscript formatting, figure illustration, figure formatting, and graphical abstract design – so you can submit your manuscript with confidence. Also, check out our resources for **Preparing Your Article** for general guidance about writing and preparing your manuscript.

Article Promotion Support

Wiley Editing Services offers professional video, design, and writing services to create shareable video abstracts, infographics, conference posters, lay summaries, and research news stories for your research – so you can help your research get the attention it deserves.

For authors who do not chose OnlineOpen

If the OnlineOpen option is not selected, the corresponding author will be presented with the Copyright transfer Agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the Copyright FAQs **here**.

For authors choosing OnlineOpen

If the OnlineOpen option is selected, the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

Creative Commons Attribution License OAA

Creative Commons Attribution Non-Commercial License OAA

Creative Commons Attribution Non-Commercial-NoDerivs License OAA

To preview the terms and conditions of these Open Access Agreements please visit the Copyright FAQs **here** and click **here** for more information.

If you select the OnlineOpen option and your research is funded by certain Funders [e.g. The Wellcome Trust and members of the Research Councils UK (RCUK) or the Austrian Science Fund (FWF)] you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with your Funders requirements.

For more information on this policy and the journal's compliant self-archiving policy please click **here**.

Liability

Whilst every effort is made by the publishers and editorial board to see that no inaccurate or misleading data, opinion or statement appears in this journal, they wish to make it clear that the data and opinions appearing in the articles and advertisements herein are the sole responsibility of the contributor or advertiser concerned. Accordingly, the publishers, the editorial board and editors, and their respective employees, officers and agents accept no responsibility or liability whatsoever for the consequences of any such inaccurate or misleading data, opinion or statement.

Appendix E: Letter of ethical approval

Dr Samantha Hartley
Senior Clinical Psychologist, NIHR/HEE ICA Clinical Lecturer
Pennine Care NHS Foundation Trust & University of Manchester
The University of Manchester,Division of Psychology and Mental Health |Faculty of Biology, Medicine
2nd Floor Zochonis Building, Brunswick Street, Manchester
M13 9PL

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

05 July 2019

Dear Dr Hartley

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Therapeutic Relationships In Child and Adolescent Mental Health Services (TRIC Study)**
IRAS project ID:	**257749**
Protocol number:	**1**
REC reference:	**19/NW/0251**
Sponsor	**University of Manchester**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The document "After Ethical Review – guidance for sponsors and investigators", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **257749**. Please quote this on all correspondence.

Yours sincerely,
Rachel Katzenellenbogen
Approvals Specialist

Email: hra.approval@nhs.net

Copy to: Ms Lynne Macrae, University of Manchester

Microsoft Exce

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Contract/Study Agreement template [TRIC Sponsor Agreement]	1	10 September 2018
Copies of advertisement materials for research participants [TRIC_SocialMedia_Example]	1	27 March 2019
Copies of advertisement materials for research participants [TRIC_Poster_Advert]	TRIC_Poster_V2	31 May 2019
Costing template (commercial projects) [Insurance Costing]	1	29 March 2019
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [TRIC Insurance]	1	29 March 2019
HRA Schedule of Events [SoE]	1	16 April 2019
Interview schedules or topic guides for participants [TRIC_TopicGuide_Phase2]	1	27 March 2019
Interview schedules or topic guides for participants [TRIC_DelphiStatements_Phase1]	1	27 March 2019
IRAS Application Form [IRAS_Form_02042019]		02 April 2019
Letter from funder [NIHR funding letter]		31 January 2018
Letter from sponsor [TRIC_Letter from sponsor]	1	29 March 2019
Organisation Information Document	1	
Other [DemographicInfo_Staff]	1	27 March 2019
Other [TRIC_WebsiteLandingPage_Phase1]	1	27 March 2019
Other [DemographicInfo_Carer]	1	27 March 2019
Other [DemographicInfo_Adolescent]	1	27 March 2019
Other [SignpostingInfo_Adolescents]	1	27 March 2019
Other [SignpostingInfo_Carer]	1	27 March 2019
Other [SignpostingInfo_Staff]	1	27 March 2019
Other [DelphiEmail_Phase1]	1	27 March 2019
Other [Study_Risk_Assessment]	1	29 March 2019
Other [TRIC_DataManagementPlan]	1	27 March 2019
Other [Clinical Trials_Malpractice Insurance]	1	29 March 2019
Participant consent form [TRIC_ConsentForm_Phase1_Word]	1	27 March 2019
Participant consent form [TRIC_ConsentForm_Phase1_onlineversion]	1	27 March 2019
Participant consent form [TRIC_ConsentForm_Phase2_word]	1	27 March 2019
Participant information sheet (PIS) [TRIC_Phase1_PIS]	TRIC_Phase1_V2_clean copy	31 May 2019
Participant information sheet (PIS) [TRIC_Phase2_PIS]	TRIC_Phase2_V2_clean version	31 May 2019
Participant information sheet (PIS) [Phase 2 tracked]	2.0	31 May 2019
Participant information sheet (PIS) [Phase 1 tracked]	2.0	31 May 2019
Research protocol or project proposal [TRIC_Protocol]	1	29 March 2019
Summary CV for Chief Investigator (CI) [Chief Investigator CV]		
Summary CV for student [Rachael Ryan CV]	1	29 March 2019
Summary CV for student [Samiran Idrees CV]	1	29 March 2019

Summary CV for supervisor (student research) [Dr Katherine Berry CV]	1	29 March 2019
Summary CV for supervisor (student research) [Dr Jasmine Hearn CV]	1	29 March 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [TRIC_CollaboratorsIndurananceCover]	1	28 November 2018

IRAS project ID	257749

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
This is a non-commercial study with a single participating NHS organisation.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	As per the Organisation Information Document no funding will be provided to the participating organisation.	A Principal Investigator is expected to be in place at the participating organisation.	For research team members that do not have existing contractual relationships with the participating organisation, Honorary Research Contracts should be in place if the activities undertaken at the NHS site involve contact with patients (e.g. to take consent), on the basis of Research Passports (if University employed) or NHS to NHS confirmation of pre-engagement checks letters (if NHS employed). The pre-engagement checks should include enhanced DBS checks and Occupational Health Clearance. No specific pre-engagement checks are required to have taken place if the members of the research team are only accessing patients' data.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated they intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix F: Participant Information Sheet

Therapeutic Relationships in Child and Adolescent Mental Health Services (CAMHS) Study: The TRIC Study

Participant Information Sheet (PIS): Phase 1

Version: 2.0

This PIS should be read in conjunction with Privacy Notice for Research (http://documents.manchester.ac.uk/display.aspx?DocID=37095)

You are being invited to take part in a research study about relationships between people who go to, or work in Child and Adolescent Mental Health Services (CAMHS). Before you decide whether or not to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully before deciding whether to take part and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

About the research

Who will conduct the research?

