Department of Health

Children Young People and Families Programme

National CAMHS Support Service

The Evidence Base to Guide Development of Tier 4 CAMHS

Zarrina Kurtz, **April 2009**

Contents

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Foreword

The National CAMHS Support Service Tier 4 Advisory group have sponsored this paper, which has been developed for us by Dr Zarrina Kurtz and hope that both providers and commissioners find it useful when thinking about current and future Tier 4 developments and the evidence base to support them.

Ever since the tiered framework for CAMHS was first used, Tier 4 was seen essentially as an inpatient service which was felt to be the necessary environment for sorting out and treating young people with the most complex needs (NHS HAS, 1995).

Until recently the idea of Tier 4 specialist CAMHS was synonymous with psychiatric inpatient provision, sometimes with day hospitals attached. Tier 4 has more recently come to be understood as multi-faceted with multi-agency services that can include inreach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as 'wrap around'. What we have seen over the past few years are innovative approaches in assessment and treatment of this most complex group of young people and the development of new intensive community focussed services.

The purpose of this paper is to present the latest information on these new developments and share with Commissioners and Providers the evidence base for development of effective services in this area.

On behalf of the National CAMHS Support Service Tier 4 Advisory Group, we hope you find the document interesting and a useful reference/resource.

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Introduction

This paper gives a summary of the evidence that is currently available and that should be taken into account for effective development of Tier 4 Child and Adolescent Mental Health Services (CAMHS). It should be read as work in progress as more evidence is becoming available at a fast growing rate. The prime focus of this evidence is community based services for children with complex needs including services that may prevent admission to and/or length of stay in inpatient care.

The evidence discussed here (in the following order) comes mainly from three sources – all reviews in one way or another of Tier 4 CAMHS:

1) A summary and analysis of Regional Reviews of Tier CAMHS undertaken across England (Kurtz, 2007)
2) A summary of the research evidence on the effectiveness of Intensive Treatment, Inpatient units, Day units and Intensive Outreach CAMHS (Green and Worrall-Davies, 2008). Another paper gives a similar and useful overview (McDougall et al, 2008)
3) Two reports that pull together the findings from evaluation of two major government programmes of CAMHS designed to address the needs of children and young people with the most severe and complex problems (Kurtz and James, 2003 & 2005; Massie, 2008).

The first source tells us what is happening in the field of Tier 4 CAMHS across the country and about innovative developments. This evidence is now two or three years out of date. The second source summarises the growing evidence base for what works in relation to models of treatment for defined conditions (Fonagy et al, 2002) and relates more directly to what CAMHS specialists do or could do when a child with a mental health disorder is referred to them. Of course the clinical imperatives for effective treatment and management of **disorders** such as eating disorders must drive the ways in which **services** function and over time lead to effective modifications in the way services operate.

The third two sources provide practice based evidence from whole-service evaluations, a still limited field. They show what works for different groups of children and give clear messages about what it takes to set up and maintain services that are effective in meeting their needs in particular about the importance of the style in which a service works.

The current picture of Tier 4 and Tier 3 services

Definition of Tier 4

Ever since the tiered framework for CAMH was first used, Tier 4 was seen essentially as an inpatient service which was felt to be the necessary environment for sorting out and treating young people with the most complex needs (NHS HAS, 1995).

However, the definition of Tier 4 varied in different regional reviews:

"For many years the idea of Tier 4 specialist CAMHS was synonymous with psychiatric inpatient provision, sometimes with day hospitals attached. Tier 4 has more recently come to be understood as multi-faceted, with multi-agency services that can include inreach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as 'wrap around' (from the Cheshire and Merseyside Review).

Many took a pragmatic definition of Tier 4 as "very specialised services in residential, day patient or outpatient settings for children and adolescents with severe and/or complex problems requiring a combination or intensity of interventions that cannot be provided by Tier 3" (as described in York and Lamb, 2005).

Tier 4 Needs

Children with Tier 4 needs frequently suffer from two or more disorders, as well as a number of factors known to increase the risk for mental health problems. The work of Rutter (1987) has established that risk conditions often occur simultaneously and the number rather than the type is predictive of outcome. Groups of children known to be at particularly high risk are shown in the box below (DoH/DfE/SSI handbook on Child and Adolescent Mental Health, 1995).

Groups at higher risk than their peers for mental health problems

- Young offenders and children from a criminal background
- Children who are being looked after by local authorities or who have recently ended a period of public care
- Children with learning difficulties
- Children with emotional and behavioural difficulties
- Children who have been sexually, physically or emotionally abused
- Children with a chronic physical illness
- Children with a physical disability
- Children with sensory impairments
- Children of parents with mental illness
- Children of parents with a substance abuse problem
- Children who have experienced or witnessed sudden and extreme trauma
- Children who are refugees.

Thus, Tier 4 must deal not only with a diagnosis of mental health disorder but also with children who, in real life, more often than not, have two or more comorbid conditions, such as learning disability **and** mental health disorder, or depression **and** a conduct disorder, **as well as** a number of risk factors.

The needs for CAMHS at Tier 4 were described in the Regional Reviews in four main ways:

i) Firstly, according to the type of **care** required by the needs of the young person, a range of types of care were described, with considerable variation in individual reviews, including emergency or acute care, intensive care, care over the medium to long term, inpatient and day patient, community based care, which includes outreach, home treatment, post-discharge and 'wrap around' services and low, medium and high secure services

ii) Secondly, a service can be described according to the type of **condition** it manages, such as eating disorder, learning disability, dual diagnosis, conduct disorders, autistic spectrum disorder

iii) Then, according to **age** group. For younger children, for older adolescents, and transition services for those about to be classified as 'adult'

iv) Lastly, according to **legal status** for young offenders and those sectioned under the Mental Health Act 1983 (and 2007 amendments).

