

Evaluation of the Primary Mental Health Specialist (Infant Mental Health) Programme in North Bristol NHS Trust and United Bristol Healthcare NHS Trust



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Final Report



University of the West of England, Bristol

Evaluation of the Primary Mental Health Specialist (Infant Mental Health) Programme in North Bristol NHS Trust (NBT) and United Bristol Healthcare NHS Trust (UBHT)

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CONTENTS

Acknowledgments	2
Evaluation summary	5
Background	12
Methods	17
Results	24
<i>The views of the PMHS workers</i>	24
<i>The views of the stakeholders</i>	40
<i>The views of the Health Visitors</i>	49
<i>The views of the clients</i>	62
<i>Evaluation of PMHS Training Work</i>	73
<i>Evaluation of PMHS activity</i>	79
<i>Measures of maternal well-being</i>	92
<i>Measures of child behaviour</i>	97
Discussion	106
Conclusions and recommendations	115
Appendices	119
1. Assessment instruments	119
2. Case summary sheet	121
3. Introductory client letter	122
4. Introductory client information sheet	123
5. Client consent form	125
6. General health Questionnaire – 12 item version	126
7. HV questionnaire letter	127
8. HV questionnaire	128
9. HV Interview consent form	130
10. Client 4 th contact letter	131
11. Client discharge evaluation letter	132
12. Client 6-month intervention evaluation letter	133
13. Client Experience of Service Questionnaire	134
14. Client interview consent form	136
15. PMHS staff evaluation flow chart instructions	137
16. PMHS Activity Record data form	138
17. PMHS training session evaluation form	139

Evaluation summary¹

Over a period of 20 months, including 12 months of intensive data collection ending on December 31st 2007, the Primary Mental Health Specialist (Under 5s) service operating in Bristol, UK was evaluated on themes of relevance, accessibility, acceptability, equity, efficiency, and effectiveness. Primary sources of data were Health Visitors (HVs), health care, social care and educational professionals attending PMHS training sessions, the PMHS workers themselves, clients of the service, and stakeholders in the service. Data obtained from eight different questionnaires or forms were supplemented by interviews with 4 different interest groups including a broad set of clinical, managerial, administrative and service-related stakeholders. Recruited clients completed questionnaires on their own well-being (on 2 occasions), their child's behaviour (on 3 occasions) and their experience of the service. Quantitative information was obtained on the time spent by PMHS staff in different activities and a geographical analysis of clients within the whole catchment area was performed in relation to indices of deprivation.

The views of the PMHS workers

As a new group of practitioners developing their role and making links with established colleagues in the CAMHS team there appeared to be both a divergence in the degree to which the PMHS see themselves as working as part of the CAMHS team and the extent to which this is deemed as appropriate. A positive working relationship with CAMHS is fundamental to the PMHS perception of acceptability of being fully integrated. Divergence of opinion was also reflected in the varying descriptions given to the tier level of working cited by each practitioner, with an emphasis on working closely with Health Visitors to support them in their preventive work with under 5s. PMHS workers reported that changes in health visiting provision and an emphasis on child protection have negatively influenced their capability to build capacity with Health Visitors Bristol wide, and there is an acknowledgement of the importance of offering training and support to other practitioners in the community such as play workers and nursery nurses to achieve this goal. There appears to be an acceptance that traditional psychotherapeutic models of working have to

¹ *This paper describes an evaluation conducted between June 2006 and March 2008 on the Primary Mental Health Specialist (Infant Mental Health) service operating in two NHS trusts in the Bristol area. It is entirely restricted to the service covering the pre-school (under 5s age groups) and not to the primary and adolescent services with similar names.*

be supplemented in the community with other indirect ways of working such as through community groups and nurseries, particularly with regard to addressing inequalities around access for minority ethnic groups. There continues to be debate around the acceptability of the name of the service, though recognition that while it is funded as part of the CAMHS teams it needs to be clear with clients that this is so.

The views of the stakeholders

There was universality in opinion on the high overall value placed on the objectives and efforts of the PMHS service, across the spread of clinical, community, managerial and administrative respondents. The clinical, administrative and managerial position of the PMHS service within the existing CAMHS teams was seen as a critical issue for the future development of a joined-up service. Clinically, the further incorporation of PMHS therapeutic work into the CAMHS working model based on multi-specialist team work was seen by most as desirable or essential. In addition, however, the contribution of specialist, community-based approaches with preventive, long-term objectives was also recognised by some to be of value in widening the scope and orientation of the more traditional, Tier-defined system of child mental health care embraced by many CAMHS professionals. The psychotherapeutic approach used by PMHS practitioners was seen as generally appropriate but concerns were voiced that other models of working embraced by the wider CAMHS teams could also be useful on occasions, reinforcing the value of closer working and possibly more internal referrals. There was broad agreement that managerial reform within CAMHS would be helpful and important in finding the optimal structures to aid closer working patterns, including more consistency in case referral management, intake and discharge procedures, and involvement in team meetings. This may also require a more formal initiation of PMHS staff into the various CAMHS specialisms.

The introduction of the PMHS service has accentuated old debates about resource allocation priorities, Tier-defined services, preventive and responsive work, linkage with adult mental health services, and the role of community-based staff such as HVs and social workers in mental health work. Cutting across many of these traditional barriers the PMHS service may act in an important pioneering role, not least in epitomising the concept of the 'expert team around the child' now being developed in the form of multi-agency panels. Retaining specialist clinical connections will remain essential, however, and the danger of

becoming peripheral requires careful consideration after further consultation and visionary management action.

The views of the Health Visitors

Case complexity and lack of progress with clients were the predominant reasons reported for contact with the PMHS service in questionnaires completed by Health Visitors, but nearly three-quarters of HVs felt that with sufficient resources they had confidence to manage all but the most difficult cases themselves. High levels of satisfaction were reported by HVs of the PMHS service in all areas of their contact and overall. Some comments relating to the desirability for PMHS staff to increase their HV contact and support work (shorten waiting times, increased communication and additional training) were received. Some HVs' responses indicated that they would benefit from further supportive assistance from the PMHS service and more time to engage themselves in intervention work, whilst others see the PMHS service as primarily offering referral opportunities.

In interviews there was a sense that HVs perceived their workload to have increased in recent years, a point not always appreciated by the PMHS who try to encourage them to continue with their clients with PMHS support or supervision. To be effective increased time consulting with individual clients would be required and HV services expanded accordingly. Less experienced HV participants valued the training opportunities offered by joint visits and supervision, but most commented on the time-consuming nature of these in relation to the other demands of their caseload. Some HVs had experienced problems in obtaining funding to attend PMHS-facilitated training to support their work with this group of clients. A number of HVs wished the PMHS service to be expanded to enable more face-to-face contact with clients. Equity issues arose in relation to referrals, with some participants commenting on variation in practice relating to families also involved with social services. The opinion was voiced of the name of the service being a barrier to referral in some communities, and the PMHS approach itself not taking sufficient account of differences in child rearing practices in other cultures.

The views of the clients

High levels of overall satisfaction with the PMHS service were recorded by clients in self-completion questionnaires with slightly higher levels in areas of contact, approach and actions, than in their perceived impact on the family. Clients especially reported valuing the engagement and individual support and counselling aspects of the service

A small number of client interviews were achieved although these comprised a range of family types (single parent, cohabiting, married) and mothers were from both professional and non professional occupational groups. The interviews where negative views were expressed suggested there may be a group of clients for whom a psychotherapeutic approach is not so acceptable, that is, those with longstanding problems, a fixed view of the cause of the problems, clear expectations of what support they required from the PMHS, or those who were unwilling or unable to reflect on possible contributing factors. The majority of interview participants, however, had been able to explore deep-seated emotional and personal issues with the PMHS and had gained insight into how their feelings might be affecting their parenting. They appeared to learn how better to communicate with their children and had a new appreciation of their child's feelings. These tools enabled them to more effectively understand and manage their children's behaviour. Participants were positive about the long term nature of the changes, though there was less consensus in terms of their confidence for the future. The name of the service was raised as being a potential barrier to service use in two cases.

Evaluation of PMHS Training Work

PMHS staff were all involved in training a very broad cadre of mostly community-based health professionals, primarily conducted in pairs lasting one or two sessions and covering various aspects of infant mental health in a mixture of single professional and multi professional groups. Attendants reported very high levels of satisfaction with the training received on a variety of indices, including both knowledge/understanding and transferable skills, especially those relating to the 'needs of the child'. Feedback data and comments suggested that further consideration of the session structures to allow more discussion time (perhaps achieved by refinements in presentation methods and longer sessions), and a greater focus on links between the training and clinical case management support to some health workers, would be appreciated. This might consist of topic specific sessions for Community Nursery Nurses and

Early Years Practitioners, or further guidance on how they can directly access advisory or supervisory contact with PMHS workers to enhance their family casework.

Evaluation of PMHS activity

Analysis of the time sheets over a complete calendar year demonstrated that client contact time, including the management of client appointments and record keeping (but *excluding* travel) exceeds the recommended 25%. Approximately 40% of PMHS time is spent in administrative work (including case recording) and travel, activity areas that might be amenable to modification. High individual variation exists in key activity time distribution that might also be useful for performance review of the service as a whole. The broad range of activities required in these posts provides particular time-budgeting challenges for PMHS staff on part-time contracts. Taking individual variation into account no statistically significant differences were determined in key activity time distributions between the PMHS service provided by the 2 NHS Trusts.

A total of 127 new clinical cases were started by PMHS staff during the 2007 calendar year. Two thirds of the first reported presenting problems related to behaviour and attachment difficulties but individual variation in recording might have influenced this. The vast majority of referrers were HVs although doctors referred directly in almost a quarter of cases. The age distribution of index children in referred cases was bi-modal with a relatively small number being referred to the PMHS service in their second year. The mean number of PMHS-client contacts *per 2007-completed case* was 5.1. The number of contacts and the intervention period appeared to be longer in one NHS Trust compared to the other, although lack of data confounded detailed analysis. Examination of the socio-economic distribution of all cases in 2007 indicated that the PMHS service as a whole was focussed on the more deprived sectors of the community and that levels of deprivation were higher in the residential areas of cases managed by UBHT than by NBT.

Measures of maternal well-being

Of the 67 carers assessed at or shortly after recruitment, 55.2% met the criterion of being at high risk of having a clinically significant affective mental condition (compared with 15.2% of a comparable group from the Health Survey for England 2005). Whilst the longitudinal trend over the PMHS intervention period was towards lower scores neither the GHQ-12

total score nor the proportion meeting the clinical criterion was statistically significantly reduced.

Measures of child behaviour

Most indices of child outcome based on the ASQ:SE questionnaires were consistent with an improvement (i.e. reduction) in the number of disturbance-indicating behaviours and carers' concerns reported. The largest differences occurred between recruitment and the 4th visit, most of these reaching statistical significance. Precise quantification of change was confounded by differences between families remaining in the evaluation for different periods, and small sample sizes. Most improvement occurred, however, in those with most apparent need. Attributing these changes to the PMHS intervention demands care as no control groups (matched cases with no PMHS intervention) were included. However significant changes determined over a relatively short period of intervention is of interest and consistent with an effect of service.

Conclusions

This study has found that the Primary Mental Health Specialist (Under Fives) staff in North Bristol NHS Trust and United Bristol Healthcare NHS Trust provide a service that crosses traditional Tier and age-defined boundaries and is highly valued by both clients and referrers to the service alike. Their training role is also valued highly and there is evidence of positive clinical impact, especially in the short term. The part played by PMHS staff providing a specialist service in managing complex family situations, including adult mental ill health and disturbed pre-school age children in the community, is unique.

Placement of the PMHS service remains problematic although, despite differences of opinion within the PMHS, the majority of stakeholders thought remaining within CAMHS was desirable. At present the PMHS service in some locations is only partly embedded in CAMHS. Changes in attitude, activity, understanding and knowledge within CAMHS and PMHS are occurring but more is required, together with more rational management structures, to promote service integration.

High levels of overall satisfaction were reported for PMHS services from Health Visitors. However, the close and time-consuming role played by PMHS staff in supporting advanced Health Visitor direct work with clients is only partly successful. Some Health Visitors see

this as expanding their understanding and developing their skills and confidence in client work, whilst many others see this as increasing their workload and would prefer to refer on clients with complex problems. Health Visitor management views are negatively affected by staff shortage and responsibility overload. The PMHS service should not shy away from reviewing this relationship constructively.

Recommendations are tentatively proposed (see page 116), covering placement and management, working practices, and clinical effectiveness, which might assist or resolve some of these issues within the new management structures that will emerge following the resolution of the contestability process to identify an integrated service provider. This refreshment opportunity should be exploited to reflect and review current practice and consider some new ways of providing this valued and valuable service. Information on the long-term effects of PMHS (and CAMHS) work with clients remains unknown and steps should be taken now to build in procedures for longitudinal assessment, so as to inform planners and policy makers on the consequences of early intervention on child development, family functioning and adult mental health.

BACKGROUND

In July 2001 a health visitor working for Bristol North Primary Care Trust was seconded to a new post (Specialist Health Visitor in Infant Mental Health 0 – 4 years of age) designed to support the needs of very young children and their parents in cases where specifically behavioural or emotional problems had emerged. The post was funded by the Bristol North Primary Care Group (now Trust) board following a recommendation by the Bristol North Modernisation Task Group on priorities to deal with health inequalities. The wider context of the post was the pressures placed on CAMHS teams to see older children of school age with more established behavioural and emotional difficulties, and the consequent low placement of the very young children on the waiting lists. A key rationale underpinning the case for this post was that by undertaking early interventions a more strategic and preventative approach to later more acute psychological problems could be introduced. This rationale has now been recognised in Standard 9 of the National Service Framework for Children, Young People and the Maternity Services (October 2004), which refers to the importance of primary care services, early intervention and the promotion of parent-child relationships in tackling mental health problems and disorders.

The post was also developed in the context of the introduction of a wider programme of training for Health Visitors in helping parents (especially mothers) experiencing problems with their infants and pre-school children. This adopted a model of empowerment based on psychoanalytic theory and learning, containment and behavioural change, and a supported supervisory structure (the “Solihull” approach). The new post holder, it was envisaged, would engage with Health Visitors in supporting their case work in these families in the community, undertaking joint visits or visits alone, and providing further training and clinical supervision.

An evaluation of this post took place over the first 6 months of the first year, focusing on the process of the development of the post, stakeholders’ opinions, and the post holder’s activities and perceptions. Whilst small in scope this evaluation reported generally favourable views of the value and importance of the new post and recommended that the post be continued, that evaluation and monitoring remained in place, and that various changes in management and activity be considered. It also recommended that parental

feedback be built in to progress post development and that some form of needs assessment was conducted prior to rolling out the programme to other localities.

Following new funding arrangements and the development of joint PCT/Local Authority commissioning for mental health services, monies became available to adopt a Bristol-wide approach to supporting mental health problems in pre-school age children. Accordingly in 2004 this single funded post (which had been maintained since 2002) was replaced by 4 new full time equivalent posts, under the management structure of the local CAMHS teams, 2 being placed in NBT and 2 in UBHT, and under the overall clinical guidance of the Consultant Child Psychotherapist based at Knowle Clinic (UBHT).

These posts (entitled “Primary Mental Health Specialist – Under 5s” (PMHS)) were to act as an “interface between Tier 1 and specialist/core CAMHS” and to support and strengthen existing Tier 1 provision by building capacity and capability (including training) in Health Visitors and *all* those working with young children, in providing direct and indirect clinical interventions, and in facilitating access to CAMHS. This development was in line with action on progressing a cadre of primary mental health workers, but unusual in making these age-specific. In the research and development agenda, post holders were asked to contribute to strategic developments in the field, in identifying service needs, in seeking users’ perspectives on service delivery, and to participate in audit, evaluation, teaching and research.

From September 2004 3 full-time and 2 part-time posts had been filled and by November 1st 2005 all PMHS staff had been in post for at least 12 months. Funding was made available by Bristol PCT to undertake a further evaluation of the programme and a proposal to implement this was prepared by Dr Jon Pollock and Ms Sue Horrocks from the Faculty of Health & Life Sciences, University of the West of England. The proposal was accepted and the final contract was signed off by the university in November 2005.

Evaluation approach

The approach adopted was to evaluate the work of the PMHS (<5s) as a *programme* (henceforth, the PMHS-Under 5’s programme) rather than as a multiple-post evaluation. The establishment, clinical supervision and management, and integration of and liaison between posts, together with the then possibility of further integration of the two NHS

Healthcare Trusts involved, indicated that these posts were best viewed as an integrated service or programme covering a Bristol-wide geographical area. However, differences between posts in working methods, line and administrative management, demographic features of the locality populations, working facilities, record keeping, and the like, were recognised to exist and offered opportunities to highlight examples of good practice within the evaluation.

To ensure topicality the proposal was designed to be concordant with the overall conclusions of the National Institute of Mental Health in England research priority setting exercise², and the “Every Child Matters: Change for Children and Next Steps” government documents. It also broadly followed the approach identified by FOCUS in their introduction to service evaluation in CAMHS³. FOCUS, part of the Royal College of Psychiatrist’s Research Unit, was launched in 1997 to promote clinical and organisational effectiveness in child and adolescent mental health services, with an emphasis on incorporating evidence-based research into everyday practice, identifying 6 key areas for service evaluation: *relevance, accessibility, acceptability, equity, efficiency and effectiveness*:

Relevance

Relevance relates to whether the service matches the clients’ needs. A modified “Experience of Service Questionnaire” (ESQ) developed to evaluate CAMHS services by the Commission for Health Improvement (CHI) was developed for this study. This is a 15-item self-completion questionnaire that assesses users’ experiences of services with respect to accessibility, humanity of care, organisation of care and environment⁴ and takes only a few minutes to complete.

Accessibility

Accessibility covers barriers to accessing the service by referrers and includes issues such as referral routes, knowledge of service by referrers (health visitors, GPs, social workers in the state and voluntary sectors, paediatricians), waiting list information dissemination, workload contact durations, and appointment systems. Information supporting this theme was obtained from stakeholder questionnaires and interviews and from discussions with the

² McCombie, C. , Chilvers, S. Research in Child and Adolescent Mental Health Services: Results of Research Priority Setting Exercise. NIME. January 2005.

³ This document is unfortunately no longer available online but can be accessed via the authors

⁴ ESQ Handbook v2 – 19 Nov02:http://www.healthcarecommission.org.uk/_db/_documents/04017626.pdf

post holders themselves. For each of the four geographical areas mapping to their CAMHS team: Bristol North West, Bristol East, Bristol South West and Inner City, and Bristol South East, a brief confidential questionnaire was delivered to all Health Visitors, requesting details of their use of the programme, and probing their experiences of accessing the programme. Telephone interviews were then conducted with a purposive sample of consenting HVs to obtain a deeper understanding of their experience of the recent PMHS service and its impact on their work, confidence and client outcome.

Acceptability

Acceptability is primarily a client satisfaction issue. This was addressed in two ways: through additional questions inserted into the modified “Experience of Service” questionnaire, and through interviews with clients. All clients agreeable to interview were identified through their final questionnaire responses and interviewed face-to-face or by telephone, according to the client’s preference. Interviews (lasting about 45 minutes) were loosely structured around the topics of the client’s view of her contact with the PMHS programme, her perception of short and longer-term outcomes in the child and themselves, and any changes they acknowledged in parental behaviour, psychological well-being, empowerment, self-esteem and confidence.

Equity

Equity relates to that part of accessibility that affects variation in opportunity for referral to the programme. This could cover ethnic, socially disadvantaged, or geographical groupings, and could also emerge if intake meetings where referral destinations are decided, were themselves adopting inequitable selective or variable criteria.

Primary inequity might be seen to operate at the level of the degree to which early parenting and child problems are not ‘visible’ to community-based health and social care professionals. For example, figures for the pre-school age population can be obtained for each geographical area and related to referral rates and case adoption rates, and crude ethnic and socio-economic comparisons made between the general population and the cases. Equity considerations *following* referral (secondary inequity), were assessed in this study through detailed interviews with each of the seven post-holders.

Efficiency

Efficiency in the programme relates to its management and assessments of any difficulties in maximising productivity of team members. It covers, therefore, issues such as working conditions, facilities and equipment, referral management and record keeping, staff support, clinical supervision, line management, administrative support for the post, activity and time budgets, job satisfaction and morale, and professional development. The evaluation team met twice individually with each post-holder to assess and to re-assess the efficiency components and to record change over the evaluation period. Interviews were also undertaken with administrative and secretarial support staff, and all relevant Trust managers. In addition, for the duration of the evaluation, a simple form was completed by PMHS workers to summarise their activities and actions, consultation details and timings on a weekly basis.

Effectiveness

Effectiveness in service evaluation includes an assessment of outcome and the specific attribution of outcomes such as health gain to service provision. In considering this most difficult area of evaluation the approach and methods of the CAMHS Outcomes Research Consortium (CORC) was consulted, although little consideration has been given so far by them to the very young child and infant. Substantial efforts were made to recruit carers to the evaluation and administer questionnaires that addressed their own emotional health (GHQ12) and the behavioural and emotional difficulties they reported in their pre-school children (ASQ-SE), and assess how these changed over the period they were engaged with the PMHS worker. The tools employed for this purpose were compatible with the CORC recommendations for a national common dataset for outcome monitoring for CAMHS and were chosen for ease and speed of completion, and for validity and acceptability in a wide variety of settings (CORC Handbook Version 2.0 , 2007)⁵. However, the CORC recommendations, which include the “Strengths and Difficulties” and “CGAS” assessment tools, do not effectively solve assessment problems across the age-range of the pre-school age group, especially in the under 3s. Accordingly, rather than employ a variety of tools for different age groups, the present evaluation focused on those assessment instruments that could be used for the whole under-fives age group.

⁵ <http://www.corc.uk.net/media/File/CORC%20Resources/Handbook/HANDBOOK%202007.pdf>

METHODS

Methodological development

In order to capture both the activity and impact of the PMHS service, and assess them in the light of the service specification and job descriptions, a number of data collection procedures were established. These covered *process* (activity budgets of the staff, referral and intake systems, numbers and types of clients seen, consultation durations and client management outcome), *opinion* (reported views of the functioning of the service by a wide variety of stakeholders), and *impact* (assessed through perceived benefits by stakeholders, clients, and PMHS staff, and clinical outcomes for the carer and the child's reported behaviour).

The PMHS service already had built-in systems to record staff activity and evaluation of the training sessions as part of their internal auditing procedures. The methods and data collection tools used for these purposes were reviewed, amended and agreed with PMHS staff, and then implemented. Stakeholder opinion of functioning and values were addressed by questionnaire and/or interview according to a protocol developed for the purpose. In addition, PMHS staff were interviewed both before and towards the end of the evaluation period. The greatest developmental need involved the preparation of a mechanism to capture clinical outcome external to clinical records. This necessitated client contact.

The clinical outcome data instruments chosen were the short form General Health Questionnaire, which addresses carer emotional well-being, and the Ages and Stages Questionnaire (Social/Emotional), which records carer-reported child behaviour and the carer's concerns about it. These tools, and the reasons for choosing them, are more fully described in the Methods section and in Appendix 1. It was recognised from the very start that a difficult compromise existed between the quantity and variety of data requested from clients and acceptability to them of compliance with the process, exacerbated by the sometimes chaotic and distressed situation surrounding their lives. As no experimental manipulation of service was practicable the approach taken was to record changes over time and attempt to demonstrate change over a short period, and also over a longer period, so that opportunities to argue attribution of any change to the service were enhanced. The underlying pragmatic rationale was that a change occurring over a short period of intervention may suffer the danger of failing to detect a slowly moving development, but

increases the possibility that any detected change can be attributed to the service intervention rather than any other influence. This principle governed the choice of the timing of the assessment periods: prior to, at, or very shortly after the first service intervention; after 4 substantive contacts with the client (defined as a planned or unplanned substantive meeting or telephone call with the carer discussing issues relevant to service provision), and at discharge back to the referring person (usually the Health Visitor), or 6 months after the first appointment, whichever was the earlier.

Research governance approval

Any form of formal data collection on NHS staff or clients requires ethical approval under the research governance framework. It also requires research approval from the relevant NHS Trust R&D department. This involved the preparation of 28 papers covering questionnaires, interview schedules, consent forms and information sheets for each recipient type, in addition to a detailed protocol including numbers and timing, for external scrutiny. Following some amendments ethical approval was granted by North Bristol NHS Trust, extended through the established linkage process to United Bristol NHS Healthcare Trust, and approved by the two Trusts' R&D Departments. University ethical approval was also then granted. Both researchers had CRB checks passed and were granted Honorary Trust contracts.

Carer recruitment

Most discussion with PMHS staff on methodology occurred in the preparatory period during their monthly team meetings and concerned carer recruitment. The overriding need was not to interfere with clinical activity but maximise recruitment opportunities as recruitment success was expected to be poor in this vulnerable client group. The process agreed was to include in the envelope containing the first appointment letter, an additional envelope with a letter introducing the evaluation to them, an information sheet, the first 2 questionnaires, and two consent forms, one of which – it was requested - could be signed and returned in the enclosed stamped addressed envelope to the evaluation research office. The procedure first implemented was for each PMHS worker, at the end of the first appointment session (most appointments took place in the carer's home), to ask the client if she had received and read the evaluation envelope and contents, and, ask if there were any questions about the evaluation they wished to ask. If the client agreed to participate (and if not already returned), the PMHS worker was then to attempt to obtain the signed

consent form and pass it on to the researchers. Receipt of the consent form in this way allowed the researcher to follow-up the client directly without any action on the part of the PMHS. This system allowed the client to ask questions of a supportive health professional and also permitted the PMHS to veto the recruitment attempt either permanently or temporarily according to their judgement. This personal approach was likely, it was envisaged, to be more successful than a direct letter.

The number of completed questionnaires, with a signed consent form, returned to the research office was small after implementation began in May 2006. Consent forms returned via the PMHS did occur but many PMHS staff found it difficult to switch between clinical discussion and evaluation talk with the client, or found it inappropriate to do so, even at the end of the first meeting when they were discussing the date of the next appointment. Opportunities for early recruitment were also reduced by PMHS staff temporarily forgetting their recruitment role and by uncertainty on whether to apply a veto or not. An extension to the project duration occasioned by staff changes and absences (see below) was requested of the ethical committees and this offered an opportunity to review the slow recruitment process and change it. Recognising that PMHS staff often found it difficult to integrate recruitment activity into a clinical session, and wanting to ensure that clinical work was never compromised by this, a new recruitment procedure system was designed, approved, and implemented for the 2007 calendar year. This involved simplifying the PMHS role to one of trying to obtain *verbal consent* from the client to be approached by the evaluation team, having already received a single information pamphlet about the evaluation inserted into the first appointment letter. This consent could be communicated by telephone or email. Once received, a researcher contacted the family by telephone to discuss the evaluation and to ask permission to bring them the consent form and baseline questionnaires. PMHS administrative staff informed the research team when each first appointment letter was sent and the PMHS veto on recruitment remained. As well as reducing the role of the PMHS staff this new system proved easier to implement and manage and initial recruitment rates increased.

Client contact

Following receipt of a signed consent form and completed first questionnaires (Stage 1) the research team awaited notification of the 4th visit by the PMHS worker. To assist this process a case summary sheet (Appendix 2) was designed to provide sufficient clinical

details to enable the case to be recorded fully in the evaluation and to prompt the PMHS worker to report the 4th visit to the research team so that the second questionnaire could be completed (Stage 2). In practice, and probably because this required, on the part of the PMHS worker, extra form filling outside their own detailed case records, the case summary sheets were only sporadically completed. Carers were sent one-follow up letter and the same questionnaire if there was no initial response within two weeks. PMHS workers and administrative staff were asked to report discharges to the research team which resulted in the final letter and questionnaires being sent. One follow-up repeat was also sent on this occasion if there had been no response. The final (Stage 3) questionnaire pack also contained a request for client interview. If, by 6 months after the date of the first appointment, notification of discharge had not occurred, the final pack was sent to the carer. Weekly or two-weekly reminders were sent to the PMHS staff or/and administrative staff to request updates on the status of clients expected to have recently had their 4th visit or be close to discharge. All clients consenting to interview were interviewed in person or over the telephone.

Questionnaires were distributed according to the following timetable:

Recruitment (Stage 1): ASQ:SE, GHQ-12

4th visit (Stage 2): ASQ:SE

Discharge/6 months: ASQ:SE, GHQ-12, Experience of Service Questionnaire

Data management and analysis

Completed consent forms and questionnaires from carers were received by the research office, logged immediately and filed in a locked filing cabinet in a locked office. Separate Microsoft Excel spreadsheets were established for client recruitment and management and carer questionnaire responses (both password-protected). Microsoft Access databases were created for entering and recording PMHS activity records, Training Evaluation Forms, and Health Visitor questionnaires. Quantitative data were analysed using Microsoft Excel, SPSS version 13 and STATA version 7. Further details about the two main assessment tools, the GHQ-12 and the ASQ:SE, including their validation statistics and how they were used in this study can be found in Appendix 1. Data from individual PMHS workers were analysed on a service basis, taking, where necessary, the clustering effects into account.

Where individual-level data were combined, summary or proportionate measures were used to equalise the weighting arising from staff with different working time contracts.

All interviews were semi-structured. PMHS interviews were recorded in face-to-face contact and transcribed verbatim, other interviews with carers and Health Visitors (personal or telephone), being documented fully in text and analysed thematically. Stakeholder interviews were documented the same day by topic area but not analysed formally as the main objective was to record understanding and opinion of service from different perspectives.

Changes to the original protocol

The original protocol defined the following tasks for the evaluation team, which are now amended by comments in italics where there were departures:

1. The development of questionnaires to supplement the ESQ for clients, and service assessment questionnaires for health visitors, and appropriate social workers and community worker groups.

Questionnaires were not applied to social workers and community workers as too few individuals were identified to warrant a separate data collection exercise. One social worker was interviewed as a stakeholder in the service.

2. Application for ethical approval from NBT and UBHT Local Research Ethical Committees and from UWE Ethical Committee. Project registration with UBHT and NBT Research Departments. CRB screening.