There are two parts to the research. This information sheet will outline the first phase which Rachael Ryan, a Trainee Clinical Psychologist on The University of Manchester Clinical Psychology Doctorate programme, will conduct. Dr Katherine Berry and Dr Samantha Hartley supervise this research. They are Clinical Psychologists and researchers at The University of Manchester.

There is a second phase of the research, which will be briefly covered in this information sheet. This phase is being led by Dr Samantha Hartley and colleagues from Manchester Metropolitan University called Dr Jasmine Hearn and Samiran Idrees. Additional information can be provided at a later stage if you are interested in this phase.

What is the purpose of the research?

The overall study aims to ask young people, parents/ carers of children who have accessed CAMHS, and staff who have worked in CAMHS about the relationships between the young people, families and the staff.

Phase 1: A Delphi study

A ‘Delphi’ study is a way of asking key ‘expert people’ their opinion on a topic. The topic of this study is relationships between young people, people who work at CAMHS and family members. You will be asked to read sentences about this topic, and say if you agree or disagree with them. Researchers then add up how many people agree with each sentence or not. We will ask you to rate how much you agree with sentences up to three times and give you feedback on if other people agreed or not.

Phase 2: A consensus conference

A small number of people (young people, carers, researchers, clinicians), including some of those who have been involved in Phase 1 will be invited to take part in a meeting to discuss the best way to support good therapeutic relationships.

Why are there two phases?

The first phase is finding out what is important to therapeutic relationships in CAMHS, and the second phase is to develop a way of helping build strong therapeutic relationships.

What is the purpose of the study and what happens next?

The reason we are running this study, is to find out from young people, parents/caregivers and staff who work at CAMHS, what is important about the relationship they have with each other. No one has asked people about relationships in CAMHS in this way, or combined the answers from these different ‘expert’ groups of people before.

The purpose of the Phase 1 is to find out what is important in these relationships and what is not. Additionally, we want to find out how good relationships can be built. We know that if young people and staff have good relationships with each other, then this makes talking about problems easier and more likely to benefit young people and their families.

We also want to develop a way of supporting good working relationships, which is the focus of Phase 2.

What will happen to the findings?

We hope to share the findings from the study with families and staff that have contact with Child and Adolescent Mental Health Services in order to help inform practical relationships and guidelines. The information will be shared in both academic journals, by email to you if you opt in, posters in CAMHS services, at team meetings and conferences/ workshops.

Disclosure and Barring Service (DBS) Check

All researchers working on this study who have access young people and potentially vulnerable adults have undergone a satisfactory DBS check.

Who has reviewed the research project?

This project was initially reviewed by the University of Manchester Research Sub-Committee of the Faculty of Biology, Medicine and Health on 15th October 2018, and approved on 20th November 2018. Additionally, all research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Greater Manchester Central Research Ethics Committee on 3rd July 2019.

Who is funding this research project?

This research is part of a bigger study looking at relationships in CAMHS and is funded by the National Institute of Health Research and Health Education England, and is led by a member of the research team (Dr Hartley). Specifically, Phase 1 has also received funding from the University of Manchester as part of a Clinical Psychology Doctoral Thesis.

What would my involvement be?

Why have I been invited to take part?

You have been invited to take part because you have an 'expert' opinion. This is because you are either a young person, a parent or caregiver who has been to CAMHS or a member of staff who has worked in CAMHS. You have had experience of the relationships we are studying, and so we want to hear your views. We plan to invite 30 young people, 30 parents/caregivers and 30 members of staff to Phase 1. Every participant will be informed about the findings of the study if they wish, once it is complete.

What will I be asked to do if I take part?

Phase 1: We will ask you to completing a brief online questionnaire, rating the importance of key parts of relationships in CAMHS. This should take approximately 15-20 minutes. You will then be asked if you would mind rating them again in a few weeks' time and so invited to leave your email address. We will send you a link via email to complete again. The second time you rate them; you will be shown overall how much other people agreed or disagreed with that sentences. Then one final time a few more weeks later, we will send you a link via email and you will be asked to rate the sentences again. We invite you to rate them up to three times, so you have the opportunity to think through if you are happy with your answer compared to other people. You don't have to change you answer at any stage.

If you were interested in taking part in Phase 2, we will ask you to leave your email address so we can send you more information. This stage would involve meeting in a group to discuss relationships in CAMHS and potentially being interviewed about the process.

Will I be compensated for taking part?

All participants are invited to leave their email address to be entered into a prize draw for Phase 1. There will be a prize of £50 Amazon voucher for each expert group (i.e. one young person, one parent/ carer, one staff member will win a voucher). Participants can be included in the draw, regardless of how many rounds of Phase 1 you complete. We will contact you if you win the prize draw via the contact information you share.

What happens if I do not want to take part or if I change my mind?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason and without disadvantage to yourself. However, it will not be possible to remove your data from the project once it has been anonymised and forms part of the dataset, as we will not be able to identify your specific data. This does not affect your data protection rights.

Data Protection and Confidentiality

What information will you collect about me?

In order to undertake the research project we will need to collect the following personal information/data about you:

- Name
- Age
- Gender
- Ethnic Group
- Relationship to person accessing CAMHS (parent/carer only)
- Profession (staff only)
- Duration accessing or working in CAMHS (if applicable)
- Type of service accessed/worked in (i.e. community/inpatient etc.).

All responses to Delphi statements are kept on an online secure server, at the University of Manchester. Any direct quotes to free-text answers may be used as part of the study report, but

these will not include your name. If you choose to provide your email address to be entered into the prize draw or to receive a summary of our findings, your email address will be kept strictly confidential in an encrypted (safely coded) document. Once you have received your study summary and the prize draw has been drawn, your email address will be deleted from all files. Your email address will also be deleted at any stage if you decide to stop taking part.

All other details you provide will be stored under your unique identifying number, known only to the research team. All individuals involved with this process would have a strict duty of confidentiality to you as a research participant. This will ensure that your identity is protected. Your consent forms will be kept in on a secured server (also password protected) or in a locked cabinet at the University of Manchester. These will be kept for either 10 years after study completion or 5 years after the last publication from the study. This is for audit (checking) purposes.

The information you provide rating your Delphi statements will be collected and compared to other participants taking part in the research, to see how much you agree or disagree with others. These answers cannot be linked with your contact details and so there is no identifiable comparison taking place. Researchers at the University of Manchester will complete this comparison.

All members of the research team have completed Good Clinical Practice training and the research is being supervised/ led by a qualified clinical psychologist who is compliant with HCPC regulations and NHS policies and procedures. If examples of bad practice are identified and there is risk of poor clinical care/ safeguarding concerns, the researcher will have a duty of care to report these. The researchers will utilise supervision to discuss these issues.

Occasionally, University of Manchester, NHS Trust or regulatory authorities might need to carry out a study audit (check) or monitoring visit to check that the study was carried out as planned. These checks would involve looking at all the information collected during the study, including your personal data.

Under what legal basis are you collecting this information?

