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**Child and Adolescent Mental Health Service provision:  
From group treatments for emerging personality  
disorders to clinician perspectives on implementing  
national referral criteria**

**Vera Elders**



**THE UNIVERSITY  
*of* EDINBURGH**

**Thesis submission for the degree of  
Doctor of Clinical Psychology**

**March 2017**

## Declaration of own work

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**Name:** Vera Elders

**Title of Work:** Child and adolescent mental health service provision: From group treatments for emerging personality disorders to clinician perspectives on implementing national referral criteria

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*“Lang gewacht,  
stil gezwegen.*

*Nooit gedacht,  
toch gekregen”*

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## 1. Thesis Abstract

**Background:** During an age of fiscal constraint and increasing pressure to provide timely access to effective, efficient and evidence based care, there is an increased need for research to develop empirically based prevention and intervention strategies for complex psychological difficulties which often present during childhood and adolescence. Child and Adolescent Mental Health Services (CAMHS) are under significant pressure to deliver timely access to services, with demand frequently outstripping capacity to deliver. These challenges have highlighted the need for services to ensure that planning supports continued improvement in quality and delivers the best possible outcomes for service users.

**Systematic Review:** A systematic review of the literature on the efficacy of group based interventions for adolescents with features or a diagnosis of Borderline Personality Disorder (BPD) was conducted. Seven articles met the inclusion criteria and underwent detailed quality analysis. All included studies reported a significant improvement in psychopathology and symptoms of distress as well as an improvement in quality of life for both group based interventions and treatment as usual. Overall, the results hold promise for current work with adolescents with BPD and highlight the importance for future research in this developing area. However, more rigorous research is required to identify the active ingredients of treatments for BPD in adolescents with a view to developing standardised treatment protocols.

**Empirical Study:** A Delphi study was conducted to explore perceptions on the relevance, practicalities, importance and feasibility of implementing nationally agreed CAMHS referral criteria from the perspective of clinicians working in CAMHS in the North of Scotland. In addition, the study aimed to explore and gain consensus on possible factors which support clinicians working in specialist services. A three round electronic Delphi survey, an iterative structured process used to gather information and gain group consensus, was completed by twenty-eight clinicians working in CAMHS. Eight open ended questions in Round 1, were analysed using content analyses resulting in ninety-eight statements to be rated by the same group of clinicians in Round 2 and fifteen statements in Round 3. Of the ninety-eight statements, eighty-four reached consensus. Results indicate that the guidelines are viewed by many clinicians as both acceptable and important, however, implementation of the guidelines can present services with significant challenges and have highlighted the importance of services having the correct infrastructure before it is possible to implement the referral criteria in a consistent and meaningful way.

## **2. Systematic Review**

### **Title page**

Title: Group based interventions for adolescents with Borderline Personality Disorder: A systematic review.

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This journal article has been written in accordance with the author guidelines for  
Clinical  
Psychology and Psychotherapy (for author guidelines see Appendix A)

## 2.1 Abstract

During an age of fiscal constraint and increasing pressure to provide timely access to effective, efficient and evidence based care, there is an increased need for research to develop empirically based prevention and intervention for psychological disorders in adolescents. Systematic research on the efficacy of time-limited, group based therapies for adolescents with symptoms of BPD however, is currently lacking. Given the possible long term adverse sequelae which may arise as a result of emerging personality disorders in adolescents there is a clear need for effective early intervention programmes which are accessible to adolescents. Such programmes could, conceivably, reduce borderline personality disorder (BPD) symptoms and ameliorate poor psychological functioning often associated with adults with BPD. In a systematic search of the literature using five electronic databases, studies investigating the efficacy of group based interventions for adolescents with features or a diagnosis of BPD was conducted. Seven articles met the inclusion criteria and underwent detailed quality analysis based on existing guidelines. Although results have to be interpreted with caution due to the heterogeneity of the treatment protocols, the identified studies indicated a reduction in psychopathology and symptoms of distress and improved quality of life for all included treatments including treatment as usual. Overall, the results hold promise for future work with adolescents with BPD and highlight the importance for future high quality research in this developing area. In particular, more rigorous research is required to identify the active ingredients of treatments for BPD in adolescents with a view to developing standardised treatment protocols.

### **Key Practitioner message:**

- The review indicates that each treatment protocol including treatment as usual or enhanced usual care resulted in an improvement in symptoms.
- Treatments for BPD in adolescents appear to be both efficacious and feasible and highlight the importance of providing treatment for adolescents.
- Further randomised controlled trials investigating the effectiveness of treatment programmes for adolescents are required.
- Insufficient evidence currently exists to determine whether group based interventions result in augmented treatment effects.

**Keywords:** Borderline Personality Disorder, Adolescents, Group interventions, Review

## 2.2 Introduction

During an age of fiscal constraint and increasing pressure to provide timely access to effective, efficient and evidence based care, there is an increased need for research to develop empirically based prevention and intervention for psychological disorders in adolescents. Adolescence is regarded as a process that is initiated at puberty and concludes when adult roles are adopted (WHO, 2014). It is characterised by a period of physical, behavioural, cognitive, social, emotional and psychological changes. Although many teenagers successfully navigate this period of dramatic change, adolescence also marks a time of increased incidence of several mental health problems such as anxiety, emotional distress and behavioural difficulties (Costello, Mustillo, Erkanli, & Keele, 2003; Paus, Keshavan, & Giedd, 2010). It is also a time during which many severe and enduring mental health problems such as bipolar affective disorder, psychosis, eating disorders, personality disorders and mood disorders can emerge (Paus et al., 2010). If left untreated, these difficulties have the potential to exacerbate and manifest themselves throughout adolescence and into adulthood.

Borderline personality disorder (BPD) is a severe and complex disorder that has been consistently linked to low quality of life, increased functional impairments, elevated risk of suicidality and an increased likelihood of developing Axis-I disorders (Beck et al., 2016; Chanen & Kaess, 2012; Fonagy et al., 2015; Miller, Muehlenkamp, & Jacobson, 2013). Aetiological theories of BPD have suggested that it is multifactorial and includes emotional vulnerabilities, genetic disposition, invalidating environments, neurobiological deficits and social-cognitive difficulties (Beck et al., 2016; Courtney-Seidler, Klein, & Miller, 2013). Applying a diagnosis of BPD to adolescents, who are still in the process of forming their personalities, has remained a controversial issue. Despite past reluctance to diagnose BPD in adolescence, the past two decades have seen a rapid increase in evidence in support of clinicians diagnosing BPD before eighteen years of age (Beck et al., 2016; Chanen, 2015; Miller et al., 2013) and has led to the diagnosis of BPD in young people being integrated into the Diagnostic and Statistical Manual of Mental Disorders,

Fifth Edition (DSM-5; American Psychiatric Association, 2013). A recent review of the literature by Chanen (2015) concluded that BPD in young people has distinct similarities to BPD in adults with regards to its structure, phenomenology, stability and validity (Chanen, 2015).

Prevalence rates of emerging personality disorders in adolescents have been estimated in the community from 3% up to 14% (Courtney-Seidler et al., 2013). Estimates for clinical samples range from 11% to 21.8% in outpatient populations with inpatient estimates ranging as high as 49% (Feenstra & Hutsebaut, 2014). It has been consistently reported that adolescents with personality disorders are at an increased risk of completed suicide compared to adolescents with Axis-I disorders (Courtney-Seidler et al., 2013; Feenstra & Hutsebaut, 2014; McMMain, 2015). Adolescents with personality disorders have also been found to experience increased problems at school, behavioural difficulties, engagement in substance abuse and risky behaviours and are more likely to develop co-morbid Axis-I disorders putting them at an increased risk of developing severe and enduring difficulties throughout adulthood (Courtney-Seidler et al., 2013; Feenstra & Hutsebaut, 2014). It has been reported that adolescents with borderline personality disorder tend to present at both inpatient and outpatient services more frequently compared with other personality disorders often resulting in costly health service use (Feenstra et al., 2012). Given the possible long term adverse sequelae which may arise as a result of emerging personality disorders in adolescents such as psychosocial dysfunction, poor psychopathological outcomes including an increased possibility of a diagnosis of BPD in adulthood as well as an increased risk of Axis I disorders and reduced quality of life; it is important for early identification and diagnosis as well as early and effective treatment programs to be developed in order to prevent entrenched patterns of functional impairment and possible iatrogenic complications (Chanen, Jackson, et al., 2008). Despite the increasing body of research and evidence in support of diagnosing personality disorders in adolescents and young people, relatively few studies on treatment for BPD in adolescents exist. Furthermore, despite the high prevalence and potential for long term adverse consequences of BPD symptoms, relatively few

treatment protocols have been developed, evaluated and validated for adolescents.

Following the publication of Marsha Linehan's work on the effectiveness of Dialectical Behaviour Therapy (DBT) in treating BPD in the early nineties (Linehan et al., 1999), an array of studies have emerged presenting empirically supported therapies to treat BPD including Mentalisation-Based therapy (MBT), Cognitive therapy, Systems Training for Emotional Predictability and Problem Solving (STEPPS), Schema Therapy, Dialectical Behaviour Therapy (DBT), Transference Focussed Therapy and psychiatric management (McMain, 2015; NICE, 2009). Although this area of research has led to significant advances in knowledge and understanding of BPD and the delivery of evidence based treatments in adults, validated therapies for adolescents remain in a relative stage of infancy. There is a need for effective interventions for adolescents which take into account the differences in the cognitive abilities and learning styles and age and stage of development of adolescents as well as their systemic context.

Although many structured and manualised treatments for Axis-I disorders have been successfully adapted for adolescents, very few controlled studies investigating the efficacy of adapted treatments for BPD in adolescents exist. Several small, uncontrolled studies on the feasibility and efficacy of adapted DBT for suicidal and self-harming behaviour in adolescents have indicated positive outcomes for DBT for adolescents (DBT-A) (Fleischhaker et al., 2011; James et al., 2014; Rathus & Miller, 2002). Chanen et al (2008) were the first to publish a randomised trial on the long term effects of Cognitive Analytic Therapy (CAT) compared to good clinical care for adolescents with BPD. Although no significant differences were found between the two groups at twenty-four months follow-up, a faster rate of symptomatic improvement was noted for the CAT group (Chanen et al., 2008). In contrast, a randomised controlled trial by Rossouw and Fonagy (2012) reported a positive outcome for their adaptation of MBT for adolescents (MBT-A). The results indicated that MBT-A was more effective in reducing self-harming behaviours and depression compared to treatment as usual (TAU) (Rossouw & Fonagy, 2012).

Whilst there is modest evidence for the effectiveness of DBT-A and MBT-A, these treatment modalities traditionally include both individual and group based therapy, resulting in a relatively resource demanding treatment package which may impede implementation across a wide range of settings and thus limit access to effective psychotherapies in some settings. Research into the effectiveness of individual compared to group therapy, or augmenting individual therapy with group therapy however, remains sparse. Indeed, there may be some advantages to group based therapy in the treatment of BPD in adolescents as outlined by Karterud (2012), who proposed that individual therapy may result in intense attachment patterns being activated alongside transference and counter transference reactions which may be difficult for the adolescent to endure. In addition, Karterud proposed that within a group setting, there is the potential for such interpersonal processes to be spread across different group members thereby reducing the intensity of the experience. As interpersonal challenges naturally occur within a group, this also provides the opportunity to explore and work on these experiences in vivo. Furthermore, as adolescents tend to be more focussed on their peers, they may be more receptive to feedback from group members than from parents, caregivers or health professionals (Karterud, 2012; Karterud & Bateman, 2011; Roelofs et al., 2016). As problems with interpersonal functioning is often a central feature of BPD, group therapy may offer direct opportunities to improve interpersonal functioning that cannot be provided through individual therapy. Both MBT and Schema therapy have advocated the use of group based therapies to support group members to mentalise or work on their schemas in vivo. As many adolescents are still part of a family system, consideration should also be given to the importance of including parents or caregivers in the treatment of BPD in adolescence. Although there may be several benefits of group based therapy, a group environment may not be suitable for all young people. A group may provide an increased chance of personality clashes which may require careful consideration from group leaders to ensure that the therapeutic relationship between the group members is not lost. Furthermore, some individuals may find the experience of a group too overwhelming and disengage from therapy. In larger groups trust may be more difficult to attain. In addition, there may be an

increased risk of confidentiality breaches as group members are not bound by a professional obligation to maintain confidentiality. Nevertheless, group based therapies for BPD may provide unique intervention opportunities that are not possible in individual therapy.

Despite reasonable evidence for the modification of MBT, CAT, and DBT, these interventions are time and labour intensive and require extensive training for therapists. Systematic research on the efficacy of time-limited, group based therapies for adolescents with symptoms of BPD however, is currently lacking. Given the high prevalence rate of BPD in adolescents as well as the serious long-term consequences, there is a clear need for effective early intervention programmes which are accessible to adolescents. Such programmes could, conceivably, reduce BPD symptoms and ameliorate poor psychological functioning often associated with adults with BPD. The following review therefore aims to summarise and evaluate the current published literature on group based interventions for adolescents and young people with symptoms (or a diagnosis) of emerging Borderline Personality Disorder with a view to provide practical recommendations for clinical practice and research.

## **2.3 Methods**

### *2.3.1 Search Strategy*

Articles for this review were identified by conducting a systematic search of the following databases: Medline, Embase, PsycINFO, CINAHL, Psychology and Behavioural Sciences. Searches were limited from January 1990 to August 2016 with all initial searches carried out by the first author. The search strategy included the following terms in combination with the Boolean operator 'AND'

1. Borderline personality disorder 'OR' Emerging borderline personality disorder 'OR' Emotional Dysregulation
2. Adolescen\* 'OR' Young People 'OR' Youth 'OR' Teen 'OR' Teen 'OR' Juvenile 'OR' Limit data to [specific age range].
3. Group Therapy 'OR' Psychotherapy Group 'OR' Group 'OR' Group treatment

Truncations [\*] were utilised to capture all relevant terms starting with the stem term (i.e. adolescen\*, may capture adolescents, adolescence, adolescent). All abstracts identified through the initial search were reviewed by the author and inclusion and exclusion criteria were applied to determine their eligibility for inclusion. The reference lists for all relevant studies were also scanned to identify any additional studies for inclusion. In addition, all citations for included studies were checked through Google Scholar to identify any new literature. Following the initial screen of all identified studies, all remaining papers were read in full and included if they met inclusion and exclusion criteria (see Figure 1.1. for full process).

