A Clinical Audit of the 2+1 Model of Brief Consultation in a CAMHS

Small Scale Service Related Project

A Clinical Audit of the Two Plus One Model of Brief Consultation in a Child and Adolescent Mental Health Service

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Abstract

The two plus one model of consultation is a brief intervention which focuses on developing a collaborative approach with a family. The retrospective project was based on a primary care CAMHS that had used the two plus one model of consultation. 117 children were referred for consultation between December 2003 and November 2004. 8 clinicians were used to deliver consultations. Measures used included the Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983), the Strengths and Difficulties Questionnaire (Parent report version (SDQ); Goodman, 1997) and a parent satisfaction questionnaire. Qualitative data was collected to obtain the opinions of clinicians using the model and of administrative staff supporting it. The data suggested that half of service users attended fewer than 3 sessions of consultation. Clinicians identified both positive and negative aspects of working with the model. Clinicians reflected that they had experienced a sense of enhanced collaboration with the service users. Difficulties with the admission procedure, waiting times and opt in figures are discussed. The audit is limited due the amount of data missing to be able to make meaningful analysis. Findings are discussed in relation to national guidelines.
A Clinical Audit of the Two Plus One Model of Brief Consultation in a Child and Adolescent Mental Health Service

A need has been identified to reduce long waiting lists for Child and Adolescent Mental Health Services (CAMHS) and to meet demands for access to services without compromising the quality of services (Heywood et al., 2003). In addition to the difficulty of long waiting lists there are high non-attendance rates of 20-35% to first appointments in CAMHS (Audit Commission, 1999). In response to these difficulties a model for brief consultation, known as two plus one (2+1), has been piloted in different mental health services (Heywood et al, 2003; Barkham & Shapiro, 1990; Barkham, Shapiro, Hardy & Rees, 1999).

Winnicott (1971) appears to have been the first to document the concept of therapeutic consultations. Winnicott constructed a model to explore children’s preconceived notions of the consultant. Winnicott (1971) aimed to make a child feel understood, to enhance the child’s trust in the consultant, to allow the therapeutic relationship to be directed towards constructive change.

The two plus one model of consultation focuses on developing a therapeutic alliance with the family. Its aim for service users is to resolve specific problems they have identified through focused work in the consultation session, which is continued by the service user between sessions (Barkham et al., 1999). The model can be adopted to work with different treatment approaches such as cognitive behavioural and psychodynamic-interpersonal models (Barkham & Shapiro, 1990). Working within this model the clinician does not assume that a therapeutic relationship will develop or that on-going therapy will be necessary (Heywood et al., 2003). A primary aim of consultation is to meet parents’ expectations of what they want to receive from a CAMHS service (Heywood et al, 2003).
The process of consultation involves having parents reflect on how they came to be referred to CAMHS, to help develop their understanding of what the cause of their difficulties may be and to establish what they expect the role of the consultant to be (Street, Downey & Brazier, 1991). This aspect of the consultation is concerned with gauging the stage of change the family is at (Prochaska & DiClemente, 1982). The intention is for the consultant to develop a collaborative approach with the family in considering viable goals for the consultation, which depends on the service user’s position in terms of his readiness to change (Street & Downey, 1996).

If the clinician considers there is a significant mental health need or if there is a serious risk of harm to the child or family, then they may suggest a referral for psychological therapy (Heywood, Kroll, Stancombe, Dunn, & Street, 2001). In the consultation the clinician may provide access to information or specialist knowledge, to help the family identify the nature of their problems and to help them identify which options are available to them.

The model judges a consultation to be ‘successful’ if the service user experiences a sense of promise or hope (Heywood et al., 2001). Consultation may result in providing parents with advice, opinions, information or ideas to help them help their children. Heywood et al., (2001) state that the consultation allows the clinician to use a range of models and their specialist knowledge but it is seen as the parent’s responsibility to indicate what they think would be helpful.

Structure

Heywood et al., (2003) developed a manualized package on how to provide the two plus one consultation approach, based on models developed by Street & Downey (1996) within a systemic context and Barkham & Shapiro (1989) in adult
psychotherapy services. The model also aims to enable families with severe
difficulties to be prioritised for specialist intervention.

The two plus one model states that following referral service users are
provided with an appointment within four weeks of having returned an opt-in form
requesting a consultation (Heywood et al., 2003). This is based on findings that
waiting list times are a category which influence whether appointments are kept
(Oppenheim, Bergman & English, 1979). A second appointment is provided two
weeks after the first and a third session is given approximately two months later
(Heywood et al., 2003). The two month gap is based on observations that such a gap
can have a productive therapeutic impact, especially if the gap is presented as part of
the intervention at the initial meeting (Wolberg, 1980). It may be criticised that the
basis for this gap is founded on observations and there is no empirical evidence to
support these observations.

As stated, following referral an opt-in questionnaire is sent to collect details
from the parents of the child(ren)’s presenting difficulties, what their concerns are and
of any involvement with other services. They are informed of what they can expect
from the three sessions and they are given information about the service. Research
supporting the use of opt-in questionnaires is presented by Wiseman & McBride
(1998) whose study with 46 families suggested that families who were required to
confirm in writing that they wished to receive an appointment were significantly more
likely to attend as compared to a control group who were given an appointment
following referral ($X^2=17.2; p<0.005$).

