

CAMHS National Conference

10 July 2008 – Walkers' Stadium Leicester

**Evidence Based Practice & Practice Based Evidence in
Child & Adolescent Mental Health Services (CAMHS) –
can they be usefully combined?**

A conference by:

National CAMHS Support Service as part of the Care Services Improvement Partnership;
and CAMHS Evidence Based Practice Unit (UCL and Anna Freud Centre) (CAMHS EBPU)

CONFERENCE HANDBOOK A starting point for discussion

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Introduction

Dawn Rees, National CAMHS Implementation Lead, NCSS & Miranda Wolpert, Director CAMHS Evidence Based Practice Unit (CAMHS EBPU)

This conference, sponsored by the National CAMHS Support Service, and run in collaboration with the CAMHS Evidence Based Practice Unit, aims to explore how best to use the academic research literature AND evidence from practice to determine the best ways to promote psychological health and wellbeing of children and young people.

Using the best available evidence should inform the commissioning, provision and review of all emotional health, well being and mental health services and is promoted in all recent national policy documents relating to children and young people. This conference will provide opportunities to help you explore what evidence means and how it informs your practice, your service and most importantly, how it can help children, young people and their families.

We suggested the following questions may be relevant in this discussion:

- How do you know your practice, or that of others, is effective?
- What is evidence based practice?
- What is practice based evidence?
- Are practice based evidence and evidence based practice equally valid?
- Where do you look for evidence?
- How does evidence based practice link with outcomes based practice?
- when you are reading what you think is 'evidence', how might you critically appraise it?

This conference handbook offers thoughts on these issues from some of the speakers and from those who responded to our call for brief entries on this topic for inclusion in this conference handbook.

We are grateful to all those who took time to contribute to this important debate, and for the range of views expressed which we anticipate will be further explored in the conference itself.

Our aspiration remains for the CAMHS EBPU to develop a paper or other relevant resources based on emergent thinking from this conference that might represent a consensus on possible ways forward and that may be of relevance to those providing services, those commissioning services and those using services.

We recognise that consensus may not be possible, in which case we would hope to represent something of the range of views expressed on the day.

Please note that contributors have neither read nor commented on each others articles and some of the papers included here were written in other contexts and are reprinted with kind permission of the authors. We have not attempted to impose a coherent style or approach or to edit the contributions in any way in order to represent the full range of views expressed and which we anticipate will stimulate thought and discussion.

We therefore offer these as food for thought.

We look forward to your further thoughts and input on the day. We anticipate that there is much to debate and discuss.

Evidence Based Practice (EBP): Talking Points

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Barry Duncan, Co-Director, Institute for the Study of Therapeutic Change

I admire those who search for the truth. I avoid those who find it.
- French Motto

1. What exactly is an evidenced-based practice? It usually means an approach that has established itself better than placebo or treatment as usual in two clinical trials. Such demonstrations are nothing to write home about; intervention of nearly any kind has demonstrated its superiority over placebo for 50 years! This research tells us nothing that we already do not know: Treatment works. So, when Multisystemic Therapy (MST) says that it is an evidence based practice, it only means that it is better than no treatment or treatment as usual, not any other systematically-applied form of treatment. When Ontario implemented MST province-wide, they found that MST was no better than treatment as usual (probation officer visits in this case) as did an independent meta-analysis conducted by the Cochrane/Campbell foundation. Is MST worth the cost of implementation?
2. What does the “evidence” touted by proponents really tell us? Treatment is on average four times more effective than no treatment and twice as effective as placebo. So when Functional Family Therapy (FFT), for example, reports in one study that the no treatment group had a 41% recidivism rate, while FFT achieved 9%, that’s great but nothing more than would be expected. Any approach systematically applied by individuals believing in what they are doing will be similarly better than no treatment. FFT has never demonstrated that it is better than any other model of treatment. Is it worth the cost of implementation?
3. When you say “evidence-based practice,” whose evidence is it? Most research regarding evidence-based practice is conducted by the very founders of the approach under study. In such circumstances, up to 40% of the results can be attributed to what is called “allegiance effects,” or the researchers’ bias toward their own models. This doesn’t mean the researchers are dishonest, it just means that the results should be interpreted with this in mind. And how much allegiance are we talking about? MST founders, for example, have received over \$55 million in grants and over \$5 million in licensing and consultation fees.
4. When you say “evidence-based practice,” what kind of evidence is it? A real look at the evidence or pulling the curtain back on the Wizard reveals not much to get excited about—a real humbug. Thousands of studies have found no difference among approaches. While a few studies have reported a favorable finding for one approach or another, the amount of studies finding differences are no more than one would expect from chance. For example, Cognitive Behavioral Therapy (CBT) proponents often point to 15 comparisons showing an advantage for CBT—however, there are 2985 comparisons that show no difference (Wampold, 2001). There is far more evidence for other factors contributing to change than what model the therapist practices: Over a thousand studies have demonstrated that the alliance between the clinician and the client is 7 times more important than the technique of the therapist. And the largest source of change (accounting for at least 40%), virtually

ignored by EBP, is accounted for by what the client brings—their strengths, struggles, culture, and preferences. The approach accounts for so little of change, while the client and the practitioner—and their relationship—account for so much. Given this evidence, is implementation of a specific model of practice worth the cost?



Consider the above picture. While the cow may give it a good shot, a swimming contest between a cow and a porpoise is not really a fair comparison. Another side of the “what kind” of evidence question is whether the study is really a fair contest—is it actually a contrast between two approaches fully intended to be therapeutic? Or is it, in fact, the pet approach of the experimenters pitted against a treatment as usual or less than ideal opponent? Consider MST’s claim that it is better than individual therapy. An inspection of one such comparison involving serious juvenile offenders (Borduin, Mann, Cone, et al., 1995) reveals MST conducted in the home, involving parents and other interacting systems, by therapists trained and regularly supervised by the founders of the approach. MST is compared with therapy of the adolescent only, with little to no outside input of parents or others, conducted in an outpatient clinic by therapists with no special supervision or allegiance. This type of comparison is an unfair comparison—a treatment as usual contrast rather than a bona fide treatment comparison. Consequently, this study, like many others claiming superiority, is set up with the winner already determined. Do such unfair comparisons justify the expense of implementation?

5. Because of the above points, and the fact that providing an EBP does not guarantee success at the individual client level, the American Psychological Association formed a task force to clarify the meaning of EBP and its implications:

Definition: Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychologist, May 2006).

Implications:

- Clinical decisions should be made in collaboration with the patient, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options.
- Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences.
- The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential.

Bottom Line:

While the way EBP is wielded (and often mandated) grossly misrepresents the actual data, the idea of it can make a lot of sense if it contains a little bit more common sense—and follows APA's definition and recommendations. Evidence then, also consists of:

- Evidence based on 40 years of outcome research supporting the common factors of change and the known predictors of success (the alliance and early change).
- Evidence of the progress and fit of services collaboratively collected with clients, which significantly improves effectiveness and efficiency in real clinical settings—or what we call “practice based evidence.”

The only way to guarantee successful outcomes at the individual client level, as APA suggests, is to systematically monitor progress with clients and tailor treatment to the individual receiving it—to move from evidence-based practice to EBP (as defined by APA) PLUS practice-based evidence.

FURTHER INFORMATION:

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Web: www.talkingcure.com and www.whatsrightwithyou.com

Making Evidence Based Practice a Reality; what does it mean and can it be done?