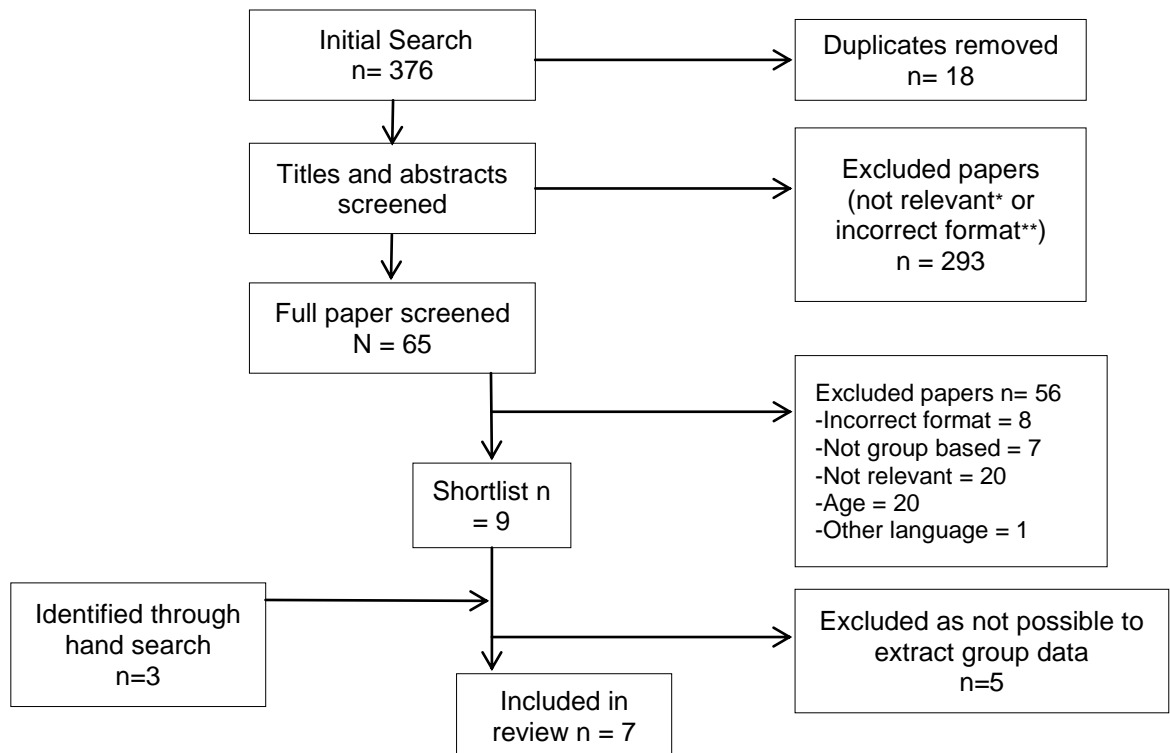
#### Inclusion criteria

1. Participants aged between 13-18 years (in line with the age range set for 'Adolescents' in the included databases), or studies with a mean age between 13-18 years or a range of one year more or less than this (e.g. 12 to 18 or 12 to 19).
2. Studies which include a group based form of psychological therapy or intervention or identifiable data from a group based intervention that could be extracted from the overall intervention.
3. Studies which include an assessment of Borderline Personality Disorder or features of Borderline Personality Disorder measured through a diagnostic interview or indicating at least two criteria of the DSM-IV / V.
4. Studies in English or Dutch language as main author is fluent in both English and Dutch.

#### Exclusion criteria

1. Studies that did not contain a group based intervention
2. Unpublished dissertations
3. Book chapters, conference abstracts or theoretical papers

**Figure 1.** Flow Chart of selection process for included papers



\*Papers that did not relate to the primary question of the review were marked as *Not Relevant*. \*\*Papers that did not meet the correct format (i.e. conference abstract, unpublished thesis) were marked as *Incorrect Format*.

### 2.3.2 Data Extraction and Quality Rating

Papers that met all inclusion criteria were examined and relevant data was extracted by the first author using a data extraction form based on the Downs and Black Quality Appraisal Checklist (Downs & Black, 1998). This included study aims and design, type of treatment intervention, sample size, length of treatment, age range, outcome measures used, and effect sizes. All studies were subsequently rated using an adapted form of the Downs and Black Quality Appraisal Checklist. This was used as it was developed specifically to apply to both randomised and non-randomised studies. The criteria consist of twenty-seven items grouped into five subscales consisting of: Reporting (10), External validity (3), Internal validity – bias (7), Internal validity – confounding (6), and Power (1). Twenty five items have a score of 1 or 0 (Yes or No / unable to determine), one item on confounding can be scored from 0-2 (yes, partially or no), with the final item on power being scored from 0-5 (based on size of

smallest intervention group). It is therefore possible to calculate an overall quality score for each paper between 0-32 which facilitates the systematic comparison of methodology across included studies. Downs and Black (1998) published a mean score of 14 for randomized and 11.7 for non-randomized studies (Downs & Black, 1998). It should be noted that the use of a summary scores has been criticised as an estimation of the degree of bias is not always reported (Jarde, 2013). Summary scores do not provide an empirical basis for the different weights given to each individual item on the checklist and therefore run the risk of giving more weight to reporting items rather than study design and methodology resulting in a higher overall score.

As many of the studies included in the review did not involve a control group, some of the items on the Downs and Black checklist were not applicable. Where items relied on having a control group, a 'not applicable' response option was added (n/a = 0). The item for power was changed to assess whether the study had made reference to a power analysis or reported effect sizes (Yes = 1, No =0), thus changing the overall highest possible score to 28. Where effect sizes were not reported for the primary outcome measures, these were calculated using G\* power (Faul, Erdfelder, Lang, & Buchner, 2007).

For the current review, all papers were scored by the author and a second reviewer on each checklist item. The inter-rater reliability for the two rates was  $k=0.82$ ,  $p<0.001$  indicating an 'almost perfect' reliability (Landis & Koch, 1977). Any discrepancies were discussed by the two reviewers and resolved by consensus whereby a 100% agreement was reached for each item.

## **2.4 Results**

### *2.4.1 Searches*

From the five databases searched, a possible 376 potential papers were identified. A flow chart of the subsequent study selection is displayed in Figure 1.1. All duplicate papers were removed resulting in 358 papers for which the titles and abstracts were screened. A further 293 papers were removed due to the papers not being relevant to the primary question (did not include a group

based intervention, age criteria, an assessment of BPD) or articles that were not published in a peer-reviewed journal. The full articles for the remaining sixty-five papers were screened and of these a further fifty-six papers were excluded. This left nine papers to be included in the review. After discussion with the second rater, a further five papers (Beck et al., 2016; Courtney, Flament, & D.B., 2015; Fleischhaker et al., 2011; Rathus & Miller, 2002; Tørmoen et al., 2014) were subsequently excluded as it was not possible to extract the group data from the overall study. Following a hand search of reference lists from the remaining papers, an additional three papers were identified, resulting in seven papers being included in the systematic review.

#### *2.4.2 Description of included studies*

Characteristics of the studies are summarized in Table 1. Five studies were conducted in the Netherlands, one in Denmark and one in Norway with a total of 339 participants all aged between 13 and 19 years (mean age 16.4). Samples sizes ranged from 4 to 109. Participants included were described as adolescents who were referred to child and adolescent mental health centres, community mental health care centres and specialist centres for emotional regulation problems, features of BPD or self-harming behaviour. Gender was reported for each study with 307 participants stated to be female. Ethnicity was indicated in three studies (Mehlum et al., 2014; Schuppert et al., 2009, 2012) with participants described as mainly Caucasian, native Dutch or Norwegian (81 – 95%). Adolescents with developmental disorders, learning difficulties, an IQ <80, features of psychotic disorder, conduct disorder, substance misuse or organic cerebral impairment were excluded from five studies. Bo et al. (2016) also excluded participants with a diagnosis of anorexia nervosa. Schuppert et al. (2009) did not report any explicit exclusion criteria. Only four studies included specific information on the proportion of participants who were prescribed psychotropic medication (Mehlum et al., 2014; Roelofs et al., 2016; Schuppert et al., 2009, 2012).

**Table 1.** Summary of included papers

Authors (year); Country	Participants age range (mean, SD) % Female	Aims/Design	Type of therapy	Length of group Follow up	Assessment of BPD	Outcome measures	Relevant findings Effect sizes (Cohen's d) of primary outcome measures
Bo et al (2016) Denmark	13-17 years (16.4, 0.9) n=25 (100% F)	Evaluation of group format MBT-A for treatment of borderline traits in adolescents  pre/post (no control)	MBT-A	1 year structured psychotherapeutic program (34 sessions of group therapy)  none	At least 4/9 DSM-5 BPD criteria	BPFS-C, YSR, BDI-Y, RTSHI-A, IPPA-R, RFQ-Y	Reduction in BPFS-C, improvement for YSR, RFQ-Y. Symptomatic improvement in borderline traits, depression, peer-attachment, parent attachment, mentalising, self-harm. d=0.14-1.52
Feenstra et al (2014) The Netherlands	14-19 years (16.73, 1.33) n=70 (82.9% F)	Investigation of long term outcome of IPA  Descriptive pre/ post study (no control)	IPA	Minimum 6 weeks up to 24 months  none	SCID-II	ADIS-C, SCID-I, SCID-II, BSI, SIPP-118, DEQ-A	Improvement on all measures. Significantly less symptom severity and better personality functioning at 24 months. d= 0.18 – 0.80
Laurensen et al (2014) The Netherlands	14-18 years (16.5, 1.57) n=11 (100% F)	Naturalistic pilot study investigating effectiveness and feasibility of inpatient MBT-A  pre/post (no control)	MBT-A	11 months (range= 6-12 months)  None	At least 2 out of 9 DSM-IV criteria for BPD measured by SCID-II	ADIS-C, SCID-I, SCID-II, BSI, SIPP-118, EUROQoL, EQ-5D	Significant decreases in BPD symptoms and improvement in personality functioning and QoL at 1 year after start of treatment.  d = 0.58 – 1.46
Mehlum et al (2014) Norway	12-18 years (15.9, 1.4) n=77 (88.3% F) DBT-A n= 39 EUC n= 38	Single blind RCT comparing DBT-A with EUC.	DBT-A	19 weeks  None	At least 2 criteria of DSM-IV BPD + self-destructive OR at least 1 criteria of DSM-IV and at least 2 sub-threshold level criteria	Self-reported self-harm episodes, SIQ-JR, SMFQ, MADRS, BHS, BSL	DBT superior to EUC in reducing frequency of self-harm, suicidal ideation & depressive symptoms. d=0.86-0.97 DBT-A d=0.16-0.41 EUC

Authors (year); Country	Participants age range (mean, SD) % Female	Aims/Design	Type of therapy	Length of group Follow up	Assessment of BPD	Outcome measures	Relevant findings Effect sizes (Cohen's d) of primary outcome measures
Roelofs et al (2016) The Netherlands	16-18 years (17.25, 0.95) n=4 (3 F)	Naturalistic multiple case study examining applicability and effectiveness of group Schema therapy for adolescents Pre/post (no control)	Group Schema Therapy	1 year, weekly groups none	KID-SCID + psychiatric evaluation + teachers and clinical observations of MDT	KID-SCID, Kidscreen-10, SDQ, SMI-A, YSQ-A, SCI,STCRS	Improvement in QOL ratings reduction in maladaptive modes, increase in healthy modes.
Schuppert et al (2009) The Netherlands	14-19 years n=43 (88.3% F) ERT n=23 TAU n=20	Multisite study comparing ERT +TAU with TAU only for adolescents with BPD.  Pilot RCT	ERT	17 weeks (1.45 hours per week)  Two booster sessions at 6 and 12 weeks post treatment	BPDSI-IV, Mood instability plus at least 1 criteria on BPDSI-IV	BPDSI-IV, MERLC, YSR	No significant difference between groups on outcome measures. BPD symptoms decreased for both groups. d=0.16-0.67 ERT+TAU d=0.15-0.49 TAU only
Schuppert et al (2012) The Netherlands	14-19 years (15.98, 1.22) n=109 (96% F) ERT n=54 TAU n= 55	Evaluation of effectiveness of ERT compared to TAU.  RCT	ERT	17 weeks (1.45 hours per week)  Two booster sessions at 6 and 12 weeks post treatment	At least two criteria from SCID-II	SCID-II BPD, BPDSI-IV, Symptoms Checklist-90-R, YQL- subscale emotion dysregulation, MERLC, Swanson Nolan & Pelham Rating Scale.	No significant differences between groups on any measurement. Both groups showed improvement from baseline to post intervention.  d=0.51 pre-post d=0.75 Follow up

Note: BPFSC-C, Borderline Personality Features Scale for Children; YSR, The Youth Self-Report; BDI-Y, Beck Depression Inventory for Youth; RTSI-A, Risk-Taking and Self-Harm Inventory for Adolescents; IPPA-R, Inventory for Parent and Peer Attachment- Revised; RFQ-Y, Reflective Function Questionnaire for Youth; ADIS-C, Anxiety Disorders Interview Schedule for DSM-IV Child Version; BSI, Brief Symptom Inventory; SIPP-188, Severity Indices of Personality Problems; DEQ-A, Depressive Experience Questionnaire for Adolescents; EUROQoL EQ-5D, Quality of Life measure; SIQ-JR, Suicidal Ideation Questionnaire; SMFQ, Short Mood and Feelings Questionnaire; MADRS, Montgomery-Asberg Depression Rating Scale; BHS, Beck Hopelessness Scale; BSL, Borderline Symptoms List; SDQ, Strengths and Difficulties Questionnaire; SMI-A, Schema Mode Inventory; YSQ-A, Young Schema Questionnaire for Adolescents; SCI, Schema Coping Inventory; STCRS, Schema Therapy Competency Rating Scale; MERLC, The Multidimensional Emotion Regulation Locus of Control; YQL, Youth Quality of Life-Research version.

### *2.4.3 Types of group interventions*

Empirical evidence was available for five types of group based psychotherapy including Emotion Regulation Therapy (ERT) (Schuppert et al., 2009, 2012), Mentalisation Based Therapy for Adolescents (MBT-A) (Bo et al., 2016; Laurensen et al., 2014), Group Schema Therapy (Roelofs et al., 2016), Dialectical Behaviour Therapy for Adolescents (DBT-A) (Mehlum, Ramberg, Tørmoen, Haga, & Diep, 2016) and Inpatient Psychotherapy for Adolescents (IPA) (Feenstra et al., 2014). The duration of the interventions ranged from 17 weeks to 24 months.

