

The Effectiveness of a Community Intensive Therapy Team on Young People's Mental Health Outcomes

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Background: UK-wide concerns about availability, cost, efficacy and inappropriate use of psychiatric inpatient provision for adolescents have led to the development of new models of intensive community based care. **Method:** This paper describes the Fife Intensive Therapy Team (FITT) model and provides an analysis of HoNOSCA (Health of the Nation Outcomes Scale for Children and Adolescents) data for 57 patients to evaluate the effectiveness of the service. **Results:** Following intervention by the FITT, a substantial and significant reduction in HoNOSCA scores was recorded. **Conclusions:** The apparent success of the model has implications for the future development of acute mental health services for young people.

Keywords: Young people; mental health; intensive therapy; community-based services

Introduction

The Mental Health of Children and Young People: Framework for Promotion, Prevention and Care (Scottish Executive, 2005) states that children and young people with severe mental health difficulties should be managed in the community wherever possible. It advocates the development of specialist community Child and Adolescent Mental Health Service (CAMHS) teams to provide intensive, flexible and rapidly accessible care. This paper describes the development and functions of one such team, the Fife Intensive Therapy Team [FITT], and evaluates its effectiveness.

Response to a local crisis

Fife is a largely rural region of Scotland with a population of approximately 360,000. The initial development of the FITT was in response to the crisis closure of the Fife adolescent psychiatric inpatient unit in 2002. An intensive, community-based service had to be set up quickly to respond to the needs of young people who would previously have been admitted, with the aim of avoiding, if possible, the need for inpatient care. This initial aim has been superseded by the more sophisticated goal of providing an alternative, more effective treatment model that is responsive to the needs of each individual young person and their family and is in line with national recommendations.

Concerns about psychiatric inpatient care

Psychiatric inpatient care for children and young people in Scotland is under increasing pressure and

is currently insufficient to meet need (Scottish Executive, 2004). Admissions of young people to adult psychiatric or paediatric wards for the treatment of mental illness are often inappropriate (Darwish et al., 2006) and it has been recommended that children and young people requiring psychiatric inpatient care should be admitted to developmentally appropriate environments (Scottish Executive, 2005). Other concerns have been raised about the value of inpatient services because of the high cost of hospital care (Gowers & Rowlands, 2005) and the difficulty of recruiting and retaining staff. This increases the stress on the young people receiving treatment as it is hard to provide the consistency in treatment that they need (Street, 2004). Moreover, the Department of Health (2006) stated that children and young people (and their parents, carers and families) with complex, severe and persistent problems need appropriate help to minimise the disruption to their lives caused by such problems, and that admission to psychiatric inpatient units and residential care should therefore be avoided where possible.

New models of care

Concerns about psychiatric inpatient provision for adolescents across the UK have led to the consideration of alternatives to traditional inpatient care and treatment and the development of new models of intensive home and community-based care (Van Den Berg & Grealish, 1996; Henggeler et al., 1997; Darwish et al., 2006). These approaches are mainly based on a bio-psycho-social, holistic model that emphasises the child's strengths and uses the expertise within the

family and the local community to maximise the support available. The theory is that a small change in a child's familiar environment will be more significant in their recovery than a larger change in a setting alien to them (Henggeler et al., 1997). Managing the young person within their community may overcome some of the perceived disadvantages of inpatient care: it avoids the loss of support from their local community; prevents the institutionalisation effects that can occur within inpatient settings; and minimizes the impact on families that occurs when a young family member is removed from their home setting (Green & Jones, 1998).

Monitoring outcomes

In providing a community based service for young people with severe mental health problems, the FITT incorporates a new model of care. The monitoring of outcomes is therefore a high priority. The Health of the Nation Outcomes Scale for Children and Adolescents (HoNOSCA) was chosen as a monitoring tool because of its extensive use in previous research to measure outcomes for this patient group (e.g. Green et al., 2001; Yates, Garralda, & Higginson, 1999; Garralda, Yates, & Higginson, 2000).

The Fife Intensive Therapy Team

The FITT is a nurse-led team whose core membership comprises a head of service (clinical nurse specialist), two senior nurse therapists, and a therapy support worker. All team members have extensive experience in responding therapeutically to the individual needs of young people who present with a broad range of severe and complex mental health difficulties. Three consultant child and adolescent psychiatrists provide regular consultation and support to the team. The consultants also provide psychiatric assessments and interventions for patients when required. Interventions are also occasionally sought from other disciplines from within the wider CAMHS multi-disciplinary workforce. The FITT forms part of a wider network of specialist CAMH teams and clinical services comprising clinicians from a range of disciplines.