Completed in full

3. Development of new generic time and activity recording sheet and data input software. Training for secretarial staff for data entry.

Completed in full

4. Development of structured interviews and interview implementation for stakeholders at management level (n=10), post-holders (n=5), clients (n=15), intake team chairs (n=4), administrative support staff (n=2), and overall programme advisor (n=1).

Completed partially as sufficient numbers in each group were not available, did not consent, were not identified or were inappropriate. A total of 18 stakeholders, 7 post-holders, and 6 clients were

interviewed.

5. Telephone or face-to-face interviews with 45 HVs

Completed partially. A total of 30 HVs agreed to interview and 20 were purposively selected for interview.. Full stratification by PMHS worker proved to be impossible due to small numbers. Questionnaire data were obtained from 55 Health Visitors.

6. Demographic analysis, using PCT data, on client population and locality population.

Completed in full

7. Preparing paperwork for outcome assessment and training, if required, for outcome recording.

Completed in full

8. Proforma development for prospective recording/transferring from casenotes post holder perceptions of key client contact events and changes in maternal health and psychological well-being, infant or child behaviour, relationships etc.

Completed in full

9. Management and analysis of data deriving from 1-4 and 6 above.

Completed in full

10. Writing report

Completed in full

The main departure lies in the smaller number of interviews achieved in certain groups. This was due to inappropriate separate categories (e.g. intake team chairs who rotate and are part of the stakeholder group), imperfect response rates, low respondent consent rates, contact difficulties and problems in identification of a substantial group of social workers and community workers from which to sample.

Staff changes

As expected in a period of service development, there were changes to the working arrangements of the PMHS such that two of the full time PMHS reduced their hours to a job

share post and a further two PMHS (0.5 wte each) were recruited. The post freed up was, after some delay, filled by two part-time staff who inevitably took some time to organise their clinical work and other duties. These changes took place during the piloting period of the project in the second half of 2006. In addition staff absenteeism due to injury or sickness was substantial with one full-time worker away for 6 months. Together these factors substantially reduced the working time period being evaluated, contributing to both the project extension and to lower client recruitment numbers.

RESULTS

THE VIEWS OF THE PMHS WORKERS

Introduction

Semi structured interviews were carried out with the seven PMHS workers between November and December 2007. Each interview lasted between 60-90 minutes and was taped and transcribed. Both the typewritten transcript and the transcript of an anonymised summary were returned to each participant for review. Two transcripts were returned with slight amendments. The interviews were guided by an interview schedule, but this was loosely adhered to as a structure and each interview covered a wide range of topics relating to PMHS role and function, experience of administrative and management arrangements, relationships with local CAMHS and colleagues working with children under 5, and views about equity of service and future developments. A thematic content analysis was carried out to identify common themes and issues, and these are reflected in the reporting structure below.

Teamwork

The PMHS posts represented a new service development in the mental health field, specifically delivering care to families with children under 5 with emotional and behavioural problems in the community. The first post-holders were responsible for building links with potential referrers by raising awareness of their role and offering support and training in infant mental health. Importantly they had also to develop a way of working with their local CAMHS team, each of which were composed of a range of mental health professionals with varying attitudes to the new posts and knowledge of infant mental health. For this reason the interviews probed the extent to which, at the end of a year, the post holders felt they together comprised a Bristol-wide PMHS team, and the extent to which each post holder felt they worked as a team within their local CAMHS.

The PMHS team comprises seven people covering the Bristol geographical area. As a team, and for strategic purposes, they are led by one overall clinical manager, though the PMHS themselves are employed by two separate Trusts and each has individual line management within their employing Trust. All except one of the PMHS has a health visiting

background; all having worked in Bristol or local environs at some stage in their career. One person had been working as a Specialist HV for Infant Mental Health (funded by the Primary Care Trust) before becoming a PMHS (funded through CAMHS). All have undertaken either a Masters degree in Psychoanalytical Observational Studies or have completed a Postgraduate Diploma or MA in Infant Mental Health. One of the PMHS is a qualified child psychotherapist.

The majority (6) of the PMHS work part time in what are nominally described as 'job share' posts, although in fact there is no sharing of clients, (this would be at odds with the psychotherapeutic relationships built with the clients) or formal cover for colleagues on leave or holiday. In fact, in one job share partnership, both PMHS are able to take leave during school holidays. In most cases there appears to be good, supportive relationships between job share partners,

'we talk things over – she is a very careful listener and astute, a good person to talk to'

and evidence of planned time for discussion, such as both people being in on a particular day of the week to 'catch up'. However, this is not always the case, and there was also evidence of disjointedness with lack of opportunity for joint working and case discussion.

There was evidence of dialogue between job share partners if concerns arose about clients – but mainly these types of concerns would be taken to individual supervision sessions or to the clinical manager. In terms of the wider team, despite there being no overall cross-Trust team manager, a whole team working approach was used for strategic planning, with named people leading on different projects, felt to be both democratic and to make effective use of the individual talents and interests of each PMHS. There is some collaboration in running training events, though a north/south Trust divide was acknowledged; for practical reasons *'the reality is that more day to day interaction'* is with colleagues in the same job-share or/and geographical location.

Administrative arrangements

Administrative arrangements vary across the posts and this in some respects leads to patchy support. Not all the secretaries are located in the same building with their PMHS, leading to problems of accessibility, not only of client records, but in terms of day to day making appointments and relaying messages,

'it does mean sometimes it will wait until the next day where it would have been better to have sent it first thing.'

Even where secretaries are housed with the PMHS there can be access problems as most have to offer a service to other clinicians working in the building, leading to delays,

'it can take a couple of weeks to get work through for PMHS',

'it is not fully realised that admin is not fully available to us – that she has other responsibilities',

'everyone is very willing but in terms of the time there is – things can get missed. A lot is left to us, which perhaps ideally would not be.'

In contrast, evidence of close and efficient working between PMHS and administration was also given, with others remarking there were no problems and that the secretary always seemed able to manage the workload efficiently.

Clinical Supervision

All the PMHS have individual clinical supervision meetings with a child psychotherapist allocated within their working hours. Access varies depending on proximity to the clinical supervisor and work commitments, but ranges from weekly to monthly between PMHS. Supervision is highly valued, *'absolutely vital' 'it is a training in itself'* and is described as essential to enable them to carry out the work they do with parents and young children in very complex situations,

'I think I can say that I probably wouldn't be operating at the same level if I didn't have that'.

'it is great to have the opportunity for supervision, it is very supportive and important for the work we do'

Particularly complicated client and work issues are taken to supervision where they can be discussed and reflected on in a safe and confidential environment. In addition a group supervision session takes place every month, although not every PMHS attends. At this session PMHS staff take it in turns to present a case for discussion. In this way they can gain knowledge and understanding about their colleagues' caseloads and work issues.

Management arrangements

Although the PMHS are employed by separate Trusts they describe similar line management arrangements with their employing Trust manager. These arrangements appear to be felt as facilitative and supportive. Regular management meetings take place

and managers are accessible in between times as needed, providing clinical support and advice. However, since some practitioners within CAMHS teams are managed separately there are practical and resourcing issues which individual line managers seem powerless to influence; for example inconveniences arising from being based in inappropriate accommodation, facilitating access to administrative support, and even in the conduct of their role within the CAMHS team. One PMHS explained that CAMHS team members having separate managers can lead to 'a lot of explaining' as

'one person's manager might have a different view than another's. It means that things don't necessarily flow as they might if there was one manager.'

An example of a possible situation where a manager might not be able to manage effectively was given,

"if a member of staff had a particular training interest and was supported by their manager – nonetheless the team might not feel that was a good use of that person's time – so there is potential for conflict there and it can get in the way".

Work patterns and client engagement

Work patterns varied between the PMHS to some extent, although all carried out face-to-face work with clients and held training sessions with practitioners. The proportion of time spent in each activity is determined by the job description and is largely adhered to; although most felt the time they spent on face-to-face contact with clients reduced the time available for other activities. One PMHS suggested the demands of the job might be unrealistic, especially for a part time post,

'We are supposed to be strategists, consultants, therapists, trainers, technicians, and researchers; it is quite hard on 3 days a week!'

The PMHS receive the majority of their referrals from health visitors. There was an acknowledgement that there have been considerable service changes in health visiting, both in terms of service delivery (i.e. the increase in skill mix in health visiting teams and the increasing number of corporate caseloads, where health visitors are not named as the family health visitor except in cases where families have identified needs) and in service priorities; regular home visits for families with new babies have been substantially reduced and contacts with families are targeted on those with documented health or social needs. Child protection and maternal depression, substance misuse and other social issues take up much HV time. The majority of PMHS have a health visiting background and there is a

tacit recognition that HVs are 'carrying' a great deal in terms of their workload, with few outlets for referral. One PMHS commented that community psychiatric nursing for a woman with post natal depression was only available in the most severe cases, either to prevent a hospital admission or to follow up a hospital admission. Another PMHS commented,

'There is huge pressure on health visiting teams and they carry very complex caseloads with potential for tragedies to occur'

The increased demands on the health visiting service create a tension in the potential achievement of the capacity building aim of the PMHS role. PMHS remarked that excessive HV workload meant it was often difficult to carry out joint work or support them in carrying out a psychotherapeutic approach with their clients, as HVs did not have the time to devote to regular lengthy visits. Furthermore, in some areas where HVs had had a lot of teaching input from psychologists they were already comparatively well skilled, and when they referred on they preferred the client to receive a direct service from the PMHS,

'Health visitors in this area are very skilled...people are happy to do joint visits but they are less keen to carry on working with us, "we referred them on to you and they are yours" and I think that is because of the pressures they are under'

Furthermore one PMHS commented

'in the mean time the situation with health visitors has deteriorated, they are more pressured, fewer staff, more leaving, low morale'.

Health visitors do not always make themselves available for a joint consultation, which is one way in which the PMHS would hope to be helping them use a more psychotherapeutic approach to their contact with the family,

'They do not want to do that – they feel when they have done what they can for the family they want to refer on'

The extent to which joint visits were carried out varied between PMHS staff, sometimes due to the preferences of the HV, and sometimes due to personal preference. One PMHS said she did not do joint visits as she felt they impeded her relationship with the client, *'people don't tell you things', 'joint visits are very stilted, the health visitor will, not 'take over' exactly, but interrupt the flow',* then the PMHS has to *'start all over again'* when contact starts. In contrast, another PMHS said she did quite a lot of joint visits and the feedback she received suggested HVs usually found them very helpful. A perception was expressed that due to the changing priorities in health visiting, most of the personal one to one support in the home was being

delivered by a skill mix team and that the development of the knowledge and skills of the team including play workers and nursery nurses should be a priority for the PMHS if capacity building was to be accomplished.

One consequence of success in building awareness of infant mental health was an appreciation by referrers of the importance in recognising potential difficulties around attachment at an early stage, before behaviours became entrenched, resulting in an increase in referrals of babies and younger children creating further pressure on mental health services,

'PMHS were supposed to take pressure off specialist CAMHS ... We were supposed to build capacity; health visitors would do more. In fact, the alternative is that going out into the community, addressing need, supporting health visitors in seeing things they have not seen before, you raise awareness and increase demand and referrals flood in.'

Although the PMHS recognised a possible loss of continuity and opportunity to pick up early problems due to reduced home visiting and corporate caseloads, not all were opposed to health visiting corporate caseloads, suggesting that if these were well organised they could draw on the skills of the whole team, and that properly managed, families with identified problems would still receive continuity of service from a named health visitor. In one part of Bristol there was a perception of the lack of support available to HVs from their managers. The PMHS in these areas said they prioritised relieving pressure on the HVs and recognised a role to act as advocates where possible.

Waiting lists seemed to vary between 1-2 weeks for babies and 10-12 weeks for older children. In some cases PMHS said they accepted antenatal referrals, where mother and child attachment problems were anticipated. The PMHS vary in their approaches to planning contacts with clients, with some offering a core programme of visits to be reviewed at the end for possible further involvement or discharge, whilst others proceeded more incrementally, reviewing need for contact on a week-by-week basis. In either case contact can be spread over a number of weeks or months, and when one-to-one contact ceases, telephone follow up is sometimes instigated over a period leading to withdrawal.

There were differences in the perception of client engagement, with some PMHS reporting no problem with this at all,

'client engagement is not an issue once I am through the door, DNAs (Did not attend) are very rare.'

Some PMHS accepted lack of client engagement was an issue, but understood the reasons,

'There are always going to be some (DNAs) – due to some clients being 'made' to accept PMHS as a result of CP case conferences – clients then are unwilling to engage. Or some clients are 'heart sink' that is have lots of problems and long history of not engaging positively with interventions – these cases are as difficult for PMHS as anyone else'

One PMHS voiced frustration with her clients not being sufficiently engaged,

'CAMHS allow 2 and these days 1 DNA before they discharge a case – but it is not so easy with these families – you can go over 6 months and see them about four times'

and in this time it is not possible to get through the work that is required to be done –

'yet there has been enough contact that family cannot be discharged as a persistent DNA, and 'sometimes families say they have not found contact useful – but this is because they have not participated in the work that needs to be done to the extent to which is required'.

The majority of PMHS identified lack of client engagement as an aspect of dysfunction that is frequently encountered in the community, requiring different ways of working, often utilising community approaches, and this is an area where the model of PMHS working is at variance from CAMHS. The acute service model of CAMHS has a low tolerance of DNAs, *'clients have to conform to the CAMHS model'*. In contrast one PMHS suggested they should try to model the behaviour they wish their clients to follow, to try and adapt their own behaviour to meet the needs of the client, in the same way they want parents to recognise what might be necessary to help improve their relationship with their child,

'I would reckon more than 50% of my first appointments cancel and it is like they are just testing you to see what you do and if you can just go along again and fit in again and see what suits them and work really hard to say I will go along with you ... You have to be prepared to be pretty tolerant of difficulties in the beginning'

The majority of PMHS envisaged more community based and group work in the future, to build up trust and reduce the stigma of mental health problems. A centralised Bristol specialist infant health service was hoped for in the future, either within CAMHS or linked to CAMHS with clear lines of accountability and referral.

Relationships with CAMHS

Integration

At the time of the interviews every PMHS had been in post for at least one year. The interviews suggested variation in the degree to which the new posts had been accepted within CAMHS, with evidence from four interviews suggesting positive, respectful relationships with the wider CAMHS team,

'The team here is flexible and interested in infant mental health; as a result they are prepared to accept us as part of the team. Even if they are not entirely sure what we do, they are interested and they understand its importance and are signed up to its importance'

Other PMHS felt well supported by their CAMHS team, considered themselves part of it, and were able to access debriefing or advice from its members as necessary. For the rest of the PMHS, however, their experience and perceptions of their relationship with the local CAMHS team varied considerably, but was felt in the majority to be developing positively, 'a work in progress',

'we are very on the edge of the team, because the team has not traditionally seen under 5s except in exceptional and rare cases, therefore we are not part of the team who are taking on the same work as the rest of the team, from that point of view I feel as though we are not particularly integrated'

Integration is a two way process and there was evidence that not every PMHS looked for full integration with CAMHS. One PMHS described the extent of integration as

'like a Venn diagram', 'we are only half in this (CAMHS) and half in our PMHS team, and that has required a lot of thought and explaining because it means we can't be full participants in the life of the team'

All the PMHS consistently described the work they carry out as being highly complex and difficult, sometimes necessitating support from or referral to colleagues within the CAMHS team, neither of which was always easy to obtain,

'In practice everyone is so busy, they are all behind closed doors; there is a half an hour slot for everyone to talk about new cases...the reality is you get about 5 minutes, which is insufficient'... 'I don't feel justice has been done to the case, or that it has been properly considered'

Over the course of the evaluation relations seemed to have improved to the extent that support from CAMHS colleagues appeared to be 'getting more accessible – it was difficult initially – but there is now more awareness about the role and more willingness', and this process has been assisted by changes in personnel with new people coming into the CAMHS teams, and being more open to the roles and skills of the PMHS. However, even within a

predominantly positive context, some PMHS comments suggested inequalities in status exist around their relative access to consulting rooms and resources,

'There is not a dedicated room for us, we are lower down the pile when it comes to priority'.. 'if we really wanted to use the toys we could'

Furthermore although there were advantages to being located with the wider CAMHS teams, being so did not necessarily foster improved relations with teams, especially where accommodation was cramped. Some PMHS were aware of tensions around the funding for their posts and queried the extent to which these could have adversely affected initial PMHS relationships with CAMHS. Moreover, the comparatively short and intense working week for some PMHS impacts negatively on the time available for communication and meetings with CAMHS practitioners and may impact negatively on their profile with the wider CAMHS team.

Cultural and organisational differences

Fundamental organisational and cultural assumptions made during the planning and development of the new PMHS posts were questioned. The first issue impacted on the importance and acceptability of the PMHS role to CAMHS and related to the value and understanding attached to infant mental health and wellbeing by CAMHS. Two PMHS raised the issue that *'there has not been a historical understanding one can work with infants'*, due partly to the fact that in their training psychotherapists start work in earnest once children can communicate verbally, around the age of three,

'In a way their training begins from seeing children from about the age of 3, verbal children, they do not set out to work with children who cannot speak- it is the way they are trained'

Second, reservations were expressed about the feasibility of transferring a primarily clinic-based model of psychotherapeutic working, adapted from the Tavistock Clinic, to a community setting. The model of work used by CAMHS fits within a traditional secondary care approach where clients are brought in to the clinic for assessment and treatment before being discharged back to the community. This model requires the client to attend appointments outside the home in a setting where a range of therapists can work together in a clinic which is resourced with equipment such as cameras and play materials and can provide child care, to enable parents to engage with the therapists. To an extent there is a tension between the way in which the PMHS are expected to carry out work with clients using similar psychotherapeutic techniques but without the back-up resources available in

clinic. The PMHS do not have budgets to enable them to rent consulting rooms or pay for toys, although they can negotiate to use health centres, children's centres or nurseries to see clients. Any equipment they need has to be transported to each location,

'it is always very useful to go to the home because you have a different picture of what is happening if you go to the home. For very young children I think it is more helpful to go to the home. But once you start doing work (with children around 2 years) which involves free play or watching the mother play with the child, that is almost impossible to do in the home – there are too many distractions'.

'it is hard to translate the clinical psychotherapeutic approach used in clinic to a form that can be used effectively in the home – it is completely different going to someone's house as a guest – you cannot control the environment'

A further question related to the characteristics of the clients the PMHS might see in comparison to those being seen by the CAMHS team. In order to access CAMHS services clients have to make an appointment and get to a clinic centre in order to receive their assessment and therapy, pointing to a degree of pre-planning and organisational skills, not necessarily present in the clients seen in the community by the PMHS. One commented that CAMHS could be viewed

'like an ivory tower – it's sheltered from the real world. CAMHS are only seeing the people who are organised enough to get to clinic – the people the most in need are least able to come to an appointment, they simply cannot get here on time and it is very boundaried here'

'The reality is that a number of cases are complex cases where there are definite mental health needs, particularly involving parents as well as children and would require more than one clinician- but they are families who won't come in to a centralised service'

The implication of this is that the client group is different, not only in terms of age, but in terms of other social and environmental factors; that the PMHS might be seeing an even more needy and challenging group of clients, those who are too troubled and disorganised to receive a service from CAMHS, creating stress and anxiety for a practitioner working in isolation.

'we are dealing with them on our own, in people's homes, without all the support and safety net of clinic work'

Although the PMHS recognised that older children and adolescents displaying aggressive or self harming behaviour had immediate and urgent needs for therapy, it was felt that the urgency of needs for therapy of younger children were not appreciated by CAMHS, despite the context of similarly complex and deep-seated problems in the family.

'There is an idea they are more senior, they do something more difficult and what we do is easier or less complicated, a more junior level of work, reflected certainly in pay'

Tier

The PMHS posts were originally planned as a specialist infant mental health service to support practitioners such as health visitors and pre-school workers, working with families with young children with emotional and behavioural problems in the home and community. The original aim of the posts was to build capacity in the community to manage early childhood problems in order to avoid subsequent referral into CAMHS, a service which mainly focused on school-age children. As such the PMHS have been 'badged' as a Tier 2 service.

The interviews suggested considerable variation between PMHS staff in their perceptions of which Tier they would ascribe to their service. The variation appeared to relate to PMHS understanding of their role, their knowledge and understanding of the health visitor role and experience of difficulties in referring clients under 5 into CAMHS. Two PMHS described their work as being between Tier 1 and Tier 2 based on their workload setting being the community, and a preventive aspect to their work

'We are the interface between Tier 1 and Tier 2 – we are out in the community and I think it is highly appropriate with the young ones'

'We are firmly stuck between Tier 1 and Tier 2 and I think we contribute hugely to tier 1 because they have very little support out there on the ground, and they are the people who are dealing with these families on a day to day basis'

A further two stated they worked at Tier 2,

'I don't have any doubt that I think I am Tier 2, ...when these people (ie people working in primary care – Tier 1) refer on to another agency that is tier 2 and that is what I am'

'I am working at Tier 2, with two joint priorities, clinical work with parents and children under 5 and raising awareness for professional working for under 5s and teaching'

However, some questioned whether they fit into a purely Tier 2 level of working, seeing themselves as officially Tier 2, but *'the area between Tier 2 and 3 is quite fuzzy'* as on occasions a complex client referral might continue to be seen by the PMHS in collaboration with a colleague from CAMHS (a criterion for Tier 3 working). A further PMHS stated that Tier 2 did not really exist in Bristol and that the PMHS plugged a gap between Tier 2 and 3. In one

area the need to provide a service for clients who had complex needs requiring input from more than one clinician and to provide support for PMHS working with these clients had resulted in the setting up of a specialist infant mental health clinic where the PMHS worked collaboratively with a CAMHS colleague in order to accommodate more complex clients in a community setting. In another area, there was a similar lack of Tier 3 service for under 5s, managed rather differently. If a complex case was identified at an intake meeting they would be put on the waiting list for CAMHS, but in the meantime the PMHS would see them. In this patch if the PMHS wished to refer a client on to CAMHS she had to '*continue working with them and try and persuade someone on the CAMHS team to work with us.*' In one case the PMHS felt the majority of the work she did was Tier 3, with the HVs carrying out the service at Tier 2 '*there is not a tier 2, but the HVs carry a great deal, and they are becoming more and more pressured*', resulting in them wanting to hand over clients. Moreover she felt that having had long term educational input from psychologists, most HVs in her patch were working at Tier 2 to some extent.

'Effectively there is no Tier 3 service here for under 5s'. 'I struggled a long time before I realised it was just a 'virtual' Tier 3 – there wasn't one'.

The considerable variation in interpretation of 'tier' suggests false boundaries in the use of the term to describe the work of the PMHS, who across individual caseloads reported a full range of working with clients. Primary Mental Health Specialists carried out indirect work with clients by supporting HVs, worked face to face with clients who frequently had other mental health needs and were also receiving services from community psychiatric nurses or social services, and also gave examples of work they carried out with clients where, where further specialist services available, they would refer on, or where they were able to work with CAMHS colleagues, continue to provide a service.

Referrals

In theory as part of CAMHS referrals to PMHS should go through the Single Point of Entry (SPE) system, where each referral is reviewed by an intake team meeting and the appropriate practitioner to take the case identified. However, practice varies according to the employing Trust. In one part of Bristol each contact a PMHS has with a child, whether by joint visit with a HV or an independent contact with the client, has to go through SPE. The process can be expedited in the case of babies, who are given priority, so that the

PMHS might start contact before the paperwork is complete. In the other area, only independent client contacts go through SPE, so that work undertaken in joint visits is not captured on records systems.

There seemed to be some ambiguity around the process of SPE referrals for PMHS work, with some PMHS explaining these go to CAMHS intake meetings, whilst the majority said in practice any referrals for children under 5 always come to the PMHS first,

(Under 5s) referrals do not get discussed at the intake team meeting – ‘they automatically get passed to us, unlike other children who always get discussed and thought about – these ones come straight to PMHS’.

‘0-5s virtually all come through to PMHS hardly any go straight on to tier 3 waiting list. They have to be really extreme cases or where autism has already been diagnosed by the paediatrician to go straight to Tier 3’.

‘any cases which come in for under 5s come directly to us – they don’t go through the system’

‘all the referrals come to us – so it is not a case of being discussed by the team’

The PMHS also remarked that younger children might be put in the PMHS tray – but at that stage the PMHS can decide whether it is likely to be a PMHS referral and if they do not agree, the referral can put back to Tier 3. If the PMHS accept the referral the child goes onto their own waiting list. Others argued that referrals were not automatically allocated,

‘They are not automatically allocated. There will always be referrals where there has not been a discussion about the case eg community paediatricians very often just write a letter and it will come if it is appropriate’.

Overall the separate management of PMHS referrals underlines the impression that some PMHS have that the CAMHS teams do not offer a service to under 5s, and that they view the PMHS as delivering a different service to a group of clients who do not have as complex or urgent needs as older children and adolescents. Furthermore, in some cases the referral process suggests PMHS may be being used as a ‘holding operation’ because of long waiting lists.

‘if it is clearly a complex case that comes to an intake meeting the team are now recognising yes that is a complex case it sounds as though it could be tier 3 and at least one of mine has been put on the waiting list for tier 3 – but it is a long waiting list and in the meantime I am seeing them’

‘That side of things is not working so well (referring on to Tier 3) and I can see why – the team feel there are not sufficient resources for them to be able to take on more children unless they have more resources – Catch 22. So that is an ongoing difficulty and there is no easy answer to that’

One PMHS felt the difficulties of referring on for children under 5 were such that the PMHS contact could be seen as an extended period of assessment rather than a therapeutic intervention, with the effect of the PMHS uncovering further problems that require more in depth working from other specialist practitioners such that when the PMHS ‘pull out’ the client then goes on to a six month waiting list for CAMHS. In effect the PMHS contact has delayed by several months the inevitable and eventual contact the client needed with CAMHS.

Service inequalities

One of issues that health visitors raised in their questionnaires and interviews (and probed in the PMHS interviews) was the extent to which an equitable service was being offered. Health visitors commented that the name of the service with the inclusion of ‘mental health specialist’ was off-putting to clients, because of the cultural and social stigma around mental illness, with a particular barrier created by this for some minority ethnic groups. Some of the PMHS shared the view that the name of the service was a barrier to referrals

‘sure that the title of the service puts people off’, ‘some clients are very worried about the title’

‘to non English speaking clients it is not an appropriate title at all’

‘very unwieldy title...anything with mental health in the title is really off putting for families because families with children under 5, particularly if they are under 3, they don’t want to think of their young child having a mental health problem,especially in areas where culturally it is not acceptable to think about anyone having a mental health problem. I know from the health visitors that it has got in the way of being able to refer.’

In some areas of Bristol the PMHS felt the need to increase access to services for people from minority ethnic groups was of greater priority, and would justify a name change.

Others see the title as an opportunity to educate the public and to remove the stigma of mental health by normalising such services,

I think it would be worse to call ourselves ‘behaviour specialists’ and then for the clients to find out we come from CAMHS. That would feel like subterfuge. I also think it gives the opportunity to talk to parents about what they mean by mental health and what I mean – which is ‘wellbeing’. ‘I don’t mean this child has got a mental illness’. We are talking about emotional wellbeing’.

A third issue that arose was the loss of professional recognition as part of a larger group of mental health specialists, an issue both of professional identity and of clarity for referrers. In this case it was felt that the arguments for keeping the term ‘infant mental health’ as a specialty alive were forceful as it is widely used academically and clinically.

The majority of PMHS recognised the difficulties of delivering a culturally sensitive service, relating to a wider agenda than simply the management of consultations using an interpreter, but an appreciation and understanding of differing parenting practices and how these fit with psychotherapeutic techniques such as play therapy. The need for interpreters for some consultations impacted on delivery of service. One PMHS commented that she was unable to offer telephone follow-up to some clients where language was limited but basic communication was possible given time and use of gestures. At this level, language was insufficient for a psychotherapeutic conversation over the phone and she might need to observe the client and assess their demeanour and attitude in person. Being able to achieve communication only at a basic level led to the feeling that in depth work was not possible; an example being given where a feeding problem had led to the client being referred to a dietician for concrete advice about feeding, as the PMHS felt her skills could not be fully utilised, *'all I can do is try to help the mother think about what force feeding might feel like for the little girl.'*

Another PMHS commented on the fact that it was not always acceptable for people to use an interpreter, and that family networks within the UK were so extensive clients did not always feel confidentiality could be guaranteed,

'most of the clients might not know the interpreter but they might know the family or links to the family. They don't want an interpreter from their own community, or one from other areas of the country such as the Midlands.'

However, not all the PMHS agreed that there were difficulties with delivering a culturally sensitive service; another PMHS had experience of carrying out useful work with a Somali family using an interpreter, being aware of cultural sensitivities. However, delivering culturally sensitive services is not just an issue for PMHS. There was awareness that comparatively few minority ethnic group families were being referred and that both health visitors and PMHS needed to take more account of cultural differences such as the meaning of 'play', and how this might differ in some societies.

Summary

As a new group of practitioners developing their role and making links with established colleagues in the CAMHS team there appears to be both a divergence in the degree to which the PMHS see themselves as working as part of the CAMHS team and the extent to which this is deemed as appropriate for the PMHS. There is considerable homogeneity of

professional background across the PMHS, though views about being integrated with or affiliated to the CAMHS team did not seem to be associated with a health visiting background. A positive working relationship with CAMHS is fundamental to the PMHS perception of acceptability of being fully integrated. Divergence of opinion was also reflected in the varying descriptions given to the tier level of working cited by each practitioner, with an emphasis on working closely with Health Visitors to support them in their preventive work with under 5s. PMHS workers reported that changes in health visiting provision and an emphasis on child protection have negatively influenced their capability to build capacity with Health Visitors Bristol wide, and there is an acknowledgement of the importance of offering training and support to other practitioners in the community such as play workers and nursery nurses to achieve this goal. There appears to be an acceptance that traditional psychotherapeutic models of working have to be supplemented in the community with other indirect ways of working such as through community groups and nurseries, particularly with regard to addressing inequalities around access for minority ethnic groups. There continues to be debate around the acceptability of the name of the service, though recognition that while it is funded as part of the CAMHS teams it needs to be clear with clients that this is so.

