The early response project:

A voluntary sector contribution to CAMHS

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KEY POINTS

- Early intervention for children at risk of developing mental health problems should be an essential feature of service planning and delivery.
- The Early Response Project (ERP) was established in primary care settings to optimise early access to services in familiar settings.
- Features of the ERP include ease of access, a client-led service and open-ended timescales.
- Speed of response was an important aim of the service. The average time between referral and contact was 8 days.

THE EARLY Response Project (ERP) was developed by the Leicester Family Service Unit, a voluntary agency and is, after the specialist CAMH service, one of the main providers of therapeutic services for children and families in its local area. The Family Service Unit (FSU) received a three-year grant from the National Lottery, and the ERP was operational from 1999 to 2002. In providing its service to families, the ERP moved out of its agency home and operated within primary health care settings. This article will set out the background and aims of the ERP, describe its activities and methods, and report on its outcomes.[1] It is hoped that the example of this particular project will suggest possibilities for the involvement of the voluntary sector in a local CAMHS strategy.

Influences

There were various strands of thinking at the FSU, which led to the development of the ERP. The overriding concern was to respond to the perceived problem of lengthy waiting times for families following referral for a specialist service. The agency's own experience of this reflected widespread concerns about waiting times across the UK, which have been well documented.[2] It is now generally accepted that early intervention for children at risk of developing mental health problems should be an essential feature in service planning and delivery.[3] Another factor that shaped the ERP was the history of solution-focused practice within the FSU. Given the evidence regarding the effectiveness of solution-focused practice over relatively short periods,[4] it was felt that this particular therapeutic approach would help to achieve the objective of early intervention.

Complementing statutory CAMH services

At the same time that the agency was shaping these aims for the ERP, the local joint CAMHS strategy was being developed.[5]

Although the thinking behind the ERP was similar to that informing the CAMHS strategy, at this stage both were being developed separately. When I was appointed as the ERP co-ordinator in the summer of 1998, I felt it was important to attempt to situate the project within the strategy. Despite the positive reputation enjoyed locally by the FSU, and the strong desire on the part of the joint strategy steering group and their manager to include the voluntary sector, this was not a straightforward task. Maintaining the profile of the ERP within the strategy, was an even greater challenge, especially as the new services being created in the statutory sector – health, education and social services – came on stream. Voluntary agencies tend not to have the infrastructure of the local statutory services, and for example, attendance at steering group meetings can be problematic. The experience of the ERP suggests that further consideration is needed concerning the involvement of small-scale voluntary sector services in multi-agency developments.

A primary health care setting

In order to best achieve the aim of providing an early response to families asking for help, we had to consider where to situate the service to be offered. Following consultation with other agencies, it was decided that we would attempt to set up family 'surgeries' in primary healthcare settings. It should be remembered that the FSU was a voluntary sector body, staffed mainly by social workers, and so this decision was not as clear-cut as it might have been with, for example, primary mental health workers employed within the health service. However, anecdotal evidence suggested that parents were far more likely to approach their GP or health visitor if they had concerns about their children, rather than approaching local social services. Therefore it made sense to be in close proximity to these professionals in providing our service.

During this setting up phase, the new joint CAMHS strategy services, also aimed at Tier 1/Tier2,[6] were being manoeuvred into place. As the first wave of these services was only to cover certain parts of the locality, it was decided that the ERP would complement this by being based in other geographical areas. Links were made with GP practices in three areas, and in two of these areas we were provided with a room in which to see families, in a GP surgery and in a health centre. The FSU's own building became the venue for the third area. During the ERP's first year and following an approach made by another GP practice, a fourth area was added, families being seen at that GP surgery.

Who could receive help from the ERP?

The service was aimed at any family where a parent or carer was asking for help, in relation to one or more of their children, of any age under eighteen. As the ERP was aimed at the primary care level, the only stipulation made was that the family were not already actively receiving a service at a higher tier. This referred to both health and social care, i.e. that they were not an open case in the specialist CAMH service or for a long-term social services child care team. The majority of referrals were received from GPs and health visitors, but any child care professional, for example duty social workers, community paediatricians and education staff, could refer families. Parents could also contact the ERP directly.