Draft article in preparation shared at this point to inform discussion (please note references and text not finalised)

Miranda Wolpert, Director , CAMHS EBPU

It seems appropriate to start by distinguishing my understanding of “evidence based practice” (EBP) from some of the ways that it is sometimes be presented. EBP does not mean only ever doing what has been found in a randomised control trial to work, nor does it mean never questioning your own practice if it conforms to the “evidence base”, nor does it mean getting rid of the need for values based practice as if everything can be answered by recourse to “the evidence”. I would argue that these were never what the original people who promoted EBP (or indeed evidence based medicine) meant it to mean, but are sometimes used to characterise EBP by its detractors.

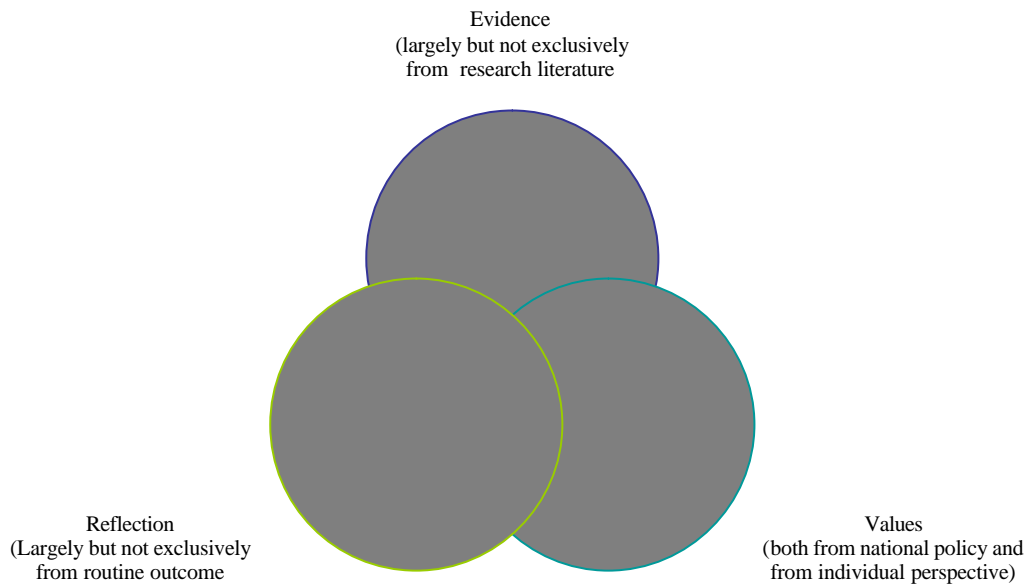
To my mind, what EBP does involve is a sequenced approach, whereby practitioners turn to the “evidence” in the first instance to help think about how best to help a child and family. They then bring to bear their own practitioner wisdom and professional judgement, influenced by the values they are operating within, and in explicit negotiation with the child and family and other stakeholders they are working with. Crucially, it means continuing to monitor and evaluate both their own work and that of the emerging research base. Thus for me EBP always includes both evidence from the academic literature and evidence from individual’s and others’ practice (PBE?)

For service users this means being made aware of what evidence there is for different interventions, but also being alerted to the limitations of the evidence base in the literature and being helped to make rational decisions using this information as part of the decision making process and to recognise they need to review if practice is working for them.

For service developers EBP thus involves turning to the academic evidence as a key source of information about which services to develop. But again this needs to be done in the context of an awareness of the limitations of the evidence and with an appreciation of the many forms of helping and interventions currently being attempted that have not yet been properly researched or evaluated. The key challenge for service providers is to find ways to make rational choices about service priorities and to ensure ongoing review and evaluation is built into all aspects of delivery so that practice based evidence can continue to emerge.

Possible Conceptual model for EBP

The conceptual model I would suggest can be represented as follows:



This model highlights the fact that evidence based practice is inevitably situated in complex interaction with the values within which both the service provider, and the child/family are operating, and requires a commitment to ongoing reflection and evaluation within that particular context.

Thus EBP must link with both values based practice (VBP) and outcomes based practice (OBP). In term of the importance of values based approach the excellent recent paper by Richard Williams and Bill Fulford (April 2007) outlines very well the interaction and complementarity's of the evidence based and values based approaches. In terms of OBP, it is important this should be seen as a vital part of EBP and not in opposition to it. No doubt Barry Duncan will have much to say on this at the conference.

To highlight that EBP is not a simple process, various modifications to its name have been suggested e.g. evidence informed practice, realist evidence based practice. I even toyed with the possibility of suggesting a new acronym IMPROVE- individual and managerial practice based on research, outcomes, values and evidence. However, on reflection I decided the one thing CAMHS did not need was another acronym, so I will keep referring to EBP in this article, but mean it to be understood within the above context and acknowledging its limitations and complexities.

Key questions

The key questions an evidence based practitioner might ask him/herself are as follows:

- What is the best ways of helping this particular child and their family?
- What are the pros and cons of different options?
- Am I likely to be able to help this child and family?
- How will I know if I/others have been helpful/unhelpful?
- how will others know if I have been helpful/unhelpful?

These may seem un-contentious and self-evident. You may all feel these are questions all practitioners ask themselves anyway. But I am not sure they are always the ones that practitioners really have asked themselves. In my experience there were instances when referrals would come in to a service and people chose who they would work with on the basis of “I have an interest in working with x”, or “I have a theory about y”. There are of course circumstances when it is appropriate for this to be the criteria of allocation (e.g. if the child presents very unusual difficulties for which there is no clear evidence or if known approaches have not worked.), but it is a question of at least turning to the evidence first. Moreover, there has historically been a lack of information for families about options and dearth of ways of evaluating the impact of interventions.

The reasons why these questions are so crucial, is because in some ways they run counter to much of our training (which is all too often based on particular theoretical schools) and they challenge the sense of identity we might derive from allegiance to particular therapeutic model. These questions, then, may be seen as being at the heart of evidence based practice- even if, as I will discuss later, many of them cannot be answered (and some may never be answered) purely from the evidence base arising from scientific research. .The drive to encourage front line practitioners to ask these questions of themselves and others, and to empower service users and service developers to ask such questions, is, I think, the biggest contribution of the EBP lobby.

No easy answers

Kazdin (2004) has suggested the key issues the research needs to address in relation to types of intervention. He suggests research on interventions should address the following five domains:

1. What are the costs, risks and benefits of this intervention relative to no intervention?
2. What are the costs, risks and benefits of this intervention relative to other interventions?
3. What are the key components that appear to contribute to positive outcomes?

4. What parameters can be varied to improve outcomes (e.g. including addition of other interventions, non specific clinical skills etc)?
5. To what extent are effects of interventions generalizable across a) problem areas, b) settings, c) populations of children and d) other relevant domains

I can't think of a single intervention we could answer all five researchable areas in depth – but I think it is a good framework for us to aspire to. (NB costs could be financial, but could also be societal or familial- would be up to a given community to agree what they are most interested in this regard).

In trying to answer these research questions, the more systematically they are studied the more confidence we can have in the results. Below is the traditional hierarchy of research evidence:

Hierarchy of evidence from research

- Ia** Evidence from meta-analysis of randomised controlled trials
- Ib** Evidence from at least one randomised controlled trial
- Ila** Evidence from at least one controlled study without randomisation
- Ilb** Evidence from at least one other type of quasi-experimental study
- III** Evidence from descriptive studies such as comparative studies, correlation studies and case-control studies
- IV** Evidence from expert committee reports or opinions, or from clinical experience of a respected authority, or both.

This hierarchy of evidence has been much debated. There are those who would argue that RCTs cannot answer some of the questions we are most interested in. I agree. But, I don't think this therefore means we should overturn the hierarchy – just acknowledge may have to look elsewhere for some of our most vexing questions and that we need to constantly look to combine evidence from a variety of sources. The interesting work of Greenlaugh and colleagues, suggests the need to look not just at results of RCTs but at other aspects along the way that research from RCTs may reveal tangentially. Combining of evidence with ones own knowledge, views of experts and hints from qualitative and other studies is the true art of evidence based practice currently.