We will collect and store personal information in accordance with the General Data Protection Regulation (GDPR) and Data Protection Act 2018, which legislate to protect your personal information. The legal basis upon which we are using your personal information is “public interest task” and “for research purposes” if sensitive information is collected. For more information about the way we process your

personal information and comply with data protection law please see our Privacy Notice for Research Participants (http://documents.manchester.ac.uk/display.aspx?DocID=37095)

The University of Manchester, as Data Controller for this project, takes responsibility for the protection of the personal information that this study is collecting about you. In order to comply with the legal obligations to protect your personal data the University has safeguards in place such as policies and procedures. All researchers are appropriately trained and your data will be looked after in the following way:

The study team at the University of Manchester will have access to your personal identifiable information, this is data which could identify you, but they will anonymise it as soon as is practicable. However, your consent form and contact details will be retained for either 10 years after study completion or 5 years after the last publication from the study, whichever is greater. These will be stored on a secure server on the computer, in a password protected file at the University of Manchester or in a locked filing cabinet, in a locked room, accessible by members of the research team only.

You have a number of rights under data protection law regarding your personal information. For example you can request a copy of the information we hold about you. This is known as a Subject Access Request. If you would like to know more about your different rights, please consult our privacy notice for research (http://documents.manchester.ac.uk/display.aspx?DocID=37095) and if you wish to contact us about your data protection rights, please email dataprotection@manchester.ac.uk or write to The Information Governance Office, Christie Building, University of Manchester, Oxford Road, M13 9PLfor guidance on the process of exercising your rights.

You also have a right to complain to the Information Commissioner's Office (https://ico.org.uk/make-a-complaint/).

Will my data be used for future research?

When you agree to take part in the research study, the information about you may be provided to researchers running other research studies in this organisation and who are running research similar to this study i.e. about mental health. We will specifically ask you if this is ok on our consent form.

These organisations may be universities, NHS organisations or companies involved in health and care research in this country or abroad. Your information will only be used by organisations and researchers to conduct research in accordance with the UK Policy Framework for Health and Social Care Research (https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/).

This information will not identify you and will not be combined with other information in a way that could identify you. The information will only be used for the purpose of health and care research, and cannot be used to contact you regarding any other matter or to affect your care. It will not be used to make decisions about future services available to you.

What if I want to make a complaint?

In the event that something does go wrong and you are harmed during the research you may have grounds for a legal action for compensation against the University of Manchester or Pennine Care NHS Foundation Trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

If you wish to make a complaint, please contact the Chief Investigator:

Dr Samantha Hartley

University of Manchester,

Division of Psychology and Mental Health,

Zochonis Building,

Oxford Road,

Manchester,

M13 9PL

Email: TRIC_study@manchester.ac.uk

Telephone:0161 716 1153

Formal Complaints

If you wish to make a formal complaint or if you are not satisfied with the response you have gained from the researchers in the first instance then please contact:

The Research Governance and Integrity Manager, Research Office, Christie Building, University of Manchester, Oxford Road, Manchester, M13 9PL, by emailing: research.complaints@manchester.ac.uk or by telephoning 0161 275 2674.

What do I do now?

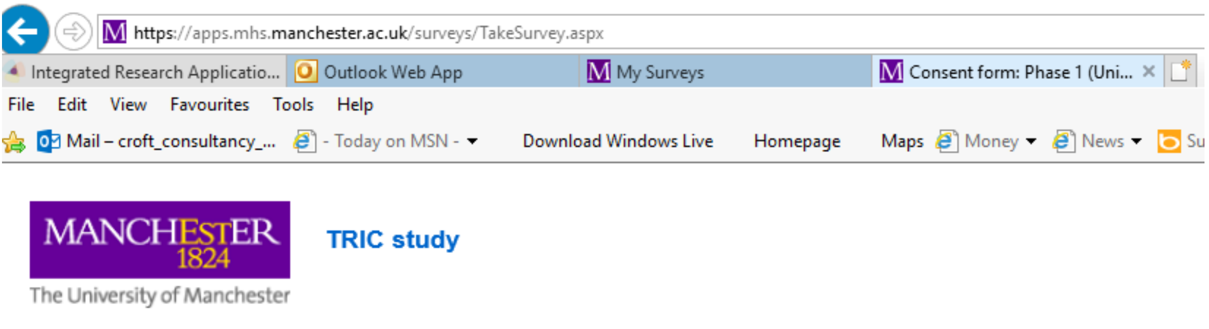
Thank you for reading this information sheet and for considering taking part in this research.

If you wish to participate you need to complete the consent form on the following page.

If you would like further information, or have any questions or concerns about any aspect of this study, please contact the research team:

TRIC_study@manchester.ac.uk

Appendix G: Participant consent form (screenshot)



Page 2 of 3

Title of Project: The TRIC study: Therapeutic Relationships in Child and Adolescent Mental Health Services. Please read the following questions carefully. Please click yes or no to the following options:

1. I confirm that I have read the attached information sheet (Version XX, Date dd/mm/yyyy) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

   ○ Yes ○ No

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without disadvantage to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part in phase one on this basis.

   ○ Yes ○ No

3. I agree that any data collected may be published in anonymous form in academic books, reports or journals.

   ○ Yes ○ No

4. I understand that data collected during the study may be looked at by individuals from The University of Manchester or regulatory authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

   ○ Yes ○ No

5. I agree that any anonymised data collected may be shared with researchers within the University and at other institutions.

   ○ Yes ○ No

6. (Optional) I agree that researchers team may keep my contact details in order to provide me with a summary of the research.

   ○ Yes ○ No

7. (Optional) I agree that researchers team may keep my contact details in order to enter me into the prize draw.

   ○ Yes ○ No

8.

I agree to take part in this study.

○ Yes ○ No

9.

(Optional) I consent to be contacted to take part in Phase 2 and understand that only a small selection of people will be invited to attend

○ Yes ○ No

10.

Participant email address

Data Protection

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants by following this link http://documents.manchester.ac.uk/display.aspx?DocID=37095

11.