Relationship between Tier 4 and Tier 3 and current unmet needs

For many reasons, inpatient environments have recently come to be regarded as neither necessary nor always the most effective for managing young people with these kinds of needs (O'Herlihy et al., 2001). Many specialist CAMHS at Tier 3 manage children with similar problems. However, because of a whole complex of difficulties under which Tier 3 services are

working in many parts of the country (see box below), referrals to Tier 4 are often determined by what problems Tier 3 cannot manage. The evidence for this comes from the consultation programme carried out by YoungMinds in many parts of the country over more than ten years (Kurtz et al, 2006) and from Regional Reviews of Tier 4 (see definition on previous page).

Problems experienced by Tier 3 CAMHS in recent years

- Referrals to Tier 3 have greatly risen
- They have seen an increase in both the severity and complexity of the cases presented
- They have experienced problems with the recruitment and retention of experienced staff
- The loss of social work and other staff who are key to a multidisciplinary team, such as education
- They often work from cramped, outdated and maybe difficult-to-reach facilities
- Not infrequently, they are poorly supported by management, administration and IT systems within their Trust.

In developing Tier 4 its relationship to the local Tier 3 services is the first premise. A range of elements need to be specified in specialist CAMHS commissioning, and which of these make up the local Tier 4 (accessed via Tier 3) will depend in each area upon the resources, skills and facilities already available to the local population. The Regional Reviews recognised that the dividing line between Tier 4 and Tier 3 is essentially unclear and that there is as yet, no way to make a clear distinction that is generalisable across the whole country.

Unmet needs by Tier 4 were identified from the National inpatient Child and Adolescent Psychiatry Study (NICAPS), carried out by the Royal College of Psychiatrists for the Department of Health (RCP, 2006). These were:

- Increasing referrals to inpatient CAMHS particularly significantly increased numbers of emergency referrals
- A national shortage of adolescent inpatient beds and a particular lack in developmentally appropriate provision for 16 to 18 year-olds
- The inability of services always to respond in a timely way to requests for urgent admission and the consequent inappropriate usage of paediatric and adult psychiatry wards as an interim resource. (see also OCC, 2006)

There were other reasons:

- Significant gaps in provision including long term therapeutic provision and post discharge services
- Significant problems in recruiting staff, especially nursing staff.

And there had also been much inter-agency confusion, in particular about the needs of children with conduct disorder and challenging behaviours

Analysis across all the Regional Reviews showed that **the following needs were unmet by specialist CAMHS**:

- Emergency provision
- Provision for Conduct disorders/challenging behaviour
- Intensive care facilities
- Community based provision, as a 'bridge' between Tier 3 and Tier 4 inpatients
- Low secure facilities
- Provision for young offenders
- Provision for older adolescents and transition to adult care

- There was felt to be considerable unmet need for inpatient provision for the Under 12s. O'Herlihy and colleagues found that in units that admit only children under the age of 14, there has been a 30% reduction in the beds available (123 to 86).
- A major need for Early intervention was identified
- A lack of services for those with learning disability with mental health needs was mentioned time and time again
- Services in general for Dual diagnosis and eating disorders were felt to be unsatisfactory
- Rare conditions and what may be called 'Low incidence needs', and for Autistic Spectrum Disorders (ASD), Aspergers, Attention Deficit Hyperactivity Disorder (ADHD).

The situation tends to be different in different areas within a region and with regards to different types of 'bed' and to different types of need.

Developmental approaches to meeting needs more effectively

Among all the Regional Reviews it was reported that a number of approaches had been developed in different places to tackle local unmet needs:

- Assertive Outreach teams to prevent inpatient care
- Early Intervention in Psychosis services to reduce demand for inpatient admission and length of stay
- Crisis Intervention/Home Treatment teams to support young people on discharge from inpatient units, reduce length of stay and prevent readmission. Home Treatment teams may also be successful in engaging with groups who would not typically take up Tier 4 services
- Safe houses in which comprehensive assessment may prevent a young person being diagnosed inappropriately as primarily needing psychiatric inpatient care
- Multi-disciplinary Referral Panel to reduce the level of inappropriate inpatient admissions. An on-call service, if it is linked to an appropriate specialist team, may well prevent inpatient admission. Concern was noted that the lack of on-call arrangements by Tier 3 may reflect the consultants' reluctance to be on-call because the lack of local inpatient beds means that they cannot place children.
- Peripatetic Specialist Assessment team to enable children to stay at home while ensuring that admission, if needed is made to the appropriate service
- Community based delivery of new treatment modalities, such as Dialectical Behaviour Therapy (DBT).