There is a danger, as with the unhelpful debate between OBP and EBP, or PBE and EBP, of setting up yet more false dichotomies in this regard. In particular the user-involvement movement has become particularly critical of RCTs which they argue do not address some of the key issues of interest and relevance to service users, and have therefore championed qualitative research as a more meaningful way forward. Whilst I would want to encourage more qualitative research, I would also want to caution about the conflation of the issue of developing meaningful research questions (including drawing on service user expertise) from any particular methodology. There is no reason why RCTs can't be better designed to include issues of relevance to service users etc. It is important that the discourse of the dispossessed is not simply overlaid onto qualitative vs quantitative research debates

Holding at least to some extent to the spirit of this hierarchy seems to me to be important, in that it challenges our natural tendencies and traditions. It is human nature to seek out confirmation for our pre-existing beliefs, to be more influenced by single anecdotes and to charisma of the messenger rather than statistics and hard gained knowledge .

This may be particularly relevant in our field where I start from the assumption that people are on the whole motivated by a genuine desire to help (I have not yet met many child mental health professional working in statutory or voluntary sectors in the UK are in it for the money). But, **purity of motive is no guarantee of good outcomes, benign intentions do not necessarily protect from harm. Moreover, complexity or richness of theoretical framework is no predictor of what works** (eg some of the simplest interventions most effective eg behavioural activation in depression in adults).

RCTs are the necessary corrective to developing research evidence that at least attempts to control for biases.

Limitations in the current evidence base

Even where there are systematic studies at the higher levels of this hierarchy there are difficulties and the flaws in the evidence base currently – these are outlined briefly below in relation to the following key problematic areas

- a) Amount of research
- b) Scope of funded and published research
- c) Design issues in research
- d) Generalisability of research

a) Amount of research

The sheer lack of research data is perhaps the first issue. This is still a very relatively new (though growing) area, with small amounts of research compared to, say, adult mental health. There are increasing numbers of intervention studies, but the amount of service level studies is still miniscule, rendering particular problems for an evidence based service development approach

b) Scope of research

Different funding streams mean some areas are more studied than others and lead to skews in the topics covered. For example, there is significantly more money available from pharmaceutical industry than academic institutions so there is consequently a disproportionately large amount of research into drug treatments as opposed to psychological treatments

There is inevitably a complex interaction between the emerging evidence base and the political priorities and preoccupations within a given country, both in terms of which topics are funded and in terms of the credence and dissemination given to any findings that emerge. The pressure to implement a favoured policy before it has been formally evaluated can mean that attempts to establish meaningful evaluation may be compromised (Rutter, 2006)

The issue of publication bias is well documented (ref). Generally the problem raised is that journals tend to only publish positive findings but may also be specific cases of choosing not to publish key findings as an important study by Whittington et al (2004) showed

c) Design issues in the research

Designing and carrying out research on efficacy of interventions in CAMH is no easy task. Lack of consensus on which outcomes to use means it is often difficult to compare findings. There is an emerging appreciation of the need to look at outcomes from a range of perspectives and across a range of domains (Kazdin and Kendall 1998,

Wolpert et al., 2005). However, there is as yet no consensus as to how to weigh the different outcomes that might arise from these different perspectives or across different domains. Thus, there no agreement as to which type of outcome should be regarded as most important (eg change in symptoms, social adaptation, experience of care, or some other dimension) nor whose view should be prioritised where views differ (eg child, parent, practitioner or others). The issue of how to make valid comparisons across studies where different outcomes have been used is yet to be resolved (Weisz, Chu, & Polo, 2004).

Lack of focus on harm until recently assumed impact if not helpful was neutral/benign. We know something of side effects of drug treatments, but we know little about the cost of unsuccessful treatments on children's lives eg in terms of stigma, school lost, sense of self blame etc.

Until recently there has been little focus on economic costings in CAMH. Scott's seminal work is now being build on and recent findings in relation to EI (ref) but Knapp and others point to limited research and what is there is weak.

Design flaws and a sense that may be biases in way things are set up eg how to deal with drop outs, It is notable that on the whole published work is in line with the researchers' pre-existing belief systems . Over 75% of the variance in outcomes of different treatment studies can be correlated with the theoretical orientation of the first author.

It is perhaps worth pointing out that as research ahs become better designed effect sizes have reduced.

4) Generalisability of the research

Most studies in this are undertaken in the US (over 90%). The populations studied are not necessarily representative in the UK, and often picked from particular populations eg selected for depression study from questionnaires completed at half time in a baseball game. A lot of interventions tested using highly supervised, monitored and trained staff- how generalise in more general settings incomplete sentence. Also they tend to have highly selected groups being treated- often with only one presenting problem whereas in routine practice most people have multiple problems Also in order to assign people to a RCT they need to have no strong preference- (this generally is only true for about 10% of people and they may be skewed in other ways

Research that looks at the impact of services using routine clinical practice, even where that could be anticipated to be relatively independent of context (such as when medication is prescribed), generally find lower effectiveness than is indicated in the studies informing the table above. (MTA Co-operative Group, 1999, Weisz, Donenberg, Han, & Weiss, 1995)

This difference may be due to differences in the populations of children seen, types of interventions made and/or outcomes assessed (Kendall & Southam-Gerow, 1995). Particular populations in UK under-researched and hard to engage...children who are looked after by the state, refugee children for example.,.

Moreover research, generally from adult mental health , stresses importance of non specific factors and relationship factors such as therapeutic alliance- these are difficult to quantify and research (Jensen, Weersing, Hoagwood, & Goldman, 2005)

Given all limitation and complexities why bother?

So why in the light of this do I still remain an advocate of EBP? If you need final arguments for EBP, with all its flaws, consider the alternatives..

- historically based practice
- tradition based practice
- intellectual persuasiveness based practice
- academic elegance based practice

In particular despite all the limitations, it seems to me that the arguments for trying to promote evidence based practice remain compelling. Natural biases in reasoning mean that people tend to make decisions based more on things that fit their assumptive world view than those that challenge it and are more influenced by the charisma of those promoting a particular approach than by evidence for its effectiveness (Garb, 1997, Kahnemann et al., 1982).

When the evidence base is not used as the basis for practice and service development, it makes it more likely that seemingly plausible but ineffective and/or harmful interventions may be introduced or continued and that new interventions that have been shown to do more good than harm may never be introduced (Muir Gray, 2001). We are at the mercy of the most charismatic rather than the most effective.

The following ,outlined as the basis for the ethos of the EBP, may also serve as the basis for a realistic evidence based practice.

- All research is provisional
- All research raises as many questions as it answers
- All research is difficult r to interpret and to draw clear conclusions from .
- *Qualitative* research may be vital to elaborate experience, suggest narratives for understanding phenomena and generate hypotheses but it can't be taken to prove anything
- *Quantitative* research may be able to show hard findings but can rarely give clear answers to complex questions

And yet, despite all the challenges, it is still worth attempting to encourage an evidence-based approach, since the alternative is to continue to develop practice based only on assumption and belief.

Practical implications

There are a wide range of interventions currently being used in children's services for which we know too little about their effectiveness (including, for example, play therapy, counselling, hypnotherapy, narrative therapy, psychodrama, attachment theory based interventions.) There are also an increasing number of interventions being used for which we have some evidence of efficacy from the literature but for which we need more information about their validity in some UK contexts (such as interpersonal therapy).