THE VIEWS OF THE STAKEHOLDERS

A total of 18 interviews were held with stakeholders in the PMHS service between November 2007 and April 2008. The stakeholder positions included one or more representatives from the following professional areas:

CAMHS Consultant Psychiatrist

CAMHS Clinical Psychologist

Locality Manager of Health Visiting Services

PMHS Manager

CAMHS Clinic Administrator

Children's Centre Director

Director of a voluntary agency

Social Worker

Community Paediatrician

Commissioning Officer

Health care practitioner with extensive experience of the PMHS service and its history and development.

The function of these largely unstructured interviews (which lasted between 40 and 90 minutes) was to provide a confidential opportunity for clinical, managerial and administrative health and social care staff with a key interest in the service to voice their opinions about the way it worked, any difficulties or problems they perceived, and how they felt it might be improved. Overall there was extensive variation in how different interviewees approached the opportunity but, in places, substantial overlap in the views expressed. These overlap areas covered all topics of discussion and clear thematic areas emerged during the interviews which form the structure of the following analysis. The following paragraphs are, therefore, organised by topic area with opinion represented in a non-attributable fashion and containing the substance of views from whomsoever made a contribution relating to the topic. The areas covered should be viewed in parallel with those expressed by the PMHS workers, the HVs and the clients themselves. Furthermore, voiced opinions were frequently qualified by the admission that they were based on knowledge of the activities of individual or small numbers of workers that might not accurately reflect the

working practices of the whole service. This is an important general feature affecting interpretation of the evaluation of a small, diverse service.

1. (a) Placement of the PMHS service within CAMHS
(b) Integration of PHMS service within CAMHS
(c) Referral systems and intake
2. Tier-defined level of PMHS activity
3. PMHS staff clinical and line management
4. PMHS working practice and management differences
5. Expectation differences of Health Visitors and PMHS workers
6. Future development ideals

1. PMHS service placement

The fundamental result of these interview sessions was that all those approached considered the PMHS Service to be very important in meeting a previously unmet need, to be probably clinically valuable (whilst acknowledging the difficulties in formally evidencing this) for both short and long term outcomes, and to be delivered by committed, skilled staff under difficult circumstances. There was broad agreement amongst those interviewed that solutions were required to clarify the PMHS service placement and role within or perimetrically positioned around CAMHS, standardise and rationalise referral and intake procedures, review and rationalise management structures and geographical and administrative support services, and clarify developmental progression of the service with respect to children's and adult services. In addition, it was evident that the four CAMHS service teams have different knowledge and experience of the PMHS service and, within some teams, demonstrate a lack of agreement over common goals or desirable team working practices related to their child and adolescent service provision. There was generally little expression of any divisive disagreement over staff professionalism or therapeutic approach beyond understandable debate over effective approaches to clinical

practice. Where differences in approach emerged there was a view that analytic orientation was not always necessarily the only management course, examples being given of supporting pre-school children presenting with soiling problems or symptoms of autism or Asperger Syndrome, and questions about the value of domiciliary therapeutic work. There was a widespread hope (and some optimism) that structural and managerial developments in the formulation and provision of children's services in Bristol created an opportunity for progressive evolution of the children's mental health services as a whole towards a more coherent and integrated system.

1. (a) Placement of the PMHS service within CAMHS

Whilst some viewed the introduction of the PMHS service as a natural extension of conventional CAMHS Tier 3 work with clear integrative potential, others found more difficulty in perceiving the benefits, voicing uncertainty over "what exactly do they DO?", asking why the service was introduced to CAMHS "without consultation", and why PMHS staff were appointed with "little or no CAMHS experience". All those expressing a view on the subject believed that the PMHS service *should* be an integrated part of CAMHS but there was substantial variation between those that experienced this as the case and those who viewed it as fundamentally distinct in its approach, responsibilities and clinical activity. One opinion was that PMHS worked to a single model rather than embracing "complex multi-disciplinary work", whilst others celebrated opportunities for referral "up", even if this increased workload. In most cases, however, there was little evidence that a recognised, agreed mechanism for such referral was being used to any degree, although this might, of course, simply reflect adequate therapeutic case management by the PMHS service. However, in one CAMHS service there were concerns mentioned that lack of Tier 3 working practice experience resulted in too many cases being brought to team meetings at a low level of need.

In contrast one senior CAMHS practitioner, self-identified as a "strong supporter", engaged thoroughly with the preventive aspects of the PMHS role at Tier 1 and also ran community-based sessions outside the clinic, emphasising how essential PMHS/CAMHS interdependence should be, and how important it was that appropriate management structures and a team work ethic were embedded in the joint service. There was a wide recognition that prior to the PMHS service there was very limited provision within CAMHS for pre-school age children and that this was being addressed by the new service.

1.(b) Integration of the PHMS service within CAMHS

Substantial differences were apparent in explanations of the importance of the closely allied topic of team work integration and the manner in which this was being undertaken or attempted. A consensus was evident in expressing both the importance and, generally, the lack of close integration. There was a view that the introduction of the PMHS service to CAMHS had not been accompanied by sufficient resources to fund ancillary and administrative staff adequately, generating tensions. One quite general view was that much more could be done to promote closer working practices but this might require compromises or/and affirmative action. Perhaps unsurprisingly those expressing the values of the PMHS service were also those most strongly reporting the benefits of closer working and how this might be achieved. These ideas included offering PMHS training opportunities in Tier 3 work, rigorously encouraging PMHS and wider team attendance at clinical case review and intake meetings, and establishing a formal pre-school age CAMHS referral system that linked closely to CAMHS single-point-of-entry requirements and file establishment formalities. Reacting to a suggestion that team meeting requirements might seriously limit clinical time for those working part-time, the opinion was voiced that compromises in this area would result in serious integrative problems and staff contracts might need review in this regard. Changes in the responsibilities and management of clinical psychologists had resulted in a drop in seeing pre-school age children within the CAMHS Tier 3 caseload dominated by older children with pressing problems. Some of these cases may be now being well-managed by the PMHS service, but opportunities may also exist here specifically for closer liaison with other CAMHS team members and some integrative joint working opportunities in the clinic as well as in the home. Instances of this happening anyway were reported during the interviews, but on the whole they were claimed to be rare.

Instances of close integration of PMHS staff and activities within the CAMHS team do exist in the service at present, but as the exception rather than the rule.

1 (c) Referral systems and intake

As the majority of referrals to the PMHS service come from HVs with whom PMHS staff have had prior contact and discussions, if not joint visits, the system generally employed differs from that conventionally operating in CAMHS through the single point of entry (SPE) mechanism. Commonly, SPE forms are generated for all referrals but these are usually

age-filtered with under 5s cases going straight to the PMHS worker's inbox. In some units a stage of prior scrutiny occurs by CAMHS staff but often the SPE form already earmarks a specific PMHS worker and, indeed, client contact with that worker may have already occurred. One view is that at best this does not aid integration and at worst can place the PMHS staff (and possibly CAMHS) at risk. Where the new Choice and Partnership (CAPA) scheme is operating, under 5s in some (but not all) services are filtered out beforehand and passed directly to the PMHS worker.

Referral systems and CAMHS integration are further linked by family problem continuity issues – families with a history of CAMHS input requiring good team communication and sometimes concerted action when a pre-school age sibling comes to the attention of the PMHS service. Under fives slots in clinical case team meetings offered an opportunity for redressing referral practice differences, but different views were expressed about how effective these were and about patchy PMHS staff attendance. An associated issue is whether part-time PMHS staff have the time and whether both job share partners have sufficient overlap to both attend these scheduled meetings.

All CAMHS services log PMHS cases formally after the (varying) intake procedures have been completed, and files have been opened. The sense that rather little team-based (i.e Tier 3) scrutiny of the pre-school age cases occurs thereafter is, in one practitioner's view, confounded by how to define 'complex needs' in very young children. Other views were expressed that indicate that more team-based work was compromised by the strictly domiciliary, psychoanalytical orientation that PMHS staff follow, contrasting this with PMHS staff working with the school age and adolescent age groups. However, several CAMHS-based staff admitted ignorance in knowledge of the clinical effectiveness of PMHS work and it may be that sharing information about this would also make a contribution to team integration and joint working practice.

As shown in the data on referrals, a significant minority came directly from doctors, mostly GPs and Community Paediatricians. Liaison seems to operate differently and one Paediatrician, who was highly supportive of the service, accessed it as a normal CAMHS SPE referral, but knew little about any consequent work done until receiving an information letter, often months later.

2. Tier-defined level of PMHS activity.

It was widely recognised that uncertainty, even confusion, exists about characterising the Tier-defined levels of PMHS work. In one case a CAMHS professional agreed that Tier-defined dogma could be unhelpful in encouraging a spirit of integration. These dogma include the already-mentioned problem of the characterisation of complex needs, making essentially preventive interventions, engaging in home-visiting therapeutics, specialising in single-model approaches, and working closely with community nurses and others conventionally working in 'primary health and social care'. Some CAMHS staff clearly saw the PMHS work as Tier 1 or Tier 1 & 2. Others were adamant in regarding the PMHS Under 5s service as Tier 3, unsurprisingly a view voiced more clearly in CAMHS teams where integration was more evident.

The usefulness of Tier-defined divisions in mental health services is clearly challenged by the essence of the PMHS role and it is beyond this evaluation to speculate at length about its practical importance. However, insofar as this topic frequently emerged naturally in stakeholder discussions it is probably necessary to simply reflect that coordination and integration of a coherent children's mental health service is likely to benefit from broad agreement on effective and useful service components at a variety of levels relating to complexity, time, location, approach, liaison and continuity. One view was that cross-tier work would be facilitated by integrated management structures

3. PMHS staff clinical and line management

Common views were expressed about the fragmentation of management within CAMHS and concerns over differences between clinical and administrative management systems. It is understood that changes in the provision and configuration of the Children's Services might involve a roots and branch re-organisation of management structures so as to provide both inter-professional management coherence within CAMHS and regional continuity resulting in a unified Bristol-wide system, minimising Trust variation in provision of service and actively managing social and geographical inequities. Key issues voiced for the PMHS Under 5s service management relate to complexity and delay in decision-making, coordination across Trusts, geographical coherence and coverage, and integrated management structures. Those commenting on management issues seemed to agree that a post-contestability single regional management system embedded within CAMHS and

covering both clinical and line management duties would be beneficial to the PMHS service.

4. PMHS working practice and management differences

As a relatively new, evolving service with 7 PMHS workers occupying 4 wte posts covering widely differing socioeconomic and cultural areas, variation in approach and experience is likely to result in different working practices. This variation provides complexity in evaluation but is useful in generating diversity to inform the development of models of good practice. However, to identify best practice when effectiveness is difficult to measure and individual practitioner differences are likely to dominate variation within a small service, requires a cautionary approach. The four CAMHS teams clearly vary in staff personalities and personal interests, in degree of integration of PMHS service, in client characteristics and in professional culture. One can only distinguish usefully a clearly articulated vision in one locality which sees the PMHS service as a specialist service of equal professional status and importance, occupying a new position in preventative mental health close to Tier 3 level requiring team input, and with aspirations for expansion into midwifery, mother-and-baby care, and family-based approaches, under a single management structure.

5. Expectation differences of Health Visitors and PMHS workers

A sense exists of differences in the expectations of the PMHS role between HV managers and PMHS workers. Individual relationships with referring HVs is clearly a core aspect of the work model and appears to work well. However, a perception exists that the PMHS workers' interests in supporting HV-led client interventions are not always received as favourably as outright case referral. Locality managers wanted to emphasise the low HV recruitment rates and the high proportion (@20%) of unfilled HV posts caused by an ageing workforce and role diversification. One suggestion was for better liaison with the HV Training Department at Kings Square House and improved recognition, notwithstanding existing PMHS job descriptions, of current limits in HV capacity. It was recognised that capturing the value of the joint and PMHS-supervised work that HVs do for behavioural and emotional problems in young children would motivate and support both professions.

6. Future development ideals

Some comments relating to a vision of the future have been presented in 4 above. The generally supported themes involved closer integration and inter-professional working

within CAMHS, clarification of roles and lines of clinical and personal management. Very recently changes have enabled social worker team leaders in South Bristol to refer, like HVs and their North Bristol counterparts, directly to the PMHS service which could go some way to filling the 'Tier 2 gap in children's mental health services'. There seems to be a perceived reluctance on the part of PMHS staff to engage with Social Work colleagues in cases of unstable family life or where child protection may be a central issue and some guidelines may be required to ensure that misunderstandings on whether behavioural problems in the under 5s that are more than attachment issues are eligible for their assistance.

Summary

There was universality in opinion on the high overall value placed on the objectives and efforts of the PMHS service, across the spread of clinical, community, managerial and administrative respondents. Some stakeholders clearly saw the Tier gap-filling activities provided by the PMHS service as pioneering and essential. The clinical, administrative and managerial position of the PMHS service within the existing CAMHS teams is seen as a critical issue for the future development of a joined-up service. Clinically, the further incorporation of PMHS therapeutic work into the CAMHS working model based on multi-specialist team work is seen by most as desirable or essential. In addition, however, the contribution of specialist, community-based approaches with preventive, long-term objectives is also recognised by some to be of value in widening the scope and orientation of the more traditional, Tier-defined system of child mental health care embraced by many CAMHS professionals. The psychotherapeutic approach used by PMHS practitioners was seen as generally appropriate but concerns were voiced that other models of working embraced by the wider CAMHS teams could also be useful on occasions, reinforcing the value of closer working and possibly more internal referrals. There was broad agreement that managerial reform within CAMHS would be helpful and important in finding the optimal structures to aid closer working patterns, including more consistency in case referral management, intake and discharge procedures, and involvement in team meetings. This may also necessitate a more formal initiation of PMHS staff into the various CAMHS specialisms.

The introduction of the PMHS service has accentuated old debates about resource allocation priorities, Tier-defined services, preventive and responsive work, linkage with adult mental health services, and the role of community-based staff such as HVs and social workers in mental health work. Cutting across many of these traditional barriers the PMHS service may act in an important pioneering role, not least in epitomising the concept of the 'expert team around the child' now being developed in the form of multi-agency panels. Retaining specialist clinical connections will remain essential, however, and the danger of becoming peripheral requires careful consideration after further consultation and visionary management action.

THE VIEWS OF THE HEALTH VISITORS

(a) Health Visitor questionnaires

Health Visitor (HV) managers in Bristol PCT produced a list of 107 HVs employed in providing services for the under 5s in July 2007. Every HV was sent a personalised letter (Appendix 7), a one page (double-sided) questionnaire (Appendix 8), and a stamped addressed envelope to return it in, in September 2007, almost exactly 2 years after the Bristol-wide PMHS service had commenced. There were 54 responses, including one from a specialised post who said she did not see under 5s. Health Visitors who had not responded and whose email addresses were known (n=32) were sent an email reminder, generating an additional 2 responses. A total of 55 (51% of the HV staff) completed questionnaires were eventually received. The conditions for ethical approval of the evaluation did not allow any further direct probing of non-responding HVs.

Service awareness and use during the past year

All respondents were aware of the PMHS service and only 3 (5% of respondents) had either never considered using or had considered but not used the service during the past year. A total of 20 (36%) had used the service on 1 or 2 occasions, whereas 31 (56%) had used it more frequently. The number of PMHS service “use events” by HVs in the latter group ranged from 2 to 12. The mean number of PMHS service uses during the previous 12 months for the 23 ‘frequent user’ group of HVs was 6.5, or approximately once every 2 months.

Reasons for HV use of the PMHS service

The vast majority of HVs (45, 82%) had used the PMHS service by referring their clients to it. Additionally, 34 (62%) HVs had (only) consulted with the PMHS about a client and the same proportion had met with a PMHS worker for case supervision. Joint visits to a client with a PMHS worker were reported by 29 (53%) of responding HVs. A total of 15 (27%) reported contact with the PMHS service at a training event, but all these HVs had also used the service for direct client-related support or contact.

Reasons for referring clients to the PMHS service

HVs were asked to rank the most frequent reasons for client referral. Overall most HVs reported the complexity of the underlying problem (mean rank 1.25/4) and lack of progress (1.79/4) as the primary reasons, with parental request (3.02/4) and potential for child protection issues emerging (3.47/4) ranking lowest. One HV commented that PMHS referral waiting times contraindicated referral for child protection issues which demanded immediate action.

Perception of personal skills in managing pre-school children with emotional or behavioural difficulties

No HVs reported confidence in managing *all* children with difficulties and only 2 (4%) felt that they could manage all cases 'were sufficient resources to be available'. However, 38 (69%) reported that, with sufficient resources, they could manage all but the most severe cases, whilst 11 (20%) had not had sufficient training to feel confident to manage them alone.

HV rating of their satisfaction with the PMHS service

A five point Likert scale was used to assess HVs' reported satisfaction with different aspects of the PMHS service. The results (see Table 1) are indicative of high levels of satisfaction in those using different service components. The proportion of HVs using the service for that purpose who recorded being "very satisfied" or "satisfied" varied from 53% to 90%, with satisfaction in the service overall recorded by 86%. Lowest satisfaction was reported with supervision meetings and 2 HVs were "very dissatisfied" with client referral. Overall feelings about the PMHS service was reported as "dissatisfied" by 4 HVs and "very dissatisfied" by 1. In the latter the HV complained later in the questionnaire of excessive referral waiting times. Those in the former category also commented on referral waits, a poor working relationship established with the family, or a premature case closure. Three out of these 5 HVs were later interviewed.

Table 1. Percentages of HVs reporting different levels of satisfaction with PMHS service components

PMHS service components	% Very satisfied	% Satisfied	% Neutral	% Dissatisfied	% Very dissatisfied	Sample size	Number 'not applicable'
Client consultation	55	33	10	2	0	49	4
Joint visits	48	41	7	3	0	29	22
Client referral	48	30	8	10	5	40	8
Supervision meetings	44	33	14	9	0	43	10
Training events	44	37	4	15	0	27	27
Liaison with care team	33	40	23	4	0	52	2
Overall	44	42	4	8	2	50	2

HV comments on the PMHS service and how it could be improved

A free text field probing HVs' views on the PMHS service was completed by 40 (73%) of questionnaire respondents. This was taken as an opportunity to compliment the type and quality of service by 17 (42%) of the 40 respondents to this question. Thirty three HVs reported on 11 distinct topics 45 times in their responses (Table 2).

Table 2. Topics mentioned in HV Questionnaire item 15: "Please use this space to comment on the PMHS service and how it might be improved *from your perspective*", in descending order of prevalence

Topic categories mentioned by HVs as factors which could contribute to an improved PMHS service	Number of mentions (N=45)
Shorter waiting times	10
Improved liaison between HV and PMHS worker	7
Additional HV training	7
Increase in PMHS capacity to respond to HV requests	5
More HV supervision by PMHS service	3
Increasing HV workforce to manage complex cases	3
Improving PMHS feedback to HVs on closing cases	3
Changing the name from 'infant mental health'	2
Widening case selection for PMHS input	2
Clarifying geographical boundaries between PMHS worker areas	2
Improving PMHS intervention work quality	1

The most commonly mentioned topic was waiting times from referral to starting work with a family, reported by 10 (25%) of the 40 contributors to the question. Sample quotes:

"I really value PMHS, however, referral time has been lengthy with up to 3 months waiting time for families. HVs at my base have good relationship with both PMHS team..."

“Quicker referral process- too long via single point of entry and by time PMHS is able to see families they have sometimes lost motivation, interest- also sometimes urgent work needed to prevent + emotional damage...”

“During this year some referrals took over 6 months to be seen but we were not told of this problem till the 6 months had elapsed! Faxing referrals could help and use of emails to consultants/infant mental health workers”

“Waiting list can be quite long- presumably there are many referrals. We only refer when we are having no success ourselves and I think parents should not have to wait too long before being seen. ...”

Communication between HV and PMHS worker was another common theme, sometimes coupled with comments on waiting times:

“excellent service - it can sometimes be difficult to arrange times/ contact infant mental health specialists...”

“I would like the service to be more accessible. It is often difficult to access our specialist by phone...”

“A more rapid and positive response to ref. Willingness to give ongoing support to family. Better liaison. More structure to action plan ...”

The desirability of more specialist as well as basic training opportunities were commented on:

“I would love to be able to access CAMHS training in specific areas of interest and expertise to help me in my work.....”

“Would appreciate training at a more demanding level to develop expertise....”

“...an excellent service. I would like more time to work on joint projects for HVs to be able to access formal training, formal training to be included in HV training...”

HVs recognised their own workforce capacity limitations as a barrier to expanding their role in undertaking joint or specialist work:

“More resources needed. PMHS to support HVs but HV nos reduced, no longer have capacity to support families in need of help ...”

“It's no use supporting HVs - there aren't any left. We need to be more proactive at the interface...”

...and also realised that the PMHS service itself had workforce capacity limitations:

“There are not enough staff available to refer to particularly when there is so much demand in areas of perceived high need ...”

“I would prefer the PH worker to be able to visit quicker and take on more clients once seen. Appears to be unable to take on due to her workload or there is long waiting time...”

“Invaluable service need to increase numbers of PMHS...”

Other comments related to feedback, supervision and quality of service which appeared to have specific case connotations, reflecting perhaps that some HVs had limited experience of the PMHS service. Two HVs reported negatively on the connotations of referring to ‘infant mental health’ as problematic for clients:

“Have raised issue of name of service as barrier to making referrals. Clients from different cultures find whole issue of IMH difficult to grasp...”

Summary

Fifty one percent of questionnaires delivered to the 107 HVs reported by their managers to work with children in Bristol PCT were completed and returned. A large majority (93%) reported using the PMHS service through client referral or by making joint visits (or both). Case complexity and lack of progress with clients were the predominant reasons for contact with the PMHS but nearly three-quarters of HVs felt that with sufficient resources they had confidence to manage all but the most difficult cases themselves. High levels of satisfaction were reported by HVs of the PMHS service in all areas of their contact and overall. Some comments relating to the desirability of PMHS staff to increase their HV contact and support work (shorten waiting times, increased communication and additional training) were received. Some HVs’ responses indicate that they would benefit from further supportive assistance from the PMHS service and more time to engage themselves in intervention work, whilst others see the PMHS service as primarily offering referral opportunities.

(b) Health Visitor interviews

Introduction

Health Visitors were asked to record on the questionnaire if they would be prepared to be interviewed by telephone to explore their perceptions of the PMHS service in greater detail and 30 (55%) agreed to this. A sample of 20 HVs was purposively selected from this group for interview, to represent variation in geographical area and demographics, size of the

health visiting team, corporacy of caseloads, and level of satisfaction with the PMHS service. A semi-structured interview format was used, guided by an interview schedule that enabled flexibility and elaboration of themes determined by the participant. Where new themes emerged these were tested with subsequent participants to check for contradictory accounts. Interviews were undertaken early in the day or in the late afternoon at the convenience of, and by prior arrangement with the HV. Data collection was carried out during October and November 2007, and continued until no new themes emerged. Full notes were taken by hand and a type written transcript returned to the participant for validation. Two responses were received, one to comment favourably on accuracy and the other to offer further information relating to the interview. Framework analysis was undertaken. This is a content analysis method which involves summarising and classifying data within a thematic framework in order to report the key elements of participants' accounts.⁶ The following themes emerged as dominant:

- *PMHS service impact on HV workload*
- *Client referrals and outcomes*
- *Access issues*
- *Range of PMHS services*
- *Service improvement*

Impact on HV workload

Participants were asked what impact the PMHS service had had on their own workload. Some participants took the opportunity to describe an increase in their knowledge and confidence in their skills with clients, enabling them to continue to work with a family where previously they might have felt out of depth, using different tools and having had the benefit of another perspective on the situation. However, there were a range of responses relating to potential reduction or increase in workload with a majority suggesting there was no impact in terms of increasing or decreasing workload, but *'just added support to carry on'*.

'Relieved it and supported it'... 'I was stuck with a family...it felt like I was attacking it from another angle'.

⁶ National Centre for Social Research (<http://www.scpr.ac.uk/>)

Less positively a minority said there was no impact on workload because the PMHS did not offer strategies of which the HV was unaware, and a few mentioned that cases were not taken up, even though the HV expressed a lack of confidence in managing it herself,

'but then the case has not been taken up even though I feel out of depth with it – otherwise I would not have referred. (PMHS) has not given it the same degree of severity as have I'.

A minority of participants described a reduction of their workload usually because they have been able to refer on clients. The PMHS service *'alleviated me of families', 'eases it a bit' 'another avenue to direct clients'*

Some participants, however, described scenarios where the service had the effect of increasing their workload, for example, where the HV carried on working with a family under supervision, when she would previously have referred. This was a source of frustration for some experienced HVs who said they referred rarely and wanted the PMHS to provide direct services for the client, but for those who use it as a learning tool this is valued as *'increasing confidence in my own skill'*

'The main problem is that the IMH is supposed to help support the HV in her work. In (locality) the problems are very complex and the HV service is so short staffed that the PMHS service actually made more work, for example the paperwork involved in making referral, then lengthy joint visit and then possibly follow up visits'

(PMHS) *'doesn't take anything off me, but rather added. Supervision meetings take 2 hours every 6 weeks'*

'Has shared load for families where (HV) have concerns – has done joint work, also has given more intensive input to some families. Sometimes the PMHS has created more work for (HV) – if joint visits are needed – or (HV) have to continue with more intensive work and although caseloads haven't changed the numbers of HVs have - they are 'doing more with less'.

The above participant said she was sometimes *'really stressed'* trying to accommodate extra time needed. Other points which were raised involved the administrative workload required to arrange joint visits, especially when link workers such as interpreters were needed, or either the HV or PMHS is part time; arranging access to the toy library or the HV team nursery nurse. The hours required for supervision were also mentioned, with this being hard to justify on a regular basis especially in busy areas with high health needs. Conflict was evident as some participants felt that the PMHS was not sufficiently aware of increased demands on their time, especially in relation to child protection and reduced staffing and that it may not be possible for HVs to offer the same amount of time and similar ways of working for clients as PMHS. Differences in caseload size means an HV cannot

offer the same service a client might get in 'face to face' consultation with PMHS who can refuse to take on a client and have much smaller caseloads. Health Visitors have difficulty resolving equity of service issues if they spend the greater proportion of their time with *'one client out of a caseload of possibly four hundred'*.

Client Referrals and Outcomes

Evidence from the interviews suggested changes in referral patterns were emerging. Some HVs had a heightened awareness of attachment problems and were referring earlier, *'when signs are more subtle'*. However, the option of referral can only be achieved if the client recognises the problem, and other HVs, who were also aware of the potential for subsequent problems, were unable to refer earlier because the clients themselves were not ready

'Families often would not recognise they had problems until quite a long way down the line, and would refuse referral at an early stage.'

Participants who described themselves as experienced HVs were frustrated when they made a referral to the PMHS and the referral was not taken on, or *'bounced back after one visit'* because they felt their experience was being questioned and their concerns not being given due credence,

'I only refer when I am really stuck with a client'

'When I do make a referral I really have tried everything'

I only refer when I am out of depth or it is outside my sphere of experience'

Frustration was expressed at lack of 'face to face' work with clients,

'I would prefer it if (PMHS) would take on more referrals face to face – there are no problems making referrals – she will guide and discuss – but perhaps thinks I can do more than I can'

Currently there is no formal means of assessing the short and long terms outcomes of PMHS interventions with families and HVs were therefore asked about their impression and experience of client outcomes from PMHS services. A number of participants commented on the complex nature of the problems presenting in the families they had referred and the ability of the families to engage in demanding and intensive work, when they talked about behaviour changes. They frequently took a pragmatic attitude to a negative outcome, often

having tried and failed to elicit change themselves There was a recognition that in many cases HVs only refer the most difficult clients,

'so it is therefore not surprising if no long term improvement...can usually predict who will do well and who won't'

Some parents 'do not engage ... they are not prepared to put in the work',

'Parents not emotionally ready...will not travel for appointment in clinic...or have a 'chaotic lifestyle'

'Client has gone back to square one'

'not to say they do not relapse- especially true in families where only one parent is biological parent – needs of adult conflict with needs of children'

Client expectations could also affect the outcome of the contact. Participants reported that some clients are looking for a *'magic wand'* to cure their problem and are perhaps not prepared, or unable to engage with the service to the extent required to resolve their deep problems, or do not understand reasons why PMHS might be asking probing questions about their background and experiences or want to watch them play with their child. Other clients are pleased their concerns have been taken seriously and are happy to engage. Clients' perceptions *'can range from it being thought a wonderful service to "that's weird"!* Furthermore the long term nature of PMHS input, in some cases up to one year could be a barrier to success, *'to work through issues'* can be *'quite demanding for the parent'*. Making full use of the service, going through the emotional work *'takes a lot of determination'* from the client'.

However, there was evidence of change as a result of contact with the service. Some participants reported what appeared to be long term improvements in client perceptions of their situation and long lasting attitude change, even where outward circumstances had not changed appreciably,

'Clients see their own situation more objectively. They have a different attitude to their problems, ... parents move on'

'majority of referrals have generally improved to the extent that HVs can then continue to support'

'often situation does not change – but attitude to it does',

'My client was left with the tools to deal with situation that was unchanged ...and recognises the pattern she was in'

'Some parents (not all) gain insight into why their children behave in the way they do, and this is long term change'

The impact on the client's subsequent relationship with the HV was probed. Most HVs were happy with ongoing relationship with their clients, reporting if there was any change it was that the relationship had been enhanced by the fact the client felt their problem had been taken seriously. However, in one case the subsequent HV service had been adversely affected because a client had disclosed issues relevant to the family's ongoing care to the PMHS – and with the client's permission the PMHS had related these to the HV. However, since the client had not disclosed these directly to the HV, the family HV felt it was difficult to raise the issue and although she would normally make mental health needs of clients a priority in her health visiting contacts she felt constrained to staying within boundaries such as developmental assessments and normal child behaviour questions, thus reducing the ongoing psychological support the HV would normally offer.