Essential features

The following features were essential in the development of the four surgeries:

- Ease of referral. Referrers could make contact by telephone, letter, or by completing a brief form. Large amounts of information were not required.
- Lack of 'gatekeeping'. If a parent lived in one of the areas served, or was on the relevant GP's list, then a service was offered (with the proviso mentioned above).
- Client-led. The parent/carer who was asking for help determined who should be seen. The only stipulation made was that we would not see a young person alone in the first instance.
- Open-ended timescales. After the initial (six month) pilot period, when two of the areas had three-session limits, parents could continue receiving help for as long as they felt it was needed.

The primary concern leading to the development of the ERP was the perceived problem of lengthy waiting times for families following referral for a specialist service.

Who provided the service?

The service offered took the form of family counselling, with solution focused brief therapy (SFBT)[1] being the method predominantly used. Most sessions were conducted by an individual worker, with co-working in some cases. The project co-ordinator undertook the majority of family work, but during the third year of operation a second worker was employed by the ERP and saw a significant number of families. Other social workers employed by the FSU, experienced in the solution focused approach, were also involved, either as co-worker or individually, on an occasional basis.

An attempted innovation of the ERP was to use volunteers, and to this end the co-ordinator provided training in solution focused skills to a group of local people already qualified or experienced in a helping profession. Five volunteers reached a stage where they were able to lead family sessions, but this aspect of the ERP ended after two years, as the project's staffing structure did not enable sufficient ongoing training and supervision. Interesting lessons were learned here, but further elaboration is not within the scope of this article.

A case history

The work done with the Greig family (all names have been changed to preserve anonymity) will serve as an illustration of how the ERP operated. They were referred by their GP via a telephone call to the project co-ordinator.

Margaret and Duncan were the parents of James, 15, their only child. Margaret had taken James to see the GP on the advice of his school, following violent behaviour that had led to his suspension. The school felt that a CAMHS referral was required. Margaret had a history of depression and had taken an overdose, described by the GP as 'fairly serious', a couple of months previously. The ERP was now seen by the GP practice as an alternative CAMHS referral route, particularly when presented with a behavioural problem.

The first action taken by the project co-ordinator was to telephone Margaret, as she was the parent asking for help. This took place the day following the referral. The service was explained to Margaret and an appointment made for six days later. It was also explained that either she or Duncan would need to attend, but that otherwise it was up to them who came. In the event, Duncan and James turned up for the first session, explaining that Margaret had had to wait at home for a delivery. Following a solution focused approach, the worker (the project co-ordinator) asked Duncan and James about their hopes for coming to the sessions, and about how they would like their lives to be different. Interestingly, they did not refer to James' behaviour at school, but both described their desire for a more peaceful atmosphere at home, where they would be able to talk to each other without a row developing. James added that he would not be worried about his Mum. They were then asked about progress already being made towards this 'preferred future' and it emerged that there had not been any arguments at home over the past two weeks. Having asked about their part in achieving this, the worker gave Duncan and James some compliments about the positive actions they were taking.

Duncan and James decided they would like another appointment and a further session took place two weeks later. This time all three attended and as it was Margaret's first session, the major part of it was devoted to her detailed description of her 'preferred future'. She had stated her overall goal as James controlling his anger, but when invited to consider the differences this would make, Margaret painted a picture of a relaxed and considerate family life similar to the descriptions of Duncan and James in the first session. Duncan and James felt that progress was being maintained or even slightly improved, while Margaret also felt that there had been improvements, but on a more modest scale.

The third and final session took place three weeks later and again all three attended. The family were continuing to make improvements, although Margaret remained more cautious than James and Duncan. She wanted James' outbursts at school to be addressed more directly, and most of the session was spent on this particular issue. James had been back at school for some weeks, and had not had any further violent outbursts. He was asked to describe how he had managed to stop these from happening and he gave some examples of having dealt with irritations at school in more constructive ways, for example by walking away from them. James talked about how he could keep these strategies going and felt confident that he could do so.