The key priority is to evaluate their effectiveness of existing interventions in real world settings. When there is no evidence base, our principle is that practice based evidence is the starting point. The key practice implication is for people to be encouraged and supported in evaluating all their interventions. The most "evidence based" approaches must be evaluated

on the ground just as rigorously as the least, to see if they work in this particular context with a particular group of children or young people.

Ways forward

What is unique about EBP is the opportunity it provides for us to learn from research literature but also to constantly challenge our own assumptions and those of others . The following points may act as a guide for daily practice for practitioners.

1. Be prepared to challenge yourself and your assumptions
2. Feel comfortable explaining your proposed actions to others- both colleagues, managers and service users
3. Instead of being wedded to a model try to develop a professional self image that is tied to idea of learning via experience of self and others
4. Be prepared to explicitly share learning, including with children and their families
5. Be explicit about your values and be prepared to discuss these and negotiate as appropriate with children and families
6. Don't accept orthodoxies just because that is the way it has always been done
7. Be prepared to constantly evaluate your work and adapt practice in the light of what you find out

Above all, follow your curiosity and be prepared to **experiment, explain, and evaluate** .

The importance of practice based evidence and a critique of attempts to disseminate evidence based practice such as “Choosing What’s best for You”

Peter Wilson, Former Director and Co-Founder of YoungMinds, Consultant Child Psychotherapist & Clinical Director of The Place2Be

‘The more we learn, the less we know’. A puzzling contradiction, not unfamiliar to some of us who toil and fret in everyday practice. Of course, we have more information than ever before; and we have our experience. And yet our knowledge is incomplete. If we are honest, we know only the half of it - of the complexities of human behaviour, of the mysteries that bring about psychic change.

This isn’t easy to acknowledge. We are besieged by pressures both from within ourselves and from without to be competent and to act with conviction. As much as I know that I don’t fully know what I am doing, I feel required to go forth as if I do - and moreover to be seen to know. In the face of so much challenge in my clinical work, I tend to fortify myself and reassure others with a sense of certainty, albeit illusory. There is not much patience for doubt.

There is a telling quote at the front of Rutter and Hersov’s *Child and Adolescent Psychiatry; Modern Approaches*, second edition. It is by Al-Ghazali (1058-1111):

*he who does not doubt, does not investigate, and
he who does not investigate does not perceive,
and he who does not perceive remains in blindness and error.*

The key here is the capacity to doubt and hence the capacity to learn. So too the readiness to perceive, otherwise blindness. We need evidence. The etymology of the word ‘evidence’ is from the Latin ‘uidere’, to see.

The question is how good – reliable, accurate - is our sight. With what degree of caution and honesty do we trust our vision and how do we tell others what we think we have seen. We have different answers depending where we come from.

For example, I am a psychoanalyst. I trained with Anna Freud as a child psychotherapist and for much of my professional life I have been a practitioner in one form of psychodynamic therapy or another. Psychoanalysis has provided me with a necessary conceptual framework - and it has encouraged me to see not only what is in front of me, but also what is within me. In this way, I have built my knowledge.

Psychoanalysts in the past have been rightly criticised and condemned for their grandiose and righteous claims. I confess I have been slightly inclined this way in my time. However I am quite clear now that I can not assert my knowledge with certainty. What I can say is that I have something valid to communicate about both the process and the outcomes of what I do: and that I can back that up with the evidence that makes sense to me – through case observations and accounts of the thoughts and feelings evoked in me in response to the children I have been trying to help. I can do my best to follow up these children to see how they have grown up.

This is practice based evidence, different of course from research based systematic and objective enquiry. The difference resides in the way it is collected and analysed and in the

preoccupations of those who conduct it. There is much to be gained from research based evidence. Through its particular lens, and despite its formidable methodological difficulties, it clearly produces important findings. But few of these are conclusive, no more than those that emerge from practice based evidence. Neither forms of evidence can lay claim to certainties and care must be taken in communicating what either have found out to the wider public – a public that demands in effect simplicity, no equivocation.

I have had a fair amount of experience of writing popular leaflets; when I was Director of YoungMinds, I wrote several – all the time trying to hold onto accuracy in the face of the public's impatience with unnecessary complication. It is with this in mind that I have been very critical of the recently produced booklet, 'Choosing What's Best For You'. In my view, it is written in such a way – with such a bold sense of sureness - that it masks much of the inconclusiveness of the evidence upon which it so heavily relies. As a result, it is unjustifiably partial in its promotion of certain types of therapy and dismissal of others. It relegates therapies with psychodynamic emphases – those which I favour and which do not produce the kind of evidence it's writers have faith in - to a kind of oblivion.

The slant of this booklet reveals an arrogance and an absence of the very virtue we should all uphold, however insufferable - that of doubt.

Developing Effective Practice in Kent

Louise Chapman, Associate Director CAMHS/ MIMHS, Kent & Medway Partnership Trust; Victoria Stevens, Service Development Lead, Kent & Medway Partnership Trust; & Nicholas Coulter, CAMHS Service Improvement Lead, CSIP South East Regional Development Centre

Background

Kent and Medway NHS and Social Care Partnership Trust - *KMPT* - provide Tier 3 and Tier 4 CAMH Services in West Kent and Medway. Historically the success of the service and any changes or developments has been based on the traditional measures of activity and contact data. Although this data is important, especially from a contractual perspective it has not demonstrated productivity or enabled the service to properly understand and communicate its performance from a service user perspective.

For some time the service experienced a number of operational and performance difficulties. These included:

- Service Users have experienced difficulties in accessing Tier 3 CAMHS across West Kent and Medway.
- Long waits for first contact from referral,
- Delays in the referral/ access pathway due to service users not attending their follow up appointments
- Lack of knowledge about service user demand and service performance
- No framework or methodology to support the continuous improvement of the service

Achievements

In 2007 The KMPT in partnership with CSIP began to develop a new demand led systems approach to the management of the service, looking to implement a new way of measuring and understanding its performance. Working with each locality team, a simplified set of measures was developed that enabled the service to understand its performance in direct response to the experiences of those that use it.

This new way of working has challenged the traditional management model.

- Development of new service user focused improvement measures to reflect the value-adding elements of each stage of care.
- New ways of understanding data and information introduced to provide a better understanding of demand patterns and service capabilities.
- Every service user and carer routinely asked about all areas of the service they experience, including the following:
 - When, where and how they want to be seen and what they want from the service.
 - What they thought of the service
 - When and how they want to be contacted, and reminded
- Front-line clinicians are actively involved in the process of collecting and analysing individual team performance and leading change.
- Collection and analysis of activity data has been used to inform productivity

Next Steps

With the support from senior management, each team is in the process of constructing a 'dash board' of demand-led performance measures and other key service improvement information. This will enable the locality management and staff to better understand the day to day demands and the service performance trends and patterns.

Shifting the management and analysis of information from a centralised function to the day to day work of locality teams will develop a new culture of continuous improvement, where senior management accept that those who do the work are best placed to understand and improve it.

Finding and Using the Evidence

Paula Lavis, Policy & Knowledge Manager, YoungMinds & Information Officer, CAMHS EBPU, and NCSS

Policy drivers encourage practitioners to ensure that their work is guided by the best available evidence. I welcome this, but what does best available evidence actually mean? Although I would stress the importance of good quality academic research, I would say that evidence is a range of different types of information and what is required will vary depending on the context.