Two of the three consultation sessions may be used to focus on the family’s
difficulties. After an initial consultation, it may be agreed that a second meeting is not
required. After two meetings it is for the family to decide if they would like an
additional meeting to evaluate the outcome of consultation and to decide if they would like further specialist intervention (Street et al., 1991).

Research

With regard to research on the average number of sessions service users are seen for intervention, Talmon (1990) indicated in a self practice audit, that the modal number of sessions service users were seen was one. Beer (1992) reviewed a child mental health service and reported that 70% of service users were seen for fewer than three sessions. Hoare, Norton, Chrisholm & Parry-Jones (1996) reported that 61% of service users in CAMHS in Scotland were seen for less than three sessions. Based on these findings, these researchers suggest that a brief model of intervention is required because the majority of service users do not attend sufficient sessions to benefit from any longer term intervention. An alternative interpretation for these findings may be that the low attendance rates reported are indicative of low service user satisfaction in these services, which may be related to the quality of services provided.

In terms of research investigating the relationship between treatment duration and outcome, Orlinsky & Howard (1986) reviewed 79 studies, 74 of which indicated a statistically significant positive correlation between outcome and length of therapy. The authors suggest that in ‘generic psychotherapy’ micro outcomes are gradually accumulated and synthesised by the service user over the course of therapy which enabled change to occur. Howard, Kopta, Krause & Orlinsky (1986) summarised the findings of 15 studies, investigating the optimum intervention length. It was reported that one service user in 3 displayed measurable improvement after a single intervention session. Orlinsky & Howard (1986) suggest that these studies imply that intervention has the greatest impact early on and a diminishing returns effect occurs, with more effort being required over a greater number of sessions to achieve further
changes. This observation has been labelled the ‘dose-effect’ (Howard et al., 1986). In other research, Callahan (2005) explored the outcome of 61 service users in psychotherapy sessions and suggested that those service users whom reliably improved in psychotherapy had remained in therapy for longer than the dose effect model would predict was necessary. It is suggested that the dose effect is perhaps dependent on a number of variables including the effectiveness of standardised measures used to measure change, the model of intervention used, the experience and training a therapist has and the severity of problems experienced by the service user (Callahan, 2005).

There have been a number of studies supporting the efficacy of solution focused brief therapy (SFBT) in CAMHS (Dejong & Hopwood, 1996; George, Iveson & Ratner, 1990; Wheeler, 1995), upon which the principles of the 2+1 model of consultation are based (Heywood et al., 2001). Much of the evidence to support the use of SFBT is based on service user satisfaction surveys. Service user satisfaction is often assumed to be a construct which reflects that user needs and wishes have been met (Donabedian, 1992). However, this view has been criticised for ignoring the power imbalance between the clinician and service user (Williams & Wilkinson, 1995). There is an implication that levels of satisfaction may reflect other variables such as a clinician’s confidence of delivery, as opposed to providing an evaluation of service quality (Williams & Wilkinson, 1995).

Street et al., (1991) present a number of case studies as evidence for the effectiveness of the two plus one model. Outcomes of individuals’ not attending following up sessions, cancelling sessions or reporting that the problem improved, were taken as evidence that the consultation was successful. The validity of this evidence may be questioned, as it is possible that families did not find the
consultations helpful, but did not wish to appear ungrateful and obliged the clinicians by providing positive feedback. Alternatively, it may be that selected case studies were chosen to support the model.

Heywood et al., (2003) piloted the two plus one package on 50 families referred to an outpatient CAMHS. Pre and post measures included the Strengths and Difficulties Questionnaire (Goodman, 1997), the Children’s Global Assessment Scale (Shaffer et al., 1983) and the Satisfaction and Effectiveness Questionnaire (Green et al., 2001; Howie et al., 1999). In comparing pre and post measures, significant improvements were reported in CGAS scores ($P<0.005$) and SDQ scores ($P<0.005$). It may be criticised that no control group was used in the study and therefore it cannot be inferred that the changes observed were associated with consultations. The use of the CGAS measure can be criticised as it is subject to biases, discussed below.

41% of parents completed a parent satisfaction questionnaire. 95% rated that they were satisfied with the consultations and advice using this model. 100% thought they had been listened to and understood. 93% were satisfied with information and advice given and 78% felt better able to cope with the problems. It may be criticised that a high attrition rate may have biased findings, as it may be that only those parents who felt sufficiently satisfied returned the questionnaire.

Barkham et al., (1999) conducted a pilot study with 120 service users assigned to either cognitive behavioural or psychodynamic interpersonal therapy under two plus one model of consultation. Findings indicated that 68% of participants made reliable and clinically significant changes, measured on the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), following two sessions of intervention. It was reported that there were no gains between those who received the consultation within 4 weeks of referral and those who were delayed before
receiving intervention. It may be criticised that due to the way participants were recruited, the participants were not representative of service users treated in mental health services, with the majority experiencing few symptoms associated with depression. Those who scored too high on measures were rejected from the study. The study did not use a control group and was subject to a number of threats to internal and external validity.