More details of services such as these can be found in the Reviews of individual regions and on the CSIP website: *www.cypf.csip.org.uk/camhs*

Research on Models of Care

Inpatient and Day patient care

Inpatient care

The research on inpatient care – much of it carried out in England by Jonathon Green and colleagues – confirms what the Regional Reviews make clear; that in order to optimise effectiveness, inpatient services need to change along with the development of new forms of community based services. The research gives the following messages regarding inpatient care:

- For acute risk management – in cases of harm to self and others – it can be questioned as to whether psychiatric inpatients is needed or even best for this. Something like a safe house near to the child's home is what is needed although highly specialist assessment may well be required from the staff team of an inpatient unit.
- Inpatient admission allows detailed assessment in a controlled environment and away from the family. The individualised assessment and intensive educational input possible within the inpatient unit can make a major impact with young people, often whose social adaptation within their community has broken down and who have a history of school failure.
- The individualised assessment and Intensive specialist treatment in an inpatient unit can at the very least lead to more effective use of other services post-discharge.

Removal from social difficulties in the external environment and exposure to the inpatient milieu can produce rapid gains in functioning (socialisation and academic achievement) and self-esteem. Nevertheless, young people with significant social impairments may not be able to make effective use of such a socially orientated therapeutic environment. This highlights the importance of comprehensive pre-admission evaluation of the child's suitability for treatment in a psychiatric inpatient setting. It is important that this evaluation focuses on the child's strengths and strengths in the family environment.

In recent models, the therapeutic milieu, as historically understood, has essentially disappeared and inpatient care has returned to its root in acute hospital practice, with the emphasis on symptom stabilisation and minimum necessary change before rapid discharge.

Disadvantages of inpatient care include:

- Loss of support from the child's local environment
- Presence of adverse effects within the inpatient environment
- Effects of admission on family life.

Day patient care

Day Units offer a very wide range of types of intervention, ranging from specific day programmes for young children with developmental problems as an adjunct to specialist school provision to intensive 5 day a week treatment interventions with whole families. Day units are often associated with inpatient units. The advantages of day units relate to:

- the flexibility of care that can be provided
- management of younger children
- work with the family and foster parental care
- an emphasis on education.

Effectiveness of Inpatient and Day patient treatment

The overall efficacy of Inpatient care across a range of disorders has been shown in rigorous research studies which have also shown the following predictors of outcome:

- High levels of aggressive antisocial behaviour and organic symptoms, as in schizophrenia predict poor outcome. Emotional disorders do better
- Intelligence measured as IQ shows a moderate positive effect but functional achievement may be more critical
- Pretreatment family functioning is a key predictor of outcome
- Longer treatment stays are, in general, associated with improved outcome
- For eating disorders, there are widely differing results
- For depression, suicidality and psychosis little beneficial effects of inpatient psychiatric care have been shown
- For conduct disorder, multimodal **day** treatment for children with disruptive disorders has produced significantly greater improvement in behaviour than in a control group
- In substance misuse, research shows additional benefits from community treatment
- For obsessive, compulsive disorder, poorer outcomes are found among those needing admission compared with those treated as outpatients.

Out of Hospital Approaches

A number of 'out-of-hospital' approaches are described by Green and McDougall. They note that in the UK, the development and evaluation of psychiatric home treatment has somewhat lagged behind developments in the US. However, a commitment to tackle the links between mental illness and social deprivation has been made explicit in the National Service Frameworks for Mental Health and for Children.

A review of home treatment studies found that patient and relative satisfaction was higher in home care compared with admission in adults and that carers found home care less disruptive and burdensome. Recent surveys show that young people and families want CAMHS to be delivered flexibly and in a variety of settings, including the home.

In adult mental health services a range of treatment models are now used sometimes allowing more patient choice and active involvement in care, all of which have the aim of avoiding hospitalisation where possible.

However, the disorders for which young people – especially children – are admitted vary greatly from those in adults, as does the developmental context. Assertive outreach, case management and wrap-around models have been adapted for use in children's services but developmentally specific models have been set up, such as treatment foster care and multisystemic therapy.

The following summarises each of the approaches:

Family Preservation is a home-based intensive service for families who need additional support beyond typical outpatient services. It can be used as a transitional service for families with children returning home from psychiatric admission, or to prevent admission. The aims are to improve parenting skills, promote healthy child development, prevent out-of-home area placement of children and provide or coordinate services needed to maintain family stability. Services are usually limited to weeks in duration. However, family contact with therapists is intensive during that time and almost double in residential units. One study – a randomised controlled trial – found at 1 year follow-up, more of the Family Preservation Group had sustained improvements in behaviour and symptom reduction that had those in the residential programme.

Home treatment can be summarised as a service for young people with mental illness who are in crisis and are eligible for hospital admission. Studies have shown that only about

15% of young people can safely be diverted from inpatient to home treatment, exclusion criteria for the home treatment being severe psychosis, life-threatening eating disorders, families living more than 30 km from the therapeutic unit and risk-taking behaviour. Home treatment was found to be as effective as inpatient treatment across diagnoses in reducing symptom scores and improving psychosocial functioning, both immediately after treatment and at 3-year follow-up. Compliance of the child with the therapeutic regime and the skill of the therapist were the most important predictors of therapeutic outcome.

Case management encompasses a number of approaches including assertive outreach, assertive community treatment, wrap-around and intensive community treatment. It can be defined as "a commonly used strategy for increasing access to and coordination of services within the care system". Case management is not a time-limited service, but is intended to be ongoing, providing clients with whatever they need whenever they need it for as long as necessary. This is a controversial point as some authors feel that the 'never discharge' philosophy encourages the pathologising of normal behaviours. But parallels can be drawn with overly long stays in hospital.

Most of the evidence for the effectiveness of assertive outreach is from studies with overlapping age groups of young people and working age adults. Broadly, assertive outreach is found to be effective despite concerns that fidelity to the model is not always adhered to. The key features are round the clock and daily availability of multidisciplinary team provision of services within the client's own setting. There is an emphasis on assisting the client in managing their illness, assistance with activities of daily living skills, relationship building and on crisis intervention.