I have a lot of experience of searching and using evidence for my own work as well as helping others to find the evidence they need. In my experience practitioners and others working with children, young people and their families often do not seem to be aware of what constitutes evidence, let alone where to find it. There may be many reasons for this, but two major reasons in my experience are not having the skills or the time to find and appraise evidence. In some respects, would you expect practitioners to be experts in finding evidence, but they should have some awareness of the information landscape, know what the limitations of different types of evidence are, and be able to critically appraise evidence

In my opinion evidence is very important because it provides practitioners with the facts necessary to help them make an informed decision, but it is only part of the process. Evidence generally consists of facts and figures on a piece of paper, and regardless of how effective the findings, they need to be disseminated, understood and implemented before they can really help anyone. So the other, possibly more crucial aspect is the expertise that the practitioner inputs into this equation.

How evidence is used, or what can be reasonably deduced or extrapolated from evidence is a skill and is possibly an art rather than a science. The experience that a practitioner brings to this process is crucial. For instance, a study may say that a particular finding is statistically significant, but it may not be clinically significant. It may not matter whether you start with evidence and put that into practice, or you start with practice, and create evidence to show that it is effective, but what is important is the interaction of the two.

I was commissioned by the National CAMHS Support Service to write a booklet that looks at how to go about finding evidence to develop child and adolescent mental health services. It uses a 12-step model to help people define and refine their query, identify different types of evidence, appraise the evidence, and to start thinking about how they will use this evidence in their work. The booklet will be launched at this conference, and will be available on websites of **EBPU** <http://www.annafreudcentre.org/ebpu/> and **NCSS** <http://www.camhs.org.uk/>

Commissioning a Comprehensive Child and Adolescent Mental Health Service: the importance of both EBP and PBE

Peter Wilson, Former Director and Co-Founder of YoungMinds, Consultant Child Psychotherapist & Clinical Director of The Place2Be & Judith Trowell, Professor of Child Psychiatry, CSIP West Midlands

Well informed commissioning of Child and Adolescent Mental Health Services (CAMHS) is very important. Without well resourced and effective services, the emotional and social lives of a good many children and young people in any given area will be at risk –at a cost to themselves and to society.

There are many practitioners involved from many different agencies and professional groups – all working together in the interests of the children and families they serve. It is essential that services are of high quality and that there is equity of access.

In the midst of such complexity and diversity, how do commissioners know how to prioritise their investments? Commissioning tiers 1-4 is not easy. Clearly, they need to refer to the available evidence on which services are the most effective and relevant to the needs of their particular communities.

There are two kinds of evidence: research based evidence and practice based evidence. Both have much to be said for them. And both have their limitations.

- Research based evidence, as provided in 'Choosing What Is Best For You', draws upon random controlled trials. It is evidence based on a systematic and objective scientific method of study. Its limitations reside in its focus on relatively discreet clinical disorders under strictly controlled 'laboratory' conditions. Most of the studies are carried out in North America with white children and families and students.
- Practice based clinical evidence draws upon the experience of practitioners in the field. Most organisations carry out clinical audits of their practice and evaluate the outcomes of their service. Through case discussion, peer review and user consultation, they work to investigate their own and their patients' perception of problems and to find the most useful intervention. This information is generally available

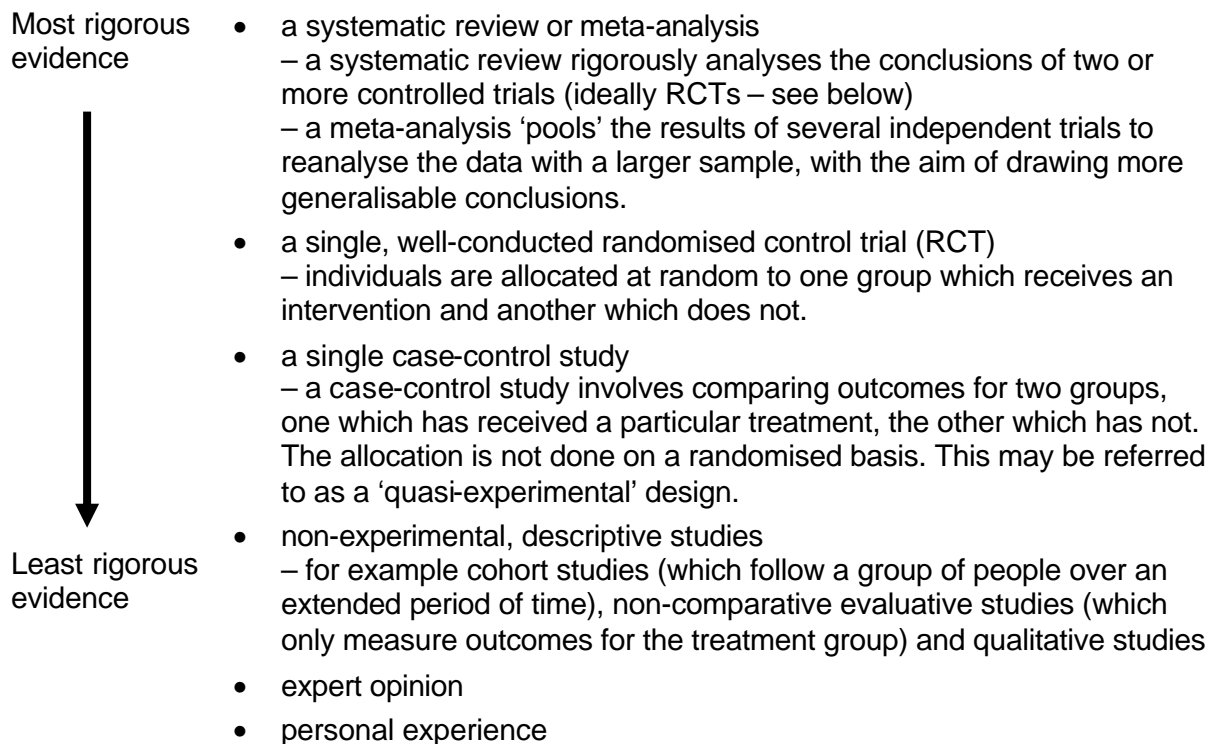
Commissioners need

- to make their own judgements based on their reading of both kinds of evidence and on their obtaining information from local services.
- to keep in mind the importance of resourcing both promotional/preventative and treatment services throughout the whole comprehensive CAMHS, tiers 1-4.
- to ensure that practitioners from a range of agencies including the voluntary sector are included in the commissioning strategy and that a skill mix is available so that there is a menu of interventions, including play therapy , music and art therapy , child psychotherapy, to give users and professionals choice so that the most helpful intervention is available.

An Evidence Informed Approach to Practice: how to build your own evidence base

Extracted and minorly adapted from advice to pathfinder sites involved in targeted mental health in schools initiative. Reprinted here with kind permission of DCSF (with particular acknowledgement to Rachel Pope who pulled this document together following consultation with stakeholders)

There are many different types of evidence. These can be categorised according to the kind of information they produce – for example how objective, insightful or descriptive it is. Evidence can range from large studies which generate statistical data to show that one approach is more successful than another, through to the personal experience of one service user or practitioner. A range of sources of evidence are summarised below:



Experimental studies

Randomised controlled trials (RCTs) are often viewed as a ‘gold standard’ in research. This is driven largely by the importance in the medical field of thoroughly testing new drugs before they come to the market. RCTs are now conducted in a number of fields, including health and education. Where the researchers are not able to randomly allocate the participants themselves, they may still be able to compare outcomes for two different groups. These are called ‘quasi-experimental’ studies.

Such studies are possible when outcomes are quantifiable (e.g. assessment ratings carried out before and after an intervention) and when it is practical and ethical to find a control group who receive no treatment or an alternative treatment. It is then possible for researchers to assess whether the intervention was beneficial, or whether the participants ended up with the same or worse outcomes than they would have done if they had not received the treatment.