Access

In general, access to services was not reported to be a problem with the flexibility around waiting times offered by the PMHS, who appeared to be able to respond to urgent referrals, and often did this before formal procedures were completed. As long as a Single Point of Entry (SPE) referral form has been completed and sent the PMHS might visit the family before the SPE is confirmed, a point much appreciated by HVs, as if the wait is 3 months some "*families can go off the boil*" in terms of interest in their referral. Wait times were reported to range from 2 weeks to 10 -12 weeks. Some participants gave a longer average wait time, with the justification that due to the fact the service had been going for longer it therefore had more referrals to handle than when it first started, or because PMHS staff had been away from work due to holidays or sickness.

As reported above the logistics of arranging joint visits can be difficult and impact on ease of access. However, in bases where HVs have regular supervision from the PMHS, access is good. Telephoning was thought to be generally easy in order to discuss clients and potential referrals, although a minority reported experiences of messages not being passed on and calls not being returned. This did not seem to be a problem where the PMHS carried mobile phones for administrative purposes. Two geographical areas in particular were cited in relation to difficulties with communication.

Echoing comments from the questionnaire, the name of the service was reported as being problematic for some participants, particularly, though not exclusively, those with

experience of working in localities with a high minority ethnic group population. One participant working in the latter type of area explained

'it needs a different name or title for their role ... the term spooks families; they are confused and worried; the perception is that their children are deranged, or that they could be taken away'.

She went on to say that there needed to be more opportunities to unpick barriers in communication, and 'de-westernise' the service as in her experience her clients do not understand or recognise the approach taken by the PMHS. She suggested those who believed that the parent has total control over the child, 'an absolute authority by right of having given birth' become suspicious and anxious if professionals question their approach.

'Perhaps the service is too ethnocentric and needs to explore other ways of communicating with different ethnic groups – perhaps try different approaches'.

Of course it might be argued that most parents feel threatened if their child rearing practices are questioned and a great deal of stigma about mental illness persists in the community whatever its ethnic make up. One participant commented that clients whose children had behaviour problems on large outlying estates were also put off the service with evidence of some withdrawing from service.....

'because of the stigma associated with mental health services'.

Other issues that emerged under the 'access' theme were problems relating to variation in boundaries, with some participants working in the centre of town not always sure of who was the correct PMHS for referrals. There were also perceived differences in the style of working between PMHS in relation to families referred to Social Services, especially where one base was serviced by more than one PMHS. It was suggested that where some PMHS were happy to work when Social Services were involved with a family, others would wait until Social Services had completed their work before being involved. In one locality bordering another PCT, the working practices in relation to engaging in face-to-face contact differed between PMHS staff working in adjacent streets.

Range of PMHS services

Despite some adverse comments relating to impact on HV workload of joint visits and supervision, most participants were positive about the range of services the PMHS offered. Joint visits were valued as facilitating the PMHS contact, especially when the clients were concerned about stigma related to mental illness.

'Useful in encouraging families to take up service'

The joint visit was found to be informative and a learning tool, and several participants reported using them as an opportunity for observing the psychotherapeutic approach, learning about the different questions to ask, and how to ask *'difficult questions sensitively'*. They also appreciated the PMHS approach to giving the client time, describing this as 'being there' for the client. However, a small number commented they did not have the time for joint visits,

"Ninety minutes is a very long chunk out of HV day"

or that they had been used as a child minder while the PMHS talked to the mother without distractions from the child.

Participants' responses to opportunities for supervision from the PMHS varied. There appeared to be a tension between the need to respond to caseload demands and making time to access potential caseload support such as supervision. A number of HVs reported they felt too pressured to put aside the time to have supervision and regular sessions had elapsed. In one place HVs had decided that due to the number of new babies they had on the caseload they could not justify time dedicated to supervision. Also time set aside for supervision was seen as a bit of 'give' in the day, that is time set aside which is acceptable to attend if nothing else is pressing. The majority valued supervision highly, seeing it as helpful to their work, offering new strategies for handling a situation and contributing to updating awareness on current research and practice. An alternative view, however, was that supervision could be felt to be threatening. One participant suggested that "going over and over on families as cases *'sometimes made HVs feel they might have missed something'* and *'could heighten anxiety'* about their handling of a situation, suggesting great sensitivity and tact is required to handle such sessions. There was variation in the extent to which supervision was deemed helpful. Some more experienced HVs felt supervision was not offering them any new strategies to try.

The majority of participants had attended training days in relation to attachment problems and infant mental health and greatly appreciated these, (see the following section). In one or two bases there appeared to be access problems with funding to support training not being available for all.

Overall opinion of service

The overall consensus of HVs through interviews confirms that of the findings from the questionnaires that the PMHS service is regarded by them as an excellent resource *'useful', 'brilliant' 'invaluable' 'like it, would like more!' 'extremely valuable', 'vital' 'absolutely essential'*. Some participants commented that the PMHS needed further funding in order to supply their own toys and nursery nurses, and they would appreciate a change in the proportion of time given to supervision being reduced in favour of more time for joint visits and face-to-face work with clients. Some participants suggested a redistribution of PMHS resources so that areas with high health need could have a greater number of PMHS workers, perhaps one to every HV base.

Summary

The findings of the interviews confirm and add depth to those of the questionnaires. The PMHS service is highly valued by HVs who see it as a valuable resource both for their own support in working with families and for the families referred for direct work with the PMHS. There was a sense that HVs perceived their workload to have increased in recent years, but that they felt this point was not always appreciated by the PMHS who try to encourage them to continue with their clients with PMHS support or supervision. It was suggested that if this is to be an effective capacity building strategy then the increased time required for consultations with individual clients would have to be acknowledged and HV services expanded to take account of it. Less experienced HV participants valued the training opportunities offered by joint visits and supervision, but most commented on the time consuming nature of these in relation to the other demands of the caseload. Some HVs had experienced problems in obtaining funding to attend PMHS-facilitated training to support their work with this group of clients. A number of participants suggested an improvement to the PMHS service would be to expand it to enable more face-to-face contact with clients. Comments around further resources being required to support the service were also evident. Equity issues arose in relation to referrals, with some participants commenting on variation in practice for families also involved with social services. A related issue was the name of the service being a barrier to referral in some communities, and the PMHS approach itself not taking sufficient account of differences in child rearing practices in other cultures.

THE VIEWS OF CLIENTS

(a) Questionnaires

On notification of a client's discharge by the PMHS back to the HV service, or 6 months following their first appointment (whichever was the sooner), those still engaged in the evaluation were sent an 'Experience of Service Questionnaire' to complete (Appendix 13). A total of 18 completed forms were returned. All 18 completed the check box, 3-point Likert Scale items asking for their level of agreement with 19 statements related to the service received, and 13 additionally provided qualitative free-text notes. Nine clients also agreed to be interviewed by telephone or in person (see below).

The check-box statements covered areas broadly definable as communication, professionalism, consideration, impact of service, and overall impression.

Table 3. Percentage of respondents (n=18) reporting 19 statements about the PMHS service as certainly, partly or not true

	<i>Certainly true</i>	<i>Partly true/ partly untrue</i>	<i>Certainly untrue</i>
<u>Communication</u>			
I feel that the people who have seen my child listened to me	83	17	0
It was easy to talk to the people who have seen my child	83	17	0
My views and worries were taken seriously	78	17	5
<u>Professionalism</u>			
I feel the people involved know how to help with my concerns	61	28	11
I have been given enough information about the help available	76	18	6
I feel that the people who have seen my child are working together to help with the problem	72	17	11
<u>Consideration</u>			
I feel that the timing of appointments was good	89	11	0
I feel that the frequency of appointments was good	88	6	6
I feel that where the appointments took place was good	89	11	0
I was treated well by the people who have seen my child	89	11	0
<u>Impact of service</u>			
I feel that, as a result of this service, the relationship I have with my child has improved	67	33	0

I feel that I would now say that the relationship I have with my child is good	67	27	5
I feel that, as a result of this service, I am better able to manage problems I might have with my child in the future	67	22	11
As a result of this service I feel more confident in my role as a parent	53	35	12
As a result of this service I feel that relationships within the family have improved	61	28	11
I feel better within myself, as a result of this service	55	39	5
<u>Impression</u>			
I feel that the service has been helpful in resolving the problem	53	35	12
If a friend needed similar help I would recommend this service	78	17	5
Overall, the help I have received from the service is good	89	11	0

The numbers are too small to draw any strong conclusions although very few (a maximum of 2) respondents regarded the positive statements in any sector to be ‘certainly untrue’. A slight trend might be apparent towards higher levels of agreement (i.e. satisfaction) in the areas of the PMHS workers’ manner of contact and approach and style of communication, than in carers’ perception of clinical efficacy and problem resolution.

Commenting on *good* aspects of the service, carers reported primarily on their appreciation and valuation of being able to talk to someone who listened in non-judgmental way....:

“...helped to speak to someone outside of friends and family who felt I could be truthful with...”

“...I felt I was supported, my feelings were valued and justified...”

“...I found it therapeutic to be able to ‘off-load’ my stresses and anxieties...”

“...good, nice person, listened, picked up relevant bits.....”

Providing a reference point and re-assurance of ‘normality’ seemed also to be appreciated....:

“....made me feel I wasn’t mad....”

“...helped me relax and realise my expectations of family life may be high/unrealistic – i.e. I am not ‘wonder women’...”

“....didn’t make me feel undervalued or stupid...”

“...she reassured me that I had genuine concerns and problems that needed to be addressed...”

“...it did help to confirm that my son was only delayed in his development and therefore immature in certain areas...”

A third positive theme related to acceptance and acknowledgment of self and the factors that may have elicited the presenting problems.....:

“...helped me ...get to the root of concerns...”

“...it has also taught me not to be so hard on myself when things go wrong...”

Comments on what carers felt was *not good* about the service generated complimentary phrases, such as “nothing!”, in 7 out of 13 respondents, several qualified by explanations of what the carers thought they needed outwith the PMHS service, including physical help with child care and support for long-standing adult relationship difficulties. In addition, some respondents used this as an opportunity to mention a desire for more frequent and longer appointment durations and a request that:

“...xxxx had had counselling training to deal with adult problems too....”

One carer’s comments in this space emphasised the hopelessness of the situation,

*“... the situation was not resolved...the external stressors of all problems existing remain....
....things are worse than ever...”*

and two others used this opportunity to state that....

“...I don’t feel like I am going anywhere with the issues that I have with my son...”

“...the session my son had made him a lot worse.. at certain times he would bite and kick”

whilst another claimed that

“...I didn’t feel like I could be comfortable with the health professional....”,

although the same respondent had found the good aspects

“...very relaxed and enjoyable....”

These comments (by only a small proportion of clients seen over the study period) emphasise the psychological significance of the emotional support for carers delivered by PMHS staff, which they may neither have the time to engage in comprehensively nor are sufficiently trained to provide. Taken together with the results of the baseline GHQ data and the client interviews, multi-professional clinical opinion is needed on how best to promote optimal coping strategies and manage the slippery interface between carer emotional well-

being and the behavioural problems of the young child. It seems unlikely that this is best approached under the sole domain of the PMHS service.

An opportunity was taken in this questionnaire to ask clients their views on the service name "Primary Mental Health Specialist (Under 5s)". Two comments were received:

".....use of the word 'mental' in any job title carries with it an image/stereotype which is quite negative..."

".....it doesn't sum up all the supportive work that was given to me and all my family..."

Summary

Eighteen carers reported their views by self-completion questionnaire on their experience of the PMHS service they received. High levels of satisfaction with the service were reported overall with slightly higher levels in areas of contact, approach and actions, than in the perceived impact on the family. Clients especially reported valuing the engagement and individual support and counselling aspects of the service

(b) Interviews

Introduction

The purpose of the client interviews was to explore in greater depth than could be gained from the questionnaires, parents' hopes for and experiences of their consultations with the PMHS, the actual service they felt they had received and whether there had been any changes for the family as a result of their contact. Finally clients were asked whether they considered these changes, if any, to be long term. During the course of the project nine mothers who had been recruited to the evaluation indicated on their final questionnaire that they would be prepared to speak to an interviewer. In addition, one mother who gave permission to be contacted by a researcher, but who discontinued her contact with the PMHS following her first visit, wished to be interviewed. Interviews were eventually carried out with six clients, all mothers. The remaining four were contacted on two occasions but were unable to be interviewed or did not return the call. Semi-structured interviews were carried out by telephone or home visit according to the mother's preference. Interviews lasted 30 minutes to one hour and five were taped and transcribed. One mother did not

wish her interview to be tape recorded for legal reasons. A thematic analysis was carried out.

In this small sample of clients seen by the PMHS over the period of the evaluation two of the participants expressed negative views of the service. In both cases the clients, whose children had long standing behavioural problems, reported specific unmet expectations for their use of the service. In the first case the participant's agenda for her contact with the PMHS was related to achieving support in a legal process to prevent the child's father having contact with the child. The client said she hoped that the PMHS would 'acknowledge' the problems with the child's behaviour and confirm these were related to contact with the father. Although the client described practical strategies she had been given by the PMHS to manage her child's distress, she was critical of the PMHS approach and felt she was not being believed when she described her fears about the child's contact with her father, and the deterioration in behaviour at the time of contact,

'I think infant mental health specialists should look into the under 5s. When they say they don't want to see their father it is not always because they don't want to upset their mother'.

The client suggested she felt let down by all the agencies involved with the family,

'It is very hard not to feel paranoid when you know you are being watched all the time with your child'.

The other client, who discontinued contact with the PMHS, was looking for specific practical support for the management of her child's eating problem. She said she wanted an 'activities and eating plan, something tried and tested...to take the stress out of mealtimes'. She commented that she felt the PMHS did not believe the mother's explanations for her child's eating problem, and resisted the opportunity to explore family dynamics saying that she felt the PMHS had 'missed the point entirely' and that the PMHS was inferring the family was unhappy, which the mother felt was not the case. In both these examples the mother's felt their own explanations for their children's problems were not heard or believed.

Interviews were undertaken with families with one or more of the presenting problems below:

- Soiling
- Sleeping difficulties

- Food refusal
- Tantrums
- Aggression
- Maternal anxiety
- Maternal depression

Two families were headed by a single parent and in both families there were ongoing problems with threats of violence from their ex-partners. Three of the participants had professional backgrounds. During the course of the interviews it was clear that some of the PMHS had offered other services such as being an advocate for their client by either writing letters on their behalf or interceding with other professionals, especially to do with social issues.

Maternal mental health

Maternal mental health was an important determinant in the referral to the service in the majority of the interviews. Mothers described a range of symptoms related to anxiety and depression reducing their ability to cope with the demands of parenting.

'I am ashamed to say I am deeply depressed and anxious'

'very anxious about the children'

'within the first half hour I was crying...realised there was a lot of emotion tied up with childbirth for me...not suffering with postnatal depression so much as post traumatic stress syndrome'

'getting panic attacks; I was really, really anxious; I stopped sleeping- went four days without sleeping at all. I was really panicking about absolutely everything, I just felt like I couldn't cope really'

In some cases maternal mental health related to severe stress in the family, coping with absent partners and single parenthood, dysfunctional relationships with their own parents coming to the fore at parenthood, domestic violence and partners' substance misuse or alcohol abuse. In some cases the full extent of the impact of these tensions and stressors did not come to light until the PMHS had started working with the client on the presenting child behaviour issue,

It started off with something relatively minor and actually she helped us through quite a big problem this year. (severe domestic violence incident)

Being heard

Clients commented positively on the quality of the communication they had with the PMHS, suggesting they particularly valued the time spent to elicit individual patterns of thought and behaviour,

'she made endless space for me, she was just very good at making space for me to talk. Just to talk.'

'would tell her (PMHS) anything really, even if it was a really daft worry, and then she would just talk things through with me and find out why I felt like that...it kind of put it in perspective really'

'Asked amazing questions, very specific after listening to me'

None of these clients described a specific expectation from their use of the service, rather describing a non-specific need for support and reassurance either in tackling their parenting problems or normalising their children's behaviour,

I just wanted to talk to someone to find out why I was so stressed out really

I found myself not being able to manage two in the way that I had expected to...

I wanted her at least to say they are not disturbed or malformed or malfunctioning...I thought if we are given a clean bill of health by somebody who is a specialist in early child development that would mean something'

'I think some support around, that I wasn't doing something wrong to begin with; to give me some ideas about what we could do to help him, to make sure we knew why he wasn't doing it (eating) , was it control, was it behaviour, was it something wrong with his body? You don't really know'

There was evidence that the supportive relationship with the PMHS continued over a prolonged period (between 6 months to a year), at the client's request. For the majority of these participants this extended period was greatly appreciated and discharge was approached reluctantly,

'She would say, would you like me to come again and I would say yes...because the directive comes from me. I said I would very much like her to come again, so we are slow in taking up that last appointment'

'I would have liked to see (PMHS) once a week for 6 months'

Psychotherapeutic approach

Each participant was asked to describe what service they had received and these accounts indicated an appreciation of the intensely sensitive, skilled listening and observation techniques undertaken by the PMHS, and the subsequent sharing of psychological insights with the mother,

'It was very helpful to talk about aspects that I remember of my own childhood, difficulties with my mother, how that was impacting on all these unconscious baggage and furniture one brings to the situation where you have got a mother and children. She was extremely good'

Such insights were combined with meeting the client's spoken need for reassurance, a confirmation of her children's normality,

'I absolutely did and at the same time it is stupid of me to keep saying this but then the reassurance is, never can replace something that is in one saying, oh maybe it is not all perfect, maybe they are not as intelligent or as perceptive, or as adept or as agile or as able as other children of their age. So in as much as I was looking for reassurance, reassurance was given in spades'

There was evidence that such in depth listening and exploring of feelings was less comfortable for partners,

'I wish (partner) had been involved in this but he really didn't want to get involved and talk about, er, there are aspects to his own childhood which are scars and he wasn't ready under such stressful conditions to start talking about them'

'He came to one (session) but he had a slightly different view from me'

One client described a joint visit from the PMHS accompanied by the health visitor, which led to a further six individual counselling consultations. The participant described herself and her husband as being at the end of their tether with being unable to manage their child's sleeping problem. She described how she had been able to open up and *explore 'things that were quite deep'* relating to separation anxiety, and although the PMHS did not work directly on the problem by offering strategies to solve the sleep problem the participant began to feel enabled. She gained insight into how her child might be feeling, and learnt how to give the child a language to articulate what he was feeling and why, resulting in the client feeling confident to manage the sleeping problem herself,

'gave me a little bit more strength, more conviction in handling things...(PMHS) thought we would crack that ourselves - and we did'

'the best thing was dealing with my issues. Vocalising that. Everything else that happened was as a result of that. The fact that things settled down were as a direct result that I was happier'

Another client had requested help with her child's soiling problem and been referred to the PMHS via her GP. By the time the referral came through the soiling problem had resolved, but an eating problem was another worrying issue for the mother. Strategies for managing mealtimes were suggested sensitively and reassuringly,

'It was nice because she used to say to me actually you are doing a lot of the right things, try this as well. Sometimes you need that because you are thinking I must be a bad mum; I am doing something wrong'

As the PMHS spent time with the family further deep-seated issues became apparent and involved more in-depth work both with the mother and all the children. The client related how the PMHS during her visits, had demonstrated how children express themselves through play,

'even when he was feeling at his lowest, you know, after the incident, he was chucking the little people out of the house, you could tell he understood what was going on'

'They were very angry and scared and without that (support from PMHS) I don't think (daughter) would have seen her father and (son)was having very bad nightmares, things chasing and scaring him. She was able to talk to him and showed me how to talk to him (using his drawings as a trigger). Sometimes as parents we listen, but we don't really listen what they are saying and how they are saying it'

The interviews indicated that the majority of participants valued the opportunity to talk and explore issues that were affecting their perception of the difficulties and uncertainties they were experiencing with their young children. They reported gaining insight into and learning to understand how their child expressed their needs and how to communicate with them. Some clients were able to use these insights to resolve the presenting problems on their own, but for others behaviour management strategies were also given where needed.

Long term changes

All the participants were positive about the enduring nature of the changes they had made,

'I think they'll be long term, I wasn't sure how to say things to them...she was giving me help on that, what angle can I take...I spend more time looking at them and talking to them now...when you are working, living and coping you don't actually see the bigger picture'

'I think there is every reason to say they are long term'

'Long term. I have a better insight into my own problems and this has had an effect on my ability to manage'

'I think it is long term, I just feel a completely different person than I was a couple of months ago even'

Interestingly despite their awareness and insights into parenting there was slightly less consensus and more ambivalence about participants' confidence for the future, although there was an openness to asking for help if necessary,

'I have learnt to ask for help. Before I tended to think people would judge me for not being able to cope...It's OK to ask for help, that's what people are paid for.'

Never felt very confident...I think I feel I do an OK job generally. I handle things quite well. I am quite calm. I am not a shouter. We don't smack our children. I think I feel more confident'

In some sense not at all, not at all. There is always that feeling of not at all, and being and having a sense of wonderment that people do cope. That mean particularly how mothers of twins cope. But I literally take this a day at a time.

'Absolutely fine – really confident, if I had problems now....I don't think oh what am I going to do. I can just take things more one day at a time. I don't get things out of proportion like I used to before'.

Name of the service

Two participants independently raised the name of the service, citing its association with CAMHS as being a barrier to use. Both were wary of mental health services because of their professional background and an awareness their use of the service would be recorded on medical notes. In one situation the health visitor had suggested the use of the service, but the client had been reluctant to accept a referral initially as the name was associated with '*mental health stigma*' which had connotations for her in her professional life where she was familiar with CAMHS, '*not sure I want to do that, go down that road*'. The other client said she thought she had to be '*a bit careful. I did not want to stigmatise. This is on medical records and so on*'. In both cases the clients were feeling so desperate they decided to overcome their concerns about the service in the hope there would be a beneficial outcome.

Summary

The evidence from these interviews has to be seen in the context of a highly selective volunteer sample of clients and as such the findings might not be representative of the whole PMHS caseload. Nevertheless the interviews comprised a range of family types (single parent, cohabiting, married) and mothers were from both professional and non professional occupational groups. The number of children in each family ranged from one to four. The interviews where negative views were expressed suggested there may be a group of clients for whom a psychotherapeutic approach is not so acceptable, that is, those with longstanding problems, a fixed view of the cause of the problems, clear expectations of what support they required from the PMHS or who were unwilling or unable to reflect on possible contributing factors. The majority of these interview participants, however, had been able to explore deep-seated emotional and personal issues with the PMHS and had gained insight into how their feelings might be affecting their parenting. They appeared to learn how better to communicate with their children and had a new appreciation of their

child's feelings. These tools enabled them to more effectively understand and manage their children's behaviour. Participants were positive about the long term nature of the changes, though there was less consensus in terms of their confidence for the future. The name of the service was raised as being a potential barrier to service use in two cases.

EVALUATION OF PMHS TRAINING WORK

Introduction

Training of relevant community-based health professionals in infant mental health forms a discrete, significant part of the PMHS service as specified in their job descriptions and description of the service they provide. Evaluation of training sessions formed standard good practice prior to this evaluation and this was continued in the present study subject to the introduction of an agreed amended evaluation form that probed specific training-related issues of expectations, informative elements, relevance to job value in knowledge/understanding, transferable skills, and areas for improvement (Appendix 17). Health visitors' experience of training was also probed in the questionnaires circulated specifically to them.

PMHS workers were asked to distribute the training evaluation session forms to all those attending each session, asking them to complete them anonymously at the end of the session, with each batch forwarded to the research evaluation office. A total of 35 sessions' forms were received containing 456 individual participant evaluation forms (an average of 13 completed forms received per training session). It is not known what proportion of those attending each training session completed their evaluation forms. Individual PMHS workers contributed variably to training over the evaluation period, partly as a result of differences in working hours, periods of absence from work, and training approaches. Most training (19/35 sessions, 54%) was conducted by two workers, 14/35 (40%) by single workers, and on two occasions (6%) by three. Eleven sessions (31%) were full day, two were evening sessions of two hours, the remainder (66%) being one session or less in duration. Training sessions were conducted in hospital facilities (16/35, 46%), in Children, Family or Early Year Centres (9/35, 26%), in Health Centres (7/35, 10%) or in various other community locations (30/35, 9%). The most common topic titles covered by the training sessions reported in this evaluation were "attachment" (10/35) and "infant mental health" (9/35), others being "infant observation" (3/35), "Solihull" (3/35), "sleep" (2/35), "play" (2/35), with single sessions on "feeding", "weaning", "PSE", "day-care settings", and "outcomes of mother baby interactions".

Training session attendant feedback

A sample of 24 out of the 35 training sessions were selected for more detailed analysis of feedback. Selection was made on the criteria of representativeness of each PMHS worker as trainer, and joint versus single presentations, so as to maximise the variety of training style and input without oversampling particular training pairs or approaches. The 24 selected sessions involved a total of 30 trainers. PMHS staff made from 1 to 7 individual contributions to all these training events (mean 4.3 contributions per trainer) and a total number of 270 individual evaluation feedback forms were received (Figure 1). In the following analysis these have not been weighted by the differing numbers of attendants at each training session.

Attendance

Of the 236 training evaluation form completers who provided an identifiable professional designation (87.4% of all forms) the majority were health visitors, nursery nurses, early year practitioners or midwives. The wide spread of community practitioners receiving training also included at least seven other cadres (Table 4), including teachers, social workers, speech and language therapists, and those in managerial or leadership roles.

Figure 1 . Distribution of training evaluation forms received in 24 selected training sessions

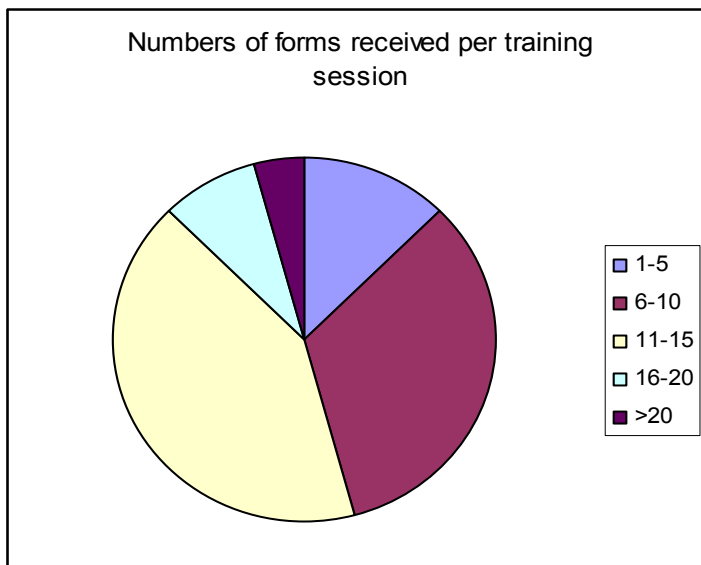


Table 4. Professional designations of those attending selected training sessions

Stated profession	Number	Percentage
HV or Student HV	84	35.6
Nursery Nurse/Community Nursery Nurse	36	15.2
Early Years Practitioners	33	14.0
Midwives	27	11.4
Community Family Workers	17	7.2
Home Start/Sure Start Workers	13	5.5
Teachers	11	4.7
Managers/co-coordinators/group leaders	7	3.0
Nurses	3	1.3
Healthcare Assistant /Activity Assistants	3	1.3
Social Worker	1	0.4
Speech and Language Therapist	1	0.4
<i>Profession not stated or unclear</i>	34	

Attendants were asked the extent to which the training met their expectations. The results (Table 5) indicate that almost two thirds of those attending had their expectations fully met in the session.

Table 5 . Degree to which expectations of training sessions were met

	Number	% of those responding
“Completely”	169	65.8
“Partly”	87	33.8
“Not at all”	1	0.4
<i>Not completed</i>	13	-
Total	270	-

Aspects found to be informative were the presentation itself (reported by 179 out of the 270 respondents, 66.3%), discussion within the session (78.1%), handouts provided (44.1%), and opportunities for networking (20%). Attendants reported that the training was either ‘highly relevant’ (77.7% of respondents) or ‘relevant’ (21.9%) in all cases but one.

Respondents were asked to specify those aspects of the training course that had improved their knowledge or understanding, or transferable skills (Table 6).

Table 6 . Proportion of training attendants reporting perception of improvement from the session

Topic area:	Knowledge/understanding % (n)	Transferable skills % (n)
Needs of child	81.1 (219)	82.6 (223)
Needs of client	55.5 (150)	59.3 (160)
Awareness of service	43.0 (116)	N/A
Accessing professional support	N/A	37.8 (102)
Confidence in case management	N/A	32.2 (87)
Referral guidelines	13.7 (37)	N/A

Paramount amongst these in both categories was the child's needs, followed by that of his/her carer. Less than one third of respondents indicated improved confidence in managing cases themselves as a result of the session. Other areas of knowledge/understanding improvement were mentioned by 36 (13.3%) of the training session attendants in a free-text section of the form. These predominantly covered, with almost identical frequency, the importance of observation, awareness of behavioural development, appreciating the depth and complexity of infant mental health, and the nature of parent-child interactions. Those in leadership roles identified the sessions as refining their ideas about staff skill and support needs. In the case of transferable skills achieved, the most prevalent category of comments related to valuing 'listening and observation skills', including 'containment' and 'reciprocity' (20/42, 48% of the comments). Other transferable skills obtained included 'speaking for the child', 'engaging with and supporting parents', and 'case and time management'.

Attendants were asked to reflect on the training session venue, duration and timing. Of those completing this section of the evaluation 96% found the venue to be good or satisfactory, 83% considered it to be 'about the right' length, and 98% reported the timing to be 'optimal' or 'OK'. Of the 33 (14%) who found the session to be 'too short', 8 (25%) were commenting on all day sessions compared to 31% of all-day sessions overall, indicating that these views were not more likely to be expressed about single session or shorter training duration categories.

Attendants were asked to identify areas of the training sessions that could have been improved (Table 7). The free text comments field on improvable aspects was completed by 67 attendants (24.8%) but after excluding inappropriate or non-specific contributions, and a few comments about equipment quality, refreshments and the like, the majority (21/35, 60%) related to a desire for more discussion time and group work, with a few additional related comments on the quality

of overheads and handouts and how other presentations could have been abbreviated or more efficiently made.