Project aims

This retrospective project was based on a primary care CAMHS that had used the two plus one model of consultation based on the manual produced by Heywood et al., (2003). Based on the findings of previous studies using the two plus one model of consultation (Heywood et al., 2003; Barkham et al., 1999), it was agreed with team clinicians that valuable project questions would be:

1. What were the waiting times for a first assessment?
2. What proportion of families opted in for intervention?
3. What proportion of families attended all three consultation sessions?
4. What proportion of families were referred for further treatment?
5. What proportion of families were discharged?
6. Was the structure of the model followed (i.e. two appointments over a fortnight and one a month later)?
7. In comparison with previous findings, were there significant improvements between pre and post measures on the:
   - Children’s Global Assessment Scale?
   - Strengths and Difficulties Questionnaire?
8. Were service users satisfied with this model of consultation, as assessed from ratings on the ‘Parent Satisfaction Questionnaire?’
9. What were the therapist’s viewsperiences of using this model for
treatment?

10. What were the difficulties experienced by the administration staff, in
supporting this model?

Ethics

The aims of the project were discussed with members of the clinical team, the
trust research and development department and the audit department. It was agreed
that the project aims were to review if the two plus one model of consultation had
been followed and therefore the project could be considered as an audit. A letter
confirming that the project was an audit was obtained from the service audit
department (Appendix A).

Method

Sample size

117 children were referred for the two plus one model of consultation in the
CAMHS between the period December 2003 and November 2004. 8 clinicians (5
clinical psychologists, 2 psychiatrists and a mental health practitioner) were used to
deliver consultations. Clinicians received a manual (Heywood et al., 2003) and two
hours training in the model, which involved role-play scenarios.

Clinicians applied the model for a half day on a weekly basis. Clinicians met
for peer supervision once fortnightly, to discuss the application of the model.

Data collection

Data for service users was collected from clinicians using a data collection
form (Appendix B) developed by the clinical team, using coding criteria already in
use by the service. Clinicians were contacted by e-mail to try and collect data. Data
was compiled onto a database using SPSS 11.5. Service user names were anonymised and the data base was stored securely on a password protected computer.

**Parent satisfaction questionnaire**

As part of the two plus one model, parents who had completed the consultation were posted a parent satisfaction questionnaire (Appendix C) following the final consultation. This questionnaire was sent up to four times, to increase opportunity to respond. The parent satisfaction questionnaire is an adapted version of the Satisfaction and Effectiveness Questionnaire (Green et al., 2001) consisting of ten items. There is no research analysing the factorial structure, the reliability or validity of the parent satisfaction questionnaire and therefore results should be interpreted cautiously. Only English language versions of this scale were available. It is unknown if this prevented any service users from completing the scale.

Replies to the parent satisfaction questionnaire were scored with questions 1, 2, 3, 4, 6, 7, 8 and 9 being given a rating between 1 and 4 (1=Yes all the time/yes completely; 4= not all). These items are intended to measure parental satisfaction with the service and opinions as to whether the consultations were helpful. This produces a rating of satisfaction between 8 (Very satisfied) and 32 (Not at all satisfied).

Questions 5 and 10 were analysed separately. Question 5 pertains to whom the parent perceived to have solved the families problems and was given a rating between 1 and 4 (1= The family only; 4= the professional only). Question 10 concerns whether or not the family has sought help elsewhere for the same problem(s) since being seen for the consultation, responses were rated with either a 1 or 2 (1= yes, 2= no).

**The Children’s Global Assessment Scale**

The Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983) has been used by clinicians as a measure of a child’s “Overall severity of disturbance”
(Bird, Canino, Rubio-Stipec & Ribera, 1987). The scale involves the clinician rating the child on a scale of 1-100, according to example descriptions of how the child is functioning. The scale aims to quantify a child’s “social and psychiatric functioning” (Bird et al., 1987), to provide a global measure of impairment. Scores above 70 indicate functioning in the normal range. Research regarding the reliability and validity of the CGAS is discussed (Appendix D). Clinicians rated service users at the first consultation and at the final consultation attended.

*Strengths and Difficulties Questionnaire*

Prior to the first consultation, parents were sent the Strengths and Difficulties Questionnaire (Parent report version (SDQ); Goodman, 1997; Appendix E), as a measure of the parent’s opinion of the severity of problems. The SDQ is a 25 item measure of “emotional symptoms (5 items), conduct problems (5 items), hyperactivity/inattention (5 items) peer relationship problems (5 items) and prosocial behaviour (5 items),” (Goodman, 1997). Items are added together to generate a total difficulties score based on 20 items. Only English language versions of the SDQ were used, although translated versions were available if required. Research regarding the reliability and validity of the SDQ is discussed (Appendix B). Post SDQs were administered at the final consultation.

*Clinician and secretary opinions*

A project aim was to identify what aspects of the model the clinicians’ viewed as useful and which aspects they viewed negatively. Clinicians were provided with a form (Appendix F) on which to record their views of the pros and cons of working with the two plus one model. This form was developed in conjunction with a clinician from the clinical team, it was designed to be very basic, so it would be quick to fill in and would maximise the chance of it being completed by clinicians.
Thematic analysis was used, as detailed by Joffe & Yardley (2004), to identify the most salient themes from the data collected. The first stage involved reading each completed form several times, identifying the ideas being expressed and generating labels to capture their essence. The second stage involved clustering similar ideas into themes. This was carried out for each completed form and then common themes were identified between clinicians’ reports.