The patients' presenting problems

The young people referred to the FITT are mostly aged between 11 and 18 years and, under a more traditional system of care, would have been at very high risk of admission to a psychiatric inpatient ward or unit. The team accepts referrals of patients who meet any of the following criteria:

- High risk of a rapid deterioration of mental health (with or without an associated deterioration of physical well being)
- Need for an intensive process of engagement
- A complex and/or diagnosable severe mental health disorder
- Urgent need of an ongoing risk assessment in relation to their current mental health

Referrals to the FITT can be routine or emergency. The response rate to referrals ranges from 24 hours to 3 days.

Nature of the work

The FITT work with young people in their own homes or in a suitably safe, community facility. The main functions and types of intervention provided to all patients seen by the team incorporate case management, continuing risk assessment, individual therapy, psycho-education for the patient and family, support in accessing alternative sources of support, and collaboration with other agencies (e.g. education, social work, adult mental health services and inpatient facilities). Other types of intervention offered include group therapy, social integration, supervision of medical interventions, and family therapy.

The FITT model emphasises the central importance of building and sustaining a therapeutic engagement with young people and their carers. This promotes the development of the collaborative partnerships necessary to promote and facilitate positive change within the social environment of each patient. In order to make sure that there is time to do this properly each clinician carries a caseload of five young people or fewer. For each patient there is an ongoing process of assessment, intensive therapeutic intervention, and review. This helps to provide a multi-dimensional understanding of an individual patient's needs within humanistic, systemic and bio-psycho-social frameworks. Flexible, responsive and adaptive interventions ensure that packages of care on offer reflect the level and nature of the assessed need. Interventions are community or home-based, and include an important component of identifying, labelling and building on the strengths of the family to enable them to continue to have the skills, confidence and stamina necessary for them to provide an appropriate level of care and support at home.

Study aims

The aims of this study were as follows: to assess the effectiveness of the FITT model by comparing patients' HoNOSCA scores between referral and discharge; and to examine personal and service characteristics affecting outcomes.

Method

Procedure

Data were collected over a period of approximately 3 years from September 2003 to September 2006 by members of the FITT. HoNOSCA scores were recorded at the point of a patient being referred to the team and on their discharge from the service. As recommended in the HoNOSCA training, all five clinicians in the service over the study period were involved in scoring the HoNOSCA: each clinician scored all the patients they were treating at both time points. They had all received HoNOSCA training. Other data recorded were: age, sex, presenting problem, information on any hospital admissions (number and type of hospital) following referral to the FITT, number of interventions and duration of time from referral to discharge (in weeks). An intervention is defined by the FITT as a clinical contact between a member of staff and a young person. The time taken for one intervention is very variable and can range from a 45-minute discussion to an entire day spent with the young person.

Measure

The HoNOSCA scale comprises 13 key clinical features, which can be grouped into four distinct categories: (1) Behavioural (aggressive/antisocial behaviour; over-activity/attention; self-harm; substance misuse); (2) Impairment (scholastic/language skills; physical disability); (3) Symptomatic (hallucinations and delusions; non-organic somatic symptoms; emotional and related symptoms); and (4) Social (peer relationships; self-care and independence; family life and relationships; poor school attendance) (Gowers et al., 1999). The scale has been found acceptable for its reliability (Brann, Coleman, & Luk, 2001), validity (Gowers et al., 1999; Yates et al., 1999) and ability to measure change (Gowers et al., 1999).

Analyses

Descriptive statistics were used to describe the sample characteristics. Wilcoxon signed ranks tests were performed to compare the mean total HoNOSCA scores on referral and on discharge, as well to compare the individual HoNOSCA items on referral and discharge, and the four main component scores (behavioural, impairment, symptomatic, and social), which were created by summing the items of each component. Non-parametric tests were chosen because the data for the majority of

single items and combined scores were not normally distributed. In order to show which was the best predictor of change in HoNOSCA score, a stepwise regression analyses was carried out, adding in 'number of interventions', 'duration of time from referral to discharge' and 'total HoNOSCA score on referral' as independent variables.