Intensive case management typically targets young people with the greatest service needs and relies more on an individual rather than team approach as in assertive community treatment. It focuses on family strengths and empowering families. And case managers act as advocates, brokers between services, and coordinate, plan and implement services.

Clinical case management is one of the intensive case management models but has the weakest effect of the models. A few studies have found that while it increased hospital admissions it significantly decreased length of stay. This suggests that the overall impact is positive but might result in 'revolving door' admissions. However, randomised trials have shown that full-time case manager models are perceived as more satisfactory and allow young people to access community rather than residential-based services, compared with treatment models where the primary worker or therapist also acts as case manager.

Wrap-around helps families develop a plan to address the child's individual needs at home and school. Wrap-around addresses a child's individual needs and builds on the child's and family's strengths, so the exact services vary. Research on the effectiveness of this model is still at an early stage. But findings suggest that this broker/advocacy model results in behavioural improvements and fewer days in hospital. However, a randomised controlled trial of treatment foster care versus case management (with wrap-around components) found that outcomes were better for young people in case management interventions than for treatment foster care and at one-third of the cost.

Multisystemic Therapy (MST) was developed as an intensive family-based approach to young offenders presenting with serious antisocial behaviours and who were at risk of being placed out of their home area. Interventions are designed to promote treatment generalisation and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts. Outcomes show that staff adherence to the treatment model correlates to strong case outcomes. It has a relatively strong evidence base. Consistently positive outcomes are reported

for young offenders compared with standard outpatient treatment (reduced offending, fewer out of home placements, less substance-related offending). It has been estimated that cost savings through this almost compensate for the increased cost of the MST treatment.

Even this highly intense form of ecologically focused care, does not substitute for the need for inpatient provision, but can reduce the need, and results in enhanced outcomes over treatment as usual.

Treatment Foster Care (TFC) comprises structured therapy within a foster family setting for young people with emotional or disruptive disorders.

The evidence base comes from two well reported randomised controlled trials. Outcomes, such as improved behaviour and reduced offending behaviour, for both psychiatrically ill and offending young people were significantly better for those who received TFC than group home or hospital care. Outcomes were dependent on four main factors; the amount and type of supervision received by the young person; consistency of parental discipline; presence of a close confiding relationship with a trusted adult and not being closely linked with delinquent or deviant peers.

Conclusions

Conclusions from the Green and Worrall-Davies 2008 analysis are that there is now research evidence supporting the use of alternatives to inpatient care for certain groups of young people with mental health problems. The evidence suggests that treatment effects of several community models of care are of similar size to those obtained through residential treatment and may be sustained longer after follow up. Some models show cost savings. MST, assertive outreach and TFC have the strongest evidence bases. Green and Worrall-Davies add that assertive outreach work is largely based on older adolescents and young adults and comparisons with 'standard' treatment do not reflect a fair comparison with CAMHS 'standard' treatments, which arguably are already more 'assertive' and 'outreach' than standard adult mental health services. The evidence surrounding MST is now extending beyond use with antisocial behaviour but needs further work robustly to demonstrate effectiveness in other disorders.

As yet there is not always the evidence to decide which model is best for which group of young people. The approaches are not necessarily new nor are they necessarily distinct from other CAMHS. They are better seen as ways of working that are integrated with Tier 3 and Tier 4 and needing some residential components.

What Can be Learnt from Two Government CAMHS Development Programmes

Key elements in the types of services discussed in the two previous sources of evidence are also found in services that were evaluated in two government programmes targeted at children with complex mental health needs with recognition of the multiplicity of their needs and that these children and their families tend not to use traditional services.

CAMHS Innovation Grant Projects

The CAMHS Innovation Grant Projects by and large were well evaluated and the common findings across all 24 projects provide convincing and generalisable messages as follows:

1) In order to be accessible, acceptable and effective, services for child and adolescent mental health may need to be delivered in a non-stigmatising environment often through the voluntary sector or universal provision such as schools. It may be necessary to visit families at home, to offer outreach facilities, and to provide active support to a young person or their family in using other services with which they may be unfamiliar.
2) Special approaches may be required not only to engage disaffected young people and their families, but also others such as those from ethnic minority communities who may face particular barriers to benefiting from existing local provision.
3) Services that are to undertake such approaches need staff who are committed to working with young people and who have the proper support, training and supervision to carry out what is often intensive and sometimes dispiriting work.
4) Services need to have sufficient capacity and flexibility and their staff need to have the skills to offer an eclectic range of interventions that can meet individual needs, and to involve young people and their families and carers in planning and evaluating the interventions they receive.
5) In work with young people and families with such entrenched and complex needs, it may well be necessary to bring about changes in attitude among staff and those managing the service, so as to create sufficient time and space to think about each individual person and case on a recurrent basis.
6) Services need sufficient time to prepare thoroughly if they are to be successful in securing engagement and building a therapeutic alliance. For example they need to be able to:

- negotiate appointments and a venue for the work
- work at the pace of individual young people

- offer a broad range of activities and therapeutic approaches
- be flexible and adaptable, within a clear framework for the approach to intervention
- provide consistent messages and behaviours from professionals towards the young person, which requires good communication and a sound system for sharing information among all members of a particular service, who may be from different agencies.