A record form (Appendix G) was also given to the two secretaries for them to record their views of the pros and cons of providing administrative support for the two plus one model. This form was also designed to be very basic so it would be quick to fill in and would maximise the chance of it being completed.

Results

Data collection

No data was obtained for 13 service users. Two sets of service user data were missing due to one of the clinicians having left the service. Eleven sets of data were missing from three clinicians who did not respond to e-mail requests for the information.

Flow chart

Figure 1 is a flow chart illustrating the number of service users whom opted in for consultation, the number of sessions attended, waiting list times, reason for closure and outcome.

From the available data one may deduce that of the 82 service users whom had opted in for the 2+1 model of consultation, 45% (n=37) were discharged, 6% (n=5) were referred to different services (Paediatrics, education service, social services, child and adolescent psychiatry or other child psychology services), 14.5% (n=12) did
not attend the initial consultation and 18.3% (n=15) received more than three sessions of consultation and data is missing for the remainder of the service users.

**Sample characteristics**

Of the service users who completed between 1 and 3 sessions of consultation (n=42), as per the two plus one model of consultation, 64.3% of children were male and 35.7% were female. With regard to ethnicity, 28.6% of service users were white British, 2.4% were recorded as being from any other white background, 4.8% indicated that they were from any other ethnic group, 28.6% did not state their background and data had not been completed on the data collection form for 35.7% of the sample.

With regard to referral characteristics, 76.2% of service users had been referred by their GP all other service users had been referred from the following: Paediatrics, neurology, oncology/ haematology, community paediatrician, health visitor, community services, school nurse and a nurse. For 69% of the population, the problem duration had been in excess of 12 months, for 24% problem duration had been under 12 months and data had not been recorded for 7% of the population.

**Primary presenting difficulties**

Table 1 illustrates the diverse range of problems families presented with.

**Appointment non attendance and cancellation**

Of 42 service users whom completed between 1 and 3 sessions of consultation, 16 (33.3%) service users failed to turn up to one appointment, 4 (14.3%) service users cancelled one appointment and 2 (4.8%) service users cancelled two appointments. Data was missing for 4 (9.5%) of the service users.

**SDQ Scores**
The mean pre SDQ score for service users whom attended between one and three sessions of consultation was within the clinically significant abnormal difficulties range (17+) in comparison with normative data for the population, (Mean=8.4 (SD=5.8); Meltzer, Gatward, Goodman, & Ford, 2000). The mean post SDQ score is classed as being within the borderline difficulties range (14-15) in comparison with normative data for the population. However, it is difficult to draw any conclusions from this data as with only 8 returned SDQs, there are too few data returned to perform parametric analysis (Cohen, 1977). Mean scores decreased between pre and post measures for each of the negative behaviour SDQ subscales, except for the peer problems subscale. The mean prosocial subscale increased between pre and post measures.

**CGAS Scores**

The mean pre CGAS score for the sample was 58 (n=30, SD = 12), suggesting “some noticeable problems in more than one area…disturbance would be noticeable to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings” (Shaffer et al., 1983). The mean post CGAS score was 64.1 (n=16, SD=15.9), suggesting that the mean level of difficulty had reduced to “some problems in one area only…but generally functioning pretty well,” (Shaffer et al., 1983).

Based on previous research it was reasoned that there was too few data available for meaningful parametric analysis. A two tailed t-test, a study would require 102 pre and post scores to achieve a .8 power probability based on a 0.5 effect size.

It appears from the outcome of consultations (See figure 1.), there were 20 service users who could have been given post CGAS scores, post CGAS data had not
been returned by clinicians for 4 service users. The remaining 22 service users were classified as either outcome unknown, no longer two plus one, referred to psychiatry or assessment/ opinion only.

*Parent satisfaction questionnaire*

9 out of a possible 31 questionnaires were returned between 2 and 6 months after consultation, for service users whom had attended between 1 and 3. 11 service users were not sent questionnaires as they were classified as either no longer two plus one or were referred to another service. 7 of the 9 service users whom had completed the satisfaction questionnaire had attended 3 sessions of consultation. The median score was 10 and the range was 9 to 30. The results suggested that 7 of the 9 parents (77.8%) were more satisfied than dissatisfied with the service they had received.

Question five on the questionnaire pertained to whom parents perceived to have solved their family’s problem(s). 6 of the parents said that it was either the family only or the family with help from the professional. 2 parents stated that it was either mainly the professional or the professional only who helped solve the problems and one parent answered not applicable.

On question ten, 7 of the 9 parents had not sought help for the same problem following consultation, whilst 2 parents had; one parent stated that this was at another clinic due to a move of house.

*Qualitative analysis*

6 clinicians provided their opinions of the pros and cons of working with the two plus one model. As intended the data provided a basic outline of the clinicians opinions of the pros and cons of working with the model. Main themes reported between clinicians were;

- The benefits of focusing around the service users’ expectations.
– A benefit of enhanced collaboration between clinician and client.
– A benefit of working as part of a larger team.
– Difficulties trying to fit to the three session structure.
– Difficulties with the admission process.