Results

Sample

There were 57 patients in the sample consisting of 27 males (47.4%) and 30 females (52.6%). The mean age of the sample was 15 ($SD = 1.8$; range 11–17), excluding two cases who were under 11 but of unspecified age. Nearly all cases (55/56 - missing data = 1) were seen by the FITT within the time scale planned.

A summary of the presenting problems on referral is given in Table 1. Mood disorder and self-harming behaviour were the most common presenting problems for this sample. The number of interventions (i.e. clinical contacts) for each patient was collected in ranges (<10; 10–20, 21–30, 31–40, 41–50 and >50). Among young people with data available on intervention ($N = 29$), the median score was found to be in the range of 21–30 interventions. The length of time from referral to discharge ranged from 2 weeks to 2 years (mean = 23.6 weeks, $SD = 14.7$ weeks; median = 20.0 weeks, $N = 55$).

Overall change in outcome

On referral, the mean HoNOSCA score was 19.12 ($SD = 6.53$) and at discharge 8.17 ($SD = 5.95$), with a mean decrease of 10.95 ($Z = -6.35$; $p < .001$, $N = 57$). Table 2 shows mean clinical HoNOSCA values for paired data on referral and discharge, and significance tests for the individual items of HoNOSCA and the four main component scores. The differences in HoNOSCA score between referral and discharge were significant for all four of the main component scores ($p < .001$). The differences in HoNOSCA score between referral and discharge were also highly significant for almost all of

Table 1. Reported problem/diagnosis on referral (percentages do not add up to 100% as more than one problem was present in some individuals)

Presenting disorder	Frequency (%)
Mood disorder	13 (22.8)
Self-harming behaviour	12 (21.1)
Psychosis	11 (19.3)
Eating disorder	11 (19.3)
Anxiety disorder	10 (17.5)
ASD (autism spectrum disorder)	5 (8.8)
PTSD (post-traumatic stress disorder)	5 (8.8)
Other constitutional (e.g ADHD, Tourettes)	2 (3.5)
Other	2 (3.5)

Table 2. Mean HoNOSCA values on referral and discharge and Wilcoxon signed ranks test values and significance levels

	Referral mean (SD)	Discharge mean (SD)	Wilcoxon Z and sig. (2-tailed)
Total HoNOSCA score:	19.12 (6.53)	8.17 (5.95)	-6.35; $p < .001$; $N = 57$
Disruptive, antisocial or aggressive behaviour	1.51 (1.33)	0.74 (0.94)	-4.32; $p < .001$; $N = 57$
Problems with overactivity, attention or concentration	1.56 (1.23)	0.68 (0.83)	-4.53; $p < .001$; $N = 57$
Non-accidental self-injury	1.63 (1.53)	0.30 (0.71)	-4.99; $p < .001$; $N = 57$
Alcohol, substance or solvent misuse	0.67 (1.12)	0.49 (0.85)	-1.26; $p = .21$; $N = 57$
Total behavioural score:	5.39 (3.26)	1.93 (1.93)	-5.89; $p < .001$; $N = 57$
Problems with scholastic or language skills	0.96 (1.07)	0.46 (0.68)	-3.93; $p < .001$; $N = 57$
Physical illness or disability	0.88 (1.32)	0.32 (0.78)	-3.22; $p < .001$; $N = 57$
Total impairment score:	1.85 (1.57)	0.76 (1.03)	-4.54; $p < .001$; $N = 57$
Hallucinations, delusions or abnormal perception	1.25 (1.55)	0.23 (0.57)	-4.36; $p < .001$; $N = 57$
Non-organic somatic symptoms	0.86 (1.22)	0.37 (0.67)	-3.30; $p < .01$; $N = 57$
Emotional and related symptoms	2.93 (0.86)	1.14 (1.04)	-6.00; $p < .001$; $N = 57$
Total symptomatic score:	4.97 (2.37)	1.71 (1.57)	-5.86; $p < .001$; $N = 57$
Problems with peer relationships	2.21 (1.07)	0.93 (0.98)	-5.44; $p < .001$; $N = 57$
Problems with self-care and independence	0.77 (0.95)	0.54 (0.87)	-2.14; $p < .05$; $N = 57$
Problems with family life and relationships	2.30 (1.09)	1.39 (1.01)	-4.70; $p < .001$; $N = 57$
Poor school attendance	1.60 (1.65)	0.60 (1.10)	-4.24; $p < .001$; $N = 57$
Total social score:	6.88 (2.84)	3.42 (2.98)	-5.86; $p < .001$; $N = 57$

the individual items ($p < .0001$), except for 'Alcohol, substance or solvent misuse' ($p = .21$) and 'Problems with self-care and independence' ($p < .05$).