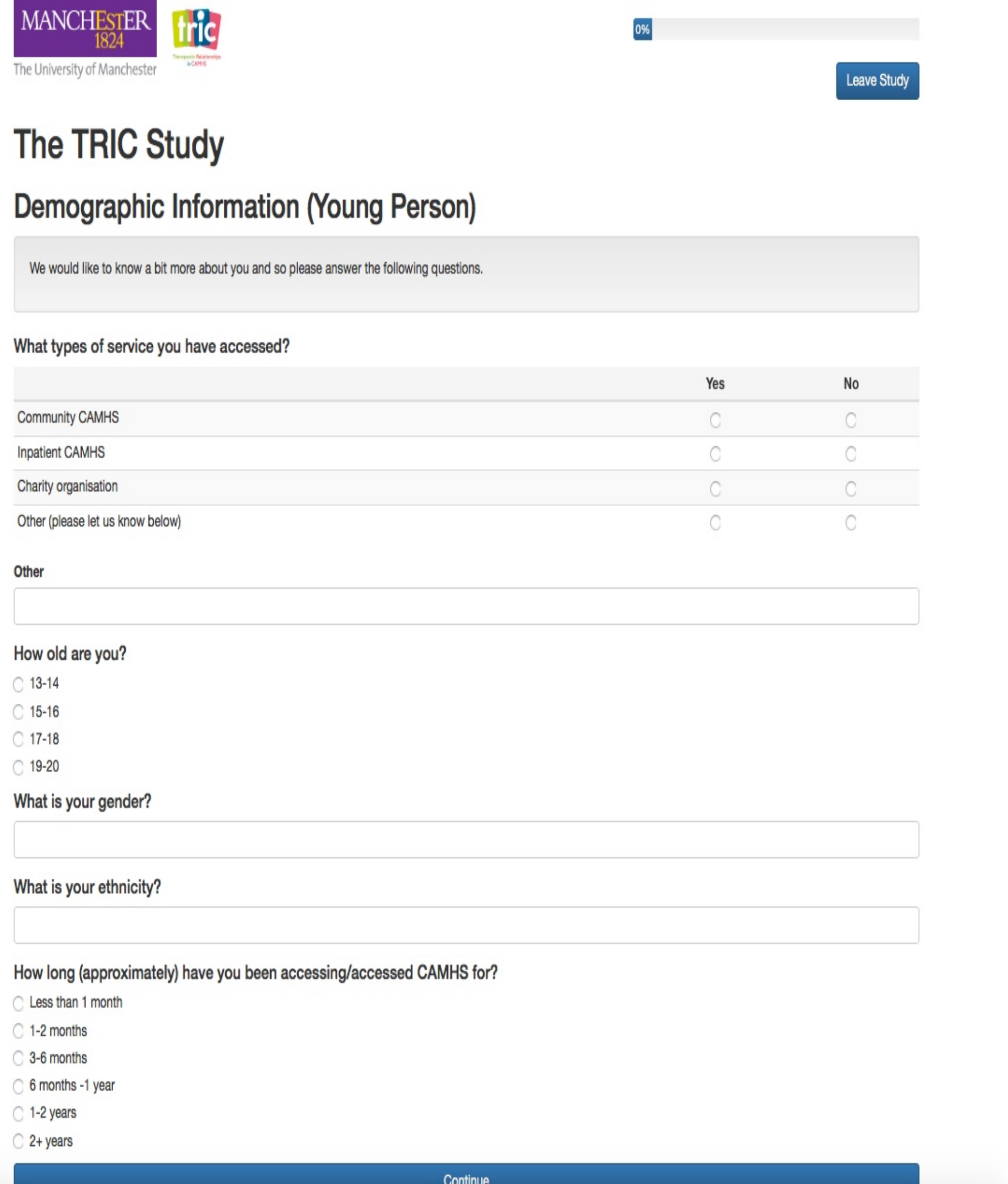
Please complete the following

Participant Name	Date

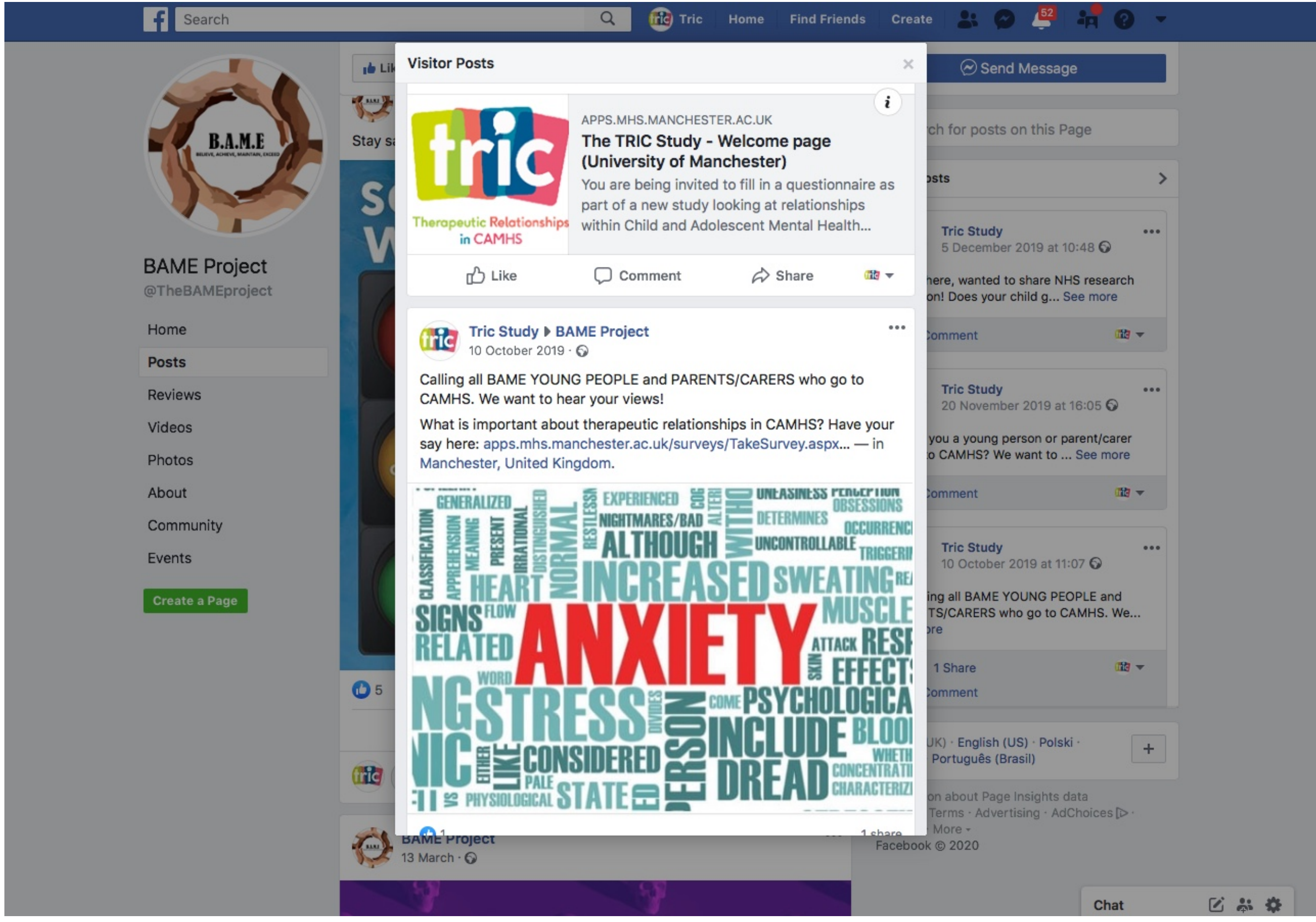
Back Next Save Cancel

| Disclaimer | Privacy | Copyright notice | Accessibility | Freedom of information |