The great advantage of experimental research is that it gives researchers and practitioners confidence that the benefits are due to the intervention itself rather than to other factors.

However the experimental approach has a number of drawbacks, particularly for educationalists and social researchers:

- many outcomes of treatment are not quantifiable, for example individual quality of life and the functioning of the child in the social environment (Fonagy, 2002)
- for educationalists and social scientists, context and environment are of central importance, calling into question the transferability of data from other countries (Davies et al, 2000)
- the majority of studies cannot answer complex questions on the impact of variables such as the timing of an intervention, the skills and style of those delivering it, and the relationship between those delivering and those receiving the intervention
- such reviews are inevitably generalisations, and will apply to a greater or lesser extent to individuals
- the tight approach required means that experimental studies do not reflect the interplay between mental health problems and challenging environments and circumstances, which is the reality facing many people with mental health problems.

Non-experimental studies

Though experimental methods are used in education and social care research, more common is the use of non-experimental methods such as observations, interviews and surveys carried out with a single cohort of participants. These can be very large groups and carried out over a long period. They can provide essential insights into levels of need, methods of intervention and the views of service users and practitioners. As such, non-experimental research informs new theoretical understandings, professional practice and the development of services.

The drawback of non-experimental research is that you cannot use it to conclude that a particular intervention has contributed to a particular set of outcomes. (Without a control group, there is always a possibility that any improvement was due to other factors, such as the normal developmental processes that would occur in the child over the period of the intervention.) When findings from one study are backed up by the findings from similar studies, and replicated over large populations, it is probably safe to conclude that this is the case. However, by itself, a non-experimental study cannot prove a hypothesis.

A proposed approach to evidence

It is important to try to bridge the gap between the high level knowledge base that is emerging from research into mental health interventions, and the complex, highly specific and often chaotic situations of individuals with mental health problems.

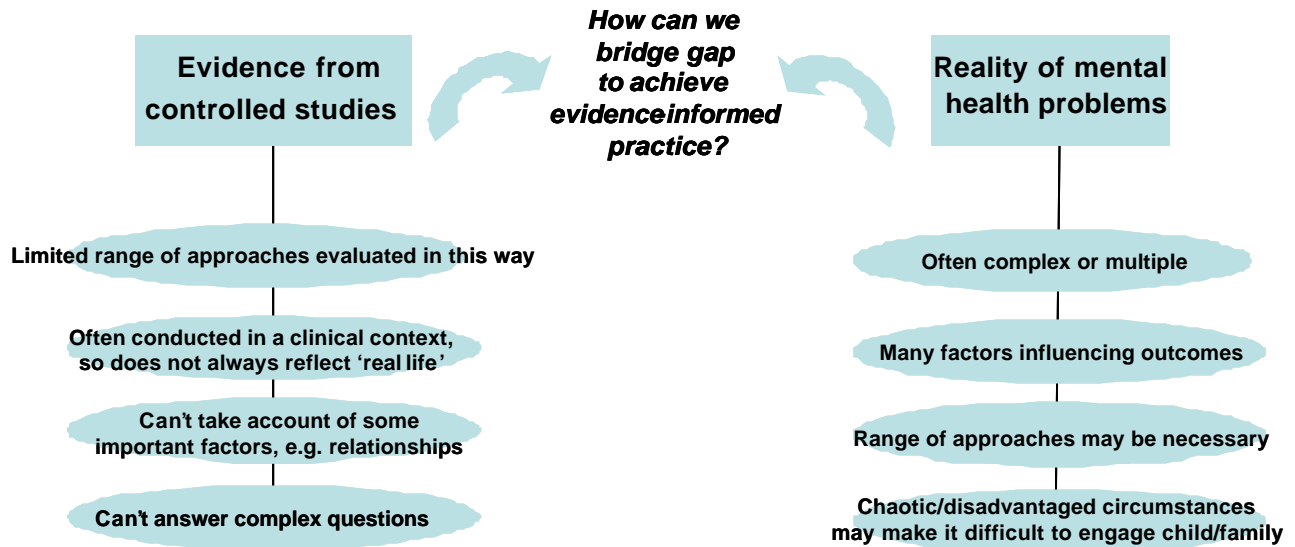


Figure 2: Bridging the gap between experimental research and real life problems

One way of doing this is to consider research-based evidence alongside practice-based evidence. This is defined as evidence from the 'real world', which is based on service user and practitioner experiences, and which has a clear connection and relevance to the changes that are being sought (Simons et al, 2003). The concept was first popularised in the United States (e.g. Duncan, Miller and Sparks, 2003), but is gaining ground in the UK as academics and practitioners increasingly recognise the importance of local areas developing an evidence base which is specific and responsive to their local context.

Therefore practice-based evidence might include:

- evaluations of projects which may not have been able to provide control groups but which may have insightful qualitative data
- case studies of local services working effectively with children and young people with particular needs
- observation
- reflective practice
- views of service users on what they want and need.

The advantages of practice-based evidence are:

- it has emerged from a practical, naturalistic setting
- it can be applied to a wide range of approaches or interventions
- it can provide rich insights
- it can be context-specific.

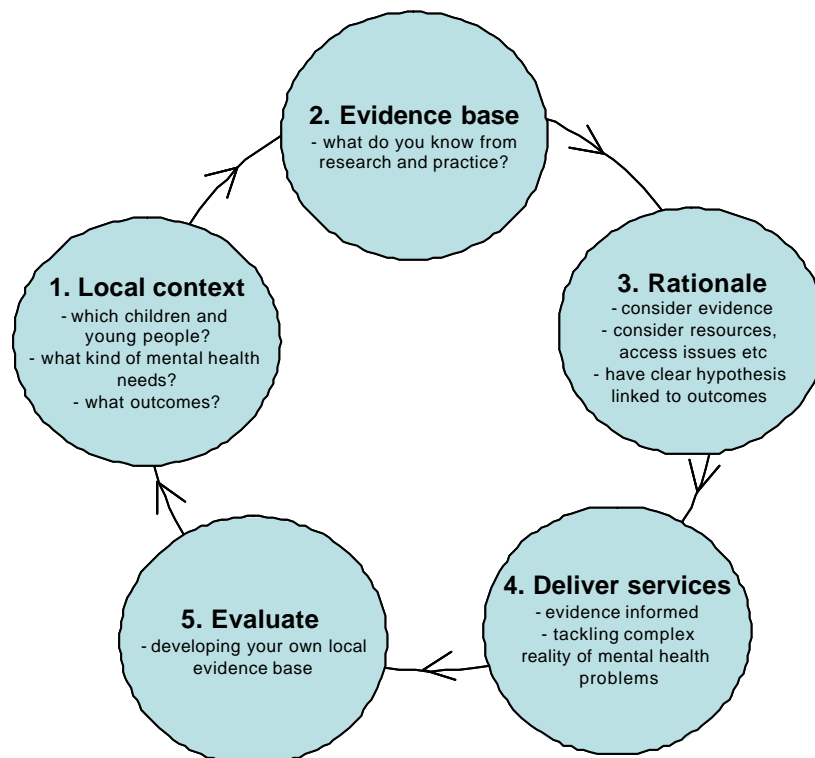
However, as with all evidence, there are some caveats that need to be borne in mind when drawing on practice-based evidence:

- it cannot demonstrate that outcomes are a direct result of a specific intervention
- it is subject to possible bias
- it may not be representative
- it may not be reported or written down in a way that others can scrutinise or understand how conclusions have been reached.

Building your own evidence base

Practitioners are encouraged to cross-reference and supplement the *findings of the research evidence base with their own local knowledge and experiences*. This can be built into a cycle for planning, commissioning and delivering services which aims to help bridge the gap between evidence and practice, as illustrated below.