Clinically significant change

Figure 1 shows how many of the patients had a clinically relevant change in HoNOSCA score from referral to discharge of four or more, (Sharma et al., 1999) and how many scored less than four. Nearly 90% of those treated improved at or beyond this 'clinically significant' change in score value. Of the 10% that do not fit into this 'clinically significant' category, there were three cases whose scores actually increased on discharge i.e. their condition deteriorated rather than improved. Thus it is clear that not all clients will benefit from this type of model but, having examined these cases in more detail, there is no specific pattern of presenting problem or length of intervention that may explain this finding.

Referral to inpatient facilities

Six admissions to inpatient facilities were made during treatment by the FITT over the period of this study, i.e. two referrals each year. These figures are in comparison to 27 inpatient admissions in 2001–02 to the Fife in-patient unit before it closed down in 2002.

Predictors of outcome: demographic, clinical and service factors

There was no difference between males (mean change = 11.63, $SD = 7.66$) and females (mean change = 10.59, $SD = 6.98$) in the extent of improvement in HoNOSCA score following FITT intervention ($t = -5.33$, $df = 54$, $p = .596$). Likewise there was no

association between age and change in HoNOSCA score ($r = 0.009$, $p = .946$, $N = 55$).

The duration of time from referral to discharge was significantly positively correlated with change in total HoNOSCA score ($r = 0.363$, $p = .006$, $N = 55$). The number of interventions was also found to be significantly positively correlated with change in total HoNOSCA score ($r = 0.426$, $p = .021$, $N = 29$). So, as the duration of time from referral to discharge or the number of interventions increased, a greater improvement in symptoms and functioning was reported.

There was a strong positive correlation between total HoNOSCA score on referral and the total change in score from referral to discharge ($r = 0.634$, $p < .001$, $N = 57$). This implies that the higher the level of symptoms and dysfunction on referral, the greater the improvement in symptoms and functioning.

Stepwise regression analyses suggested that the total HoNOSCA score on referral was the most important predictor of change (Beta = 0.744, $t = 5.781$, $p < .001$) meaning that improvement in symptoms was best explained by the greater number or severity of symptoms on referral. The number and duration of interventions were excluded from the predictive model.

Discussion

Main findings and comparison with previous literature

Following intervention by the FITT, a substantial and highly significant reduction in HoNOSCA scores was recorded. This represents a considerable reduction in both social and psychological dysfunction in the patients monitored. Using the policy adopted by Sharma, Wilkinson and Fear (1999) of categorising a change in score of 4 or more as being 'clinically significant', it has been seen that nearly 90% of the cases achieved this following treatment by the FITT. Although Sharma et al. (1999) developed this policy for the adult version of this scale (the HoNOS), we decided to apply the same level of change in score as 'clinically significant' as it is in line with Garralda et al.'s (2000) finding that 'marked improvements in parents' and referrers' global outcome measures were associated with HoNOSCA change scores of 4–5'.

Given the lack of control group, it cannot be assumed that any changes are as a result of the intervention by the FITT. However, the average change in clinical score attained by the FITT (10.95) was much greater than in previous studies. Garralda et al. (2000) found the mean decrease in HoNOSCA score in a sample of outpatients to be only 3.61 at 6 months after the initial consultation. Another study, sampling an inpatient population, recorded a mean decrease in HoNOSCA score of 5.76 from admission to discharge (Green et al., 2001). Patients in this study had a much higher HoNOSCA score on discharge (13.24) than patients in the FITT study (8.17). Gowers and Smyth (2004), who carried out a study involving adolescents suffering from anorexia nervosa, found an initial mean score of 18.8, which only dropped to 14.7 on the second assessment (change of 4.1). However, in their study the second assessment using HoNOSCA was taken after only 6 weeks of treatment (Gowers & Smyth, 2004). In contrast, the FITT