Some clinicians reported how service users’ seemed to respond well to the model, as it focused on what they wanted:

“Good way of engaging with families and thinking about what they want from contract with our service.” “It motivates families/ young people.” “Well accepted by families, commented that they felt listened to.”

Some of the clinicians indicated that the consultation felt collaborative:

“The message from the beginning that it is short term consultation increases the chances of a collaborative approach.” “The emphasis on what they want to do about it (The difficulty) is good.”

Most of the clinicians reported that whilst working with the model they found a multidisciplinary team approach helpful and supportive:

“I liked the team approach and working across disciplines.” “It was good to discuss clients’ with colleagues… it was interesting to have discussion, get peoples opinions, the model is set up to discuss clients with psychiatry. With generic work, we will not get to see a client sometimes for 3 months, after having discussed the case in the team.” “Some good team discussion and skill sharing. Sense of joint ownership of problem of how to manage high referral rate between psychology and psychiatry.”

Most of the clinicians reported finding it difficult to work to the structure of three sessions:

“Can feel a bit unsympathetic saying three sessions and you are out….difficult if not all resolved in three sessions, felt bad.” “It can be difficult to stick to a 2+1
model and still conduct a thorough assessment, e.g. psychometrics may be necessary.”
“Hard to return families to a waiting list if more than 2+1 needed.” “Many cases don’t fit the model.” “There is a risk of missing the problem…no in depth formulation.”

Some of the clinicians indicated that they thought there were difficulties with the admission procedure:

“Needs accurate info from referrer to allow appropriate directing to 2+1.”
“Complex admission procedure… my impression is that families ended up waiting longer due to opting in system… Opt in system excludes people with literacy problems.” “Monday afternoons (The day of the clinic) could be restrictive for families.”

One of the two secretaries returned the form expressing their opinion of providing administrative support for the model. No particular advantages were reported for providing support to this particular model, however it was stated that:

“There was confusion with 2+1 referrals being stored and mistakenly put in general referrals cabinet. Confusion whether referral belonged to psychology or psychiatry which was important for information to be entered correctly on the computer.”

Discussion

The findings are discussed in relation to the project aims, followed by a general discussion.

1. What were the waiting times for a first assessment?

The mean waiting time between the date a referral was received and the first offered appointment was 8.7 weeks (SD= 4.3). Although waiting times were longer than that advocated by the model, non-attendance rates were not as high as that reported by the audit commission (1999) of 20-35%.
2. What proportion of families opted in for intervention?

The majority of service users (70%) opted in for intervention, however the reasons why service users did not opt in is unknown. Such reasons may include difficulty in completing opt-in forms due to literacy difficulties or not understanding the English language opt in form. The equity of relying solely on an English language opt-in form can be questioned. Possible options to be considered include providing information in different languages and offering service users’ appointments by telephone in addition to by post.

The study found that 14.5% of service users who opted in for intervention did not attend any appointments. This figure is a lot higher in comparison to studies that have indicated first appointment non-attendance rates of 0% and 5% (Wiseman & McBride, 1988; Stallard & Sayers, 1998). The reason for this is un-clear but may be explained due to differences between populations on variables such as economic background, severity of difficulties, appointment waiting times or history effects. The attendance rates to first appointments were however higher than that indicated by the Audit Commission (1999) for CAMHS, which may suggest that opt in is effective in reducing non-attendance.

3. What proportion of families attended all three consultation sessions?

As had been reported by Heywood et al., (2003) the data suggested that half of service users (49.5%) attended fewer than 3 sessions of consultation. As indicated by Talmon (1990) the modal number of sessions attended was 1. The low attendance rate may be indicative of low service user satisfaction, related to the quality of services provided or it may be that service users found fewer than three sessions to be sufficient to help with their difficulties.

4. What proportion of families were referred for further treatment?
Clinicians could only record a limited number of responses in categories of outcome and reason for discharge. The figures are confusing as categories overlap and do not correspond with one another. The ‘no longer 2+1’ description appears in both outcome and reason for closure categories and it is inadequate in that it does not distinguish between whether a service user was referred to another agency, placed back on the waiting list or was going to receive further sessions of intervention.

Tentative deductions suggest that 6% (n=5) of service users were referred to different services (Paediatrics, education service, social services, child and adolescent psychiatry or other child psychology services). This figure is the same as that reported by Heywood et al., (2003), for referrals from 2+1 to a day service.

5. What proportion of families were discharged?

45% (n=37) were discharged, which is similar to the rate reported by Heywood et al., (2003) of 48%.

6. Was the structure of the model followed (i.e. two appointments over a fortnight and one a month later)?

The method in which the data were collected did not detail the length of time left in-between sessions and so it is not possible to specify whether this aspect of the model was adhered to.

7. In comparison with previous findings, were there significant improvements between pre and post measures on the:

– Children’s Global Assessment Scale?

– Strengths and Difficulties Questionnaire?