7) In order to meet the needs of children, young people and their families effectively, within a local CAMHS system, the roles and responsibilities of individual services need to be clearly defined and understood. However, the working relationships between services and their collaborative input for individual clients should be as integrated and flexible as possible.

8) It is important that services working in this way are enabled to carry out reflective learning as this helps to maintain staff motivation and skills and improve practice.

9) The use of standardised measures of their problems and of the changes that have been achieved helps to increase self-awareness in young people and parents and carers, as well as understanding among everyone who works with them.

10) It is important that child and adolescent mental health services monitor their impact across all domains and not solely within relatively narrow professional and agency performance management agendas. If this can be achieved then the evidence for good practice can be critically examined by all agencies. Agencies can then pull together more effectively to ensure the delivery of good quality services.

11) Service evaluation is time consuming and labour-intensive. Care must be taken to avoid bias in the interpretation of findings and in methodological design and implementation. Although practical difficulties (and a lack of interest) may mean it is only possible to obtain the views of relatively few young people, parents and carers, it is nevertheless essential that their views are sought on a regular basis and taken into account in service development. Across all the projects, user views contributed information that was not available from other sources, providing key insights into how and why services were or were not working. See also Appendix 1.

Children's National Service Framework Development Initiatives

These 19 projects give essentially the same messages, which are set out at Appendix 2.

Relevance of the evidence discussed above for development of Tier 4

1) The effectiveness of interventions to meet the complex and often entrenched mental health needs of children and young people depends upon these young people **taking up the appropriate service, engaging with the therapeutic activity and staying with it**.

Therefore whatever is needed has to be delivered in a style that promotes take-up: non-stigmatising venue (outreach in community settings or home; voluntary sector front; prefer to be regarded as 'bad' not mad); convenient time and place; involving young person in deciding on the type of intervention and in monitoring his or her progress; building a trusted relationship with the young person.

2) Effectiveness is greatly enhanced by **intervening at the earliest stages** of possibly severe and complex problems.

This means enhancing the presence of mental health expertise in universal services and especially in services that target groups of children at known high risk of mental health problems such as looked after children and young offenders. It also means lowering thresholds for access to tradition al Tier 4 provision, perhaps in offering assessment, advice and consultation.

3) Services will be more effective if access to them is **not dependent upon crisis situations** but follows planned care pathways. Thus, inpatient admission happens as part of a continuum of care for defined clinical need.

   This means the recognition that children who have severe and complex mental health problems, essentially, have a chronic condition. In order for convincing outcomes to be demonstrated, interventions must be sufficiently long term to allow them to make an impact on multiple developmental pathways as they emerge in the midst of varying biological and environmental situations. Children and families will need advice and help at intervals during their lives. Every effort should be made to make this available, not necessarily dependent upon a formal referral; so that the young person can have ready access to a known and trusted professional before things get too serious; and so that services can work flexibly in response.

4) Effectiveness depends crucially upon a **full understanding of the needs of the child**.

   Assessment of complex, entrenched needs requires specialised expertise and may require getting to know the child over a period of time. Mild to moderate learning disability may be masked by mental health symptomatology and so may depression by acting out behaviours.

5) In order effectively to address mental health needs, it is often necessary first to help the child **tackle what may seem their more immediately pressing problems**.

   This will almost certainly mean working with their family and or school on relationships or non-attendance or poor academic performance.

6) Dealing with mental health problems is more effective if **the child's strengths, self-efficacy and resilience are promoted**.

   Again, this is dependent upon a reliable trusted relationship between therapist and child and also upon help from the child's family and school and peers.

7) Effective interventions depend above all on the staff who deliver them. **Staff need support** in working with children with severe and complex problems.

   They need reflective opportunities, consultation with relevant others and appropriate supervision of their work. The implications for service organisation and management in working with the evidence presented in this paper form the basis of a best practice implementation guide that has usefully been developed for mental health services for adults: New Ways of Working (DH, CSIP, NIMHE, 2007).

8) It must be acknowledged that the effectiveness of the service – its **outcomes – can be measured across many domains**.

   It may not show as improvement in mental health state but may, simply, in the child's being able to cope and/or move on from a difficult situation.

9) This leads to the crucial recognition that **no-one service or agency – let alone professional discipline – can make effective changes alone**.

   These very needy and expensive children are everybody's business and all the relevant children's services have to work together in order to make a real difference to their lives as children and as future adults.

Evidence from Other Studies

1) More than ten years before the CAMHS programmes were set up and evaluated in Britain, a very large, rigorously scientific, whole service evaluation was carried out in the US (Bickman et al, 1996a). The Fort Bragg study compared an integrated multiagency approach with the usual provision for children with mental health problems. The findings showed very little difference in outcomes between the approaches. However, this study highlighted the importance as an outcome, of parent and child views, which were overwhelmingly more positive among those receiving the integrated multiagency provision. And some of the most telling evidence was for the link between effectiveness and the style of therapeutic approach and service delivery. A didactic approach has been further demonstrated to be less successful than one focused on relationship building, particularly in prevention, but also when intervention needs to continue over the long term (Attride-Stirling, 2001).

   Whole service evaluation, as attempted in the English CAMHS programmes and the Fort Bragg studies, is difficult and suitable methodologies are in the process of being developed. The Fort Bragg study for example, initially demonstrated that what could be learnt from this extremely expensive study was limited to fairly broad-brush conclusions. Further studies by the same team have shown, for example, that examining a multi-agency model of care would not yield information on what was and was not effective unless the precise inputs that each child actually received were identified (BIackman et al, 1996b).