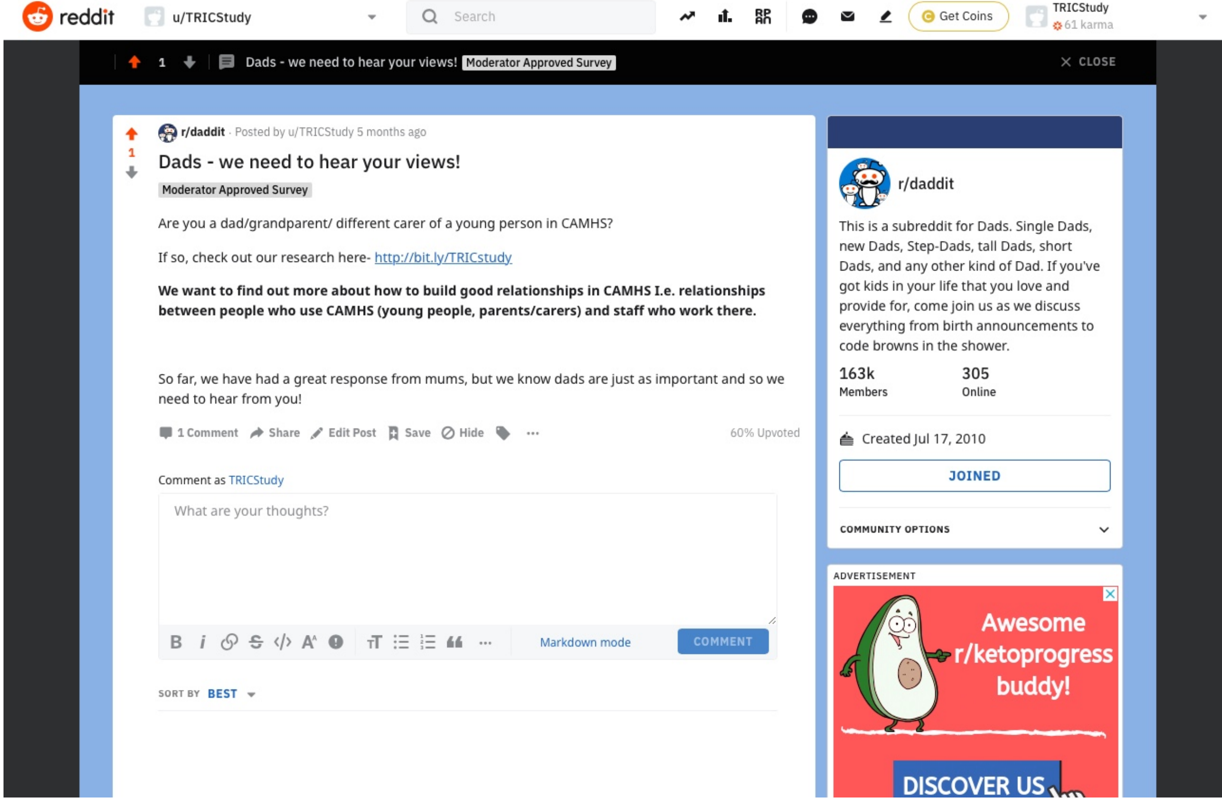
Appendix H: Demographic questionnaire (example of young person screen shot)



Appendix I: BAME social media post



Appendix J: Fathers social media post



Appendix K: Feedback from young people and staff on study image

Feedback: Nursing staff and young people were asked on the adolescent inpatient ward about which logo they preferred. They preferred logos 2 and 4. They liked the multiple colours of both. They particularly liked the speech bubble and the letters were clear in 2. For 4 they liked the colours but the letters seemed less clear (some found the 'I' difficult to see). Overall, they thought you should go with 2.