There were too few data returned to perform parametric analysis (Cohen, 1977). Mean scores on the total SDQ were slightly lower than that of service users in the study by Heywood et al., (2003) (Mean=19.8 (SD 6.9) Vs 25.78 (SD 4.8)),

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suggesting that the parent’s perceptions of difficulties of their children in this study were not as severe. However, the mean CGAS scores were similar (56.57 (SD 11.86) Vs 58 (SD 12)), suggesting that clinicians rated the children to be functioning at a similar level.

Similar to the predictions of Barkham & Shapiro (1989) suggesting that 36% of service users would show measurable change within 3 sessions of consultation, in the present study clinicians subjectively rated 38% of service users to have made improvements with up to 3 sessions of consultation. It is not known if these improvements are clinically significant.

With regard to the SDQ it may be criticised that specific difficulties are not measured, such as eating difficulties or enuresis. Furthermore, it may be criticised that neither naturalistic nor interventional longitudinal studies have repeatedly administered the SDQ and its use as a follow up measure has not been systematically evaluated (Rothenberger & Woerner, 2004). The way the SDQ is phrased, it may be questioned if it colludes with a parent’s often false impression that the difficulties experienced are due to something being ‘wrong’ with their child, as opposed to helping the parents view the possible systemic nature of the problem. As the SDQ contains few items for each subscale and respondents are limited to a choice of three responses per item, it may questioned how valid the measure is in providing a useful understanding of the severity of problems experienced.

Only the parental version of the SDQ was used in this study. Goodman, Ford, Simmons, Gatward & Meltzer (2000) reported that a child status was better indicated when parent, teacher and self reports were available. Additional versions of the SDQ may be considered for use in future applications of the two plus one model.
Interpretation of cross cultural comparisons of SDQ scores require careful consideration due to different levels of expectations, permissiveness and tolerance to behaviours, which together could lead to large differences between cross cultural family scores (Waldron, Sharry, Fitzpatrick, Behan & Carr, 2002).

**CGAS**

There are a number of factors suggested to influence the ratings on the CGAS, which include the relationship between the rater and the subject, training in the use of the instrument and the data available to the raters (Goldman, Skodol & Lave, 1992). The interrater reliability on the CGAS for the clinicians in this project was unchecked.

There is variability as to how the CGAS can be applied which may have influenced clinician’s ratings. On the original instructions for the measure (Shaffer et al., 1983), the score was designed to indicate the lowest level of functioning over a specified time. Other researchers have used the measure to reflect current functioning and average functioning (Bird et al., 1990). It is unknown whether the clinicians in this project were attempting to assess current functioning, average level of functioning or lowest level of functioning.

It is possible that the CGAS may be subject to an expectancy effect (Robson, 2003). It is suggested that clinicians may expect or may look out for positive change from the initial consultation, which may bias post CGAS ratings. Although there is research to suggest the CGAS has good reliability (Appendix D), there appears to be no research investigating inter-rater reliability between pre and post CGAS measures in a clinical setting.

8. Were service users satisfied with this model of consultation, as assessed from ratings on the ‘Parent Satisfaction Questionnaire?’
Similar to the findings of Heywood et al., (2003) the majority of parents indicated that they were more satisfied than dissatisfied with the service they had received. A limitation of the satisfaction questionnaire used is that it only asked for the parents’ perspectives and not the children’s. Variables which have been indicated to influence service user satisfaction reports include users’ perception of their rights to access a service and perceptions of whether a service is responsible for outcome (Williams & Wilkinson, 1995). This would support the findings, as service users reported perceiving change more as a result of the family’s influence as opposed to the clinician’s.

There are difficulties associated with the parent satisfaction questionnaire used. Stallard (1996) reported that satisfaction levels in postal surveys are usually high because there is a bias towards more favourable views of questionnaire respondents. To obtain greater variability of satisfaction reports, Stallard, (2001) suggests that qualitative methods are useful and should seek out dissatisfaction, as opposed to using quantitative measures to confirm satisfaction with current practices.

Using inadequately developed measures to obtain service user perspectives can give misleading results. Such measures may impose a form of censorship as service users are limited as to how they can express their concerns about the care they received and clinicians may develop a false impression that service users are highly satisfied with the service they received when in fact they may be discontented (Stallard, 2001). Stallard’s (1996) Parent Satisfaction questionnaire is an alternative measure which has been developed and has been indicated to possess good construct and concurrent validity and good internal reliability.

9. What were the therapist’s views/ experiences of using this model for treatment?
The qualitative data indicated that clinicians identified both positive and negative aspects of working with the model. Clinicians reflected that they had experienced a sense of enhanced collaboration with the service user, suggesting that this primary aim of the model had been achieved. The observation that the admission procedure seemed overly complex and inequitable, indicated that this is an area of concern for clinicians. This could be addressed through discussions with clinicians, referrers and service users, to identify how the admissions procedure could be simplified. In line with NSF guidelines it is indicated that service users should also be offered a choice as to what psychological services feel most appropriate (NSF, 2004).

It was recognised that the method of data collection used for the qualitative analysis would not produce a very rich source of data. This method was chosen to maximise response rates from clinicians to allow for the identification of basic underlying themes between clinicians. It would have been useful to interview staff individually using a semi-structured interview, which would have allowed for content analysis or IPA (Boyatzis, 1998). Had more data been collected it would have been useful to have had more than one researcher to audit the themes identified and to have a ‘blinded’ researcher match a range of unlabelled quotations to their corresponding themes (Barker, Pistrang, & Elliott, 2002).