2) Multi-Systemic Therapy (MST) was also developed originally in the US, as a model for the provision of multifaceted services for children with complex needs. MST uses multiple interventions in combination as the clinical picture indicates (Henggeler and Borduin, 1990). A large number of evaluation studies have shown very promising outcomes, particularly in relation to reducing substance misuse and criminal behaviour in young people. Ongoing studies are investigating treatment processes and potential moderators of MST, and the dissemination of MST to various community settings (Henggeler et al,1997).

   A 10 year follow-up of the major randomised trials are underway and whilst this approach is regarded as having major strengths (see review by Bourduin, 1999), a number of challenges remain in its effective implementation (Fonagy et al, 2002). The combination of techniques required for effective practice is not made clear. It is not clear which techniques are essential and which are optional or how the therapist may decide between these categories. There are no unequivocal algorithms for the dosage required for the treatment to be clinically effective. Further, given the difficulties in delivering high quality care, even within a single modality, the challenge of combining these yet retaining treatment integrity, are considerable.

   In England, 10 trials of MST have been funded. Initial findings from the first of these to be established (in Cambridge and in Camden & Islington) are very positive in relation to criminal offending, antisocial behaviour, family relationships and involvement of the young person in education, but have not yet been

published. In addition, there are positive findings from an evaluation of MST, aimed at preventing more serious and long-term complications (including personality disorders) in young people with conduct disorder (Gilbert et al, 2007).

3) Dialectical Behaviour Therapy is a form of Cognitive Behaviour Therapy developed by Marsha Linehan (1983) for difficult to engage individuals who have problems controlling their emotions and behaviour. In 2007, Alec Miller and colleagues adapted this standardised programme to work with young people with multiple problems. DBT is currently the recommended treatment for borderline personality disorder and deliberate self-harm (NICE, 2004). There are programmes with positive outcomes running in Shepway, East Kent and in Oxford.

4) Systematic reviews (regarded as gold standard because any relevant RCTs are included in the analysis) have been carried out on preventive programmes for child mental health. The findings from these have been summarised in relation to the Sure Start programme (Kurtz, 2004) and are essentially the same as those from the programmes that are working with older children with complex needs. The key messages are given in Appendix 3.

5) Finally, it should be noted that a new Public Health Review Group has been set up within the Cochrane Collaboration. The focus of this group will be on complex multisectoral and community-based interventions and in particular, on building the evidence base for the effectiveness of interventions to make an impact on equity and inequalities (Doyle at al, 2008).

Discussion

The lessons in improving CAMHS that can be learnt from the programmes and studies described above cover the seven dimensions of good quality in health care provision that were set out by Maxwell in 1984.

Good quality services should be:

- Equitable
- Accessible
- Acceptable
- Appropriate
- Effective
- Ethical
- Efficient.

These dimensions are inter-related, in that equitable provision is to a greater or lesser extent, dependent upon matters of accessibility and acceptability. It cannot be seen as equitable if a service exists but is known to be poorly acceptable to the population that it serves.

Thus, the evidence required to ensure quality in service provision must take into account a range of considerations when deciding that provision is successful. It is from assessing and measuring the range of outcomes set out by Hoagwood et al. (1996) that the evidence base on 'what works' can best be derived:

Comprehensive Conceptual Model of Outcomes of Mental Health Care for Children and Adolescents	
Domains	Examples
Symptoms & diagnoses	Distractibility, impulsivity, depression, anxiety
Functioning	Capacity to adapt to the demands of home, school, and community
Consumer perspectives	Quality of life, satisfaction with care, family strain or burden
Environments	Counterpoint to functioning domain: stability of child's primary environments (marital relationships at home, classroom stability, availability of social supports)
Systems	Type, duration or change in use of services, change in restrictiveness of services, organisational relationships and co-ordination, costs and mechanisms of financing

It should be noted that the evidence that we now have in Britain remains limited in terms of the 'gold standard' for the evidence upon which the introduction of a new drug must usually depend – the randomized controlled trial (RCT), which is classified as 'quantitative' research. However, much of the evidence that is pertinent for service development comes from methods classified as 'qualitative'. "These two types of research can be distinguished in that "those engaged in qualitative research proceed by inductive methods, that is by moving from observable data to theory, whereas quantitative researchers proceed by deduction, testing theory by experiment and observation. Those engaged in qualitative research are said to focus on events in natural settings, whereas quantitative research is undertaken in experimental settings" (Graham, 2000). Graham goes on to give a very useful discussion of the strengths of both approaches.

Sir Michael Rawlins, chair of the National Institute for health and Clinical Excellence (NICE) was recently quoted from his Harveian Oration (The Independent, 16th October 2008) as saying: "Decision-makers have to incorporate judgements in reaching their conclusions. Experiment, observation and mathematics have a

crucial role to play in providing the evidential basis for modern therapeutics. Arguments about the relative importance of each are an unnecessary distraction. Hierarchies of evidence should be replaced by embracing a diversity of approaches. This is not a plea to abandon RCTs and replace them with observational studies. Rather it is a plea to investigators to continue to develop their methodologies; to decision-makers to avoid adopting entrenched positions about the nature of the evidence; and for both to accept that interpretation of evidence requires judgement."