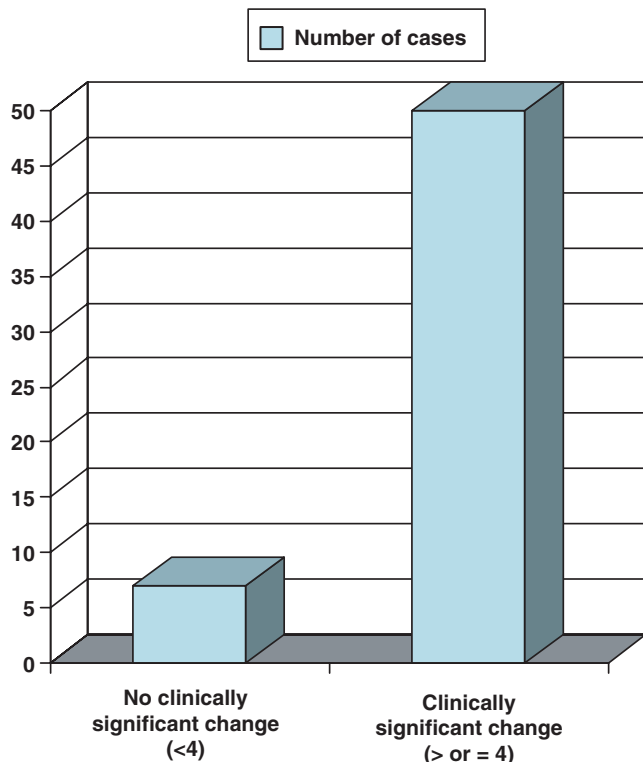


Figure 1. Number of clinically significant changes in scores from referral to discharge

saw young people for an average of 23 weeks, which may explain the greater improvement.

On closer examination of the individual component HoNOSCA scores, most showed a statistically significant improvement ($p < .001$) except for 'Alcohol, substance or solvent misuse' and 'Problems with self-care and independence'. The mean scores on these two items were lowest on referral, suggesting that they did not reduce over the intervention period because patients, on average, were reported as having only minor problems in those areas.

Predictors of outcome

The improvements in HoNOSCA scores could be attributed to interventions made by the FITT. The reduction in hallucinations and emotional symptoms could be attributed to a number of interventions, such as the supervision of drug regimes and identifying ways of maintaining compliance within a community setting. Identifying stressors early and quickly modifying the environment and providing individually tailored psychotherapeutic and psychosocial interventions that relate to the young person can also contribute to the reduction of these symptoms. Psychotherapeutic and psychosocial interventions may also have been responsible for other areas of improvement, for example in peer relationships and disruptive behaviour. The process of effective and thorough engagement, which promotes the young person and their family as being integral to the success of the treatment and places their needs at the centre of all decision making, is seen as essential. This, in addition to family therapy, is likely to have played a major part in the overall improvement seen in family life and relationships as well as positively influencing all other outcomes. It should also be noted that since a number of therapeutic interventions were often carried out for each individual patient, it is impossible to attribute any particular outcome to any one intervention.

Outcome following intervention by the FITT was not affected by the age or sex of the patient, which is in line with previous research in this area (Walrath, Mandell, & Leaf, 2001). This result could, at least in part, be attributed to the adaptability of FITT and the range of therapies at their disposal. These key features of the service allow the interventions offered to be tailored to the individual patient's needs.

Longer duration of time from referral to discharge and a greater number of interventions led to a greater improvement in the patient's symptoms and functioning. It has been proposed that, in certain forms of therapy, the greatest benefits derive from the relationship between the patient and therapist, which needs time to develop (Hubble, Duncan, & Miller, 1999). Moreover, extended time may allow the therapist to focus on helping the young person develop ways to increase their enjoyment of life and integration in society. This will not only reduce the likelihood of relapse but will help them flourish, i.e. to have better mental health or a sense of personal wellbeing (Keyes, 2007).

The most significant predictor of change in score from referral to discharge was initial HoNOSCA score on referral; patients with the most severe or complex difficulties on referral achieved the greatest reduction in

these difficulties. This effect was also noted by Garralda et al. (2000). This relationship could be attributed to the focusing of resources, in this case onto those patients with the most complex difficulties or the most acute disorders. Alternatively, it could be considered that the higher the HoNOSCA score on referral, the greater the decrease in score that must be achieved before the patient falls into a 'normal' range of function, and therefore the greater the decrease in HoNOSCA that must be achieved before discharge of the patient. A similar result was reported by Hemphill and Littlefield (2006), where children with reported higher levels of pre-existing behavioural and emotional problems showed greater improvement.