### *2.4.4 Assessment of BPD*

The studies included reported four different methods to assess traits of borderline personality disorder in adolescents. Schuppert et al. (2009) administered parts of the Borderline Personality Severity Index-IV (BPDSI-IV) where participants had to meet the criterion for mood instability in combination with a minimum of one other BPD symptom. The BPDSI-IV is a semi-structured interview which assesses both frequency and severity of BPD symptoms during the previous three months. It contains 70 items and nine subscales which are directly related to BPD criteria as outlined by DSM-IV. The BPDSI-IV has been well validated in adults with BPD (Giesen-Bloo, Wouters, Schouten, & Arntz, 2010). Cut off scores for adolescents however, were not specified. Schuppert et al. (2012), Laurensen et al. (2014) and Feenstra (2014) administered the Structured Clinical Interview for DSM-IV for Axis I disorders (SCID-I) and set a cut off for inclusion if participants met at least two out of nine criteria. Although the SCID-I was originally developed for adults, it has been found to be acceptable for use with adolescents (Chanen, Jovev, et al., 2008). Roelofs et al. (2016) administered the Kid-SCID alongside an evaluation by a psychiatrist, clinical observations and information from teachers to inform their diagnosis of borderline personality disorder. A validation study of the Dutch version of the Kid-SCID reported internal consistency to be moderate to good (Roelofs, Muris, Braet, Arntz, & Beelen, 2015). In the study by Bo et al. (2016) all participants

were evaluated for personality pathology by experienced psychiatrists and included if found to meet at least four out of nine criteria for BPD as outlined by DSM-V. Similarly, in the study by Mehlum et al (2014) all participants were screened by a diagnostic interview carried out by experienced clinicians and participants were included if at least two criteria from the DSM-IV BPD were met as well as at least two episodes of self-harm within the previous sixteen weeks.

#### *2.4.5 Screening and Outcome Measures*

A variety of screening and outcome measures were used in the included studies. Most studies relied on self-report measures with only two studies including parent rated scales. A structured interview format for diagnosis of BPD such as the Borderline Personality Disorder Structured Interview IV for adolescents (BPDSI-IV-ado), the Structured Clinical Interview for DSM-IV Axis II Personality disorders or the Kid-SCID was used by all studies to identify traits of personality disorders. In addition, self-reported screening measures for features of personality disorders such as the Severity Indices of Personality Problems (SIPP-18), Borderline Symptom List and the Borderline Personality Features Scale for Children (BPFS-C) was also used. Three studies (Bo et al., 2016; Feenstra et al., 2014; Mehlum et al., 2014). Laurensen et al. (2014) measured distress as their primary outcome using the Brief Symptom Inventory; secondary outcome measures included severity of personality problems and quality of life as measured by SIPP-18. In addition, mood was assessed by the Anxiety Disorders Interview Schedule for DSM-IV Child Version (ADIS-C) and quality of life through self-reported ratings on the EuroQol EQ-5D. All measures were administered at baseline and at twelve months following start of treatment. Schuppert et al. (2009, 2012) measured severity of BPD symptoms as their primary outcome with the BPDSI-IV-ado. Secondary outcomes aimed to measure general psychopathology and emotional dysregulation through the Symptom Checklist-90-R, The Life Problems Inventory – Emotional Dysregulation Subscale and the Multidimensional Emotion Regulation Locus of Control and the Youth Self Report. All measures were taken at baseline and post-treatment. In addition, the Child Depression Inventory was administered to

assess mood. Roelofs et al. (2016) measured quality of life as their primary outcome using the KidScreen pre and post treatment. In addition, they measured emotional and behavioural difficulties with the Strengths and Difficulties Questionnaire (SDQ, completed by adolescents and parents). In addition, Roelofs et al (2016) investigated changes in schemas and modes through the Schema Mode Inventory (SMI), Young Schema Questionnaire - adolescents (YSQ-A) and the Schema Coping Inventory. Mehlum et al (2014) administered the Child Behaviour Checklist (completed by parents) to assess emotional and behavioural difficulties as well as the Children's Global Assessment Scale to measure global level of impairment (C-GAS). The primary outcome for their study was the number of reported self-harm episodes as well as self-reported ratings on the Suicidal Intent Scale (SIS). In addition, The Short Mood and Feelings Questionnaire (SMFQ), Beck Hopelessness Scale (BHS) and the self-report Borderline Symptom List (BSL) were measured at baseline, 9, 15 and 19 weeks. Feenstra et al.'s (2014) primary outcome measures included the BSI, SIPP-18 and the Dutch short version of Depressive Experience Questionnaire for Adolescents (DEQ-A) measured at baseline, 6, 12 and 24 months. Finally, Bo et al (2016) administered the BPFS-C, Youth Self Report and Beck Depression Inventory for Youth as the primary outcome measure to assess features of borderline personality disorder and mood at baseline and end of treatment. In addition, the study reported outcomes for Risk Taking and Self-Harm Inventory for Adolescents (RTSHI-A), Inventory of Parent and Peer Attachment (IPPA-R) and the Reflective Function Questionnaire for Young (RFQ-Y).

#### *2.4.6 Study findings*

Three studies included in the review could be classed as randomised controlled trials. The first was conducted by Mehlum et al. (2014) where seventy-seven adolescents screened for features of borderline personality disorder were randomized to receive nineteen weeks of either DBT-A consisting of weekly individual sessions, multifamily skills training, family therapy and telephone coaching or Enhanced Usual Care (EUC) which included weekly individual treatment for a minimum of nineteen weeks. DBT is a CBT based treatment that

uses change and acceptance techniques within a dialectical framework. Although originally developed for chronically suicidal adults, DBT has been adapted for adolescents to make it more developmentally appropriate by including families in the treatment, reducing the length of treatment and the number of skills taught. Following the intervention, it was reported that DBT-A group was superior with regards to reducing the frequency of self-harm, suicidal ideation and depressive symptoms with large effect sizes being reported for the DBT-A condition. Weak to moderate effect sizes were reported for the EUC condition. With regards to borderline symptoms and hopelessness, a reduction in symptoms was reported for both conditions, however there were no significant between group differences for these outcomes. A relatively good retention rate was reported, with no differences between the two conditions. It is important to note that the main difference between the two conditions was that there was no group intervention for EUC. This represents a significant difference between the conditions, however, mediator analysis of the treatment intensity (i.e. addition of a skills training group in the DBT-A condition) did not indicate that there was an association between treatment and outcomes.

Two further randomised trials conducted by Schuppert et al (2009, 2012) evaluated the effectiveness of ERT compared to TAU initially in a pilot study for which they recruited forty-three adolescents who were randomly allocated to receive either ERT + TAU or TAU only. ERT was a seventeen week manualised group training for adolescents with features of BPD which was developed as an add-on treatment to treatment as usual (TAU). In addition, two booster sessions at six and twelve weeks post-treatment were offered for the ERT condition (Schuppert et al., 2009). The treatment was developed to focus specifically on problems with emotion regulation using the structure outlined by Systems Training for Emotional Predictability and Problem Solving (STEPPS) as well as some elements from DBT skills training and Cognitive Behavioural Therapy (CBT). Clinician-rated interview scores on the BPDSI-IV were found to improve over time for both groups however, no significant differences were found for the affect regulation subscale as measured by the MERLC. With regards to the secondary outcome measures, although a trend was found for the internalising subscale of the YSR, this was not significant. Between-group

analyses on all outcome measures did not show a significant effect between the two conditions. The authors conducted an analysis of outcome measures of non-completers from their first assessment and found no significant differences between the two groups on the three primary outcome measures. A significant difference was reported for one of the secondary measures in which lower scores for internalising behaviour on the YSR was associated with a higher rate of dropout. The authors commented on the possibility that the relatively low scores on the BPDSI-IV may have left little room for improvement and thus a relatively small decrease in scores was noted. Furthermore, due to the lack of validated assessment tools for adolescents with BPD, the BPDSI-IV may not have picked up on difficulties pertinent to this age group. Finally, the authors speculated whether the lack of differences could be accounted for by the high quality of TAU in the Netherlands for adolescents with borderline personality disorder. Based on the findings of the pilot study, Schuppert et al (2012) conducted a larger study of ERT recruiting 109 adolescents with borderline traits who were randomised to receive ERT + TAU or TAU only. The adolescent adapted and validated version of the BPDSI (BPDSI-IV-ado) was administered to assess severity of borderline symptoms. The authors followed an intent-to-treat analysis and reported significant improvements on the severity of BPD symptoms, quality of life and general psychopathology across groups, however, not between groups. All three studies ensured adherence to their respective treatment models through independently rated audiotapes and reported high fidelity to the model.

The remaining studies included four non-randomised studies which did not use a control group. Feenstra et al (2014) recruited seventy adolescents who were referred to a specialist inpatient mental health care unit for complex personality pathology. All seventy participants were placed in a group of up to ten adolescents and received group psychotherapy sessions up to three times a week. IPA aims to help patients to identify and explore relational patterns through constant interaction with other adolescents within an inpatient setting. At post treatment, significant improvement on all outcome measures was reported. In particular, self-reported symptom severity was greatly reduced

alongside improvements in personality functioning twenty-four months following the start of treatment.

A study by Laurensen et al. (2014) conducted in an inpatient setting, evaluated the feasibility of adapting MBT-A for adolescents with borderline symptoms. MBT is based on psychodynamic psychotherapy as well as attachment theory. MBT aims to help patients gain insight into their own and other people's mental states (mentalising capacity), in order to help patients regulate their thoughts and feelings and promote interpersonal functioning (Bateman & Fonagy, 2001). MBT-A was developed specifically for adolescents and consists of both individual and family sessions. Laurensen et al. (2014) recruited eleven female adolescents who received four weekly group psychotherapy sessions for up to twelve months. Post treatment outcomes indicated significantly less symptomatic distress as measured by the BSI as well as improvements in personality functioning and quality of life at twelve months after the start of treatment. Due to the small sample size however, further analysis of the moderators of treatment was not possible.

Roelofs et al. (2016) recruited six participants to a naturalistic multiple case study, however, only four consented to participate in the study. They developed a Group Schema Therapy programme for adolescents (based on adult group schema therapy described by Farrell and Shaw, 2012) with personality problems. The programme consisted of weekly group sessions which lasted between six months to a year. Following a year of treatment during which the participants received weekly schema therapy group sessions and parental group meetings on a fortnightly basis, all four participants reported improvements in quality of life and a reduction in symptoms of psychopathology. In addition, all participants' self-reported scores for schemas and modes showed a positive change for dysfunctional modes. Parent rated changes were found to be more positive than those reported by the adolescents. No clinician ratings were used as part of the outcome measures to assess whether there was a reduction in borderline symptomatology. Further statistical analysis was not possible due to the design and limited sample size.

Finally, Bo et al. (2016) recruited thirty-four female adolescents to participate in a structured mentalisation-based group for one year. Only twenty-five participants completed the study and were included in the final analysis. Post treatment data showed a significant reduction in borderline personality symptoms as measured by the BPFS-C. A significant improvement in self-reported general pathology, mentalising and peer to peer attachment was also found.

#### *2.4.7 Methodological quality*

The quality assessment ratings as measured by the adapted criteria of Downs and Black (1998) are displayed in Table 2. Although the original criteria do not specify a cut-off point for low or high quality papers, a mean score of 14 for randomised and 11.7 for non-randomised studies was published by Downs and Black for their checklist (1998).

Higher scores in terms of quality were given to studies that randomised participants and included a control group (Mehlum et al., 2014; Schuppert et al., 2009, 2012). The remaining studies did not include a control group, however, they did use valid and reliable measures and all but the lowest quality rated study used semi-structured interviews to assess for features of borderline personality disorder at baseline and post treatment. As no control group was used for these studies, it was not possible to randomise participants in order to control for possible confounding variables, however baseline assessments for included participants were compared to baseline data of excluded participants in the study by Feenstra et al (2014). Despite a reported improvement in borderline symptomatology, quality of life and general psychopathology in these studies, due to the lack of control group, definitive conclusions in terms of treatment effects of the intervention cannot be reported. Furthermore, it was not possible to conduct any robust statistical analyses due to the limited sample sizes in the studies by Roelofs et al. (2016) and Laurensen et al. (2014).

The three highest rated papers could be defined as randomised controlled trials which included the use of randomisation, blinding of researchers and a control

group (Mehlum et al., 2014; Schuppert et al., 2009, 2012). Mehlum et al (2014) scored lower due to the principal confounders and patients lost to follow up not being described. It was not possible to blind participants to the intervention they received for any of the studies and adverse events were only considered by Laurensen et al. (2014). Although most studies included measures that have been validated for use with adolescents, several measures had to be translated (Bo et al., 2016; Lars Mehlum et al., 2014) and it was not always possible to determine whether the translated measures had been validated. All studies clearly described their inclusion and exclusion criteria as well as the study setting and recruitment procedure. Although six out of the seven studies reported effect sizes, more detailed statistical analysis was often not possible due to small sample sizes. The presentation of all included papers was generally good although actual probability values were not always reported in three papers (Laurensen et al., 2014; Roelofs et al., 2016; Schuppert et al., 2012).

**Table 2.** Methodological Quality of included studies

	Study Quality (0-11)	External Reliability (0-3)	Internal Reliability (0-7)	Internal Reliability-Confounding (0-6)	Power (0-1)	Total score
Bo et al (2016)	8	3	5	2	1	19
Feenstra et al (2014)	8	2	4	2	1	17
Laurensen et al (2014)	8	2	4	3	1	18
Mehlum et al (2014)	7	3	4	5	1	20
Roelofs et al (2016)	6	2	4	2	0	14
Schuppert et al (2009)	10	2	4	4	1	21
Schuppert et al (2012)	10	3	6	6	1	26

## **2.5 Discussion**

This systematic review summarises and evaluates the current published literature on group based interventions for adolescents with features or a diagnosis of Borderline Personality Disorder. The papers included highlighted that psychosocial interventions can be effective in reducing symptoms of distress and general psychopathology as well as improving quality of life for adolescents, with all papers reporting an improvement on their primary outcome measures. However, as only seven papers could be included in this review, the results have to be interpreted with caution. Although several therapeutic models indicate positive outcomes in the treatment of borderline pathology, the evidence base for group based interventions remains extremely limited and is currently insufficient to make any concrete positive or negative treatment recommendations. This is in keeping with the results of a randomised trial by Green et al. (2011) which found no significant difference between a group based intervention for adolescents presenting with repeated self-harm compared to routine care. Although no differences between treatments were reported, an overall improvement in functioning was reported across all participants (Green et al., 2011). A study by Chanen et al. (2008) comparing Cognitive Analytic Therapy (CAT) and Good Clinical Care indicated a substantial clinical improvement across groups; however they found no significant differences on the primary outcome measures between the two groups. The results of the current review indicate that intervention for adolescents with features or a diagnosis of borderline personality disorder is warranted and highlights the potential positive effects of a range of treatments as well as the beneficial effects of treatment as usual, good clinical care and enhanced clinical care. It may be that the identification and diagnosis of personality disorders alongside enhanced clinical care, could act as the first steps towards a better understanding of early intervention and ultimately provide a starting point towards developing a comprehensive treatment strategy for BPD in adolescents.