Weisz et al (1995) explored why, to date, therapy in experiments appears to have shown larger effect sizes than therapy in clinics. They find that beneficial therapy effects are associated with three factors which are more common in research therapy than in clinic therapy: (a) the use of behavioural (including cognitive-behavioural) methods, (b) reliance on specific, focused therapy methods rather than mixed and eclectic approaches, and (c) provision of structure (eg. through treatment manuals) and monitoring (eg. through review of therapy tapes) to foster adherence to treatment plans. The authors conclude that these three factors all involve dimensions along which clinic procedures could be altered.

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Appendix 1

Summary of what works from the CAMHS Innovation Grant Projects (Kurtz and James, 2003)

Key elements in a service that 'works'

For children and young people, the service should:

- Be readily accessible, for example by offering home visiting and outreach, at times that can be negotiated to suit the service user
- Be acceptable by providing a non-stigmatising environment and being welcoming, respectful and empowering
- Fully recognise the problems of the child/young person and sensitively undertake careful standardised assessment of their needs
- Have the capability and understanding to work with the context in which the young person lives (eg for minority ethnic communities)
- Seek to engage children, young people and their parents/carers
- Address the possible need to change attitudes of young people and their parents/carers and those of the staff working in the service
- Offer a range of interventions tailored to suit individual needs, to include individual therapy as well as other therapies and practical support
- Offer advice, consultation and training to others working with children and families
- Work in close collaboration with a number of relevant disciplines and agencies
- Have the capacity to keep in touch with young people over the long term, if necessary, and to offer further short term interventions and/or arrange for other appropriate support services.

For professionals, managers and commissioners, the service needs to have:

- Clear and achievable aims, objectives and vision shared by all agencies and the staff team
- Effective and consistent leadership endorsed by all agencies
- Strong inter-agency commitment over the medium to long-term, including a steering group or strategy group willing to tackle tricky issues
- Commitment to consulting with and acting on children's and families' views
- Links with existing services within CAMHS, including the integration of the service within the CAMHS tiered framework and CAMHS development strategy
- Links with other services and initiatives outside CAMHS eg education, the voluntary sector and area based initiatives
- An ability to attract new sources of funding
- Retention of stable, multi-disciplinary staff group with opportunities for training and development
- Positive commitment to continued evaluation and audit
- Balance between providing a direct service to users and influencing the broader network.

Appendix 2

Summary of what works from the NSF CAMHS Development Projects (Massie, 2008)

- An holistic and integrated approach to young people is essential taking into account their social, education, housing, relationship and health needs
- A social and educational goal-orientated approach can be very helpful for young people with complex disorders
- Services were most effective if responding to the needs as identified by the young people and their families themselves – a true partnership and approach to service delivery
- Flexibility and responsiveness in terms of being available in community locations and outside the traditional hours of 9am-5pm
- Intensive support over time limited periods for those with complex disorders including learning disabilities and those on the Autistic Spectrum
- Training staff who work in universal service settings in order to run effective early intervention services for outreach projects
- A focus on care pathways and a single point of access to assist equity of access
- Invest to save services – almost all achieved cost efficiencies whilst also improving service responses
- User participation in different ways, for example, when receiving services a partnership approach to agreeing goals or deciding what services are needed. Informing service design through consultation with users and with other services, encouraging feedback on the services that have been delivered, participation in planning and management, especially user involvement in the membership of steering groups or recruitment panels.

What has been learned?

- Standardised measurements of change make a valuable contribution to our learning about what works in CAMHS but the findings cannot be conclusive in such short lived projects and in the absence of control groups
- Commissioners and strategists should note the importance of spending adequate time in engaging clients/patients – this was a central theme in almost all projects.

Service process and planning

What has been learned?

- Two years is a very short time for projects to become established and then to undertake effective evaluation and to produce the evidence which will inform submissions for mainstream funding. A three year period would achieve better results
- A robust needs assessment is likely to lead to more focused service provision with more chance of meeting defined objectives.

Multi-agency working:

- Partner agencies need flexibility and mutual respect for each others' approach
- A shared vision is essential to building new services
- Human resources and finance departments need to find ways of supporting multi-agency working more readily.

Steering groups:

- An important element of success is the establishment of a robust steering group to ensure that projects are well governed, adhere to stated aims and objectives, are guided through difficulties and changing circumstances, and that project leaders are supported

- Service user representatives on steering groups have the potential to hold professionals accountable for making sure that a strong user voice is considered in the whole life of the project.

Team leadership:

- Strong casework and managerial supervision is essential in supporting workers who deal with clients who have complex needs and high levels of distress
- Projects leaders need to be committed and resilient, and able to safely contain the team while allowing creativity
- A constant focus on the shared vision is essential.

Sustainability:

The projects demonstrated that the likelihood of being sustained beyond the project period is influenced by:

- Integration into strategic planning processes
- Re-engineering of local services through 'invest to save' mechanisms
- Building capability and capacity in the local workforce using the time of workers employed in the mainstream such as Primary Mental Health Workers focusing on demonstrable outcomes.

Appendix 3

Summary of the evidence for what works in preventive programmes for Child and Adolescent Mental Health

The evidence presented in the paper for Sure Start (Kurtz, 2004) is taken almost entirely from two reviews:

Peter Fonagy, Freud Memorial Professor of Psychoanalysis at University College London, reviewed the evidence for the effectiveness of preventive interventions for child and adolescent mental health to inform the Acheson report on Health Inequalities, that was commissioned by the new Labour Government in 1997 (DoH, 1997).