Study limitations

Since outcome was measured at discharge rather than at a fixed period of time (e.g. 6 months) as in many previous studies (e.g. Garralda et al., 2000), it is possible that the change in HoNOSCA score may have been inflated and could have been as a result of other factors, such as the chance of fluctuations in psychopathology underlying the young person's difficulties rather than the impact of intervention by the FITT. In other words, the patients could have improved spontaneously over time without any intervention. However, the mean length of intervention by the FITT was 23.6 weeks, i.e. approximately 6 months, so the majority of the patients were being discharged around this time.

Moreover, the statistical phenomenon of 'regression to the mean' may explain the difference found, meaning that it is not the intervention that makes the difference, but the natural regression to the population mean over a period of time. This may be particularly true because of the extreme nature of the group: the sample scores on referral were not normally distributed, i.e. the sample was taken from a group who were likely to have HoNOSCA scores in a range much higher than the average population mean. The severity of cases referred to the FITT is at the same level as would normally be referred to an inpatient unit: a previous study involving a CAMHS *inpatient* population reported a mean HoNOSCA score on referral of 19.0 (Green et al., 2001), which was very similar to that recorded by the FITT. The phenomenon of regression to the mean may also explain why the strongest predictor of change was a high HoNOSCA score on referral. However, the scale of the reduction in scores is much greater than previous studies with similar patient groups, suggesting that the FITT interventions may indeed be having an impact for the majority of patients. Moreover the client group were significantly unwell on referral as indicated by their high HoNOSCA scores, so the chances of them just 'getting better' over time were slim.

There is also a concern that the clinician performing the test may unconsciously have scored in a biased way, i.e. they may have wanted to believe, or already believed, their treatment programme was effective. The test does indeed rely on the honesty of the rater. Moreover, the clinicians may simply have reported a lower score the second time around, a phenomenon referred to as attenuation. However, the clinicians involved were actually primarily aiming to identify where there were shortcomings and therefore not look-

ing to over-emphasise their effectiveness. Moreover, for pragmatic reasons, it was necessary for the same clinician who treated the patient to rate the patient before and after treatment. This method is recommended in the HoNOSCA training information.

The study is also limited by the lack of feedback from other informants, i.e. patients, families and referrers about their perceptions of difficulties as this would have provided a much wider view of the outcomes of service delivery. However, the HoNOSCA user-rated scales were not available at the time this study was carried out. Also, there were insufficient resources at the time of this study to administer questionnaires to these groups. Further research should consider using multiple informants and also measuring patient/family satisfaction with the service and their views on how it has worked for them and any improvements that they think could be made.

Implications for practice

This data show that the establishment of a community-based intensive therapy team within Fife CAMHS has ensured that young people presenting with severe mental illness (equivalent to an inpatient population) in Fife have been treated, where possible, in their own environment in a manner that has resulted in significant improvements in HoNOSCA scores. In managing young people within their own environment, the difficulties arising from inpatient admission are avoided and the focus is no longer only on reducing the symptoms of mental illness, but on ensuring the young person functions at their optimum level within their own community. By engaging families, schools and communities in partnerships in such a way that existing skills and strengths are identified, a network of support is created where those involved feel part of the solution rather than part of the problem.

It is important to stress that community models such as the FITT do not replace the need for inpatient care. There are some children and young people who, despite a fully comprehensive community mental health service, require an intensity of treatment that can only be provided on an inpatient basis (Scottish Executive, 2004). However, it is also acknowledged that the development of community-based services may have an impact on the use of inpatient units in the longer term (Scottish Executive, 2004). The success of non-hospital acute models such as the FITT is already contributing to a re-evaluation of acute service provision nationally. This is primarily through the encouragement of new thinking about the possibilities of providing a different type of community care; one that fills the current gap between more traditional models of community provision and an inpatient service. If services such as the FITT become more widely available, it may be possible to shorten considerably the length of admissions of some patients who do require hospitalisation.

The success of the FITT raises a number of questions at national level about the financial implications of providing alternatives to inpatient care. Due to the intensive nature of the service provision, the FITT is not cheap when viewed in the context of other CAMHS. However, when compared to the costs of financing out-of-area admissions to specialist inpatient resources,

this type of model represents excellent value for money (Beecham et al., 2003). By investing in this model, and through the careful embedding of the model within a supportive wider CAMH Service context, NHS Fife has demonstrated how resources can be used to their full potential, whilst fulfilling the recommendations of the Scottish Executive (2005) for 'intensive, flexible and rapidly accessible care'.