It is clear that a paucity of research exists for group based interventions for borderline personality disorder in adolescents. Indeed, a review by Chanen

(2015) outlined that to date, there appears to be more research on the etiological basis of BPD including genetics, neurobiology and a biosocial theory of BPD rather than treatment focussed research (Chanen, 2015). The small number of studies found for this review is testament to a literature base that is still in its infancy. Although the emergence of research in this area, particularly with regards to treatment (individual and group based) is encouraging and is suggestive that early diagnosis and treatment are effective, more work is required.

Whilst all studies reported an improvement for participants with regards to their primary outcome measures, the effect sizes for the reported mean differences on outcomes measures ranged from small to large. It is important to note that although all included studies reported an improvement, not all studies were able to comment on whether the changes represented a clinically significant change. Five studies included an estimate of the number of participants who fell below the clinical cut-off for borderline personality disorder or moved within a normative range, ranging from 18% to 53%. It would appear that these results are consistent with those reported in adult BPD literature which has indicated that recovery from BPD in adulthood may require intensive, structured and long term evidence based treatments specifically developed for adults with BPD (Giesen-Bloo et al., 2006; Schuppert et al., 2012).

#### *Implications 2.5.1*

Whilst the review has aimed to synthesise the available data, it is important to note that there is a wide variation of treatments within the review. There was no consistency in the lengths of treatment, the theoretical basis for interventions or the study settings as well as a lack of comparison between treatments or the use of a control group. The majority of studies did however ensure fidelity to their treatment through independently rated audiotapes. In addition, all therapists delivering treatment received treatment specific supervision for the duration of the interventions. Treatment duration varied from seventeen weeks to twenty-four months and was delivered on an outpatient basis for five of the included studies (Laurensen et al., 2014; Mehlum et al., 2016; Roelofs et al.,

2016; Schuppert et al., 2009, 2012) whilst two were delivered on an inpatient basis (Bo et al., 2016; Feenstra et al., 2014). Furthermore, there was great variability in the amount of additional input that was provided for participants across studies. Whereas in the study by Schuppert et al (2012) participants were free to use mental health services (in addition to being offered ERT or TAU) and Bo et al (2016) who offered an introduction to MBT for parents alongside the group, the other four studies included in this review offered individual sessions as well as family sessions as part of the overall intervention. Given the variability in the amount of treatment received, alongside the lack of control group in four of the included studies, it was not possible to determine whether the group component was indeed the 'active ingredient' with regards to reported improvements on the primary outcome measures. Whilst the included studies have ostensibly reported group based interventions, it is important to note that the majority of studies have offered far more comprehensive treatment packages, the impact of which has not always been fully considered in the results. Nevertheless, whilst it remains unclear whether a group component adds particular benefits as outlined by Karterud (2012), it is important to note that no adverse effects were reported in the included studies and both individual and group based treatments resulted in significant improvements.

Although the scores for methodological quality of the majority of the included studies fell above 70% of the total available score, the heterogeneity of the data, particularly with regards to the differences in the assessment of BPD in adolescents and the treatments used, makes it difficult to draw any strong conclusions regarding their findings. As some studies used a naturalistic design to explore the effects of the treatment in an ecologically valid way, while important for the generalisability in terms of clinically relevant findings, it limits the possibility of replication and does not allow for the treatment to be assessed in a controlled manner. Whilst most studies used a structured clinical interview for the assessment of BPD as part of their inclusion criteria, no consistent or comparable inclusion or exclusion criteria were used across the studies. Given that the research area is still in an early stage, replication of design will be an important part of determining the validity and reliability of effects. As almost no

adjustments were made in the included studies to control for potentially confounding effects, further validation of findings in a controlled way is required.

Furthermore, although the studies by Schuppert et al (2009, 2012) and Mehlum et al (2014) used EUC and TAU, it cannot be assumed that these control groups are comparable as neither were manualised nor checked for treatment fidelity. It was also not possible to fully determine whether the samples of participants in the included studies are comparable as participants were recruited at different phases of illness with some presenting with early stage whilst others were included with an enduring disorder. In addition, as the studies applied different inclusion threshold criteria for symptoms of, or a diagnosis, of BPD the data is likely to reflect a heterogeneous sample. For instance, whilst some studies focused on specific features of BPD as measured by the BPDSI-IV (Feenstra et al., 2014; Schuppert et al., 2009, 2012), other studies explored frequency of suicidal and self-harming behaviour (Mehlum et al., 2014). It cannot be assumed that an adolescent with one or two features of BPD would necessarily require the same level of input as an adolescent who meets the criteria for a diagnosis as outlined by DSM-5. Given the heterogeneous sample and the differences in treatment offered it is not currently possible to determine whether any improvement in BPD symptoms can be attributed to the group based aspects of these interventions. Nevertheless, NICE have recommended that people with BPD are offered multi-modal interventions even though it may be difficult to disentangle which elements of these interventions ultimately lead to positive outcomes (Omar, Tejerina-Arreal, & Crawford, 2014)

It is important to note that many patients did not consent to take part in the study and attrition rates remain high (between 26-58%) in most studies. Schuppert et al (2012) and Laurensen et al (2014) reported relatively low attrition rates of 19% and 15% respectively. Schulz and Grimes (2002) have considered that a loss of greater than 20% of participants in randomised trials is likely to pose a threat to a study's validity and the findings of the other included studies therefore need to be interpreted with caution.

With regard to outcome measures, the review identified four outcome measures that were used by more than one study however; the methodologies of the studies were found to be too heterogeneous in terms of intervention type, psychotherapeutic orientation, whether a control group was used, treatment intensity and duration to draw any conclusions about the overall utility, reliability and validity of these measures. Indeed, few measures included in the studies used outcome measures which have demonstrated psychometric properties in adolescents with BPD. Nearly all of the included studies relied primarily on self-report measures and the BPFSC (Crick, Murray-Close, & Woods, 2005) is currently the only published self-report measure for assessment of BPD features in adolescents. Only Bo et al's (2016) paper describes the use of this measure. Given the wide range of measures used, it was not possible to compare the primary outcomes of the studies, although some comparisons could be made when grouping the outcome measures to their relative domains such as improvements in symptoms of distress, general psychopathology, quality of life and whether participants moved from a clinical to a normative range.

Whilst all included studies included adolescents who met the criteria for features or a full diagnosis of BPD as measured by a structured clinical interview, there was no consistency across the studies in how these criteria were applied. By including both first presentation and more enduring presentations of BPD, this could potentially introduce a confounding variable of potentially increasingly entrenched interpersonal difficulties, and it was not possible to measure whether a group based intervention might be particularly helpful for certain presentations or whether it would have utility within a stepped-care treatment model. Although research into treatments for adolescent BPD is still in its infancy, developing research may wish to focus on different phases of illness which may provide important insights for possible BPD pathways within healthcare settings. In addition, in order to determine optimal duration, frequency and intensity of treatments, further randomised controlled trials are required that include manualised treatment and control conditions to ensure treatment fidelity. Furthermore, studies which use validated measures, including self-reported measures as well as parent and

clinician rated scales in combination with further qualitative feedback from clinicians, parents or teachers to support the outcomes are required.

### *Future Directions 2.5.2*

In order to further clarify our understanding of possible evidence based interventions for BPD in adolescents, more high quality studies are needed with a particular focus on rigorous study designs and the use of standardised measures for BPD in adolescents. It was not possible to draw any definitive conclusions regarding possible long-term prognosis of group based interventions for adolescent BPD as the studies included in this review did not report beyond six weeks post treatment. Future research should aim to include longitudinal research to measure the long term effects of treatment. Furthermore, research that includes a control group may help to better understand the active ingredients of complex interventions for BPD. Given the positive results reported by Schuppert et al (2009, 2012) and Mehlum et al (2014) for TAU and EUC, it may be that these could be further investigated and potentially developed in the first instance rather than developing further complex, skill and resource intensive treatments. With regards to future delivery of services, it would appear possible for all services to offer TAU and provide amelioration of symptoms without a need for additional training or funding. Furthermore, it would appear that the diagnosis of BPD in adolescence could be of benefit to patients as a reluctance to diagnose may lead to a delay in possible treatment. Finally, as adolescent services are in a position to intervene early, it would be important to ensure that transition work between CAMHS and adult services are carefully co-ordinated to ensure continuity of low intensity interventions and to prevent the possibility of a disjointed move to highly specialist interventions within adult services.

The current research indicates that psychotherapeutic interventions for adolescents with BPD are certainly a potentially efficacious intervention, however, at present it is not possible to definitively determine whether a group based component yields superior results. Many variables remain to be tested and/or controlled in order to establish an effective and standardised

intervention. A meta-analysis of the data, once the research area has grown, may be able to consider some of these factors in more precise detail. Given the increasing need for research to develop empirically based prevention and intervention for psychological disorders in adolescents, the current research has demonstrated clear benefits although the precise mechanisms still remain to be established through further research. BPD in adolescents remains a challenging public health problem that merits further research and clinical effort to reduce the long term adverse effects.

## **2.6 Limitations**

One limitation of the current review is the choice to set relatively broad inclusion criteria due to the relative lack of research in this area, resulting in a varied range of designs in the included studies. Given the range of included studies, the validated checklist by Downs and Black (1998) had to be adapted. Although adaptations to the checklist were based on previous literature, this may have had an impact on the reliability and validity of the checklist. Efforts were made to decrease the level of bias where possible by including an independent second reviewer and calculating Kappa coefficients for all included studies. The review was qualitative as quantitative analysis was not deemed possible due to the methodological differences between the studies. In order to draw more definitive conclusions in the future, a review of combined effect sizes would improve this in the event of further publication of studies in this area. Whilst studies published in both English and Dutch language were included in the review, the exclusion of unpublished studies may have led to a publication bias. Indeed, as the majority of studies were conducted in the Netherlands, this may impact on the generalisability of the overall results. Although the general outcome from this review is suggestive that group based treatments are an effective intervention for BPD in adolescents, the results are constrained by the lack of randomised controlled studies and limited papers included in the review. Furthermore, few studies included a control group which limits the ability to attribute any reported effects to the specific intervention. Nevertheless, it was decided to include all relevant papers in this review in order to provide an overview of the current literature.

## **2.7 Conclusion**

Overall, the implications for using a group based intervention for treatment of BPD symptomatology in adolescents is positive; however several unanswered questions remain at present. Further research in this area including RCTs and long term follow up are required to gain a better understanding of the mechanisms for change of various treatment protocols. This review points to an area which remains in relative infancy both in terms of the development of theoretically driven assessment and treatment strategies for adolescents with BPD, and in terms of developing an evidence base based on high quality research. Nevertheless, this review adds to the current literature in a number of ways. Most importantly with all included studies showing the potential efficacy and feasibility of treatment (both for early intervention and later stages) of BPD in adolescents, this highlights that treatment for BPD in this age range is an exciting avenue for research and development with important clinical implications. Furthermore, given the equally positive outcomes for treatment as usual and enhanced usual care that has emerged from this area of research, it would appear important to direct further attention to this particular area of research to enable effective care pathways for adolescents with BPD both within and out with specialist care. Although the research remains unclear whether group based interventions are as efficacious as stand-alone treatments or result in augmented treatment effects, the included studies suggest group based interventions are both an acceptable and feasible means of providing treatment for adolescents.

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### 3. Journal Article

#### Title Page

Implementing nationally agreed guidelines in Child and Family Mental Health Services: A Delphi Study

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### 3.1 Abstract

**Objectives:** To explore perceptions on the relevance, practicalities, importance and feasibility of implementing nationally agreed CAMHS referral criteria from the perspective of clinicians working in CAMH services in the North of Scotland. The study also aimed to gain consensus on professional and personal factors which support clinicians working in CAMHS.

**Method:** A three round electronic Delphi survey was completed by twenty-eight clinicians working in CAMHS.

**Results:** Results indicate that the guidelines are viewed by many clinicians as both acceptable and important, however, implementation of the guidelines can present services with significant challenges with certain statements rated as important but not necessarily feasible to implement.

**Conclusions:** The study has highlighted the importance of services having the correct infrastructure before it is possible to implement the referral criteria in a consistent and meaningful way, that both maximises use of capacity and allows staff to feel valued.

**Key words:** Delphi technique, service improvement, Child and Family Mental Health, National Referral Criteria

### 3.2 Introduction

It has been estimated that one in ten children will develop a diagnosable mental health condition, ranging from short spells of depression or anxiety through to severe and enduring conditions (Department of Health, 2015). If left untreated, these conditions can leave many children and young people feeling isolated, frightened, and lead to risky behaviours such as smoking and drug and alcohol use (Department of Health, 2015; Intercollegiate Working Party On Adolescent Health, 2003) in addition to impacting on their day to day functioning and educational performance. It is often the case that, despite the availability of effective and evidence based interventions, children and young people frequently do not meet the threshold for accessing specialist services and subsequently may not receive the help they need (Department of Health, 2015).

Following the publication of several governmental level policy and guidance documents aimed at promoting modernisation and strengthening the ways in which the NHS delivers care to children and young people, service redesign has become a key priority for health boards across the UK (*ChildHealth 2020 A strategic Framework for Children and Young People's Health*, 2014; Department of Health, 2004, 2015, NHS England, 2015, 2016). These documents have set out a strategic vision for services to work towards improved and integrated healthcare services; delivering services in a child-centred way; with a focus on early intervention and health promotion; delivering safe and sustainable services and delivering education and training with a focus on evidence based practice (BPS, 2015; Department of Health, 2015; Healthcare Improvement Scotland, 2011). In 2013, the Scottish Government published its strategic workforce vision with the aim of moving towards a sustainable model of delivery of care across the whole of Scotland in the midst of a challenging financial climate, a changing demographic and a significant increase in referrals to mental health services (The Scottish Government, 2013). Additionally, the Scottish Government has outlined and implemented national targets for NHS Scotland in areas of Health improvement, Efficiency, Access and Treatment (HEAT) / Local Delivery Plans (LDP), developed

Integrated Care Pathways, a CAMHS competency framework and referral guidelines (Information Services Division, 2012; ISD Scotland, 2016).