1

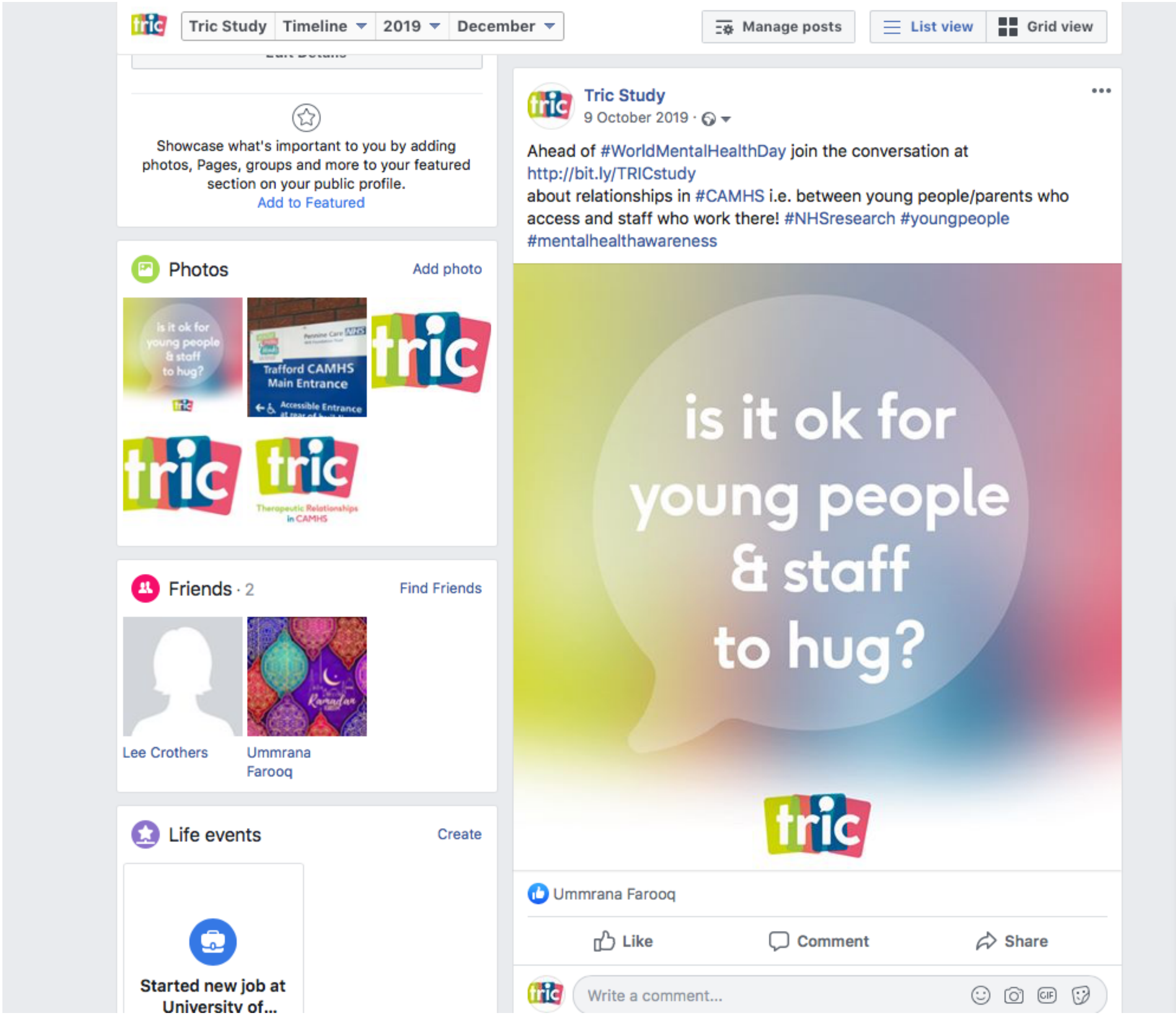
2

3

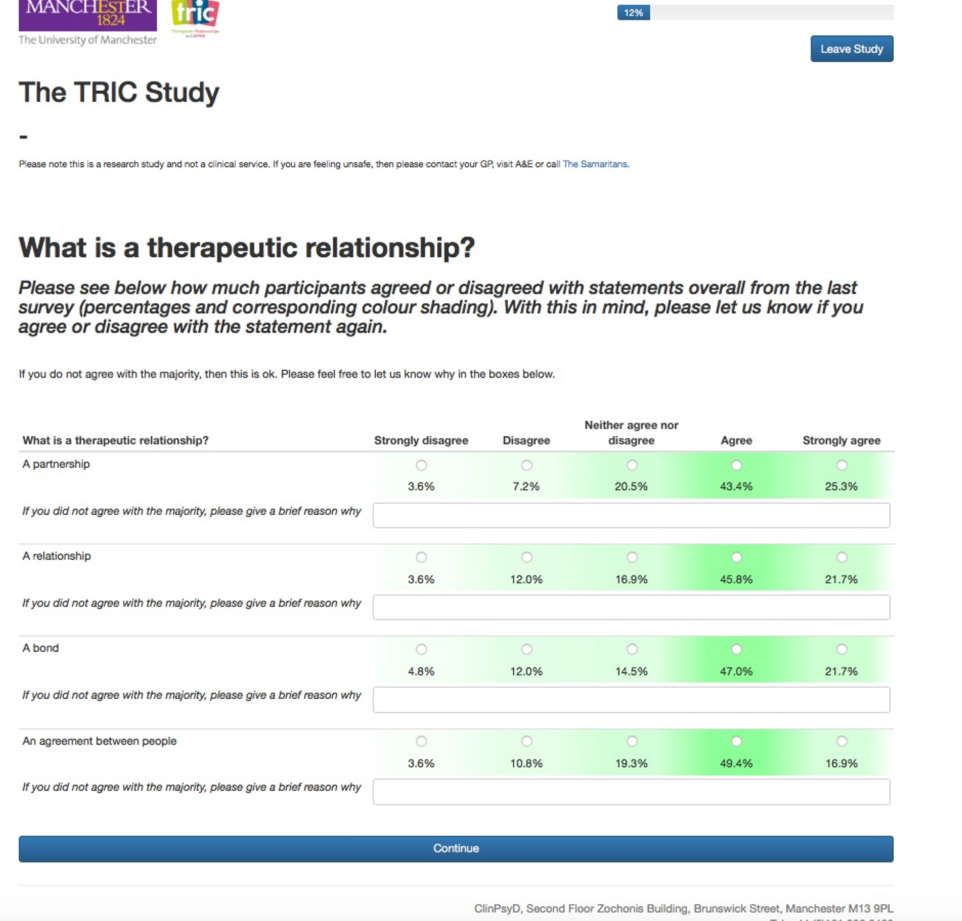
tric
therapeutic relationships in camhs

4

Appendix L: Social media post (Delphi statement)



Appendix M: Delphi questionnaire (example of page one, round three screen shot)



MANCHESTER 1824 The University of Manchester

12%

Leave Study

The TRIC Study

-

Please note this is a research study and not a clinical service. If you are feeling unsafe, then please contact your GP, visit A&E or call The Samaritans.

What is a therapeutic relationship?

Please see below how much participants agreed or disagreed with statements overall from the last survey (percentages and corresponding colour shading). With this in mind, please let us know if you agree or disagree with the statement again.

If you do not agree with the majority, then this is ok. Please feel free to let us know why in the boxes below.

What is a therapeutic relationship?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
A partnership	3.6%	7.2%	20.5%	43.4%	25.3%
If you did not agree with the majority, please give a brief reason why					
A relationship	3.6%	12.0%	16.9%	45.8%	21.7%
If you did not agree with the majority, please give a brief reason why					
A bond	4.8%	12.0%	14.5%	47.0%	21.7%
If you did not agree with the majority, please give a brief reason why					
An agreement between people	3.6%	10.8%	19.3%	49.4%	16.9%
If you did not agree with the majority, please give a brief reason why					

Continue

ClinPsyD, Second Floor Zochonis Building, Brunswick Street, Manchester M13 9PL
Tel: +44 (0)161 306 0400

Appendix N: List of excluded Delphi statements

A table of excluded items

Statement	OVERALL agree	OVERALL disagree	Round excluded
What is a therapeutic relationship			
A holistic approach*	67	4	3
Showing empathy for each other*	65	10	3
One person largely giving the support and the other mostly receiving the support*	61	16	3
An exchange of personal information, predominantly one way*	49	22	3
A professional friendship*	47	35	3
Feeling what another person is experiencing	35	46	2
What helps build a good therapeutic relationship			
If the staff member likes the young person/parent	69	10	3
If sessions can happen at school/college	66	6	3
If the young person/parent gets back to the staff member the same day if they have called	66	2	3
If pictures are used to help understand the work	64	2	3
If the parent/carer can stop the session if they want to	60	18	2
If the staff member is seen as important by the parent/carer	59	14	2
If the staff member tells the young person or parent/carer why they do their job	59	19	2
If the session “picks-up where it left off” the next time the young person or parent/carer and staff member meet	58	11	2
If the young person initiates (starts) the discussion	58	3	2
If the young person or parent/carer have an outdoor space to talk with staff	58	6	2
If things talked about by the parents/carer to the staff member are kept private from young people (unless harm is imminent)	58	19	2
If staff and young people play games together when they meet	58	11	2
If the parent/carer is compassionate to others	58	6	2
If the staff member initiates (starts) the discussion	56	2	2
If sessions are held at the same time/place*	56	11	3
If conversations are written down	55	15	2
If the staff member reveals something about themselves	55	13	2
If the staff member does not show if they are upset	52	23	2
If the young person and staff member make an emotional attachment	51	26	2
If the young person is compassionate to others	50	11	2
If the staff member talks to different family members	49	14	2
If the staff member is the young person's ally	48	30	2