This work took place during the ERP's initial 6 month pilot period, and so ended at this point, due to the three-session limit. During the pilot, one of the areas offered open-ended sessions, yet an early response still proved possible there. The decision was therefore taken to lift the limit on the number of sessions families could have. The families could decide when the work should be finished, which fitted more with a solution focused way of working.

Outcomes

During its three years of operation the ERP received 558 referrals. All were contacted, by telephone where possible, otherwise by letter and for the vast majority an appointment was made. In a small number of cases, following a telephone conversation, the parent decided not to take up the service offered. Four hundred and fifteen families (74%) were seen. The average number of sessions per family was 2.7, which appeared to confirm that an imposed limit of three sessions was not necessary. A breakdown of those making the referrals is illustrated in table 1.

An important aim of the ERP was to respond as quickly as possible following a request for help. The times that elapsed between referral and first contact, and between referral and first session, were therefore recorded as part of the project's evaluation. The average time between referral and first contact was 8 days (including non-working days), and between referral and first session was 19 days.

Source of referrals	Number of referrals made
GP	171
Health visitor	156
School nurse	8
Community Paediatrician	26
Social services	74
Education	71
Community psychiatric nurse	2
Voluntary agency	2
Probation	1
Self (or other family member)	94

Table 1. *Breakdown of referrers to the project*

Three measures were used to follow up the effectiveness of the ERP's work. Questionnaires were sent out to parents and referrers at the end of each involvement. This practice continued throughout the life of the project, and a telephone follow up study was carried out with the first 72 families who had been seen.

Attempts were made to contact these families between six months and a year following completion of the work with them. The telephone follow up was carried out by student social workers on placement at the FSU, and was not extended beyond the first 72 families due to those placements ending.

The main results of the client follow up are summarised in tables 2 to 5. There was approximately a 25% return rate for parent questionnaires (101), 81% stating that the problems which led to the referral had improved, and 78% that they were coping better than at the time of referral. The students undertaking the telephone follow up managed to contact 40 (56%) of the 72 parents in the sample. Problems had decreased for 62.5% of respondents, another 30% said they were now still the same, only 5% said they had become worse) and 75% that they were now coping better with difficulties.

"Since you were referred to the ERP, the problems that led to the referral have...?"		
Improved a lot	38	38 (%)
Improved a little	43	43 (%)
Stayed the same	13	13 (%)
Became a little worse	4	4 (%)
Become worse	3	3 (%)

Table 2. *Parent questionnaire, question 1*

"Since you were referred to the ERP, you feel that you have coped with difficulties which continue...?"		
A lot better	39	39 (%)
A little better	39	39 (%)
The same as before	18	18 (%)
Not as well	3	3 (%)
Did not answer	2	2 (%)

Table 3. *Parent questionnaire, question 3*

Client's problem rating after 6 months to 1 year		
Improved a lot	16	40 (%)
Improved a little	9	22.5 (%)
Stayed the same	12	30 (%)
Became a little worse	1	2.5 (%)
Become worse	1	2.5 (%)
Did not answer	1	2.5(%)

Table 4. *Telephone follow up, question 1*

Coping level after 6 months to 1 year		
A lot better	22	55 (%)
A little better	8	20 (%)
Same as before	8	20 (%)
Not as well	2	5 (%)

Table 5. *Telephone follow up, question 2*

The majority of referrers contacted had not had further contact with the family since the referral, which was felt likely to be a positive sign. Where there had been further contact, referrers were asked to assess on a scale between 0 (worse) and 10 (better) the improvements in the problem and how the parents were coping. The average ratings were 6.2 and 6.5 respectively.

Conclusion

The experience of the Early Response Project demonstrates that the voluntary sector can play a useful role in a local CAMHS strategy. The positioning of the ERP outside mainstream services provided the freedom to develop an innovative way of working, while still complementing the statutory provision. The results, particularly given the different methods of evaluation utilised, bear out the effectiveness of a solution-focused approach. ◆

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