At present, Child and Family Mental Health Services (CAMHS) are under significant pressure to provide timely access to safe, effective and efficient care during a time of fiscal constraint when demand frequently outstrips service capacity to deliver. These challenges highlight the need for future workforce developments to ensure that service planning supports continued improvement in quality and delivers the best possible outcomes for children, young people and their families. The Integrated Care Pathways (ICP's) for CAMHS final standards have highlighted the importance of services identifying ways in which children and young people's journey of care can be improved (Healthcare Improvement Scotland, 2011). As part of the final standards, Healthcare Improvement Scotland has identified a need for universally agreed criteria to aid in the referral process and ensure that children and young people are being referred to the most appropriate service. Furthermore, the provision of good quality referral criteria has been promoted as a way of expediting decision-making processes to ensure timely access to the most appropriate services (Healthcare Improvement Scotland, 2011). The national CAMHS referral criteria were developed by Information Services Division (ISD) Scotland in 2012 following the identified need to standardise access to specialist CAMH services and are currently the only published criteria for CAMH services in Scotland. The criteria were designed to define a threshold at which point a specialist CAMH treatment intervention is deemed appropriate with the aim of improving the consistency of service delivery across Scotland (ISD Scotland, 2012). The development of suitable referral criteria is likely to have implications for the organisation and development of services, training and interventions which aim to improve quality of care for service users. At present however, despite a wealth of mental health policy frameworks, there is a paucity of evidence on the optimal organisation of specialist CAMH services.

Many mental health policy frameworks have outlined the need for increased partnership working to deliver effective and efficient care and improve the quality of this care for children and adolescents; however, implementing change in health and social care settings can be particularly challenging due to the

complex relationship between a wide range of stakeholders, professionals, service users, carers and other organisations (NICE, 2007). It has been well documented that engaging clinicians is an essential precondition for the success and sustainability of quality improvement initiatives within health systems (NICE, 2007; Siriwardena, 2009). Clinical staff have an in depth knowledge of the strengths and weaknesses of the systems within which they work, which puts them in a unique position to identify possible solutions (Bethune, Soo, Woodhead, Van Hamel, & Watson, 2013). Following the publication of the Boorman report on the health and well-being of staff in the NHS, staff engagement has been increasingly linked with staff well-being (particularly psychological well-being) which in turn, has been found to be a fundamental factor in building and sustaining successful performance in the NHS (“NHS Health and Well-being Final Report,” 2009). Although clinician engagement is unlikely to be the sole factor responsible for successful organisational change, it has been reported that successful staff engagement is essential for improvement initiatives to work (Barnard & Stoll, 2010). A number of studies have identified barriers to engaging in change processes including a lack of time, inadequate resources, pressure of competing demands, insufficient skills, disinterest and inadequate rewards (Siriwardena, 2009; Wolfson et al., 2009). Gaining an understanding of health professionals’ wellbeing and possible barriers to engagement may not only reveal insights into how to involve staff in change processes but should ultimately aid in working towards sustainable service improvements.

At present, it is difficult to ascertain whether published government guidelines are consistently being implemented across CAMH services in Scotland; or whether a gap exists between proposed best practice guidelines and ‘real-world’ implementation and practice. Furthermore, little is known about clinicians’ attitudes towards implementing the national CAMHS referral criteria as part of routine care. At present, a dearth of literature exists on the implementation of clinical guidelines in Mental Health care. A study by Hall et al., (2016) investigated the challenges of implementing clinical guidelines for ADHD as outlined by NICE by gaining a consensus from healthcare professionals on ADHD medication management strategies. Expert consensus indicated that

certain recommendations are both important and feasible, whereas others were found to be important but not feasible and thus present significant implementation challenges which may in turn inform future guidelines. Gaining consensus through expert opinion has also been used to determine research priorities, establish best practice and to identify essential components of providing care in mental health services (Huijg et al., 2013; McIlrath, Keeney, McKenna, & McLaughlin, 2010; Thangaratinam & Redman, 2005). A study by McIlrath et al. (2010) sought to gain a consensus on appropriate benchmarks for effective primary care based nursing services for adults with depression. The results indicated similar views between health care professionals with regards to appropriate benchmarks which in turn provided a foundation for depression improvement initiatives. A study by Huijg et al. (2013) aimed to identify factors relevant to the adoption and implementation of physical activity interventions in Primary Care.

The Delphi method is a structured process that can be used to gather information and gain group consensus for complex problems where there is likely to be a range of opinions (Keeney, McKenna, & Hasson, 2010; Powell, 2003). The Delphi technique is often used because of its ability to structure and organise group communication. It aims to converge opinion on a topic with a group of experts across diverse locations and areas of expertise without the need to bring the group together (Petry, Maes, & Vlaskamp, 2007). The Delphi technique can be used as an exercise in group communication with the aim of exploring and understanding a complex problem among group members who are expected to have differing opinions. It offers an enhancement to established surveying techniques through the use of multiple rounds of data collection and the opportunity for feedback among participants in cases where the group experiences difficulty reaching agreement (Iqbal & Pison-Young, 2009).

In its original form, the Delphi method consists of three or more rounds of questionnaires distributed to an expert panel. The first round often allows panellists to brainstorm ideas on a particular topic through open ended questions (Skulmoski, Hartman, & Krahn, 2006). The responses are subsequently analysed and used to construct the questionnaire for round two.

During round two, panellists are asked to rank the importance and feasibility of the statements or questions based on their expert opinion (Keeney et al., 2010). Rounds continue until a consensus is reached and often involve participants being anonymously presented with quantitative group results as well as the participant's own response (Boulkedid, Abdoul, Loustau, Sibony, & Alberti, 2011), to enable comparison with responses of other group members.

This study used the Delphi method to explore perceptions on the relevance, practicalities, importance and feasibility of implementing the nationally agreed CAMHS referral criteria as outlined by ISD Scotland from the perspective of clinicians working in CAMH services in the North of Scotland (covering the Highland, Grampian and Tayside NHS Board regions). In addition, the study aimed to explore and gain consensus on possible professional and personal factors which support clinicians working in specialist services. By gaining an understanding of the factors that underpin the process of implementing the referral criteria it may be possible to develop strategies to most effectively introduce guidelines in CAMH services; as well as facilitating quality improvement initiatives and identifying possible barriers of implementing national guidance.

### **3.3 Methodology**

#### *3.3.1 Design*

The proposed study was exploratory in nature. A three-round Delphi method was used to answer the research aims. A key advantage of the Delphi method is its ability to provide a structured approach to collecting data in an iterative manner with controlled feedback, whilst maintaining anonymity between panel members. The Delphi method was considered the most appropriate method to use in the present study for three key reasons. Firstly, face-to-face discussions were deemed impractical due to the large geographical area, clinicians' time constraints and the number of people involved. Secondly, the Delphi method can preserve anonymity amongst respondents in order to remove the possible effects of group pressure due to status or dominant personalities (Keeney et al.,

2010; Thangaratinam & Redman, 2005). Finally, the Delphi method provides a structured means of engaging a range of health care professionals in different sites to become actively involved in the research process to explore some of the underlying assumptions that might lead to different opinions (Hasson, Keeney, & McKenna, 2000). Although there are a number of disadvantages to using a Delphi method such as the tendency of the method to eliminate extreme positions from participants which may lead to a middle-of-the-road consensus; the requirement of participants to be able to provide written feedback; the relatively long process of undergoing three iterations and thus a lengthy time commitment from participants, it was felt that the method was preferable over the use of individual interviews, single questionnaires or focus groups as these methods did not provide the systematic, structured process that allows for several iterations of the data to be reviewed by participants in geographically scattered areas with the aim of reaching consensus.

### *3.3.2 Expert Panel*

The first stage of the Delphi method involves setting up a panel of participants, or 'experts'. McKenna (1994) defined experts as a group of 'informed individuals' who are specialists in their field. An expert has also been defined as someone who has knowledge about a specific subject (Sinead Keeney, Hasson, & McKenna, 2001; McKenna, 1994). The panel selection in the Delphi method is of critical importance to the strength and validity of the study as the expert opinion of the panel members form the basis of each round and thus the results are only as good as the participants providing the responses. A purposeful sample of clinicians working in North of Scotland CAMH services (covering ages 0 – 18) was recruited for this study. All clinicians working in the services who met the inclusion criteria were sent information regarding the study and invited to take part. A heterogeneous sample was used to ensure that a broad spectrum of opinion was captured (Moore, 1987; Synowiez & Synowiez, 1990).

The sample was selected using the following inclusion criteria:

1. Any fully qualified mental health clinician (Child and Adolescent Psychiatrist, Clinical Psychologist, Mental Health Clinician, Primary Mental Health Worker, Allied Health Professional, Nurse Specialist) currently working in specialist CAMH services in the North of Scotland.
2. Individuals with at least one year's experience of working with children and adolescents within CAMHS.
3. Experience of allocating referrals.

### *3.3.3 Sample size*

At present, no agreed sample size for Delphi studies exist and the number of experts required can vary considerably depending on the topic under investigation, the relevant perspectives required and the availability of resources (Turoff, 2006). Although relatively small sample sizes (between 10-15) have been advocated for homogeneous samples, a larger sample size between 10-50 has been recommended for heterogeneous samples (Linstone & Turoff, 2002). Due to the multiple feedback process of the Delphi technique, the potential for high rates of attrition can occur. Keeney et al. (2010) have proposed that a 70% response rate is required to maintain scientific rigor in each round. Boulkedid et al. (2011) have advocated the use of written consent, clearly outlined procedures and email reminders to reduce the level of attrition.

In order to ensure a sufficient number of panel members, a large sample of clinicians working in CAMH services in three health boards in the North of Scotland were contacted (n=65). The North of Scotland was chosen due to the similar nature of the three services in terms of the large rural areas that each area covers. Furthermore, the three areas are part of the North of Scotland CAMHS Tier 4 Network which aims to work towards providing consistency in Tier 4 services across the three health boards.

### *3.3.4 Procedure*

Identified clinicians were sent an email detailing the purpose and aims of the study along with a link to the initial survey, designed using Smartsurvey.co.uk. The link also included an outline of the study procedure, ensured anonymity between participants and provided the option to give electronic consent (Appendix D). Three weeks following the initial email, a reminder email was sent to identified clinicians (Appendix F). A similar emailing procedure was followed for Rounds 2 and 3 of the survey. Participants were given approximately five weeks to complete Rounds 1 and 2 and three weeks to complete Round 3. Identified clinicians who did not respond to Round 1 were not invited to any further rounds.

### *3.3.5 Round 1*

The Round 1 questionnaire comprised of three sections. The first asked for demographic information including gender, years' qualified, job title and correspondence details. The second section included eight open-ended questions (Table 1). These were devised to (i) gain consensus on the validity of the nationally agreed CAMHS referral criteria; (ii) determine expert opinions regarding best practice and identify areas for further development. The third section included two open ended questions to identify what clinicians need to feel valued and supported in CAMH services.

The questions for Round 1 were generated following a review of the literature of Delphi studies in health care settings and through discussion with service leads and managers. The questions were subsequently reviewed by two further clinicians to ensure that the wording of each question could be easily understood.

**Table 1.** Round 1 questions

<b>Section 1</b>	<b>Questions</b>
1	How closely aligned is your service to following these guidelines?
2	How do you feel the current criteria meet patient needs?
3	What is important in order for your service to be able to implement the nationally agreed CAMHS criteria?
4	What has been helpful in your experience of adhering to the referral criteria?
5	What are some of the barriers in adhering to the referral criteria?
6	In what ways have you modified the guidelines to suit your service?
7	Thinking of your service, what are examples of good practice of implementing the nationally agreed guidelines?
8	Are there any additional areas that should be included in the referral criteria? If yes, please indicate what else should be included?
<b>Section 2</b>	<b>Questions</b>
9	What do you need to feel personally valued and supported in a specialist CAMH service?
10	In what ways are, or could, the values and support needs you identified above be best met?

### *3.3.6 Content Analysis*

Responses from Round 1 were analysed using content analysis, based on the procedure outlined by Graneheim and Lundman (2004). Content analysis is a systematic coding and categorizing approach often used to explore large amounts of information in order to determine patterns, structures and relationships of discourses as well as their frequency (Vaismoradi, Turunen, & Bondas, 2013). Content analysis has been reported to be the most suitable method for reporting of common issues found in the data (Green & Thorogood, 2013). As the proposed study aims to analyse responses from Round 1 and describe the manifest content, content analysis was found to be the most appropriate research tool to organise the data in a structured way.

All statements from Round 1 were transferred from SmartSurvey to a Microsoft Word document and were read through in full by the first author to become familiar with the data and to note general themes in relation to the study aims (Burnard, 1991). The data was subsequently entered into QDA Miner 4 (Version 1.4.6) for further analysis. The software package was used to code,

annotate and analyse the data from Round 1. Once coded, the software was used to count the number of categories and codes. The unit of analysis was the response to the open ended questions from each participant. The responses from sections one and two of the questionnaires were analysed separately as the questions were devised to answer separate aims of the study. The analysis of the open-ended questions aimed to analyse the manifest content of meaning units including words, and sentences related to each other by their content or context. The meaning units were subsequently condensed into shorter statements whilst preserving the meaning. A process of abstraction was then used to code and categorise the data into themes. Statements that were the same or similar were grouped together to form a singular statement or category. Colour codes were assigned to each condensed meaning unit to differentiate between different categories and sub-categories. This process was repeated until no new codes emerged and where possible, categories and sub-categories were collapsed, resulting in seven categories for section one and two categories for section two which in turn were grouped into five themes. An example of this process is provided in Appendix H.