10. What were the difficulties experienced by the administration staff, in supporting this model?

In terms of administrative support, the qualitative data indicated that closer examination of the administrative systems may be beneficial to reduce confusion in filing documents between psychology and psychiatry departments.

General Discussion.

Diversity
The national statistics for ethnicity mix for the region is 96.13% white, 0.99% mixed, 1.38% Asian, 0.58% black, 0.91% Chinese or other ethnic group (Department of Health, 1991). This suggests that for the data collected, ethnic minority groups were overrepresented which may be due to greater economic deprivation of ethnic minority groups, this being associated with increased mental health needs (Department of Health, 2005).

**Data collection/ recording**

There are limitations with the way data was recorded. The fact that clinicians were only able to code a single description for outcome and reason for closure categories is open to criticism. The codes may be regarded as a fairly simplistic way of attempting to judge the outcome of a consultation, it may not, for example, adequately describe a situation where certain aspects of a problem improved whilst other aspects deteriorated. It is a fairly arbitrary and subjective method for rating improvements and the validity may be questioned.

The coding criteria for outcome is confusing, for terms such as ‘Assessment/opinion only,’ provides little information, as the 2+1 model is in essence a form of assessment/opinion, therefore the difference regarding sessions for which the outcome was recorded as ‘assessment/opinion only,’ is not clear.

Similarly, it is not known under what circumstances the family chose to end the consultation and under what circumstances professionals closed the case against the parent’s wishes. The simplistic outcome categories used suggest that the service is not developing a full understanding of the experience of its service users.

The audit is limited due the amount of data missing to be able to make meaningful analysis, results may be biased and are underpowered for statistical analysis. In particular this has limited the investigation of project aims 7 and 8. Future
audits may acquire a richer source of information by directly accessing service user files as opposed to having clinicians’ code information.

Measuring outcome

The model judges a consultation to be successful if the service user experiences a sense of promise or hope (Heywood et al., 2001), but it is not clear if a sense of promise or hope is associated with positive maintained change. It is suggested that more factors relating to outcome need to be considered to assess outcome. It seems that there is balance to be had between providing measures detailed and long enough to have a valid understanding of the difficulty without being excessive to put off the parent/children or teacher from completing (Waldron et al., 2002). Rather than providing an overall measure of functioning, which covers a large number of variables in little detail, it may be beneficial to administer more specific measures relating directly to the children’s primary difficulties e.g. anxiety, behavioural problems, enuresis etc.

Theoretical basis of the model

It is implied that with the 2+1 model, clinicians do not work within the restrictive confines found with other interventions, which may impose diagnoses, formulations or expectations for intervention (Heywood et al., 2003). However, it may be criticised that the 2+1 model imposes its own set of expectations upon a family. The model requires a family to have a good understanding of what might be causing their difficulties, why they arose, how they are being maintained and what would help. It seems that the model places the majority of the responsibility for change onto the family. There is no research to indicate what variables may influence the outcome of a family receiving this intervention.
In terms of the parent satisfaction questionnaires returned, suggesting that the majority of parents did perceive that they had been responsible for change, this may indicate that the model is achieving one of its goals. However, as discussed there are difficulties associated with the validity of the satisfaction questionnaire used and thus interpreting this data.

The model indicates that those users who are identified as having significant health needs may proceed to receive psychological therapy. However, it is not defined what is considered to be a significant health need and it is not clear if this category is limited to those at risk of some form of physical harm. The equity of providing psychological therapies only to those identified as having ‘significant’ health needs, may be questioned. If a family can receive psychological input at an early stage of a difficulty, then this is likely to increase the chance of preventing the problem from continuing into adult life and affecting the next generation (NSF, 2004).

It appears that there is nothing new in the therapeutic stance of the 2+1 model, which is not already inherent in other traditional therapies, i.e. forming an alliance. The NSF (2004) identifies that “The process of ‘engagement’ and establishing a trusting therapeutic relationship can be a necessary prelude to a treatment intervention and may take some time.”

It may be criticised that underpinning theoretical aspects of the 2+1 model are based on observations made by clinicians (Street et al., 1991; Wolberg, 1980) that have no empirical support. For example the ideology of the length of the gap between sessions and the content of session material which focuses on aspects such as the referral pathway have no empirical support for their therapeutic benefit. It is therefore questionable how this model of consultation fits in with the NSF guidelines (2004)
that “All children, young people and their families have access to mental health care based upon the best available evidence.”

There is still clearly a need for further investigation into the effectiveness and efficacy of the 2+1 model of intervention. It could be provided by a combination of parent satisfaction reports, qualitative interviews with clinicians and service users, as well as quantitative standardised measures.

With the government putting pressure on services to take into account service user views, CAMHS may face a dilemma between using ‘gold standard’ evidence based models of practice and meeting service user expectations (Wheeler, 2001). Wheeler (2001) suggests that clinicians tend to use models according to preference, which services adopt before rigorous research confirms their efficacy. With the observation that within mental health services there are limited resources and an increasing demand for services, the two plus one model of consultation may seem like an appealing model to adopt, but the limited evidence to support its efficacy makes it difficult to justify over other psychological interventions, for example parent training programmes, cognitive therapy and family therapy, which are grounded in an extensive evidence base (Carr, 2000).