References

- Beecham, J., Chisholm, D., O'Herily, A., & Astin, J. (2003). Variations in the costs of child and adolescent psychiatric inpatient units. *British Journal of Psychiatry*, *183*, 220–225.
- Brann, P., Coleman, G., & Luk, E. (2001). Routine outcome measurement in a child and adolescent mental health service: An evaluation of HoNOSCA. *Australian and New Zealand Journal of Psychiatry*, *35*, 370–376.
- Darwish, A., Salmon, G., Ahuja, A., & Steed, L. (2006). The community intensive therapy team: Development and philosophy of a new service. *Clinical Child Psychology and Psychiatry*, *11*, 591–605.
- Department of Health (1992). *Health of the nation strategy*.
- Department of Health (2006). *Report on the implementation of Standard 9 of the national service framework for children, young people and maternity services*.
- Garralda, M. E., Yates, P., & Higginson, I. (2000). Child and adolescent mental health service use HoNOSCA as an outcome measure. *British Journal of Psychiatry*, *177*, 52–58.
- Gowers, S. G., Harrington, R. C., Whitton, A., Lelliott, P., Beevor, A., Wing, J., & Jezzard, R. (1999). Brief scale for measuring the outcomes of emotional and behavioural disorders in children: Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). *British Journal of Psychiatry*, *174*, 413–416.
- Gowers, S. G., & Rowlands, L. (2005). Inpatient services. *Current Opinion in Psychiatry*, *18*, 445–448.
- Gowers, S. G., & Smyth, B. (2004). The impact of a motivational assessment interview on initial response to treatment in adolescent anorexia nervosa. *European Eating Disorders Review*, *12*, 87–93.
- Green, J. M., & Jones, D. (1998). Unwanted effects of inpatient treatment: anticipation, prevention, repair. In J. M. Green & B. W. Jacobs (Eds.), *Inpatient child psychiatry: Modern practice research and the future* (pp. 212–220). London: Routledge.
- Green, J., Kroll, L., Imrie, D., Frances, F. M., Begum, K., Harrison, L., & Anson, R. (2001). Health gain and outcome predictors during inpatient and related day treatment in child and adolescent psychiatry. *American Academy of Child and Adolescent Psychiatry*, *40*, 325–332.
- Hemphill, S. A., & Littlefield, L. (2006). Child and family predictors of therapy outcome for children with behavioural and emotional problems. *Child Psychiatry and Human Development*, *36*, 329–349.
- Henggeler, S. W., Rowland, M. D., Pickrel, S. G., Miller, S. L., Cunningham, P. B., Santos, A. B., Schoenwald, S. K., Randall, J., & Edwards, J. E. (1997). Investigating family-based alternatives to institution-based mental health services for youth: Lessons learned from the pilot study of a randomized field trial. *Journal of Clinical Child Psychology*, *26*, 226–233.
- Hubble, M. A., Duncan, B. L., & Miller, S. (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.
- Keys, C. L. M. (2007). Promoting and protecting mental health as flourishing. *American Psychologist*, *62*, 95–108.

- Scottish Executive (2004). *Psychiatric inpatient services for children and young people in Scotland: A way forward*. Child Health Support Group: Inpatient Working Group Report.
- Scottish Executive (2005). *The mental health of children and young people: A framework for promotion, prevention and care*.
- Sharma, V. K., Wilkinson, G., & Fear, S. (1999). Health of the Nation Outcome Scales: A case study in general psychiatry. *British Journal of Psychiatry*, 174, 395–398.
- Street, C. (2004). In-patient mental health services for young people: Changing to meet new needs? *Journal of the Royal Society of Health*, 124, 115–118.
- Van Den Berg, J. E., & Grealish, E. M. (1996). Individualised services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Studies*, 5, 7–21.
- Walrath, C. M., Mandell, D. S., & Leaf, P. J. (2001). Response of children with different intake profiles to mental health treatment. *Psychiatric Services*, 52, 196–201.
- Yates, P., Garralda, M. E., & Higginson, I. (1999). Paddington Complexity Scale and Health of the Nations Outcomes Scales for Children and Adolescents. *British Journal of Psychiatry*, 174, 417–442.