If staff and the young person or parent/carer have informal chats on corridors	44	23	2
If the staff member is there for the young person or parent/carer immediately if they need them	44	34	2
If the goal of "the work" is the parent/carer's	35	39	2
If the parent/carer initiates (starts) the discussion	31	15	2
If the goal of "the work" is the staff member's	30	48	2
If the staff member has been in the job more than a year	29	29	2
If the staff member is the parent/carers ally	28	38	2
If the parent/carer and staff member make an emotional attachment	25	39	2
If staff members give the young person or parent/carer a hug	23	41	2
If young people/parents don't tell staff members everything about each other	22	39	2
If staff and the young person or parent/carer only talk in the therapy room	18	47	2
If the working relationship is formal	17	52	2
What hinders a good therapeutic relationship?			
If the parent/carer has a lack of power in the relationship	69	11	3
If the staff member has a lack of power in the relationship	60	14	2
If the parent/carer acts in a defensive way during the work together	60	18	2
If the parent/carer is seen as the expert	56	28	2
If the staff member is seen as an expert	49	37	2
If the young person acts in a defensive way during the work together	44	30	2
If young people and staff members make decisions and don't include the parent/carer	44	35	2
If the parent/carer is showing a lot of anxiety during the work	39	44	2
If the young person is seen as the expert	35	47	2
If the young person is showing a lot of anxiety during the work	30	54	2
If the staff member asks things that are too personal	30	44	2
If meetings take place somewhere that is too quiet	21	53	2
If the staff members gives a hug to a young person or parent/carer	21	44	2
If the parent/carer initiates (starts) the discussion	14	58	2

Appendix O: Statements suggested by participants and rationale for inclusion/ exclusion

Question asked:

What is a therapeutic relationship?

Please add any more definitions of therapeutic relationships below if they are not already included:

Results:

Additional statement	Included	Why	Statement generated
A sense of safety, reliability and consistency	Yes	Because these are not already covered in definitions of a therapeutic alliance but are descriptive words of relationships	• A sense of safety • A sense of reliability • A sense of consistency
A mutually agreed alliance and understanding that each party will show respect, empathy, and be non-judgemental with the aim of working towards a collaborative goal.	Yes - partly	Because these are not already covered in definitions of a therapeutic alliance but are descriptive words of relationships. Not included joint co-operation as this response is already included and reached agreement on	• Showing respect for each other • Showing empathy for each other • A sense of consistency
An ongoing connection between two people with boundaries for the professional and the service user.	Yes	Talks about boundaries. Removed the idea of it being between two people, and also the professional and service user as these are not phrases currently used. I rephrased to family and staff member	· A relationship with boundaries
Non-judgemental, respectful	No	Already included from previous suggested statements	N/A
I think a therapeutic relationship is about having a genuine connection with a client in which there is a sense of trust and collaboration in terms of working together towards a mutually	Yes, partly.	Included sense of trust. Not included others comments as they are already included in statements	· A sense of trust

agreed goal. I think empathy by the therapist and boundaries/agreements around what is expected from both parties also helps to strengthen this.			
Open honest conversation, empathy	Yes, partly	Included is an open and honest conversation. Not included empathy as already included from other suggestion	· Is an open, honest conversation
Safe relationship where a person can feel contained and supported to explore experiences and work towards changes	No	Already included in other suggestions	N/A
Collaborative, boundaries, empathetic	No	Already included in other suggestions	N/A
Being able to openly talk about what the issues are, being honest	No	Already included in other suggestions	N/A
Open communication built through time, patience and actions that develop a strong level of trust and security	No	Already included in other suggestions	N/A
Respectful relationship A positive connection	No	Already included in other suggestions	N/A
I think that a therapeutic relationship should include some sort of connection/bond/trust, because if such doesn't occur a young person may not be able to feel like they can express their emotions to a full extent, I think that the therapist or whoever they are seeing should be welcoming and able to get the patients attention and explain things clearly so they understand what going on, they should be friendly so the patient	No	Already included in other suggestions and then not appropriate to include what happens if it doesn't occur	N/A

feels like they can actually trust them. However I don't think it should be an emotionally attached kind of relationship if that makes any sense, in a way that one becomes way too attached as a patient eventually needs to be able to manage things on their own with gained skills.			
Non-judgemental and trustworthy, almost like a professional friendship	Partly	Majority already included. Used statement of a professional friendship	· A professional friendship
A supportive non-judgemental relationship	No	Already included in other suggestions	N/A
A more holistic approach	Yes	A new generation of idea	A holistic approach
Non judgemental	No	Already included in other suggestions	N/A
Mutual respect, understanding	No	Already included in other suggestions	N/A
Respect (Mutual)	No	Already included in other suggestions	N/A
Trusting, Facilitating, Empowering	Partly	A sense of trust already included in previous suggestion. Facilitating is not included as not a definition but more of a process. Empowering included as new statement	· A sense of empowerment
A strong professional relationship	No	Already included in other suggestions of strength or professional relationship	N/A
The professional is in a supporting role. There is mutual respect and regard for each other and the purpose of the relationship. Generally, I find young people can only benefit from a therapy/intervention if they like/respect the person in the helping role. An agreement where one person is in a position of power	No	Already included through being supportive, mutual respect and purpose of relationships. Trust and empowerment are new statement generated from others. Position of power is described further in statements about what builds a good relationship, rather than contributing to	N/A

and trust, where their role is to empower another person / other people.		the definition.	
A relationship where one person is supporting another, where the exchange of personal information is predominantly one way. One person largely gives the support and the other mostly receives the support.	Partly	Support already covered in other statements. Added exchange of personal information as this is new. The giving and receiving of support is also added. Not sure about this though as it talks about it being a supportive relationship already.	· An exchange of personal information, predominantly one way. · One person largely giving the support and the other mostly receiving the support.
Supportive working relationship	No	Already included in other statements	N/A

Question asked:

What helps to build a good therapeutic relationship?

Please add any more ideas of what builds therapeutic/working relationships below if they are not already included:

Results:

Statement	Included	Why	Statement generated
If staff member is willing to allow, and encourage, open channels of communication. If a staff member explains the best ways to communicate with them out with appointments, e.g. email, and advises of a likely timescale for response.	Yes	New statement	• If staff member is willing to allow, and encourage, open channels of communication • If a staff member explains the best ways to communicate with them about appointments, e.g. email, and

			advises of a likely timescale for response.
Clear expectations of the therapeutic relationship are discussed so all parties are aware of what is expected from them	Yes	New statement – combined with statement below	N/A
Humour can help sometimes (if the situation is appropriate). Non-problem talk can also be beneficial. Being collaborative rather than prescriptive. Having regular sessions (same time/place if possible) helps set expectations around when the client/family will see you, which can help. Flexibility can also help - e.g. in terms of re-arranging missed appointments, returning calls Following through on what you say you're going to do in a timely manner helps build relationships I think	Yes	To humour. Non-problem talk already included. Having sessions at it time and place included. Flexibility included. Also staff member saying what they are going to do in a timely manner also included	• If humour is sometimes used (when appropriate) • Having regular sessions (same time/place) • If the staff member is flexible in terms of re-arranging missed appointments, returning calls • If the staff member follows through on what they say they're going to do in a timely manner