Figure 3: Building your own evidence base



When considering the evidence base in relation to your local context, and deciding what interventions are likely to be most effective locally, the key requirement is to have a clear rationale for what you are doing. This needs to be grounded in your local context, resources and desired outcomes, while taking into account the findings from other studies. Ultimately, this development process will become part of the wider cycle of joint planning and commissioning of children's services, as illustrated right.

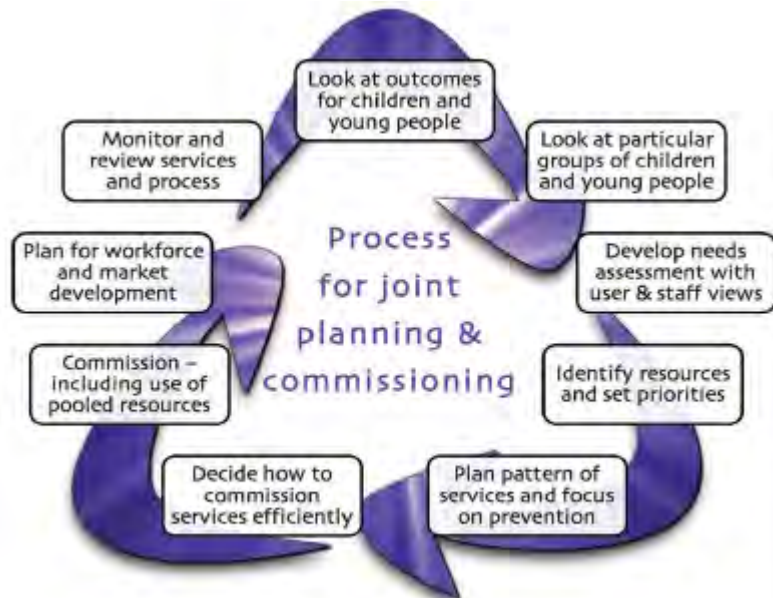


Figure 4: Joint planning and commissioning of children's services

Appendix 1: Child Outcome Rating Scale and Outcome Rating Scale for Adolescents

Barry Duncan, Co-Director, Institute for the Study of Therapeutic Change

There is strong evidence supporting the Child Outcome Rating Scale (CORS; for children 6-12) and the Outcome Rating Scale (ORS; for adults and adolescents 13-17) as reliable, valid, and feasible measures of youth benefit from mental health and substance abuse services. The Institute for the Study of Therapeutic Change (ISTC) has systematically collected data for four years at three clinical sites serving youth, while the measures have been in use in many more, including now the state of Arizona as well as other regional systems of care. There are over 10,000 registered users of the measures. The preliminary validation study is complete and in press: Sparks, J., Duncan, B., Miller, S., Bohanske, R., & Claud, D. (in press). Giving Youth a Voice: A Preliminary Study of the Reliability and Validity of a Brief Outcome Measure for Children, Adolescents, and Caretakers. *Journal of Brief Therapy*. Over 3000 clients participated in this validation study. The CORS and ORS are significantly correlated with the Youth Outcome Questionnaire (YOQ 30), and have robust reliability, validity, and perhaps more importantly, feasibility. The following is excerpted from the validation study:

Reliability

Reliability, based on 1495 adolescents and 1961 children (over 20,000 administrations of the CORS and ORS) was estimated using Cronbach's coefficient alpha, a measure of the internal consistency of the measure. The ORS and the CORS display strong evidence of reliability, with coefficient alpha estimates of .95 and .87 respectively. These are very high coefficients of reliability for such brief measures, suggesting that all four of the items tap the factor that most if not all outcome measures tap, global distress.

Construct Validity

Construct validity rests on the assumption of an underlying trait or state that the questionnaire purports to measure. In the case of outcome questionnaires, the underlying state, based on factor analysis of many outcome measures, is global distress. More specific constructs such as "depression," "anxiety," and "interpersonal problems" can be shown to share a large percentage of variance with the global distress factor. Constructs based on diagnostic nomenclature such as "anxiety disorder symptoms" or "symptoms of depression" appear to have very little predictive value, as both anxiety and depression symptoms load heavily on the global distress factor. The high coefficient alphas provide strong evidence that the ORS/CORS is measuring a single factor. Studies of concurrent validity invariably confirm that measures with similar item content assessing symptoms of depression, anxiety, social distress, and impairment in daily functioning are highly correlated. Given the substantial body of research supporting the existence of the global distress factor, it is reasonable to suspect that the CORS/ORS is likewise a valid measure of global distress and will correlate with other established measures like the YOQ-30. And it does, as will be shown below.

Construct validity is also demonstrated if the measures prove to be sensitive to change over time for youth receiving mental health or substance abuse services. Both samples showed significant pre-post change.

First Assessment	Last Assessment		Pre-post change		Effect Size (Change/SD at intake)		Significance (One tailed t-test)	
	Mean	SD	Mean	SD	Mean	SD		
ADOL-ORS (n=1495)	25.9	8.1	33.6	6.5	7.9	8.3	0.98	p<.001
CARETAKER-CORS (n=1961)	21.1	7.8	24.4	7.7	3.25	7.9	0.42	p<.001

The first sample is of adolescents only while the second is of caretaker ratings on the CORS. The two samples differed significantly in both intake scores and change scores, as expected given that youth tend to rate outcome measures higher (less distress) than their caretakers.

Construct and Concurrent Validity

The construct validity of the CORS/ORS rests in part on the finding that the items load on a common factor shared with other similar outcome measures. Correlations between the CORS/ORS and Caretaker CORS/ORS scores and scores from the well-validated YOQ-30 provide further evidence of construct validity as well as concurrent validity.

The following concurrent validity correlation matrix provides results for children and adolescents from a normative sample that received 3 concurrent administrations of the ORS/CORS and the YOQ for both youth and caretakers (CT). Note that correlations between the ORS and YOQ will be negative since the low score reflect low distress on the YOQ while on the ORS high scores are low distress. Another normative sample is currently in the data collection phase.

CORS/ORS and YOQ correlation matrix
N=354 (all administrations combined)

CORS/ORS	CTCORS/ORS	CT-YOQ
CORS/ORS	1	0.72*
CTCORS/ORS	0.72*	1
CT-YOQ	-0.63*	0.7*

The CORS/ORS was significantly related to the YOQ in all cells of the matrix demonstrating strong concurrent validity with the well researched but much longer YOQ. Interestingly, the correlation was also significant between youth and caretaker ratings, suggesting that giving voice to youth via outcome measures is supported by the evidence. Although adolescents have long had this opportunity, the CORS is the first outcome measure that taps into the perspective of children ages 6-12.

Other indications of construct validity are reported in the in press article: the ability of the measures to differentiate between normative and clinical samples, between different levels of severity, and the demonstration of stability in non-clinical populations vs. change sensitivity, beyond regression to the mean, in clinical populations.

Conclusions

The ORS/CORS provides a brief measure of global distress suitable for assessing treatment outcomes. The reliability compares favorably to well-established outcome measures containing many more items. The high coefficient alpha and pre-post differences provide evidence of construct validity; the high correlations with the YOQ provide evidence for concurrent validity—that both measures appear to measure the broad construct of global distress.

Feasibility and Immediacy of Feedback

In addition to establishing a system that is valid and reliable, a major goal of the ISTC has been making the collection and use of outcome data user-friendly for both providers and consumers. As is news to no one on the front lines, and especially in the public sector, the number of forms and other oversight procedures has exploded. Few have the time to devote to the repeated administration, scoring, and interpretation of lengthy measures. Brown et al. (1999), for example, found that practitioners did not consider any measure that took more than five minutes to complete, score, and interpret practical. After experimenting with a number of outcome measures, we found that similar tolerance levels apply to consumers. Clients quickly tire of measures that lack obvious face validity, require more than a few minutes to complete, or appear to take away from time spent with the counselor. Low compliance rates are the most frequent result. Indeed, the longer measure used in the child validation study reported above was met with similar responses making data collection difficult at best.