Table 7. Areas with room for improvement of training sessions

	Number of comments	% of all attendants (n=270)
Discussion	34	12.6
Presentation	29	10.7
Handouts	25	9.3
Networking	14	5.2

The final part of the evaluation form allowed attendants to reflect overall on the training sessions in a free non-directive way. Thirty six percent (99/270) took this opportunity. One half of these contained non-specific positive comments and gratitude alone (50/99, 50.5%), and others used this as an opportunity to repeat earlier comments on the venue and its facilities (13/99, 13.1%), or emphasise their desire for longer sessions (11/99, 11.1%), mostly relating to more discussion time. Some specific individual recommendations were also presented. Requests were voiced for more specific information on attachment and how to deal with insecure attachment situations. Similar comments were made about sleeping and behavioural problems and maternal mental health. Several of the Early Years Practitioners felt that their professional training had already covered the material presented and suggested that background knowledge information on the type of attendants be obtained by trainers to inform the main training sessions. Several participants expressed a desire for the sessions to be flexible enough to discuss their own cases, or to lead on to clinical support opportunities.

Summary

The PMHS staff are all involved in training a very broad cadre of mostly community-based health professionals, primarily conducted in pairs lasting one or two sessions and covering various aspects of infant mental health in a mixture of single professional and multi professional groups. In a representative, stratified sample of feedback forms, those attending reported very high levels of satisfaction with the training received on a variety of indices, including both knowledge/understanding and transferable skills, especially those relating to the 'needs of the child'. Feedback data and comments suggest that further consideration of the session structures to allow more discussion time (perhaps achieved by refinements in presentation methods and longer sessions), and a greater focus on links between the training and clinical

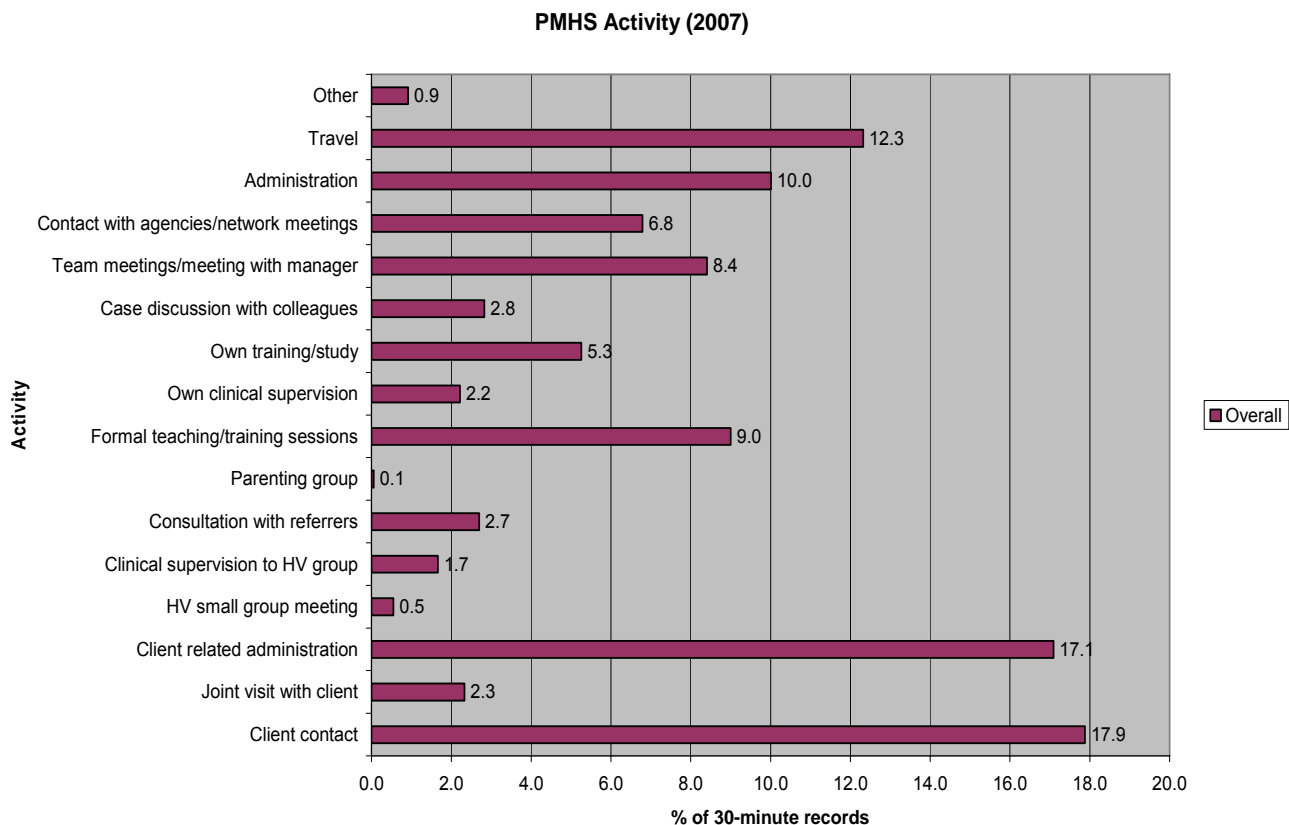
case management support to some health workers, would be appreciated. This might consist of further topic specific sessions for Community Nursery Nurses and Early Years Practitioners, or how they can directly access advisory or supervisory contact with PMHS workers to enhance their family casework.

EVALUATION OF PMHS ACTIVITY

All PMHS workers were asked to complete activity sheets (Appendix 16) which recorded the time spent (in half-hour units) in each of 16 categories on a daily basis and summarised over a week. The activity categories ranged from direct client contact time to administration and meetings with their line manager. A total of 260 sheets relating to the 2007 calendar year were received from 6 of the 7 PMHS workers representing (assuming 6 weeks holiday/absence per worker per year), an approximate return rate of 94.2%. A total of 11,502 half-hour activity units were recorded from the team.

The overall activity distribution of the PMHS workers providing these data are presented in the Figures and Tables below. In descending order most time was spent in client contact, client-related administration and travel. Whilst the PMHS post job descriptions only list the types of activities to be covered, a paper written on behalf of the PMHS service in August 2005 provided more detail and clarification on the way PMHS workers were expected

Figure 2. The proportion of time recorded in different activities over the 2007 calendar year by the PMHS service as a whole (N=11502).



to function⁷, including as one of the three core components, the balance of work. The paper stated that the “balance of consultation, joint work, supervision, training and liaison with direct therapeutic work is a ratio of 75% to 25%”. It specified that the 25% related to the proportion of PMHS time allocated to direct therapeutic work and should include recording, planning and administrative time, but exclude joint direct work which should be regarded as capacity building.

The proportion of time spent over 2007 in direct therapeutic work was 17.9% to which can be added the relatively heavy client-related administration time of 17.1% to total 35.0% (Table 8). The time sheet completion instructions specify that the “Administration” category does *not* include client-related activities but it may be the case that the two categories were not completely distinguished. Furthermore the above proportions exclude travel time (12.3%) which is also mostly related to achieving client contact. If only the proportion of activities specified in the ‘balance statement’⁷ is considered (omitting some activity categories not represented at all within it, such as management meetings, own study, and personal supervision), the proportion of time spent overall in direct clinical contact (including client-related administration) becomes 49.4%, and this ignores travel time altogether. The proportion of time spent in direct face-to-face (or telephone) clinical *contact* is only 38% of the time spent in “direct clinical contact *activities*” (including travel time). PMHS staff are engaged in direct client contact work, its management and its logistics, for considerably more time proportionately than previously recommended. It might also be noted that very little time is spent in clinical advice/supervision work with HVs. Together, ‘HV small group meetings’ and ‘Clinical supervision to HV group’ only comprised 2.2.% of the records, the same proportion as PMHS staff’s own clinical supervision.

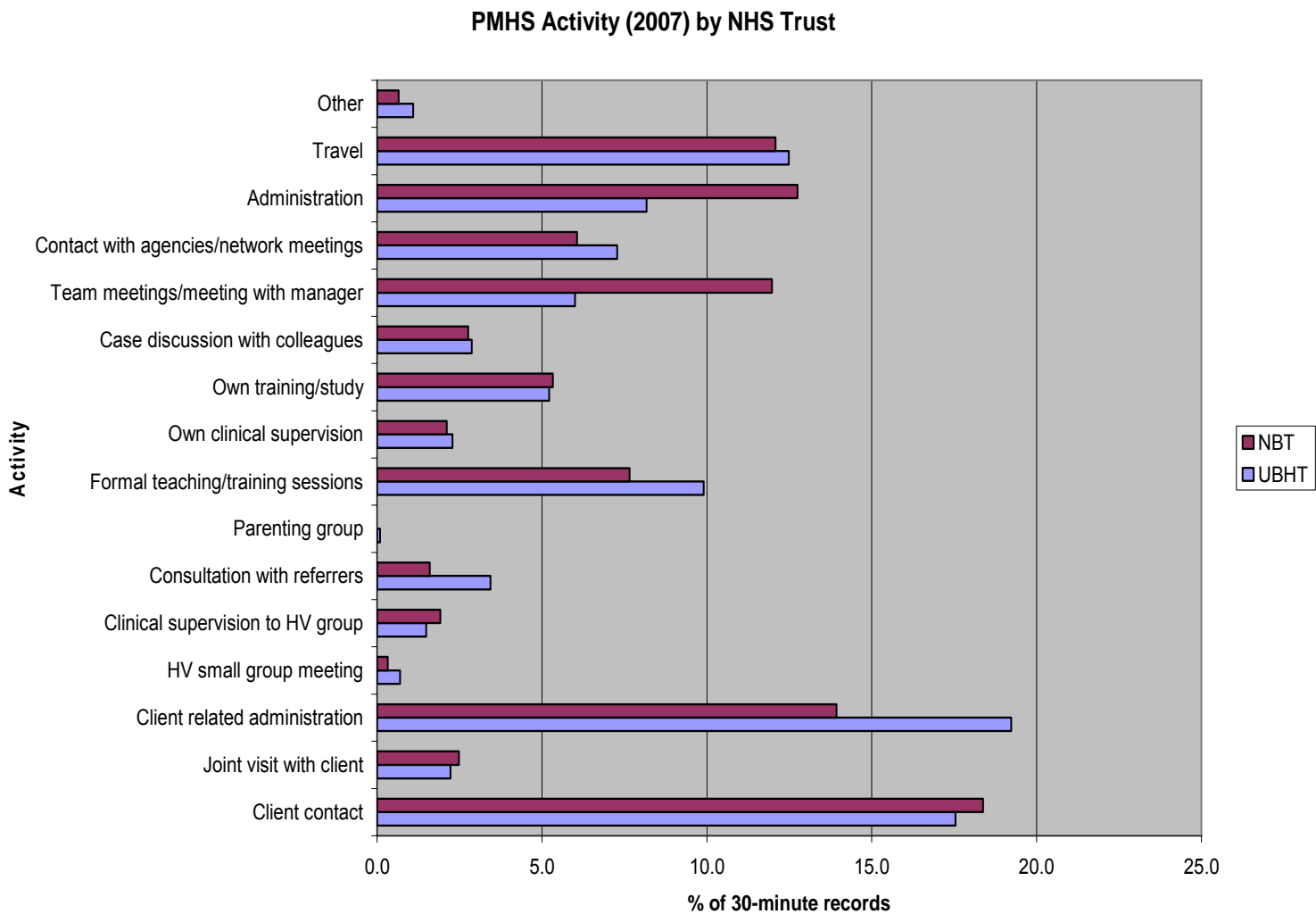
⁷ Pickering, M. 2005. Primary Mental Health Work Across Bristol: The Service Model.

Table 8. The proportion of time (% of half-hour records) spent by all PMHS staff in different self-recorded activities overall, and by NHS Trust.

Activity	% of records overall (N=11502)	% of UBHT records (n=6866)	% of NBT records (n=4636)
Client contact	17.9	17.5	18.4
Joint visit with client	2.3	2.2	2.5
Client related administration	17.1	19.2	13.9
HV small group meeting	0.5	0.7	0.3
Clinical supervision to HV group	1.7	1.5	1.9
Consultation with referrers	2.7	3.4	1.6
Parenting group	0.1	0.1	0.0
Formal teaching/training sessions	9.0	9.9	7.7
Own clinical supervision	2.2	2.3	2.1
Own training/study	5.3	5.2	5.3
Case discussion with colleagues	2.8	2.9	2.8
Team meetings/meeting with manager	8.4	6.0	12.0
Contact with agencies/network meetings	6.8	7.3	6.1
Administration	10.0	8.2	12.7
Travel	12.3	12.5	12.1
Other	0.9	1.1	0.6
<i>TOTAL</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>

Differences in working models between NHS Trusts might be expected to have influenced the proportions of time spent in different activities by their respective PMHS staff. These differences, however, turned out to be small in relation to client contact (Figure 3). More time was apparently spent in client-related administration and less time in administration in UBHT than in NBT but this may reflect recording distinctions rather than actual time differences as put together the total administration time in UBHT (27.4%) and NBT (26.0%) were very similar. NBT staff, however, spent twice as much time in team/managerial meetings than UBHT and it would be of interest to know if this difference reflected any greater degree of participation of NBT PMHS staff in their CAMHS environment.

Figure 3. The proportion of time recorded in different activities over the 2007 calendar year by the PMHS service in each NHS Trust.



Variation in activity between PMHS workers and between Trusts were examined by deriving variables itemising the proportion of time spent in each of 5 key activity types (client contact, client-related administration, teaching or training, administration, and travel) per week per PMHS worker. Each week's values were regarded as statistically independent and the values were approximately normally distributed on inspection.

One way analysis of variance across the 6 PMHS workers returning data indicated statistically significant variation between them in the proportion of time spent in client contact ($F=5.48$, $df=5$, $p<0.001$, range 12.5% to 22.8%), in client administration ($F=15.31$, $df=5$, $p<0.001$, range 11.5% to 24.6%), in other administration ($F=19.54$, $df=5$, $p<0.001$, range 5.8% to 19.7%), in travel ($F=29.99$, $df=5$, $p<0.001$, range 8.2% to 18.3%) but not in teaching/training ($F=1.93$, $df=5$, $p=0.091$, range 5.5% to 11.6%). Combining the two

'administration' activities evened the differences in proportions but did not reduce the significance of the inter-individual variation ($F=20.32$, $df=5$, $p<0.001$, range 21.2% to 35.9%). It may be of interest that the lowest proportion of time spent travelling occurred in the one PMHS worker with a full-time contract. It is important to bear in mind that, despite some guidance being provided, an unknown proportion of this variation is probably accounted for by variation between workers in how they categorised some activities on the recording time sheets.

Comparison of the major PMHS activities across NHS trusts was undertaken taking the clustering effects of each Trust's PMHS worker into account by using the 'svymean' and 'svytest' statistical procedures available in STATA 7. This properly adjusts the direct NHS Trust comparison by allowing for the significant variation determined between workers within Trusts, which has the effect of increasing standard errors and correctly reducing the significance of any differences determined (Table 9). The adjusted Wald tests of the Null Hypotheses that no differences exist between NHS Trusts in the proportion of time spent by their PMHS staff in each of the 5 key activities, indicated that this hypothesis could not be rejected for any activity, indicating that no statistically significant differences could be determined between NHS Trusts. It should be noted, however, that the small number of workers raises the probability of Type II errors (false negative results of statistical tests) in such analyses.

Table 9. Adjusted estimates of the proportion of time in percentage points spent by PMHS staff in NBT (n=3 workers) and UBHT (n=3 workers) in 5 key activity areas.

<i>Activity</i>	NBT		UBHT		<i>F</i>	<i>p</i>
	<i>Estimate</i>	<i>Standard error</i>	<i>Estimate</i>	<i>Standard error</i>		
Client contact	18.1	2.9	17.5	0.3	0.04	0.85
Client admin (a)	14.0	1.3	18.7	3.1	1.87	0.24
General admin (b)	13.6	3.5	8.0	1.5	2.15	0.22
Total admin (a+b)	27.7	4.7	26.7	4.6	0.02	0.89
Teaching	6.3	0.5	9.5	1.6	3.29	0.14
Travel	11.9	2.6	13.2	2.9	0.1	0.76

Summary

Analysis of the time sheets especially completed for the evaluation demonstrates the reported activity distribution of PMHS staff in Bristol over a complete calendar year down to 30-minute units. Client contact time, including the management of client appointments and record keeping (but *excluding* travel) exceeds the recommended 25%. Approximately 40% of PMHS time is spent in administrative work (including case recording) and travel, activity areas that might be amenable to modification. High individual variation exists in key activity time distribution that might also be useful for performance review of the service as a whole. The broad range of activities required in these posts provide particular time-budgeting challenges for PMHS staff on part-time contracts. Taking individual variation into account no statistical differences were determined in key activity time distribution between NHS Trusts' PMHS service.

PMHS caseload in 2007

Each PMHS worker and their administrative staff were asked to inform the research office when a new appointment letter was sent out, with an identifying code, the child's date of birth, the first appointment date, and a contact telephone number for the client. The research office then requested information on whether or not verbal consent to approach the client had been obtained by the PMHS worker on her initial visit (or thereafter). Personal contact was then made to attempt to obtain signed written consent and distribute questionnaires. At the end of the evaluation period each PMHS worker was asked to amend and complete details of the cases they had seen for the first time in 2007 and send in copies of the Case Summary Sheets if these had been completed, or equivalent details specifying the presenting problem, referring professional type, number of substantive contacts with the client, date of discharge (if appropriate) and outcome code. Completed case summary sheets were received from 5 PMHS whilst 2 only provided basic information on the spreadsheet distributed to them. It is important to recall that only cases formally referred in and adopted as CAMHS cases are included in this analysis. An unknown number of cases were managed throughout by the HV with ongoing support from the PMHS; these are not included in the following analysis.

Over the 2007 calendar year a total of 127 new first appointments (65 in NBT and 62 in UBHT) were scheduled for the PMHS service across Bristol. Of these only 9 (7.1%) had not been previously communicated to the research team. A total of 51(40.2%) of new 2007 clients provided written consent to complete questionnaires, 5 were vetoed by the PMHS worker and 2 had scheduled first appointments but, in fact, were never seen (Table 10). Positive consent rates did not differ between Trusts.

Table 10. Overall and Trust-based case distribution by client consent type

Consent type	Overall Frequency	Overall Percent	NBT % (n=65)	UBHT % (n=62)
Yes	51	40.2	38.5	41.9
No	60	47.2	38.5	56.5
Not known to the evaluation	9	7.1	13.8	0
Vetoed by PMHS	5	3.9	6.2	1.6
Not seen by PMHS	2	1.6	3.1	0
<i>Total</i>	<i>127</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>

The case summary sheets contained an open field to describe the presenting problem but no guidelines were provided by the research team on how to complete this. The first one reported was categorised *by the researchers* into one of 8 problem areas and the distribution of these is presented in Table 11 in descending order of overall frequency. Behavioural difficulties, challenging behaviour, or aggressive behaviour together formed the most prevalent category, followed by relationship, bonding or attachment difficulties, feeding, sleeping and crying. These figures are indicative only and provide a very rough guide to caseload characteristics as PMHS workers varied in their description of similar family situations and in the order in which certain categories were recorded. Furthermore there were high degrees of category overlap with most “attachment” categories, for example, also involving behavioural characteristics. Differences between Trusts in the distribution of presenting problem illustrated in Table 11 should not, therefore, be considered necessarily significant.

Table 11. Overall and Trust-based case distribution by first-reported presenting problem

Categorised problem	Overall Frequency	Overall Percent	NBT % (n=50)	UBHT % (n=54)
Behaviour	51	49.0	40.0	57.4
Attachment	19	18.3	30.0	7.4
Feeding	10	9.6	10.0	9.3
Sleeping	9	8.7	4.0	13.0
Crying	4	3.8	6.0	1.9
Toilet	2	1.9	4.0	0
Maternal depression	3	2.9	0	5.6
Other	6	5.8	6.0	5.6
<i>Total</i>	<i>104</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>

The number of cases deriving from each referring professional is presented in Table 12, although it should be noted that the professional identity of the referrer was known for only 65% of referrals in 2007. Whilst HVs formed the vast majority of referral sources, both GPs and Paediatricians are referring directly to the service (doctors together comprising 24% of known referrers). Single episode referrers included Occupational Therapists, Speech and Language Therapists, and a Clinical Psychologist (presumably from within the CAMHS team). No differences in referring professional was apparent between Trusts although during the evaluation it was known that Social Work Managers in NBT had direct referring agreement, whilst those in UBHT did not. It is clearly important that community-based

health and social care professionals at all levels of expertise and experience are aware of both how and when to refer, directly or indirectly, to the service.

Table 12. Overall and Trust-based case distribution by referring professional

Referrer to PMHS service	Overall Frequency	Overall Percent	NBT % (n=31)	UBHT % (n=51)
HV	59	72.0	74.2	70.6
GP	9	11.0	6.6	13.7
Paediatrician	10	12.2	9.7	13.7
OT	1	1.2	3.2	0
SLT	1	1.2	0	2.0
CMO	1	1.2	3.2	0
Clinical Psychologist	1	1.2	3.2	0
<i>Total</i>	<i>82</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>

The case summary sheets contained a closing case outcome field categorised into 5 options. These were recorded by the PMHS for 78 (61%) of the 127 cases started in 2007 and interpretation should be consequently guarded in recognition of the possible bias against both long-term and very short-term cases. Outcome data from NBT (available for only 43% cases) was much less well represented than in UBHT (81%). Furthermore, category 1 “case closed”, whilst labelled additionally as ‘problem resolved’, included many cases where the PMHS appended the recording with ‘not resolved’ and the data are presented here simply as ‘case closed’ for any reason, including change of address and disengagement with service.

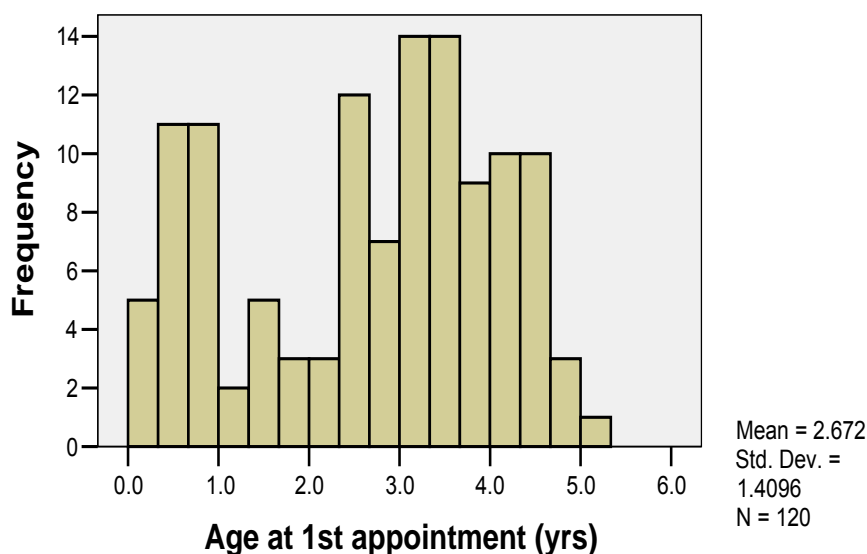
Overall nearly 60% of the cases started in 2007 were closed within the evaluation period, with 20% being referred on either to other CAMHS team members or to other agencies (Table 13). Referral on may have been slightly more common in UBHT than in NBT although formal statistical analysis is contraindicated by the level of missing data, especially from NBT.

Table 13. Outcome classification in PMHS cases started in 2007

Outcome category	Overall Frequency	Overall Percent	NBT % (n=28)	UBHT % (n=50)
Case closed	45	57.7	64.3	54.0
Referral to CAMHS	7	9.0	3.6	12.0
Referral to other agency	9	11.5	7.1	14.0
Support HV	1	1.3	0	2.0
Case continuing	16	20.5	25.0	18.0
<i>Total</i>	<i>78</i>	<i>60.9</i>	<i>100.0</i>	<i>100.0</i>

The age of the index children varied from birth (or even antenatal first appointments in 2 cases) to 5 years of age (mean 2.7 years, SD 1.41 years). Age and first appointment data were available for over 94% of cases (Figure 4).

Figure 4. Age at first appointment for all cases first seen in 2007.



The age distribution is bi-modal with an infancy (0-1 year) peak and another mode at around 3.4 years. There were relatively few cases aged between 1 and 2 years at their first appointment. There was no statistical difference in the age distributions of cases seen by the two NHS Trusts (Mann Whitney Test: U=1699, Z=-0.52, p=0.6).

The number of substantive contacts, either face-to-face or by telephone, ranged from 0 to 24 (Figure 5) but this statistic was biased against large numbers in view of the cut-off point for the evaluation analysis and the numbers of first-time appointments in 2007 that were

still being seen at the time. The mean number of contacts per case opened and closed in 2007 was 5.6 (SD 4.3) in UBHT and 4.2 (SD 4.7) in NBT although data were provided on only half the number of cases in the latter. Assuming that differential missing data did not bias the results a test of this difference is permissible, and it just reached statistical significance (Mann Whitney Test, $U=410$, $Z=-1.99$, $p=0.046$). The duration of the intervention period (first appointment date to discharge/referral, Figure 6) was also longer in UBHT (mean 19.05 weeks, SD 13.9 weeks) than in NBT (mean 15.05 weeks, SD 10.9 weeks), and by approximately the same proportion as contact frequency, but this difference failed to reach statistical significance (Mann Whitney Test, $U=473$, $Z=-1.11$, $p=0.27$), possibly due the shortage of quantitative data available from NBT.

Figure 5. Overall distribution of number of contacts per 2007-started case

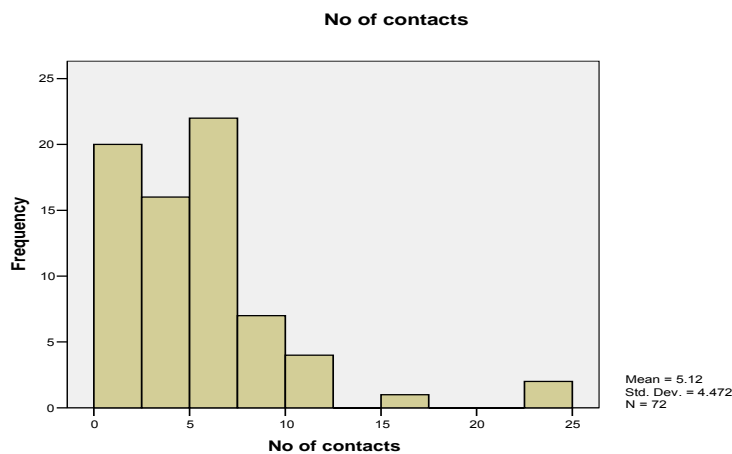
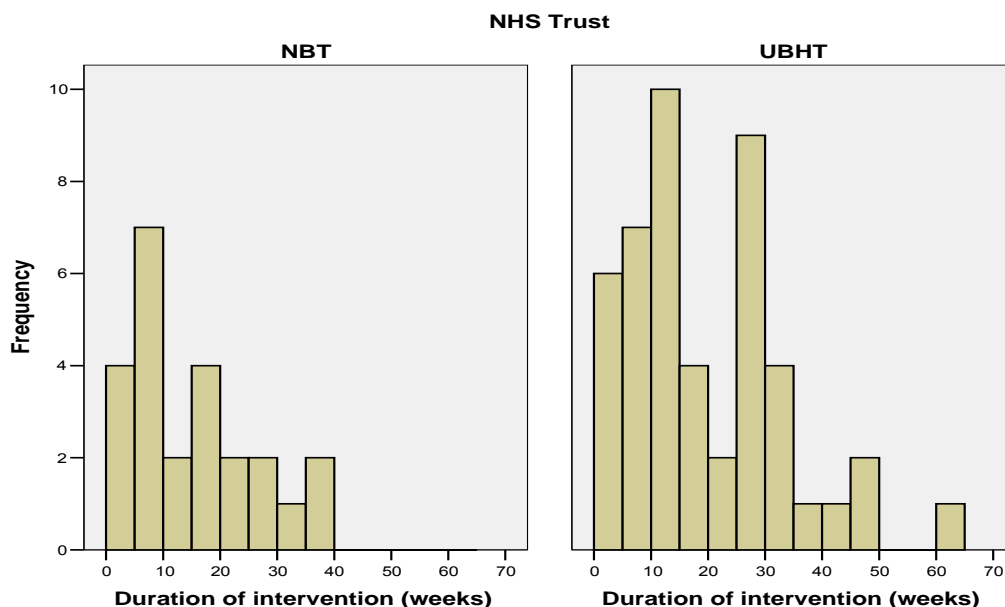


Figure 6. Duration of PMHS intervention (in weeks) in cases started in 2007, by Trust



PMHS caseload geography

The PMHS service covers the four health sector areas in Bristol mapping to each CAMHS locality, based in Southwell Street in the city centre (Bristol South West), Knowle Clinic (Bristol South East), Southmead Hospital (Bristol North West), and Downend Clinic (Bristol East). PMHS staff respond to referral requests mostly from community-based health professionals but do not themselves attempt to provide a needs-based service. A modern equitable service provision system might be expected to take account of the distribution of socially or/and economically disadvantaged groups within the catchment area on the grounds of their higher levels of need. It should be understood, however, that little is known at present specifically about the socio-economic distribution of need for this service. Geographical measures of social deprivation, however, can be deduced from national statistics.

Client postcodes for those receiving input from the PMHS service for the first time in 2007 were translated into Lower Super Output Areas (LSOA) using the GeoConvert facility provided by the Census Dissemination Unit, part of the Economic and Social Research Council supported national census programme.⁸ This used the National Statistics Postcode Directory for February 2007. There are 32,482 LSOAs in England, each comprising a minimum population of 1000 (mean 1500) individuals, and 3226 in the South West region. In Bristol there are 253. These geographical units of population are small enough to confer a degree of social and economic homogeneity in terms of the population characteristics they possess and the Index of Multiple Deprivation (IMD) has been calculated for all from the 2004 IMD database. The IMD is now the standard deprivation statistic used in government and comprises integrated, weighted measures of health deprivation and disability, employment, income, education, skills and training, living environment, and barriers to housing and services.