Acceptance of the person and their experiences not matter what they are ability to have difficult conversations	Partly -	Acceptance of difficulties included, but difficult conversations not as already included in phrase "talk about the right problems"	• If the staff member shows acceptance of the persons difficulties
I think it depends on the young person a lot of the time. So sometimes I will be more relaxed / boundaries etc. etc. depending on what fits the YP and what they're coming with	Not included	As feels like a reflection and not transferable	N/A
Having a common ground Sharing a like of something/someone	Not included	As already have comment about hobbies in statements	N/A
Trust, understanding	No	Already included in suggestions	N/A
Working to build trust in both the child and parents by allowing all voices to be heard in separate circumstances to facilitate a thought provoking growth process. Support councillors for carers	Yes, partly	Trust included but not included voices heard as already a statement	• If there is trust between the family members and staff
A knowledge of the education system for the member of staff The member of staff understanding the local areas	Yes	New statement	• If the staff member knows about local services i.e. schools

Being able to have a sense of humor. A bit of banter and a laugh is key when needed to lighten the world. For the camhs worker to seem 'human' and to some degree be able to show their emotions, interests, views and their life experiences (with some boundaries to stop it becoming inappropriate).	No	Humour already included and other comments about the staff member being human are already included as statement of "staff member not seen as perfect"	N/A
Honesty boundaries expectations are clear	No	Already included	N/A
An understanding of the work that is commencing. A mutual agreement of what is expected and what isn't e.g. lateness, completing tasks etc.	Partly	Included understanding of work that is commencing. Original statements talk about treatment plan and it being explained, but not about the rules or expectations of the working relationship	If clear expectations are discussed e.g. lateness, completing tasks etc.
If the staff member acts upon requests made If the staff member gives feedback in partnership with the young person If feedback is given about progress	Partly	Staff member acts upon requests made is already included in statement above. Not included giving feedback in partnership or in progress as these are already included in original statements of "If the young person/parent/staff	N/A

		member can give	
		honest feedback about how the work is going" – combined with statement above about clear expectations	
Appropriate personal disclosure, creatively adapting work to suit their interests/ hobbies, regular check ins /reviews of the work, addressing dynamics in sessions, responding to ruptures	Partly	Not included appropriate personal disclosure as statement "If the staff member reveals something about themselves". Included adapting work for hobbies. Similar statement asked about the staff member asking about hobbies but not quite the same question. Regular check ins is not included due to "feedback about how the work is going" statement already included above. Included dynamics, but also added hidden feelings to make it more explanatory for YP. Not sure about the "ruptures" – put it as "disagreements"	• If the staff member adapts work to include a young persons interests/hobbies • If the staff member is able to address the dynamics/unspoken feelings between them and the young person/parent in the session If the staff member is able to address disagreements in the session

Question asked:

What gets in the way of a good therapeutic relationship?

Please add any more ideas of what makes therapeutic/working relationships difficult below if they are not already included:

Results:

Statement	Included	Why	Statement generated
Repeated refusal to acknowledge queries or other communications.	Yes	New statement but following up on actions was already an agreed statement about what builds good relationships and so not included	If the staff member does not acknowledge of answer questions
Past experiences of professionals/ services	no	Not a specific statement	N/A
Not following through on agreed actions. Not listening properly to what has been said. Being overly prescriptive. Being punitive/blaming/critical. Sharing information (non-risk related), which it hasn't been agreed is ok to be shared. Not picking up on non-verbal cues from clients/families.	Yes, partly	New statements - will be broken down. Not including the statements of being prescriptive as this is covered in statement of "staff member telling the young person/parent what to do"	If information is shared which is not risk related without permission
Inconsistency, cancelled appointments	Yes	Cancelled appointments included. Not included was inconsistency as this was very broad and could be interpreted in different ways. It also does not specify who is being inconsistent or what? Time or place of appointments? Behaviour (of client or staff), emotion? (Of client). Purpose of	If appointments are cancelled regularly

		Delphi is to create definition and this needs further exploration as a concept, which is beyond the scope of this research.	
Poor planning and a lack of mutually agreed goals/ direction. A lack of honesty and empathy	No	The opposite of goals is included in “if the work has a focus or a goal”. Statements already included what hinders is lack of honesty, “if the young person, parent/carer, staff member is honest about how they feel” Opposite statement in what builds good relationships, “empathy” and “if the staff member is empathic/empathetic”	N/A
No connection	No	This is too broad. The purpose of the Delphi is to define the connections and it’s qualities	N/A
Parent excluded (unless agreed with the young person)		Parent excluded has been developed into a statement as I think this refers to parents feeling excluded as they are often in the waiting room while the young person has the appointment	If a parent/carer is excluded from sessions
Lots of cancelled of appointments	No	Already included cancellation of appointments	N/A
The staff member being only a staff member, cutting straight to the chase and doesn’t use any problem free talking to help ease into talking	Partly	This is already included in what builds a good relationship in terms on “If non-problem things are talked	If staff members talk straight away about difficult topics

about difficult stuff such as trauma, self harm or suicide attempts etc. For example for the first 5-10 minutes of the meeting, the camhs worker and the young person talk about hobbies (me and my worker both enjoyed comic books, so would often talk about new comic books, or we would talk about music, he would be a big kid and we would make silly jokes), this helped build trust. When you have a camhs worker who just says "hi, have you self harmed since last time?" without you being able to get to build up trust with them it gets hard to open up. Especially when they get annoyed at you for trying to share a joke or talk about something else. For me to be able to talk about my mental health I have to be able to trust the worker, and I struggle to do this if they simply try to do their job at face value and not show you a bit of their personality		about " and "If the staff and family members are talking about the right problems" and "If the staff member does not shy away from asking about difficult things". Purposely not put examples of trauma or self harm as don't want to be prescriptive about what difficult things are and also don't want to be triggering. – (Discussion with research team) - interpretation is staff talking straight away about difficult topics	
Noise/too quiet lack of privacy trust confidentiality	Partly	This is already covered in what might hinder good relationships, "If meetings take place somewhere that is too quiet" and " If meetings take place somewhere that is too busy" Statements generated	If there is a lack of privacy and in the session (i.e. conversations can be overheard)

		for lack of privacy /confidentiality Trust is already included in what builds good relationships	
The staff member not taking the young person seriously	No	Feel this is another version of other statements i.e. " If the staff member isn't shocked by what the young person says" and "If the staff member understands the young person's or parent/carers point of view"	N/A
If you are involved in care coordination also such as CAF, CIN meetings etc. and these get in the way of the relationship.	Yes	As this is a new potential issue discussed	If the staff member is involved in organising more than one aspect of the young person's care i.e. care coordination or decision making meetings
I find that young people generally get put off by an approach that is too formal.	No	Already included in what builds a good relationship "If the working relationship is formal"	N/A
I have also found that young people prefer not to attend Outpatient CAMHS departments that are based in hospitals	Yes	Location discussed already (school/college) but this is an additional scenario	If sessions take place in hospitals
Limited boundaries, not managing ending well	Partly	Boundaries already discussed in what builds good relationships "If the staff member has boundaries" Statement developed for not managing endings well	If ending the sessions is not managed well by the staff member

End of appendicies