### *3.3.7 Round 2*

The analysed responses from Round 1 were used to design the questionnaire for Round 2. This was emailed to participants who had completed the first round. In order to turn each statement into a question, some items were prefaced with 'There should be' followed by direct statements from participants. Items were discussed between researchers in terms of comprehensibility and amended as required. The Round 2 questionnaire comprised ninety-eight items, with sixty-nine statements pertaining to the National CAMHS referral criteria and twenty-nine to identifying and meeting the support needs of staff as identified by participants in Round 1. The items were listed under nine categories identified from the content analysis. Participants were asked to rate their agreement for each item on a 5-point Likert Scale (1- Strongly Agree; 2 – Agree; 3 - Neither Agree nor Disagree; 4 - Disagree and 5 - Strongly Disagree) based on McIlrath, Keeney, McKenna, & McLaughlin (2010). Additionally, participants were invited to comment or propose a revision after each item

(Boulkedid, Abdoul, Loustau, Sibony, Alberti, et al., 2011). Following data collection of Round 2, frequencies, median and interquartile range were calculated using Statistical Package for Social Sciences (SPSS) version 17 and consensus criteria were applied to determine whether items would be included, excluded or re-rated in Round 3.

### *3.3.8 Round 3*

Items that did not achieve a consensus level of 75% or agreement above 51% in Round 2 were included in the Round 3 questionnaire. During Round 3, participants who responded to Round 2 were asked to re-rate the items, using the same Likert scale, after being presented with the overall percentage agreement for each item, their own response as well as responses from other participants and a summary of comments for each item. Once again, participants were invited to comment or propose a revision after each item.

### *3.3.9 Consensus*

There is currently no agreed general standard for measuring consensus for the Delphi method (von der Gracht, 2012). As with many aspects of this method, the literature only provides limited guidance on consensus levels (Keeney et al, 2006). A paper by Loughlin and Moore (1979) suggested that consensus is reached when there is 51% agreement amongst participants; Green et al (1999) on the other hand, advocate an 80% consensus level (Green, Jones, Hughes, & Williams, 1999). In keeping with previous research conducted in health care settings, this study employed a 75% consensus level as outlined by Keeney, Hasson, & McKenna, 2006. The consensus criteria for the inclusion or exclusion of items were therefore as follows:

1. If at least 75% or above of participants rated an item as 'Agree' or 'Strongly Agree', the item was included.
2. If 51-75% of participants rated an item as 'Agree' or 'Strongly Agree', participants were asked to re-rate the item in Round 3.
3. Any items that fell below 51% agreement were excluded.

### **3.4 Results**

#### *3.4.1 Participants*

In total, forty clinicians accessed the link for the Round 1 questionnaire; of these, one clinician opted out of the study, eleven clinicians partially answered the questionnaire and twenty-eight fully completed Round 1. As there was insufficient data from the eleven partial questionnaires, these were excluded from the Round 1 analysis. Recruitment was sought through three Scottish health boards in Grampian, Tayside and Highland. Participants included were from NHS Grampian (Aberdeen City / Aberdeenshire, n=22 and Moray, n=1) and Highland (n=5). Round 2 was completed by twenty-six clinicians (92.8%) and Round 3 by twenty-one (75%). The original twenty-eight participants included thirteen Psychologists, seven Psychiatrists, six Nurse Specialists, one Art Therapist and one Primary Mental Health Worker. There were twenty-one female participants and seven males. Participants had been qualified between one to thirty-five years (mean = 13.5) and had between two and twenty-eight years of experience of working in CAMHS (mean = 10.3).

#### *3.4.2 Content Analysis*

A total of 322 codes for Section 1 and 130 codes for Section 2 were identified (Appendix G). The codes were arranged into 7 Categories and 52 sub-categories for Section 1 and two categories and nineteen sub-categories for Section 2. These were grouped into four themes, namely: (i) Access to Services, (ii) Meeting Patient Needs, (iii) Implementation and (iv) Staff Needs.

The first theme, 'Access to Services', related to statements that made reference to both positive and negative factors which affect patients accessing CAMH services. The categories associated with this theme were 'Barriers to implementing the referral criteria', 'Examples of good practice', and 'Consistency'. The codes highlighted that at present, a number of barriers exist which prevent the guidelines from being fully implemented such as not having adequate staffing levels, a clear service vision, clear referrals, joined up

working between different services, access to early intervention and support from managers. Statements ranged from practical issues such as “*Having access to appropriate administrative support*” to more strategic issues such as “*CAMHS services should have a truly multidisciplinary systemic approach, taking a holistic and recovery based model*”. The codes also included statements around current good practice and the need for consistency both within and across services.

The second theme, ‘Meeting Patient Needs’, included the categories ‘Patient Centred Care’ and ‘Additional areas to develop for the Guidelines’. The codes in these two categories highlighted the importance of prioritising the best interests of the patients and their families. Additionally, unmet needs of patients were highlighted, for example, “*Many patients and their families would benefit from earlier intervention. Whilst these criteria are appropriate for a purely tier 3/4 service, there seems to be a gap in specialist service provision at the early intervention/tier 2 level. The current criteria demands that things have deteriorated to such a point that functioning is impaired or there is a risk of harm. I think that families and patients would prefer to receive input earlier in the development of the problem.*” The codes also included a range of statements relating to additional areas that could be developed in the referral criteria such as the inclusion of developmental disorders, assessment of risk, Looked After and Accommodated Children (LAAC) and motivation of the child, young person and their family / carers.

The third theme, ‘Implementation’ contained two categories: ‘Modifying the Guidelines’ and ‘Requirements’. These categories comprised of codes that were related to ways in which services have modified the current guidelines and translate into practice. The codes highlighted that in order to fully implement national guidance; a basic infrastructure is required within CAMH services with codes in these categories pertaining to specific requirements such as realistic expectations of the service, strong leadership, multidisciplinary teams, availability of other agencies and good working relationships with other agencies.

The final theme, 'Staff Needs', also contained two categories: 'Support Needs' and 'Meeting Needs'. The codes in these categories highlighted the importance of feeling supported by colleagues, recognising each other's skills and contributions, the role of supervision, clear communication between clinicians and management, ongoing training and continued professional development and opportunities to progress within the service. Codes included statements such as: *"For my skills and my professional opinion to be recognised and respected. For there to be a culture of respect across the service and allowing for diversity. For my personal goals to be incorporated into my professional development when appropriate"*.

### 3.4.3 Round 2

The analysed responses from Round 1 were used to devise the questionnaire for Round 2. This included a five point Likert scale for rating agreement of items and had a space for further comments. A total of twenty-six responses were received in Round 2. During this round one Nurse Specialist dropped out due to ill health and one Psychiatrist due to workload demands. During Round 2, seventy-seven items reached consensus at 75%. A total of fifteen items reached between 51-75% consensus and were therefore included in Round 3. Six items were excluded.

**Table 2.** Summary of comments from Round 2

<b>Section heading</b>	<b>Summary of comments</b>
Consistency	<ul style="list-style-type: none"> <li>- Requirement for joint working with partner agencies to allow guidelines to be implemented in a meaningful way.</li> <li>- Clinical judgement and experienced clinicians are important when applying criteria.</li> <li>- Consistent approach is vital to protect capacity</li> <li>- Criteria need to be matched to service remit</li> </ul>
Examples of good practice	<ul style="list-style-type: none"> <li>- Coming to a consensus through team meetings, case examples and discussions with team members was seen as important by all respondents. However, there were concerns around guidelines creating boundaries which may lead to some referrals falling between the gaps.</li> <li>- Some advocated the importance of early intervention within a tiered system to ensure equitable access to services.</li> <li>- Some participants reported that offering triage</li> </ul>

<b>Section heading</b>	<b>Summary of comments</b>
Examples of good practice	<p>appointments should not be offered as many CAMH services do not currently have the capacity to meet the demand.</p> <ul style="list-style-type: none"> <li>- Having an ongoing dialogue with referrers was generally reported as an important part of accepting referrals.</li> </ul>
Working as a team	<ul style="list-style-type: none"> <li>- Having clear job descriptions for team members was found to be important.</li> <li>- Participants also reported the importance of feeling supported within the team.</li> <li>- Some concerns were raised about whether job descriptions could prove to be restrictive if used too strictly.</li> </ul>
Barriers	<ul style="list-style-type: none"> <li>- Comment was made about the ambiguity of some of the wording in the referral criteria.</li> <li>- Managers should be informed by clinicians who have a more robust understanding of day to day work.</li> <li>- Quality of care is important and should not be compromised by Government targets.</li> <li>- Pressure on services can influence decision making when accepting referrals.</li> <li>- All patients should be treated equally regardless of geographical location.</li> <li>- Guidelines should be used to promote best practice.</li> <li>- Early intervention for lower tier cases was reported to be important however, a range of opinion on how to implement early intervention was expressed.</li> </ul>
Modifying the referral criteria	<ul style="list-style-type: none"> <li>- Was not thought helpful to automatically accept repeat referrals.</li> <li>- Participants reported that it's important to signpost referrers to other agencies when referrals do not meet threshold.</li> </ul>
Additional areas	<ul style="list-style-type: none"> <li>- There was a divergence in opinion regarding the addition of developmental disorders, and Looked After and Accommodated Children, and further criteria around consent.</li> <li>- Some participants proposed that these areas are important but do not need to be specifically mentioned within the CAMHS referral criteria.</li> </ul>
Implementation	<ul style="list-style-type: none"> <li>- Important to have robust qualitative and quantitative outcome monitoring.</li> <li>- Equity of services is important but difficult to deliver.</li> <li>- National criteria assume a good level of primary care provision in order to be implemented.</li> <li>- Implementation depends on how services are commissioned.</li> </ul>
Supporting Staff	<ul style="list-style-type: none"> <li>- Trust and communication are key in supporting staff</li> </ul>
Meeting staff needs	<ul style="list-style-type: none"> <li>- Important to acknowledge hard work however hard work can be difficult to define.</li> </ul>

### Round 3

A total of twenty-one responses were received in Round 3. There were fifteen items to be re-rated during Round 3. Of these, nine items were revised based on the comments from Round 2. During round 3, seven items reached consensus. A summary of the comments for Round 3 are presented in Table 3.

**Table 3.** Summary of comments Round 3

Item	Summary of comments
It is important for CAMH services to balance their time between the most severe cases and early intervention	<ul style="list-style-type: none"><li>- CAMHS should dedicate some of their time to those most in need, however, a range of skills are required across the service. Skills should be used where they are required.</li><li>- Within a tiered system there is also a role in early intervention and prevention</li><li>- There needs to be a balance, both prevention and early intervention are also important and skilling up those in Primary Care to recognise early signs of mental health problems and respond to appropriately.</li><li>- There needs to be a balance between most severe cases and early intervention.</li><li>- Only working with people who meet the national CAMHS criteria does not allow for early intervention.</li><li>- Early intervention is an important role and a strong driver for service development</li></ul>
CAMHS should only offer post assessment contact for patients with developmental disorders when there is a co-morbid mental health condition	<ul style="list-style-type: none"><li>- Contingent upon the presenting difficulty, and the availability of alternative resources</li><li>- Depends on what 'specialist' means</li><li>- Depends on whether assessment is included in 'treatment'</li><li>- Where there is a co-morbid mental health difficulty</li><li>- Treatment needs to be delivered in the most appropriate contexts</li><li>- This will come at a cost</li></ul>
If a referral does not meet threshold criteria for specialist CAMH services, there should be clear referral pathways for lower intensity services	<ul style="list-style-type: none"><li>- Patients who do not meet the threshold should receive support from universal services at Tier 1 and 2 and if this does not work then tier 3 services are required</li><li>- Should not have to be at a crisis point before being seen</li><li>- CAMHS is tiered. Specialist CAMHS (Tier3+) are for children and young people who have clear deterioration in functioning. So Tiers 1 and 2 should have preventative and health promotion components</li><li>- Early intervention is therefore very important</li><li>- PMHW support should be available to all children and young people, in their</li></ul>

Item	Summary of comments
There should be a clear agreed definition of 'Mental Health'	<p>communities</p> <ul style="list-style-type: none"> <li>- Impossible to come to a consensus on a definition</li> <li>- There already is a distinction between mental health and mental well-being</li> <li>- The World Health Organisation already have a definition of Mental Health</li> <li>- Would be difficult to arrive at a consensus as it is too big and broad a term</li> </ul>
There should be a clear agreed definition of 'Psychological Distress'	<ul style="list-style-type: none"> <li>- Cannot operationalise a subjective experience</li> <li>- Not possible to come to an agreed definition</li> <li>- We have to recognise individual differences in the experience of psychological distress/coping and how this manifests</li> <li>- Better to focus on how we define psychological distress that requires CAMHS: This is more focused and pragmatic (applied rather than essentialist)</li> <li>- Definition should be applied from a person-centred point of view</li> </ul>
There should be clear guidance on how to apply the referral criteria, this guidance should be informed by clinicians	<ul style="list-style-type: none"> <li>- Managers need to be guided by clinicians who often have more robust understanding and knowledge of the day to day</li> <li>- Management may be non-clinical</li> <li>- Some managers do not have any clinical experience and do not necessarily understand what our service does.</li> <li>- Clinical decisions should not be made by non-clinical staff</li> <li>- Applying the referral criteria must be a clinical consensus rather than management. However, it is helpful if the management are clear about what is not CAMHS business such as grief work, ASD assessment or anything to do with risk for example</li> <li>- Requires bottom up and top down discussions to achieve team ownership of the criteria</li> </ul>
Geography should not have an impact on whether a referral meets threshold criteria	<ul style="list-style-type: none"> <li>- Whilst there may be locally based services available to remote geographical areas, a CAMHS assessment should be the baseline for any intervention</li> <li>- Should not impact on decision making about whether a referral meets criteria</li> <li>- Geography shouldn't impact on services available to patients</li> <li>- All patients should be treated equally, regardless of geographical location</li> </ul>
There should be specific services for Tier 1 and Tier 2 cases within CAMHS	<ul style="list-style-type: none"> <li>- Within CAMHS, but not within specialist CAMHS</li> <li>- Having Tier 1 and 2 services within CAMHS can create a blur on role of specialist CAMHS. Close links are essential to improve patient experience</li> <li>- Cannot be specialist and see all children and</li> </ul>