LSOA IMD values were obtained for all of Bristol and for those including the client home address postcodes. Two client postcodes mapped to addresses outside the Bristol city boundaries. Because up to 4 different client address postcodes mapped to single LSOAs (one to many configuration) a file was produced to analyse at the level of LSOA only (one

⁸ <http://geoconvert.mimas.ac.uk/index.htm>

to one configuration), so as to account for postcode clustering effects. A total of 81 caseload LSOAs were determined from 110 postcodes, 39 from NBT and 42 from UBHT. Firstly a comparison of overall caseload to non-caseload LSOA IMD values was made to assess the degree of social randomness of the service caseload within Bristol. The mean value of the caseload LSOA IMD (n=81, ranked nationally) was 93.3 compared to 142.2⁹ (n=171, non-caseload), a highly statistically significant difference (Mann Whitney Test, U=4238, z=-4.97, p<0.001). The PMHS service is currently clearly being provided to the more deprived sectors of the population. Secondly, comparisons were made between Trusts and this analysis demonstrated that the UBHT starting caseload in 2007 came from more deprived areas (n=42, mean rank 35.0) than NBT (n=39, mean rank 47.5; Mann Whitney Test, U=567, Z=-2.39, p=0.017).

Summary

A total of 127 new cases were started by PMHS staff during the 2007 calendar year. Two thirds of the first reported presenting problems related to behaviour and attachment difficulties but individual variation in recording might have influenced this. The vast majority of referrers were HVs although doctors referred directly in almost a quarter of cases. The age distribution of index children in referred cases was bi-modal with a relatively small number being referred to the PMHS service in their second year. The mean number of PMHS-client contacts per 2007-completed case was 5.1. The number of contacts and the intervention period appeared to be longer in UBHT than NBT, although shortages in data confounded this analysis. Examination of the socio-economic distribution of cases in 2007 indicated that the PMHS service was focussed on the more deprived sectors of the community and that levels of deprivation were higher in cases managed by UBHT than by NBT.

⁹ IMD ranks from most deprived to least deprived; lower scores indicating higher deprivation

MEASURES OF MATERNAL WELL BEING

The 12-item short version of the General Health Questionnaire (GHQ12, Appendix 6) was administered to carers as soon as practicable after signed consent had been received. The GHQ12 is a self-completed 12-item, 4-point Likert scale instrument probing feelings of depression and anxiety, taking about 2 minutes to complete. It is a shortened version of the 60-item General Health Questionnaire widely used to assess adult well-being in community surveys. Validation of the GHQ12 has been extensively undertaken (see Appendix 1) with excellent results using both scoring systems¹⁰. External validation against robust specialised psychiatric tools has established clinical cut-offs of both 2-3 and 3-4, using the shortened scoring system⁶.

(a) Referral

A total of 67 GHQ12 questionnaires were completed shortly after referral in this evaluation to provide a baseline of maternal wellbeing at the beginning of the PMHS contact period. Most mothers had already received at least one clinical contact with the PMHS at the time of GHQ12 completion. The questionnaire was administered a second time on discharge or 6 months after the first PMHS appointment, whichever being the earlier. The results of changes in GHQ12 scores over the PMHS contact period are presented later in this section.

The Health Survey for England (HSE) is a series of annual surveys about the health of people in England. The HSE was first proposed in 1990 to improve information on morbidity by the (then) newly created Central Health Monitoring Unit within the Department of Health. This information is used to underpin and improve targeting of nationwide health policies. Since 1994 the survey has been carried out by the Joint Survey Unit of the National Centre of Social Research and the Department of Epidemiology and Public Health at University College London. The survey covers a representative sample of all adults aged 16+ in private households in England.

A regular feature of many HSE sweeps has been the inclusion of the GHQ12 and, for the purpose of comparison in the present evaluation, the 2005 HSE dataset was interrogated.

¹⁰ The original scoring system of 0,1,2,3 for each item (maximum total GHQ12 score 36) has been widely replaced with a 0,0,1,1 system (maximum score 12) with negligible loss of validity.

All women aged between 18 and 40 were selected from the HSE dataset, irrespective of their reproductive history, and their GHQ12 score distributions obtained. This provides a crude, contemporary comparison group of the expected GHQ12 scores for women of reproductive age nationally (Figure 7). The majority of HSE2005 women of reproductive age (59.7%) had a GHQ12 score of 0 (PMHS carer comparison 13.4%) with asymptotically declining higher scores. The PMHS carer group, in contrast, had a much more even distribution across the range with consistently higher proportions of women scoring 3 or more when compared with the national sample for each GHQ12 total score.

Signs indicative of a clinically significant emotional condition requiring professional care are generally accepted at GHQ12 total scores of 4 or above. Table 14 presents the categorised score distribution statistics from the two samples showing that whilst 15.2% of the HSE 2005 sample met this criterion, 55.2% of the PMHS carer group shared this characteristic (shaded row, below).

Figure 7. Distributions of GHQ12 total scores in the PMHS evaluation (referral scores, n=67) and all women aged 18-40 from the Health Survey for England 2005 dataset (n=1333).

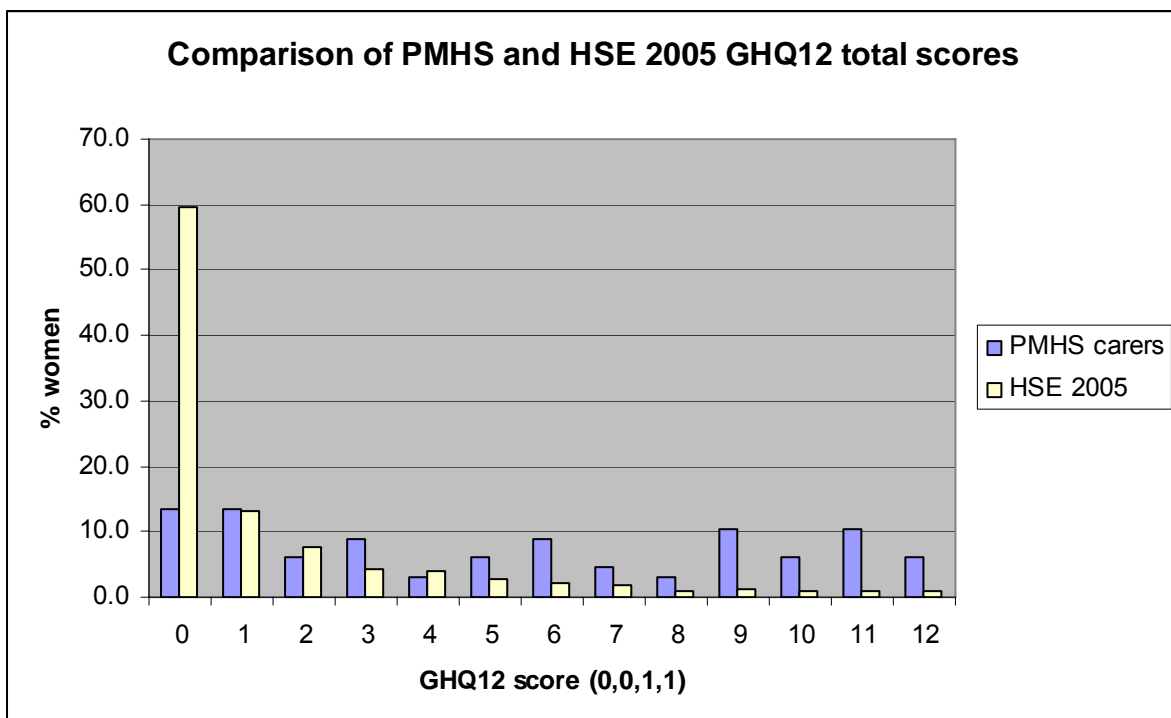


Table 14. Categorized GHQ12 total score comparison between HSE2005 (n=1333) and PMHS (n=67) samples

GHQ total score (0,0,1,1)	HSE 2005 (% , n)	PMHS (% , n)
Score 0	59.7 (796)	13.4 (9)
Score 1-3	25.1 (334)	28.4 (19)
Score 4+	15.2 (203)	55.2 (39)

(b) Changes in carers' General Health Questionnaire responses

A total of 16 carers submitted two completed GHQ questionnaires separated by periods ranging from 7 to 37 weeks (mean 22.6 weeks, sd=10.1). Figure 8 shows that a very wide range of score changes was observed (-21 to +10) with a mean score change indicating a health improvement (negative value of change) of 3.4 points (sd=8.3). A 2-tailed Wilcoxon Signed Ranks test assessing the probability that this change was overall in a negative direction, however, proved non-significant ($T+=38.5$, $T-=97.5$, $z=-1.528$, $p=0.126$). Consideration must, however, be given to the low proportion of carers providing data on follow-up. It is unclear whether avoiding any selection bias would have clarified any general direction of change as women whose wellbeing improved (increased likelihood of negative GHQ score changes) might have either been less or more likely to participate. In any case the facts that GHQ probes "recent" feelings and the small sample size increase the possibility of a Type II (false negative) error. A scatterplot of GHQ score changes against assessment interval reveals no clear relationship ($r_{sp}=-0.04$, $p=0.88$) although the lower scores on re-test are clearly illustrated (Figure 9).

Figure 8. Distribution of change in GHQ total score (n=16): score at time t2 – score at time t1, with negative values indicating a health gain over the PMHS intervention period

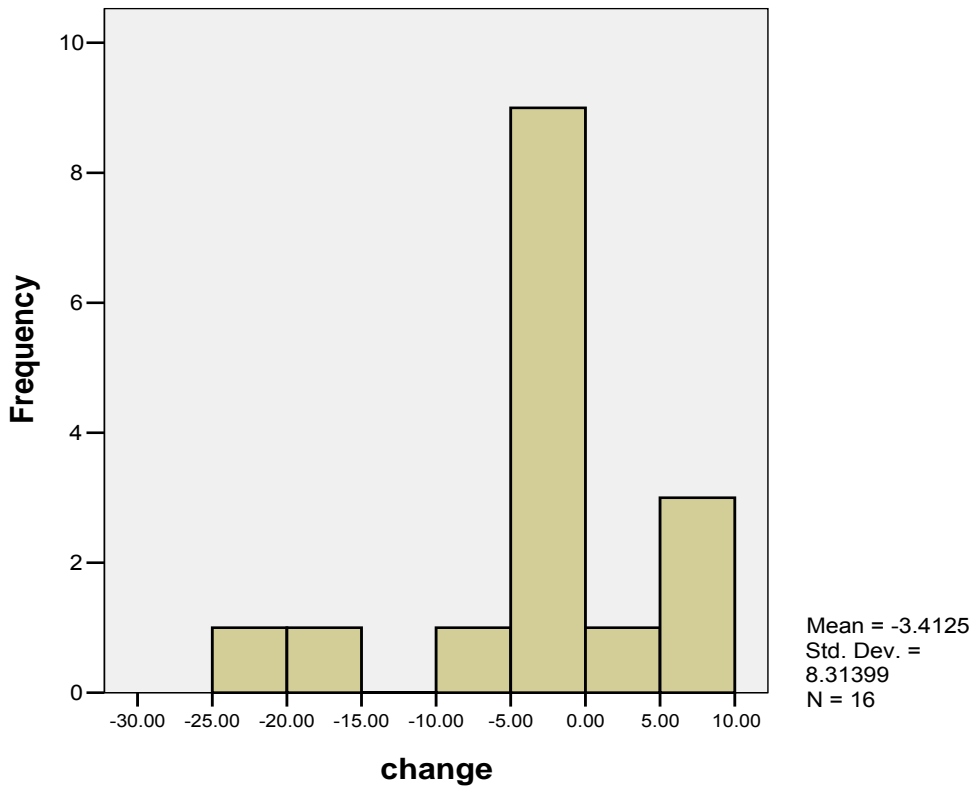
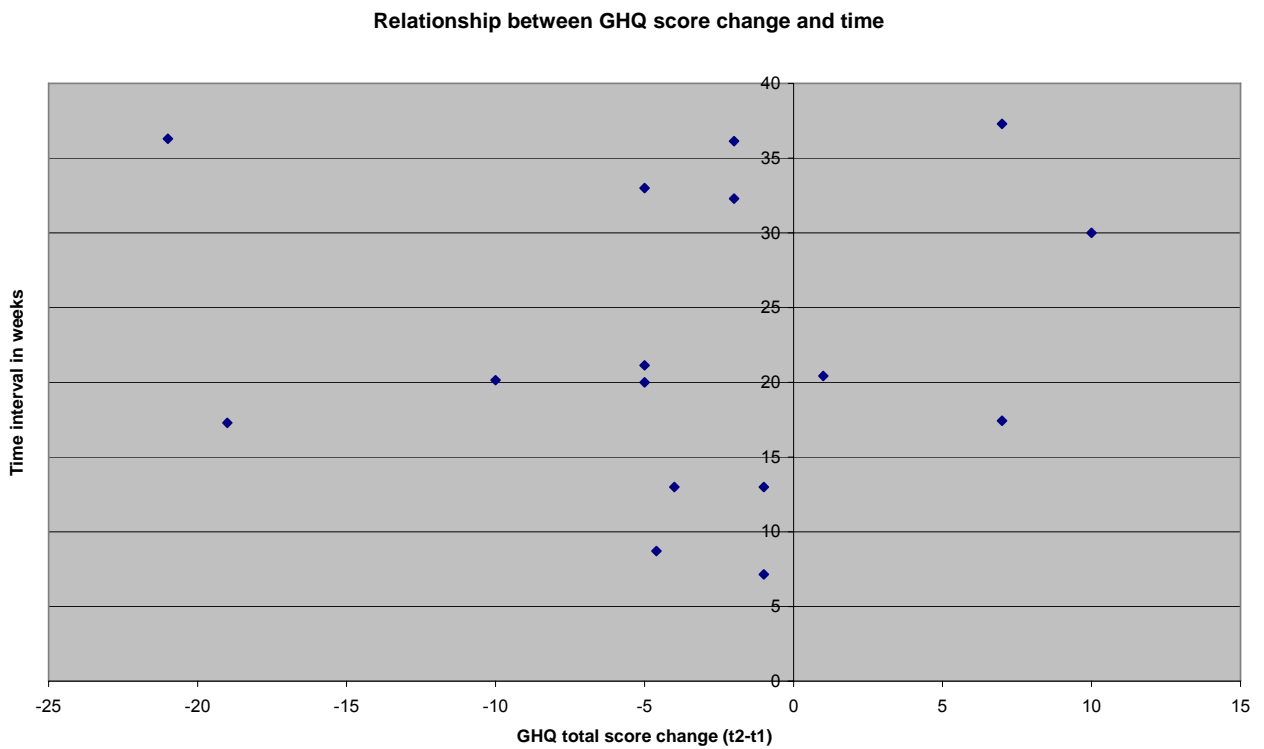


Figure 9. GHQ total score change plotted against GHQ assessment interval



At re-assessment on discharge or after 6 months the proportion of carers reaching clinical significance in their GHQ scores changed little (6/16 versus 7/16). Over the inter-assessment interval 4 carers moved out of the 'clinically significant' group (crossing the 3.5 score threshold) whilst 3 moved in. Using a 2.5 score threshold, as recommended in some validation studies, 5 moved out of clinical significance whilst 3 moved in. Given the short-term nature of the feelings probed, the lack of a clear improvement statistic, the possible selection bias, and the small sample size it is not possible to claim any overall change in GHQ-defined dysthymic status for these women.

Summary

Using a cut-off of 3.5 on the General Health Questionnaire (12-item version), scored as 0,0,1,1, 55.2% the 67 carers' assessed at or shortly after recruitment met the criterion of being at high risk of having a clinically significant affective mental condition. As a screening device no diagnostic certainty can be attributed to GHQ scores but this measure meets conventional interpretations used in surveys of mental health. Comparison with a national sample of women aged 18-40 from the Health Survey for England (2005) indicated a 3.6 times higher prevalence. A disappointingly small sample was available for longitudinal assessment to assess change up to discharge or 6 months. Whilst the overall longitudinal trend was towards lower scores neither the GHQ-12 total score nor the proportion meeting the clinical criterion was statistically significantly reduced.

MEASURES OF CHILD BEHAVIOUR

The objective of PMHS clinical work is to help parents resolve the emotional, behavioural and attachment problems they are presenting to the health services. Both positive changes in the parents' well being and in the child's behaviour (and interactions between them) may be seen as desirable outcomes. The self-reported GHQ data make a small contribution to evaluating the former, indicating that whilst overall there was a health gain trend over the PMHS intervention period, this failed to reach either statistical or clinical significance, possibly partly as a result of small sample size. The carer's reports of her child's behaviour reflect both her own state of mind and the child's behaviour itself. Ideally an evaluation of clinical efficacy would obtain objective measures of the child's behaviour and emotional health, but this was well beyond the resources available in the present study. In this evaluation the carer's questionnaires about the child were the only measures of child behaviour and behavioural change employed and one must consequently be cautious in interpreting their significance as an unbiased representation of behaviour. However, as an essentially interactive measure of the child's behaviour as seen (and recorded) by the primary carer, the carer-completed Ages and Stages (Social-Emotional) Questionnaire (ASQ-SE, see Appendix 1)) can justifiably be interpreted as a joint index of mother-infant functioning, the essence of the PMHS specialists' psychodynamic and psychoanalytic approach in their clinical work with the carer.

In the following description of results a derived measure defined as the percentage of the obtained ASQ score above the cut-off for that age-band is used. The eight age-specific questionnaires cover different developmental stages and are composed of different numbers of questions. The system used to score the child is consistent across questionnaires (5 for a question response indicating mild disturbance – "V-answers", 10 for one indicating marked disturbance – "X answers", and 5 if the behaviour reported was "of concern" to the mother), but the total varies according to the number of questions. Accordingly the cut-off point determined through the validation procedure by the instrument's authors (see Appendix 1), varies for each age band. To aid comparison *between* children of different ages and *within* children who passed into the next age-band during the PMHS intervention period, the ASQ score was converted to a value relative to the cut-off point for clinical action, as agreed with the instrument's senior author (Squires, pers.comm). A value of 100% can be interpreted, therefore, as a score marking the

threshold for health professional intervention as based on the validation process used for a North American population (see Appendix 1). Considering possible cultural differences in child behaviour, carer reporting, and the criteria marking an intervention need, this threshold should be taken as a rough guide rather than some inflexible gold standard, but the derived variable used here is consistent, logical and fit for the purpose of internal comparison.

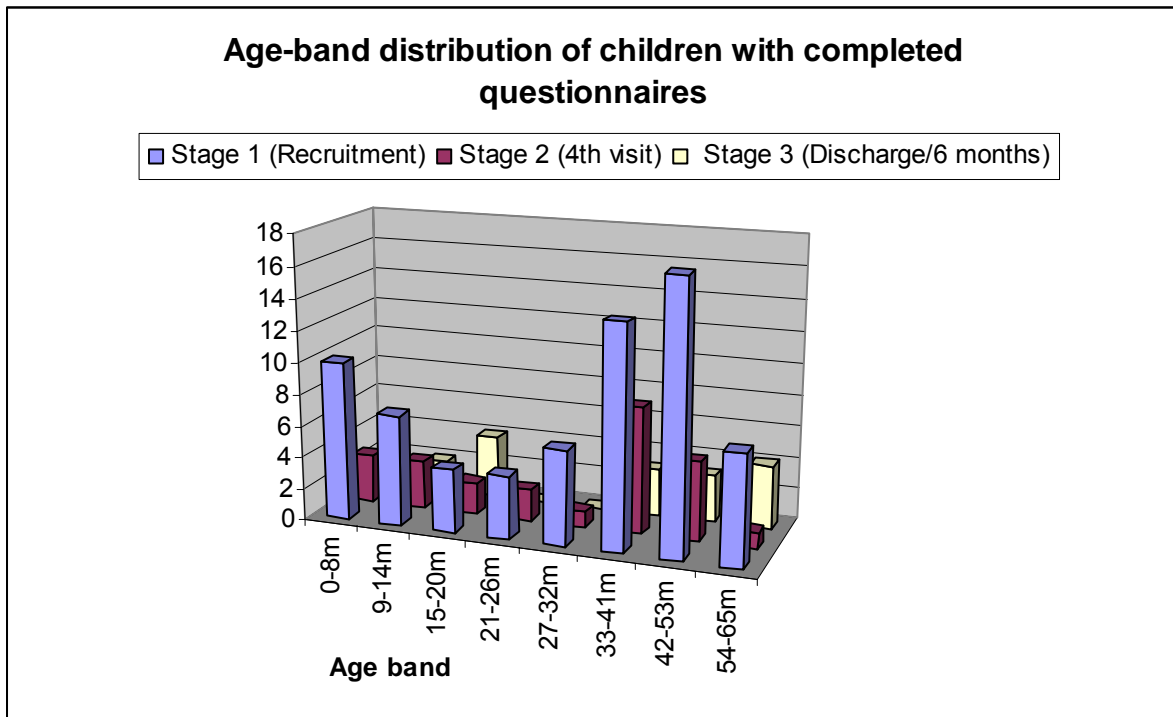
Questionnaire completion rates and compliance

Seventy six clients agreed to participate in the evaluation and signed a consent form. During the evaluation a total of 69 completed ASQs were received at recruitment (Stage 1, 91%), a further 25 after the 4th clinical visit or substantial contact (Stage 2, 33%), and 17 (22%) after discharge or 6 months of PMHS work (whichever was the sooner, Stage 3). The high continuity loss was due to carers who failed to return stage 2 or stage 3 questionnaires (one-repeated follow-up was undertaken and then a passive refusal assumed), no 4th visit achieved, failures to be informed of a 4th visit, client withdrawals from service, vetoes from the PMHS workers because of serious family complications, failure to keep appointments and early discharge, referrals into Tier 3 services, house moves, and loss of contact. For 31 out of the 76 (41%) consenters no 4th visit date was obtained for one of the above reasons and 16 of the 76 (21%) were sent second ASQ questionnaires without them being returned. Whilst this client group were often difficult to contact and lived socially and emotionally disturbed lives, often in deprived communities, the second stage compliance rate for those 'remaining in the system' was 79%, raising the importance of acknowledging the effects of this disengagement or diversion from PHMS service as an important issue. PMHS staff complete a relatively small proportion of their referred clients to clinically-indicated absolute discharge.

Different client problems, caseload pressures and clinical decisions, together with variation in appointment compliance and PMHS absences ensured great variation in the period within which interventions occurred. From the 23 Stage 1 to Stage 2 durations with known dates, the mean period was 88.3 days or 12.6 weeks (standard deviation=46.6 days). The 17 Stage 1 to Stage 3 known durations had a mean of 170.5 days or 24.4 weeks (sd=65.0 days).

The age band distribution of the children whose carers contributed behavioural data did not vary greatly over the PMHS intervention period (except for a small preponderance of those aged 15-20 months contributing a full data set, Figure 10).

Figure 10. Age distribution of children whose carers completed ASQ:SE questionnaires



The number of “V” answers at Stage 1 ranged from 1 to 21 with two modes at 5 and 9. The distributions were more unimodal at later stages. This overall pattern was repeated for “X” answers and “Concerns” each of which had modes of value 0. The proportion of carers with *no* “X” answers at Stages 1,2 and 3 was 20.3%, 28.0% and 35.0% respectively, for “Concerns” the comparable statistic was 27.9%, 50.0% and 75%. This demonstrates the overall decline in the numbers of these responses by Stage better than Table 15’s summary statistics. As questionnaire length increased with child age, the *proportionate* decrease in these responses was even higher, indicating a tendency for carers to report disturbed behaviour in their child with decreasing frequency over the period.

Table 15. Rates of “V”, “X” and “Concern” responses in ASQ:SE questionnaires at the three stages of PMHS intervention

Stage	<i>Recruitment (Stage 1)</i>			<i>After 4th visit (Stage 2)</i>			<i>Discharge or 6 months (Stage 3)</i>		
	No of “V” answers	No of “X” answers	No of “Concerns”	No of “V” answers	No of “X” answers	No of “Concerns”	No of “V” answers	No of “X” answers	No of “Concerns”
N	69	69	68	25	25	24	17	17	16
Mean	8.8	4.0	3.8	8.6	2.9	2.0	8.1	2.5	0.6
Median	9.0	3.0	2.0	8.0	2.0	0.5	8.0	1.0	0

Note: “V” answers indicate a mild disturbance, “X” answers indicate a substantial disturbance, “Concerns” are built-in but optional additions to any question

A clear downward trend over the PMHS intervention period, despite high variation, is illustrated in the ASQ:SE results as presented as the percentage of the clinical intervention cut-off threshold recommended by the tool’s authors (Table 16). The mean long-term difference of 66.3% (representing itself a percentage difference of 38.3% over Stage 1 baseline) indicates a substantial change in the carers’ reporting of their children’s behaviour. At recruitment 75.0% of the 68 ASQ:SE scores were above the clinical

Table 16. ASQ:SE total scores as a % of the clinical intervention threshold (cut-off) at the three stages of PMHS intervention

Stage	<i>Recruitment (Stage 1)</i>	<i>After 4th visit (Stage 2)</i>	<i>Discharge or 6 months (Stage 3)</i>
	ASQ:SE total score as a % of cut-off	ASQ:SE total score as a % of cut-off	ASQ:SE total score as a % of cut-off
N	68	25	17
Mean	173.2%	137.6%	106.9%
Median	152.5%	128.6%	84.7%
SD	102.8%	83.7%	81.4%

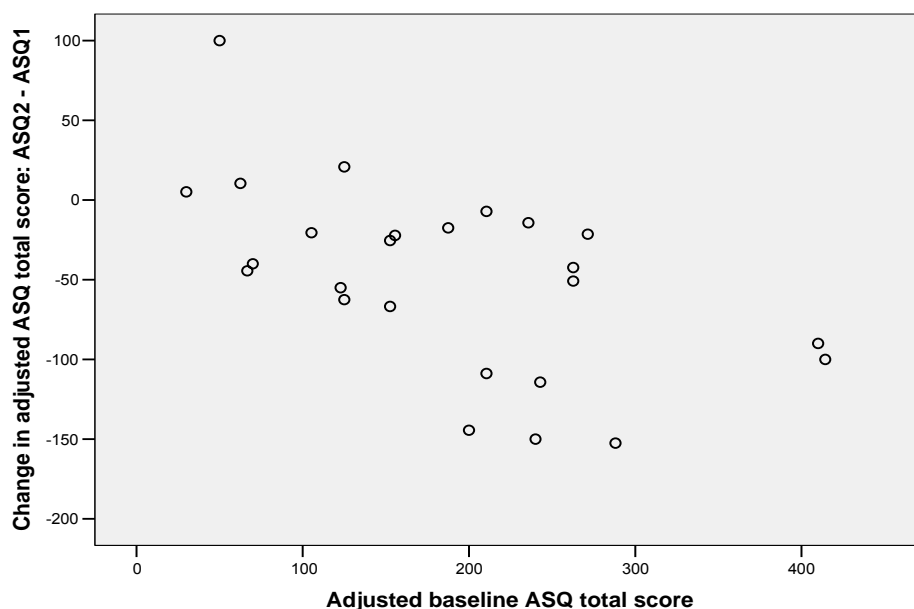
intervention threshold. By Stage 2 this had reduced to 60.0% and by Stage 3, 35.3%. By discharge (or 6 months after the first appointment) the mean ASQ:SE score was only just above (by 6.9% of the score) the published cut-off for clinical intervention, a drop from 73.2% above.

Care is needed, however, in interpreting these interesting apparent downward trends as incomplete data meant that individuals were selectively lost from follow-up. Comparative analysis of the recruitment or Stage 1 ASQ data in those who completed only that data stage (n=39), those that completed both Stages 1 and 2 only (n=13) and those that

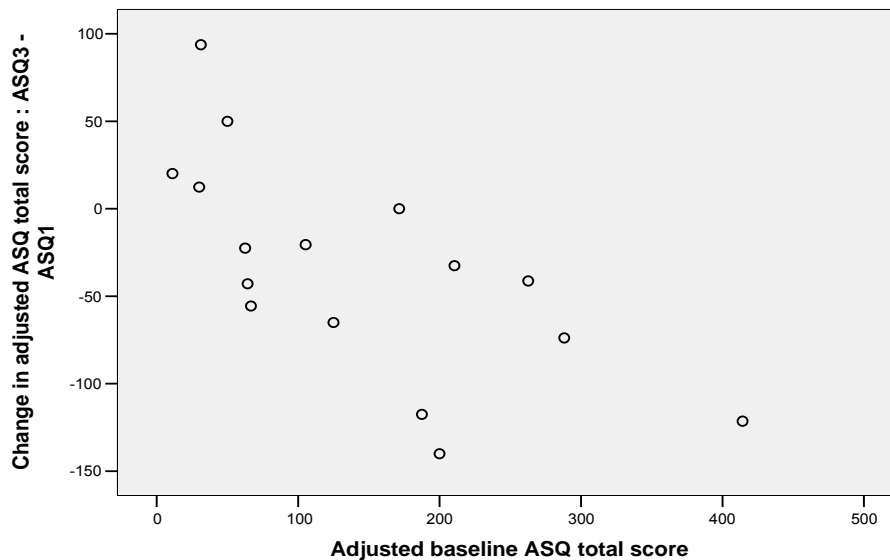
completed all three Stages (n=17), indicates that the middle group had higher baseline ASQ:SE adjusted scores than the others. These differences either reached or almost reached statistical significance in the comparison between the latter two groups (Mann-Whitney Tests: No of X + V answers, U=62.5, p=0.04, No. of concerns U=58.5, p=0.05, Adjusted ASQ1 score, U=63.5 p=0.07). This suggests that those remaining in the evaluation and 'continuing the course' to discharge with the PMHS service were those with slightly lower baseline ASQ results at recruitment. However, despite this difference and the impact of any 'regression to the mean', the adjusted ASQ change over both Stage1 to Stage 2 and Stage 1 to Stage 3 intervention periods were highly correlated with the baseline ASQ value (Spearman's r: -0.56, p=0.004 Stage1/Stage2; -0.75, p=0.001 Stage1/Stage3, see Figures 11 and 12). This suggests that, if the change can be attributed to service, the effects of PMHS work are greatest in those with the more pronounced initial needs.