Feasibility is a critical issue in outcome management. Though it may be distressing to researchers, the ease with which an instrument can be explained, completed, interpreted, and then integrated into ongoing care is much more likely to influence utilization than either validity or reliability. One way to assess feasibility is to compare the compliance rates of different measures in clinical settings with similar clients and treatment mandates. Miller, Duncan et al. (2003) made just such a comparison at two community mental health outpatient centers and reported significant differences. Utilization of the 4-item ORS reached 86% at the end of one year while the 45-item OQ 45 dropped significantly by six months and finished the year at 25%.

Moreover, longer measurement systems can create significant management problems. In reaction to a managed care company's introduction of the OQ 30, just 30 items, it was recently reported in the *New England Psychologist* that providers complained about its length and frequent administration, that it cut into sessions and increased workload, and that some items were intrusive. The response by clinicians was so severe that it led the State Psychological Association president to say, "I have never seen such negative reaction from providers." This is not an infrequent reaction in our experience.

To be sure, because of its brevity, the CORS/ORS is weaker psychometrically than the YOQ (30 items) or other longer scales like the Ohio Scales (48 items on the short form). Neither does the instrument offer the same breadth of assessment as the longer scales. At the same time, a measure that goes unused is useless regardless of its strengths. In the real world of delivering services, finding the right outcome measure means striking a balance between the competing demands of validity, reliability, and feasibility. The development of the ORS, and subsequently the CORS reflects our attempt to find such a balance.

Intimately related to feasibility is the issue of the immediacy of feedback—whether the measure has an intended clinical use to improve the effectiveness and efficiency of rendered services. Most if not all other youth outcome measures (there is actually a small family of measures and all tap into global distress, hence their strong correlations with one another) were developed primarily as pre-post and/or periodic outcome measures. Such instruments, like the 48 item Ohio Scales, provide an excellent way to measure program effectiveness but are not feasible to administer frequently, and therefore, do not provide real-time feedback for immediate treatment modification before clients drop out or suffer a negative outcome—in short they are not clinical tools as much as they are management or oversight tools. The ORS/CORS was designed as a clinical and outcome tool to provide immediate feedback to both clients and providers to improve the effectiveness of services, and as a way to measure outcome at individual, program, and agency levels. Given their feasibility, the ORS/CORS can provide immediate feedback not only based on client scores but also in comparison to normative trajectories of change of a large and growing clinical data base (over 300,000 administrations).

About Client Directed Outcome Informed (CDOI) Services

CDOI is not a model of practice. Rather, CDOI is better described as a continuous quality improvement (CQI) delivery system that provides real-time feedback to clinicians and clients to improve the quality and outcome of delivered services. Any interaction with a client can be client-directed and outcome-informed when the client's voice is privileged and helps purposefully form strong partnerships with clients: (1) to enhance the factors across theories that account for successful outcome (based on 40 years of research evidence); (2) to use the client's ideas and preferences to guide choice of technique and model (based on alliance research); and (3) to inform the work with reliable and valid measures of the client's experience of the alliance and outcome (practice based evidence). The State of Arizona now includes CDOI on its Best Practices list in recognition of the importance of broadening "evidence based practice" to include "practice based evidence."

Why Is CDOI Service Delivery a Good Idea?

- There is a growing worldwide movement, both private and governmental, to involve consumers in mental health and substance abuse care and improve the outcome or value of rendered services. CDOI proactively partners with consumers to improve the value of the care they receive and is the only system that includes clients in all aspects of outcome management.
- The use of evidence based practices (EBP) does not guarantee success. In recognition of the inability of any model to predict success for the individual client, the APA Task Force on EBP suggested that “ongoing monitoring of patient progress and adjustment of treatment as needed are essential.” The broader APA definition also includes all available research evidence about outcome and acknowledges the importance of collaboration and client preferences. CDOI provides a method to combine EBP with “practice-based evidence” to ensure success at the individual client level.
- A small percentage (about 10%) of the total number of people treated—unsuccessful clients—accounts for 60-70% of expenditures in mental health and substance abuse; Drop out rates average 47% (higher for youth); Making matters worse is the fact that clinicians often fail to identify people at risk for dropping out or unsuccessful outcome. CDOI provides an early warning system to identify failing clients based on the best known predictors of outcome and retention.
- Two factors are strongly predictive of retention, progress, and the eventual success of treatment: The consumer’s rating of the alliance with the provider of services and the consumer’s rating of early progress in response to the provider, level, and type of treatment offered. CDOI monitors these two predictive variables with reliable, valid, and feasible outcome and alliance measures.
- Providing clinicians with ongoing consumer feedback regarding the alliance and progress in treatment dramatically increases success rates for at risk client (65% on average) as well as the cost-effectiveness (reduces cancellations, no shows, length of stay, etc) of provided services (see Miller, Duncan, et al., 2006; referenced articles available on request).

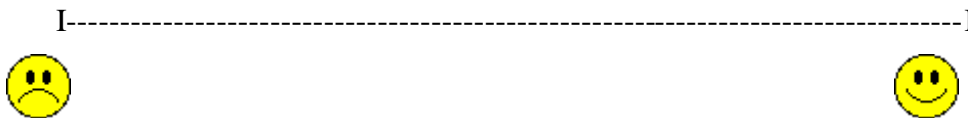
NB scales given below for reference only – to use you need to go to website to download and print out properly as length of line is crucial and although they are free they require copyright permissions.

Child Outcome Rating Scale (CORS)

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

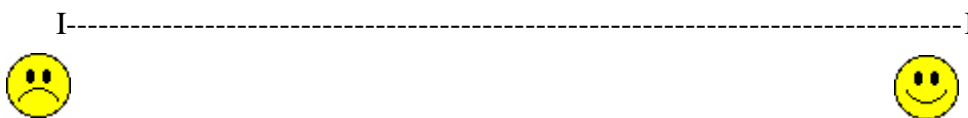
Me

(How am I doing?)



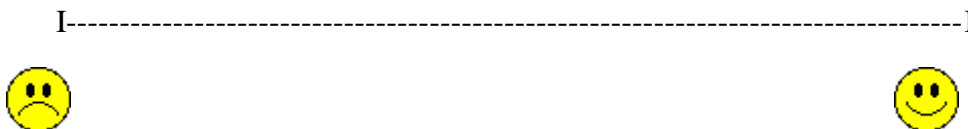
Family

(How are things in my family?)



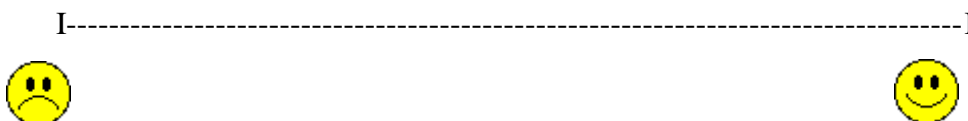
School

(How am I doing at school?)



Everything

(How is everything going?)



Institute for the Study of Therapeutic Change

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Child Session Rating Scale (CSRS)

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

did not always
listen to me.



listened to me.

How Important

What we did and
talked about was
not really that
important to me.



What we did and
talked about
were important
to me.

What We Did

I did not like
what we did
today.



I liked what
we did
today.

Overall

I wish we could do
something
different.



I hope we do the
same kind of
things next time.

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