Item	Summary of comments
	<ul style="list-style-type: none"> <li>- young people</li> <li>- Should be embedded in schools and communities rather than in hospitals</li> <li>- Having a tiered system doesn't always work as it is not easy to define what Tier 1,2,3 do</li> </ul>
Resources (e.g. staffing) should be matched to meet service demands	<ul style="list-style-type: none"> <li>- Question is unclear</li> <li>- Is capacity the same as resource?</li> <li>- Matched to demand rather than capacity</li> <li>- Resources should be matched to capacity demand</li> </ul>
There should be specific guidelines for each Tier	<ul style="list-style-type: none"> <li>- Tiered system may not be helpful in practice</li> <li>- Specific, but not micro-managed</li> </ul>
There should be additional guidelines for CHOICE appointments	<ul style="list-style-type: none"> <li>- Additional to what?</li> <li>- There are guidelines available already</li> </ul>
There should be criteria for Looked After and Accommodated Children	<ul style="list-style-type: none"> <li>- LAAC should not be a reason to discriminate</li> <li>- There should be criteria for all children and young people</li> <li>- Mental illness is mental illness whether in Looked after children or not but there is up to 80% more possibility of LAC having mental illness than the general population</li> <li>- Yes, given corporate parenting responsibilities that have now been widened beyond councils to include health boards</li> <li>- Need to take into account other services involved, and stability / security to engage with CAMHS</li> </ul>
There should be strict referral criteria for accessing specialist services	<ul style="list-style-type: none"> <li>- Fair referral criteria</li> <li>- Everything in life needs flexibility. Mental disorders may fit in clear cut boxes but real life patients do not.</li> <li>- 'clear' not 'strict'</li> </ul>
The National criteria should be used to screen all referrals across Scotland	<ul style="list-style-type: none"> <li>- The National criteria assume a good level of primary care or tier 1 provision.</li> <li>- Depends on the CAMHS remit when the service was commissioned</li> </ul>
There should be a reduction in pressures from the top down	<ul style="list-style-type: none"> <li>- Pressure is an individual thing and also depends on what is going on in one's personal and social life</li> <li>- Pressure should move in both directions</li> <li>- If the purpose of the pressure is clear and in keeping with the service values, mission and vision, then - yes. Pressure from top down is helpful. Anything from a less clear cause will produce decreased morale, animosity and disengagement.</li> </ul>

### 3.4.4 Results all Rounds

A total of eighty-four items across the three rounds reached consensus (i.e. rated as Strongly Agree or Agree by >75% of panel members). The items were divided into eight subheadings that map onto four different themes. The items that reached consensus are presented in Table 4 along with the group percentage of agreement, median, interquartile range, and at which round the item was included or excluded. Of the fifteen items that were re-rated in Round 3, seven items reached consensus and are also displayed in Table 4. The fourteen items that did not reach consensus are presented in Table 5.

**Table 4.** Statements that achieved consensus

Question	% Agreement	Median, IQR	Round included
<b>Consistency</b>			
- Guidelines should be open to interpretation and allow for clinical judgement.	76.9	2, 0	2
- Guidelines should be consistently applied across all CAMH services	84.6	2, 1	2
- There should be clarity on what the core work of the service is	96.2	1, 1	2
- There should be clear service priorities	96.2	1, 1	2
<b>Examples of Good Practice</b>			
- There should be regular referral consensus meetings	88.5	2, 1	2
- There should be opportunities to discuss referrals with colleagues	100	1, 1	2
- There should be close working relationships between primary and secondary care	100	2, 1	2
- There should be opportunities to network with partner agencies	92.3	1, 1	2
- There should be good access to third sector services	84.6	1.5, 1	2
- CAMH services should provide a stepped model of care	76.9	2, 1	2
- Patient needs should be prioritised	88.5	1, 1	2
- It is important for CAMH services to balance their time between the most severe cases and early intervention*	85.7	2, 1	3
- CAMH services should offer consultation clinics to reflect on complex cases with other professionals	96.2	1.5, 1	2
- Referrals should be screened by experienced clinicians	88.5	2, 1	2
- A regularly updated resource directory with appropriate resources for children and young people should be available to all health professionals	96.2	1, 1	2
- CAMH services should seek to educate referrers on the CAMHS referral criteria	88.5	2, 1	2
- Referrals should contain information regarding any previous input	84.6	2, 1	2

Question	% Agreement	Median, IQR	Round included
<b>Working as a team</b>			
- There should be regular team discussions about service priorities	96.2	2, 1	2
- Multi-disciplinary teamwork is an essential prerequisite for an effective CAMH service	96.2	1, 1	2
- There should be a range of disciplines in a CAMHS team	100	1, 0	2
- Staff should feel supported by the service management	100	1, 1	2
- There should be defined responsibilities for each team member	76.9	2, 1	2
- If a referral does not meet threshold criteria for specialist CAMH services, there should be clear referral pathways for lower intensity services*	95.5	1, 1	3
- Addressing children and young people's psychosocial health is as important as addressing their medical needs	96.2	1, 1	2
- There should be clear guidance on how to apply the referral criteria, this guidance should be informed by clinicians*	81	2, 1	3
- Clinicians should not feel pressured to accept referrals due to pressure from Government targets	80.8	2, 1	2
- Clinicians should not feel pressured to accept referrals due to pressure from referrers	80.8	2, 1	2
- There should be sufficient time to read through referrals	96.2	1, 1	2
- There should be a well-resourced team	96.2	1, 0	2
- Geography should not have an impact on whether a referral meets threshold criteria*	90.5	1, 1	3
- There should be a focus on early intervention	80.8	2, 1	2
- There should be adequate numbers of primary care health professionals to assist in the recognition and management of Tier 1 and Tier 2 cases	88.5	1.5, 1	2
- There should be staff training on how to apply the referral guidelines	84.6	2, 1	2
- Referrals should contain clear information to be able to determine whether it meets the referral criteria	92.3	2, 1	2
- Resources (e.g. staffing) should be matched to meet service demands*	80.9	2, 1	3
<b>Modifying the criteria</b>			
- There should be specific guidelines for each Tier	76.2	2, 0	3
- Referrers should always receive information about other services or options when a referral is not accepted	92.3	2, 1	2
- Referrers should be signposted to other services on a regular basis	80.8	2, 0	2
<b>Additional Areas</b>			
- Children and young people should consent to a referral being made to CAMH services	76.9	2, 1	2
- There should be agreed criteria around assessing risk	92.3	2, 1	2
- There should be an indication of the child or young person's motivation to attend	76.9	2, 0	2
- There should be guidelines for developmental disorders	84.6	2, 1	2

<b>Question</b>	<b>% Agreement</b>	<b>Median, IQR</b>	<b>Round included</b>
- There should be guidelines for conduct disorders	76.9	2, 0	2
- There should be guidelines for somatic and physical disorders	84.6	2, 0	2
- There should be guidelines for urgent / emergency criteria	88.5	1.5 , 1	2
<b>Implementation</b>			
- Services should be equitable for patients	84.6	1.5 , 1	2
- There should be robust outcome monitoring	96.2	2, 1	2
- Effective implementation of the guidelines should be evidenced	76.9	2, 0	2
- There should be strong leadership within the service	96.2	1, 0	2
- There should be sufficient administrative support	100	1, 0	2
- There should be strong links with social work	100	1, 1	2
- There should be strong links with education	92.3	1, 1	2
- There should be clear referral criteria for accessing specialist services*	95.3	2, 1	3
- There should be sufficient IT systems	100	1, 0	2
- There should be effective communication between primary and secondary care	100	1, 1	2
- There should be effective communication between key stakeholders	100	1, 1	2
- There should be an increase in health promotion	84.6	2, 1	2
<b>Supporting Staff</b>			
- There should be opportunities for CPD / training	100	1, 1	2
- There should be opportunities to develop innovative services	100	1, 1	2
- There should be a clear and coherent service vision	100	1, 1	2
- There should be transparency between managers and clinicians	100	1, 1	2
- Professional opinions of all team members should be recognised and respected	96.2	1, 1	2
- Everyone's contributions should be valued	96.2	1, 1	2
- Individual skills should be recognised by the team as well as managers	96.2	1, 1	2
- There should be a supportive culture in CAMHS teams	100	1, 1	2
- There should be regular MDT supervision	80.8	2, 1	2
- There should be regular individual supervision	88.5	1.5, 1	2
- There should be opportunities to progress within the service	96.2	2, 1	2
- It is important to understand one's role within the service	100	1, 1	2
- It is important to have trusting relationships with your colleagues	100	1, 1	2
- It is important to function within your own discipline	80.8	2, 1	2
- It is important for other team members and managers to be aware of what I do	96.2	2, 1	2
- It is important to get feedback from patients and families	100	1, 1	2
- It is important to get feedback from management	96.2	2, 1	2
<b>Meeting Support Needs</b>			
- There should be a focus on team processes	88.5	2, 0	2
- There should be a culture of respect	100	1.5 , 1	2
- There should be regular face to face contact between clinicians and managers	92.3	2, 1	2

Question	% Agreement	Median, IQR	Round included
- There should be a clear management structure	100	1, 1	2
- There should be meaningful line management	96.2	1, 1	2
- Achieved goals should be acknowledged and celebrated	96.2	2, 1	2
- There should be an effective appraisal process	100	2, 1	2
- There should be an acknowledgement of hard work	84.6	2, 1	2
- There should be time to meet patient needs rather than just meeting waiting times	100	1, 0	2
- There should be regular and clear communication between clinicians and managers	100	1, 1	2

\*=Revised item based on comments

**Table 5.** Table of excluded statements

Question	% Agreement	Median, IQR	Round Excluded
- CAMH services should offer triage / screening appointments for referrals which do not clearly meet the referral criteria	50	2.5, 2	2
- CAMH services should offer CHOICE appointments for all referrals	23.1	4, 2	2
- CAMHS should only offer post assessment contact for patients with developmental disorders when there is a co-morbid mental health condition*	66.7	2, 2	3
- There shouldn't be a distinction between medical, psychological and social difficulties.	34.6	3, 2	2
- There should be a clear agreed definition of 'Mental Health'	65.4	2, 1	3
- There should be a clear agreed definition of 'Psychological Distress'	57.7	2, 1	3
- The guidelines should be specifically used to reduce government waiting times	11.5	4, 2	2
- There should be specific services for Tier 1 and Tier 2 cases within CAMHS*	52.4	2, 1	3
- Repeat referrals should be automatically accepted for triage / screening / CHOICE	34.6	4, 2	2
- There should be separate criteria for Looked After and Accommodated Children*	38.1	3, 2	3
- The National criteria should be used to screen all referrals across Scotland	52.4	2, 1	3
- There should be a reduction in pressures from the top down	28.6	3, 1	3
- There should be opportunities for non-work related discussions	50.0	2.5, 1	2
- There should be additional guidelines for CHOICE appointments	33.4	3, 2	3

\*= Revised item based on comments

### **3.5 Discussion**

To the best of our knowledge this was the first study which has explicitly sought to understand the real life implications and determine staff perceptions on implementing the national CAMHS referral criteria as outlined by ISD Scotland. Furthermore, this study aimed to explore and gain consensus on possible professional and personal factors to support clinicians working in CAMH services. The Delphi method proved to be a useful method to identify a wide range of issues which impact on implementation of the National CAMHS referral criteria. Although a wide range of health professionals including nurses, psychiatrists, psychologists, primary mental health workers and art therapist were included in the expert panel, the majority of statements generated from Round 1 reached consensus leaving only a small proportion of statements that led to a divergence of opinion.

Following the three Delphi rounds, eighty-four statements reached consensus. Of these, twenty-two reached 100% consensus with more than half of these falling under the headings of Supporting Staff and Meeting Support Needs. The remaining statements highlighted the need for basic infrastructure such as appropriate IT systems, secretarial support, effective communication between services as well as clinicians and managers and the availability of a range of disciplines within a CAMHS team and access to primary care and third sector services. Other statements highlighted the need for clarity and consistency in service delivery such as focusing on early intervention and health promotion, prioritising patient needs, offering consultation and providing equitable services across Scotland. Furthermore, there were high levels of consensus relating to ensuring a workplace culture in which all colleagues are respected with close working relationships between clinicians and managers. Research into professionals who seek to enhance safety and quality in healthcare organisation has identified culture as a frequent barrier to change (Carroll & Quijada, 2004). It has been reported that the process of developing a culture that supports the implementation of government guidelines is therefore more likely to succeed if professionals working in health services are actively involved

in designing innovative ways of providing services (Carroll & Quijada, 2004; Huijg et al., 2013).

With regards to additional areas that could be incorporated into the referral criteria, consensus was reached for statements around assessment of risk and motivation as well as suggestions for additional guidelines specific for developmental disorders, conduct disorders, somatic and physical disorders and urgent criteria. With many suggestions reiterating the recommendations of published NICE guidelines which recommend improved access to Mental Health services for assessment and diagnosis of Autism, Conduct Disorders and ADHD (NICE, 2013; 2011; 2008).

Although respondents and therefore the overall results provided limited suggestions for revision of the guidelines, comments from Round 1 instead highlighted the necessity of access to and support from other services such as primary care and voluntary services, links with education and social work, and appropriate staffing levels as crucial factors in being able to effectively implement the referral criteria. The results indicate that in order to do this effectively, staff working in CAMH services should also have clear roles and responsibilities with clear lines of communication with management. In Round 1, it was frequently noted that some referrals are accepted due to the unavailability of other services which, if unaccepted, can lead to referrals 'slipping through the net' and result children and young people not being able to access the appropriate service. It was reported that this often leads to a tension between protecting service boundaries and the realisation that there may be no other services available with some participants reporting inconsistencies in applying the referral criteria depending on the availability of different services both within and out with CAMH services. Of particular note, was a frequent call for an increase in early intervention although there was a difference in opinion as to which service / services would be responsible for providing this type of intervention.

### *3.5.1 Implications for CAMH services*

In terms of implementing the referral criteria, panellists reported that they require sufficient clinical knowledge and skills as well as experience in order to feel confident to effectively screen referrals using the referral criteria, although what constitutes the knowledge and skills was not outlined during the Delphi process. The importance of monitoring effectiveness of implementation of the criteria was highlighted by panellists. This could be potentially achieved via audit. A possible method to ensure consistency and also improve staff confidence in implementing the referral criteria could be through services holding regular referral consensus meetings. This would also help to identify trends in referral patterns to develop new interventions and better match resources to demand.

Other factors in this study which were reported to hinder implementation often included statements around insufficient time and resources. This is perhaps not an unexpected finding given the importance of these factors particularly during a time of increasing fiscal constraint with similar findings having been reported in studies on providing innovative solutions to health care (Fleuren, Wiefferink, & Paulussen, 2004). With regard to staff needs, developing a culture in which staff feel valued requires an environment in which staff feel supported and respected, have access to regular supervision and focuses on staff development. This could be further supported by services ensuring access to professional development and training opportunities to enable staff to develop skills that match the aims of the service. Given the ongoing pressure on services, it would be of particular importance during a time of systemic change to provide dedicated time for staff needs. This is in line with previous research in health promotion interventions which has indicated that skills, self-efficacy and reinforcement are key to moving from adoption to implementation of new interventions (Bartholomew et al., 2011; Huijg et al., 2013).