Figures 11 and 12. Scatterplots showing the relationships between baseline adjusted ASQ total score and change in that score over two time periods of PMHS intervention

Association between adjusted ASQ score change at the time of the 4th visit and baseline adjusted ASQ



Association between adjusted ASQ score change over the PMHS intervention period (or 6 months) and baseline adjusted ASQ



Note: The “adjusted” values plotted represent the % value of the appropriate ASQ:SE total score cut-off point for clinical intervention. A plotted score of 100 therefore is equivalent to that clinical threshold value for a child of that age. Negative change values indicate a lower score (less disturbance) in the later period.

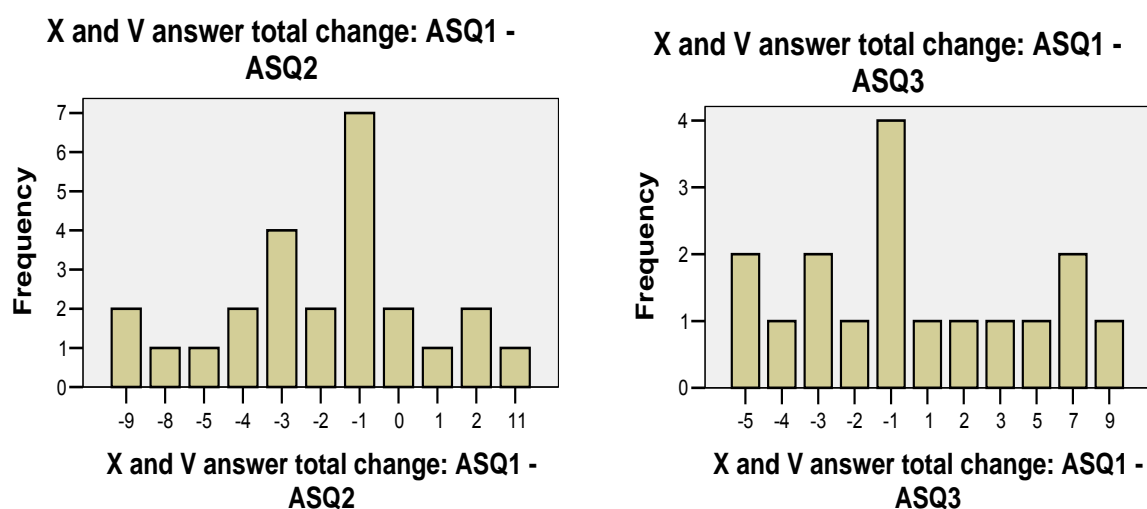
Accordingly, for the same care-child dyads the number of “V” or “X” responses from the ASQ were added together and the short-term (Stage 1 to Stage 2) and longer term (Stage 1 to Stage 3) changes over the PMHS intervention period computed. The change in the median value of the total number of “V” or “X” numbers over the short-term recorded by carers for their child was negative, indicating a modest reduction of about 9%, with, however, substantial variation (Table 16 and Figure 13). The numbers of “Concerns” (drop in median values by 47%) and the change in the median ASQ total score as a percentage of cut-off (drop by 28%) also declined substantially in the short term. This trend was not continued over the longer period, possibly indicating a solution “threshold” effect or the appearance of new problems. However, the small numbers make further similar analysis speculative in this regard.

Table 16. Change in ASQ:SE response totals between Stages 1 and 2, and between Stages 1 and 3.

	Change in number of "V" plus "X" answers		Change in number of "Concerns"		Change in ASQ:SE total score as a % of cut-off	
	Stage 2 minus Stage 1	Stage 3 minus Stage 1	Stage 2 minus Stage 1	Stage 3 minus Stage 1	Stage 2 minus Stage 1	Stage 3 minus Stage 1
N	25	17	24	16	25	16
Mean change	-1.8	0.5	-2.2	-2.3	-48.6%	-34.8%
Median change	-1.0	-1.0	-2	-1.5	-42.4%	-36.9%
SD	4.0	4.4	3.2	4.0	58.9%	62.7%

Note: A negative value indicates a lower number at the later stage

Figure 13. Changes in the numbers of 'V' plus 'X' ASQ:SE responses over two intervention time periods (Stage 1-Stage 2, and Stage 1-Stage 3).



Numerical analysis of changes in the numbers of different types of responses over time must be assessed with caution, both because of developmental changes in the children and differences over time to be expected in the carers' reporting of the same behaviour. Furthermore, the numbers of cases with complete datasets is small and variation both between and within carers in their reports is high. Of greater validity, therefore, is the evaluation of trend which can be statistically assessed by using a non-parametric test which computes the probability that the first measure in the same pair is greater or smaller than the second, by whatever amount. The present data lend themselves to this approach and as rankings of different carers' reports may not be reliable (carers are likely to vary

greatly in their reporting of similar behaviour), the Sign test is probably preferable to the more powerful Wilcoxon Matched Pairs Signed Ranks test.

Table 17, below, presents the results of both the Wilcoxon and Sign test analyses of changes in questionnaire answer response rates. The results show that a highly statistically significant reduction in the numbers of “X” responses (and the number of “V” and “X” responses combined) occurred between Stage 1 and Stage 2, but not between Stage 1 and Stage 3. A significant or a highly statistically significant reduction in the numbers of “concerns” and the degree to which the total ASQ:SE score cleared the intervention threshold was observed for both intervention time periods. It should be recalled that the analysis of *absolute* numbers of responses do not take into account the small *increase* in disturbed responses expected in some cases where later stages employed questionnaires with larger numbers of questions, which would have the effect of reducing any differences found and lowering statistical significance. This factor is likely to affect the Stage 1 to Stage 3 statistics more than the Stage 1 to Stage 2 statistics and the results could be consistent with a PMHS effect that manifests itself quite quickly and then settles down, reverses slightly, or becomes influenced by new concerns. It must be considered, however, that this analysis only examines the probabilities associated with finding differences from observational data, and attribution of these differences to any particular intervention or factor is speculative.

Table 17. Non-parametric statistical tests computing the probability that reductions in indices of disturbed behaviour over the PMHS intervention period could be due to chance (statistically significant results in **bold**)

Period comparison / Effect index/ Statistical test	Wilcoxon Matched Pairs Signed Ranks test		Sign test	
	Z	P (2 tailed)	P (2 tailed)	
Comparison of Stage 1 (Recruitment) to Stage 2 (4 th visit)	Number of V answers	-1.26	0.21	0.40
	Number of X answers	-2.83	<0.01	<0.01
	Number of X+V answers	-2.74	<0.01	<0.01
	Number of Concerns	-3.27	0.001	0.012
	% ASQ of threshold	-3.56	<0.001	<0.01
Comparison of Stage 1 (Recruitment) to Stage 3 (Discharge or 6 months)	Number of V answers	-0.95	0.34	1.00
	Number of X answers	-1.14	0.25	0.55
	Number of X+V answers	-0.14	0.89	0.63
	Number of Concerns	-2.78	<0.01	0.012
	% ASQ of threshold	-2.10	0.04	0.12

Note: A negative Z value indicates a lower rate in the later stage

Summary

The Ages and Stages (Social/Emotional) questionnaire was used to assess carer-reported behavioural change between recruitment and the 4th visit, and between recruitment and discharge/6 months. Total scores were adjusted to reflect the % they represented in relation to the clinical cut-off for intervention established previously in validation studies. In addition the number of moderate and severe disturbance responses and the number of concerns reported were analysed. Most indices of outcome were consistent with an improvement (i.e. reduction) in the number of disturbance-indicating behaviours and carers' concerns reported. The largest differences occurred between recruitment and the 4th visit, most of these reaching statistical significance. Precise quantification of change was confounded by differences between families remaining in the evaluation for different periods and small sample sizes. Most improvement occurred, however, in those with most apparent need, as judged by adjusted ASQ:SE scores. Caution must be exercised in interpreting these results as greater numbers may have conferred greater significance to the differences found. Furthermore, attributing these changes to the PMHS intervention demands care as no control groups (matched cases with no PMHS intervention) were included. However significant changes determined over a relatively short period of intervention is of interest and consistent with a clinical effect.

DISCUSSION

Relevance

The appropriateness of the PMHS service to clients' needs can be addressed statistically, and by capturing service users' opinions. There can be little constructive debate about the high incidence (often placed between 10% and 20% of the population) of behavioural and emotional problems in pre-school age children, nor of the impact these can have on parenting, family functioning and on carer health, which has been widely researched. The less well researched (and consequently more theoretical) argument that an early solution to attachment problems and family dysfunction reduce the need for later service involvement can also be claimed, if not currently fully evidenced. Pressure on CAMHS to try to manage the more pronounced and acute difficulties present in older children, together with the workload and skills demands in those working in the community, together define the 'Tier 2 gap' for this client group, a gap the PMHS service attempts to fill.

Client users' needs were assessed in this evaluation from carer questionnaire relating to their experience of the service received after discharge (or 6 months), and from 6 face-to-face or telephone interviews with them. Whilst all carers returning the final questionnaires completed the ESQ (n=18), 47 carers were sent them, a return rate of 38%. This low figure reflected the natural eventual disengagement of the carer from both service and the evaluation but also included a number of respondents initially consenting but failing to maintain an involvement in the evaluation. The client-derived evidence presented in this report has to be seen, therefore, in the context of a self-selected, volunteering sample and as such the findings might not be representative of the whole PMHS caseload or those initially consenting to the evaluation. However, a wide range of carers were still included in relation to family and occupational status.

Notwithstanding this caveat, carers reflected on their experience with the PMHS service with high levels of satisfaction in the questionnaires, repeated in the interviews. Of particular mention were the high values placed by them on the type of personal contact achieved and the time made to non-judgmentally explore deep personal issues relating to their feelings about themselves, their child, and their parenting. Not all respondents found the psychodynamic and analytic approach comfortable and one view was that it was more appropriate for some than for others. No sense emerged, however, that this approach was

being imposed insensitively, but the view may explain the slightly lower levels of satisfaction reported in relation to the *impact of the service on family functioning* and their confidence in the future, than in their understanding of the child's behaviour, the feelings generated, and their responses to it.

Some stakeholders in the service questioned the relevance of the PMHS service *within the context of Tier 3 CAMHS* but all expressed support for the service objectives and most valued PMHS staff and their work highly, recognising the importance of preventive, early work with carers and young children. Others *within CAMHS* expressed these views more strongly, emphasising the critical relevance and need for deep integration of a specialist service dealing with emotional and behavioural difficulties in the 'forgotten' infant and pre-school child.

Training sessions run by PMHS workers were attended by a wide variety of professionals working directly and indirectly in the healthcare and family support professions and were very well received in general. Some suggestions were made to increase the amount of discussion time and clinical case support in group settings but both knowledge and understanding, and transferable skills, were acknowledged to have benefited substantially from the sessions.

Accessibility

The overwhelming majority of referrals in to the PMHS service come from Health Visitors, even when the origin of the referral might have involved GPs, Social Workers, Paediatricians or others. Knowledge of the service offered, understanding of the referral routes and communication between HVs and PMHS workers is, therefore, of paramount importance. Questionnaires to all HVs with child care responsibilities and a sample of telephone interviews formed the data source addressing this issue. The ability of the PMHS staff to manage the cases referred to them comprises part of the accessibility matrix. Accessibility is also contained in the relationship between the social and geographical distribution of need and the service available, offered and received.

Generally high levels of satisfaction were reported by HVs of the PMHS service in all areas relating to contact and liaison, although some expressed difficulties in prompt telephone contact. The service itself was valued and used and all HVs contacted regularly referred or

sought advice from PMHS workers. Despite only a 55% response rate to the HV questionnaire, HV interviews, training evaluation form scrutiny, and discussions with stakeholders indicated that the PMHS service was now widely known about and built in to their own service activity. However, whilst accessing PMHS staff was not voiced as an issue, differences emerged between HVs, HV Managers and PMHS staff in their expectations of their respective contributions to a community-based Tier 1 (supported by Tier 2) extension of the PMHS approach. In particular, both the service planning process and the job descriptions of PMHS workers refer to a substantive training and support role for HVs and others in developing skills for their own Tier 1 work by “supporting and strengthening existing Tier 1 provision through building capacity and capability within health visitors, Sure Start workers, primary care colleagues, early years educators, social workers and other agencies working with young children.” One tension relates to the fact that whilst locality managers were involved in developing the blueprint for the PMHS service, the degree to which it was to be used primarily as a “referral” rather than as an “advisory and supportive” service seems to have remained unclear. This tension appears to have developed around the issue of workload (both HVs and PMHS staff), perceived competence and confidence (HVs), and clinical supervision (not required if the ‘referral model’ predominates). So some comments by HVs relating to the desirability of PMHS staff to increase their HV contact and support work (shorten waiting times, increased communication and additional training) were received, together with an understanding of the increasing clinical contact time workload pressures being placed on the HV service as a result of staff shortages and expanding portfolios of public health responsibilities. There remain signs that whilst agreeing on the need for greater accessibility, a gap exists in locating the responsibility for implementing this without further resources being made available to the HV service, to the PMHS service, or to both.

‘Accessibility’ needs clarification with respect to whether it refers to timely and appropriate high-level clinical intervention work in the home, or whether it should be defined by specific referral on to a Tier 2 clinical service (the ‘equity’ component of accessibility being discussed below). In the case of the latter referral timings and the interval between referral and clinical contact were not highlighted by HVs as problematic although some reported wait times of 2 months or more, made worse when trying to arrange joint visits by two part-time workers. The agreement of PMHS workers to see families on completion of the SPE

form or even before (justified by streamlining assessment procedures) was broadly welcomed by HVs (whilst questioned by some members of the CAMHS teams).

Acceptability

Acceptability as a client satisfaction issue has been discussed in the section on Relevance, above, and it also links to Equity issues, below. In addition, however, the concept includes the degree to which suggested referrals are agreed by the client, and continuity and completion rates to discharge (mediated by appointment scheduling issues).

Perhaps the most frequent PMHS worker comment relating to acceptability was in the degree to which clients were engaged in the process, with poorer levels sometimes manifested by failure to keep appointments. Reasons for this were cited as the difficult and sometimes chaotic lives led, loss of motivation when it became clearer that simple 'external' solutions were unlikely, and reluctance on the part of some clients to allow the analytical approach to offer enlightenment and improvement. Softer actions than simple discharge for reacting to client engagement difficulties seems to characterise the community-located PMHS work in comparison with the clinic-located CAMHS specialist work and its acute, statutory caseload responsibilities. Client views reinforce the value they placed especially on the personal approach and the supportive one-to-one relationship that emerged. Whilst this evaluation neither received or specifically sought information about the influence of location on PMHS consultative work, beyond identifying the clear logistical complication that client home-based work entails in travel, failed appointments, toy prop transport, and diversionary situations inside the home, it is hard to imagine that clinic appointments as a rule would not impact on important aspects of the therapeutic relationship. Assuming appropriate play room and other facilities were available, however, it would be wise not to assume that clinic appointments could not be used creatively as *part* of the PMHS strategy for engagement, and, of course, it would offer further opportunities for joint work with CAMHS team members.

Equity

Postcode analysis of the 2007 starting caseload indicated that the PMHS service is, probably appropriately, disproportionately seeing clients living in the more deprived sectors

of Bristol. As a responsive cross-Tier service, however, monitoring the relationship between community-assessed need and the needs of the intake cases should be part of good practice. There was some evidence, for example, that PMHS staff in UBHT were encountering cases from more deprived areas, and were having a larger number of contacts over a longer intervention time period than their colleagues in NBT.

Health Visitors commented on two aspects of equity in service provision: possible stigma-associated reluctance by clients to engage in a service managing “mental health” issues in very young children, and the (sometimes linked issue) of cultural relevance for minority ethnic groups. A few clients and PMHS staff voiced similar opinions about the name of the service in their questionnaires but others saw using the name as an opportunity to combat prejudice, despite some perceived dangers in engaging with some client from ethnic groups.

Communication difficulties (especially over the telephone) and the use of interpreters did on occasion create barriers and, in some cases (according to the PMHS staff) limit in-depth psychotherapeutic work. Ethnicity was not recorded in the caseload data collection method but an impression was gained by PMHS staff that referrals of ethnic minority families were relatively rare.

Efficiency

One core efficiency theme that crosscuts the whole evaluation, with diverse contributions from many angles, is “placement/management”, here taken together as they inter-link closely. Is CAMHS the best place for the PMHS service to be located and can existing CAMHS management structures support it? PMHS (Under 5s) staff work differently from Tier 3 CAMHS staff and for the most part have different clients, but no evidence emerged from stakeholders indicating that a different placement should be seriously considered, notwithstanding tensions over consultation at the time of PMHS introduction, funding, referral systems, and the sharing of clinical responsibility. Within the PMHS, however, there existed more diversity of opinion about optimal placement/location, partly borne of difficult early experiences of integration. It was, nevertheless, also clear that examples of successful, intimate integration do exist to provide a joined-up service across the age range.

Voiced areas of concern included how initial referrals are managed and records kept, ensuring that cases approved for the PMHS service are appropriate, enabling referrals within the team to be efficient and timely, establishing what Tier PMHS staff were working at, and uncertainties about clinical effectiveness. Most of these issues can be reduced to an apparent problem in preparation for the introduction of the service, poor communication, and, probably fractioned management structures. Less clear is whether professional boundaries and differences in therapeutic approaches remain problematic, and, if they do, whether or not they preceded introduction of the PMHS service.

This complex area rapidly approaches the limits of the evaluation, but, looking forward to new service provision arrangements that transcend existing Trust boundaries, it would seem profitable to seriously consider renewing efforts at integration, re-affirming placement of the PMHS service centrally within CAMHS, and engaging in formative action to support this via a more coherent management structure that does not separate clinical from administrative management, and is itself located within CAMHS. Professional development work may be required to enable staff to fully understand all the specialisms within CAMHS but this should be accompanied by efforts to maximise PMHS staff participation in referral, clinical conference and service development team meetings. Cases should come under regular CAMHS review to facilitate timely referral within the team when appropriate as, although data were not obtained specifically, it is unlikely that the relatively low *reported* rates of intra-team referral reflect clinical need in enduring and complex cases. A commonality of referral systems and record keeping is essential and most teams have moved towards this already. The implications of wider participation of all PMHS staff within CAMHS should be reflected in their contracts of employment, including the role of part-time working.

A consequence of better integration should be the more efficient sharing of common resources and any practice of placing administrative support staff at distance from the PMHS/CAMHS service centre should be avoided as it undoubtedly confounds the speed and accuracy of communication within the service. Attention to the availability of consultation rooms for clients with older pre-school age children for those PMHS workers wishing to explore the opportunities this confers on more efficient time management and client engagement might be considered.

Time management efficiency issues could follow a better understanding of the substantial individual variation determined in activity categories together with the major burden of administration and travel time. PMHS staff are engaged, in the course of their cross Tier role, in a great variety of activities and, whilst this is a particular strength of the service, it provides substantial challenges in optimising time allocation strategies. It is hard to see how, with 40% of the time spent in administration and travel, a PMHS worker on a half-time (or less) contract can properly engage in the other 10 or so activities (*excluding* direct clinical contact work) forming their responsibility areas. Reviewing the arrangements available for PMHS support staff and considering new ways of working might prove beneficial for efficiency.

One area where efficiency might be improved is in the training. Three fifths of all training sessions were delivered by 2 or 3 PMHS workers and most of these were one session in duration. Whilst there may be cogent reasons why joint delivery of training is preferable it should be recognised that this is expensive in terms of staff time in a very small service totalling 4 w.t.e posts. Initial training sessions might well profit from supportive or split trainer sessions but in development these can probably be reduced in number.

Effectiveness

Should all under 5s be referred directly only to the PMHS worker within CAMHS and should clinical work start before an SPE form has been received by the service? These questions form important parts of the debates over placement and integration, clinical responsibility, Tier-based service provision, and, clinical effectiveness, and as such fly close to the evaluation remit. They also adhere to the issue of HV referral to sole PMHS work and what HV training and supervision should be provided. Some CAMHS teams have an active gatekeeping service for under 5s referral, others pass them directly without delay to PMHS staff leaving intake decisions to their judgement. Many SPE forms received for under 5s name the PMHS worker as already engaged or contacted. SPE referral to reception by service durations are now mostly within 5 working days, often faster, and new SPE forms are reviewed on a daily basis in some CAMHS and less frequently in others. So long as the referring HV or other professional submits the form promptly, there is little reason, therefore, to regard this as a significant 'outwith CAMHS delay' confounding rapid responsive intervention. Initial work prior to receiving the SPE is not, therefore, warranted on the basis of speed, although some PMHS workers may wish to see the client with the

HV first in order to assess suitability for referral. Referral training may reduce the need for this further and contribute to a more unified CAMHS referral procedure and alleviate concerns over the clinical and legal responsibilities of pre-referral clinical intervention.

Some PMHS staff do not undertake joint clinical visits with HVs and, as many HVs (and their managers) express the desire to 'hand over' cases, a 'step back' from an intimate Tier1/Tier2 model might be fruitfully reviewed. More attention to supporting HVs in their less complex parent-child attachment and behavioural work via training and supervision (at the expense of joint visits) may be more economical, more effective clinically, and clarify the role of PMHS within CAMHS. It might also enable a more uniform referral system in CAMHS, together with the concomitant paper work, to evolve, and assist professional integration and internal referral.

Part of the answer to questions about clinical effectiveness is included in earlier discussion of client questionnaires and interviews and user perceptions of the service in relation to outcome. The values of the service were not, however, universally seen by users in terms of 'clinical outcome', and personal support and counselling were appreciated in their own right, irrespective of impact on child behaviour. More objective attempts to assess, in a non-controlled way, changes in both carer and child emotional well-being were only partly successful as a result of imperfect timely notification of new clients, poor continuity of family engagement in the evaluation, and, consequently small sample sizes and attrition bias. Nevertheless, whilst only some indices of change reached statistical significance, the overall trends for both carer and child indicated improvement, especially (for the child) in the short term. Making the reasonable assumption that families were not already on a downward (i.e. improving) trajectory at the time of referral, the results over the short-term are encouraging as this intermediary assessment stage was introduced specifically to argue for the attribution of change to the service, rather than extraneous or simply temporal factors. Furthermore, the degree of improvement in the child (as reported by the carer) was highly correlated with the baseline ASQ score, suggesting that the service effect might be dependent on the acuteness of the case. It must be recalled, however, that interpretation is somewhat confounded by the fact that child behaviour measures were carer-reported, that high attrition rates introduce bias thereby limiting generalisation, and that control groups were absent. Formal attribution of any clinical improvement to the intervention of the PMHS service has to remain cautionary.

The baseline measures of emotional health in the carer and 'mental health' in the child are indicative of a group in great need of help and it seems of little doubt that PMHS clients that were seen required support and help from the mental health services. High rates of probable 'caseness' of affective disorder characterised the sample of carers (over 55% with a GHQ >3) and their (index) children (75% over the ASQ:SE clinical intervention threshold). The latter proportion had reduced by over one half by discharge, but this was not seen as clearly in the carers' scores. The role of the PMHS staff in managing (or, at least, working around) psychiatric disorder in carers needs acknowledgment as they are neither trained for this task nor do they have the time to prioritise it, their activities being focused on the linked, but also distinct, topic of carer-child attachment, parenting, and child behaviour. Because of the divisions in mental health service provision, and strains of capacity in adult mental health services, onward referral of carers is more likely to be towards their GP who are themselves most likely only to be able to treat pharmacologically. PMHS workers are, in a sense, providing a community-based mother and baby mental health service, and with only one third of their time contracted for clinical work, provision for the 408,000 population of Bristol, is restricted to 1.3 full-time equivalents engaging in direct or indirect clinical work.

CONCLUSIONS AND RECOMMENDATIONS

Overall summary of findings

This study has found that the Primary Mental Health Specialist (Under Fives) staff in North Bristol NHS Trust and United Bristol Healthcare NHS Trust provide a service that crosses traditional Tier and age-defined boundaries that is highly valued by both clients and referrers to the service alike. Their training role is also valued highly and there is evidence of positive clinical impact, especially in the short term. The part played by PMHS staff providing a specialist service in managing complex family situations, including adult mental ill health and disturbed pre-school age children in the community, is unique. This evaluation must be recognised as making no contribution whatsoever to determining any possible preventive impact of the PMHS on school age, adolescent and later mental ill health, and very little on other child and adult family members, both of which might be significant.

Placement of the PMHS service remains problematic although a majority view is that CAMHS is probably its best location. Undoubtedly at present the PMHS service in some locations is only partly embedded in CAMHS. Changes in attitude, activity, understanding and knowledge within CAMHS and PMHS are occurring but more is required, together with more rational management structures, to promote service integration. One opportunity afforded by any new post-contestability configuration of service is to review these arrangements, although the dangers of losing very close relationships with Tier 2 and Tier 3 CAMHS specialisms should not be underestimated.

The close and time-consuming role played by PMHS staff in supporting advanced Health Visitor direct work with clients is only partly successful. Some Health Visitors see this as expanding their understanding and developing their skills and confidence in client work, whilst many others see this as increasing their workload and would prefer to refer on clients with complex problems. Health Visitor management views are dominated by staff shortage and responsibility overload. The PMHS service should not shy away from reviewing this relationship constructively to maximise their effectiveness in achieving the best balance of direct and indirect clinical work.

Recommendations

These recommendations are based on the status quo with respect to community child, adolescent and family service provision arrangements, acknowledging that some may be made redundant or be superseded by post-contestability changes. The four CAMHS vary in their existing position with regard to the following recommendations which, if implemented, would bring them all 'into line'.

PLACEMENT, MANAGEMENT AND WORKING CONDITIONS

1. If further integration of the PMHS service within CAMHS is considered desirable, improvements might be achieved by:

- (a) meticulous attendance by all PMHS staff in all relevant CAMHS team meetings¹¹.
- (b) implementing a single, integrated intake system for all age groups referred to CAMHS based on the SPE system.
- (c) improving understanding by PMHS staff of CAMHS specialist work through closer liaison with staff or/and specific training opportunities
- (d) restructuring PMHS management into an integrated clinical, administrative and personnel role that dovetails into CAMHS specialism management structures on an equal footing
- (e) consideration by all CAMHS and PMHS staff of the value added by cross-Tier working, home and community-based clinical work, and the potential preventive impact on treatment in the long term of specialist PMHS work
- (f) ensuring that all PMHS staff have close access to adequate administrative and secretarial support

¹¹ This could prove more difficult for part-time PMHS staff but their contracts (and those of future appointments) need to emphasise the central importance of this key recommendation.

METHODS OF WORKING

2. The PMHS service should reflect, now that it has been established for over two years, on how their working methods could be improved for efficiency and effectiveness.

Questions that are likely to emerge from this review are:

- (a) Is the proportion of time spent in direct clinical work sufficient to provide an adequate service and should this be increased through review of priorities?
- (b) Can all the benefits of joint clinical work with Health Visitors be clarified and should training focus on problem identification and referral skills coupled with a trend towards more direct or/and less joint clinical work?
- (c) Can joint training sessions with PMHS colleagues be justified in relation to time pressures on other priority areas (see (2b) above)?
- (d) Would dedicated clinic facility availability for some clients with older pre-school age children be advantageous for PMHS work in terms of therapeutic value or/and efficiency?
- (e) Are client caseload characteristics distributed equitably or appropriately across PMHS staff?

CLINICAL EFFECTIVENESS ISSUES

3. The value of monitoring clinical effectiveness in a service should not be underestimated and, whilst difficult, successful demonstration is an effective device to either defend or argue for service development and expansion.

- (a) A system to monitor clinical outcome over baseline measures should be considered as part of routine service work.

- (b) The findings of high rates of affective disorder in carer clients of the PMHS service requires attention. A formal maternal mental health assessment process, with training if required, should be introduced to PMHS staff, together with guidance on how to refer on as appropriate. Service delivery for adult carer mental health problems needs to be addressed in a wider setting for family-based mental health service provision across Tiers.

APPENDICES

Appendix 1

ASSESSMENT INSTRUMENTS USED IN THIS EVALUATION

The General Health Questionnaire was developed by David Goldberg¹² as a screening instrument to help detect current psychiatric disorders, diagnosable by a subsequent psychiatric interview. Factor analysis has confirmed its coverage of four distress areas (depression, anxiety, social impairment and hypochondriasis)¹³. The questionnaire is designed to identify recent emotional disturbance reported by the respondent as altered from the normal state and is not used for distinguishing psychiatric disorders.

The GHQ has been frequently used in general population surveys and is routinely applied in the annual "Health Survey for England". The full version consists of 60 items each recorded as a 4-point Likert scale (Better, Same, Worse, and Much Worse, than usual), but a variety of shorter versions have also been validated. Scoring is achieved by using the values 0,1,2,3 as Likert scaling, but a 0,0,1,1 binary approach has been found to correlate highly ($r=0.92-0.94$).¹⁴ In the present evaluation brevity of questionnaire was considered to be of paramount importance and the GHQ 12-item version (see Appendix 6) which takes just 1 or 2 minutes to complete was adopted.

The GHQ has been widely evaluated internationally¹⁵ and Goldberg¹ estimated the sensitivity for the GHQ -12 as 93.5% (specificity 78.5%) in a General Practice population. Split-half reliability for GHQ-12 was 0.83 and Cronbach's alpha coefficients ranged from 0.82 to 0.9 in 4 studies⁴. As a screening device with validated cut-offs the GHQ total score has limited clinical application as a continuous measure. Greater attention should be paid, therefore, to the criterion-based group differences (i.e. the proportion of carers meeting the clinical criterion, taken as a GHQ12 score of 4 or more in this study to conform to its use in the Health Survey for England).