Professor Jacqueline Barnes, a core investigator for the National Evaluation of Sure Start at the Institute for the Study of Children, Families and Social Issues at Birkbeck College London published a review on Interventions Addressing Infant Mental Health Problems (Barnes, 2003), based on a more detailed review for the Mental Health Foundation (Barnes and Freude-Lagevardi, 2002). This majors on interventions in infants and their mothers, and organises the material in terms of the psychological theory underpinning these interventions.

There is a great deal of congruence in the conclusions drawn from these sources, so that relatively confident statements can be made about the efficacy of a variety of preventive and mental health promoting strategies in children and their families. And a major meta-analysis of primary prevention studies for the mental health of children and adolescents (quoted in Fonagy et al, 2000 and 2001) showed that effects, such as enhancing competence and reducing problems, were comparable in size to those reported for other types of psychological, health educational and behavioural interventions, eg. to prevent smoking and alcohol use in children. The evidence can be summarised as follows:

1) Most approaches have many common elements. The specific theoretical underpinnings may be less important than the behaviour of the intervenor. If they are able to engage with the parent and establish a shared perspective, agreeing that intervention is necessary, they are likely to be able to enhance parental and infant outcomes. In general, caring and protective relationships are potent protective factors against adverse outcomes. "To hug is to buffer", and this conclusion applies as much at the level of society and community intervention as it does at the level of families and individuals.
2) Whatever the theoretical background, strategies need to be flexible, taking account of family perspectives, the severity of the problem, and the environmental context. It is also important to address not only the overt parental behaviour, but the associated underlying attitudes and beliefs.
3) The question of the relative effectiveness of one treatment when pitted against another is far less relevant than the potential value of combining modes of intervention (Kazdin, in press). To achieve lasting impact with high-risk infants and parents, no single approach will have all the answers. Multi-disciplinary strategies are needed. The heterogeneity within an approach (such as psychodynamic) may be as great or even greater than the difference between one conceptual model and another. No approach has emerged as superior to other approaches. The result of reviews of outcome can better be phrased as a question rather than as an answer: how can approaches be combined to maximise effectiveness? There is much in the findings reviewed to recommend combining treatment approaches (eg. the limited effects of individual treatments, the multiple determinants of most disorders, the high prevalence of multiple problems). But identifying what combinations of treatments administered to which groups maximises efficacy requires further investigation.
4) Most professional trainings are inconsistent with this pragmatic approach. Frequently they are model-based. Most professionals have inadequate training in treatments of demonstrated efficacy.
5) A large number of mental health promotion programmes focusing on teaching interpersonal problem solving that have been carried out but appear to be only moderately effective in ameliorating problems. By

contrast, interventions which promote individuals' capacities for awareness of feelings and the causes and consequences of behaviour improve competence related to both of these and successfully reduce problems. They are particularly effective for younger children, as they are in the process of developing their capacities in emotion regulation and social cognition.

6) There is good evidence that effective programmes have in common the following features:

- **Comprehensiveness** – Successful programmes include multiple components because no single programme component can prevent multiple high risk behaviour
- **System orientation** – Interventions should be aimed at changing institutional environments as well as individuals
- **Relatively high intensity and long duration** – Successful programmes are rarely brief. Short-term programmes have, at best, time limited benefits, especially with at-risk groups. Multi-year programmes tend to have an impact on more risk factors and have more lasting effects
- **Structured curriculum** – There is no clear indication as to the 'ideal curriculum' for preventive interventions, but proactive interventions should be directed at risk and protective factors rather than problem behaviours. In this way multiple adverse outcomes may be addressed within a single programme.
- **Early commencement** – This has been shown to be essential, and intervention during pregnancy brings additional benefits.
- **Specific to particular risk factors** – It is unrealistic to hope that a generic preventive intervention will be able to reduce the risk for all psychological disorders. Prevention needs to be disorder, context and objective specific.
- **Specific training** – There is less consistency in the literature on the qualifications required to carry out preventive work. Most studies in the UK use health visitors who have a statutory obligation to visit young children and their carers.
- **Attention to maintaining attendance** – Those families most in need of early prevention programmes are likely to need high levels of support to engage in an intervention, and continued assistance to maintain attendance. In experimental programmes, they are the most likely to drop out.

7) Approaches which are based on a single conceptual model, however broad, can no longer be considered tenable for several reasons because they tend to highlight only one or two of the multiple determinants which are now known to operate in the causation of psychological disorders in children and they cannot provide adequate accounts of the complex developmental paths (vulnerabilities, risk factors and the absence of protective influences) which combine ultimately to bring about mental disorder.

Finally, there appear to be a number of necessary but not sufficient factors associated with programmes that are effective (adapted from Barnes, 2003). Primary factors work in an all or nothing manner predominantly related to engagement of the family in intervention and based on their perceptions and beliefs about its potential benefits:

- Shared decision making between the parent and therapist/intervenor
- Trust and respect in the relationship between parent and intervenor
- Non-stigmatising presentation of the intervention
- Cultural awareness and sensitivity in planning and delivering interventions
- Crisis and practical help prior to, or alongside, other forms of intervention.

If these are not addressed, it will be difficult to achieve changes in behaviour. Fine-tuning of the intervention can then be decided upon according to specific circumstances, in terms of:

- Choice of theoretical model
- Choice of intensity and duration of intervention
- Choice of timing/location – during working or out-of-work hours/home, clinic, community venue
- Choice of intervenor – professional, paraprofessional.