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Table 1: Primary presenting difficulties

<table>
<thead>
<tr>
<th>Difficulty description</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tantrums/outbursts</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>School discipline problem</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>School refusal/phobia</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Bullying/fighting peers</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Cruelty/Brutality</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Aggressive behaviour</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Non-compliance at home</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Attention problems</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Irritability/moodiness</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Mood swings</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>General Anxiety</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Relationship difficult involving parent(s)/carers(s)</td>
<td>3</td>
<td>7.1</td>
</tr>
<tr>
<td>General Family relationship problems</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Relationship difficulty with peers</td>
<td>2</td>
<td>4.8</td>
</tr>
<tr>
<td>Marital difficulties</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Referrer concern but no clinical abnormality</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>85.7</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td>14.3</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>100.0</td>
</tr>
</tbody>
</table>
A Clinical Audit of the 2+1 Model of Brief Consultation in a CAMHS

117 service users referred to the 2+1 model of consultation

82 (70%) services users opted in.

35 (30%) service users did not opt in.

Did not attend any appointment:

Total = 12 (14.5%)

1st Appointment waiting list time:

Appointment within 4 weeks: Total = 0
Appointment within 4-10 weeks: Total = 4
Appointment within 11-13 weeks: Total = 3
Appointment within 14-16 weeks: Total = 4
Data missing: 1

Attended less than 3 sessions:

Attended 1 session: Total = 19 (23.2%)
Attended 2 sessions: Total = 10 (12.2%)

Attended 3 sessions (2+1 model):

Total = 13 (15.9%)

Attended more than 3 sessions:

Attended 10 or more sessions: Total = 1 (1.2%)
Attended 4-9 sessions: Total = 13 (15.9%)
Data missing: Total = 1 (1.2%)

Reason for closure:

Closed by mutual consent/assessment complete: Total = 10
Lapsed following 1st appointment: Total = 10
Lapsed after 2nd appointment or later contact: Total = 1
Closed on family initiative: Total = 3
Professional close - overrides carers wishes: Total = 3
No longer 2+1: 2

Reason for closure:

Inappropriate referral: Total = 1
Closed by mutual consent/assessment complete: Total = 8
Closed on family initiative: Total = 1
Inappropriate referral: Total = 1
Professional close - overrides carers wishes: Total = 1
Data missing: Total = 4

Reason for closure:

Closed by mutual consent/assessment complete: Total = 10
Lapsed following 1st appointment: Total = 9
Lapsed after 2nd appointment or later contact: Total = 11
Case still open: Total = 1
Data missing: Total = 2

Outcome:

Problem partly resolved: Total = 2
Problem largely resolved: Total = 3
Problem(s) partly resolved: Total = 5
Problem the same: Total = 3
Assessment/opinion only: Total = 2
No longer 2+1: 2
Unknown: Total = 9

Outcome:

Problem(s) resolved: Total = 1
Problem(s) largely resolved: Total = 4
Problem(s) partly resolved: Total = 1
Problem the same: Total = 1
Referred to psychiatry: Total = 1
No longer 2+1: 5
Unknown: Total = 5

Outcome:

Problem(s) resolved: Total = 1
Problem largely resolved: Total = 4
Problem(s) partly resolved: Total = 1
Problem the same: Total = 1
Case no longer 2+1: Total = 8
Unknown outcome: Total = 1

Figure 1: Flow chart
Table 2: SDQ Scores for service users who attended between one and three sessions of consultation

<table>
<thead>
<tr>
<th>Pre SDQ Scores</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Post SDQ Scores</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDQ total</td>
<td>37</td>
<td>19.8</td>
<td>6.9</td>
<td>SDQ total</td>
<td>8</td>
<td>14.6</td>
<td>9.6</td>
</tr>
<tr>
<td>Prosocial subscale</td>
<td>37</td>
<td>5.7</td>
<td>2.9</td>
<td>Prosocial subscale</td>
<td>8</td>
<td>7.1</td>
<td>3.2</td>
</tr>
<tr>
<td>Conduct problems subscale</td>
<td>37</td>
<td>4.8</td>
<td>2.9</td>
<td>Conduct problems subscale</td>
<td>8</td>
<td>2.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Emotional problems subscale</td>
<td>37</td>
<td>5.1</td>
<td>3.1</td>
<td>Emotional problems subscale</td>
<td>8</td>
<td>2.8</td>
<td>3.4</td>
</tr>
<tr>
<td>Hyperactivity subscale</td>
<td>37</td>
<td>6.1</td>
<td>3.0</td>
<td>Hyperactivity subscale</td>
<td>8</td>
<td>5.0</td>
<td>3.3</td>
</tr>
<tr>
<td>Peer problems subscale</td>
<td>37</td>
<td>3.7</td>
<td>2.2</td>
<td>Peer problems subscale</td>
<td>8</td>
<td>3.8</td>
<td>2.7</td>
</tr>
</tbody>
</table>