The Ages and Stages (Social-Emotional) Questionnaire (ASQ:SE) is a parent-completed child-monitoring system used for screening for social-emotional difficulties in pre-school age children. Developed in the United States as part of the Early Intervention Program at the University of Oregon, the User's Guide¹⁶ describes the function of the questionnaire as assessing compliance, communication, adaptive behaviours, autonomy, affect and interactions in 8 age-banded versions covering the age range 3-66 months. It is unique as a screening instrument in covering the whole pre-school age range although interpretive derived scoring systems are required to assess longitudinal changes across age-bands. The ASQ:SE is part of a wider screening instrument for developmental problems called the

¹² Goldberg, D. 1972. The detection of psychiatric illness by questionnaire. London, Oxford University Press (Maudesley Monograph No. 21)

¹³ Worsley, A., Gribbin, CC. 1977. A factor analytic study of the twelve item General Health Questionnaire. Australian and New Zealand Journal of Psychiatry. 11: 269-272

¹⁴ Banks, M.H. 1983. Validation of the General Health Questionnaire in a young community sample. Psychological Medicine. 13:349-353.

¹⁵ Vieweg, B.W., Hedlund, J.L. 1983. The General Health Questionnaire (GHQ): a comprehensive review. Journal of Operational Psychiatry. 14:78-85

¹⁶ Squires, J., Bricker, D., Twombly, E. 2003. The ASQ:SE User's Guide. Paul Brookes Publishing Company, Baltimore, Maryland

Ages and Stages Questionnaires¹⁷. The purpose of the tool is to identify children needing further testing and possible referral to early intervention services. The number of items ranges from 19 (<8 months) to 33 (<65 months) and the questionnaires take between 10 and 20 minutes to complete.

Validity and reliability studies were conducted on the ASQ:SE between 1996 and 2001 with a normative sample of 3014 children. Internal consistency was high (Cronbach's alpha 0.67 – 0.91, depending on the age version, overall 82%, n=1994) and test-retest reliability over 1 to 3 week intervals was 94%, n=367. Overall concurrent validity, using the Child Behaviour Checklist¹⁸ and the Vineland Social-Emotional Early Childhood Scale¹⁹, was 93% (range 81% to 95%). Sensitivity was 78% (range 71% to 85%) and specificity 95% (range 90% to 98%), using individually assessed Receiver Operating Curve-based cut-off points. More than 97% of parents rated the ASQ:SE as "easy to understand and appropriate".

As the number of questions (and cut-offs) varied between age-band questionnaire versions, ASQ score analysis is based on the adjusted measure of the score obtained as a percentage of the validated cut-off for that version

¹⁷ Bricker, D., Squires, J. 1999. Ages and Stages Questionnaires (ASQ): A parent-completed child monitoring system. 2nd edition. Paul H Brookes Publishing Co. . Baltimore, Maryland.

¹⁸ Achenbach, T. 1991. Manual for the Child Behavior Checklist/4-18 and 1991 profile. Burlington, University of Vermont, Department of Psychiatry.

Achenbach, T. 1992. Manual for the Child Behavior Checklist/2-3 and 1992 profile. Burlington, University of Vermont, Department of Psychiatry

¹⁹ Sparrow, S., Balla, D., Cicchetti, D. 1998. Vineland Social-Emotional Early Childhood Scale (SEEC) . Circle Pines., MN: American Guidance Service.

APPENDIX 2: CASE SUMMARY SHEET

PRIMARY MENTAL HEALTH SPECIALIST CASE SUMMARY SHEET

Case number:

Child's name:

Child's DOB:

Carer's name:	Telephone number:
Address:	Relationship to child:

Date of referral:

Referral source¹:

Intake team decision date:

Referral reason:
Presenting problems:
Family circumstances:

CONTACT RECORD²:

No	Date	Type ³	Reason for contact ⁴	Issues discussed	Issues resolved	Outcome code ⁵
1						
2						
3						
4						
AFTER FOURTH SUBSTANTIVE CONTACT PLEASE INFORM EVALUATION TEAM BY EMAIL						
5						
6						

1 Referral source: Name and designation of referrer

2 Contact: A contact is a planned or unplanned substantive meeting or telephone call with the carer discussing issues relevant to service provision (i.e. not administrative).

3 Type of contact. Use as many codes as apply: T Telephone F Face to face J Joint visit with HV P Planned contact UP Unplanned substantive contact

4 Reason for contact. Record with text if the child has a new or exacerbated problem or the carer has a new or exacerbated concern

5 Outcome codes: 1: Problem resolved –case closed 2:Referral to Tier 3 CAMHS 3: Referred to another agency

4:Ongoing support to HV 5: Continue visit



Dear Parent/Carer,

Re: Evaluation of the Primary Mental Health Specialist Service for children 0- 5

We are writing to you because you have been having some concerns about your young child and have been referred to a new type of specialist health worker. The sort of problems you are experiencing are quite common and until recently there have been few services available to help.

In the past year or two, however, the NHS has provided, in the Bristol area, a small team of specialists who are skilled in dealing with these problems and, together with your Health Visitor and GP, it is hoped that this new service will make a real difference. As it is a new service we need to know how effective and useful it is to parents and carers. To do this requires an evaluation and we have been asked to carry out this evaluation. We can only do this with your help as we need to know what you feel about the service and assess what difference it has made to you, your child and your family.

So we would very much like to ask for your help by agreeing to provide us with some information over the period that you are using the new service. Firstly, we would like you to read the enclosed leaflet (which gives you more information about the study). If you agree to take part, please:

- sign one of the pink consent forms
- complete the two short questionnaires (green and white)
- return one signed consent form and both questionnaires in the stamped, addressed envelope provided.

If you need more time to think about this or discuss it with friends or family that would be fine. The specialist worker herself will be happy to discuss the evaluation with you when you first meet.

Participation is entirely voluntary and if you decide not to take part it will not alter the care you or your child receives in any way. Any information you do provide will be completely confidential and no-one involved in the service will have access to it. If you would like any more information about the study, including other aspects of the evaluation, please contact Dr Jon Pollock on telephone 0117 3288451 or Sue Horrocks on telephone 0117 3288484. We very much hope you will agree to take part and thank you for reading this letter.

Yours sincerely

Dr Jon Pollock



Evaluation of a Primary Mental Health Specialist Service for children 0-5 years

We would like to invite you to take part in a study to find out more about your views and experience of the primary mental health specialist service for children under five. Before you decide it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information and if you so wish discuss it with your friends or family. If you would like more information or would like to discuss the research please use the contact numbers given at the end of this sheet. We would be happy to hear from you.

Who is organizing the research?

Dr Jon Pollock and Sue Horrocks, who are carrying out the study, are experienced researchers in this field. The project has been reviewed by Southmead Research Ethics Committee and the University of the West of England Research Ethical Committee for implementation across Bristol. This research project is known to and receives the full cooperation of the specialist health workers involved in your child's care.

Who has reviewed the study?

This study has been checked by independent researchers at the University of the West of England, Bristol as part of the quality assurance process required for sponsors of research

What is the aim of the study?

You may already know that your local Primary Care Trust is funding a new type of mental health specialist post in the community. We want to know about people's views and experiences of using the specialist service.

Why have I been chosen?

Your child has recently been referred to the primary mental health specialist service. Parents of all children who are referred to the service from January 1st 2006 to December 31st 2007 will be asked to take part.

Do I have to take part?

No, taking part is voluntary. It is up to you to decide whether or not to take part. If you decide not to take part your care, or your child's care, will not be affected in any way, either now or in the future.

What will I be asked to do if I take part?

If you agree we will make contact with you and arrange a convenient time to meet for 10-15 minutes. You will be asked to complete 2 short questionnaires, one about your child's behaviour and one about your own health. You will be asked to complete a similar questionnaire about your child's behaviour after your specialist worker has made a few visits and again at the end of your time with the service. At this time you will also complete a service evaluation questionnaire and a further questionnaire about your own health. All

these questionnaires require, in the most part, tick box answers rather than asking you to write in any detail. The child behaviour questionnaire takes about 10 minutes to complete, the other questionnaires about 5 minutes each

If, at a later stage, you agree to be interviewed, a researcher will contact you to arrange a time at your convenience. The interview will take place by telephone, or in your home or at another location of your choice. It will take about twenty minutes. We will then gather the information from all the interviews to be analysed. It will not be possible to identify you, and the information you give will be completely confidential to the study. We are only interviewing a few participants. If you do not wish to be interviewed, we would still very much like you to take part in this evaluation.

What are the down sides of taking part in the research?

You will be asked to give up about 10 minutes of your time to complete the questionnaires on each of three occasions. The interview will take about 20 minutes. We do not expect there to be any other down sides to taking part.

What are the possible benefits to taking part in the research?

You will have a chance to share your views and experiences of the primary mental health specialist service. It is hoped that information from the study overall will help inform health service planners about the kind of services needed by the many parents who, at one time or another, have children with emotional or behavioural difficulties.

Confidentiality

Any information you give on the questionnaire will be strictly confidential to the study and stored securely on a password protected computer.

What will happen next?

If you are happy to take part please *just let the specialist worker know when she makes her first visit*. If you wish to discuss this evaluation with her please do so when she makes her first visit.

What do I do if I would like to know more?

Please contact

Dr Jon Pollock at the Faculty of Health and Social Care, University of the West of England
on 0117 328 88451

Email: jon.pollock@uwe.ac.uk

OR

Sue Horrocks at the Faculty of Health and Social Care, University of the West of England
on 0117 328 8484

Email susan.horrocks@uwe.ac.uk

APPENDIX 6: GENERAL HEALTH QUESTIONNAIRE – 12 ITEM VERSION

QUESTIONNAIRE ON YOU AND YOUR HEALTH

Your date of birth: _____

Child's date of birth: _____

Child's sex: M or F (*please circle*)

Ages of any other children in your family _____

We should like to know how your health has been in general *over the past few weeks*. Please answer all the questions below simply underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those you had in the past.

Have you *recently*.....

Been able to concentrate on whatever you're doing?

Better than usual Same as usual Less than usual Much less than usual

Lost much sleep over worry?

Not at all No more than usual Rather more than usual Much more than usual

Felt that you are playing a useful part in things?

More so than usual Same as usual Less useful than usual Much less useful

Felt capable of making decisions about things?

More so than usual Same as usual Less so than usual Much less capable

Felt constantly under strain?

Not at all No more than usual Rather more than usual Much more than usual

Felt you couldn't overcome your difficulties?

Not at all No more than usual Rather more than usual Much more than usual

Been able to enjoy your normal day-to-day activities?

More so than usual Same as usual Less so than usual Much less than usual

Been able to face up to your problems?

More so than usual Same as usual Less able than usual Much less able

Been feeling unhappy and depressed?

Not at all No more than usual Rather more than usual Much more than usual

Been losing confidence in yourself?

Not at all No more than usual Rather more than usual Much more than usual

Been thinking of yourself as a worthless person?

Not at all No more than usual Rather more than usual Much more than usual

Been feeling reasonably happy, all things considered?

More so than usual About same as usual Less so than usual Much less than usual

APPENDIX 7: HEALTH VISITOR QUESTIONNAIRE LETTER

Date

Dear {Name of Health Visitor},

Re: Evaluation of the Primary Mental Health Specialist Service for children 0- 5

It has been estimated that between 10 and 20% of pre-school children experience emotional or/and behavioural problems of sufficient severity to require professional care. To date services available to meet this need have been largely met within the heavy workload of the Health Visiting service.

Following new funding arrangements and joint Primary Care Trust and local Authority commissioning for mental health services, four new full time equivalent posts designated as Primary Mental Health Specialist –Under 5s have been created across the Bristol Trusts, both to support and strengthen existing Tier 1 provision by building capacity and capability (including training) in health visitors and all those working with young children, and to act as an interface between Tier 1 and core CAMHS.

It is hoped that by intervening early in families where children under the age of 5 show signs of emotional and behavioural difficulties, more chronic and severe psychological problems in older children and adults could be prevented (DH 2004).

As part of the evaluation of this new service, you are being asked to kindly complete a short, absolutely confidential questionnaire, which asks you about your awareness, use and opinion of the PMHS service in your area over the past 12 months. It is very important that the views of those professionals who use the service are adequately represented. At the end of the questionnaire a question invites you to take part in a short telephone follow up interview to explore your experience in more depth. If you would be prepared to be interviewed please give your contact details in the space provided. If you do not wish to be interviewed we would still very much like to receive your views as requested in the one-page questionnaire, which should take no longer than about 5 minutes to complete.

This evaluation is independent of, but receives the full cooperation of the Primary Mental Health Specialist (Under 5s) programme and staff.

Please read the enclosed information sheet but If you would like any more information about the study, including other aspects of the evaluation, please contact Dr Jon Pollock on telephone 0117 3288451 or Sue Horrocks on telephone 0117 3288484.

Thank you for reading this letter

Yours sincerely

Dr Jon Pollock

Department of Health (2004) National Service Framework for Children, Young People and Maternity Services

APPENDIX 8: HEALTH VISITOR QUESTIONNAIRE

Study ID: □□□□□

1.	Are you aware of the Primary Mental Health Specialist (PMHS) service for children aged 0-5 with emotional or behavioural difficulties (EBD)? <i>{If you answer "no" please just answer questions 12 and 13 and return the questionnaire}</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2.	How many times have you used the PMHS service in the past year? Never considered using the service Considered but never used the service Used the service on 1 or 2 occasions Used the service more frequently (please indicate number of times) If you have not used the service please now go to question 9		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
3.	If you have used the service, for what purpose was this? <i>{Please tick all that apply}</i>	Consultation about a client (but no joint visit or referral) Joint visit with client Client referral Supervision meeting Training event Other:	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4.	Please rate your satisfaction with using the PMHS service for consultation about a client <i>Very satisfied</i> <i>Satisfied</i> <i>Neutral</i> <i>Dissatisfied</i> <i>Very dissatisfied</i> <i>Not applicable</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
5.	Please rate your satisfaction with PMHS joint visits to a client <i>Very satisfied</i> <i>Satisfied</i> <i>Neutral</i> <i>Dissatisfied</i> <i>Very dissatisfied</i> <i>Not applicable</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
6.	Please rate your satisfaction with client referral <i>Very satisfied</i> <i>Satisfied</i> <i>Neutral</i> <i>Dissatisfied</i> <i>Very dissatisfied</i> <i>Not applicable</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
7.	Please rate your satisfaction with supervision meetings <i>Very satisfied</i> <i>Satisfied</i> <i>Neutral</i> <i>Dissatisfied</i> <i>Very dissatisfied</i> <i>Not applicable</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
8.	Please rate your satisfaction with PMHS formal training events <i>Very satisfied</i> <i>Satisfied</i> <i>Neutral</i> <i>Dissatisfied</i> <i>Very dissatisfied</i> <i>Not applicable</i> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
9.	In your experience, with which members of the care team does the PMHS liaise for referral purposes <i>{Please tick all that apply}</i> HV Practice Nurse GP Nursery Nurse School Nurse Social worker Other Other please describe.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
10.	How would your rate your satisfaction with liaison between the PMHS and other members of the care team?		

	Very satisfied <input type="checkbox"/>	Satisfied <input type="checkbox"/>	Neutral <input type="checkbox"/>	Dissatisfied <input type="checkbox"/>	Very dissatisfied <input type="checkbox"/>	Not applicable <input type="checkbox"/>	PT O
11.	How would you rate your overall satisfaction with the services provided by the PMHS?						
12.	What support services for families with children who have emotional or behavioural difficulties (EBD) are available in your local area? <i>{Please tick all that apply}</i>						
	Local Authority Day Nursery <input type="checkbox"/> Charitable funded e.g. Barnardos nursery <input type="checkbox"/> Family Centre <input type="checkbox"/> Private Nursery <input type="checkbox"/> School Nursery <input type="checkbox"/> HV run groups <input type="checkbox"/> Informal voluntary groups eg play group, mother toddler group <input type="checkbox"/> Homestart or equivalent <input type="checkbox"/>						
13.	How confident do you feel in your own skills to assist families with children with EBD? <i>{Please tick the statement that most nearly applies in your work with children under 5}</i>						
	I feel confident to manage all children with EBD <input type="checkbox"/> I feel confident to manage all children with EBD, but do not have sufficient resources <input type="checkbox"/> I feel confident to manage all but the most severe EBD, but do not have sufficient resources <input type="checkbox"/> I have not had sufficient training to enable me to feel confident to manage children with EBD <input type="checkbox"/> If other please describe						
14.	What would be the most frequent reason for you referring a client to the PMHS? <i>{Please rate from 1 – 4 with 1 being the most frequent reason}</i>					Please rank each option from 1 to 4...	
	The complexity of the presenting problem <input type="checkbox"/> Lack of progress with the problem to date <input type="checkbox"/> Potential child protection issues arising <input type="checkbox"/> Parental request for specialist help <input type="checkbox"/> Not applicable, I have not referred a client to the PMHS <input type="checkbox"/> Other – please describe.....						
15.	Please use this space to comment on the PMHS service and how it might be improved from your perspective:						
<u>We would like to interview a small number of health visitors about their experience of using the PMHS. The interview would be short and would take place over the telephone. It would last about 20 minutes. Please give your contact details if you would be prepared to be interviewed.</u>							
Name:				Base:			
Telephone No:				Best time to call you:			

Thank you very much for completing this questionnaire. Now please return it in the Free Post envelope provided. If you have any questions about the study please contact Sue Horrocks, telephone 0117 3288484 or email: Susan.Horrocks@uwe.ac.uk

APPENDIX 10: CLIENT FOURTH CONTACT LETTER

Friday, 23 May 2008

Dear Ms

RE: Primary Mental Health Service (Under 5s) Evaluation

You have now had your 4th contact with the Primary Mental Health Specialist service and we are very interested to find out how things are going.

So that we do not take up much of your time we would just like you to complete the enclosed short questionnaire about your child and return it to us in the stamped addressed envelope, as you have done before. It should take no more than 10 minutes.

If you have any further questions about the evaluation please give me a call or write. I would be happy to answer any questions you might have.

With many thanks,

Dr Jon I Pollock

Tel: 0117 3288451

23 May 2008

Dear

Primary Mental Health Specialist (Under 5s) Evaluation

I understand from your specialist worker that you are likely to be supported in the future by your Health Visitor and that she may not need to see you and your child any further.

This will bring to an end this part of the evaluation of the service you have received and we would like to complete our records of this time by asking you to kindly complete the enclosed questionnaires. Two of these, one relating to your child and one about your own health, you have seen before and they can be completed in about 15 minutes. The third and final questionnaire should also take only a few minutes and asks you about your feelings about the service. Please complete these and return all 3 in the stamped addressed envelope provided.

May I remind you that all this information is completely confidential and cannot be linked to you. Nor will it be seen by anyone outside the research team.

Thank you very much for all your help over this evaluation. We hope the findings will result in improvements in this type of support in the future. We also very much hope that the difficulties you have had with your young child have improved.

If you have any further questions about the evaluation please give me a call or write. I would be happy to answer any questions you might have.

With many thanks,

Dr Jon I Pollock
Faculty of Health & Social Care
University of the West of England, Bristol
Tel: 0117 3288451

Friday, 23 May 2008

Dear Ms

Primary Mental Health Specialist (Under 5s) Evaluation

I understand from your specialist worker that you have now been seeing her for over 6 months. We would now like to bring to an end this part of the evaluation of the service you have received and we would like to complete our records of this time by asking you to kindly complete the enclosed questionnaires. Two of these, one relating to your child and one about your own health, you have seen before and they can be completed in about 15 minutes. The third and final questionnaire should also take only a few minutes and asks you about your feelings about the service. Please complete these and return all 3 in the stamped addressed envelope provided.

May I remind you that all this information is completely confidential and cannot be linked to you. Nor will it be seen by anyone outside the research team.

Thank you very much for all your help over this evaluation. We hope the findings will result in improvements in this type of support in the future. We also very much hope that the difficulties you have had with your young child have improved.

If you have any further questions about the evaluation please give me a call or write. I would be happy to answer any questions you might have.

With many thanks,

Dr Jon I Pollock
Faculty of Health & Social Care
University of the West of England, Bristol
Tel: 0117 3288451

APPENDIX 13: CLIENT EXPERIENCE OF SERVICE QUESTIONNAIRE

EXPERIENCE OF SERVICE QUESTIONNAIRE

We are very interested to hear about your experience of using the primary mental health care service. This information will help improve the service and possibly make it more widely available to the carers of young children.. *Your responses will be kept entirely confidential and will only be seen by the researchers involved in the evaluation.* Please think about the appointments you, your child and/or your family have had with this service. Below is a list of phrases that describe feelings and opinions about the service. For each item please tick the box that best describes what you think or feel about the service.

	Certainly true	Partly true/ partly untrue	Certainly untrue
I feel that the people who have seen my child listened to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It was easy to talk to the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was treated well by the people who have seen my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My views and worries were taken seriously	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel the people involved know how to help with my concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been given enough information about the help available	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the people who have seen my child are working together to help with the problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a friend needed similar help I would recommend this service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the timing of appointments was good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the frequency of appointments was good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that where the appointments took place was good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that the service has been helpful in resolving the problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that, as a result of this service, the relationship I have with my child has improved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that I would now say that the relationship I have with my child is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel that, as a result of this service, I am better able to manage problems I might have with my child in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a result of this service I feel more confident in my role as a parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a result of this service I feel that relationships within the family have improved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel better within myself, as a result of this service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall, the help I have received from the service is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now please turn over the page.....

EXPERIENCE OF SERVICE QUESTIONNAIRE

Please indicate below what you felt was good or not so good about the service you have received..

Thinking about your experience please write what you felt was good about the service:

Now please tell us what you felt was NOT so good:

Finally we would be interested to know of your feelings about the use of the name "Primary Mental Health Specialist (Under Fives)" to describe the person you have been seeing. Please indicate below if you have any opinions on the name:

.....

.....

We would like to have the opportunity to talk with you briefly about your use of the service. This is entirely voluntary and would consist of a telephone call or a visit that would last about 20 minutes. If you would be prepared to do this please tick this box:

If you have ticked the box above please also tick the appropriate box below:

I would prefer to be visited:

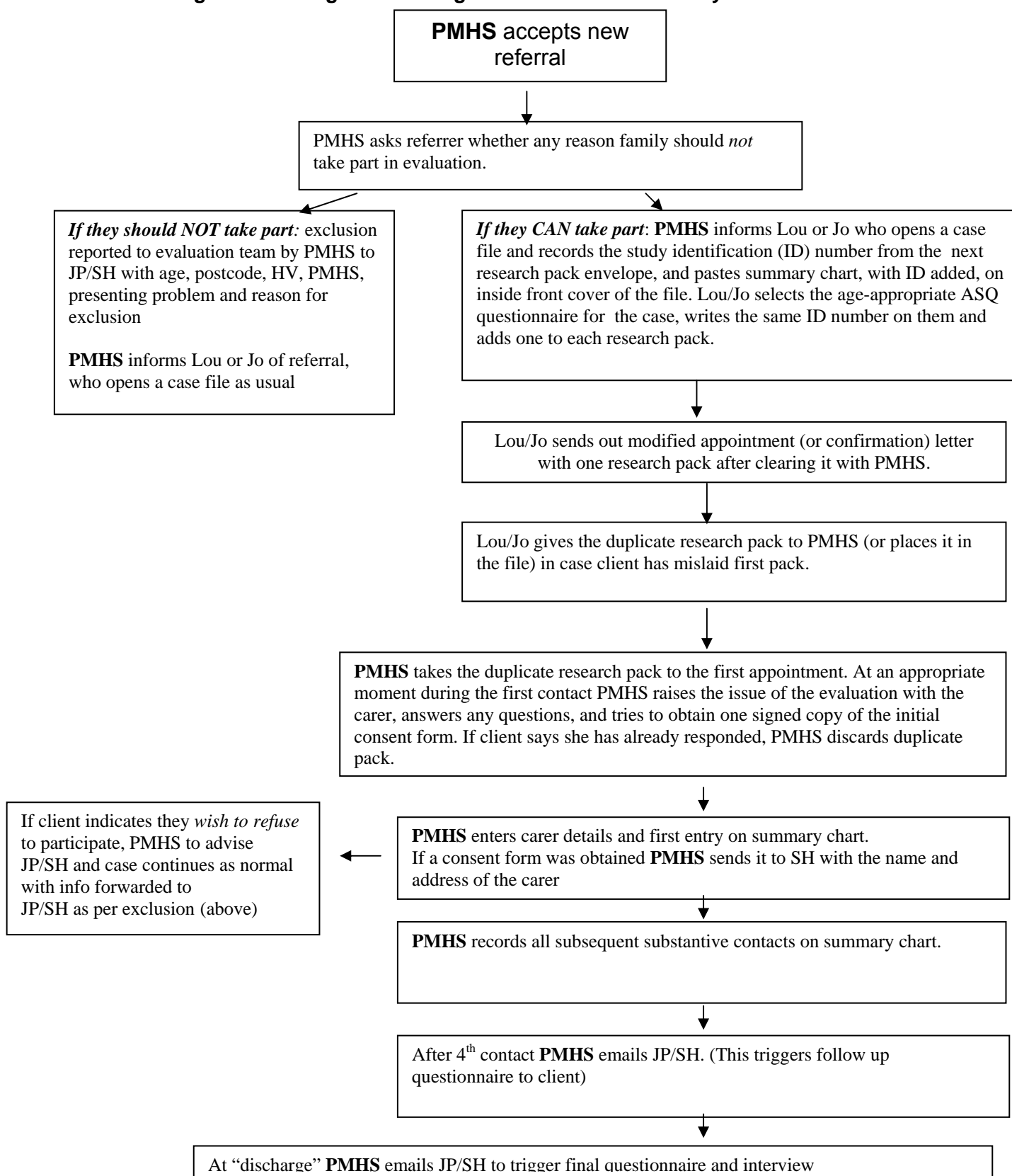
I would prefer to be telephoned:
{Please write down your telephone number:_____}

MANY THANKS FOR COMPLETING THIS QUESTIONNAIRE. PLEASE NOW PUT IT IN THE STAMPED ADDRESSED ENVELOPE, TOGETHER WITH THE OTHER TWO QUESTIONNAIRES, AND POST IT TO US.

WE ARE MOST GRATEFUL FOR YOUR CONTRIBUTION TO THIS SERVICE EVALUATION

APPENDIX 15: ORIGINAL PMHS FLOW CHART INSTRUCTIONS

Primary Mental Health Specialist Evaluation
Original flow diagram showing tasks to be carried out by the PMHS service team



Contacts: jon.pollock@uwe.ac.uk tel:0117 3288451 susan.horrocks@uwe.ac.uk tel: 0117 3288484

APPENDIX 16: PMHS ACTIVITY RECORD DATA FORM

Name..... Week beginning..... Week ending.....						
Please mark times in number of half hour slots per day						
	MON	TUES	WEDS	THUR	FRI	Total
<i>Client contact</i>						
<i>Joint visit with other practitioner to client</i>						
<i>Client related administration</i>						
<i>HV small group meeting to discuss IMH issues and case-handling</i>						
<i>Clinical supervision to HV Group</i>						
<i>Consultation to referrers re. cases</i>						
<i>Parenting Group</i>						
<i>Formal teaching or training sessions</i>						
<i>Own clinical supervision</i>						
<i>Own Training/Study</i>						
<i>Case Discussions with Colleagues</i>						
<i>Team Meetings/Meeting with Line Manager</i>						
<i>Contact with Agencies/ Network meetings</i>						
<i>Admin</i>						
<i>Travel</i>						
<i>Other. (Please give date and hours)</i>						
TOTALS						

Time sheet definitions:

Patient contact =face to face and substantive telephone contact

Patient administration =including managing video material

Own clinical supervision = face to face or telephone

Teaching or training – includes all preparation

Own training or study = includes learning to use video equipment, reading papers etc.

Admin = includes travel expenses, activity records (time sheets etc.)

APPENDIX 17: PMHS TRAINING SESSION EVALUATION FORM

Child & Adolescent Mental Health Service
 Primary Mental Health Specialists (Under Fives)
Training Evaluation Form

<i>Please complete this form so that we can monitor, evaluate and improve our training provision.</i>		
TITLE OF TRAINING SESSION:		
DATE:	TIME:	LOCATION:
NAME OF TRAINER(S):		
Your Designation (e.g. HV, School Nurse, Social worker):		
1. What were you hoping to gain from the session?		
2. Did the session meet your expectations?	Not at all <input type="checkbox"/>	Partly <input type="checkbox"/> Completely <input type="checkbox"/>
3. Please record any aspects of the session you found to be informative?	Presentation <input type="checkbox"/> Discussion <input type="checkbox"/> Handouts <input type="checkbox"/> Networking <input type="checkbox"/> Other (please describe) :	
4. Please record any aspects of the course could be improved?	Presentation <input type="checkbox"/> Discussion <input type="checkbox"/> Handouts <input type="checkbox"/> Networking <input type="checkbox"/> Other (please describe) :	
5. The relevance of the training to my job was:	Highly relevant <input type="checkbox"/> Relevant <input type="checkbox"/> Not relevant <input type="checkbox"/>	
6. Please record any of the following aspects of your <i>knowledge/understanding</i> that improved as a result of the session	Awareness of service <input type="checkbox"/> Needs of client <input type="checkbox"/> Needs of child <input type="checkbox"/> Referral guidelines <input type="checkbox"/> Case management techniques <input type="checkbox"/> Other (please describe):	
7. Please record any of the following <i>transferable skills</i> that you felt might have improved as a result of the session	Assessing the needs of the client <input type="checkbox"/> Assessing the needs of the child <input type="checkbox"/> Accessing professional support <input type="checkbox"/> Confidence in case management <input type="checkbox"/> Acquisition of new skills (please describe): Other (please describe):	
8. The <i>venue</i> for the session was:	Poor <input type="checkbox"/>	Satisfactory <input type="checkbox"/> Good <input type="checkbox"/>
The <i>duration</i> of the session was:	Too short <input type="checkbox"/>	About right <input type="checkbox"/> Too long <input type="checkbox"/>
The <i>timing</i> of the session in the day was:	Inconvenient <input type="checkbox"/>	OK <input type="checkbox"/> Optimal <input type="checkbox"/>

Please write any further comments you would like to make here:

Thank you for completing this form. *Please hand it to the trainer when you leave, or send it to Louise Matthews, CAMHS, UBHT, Southwell St, Bristol.*