It should be noted that the existence of consensus through the Delphi method does not equate to having found the correct answer and instead merely indicates that the participants have agreed on a set of issues (Keeney, Hasson,

& McKenna, 2001). Whilst there was a high number of statements that reached consensus amongst the panellists, it may be that some statements are more indicative of professional aspirations for working towards delivering the best possible care for children and young people; rather than providing measurable or feasible / realistic options in terms of current or future service delivery. Furthermore, given the volume of statements, this may have led to a broad overview of important factors and limited the possibility to develop more specific guidelines. Indeed, many responses may be reflective of the difficulties in providing equitable services within a complex system which requires clinicians to hold many competing demands in mind whilst aiming to provide person centred care.

It would seem of utmost importance to have the correct infrastructure in place before any quality assurance in implementing guidelines can be meaningfully and reliably measured. Without the correct infrastructure, services run the risk of increasingly lengthy waiting times that may breach HEAT / LDP targets. Without adequate IT systems and sufficient administrative support, there is a heightened risk of both clinical and corporate governance failures.

Despite consensus on general factors regarding the content and process of implementation of national guidelines, it remains important that these are considered within local health boards and reflect local circumstances. Nevertheless, the statements that reached consensus may provide a basis for CAMH services to identify gaps in services, indicate areas where additional resources are required, encourage sustainable improvements and establish quality indicators and as a starting point to monitor, evaluate and improve CAMH services. The included statements have raised awareness around some of the important issues currently facing CAMH services in the North of Scotland.

In terms of service development regarding implementation of these guidelines the following were reported to be of highest priority. First, adequate infrastructure of CAMHS services is paramount in enabling services to effectively implement the referral criteria. Second, improved access to primary care and third sector services are required in order to enable CAMHS to deliver services to children and young people in need of specialist care. Finally, in

order to ensure a sustainable workforce, it would be important for services to ensure access to regular supervision as well as training opportunities for all members of staff.

### *3.5.2 Limitations*

The study has some important limitations which need to be considered. First, ensuring appropriate composition of panels for the Delphi method is central to determining the legitimacy of its findings (Keeney et al., 2010; McKenna, 1994; Skulmoski et al., 2006) and considerable care was taken to ensure that the eligibility criteria were sufficient to reflect a range of expertise. It should be noted however, that there were no participants from one of the included health boards (NHS Tayside) and therefore the opinions may not be reflective of all services in the North of Scotland. Furthermore, it could not be ruled out that a different group of panellists may have produced a different set of statements. Future research should consider inviting clinicians from all health boards across Scotland, or indeed the UK, to participate to form a consensus for CAMH services in general.

Second, it has been reported that both quantitative and qualitative feedback following each round are an essential component of the Delphi procedure in order to inform each participant of their response relative to the rest of the panel (Boukdedid, Abdoul, Loustau, Sibony, Alberti, et al., 2011). This aims to allow all participants to reconsider their responses in light of the group responses. Accordingly, space for comments was added after each item in Round 2 and 3. Although this may have helped to improve the reliability and validity of the study by allowing participants to elaborate on their responses and assist with their decision making in subsequent rounds; given the large number of statements in Round 2, there may be a threat of a response bias as only a limited number of participants commented further on the items. Having fewer items may have encouraged more participants to complete the comments and ultimately may have resulted in a more specific set of statements. In addition, pilot testing of the questions in Round 1 may have streamlined the number of questions and ensured that all statements were easily understood by participants.

It is important to note that not all feedback could be used as some participants reported frustrations regarding their current working environment rather than providing constructive comments for the revision of the item and this therefore limited the number of comments that were relevant in terms of the purpose of the study to be fed back to the entire group.

Third, the responses from Round 1 required some editing in order to produce statements for the Round 2 questionnaire. Although every care was taken to ensure the original meaning remained intact, it may be that some statements were slightly altered through this process and unintentionally distorted the true meaning as reported by participants. At present, there remains a lack of agreement in terms of best practice around interpretation of results from Round 1 (Iqbal & Pison-Young, 2009; Thangaratinam & Redman, 2005).

Finally, the study only included health professionals. To truly understand the value and relevance of referral guidelines it would be important to include the opinions of different stakeholders and also service users in order to ensure that the results reflect the diversity of opinion in across services and establish a clearer understanding of values from both a provider and a consumer's perspective.

### **3.6 Conclusion**

The Delphi method proved to be a helpful way of systematically identifying and gaining consensus on senior clinician's perceptions on the relevance, practicalities, importance and feasibility of implementing published CAMHS referral guidelines. Furthermore, consensus on a list of statements pertaining to staff needs and ways to meet these needs was established. This study provides further evidence that the Delphi method provides a validated way to establish consensus within health care particularly for complex issues, supporting previous notions that the technique could be used as an alternative to meetings to avoid the possible challenges of powerful personalities, group pressure or a hierarchical structure. The study has further highlighted the importance of

services having adequate infrastructure necessary to implement the referral criteria in a consistent and meaningful way. These findings may be used to inform updates to clinical guidelines and help services focus on implementation strategies for those statements that were identified by the panel as important. Although this study is a step towards effectively implementing the referral guidelines as well as providing a basis for future quality improvement, further research is required to establish the extent to which government guidelines are currently being adhered to within Mental Health services and gain a better understanding of the factors that might lead to poor adherence.

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## 4. Appendices

### 4.1 Appendix A. Clinical Psychology and Psychotherapy submission guidelines

## Clinical Psychology & Psychotherapy

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- Enter an **abstract** of up to 250 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
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- Include up to six **keywords** that describe your paper for indexing purposes.

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- **Research Articles:** Substantial articles making a significant theoretical or empirical contribution.
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Example: According to Irene Taylor (1990), the personalities of Charlotte. .
3. **If both the name of the author and the date are used in the text, parenthetical reference is not necessary.**  
Example: In a 1989 article, Gould explains Darwin's most successful. . .
4. **Specific citations of pages or chapters follow the year .**  
Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).
5. **When the reference is to a work by two authors, cite both names each time the reference appears .**  
Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .
6. **When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al.* (meaning "and others") .**  
Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al.*, 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al.* in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.
7. **When the reference is to a work by a corporate author, use the name of the organization as the author.**  
Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).
8. **Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .**  
Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .
9. **Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .**  
Examples:
  - List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)

- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

## Reference List

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References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information about APA referencing style, please refer to the APA FAQ. Please note that for journal articles issue numbers are not included unless each in the volume begins with page one.

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Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486.

doi:10.1176/appi.ajp.159.3.483.

### Book edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

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4.2 Appendix B. Data extraction form, adapted from Downs and Black (1998)

**Rater:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**First Author:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Number of participants	
% Female	
Age range (mean)	
Type of therapy	
Length of group	
Primary outcome measures	
Effect size	

**Study Quality**

No.	Questions	Yes (1)	No (0)	Comments
1	Aims of study (Are aims / hypothesis clearly described)			
2	Main outcomes clearly described			
3	Characteristics of patients clearly described			
4	Interventions clearly described			

No.	Questions	Yes (2)	Partially (1)	No (0)	Comments
5	Are distributions of principle confounders in each group of subjects described				

No.	Questions	Yes (1)	No (0)	Comments
6	Are the main findings of the study clearly described			
7	Does the study provide estimates of the random variability in the data of the main outcomes			
8	Have all important adverse events that may be a consequence of the intervention been reported			
9	Have characteristics of patients lost to follow-up been described			
10	Have actual probability values been reported			

### External Validity

No.	Questions	Yes (1)	Unable to determine (0)	No (0)	Comments
11	Participants representative of entire population from which they were recruited				
12	Were subjects who were prepared to participate representative of the entire population				
13	Were staff, places, and facilities where patients were treated representative of treatment majority of patients receive?				

### Internal Validity - Bias

No.	Questions	Yes (1)	Unable to determine (Or not applicable) (0)	No (0)	Comments
14	Was an attempt made to blind study subjects to the intervention they received				
15	Was an attempt made to blind those measures the main outcomes				
16	Were any of the results based on 'data dredging' – was this made clear				
17	Do analysis adjust for different lengths of follow-up of patients				
18	Were the statistical tests used to assess the main outcomes appropriate?				
19	Was compliance with the interventions reliable				

20	Were main outcomes measures valid and reliable				
----	--	--	--	--	--

**Internal Validity – confounding**

No.	Questions	Yes (1)	Unable to determine (Or not applicable) (0)	No (0)	Comments
21	Were the patients in different intervention groups or were the cases and controls recruited from same population				
22	Were the study subjects in different intervention groups or were the cases and controls recruited over the same period of time				
23	Were the participants randomised to intervention groups				
24	Was the randomised intervention assignment concealed from both patients and health care staff until recruitment was complete				
25	Was there adequate adjustment for confounding in the analysis				
26	Were losses of patients to follow-up taken into account				

**Power**

No.	Questions	Yes (1)	No (0)	Comments
27	Reference made to Power or effect sizes			

**Additional comments:**

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### 4.3 Appendix C. Journal of Clinical Psychology – Submission Guidelines

## Journal of Clinical Psychology

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Edited By: Timothy R. Elliott (Editor) and Barry A. Farber (In Session)

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2. Go to the URL <http://mc.manuscriptcentral.com/jclp>
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure.
6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).
7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

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#### Manuscript Preparation

**Format** . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the *Journal of Clinical Psychology* utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

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**Abstract**. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:

**Objective(s):** Succinctly state the reason, aims or hypotheses of the study.

**Method (or Design):** Describe the sample (including size, gender and average age), setting, and research design of the study.

**Results:** Succinctly report the results that pertain to the expressed objective(s).

**Conclusions:** State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

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- **Editorials** . Unsolicited editorials are also considered for publication.
- **Notes From the Field** . Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.
- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

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#### 4.4 Appendix D. Initial invitation email for Delphi Study



### **Initial invitation email for: Implementing nationally agreed guidelines in Child and Family Mental Health Services: A Delphi Study**

Dear #FirstName#,

I am a trainee clinical psychologist at the University of Edinburgh, currently working in NHS Grampian. I am inviting you to be part of an online expert panel as part of my research exploring how the nationally agreed CAMHS referral criteria have been implemented in the North of Scotland, and whether the criteria are effectively managing demand for services. In addition, the study aims to explore and gain consensus on possible professional and personal factors to support clinicians working in specialist services both at a systems and individual level.

#### **What will participation involve?**

Participation will involve being part of an expert panel for a Delphi Study comprising of 3 Rounds of questionnaires in the form of an online survey. The Delphi method aims to achieve consensus in an iterative and structured manner. The key features of the method are to maintain anonymity between participants and to provide controlled feedback following each round.

The process has been designed to be as straightforward as possible and should take no longer than **15-30 minutes for each round**. There are no right or wrong answers to the questions. This study is seeking your expert opinion.

The outline of the study is as follows:

1. **Round 1** - The first round will consist of a small number of open-ended questions related to the implementation of the nationally agreed CAMHS referral guidelines. In addition, the round 1 survey will ask open ended-questions about the support that is required to effectively implement a specialist CAMH service. After all responses have been received, the information will be collated and the key concepts will be elicited using content analysis. The analysed data will then be used to construct the Round 2 questionnaire.

2. **Round 2** - The second round questionnaire will display the results from round 1, followed by questions based on the information collected in Round 1. You will be asked to rank the importance and feasibility of each item.
3. **Round 3** – The third round of the questionnaires will provide you with detailed feedback of the results from the previous rounds. You will then be invited to reflect on your responses in the context of the group responses and will have the opportunity to reconsider your response should you wish to do so.

On completion of all 3 Rounds, detailed feedback will be provided to each participant.

	Survey Open	Returned By
<b>Round 1</b>	August	+ 5 weeks
<b>Round 2</b>	October	+ 5 weeks
<b>Round 3</b>	December	+ 3 weeks

It is important that you understand that your participation in this study is entirely voluntary. Any information that you provide will be confidential and when the results of the study are reported, you will not be identifiable in the findings. Your name will not be recorded on any rounds; instead, you will be allocated a unique code that can only be identifiable to the researcher. You will remain anonymous to the other participants throughout the study.

**If you would like to take part in this study or would like further information, please go to:**

#Optinlink#

If you do not wish to respond to this survey, please click on the link below to decline:

#DeclineLink#

This study has been granted ethical approval by the University of Edinburgh and has been reviewed by Research and Development for NHS Grampian. If you have any concerns about this study, please contact my supervisor Dr Emily Newman, Lecturer in Clinical Psychology, on [emily.newman@ed.ac.uk](mailto:emily.newman@ed.ac.uk).

Thanks in advance for responding to the survey,

Vera Elders  
 DClinPsychol Programme  
**University of Edinburgh**

#### 4.5 Appendix E. Round 1 Invitation and Questionnaire

### 1. Invitation to Round 1 questionnaire

## Welcome to Round 1 of this study

The first round of this Delphi will ask you nine questions –

- (i) How closely aligned is your service to following these guidelines?
- (ii) How do you feel the current criteria meet patient needs?
- (iii) What is important in order for your service to be able to implement the nationally agreed CAMHS criteria
- (iv) What has been helpful in your experience of adhering to the referral criteria?
- (v) What are some of the barriers in adhering to the referral criteria?
- (vi) In what ways have you modified the guidelines to suit your service?
- (vii) Thinking of your service, what are examples of good practice of implementing the nationally agreed guidelines?
- (viii) Are there any additional areas that should be included in the referral criteria? If yes, please indicate what else should be included?
- (ix) What do you need to feel personally valued and supported in a 0-18 specialist CAMH service?

There is space below each question for you to detail your answers. Please be as detailed in your response as possible.

**It is estimated that this stage should take no longer than 30 minutes to complete.**

Please complete the demographics section at the end of the questionnaire. It is important that the researcher can identify your responses as the Delphi process has individual feedback to every panel member built into the process.

Many thanks,

Vera



# THE UNIVERSITY *of* EDINBURGH

## **Implementing nationally agreed guidelines in Child and Family Mental Health Services: A Delphi Study**

### **1. Participant Information (1)**

#### Study information

Thank you for your interest in taking part in this study. Please read the following information below before agreeing to take part.

#### **Background:**

It has been estimated that one in ten children in Scotland will develop a diagnosable mental health condition. If left untreated, these conditions can leave many children and young people feeling isolated, frightened, increase the likelihood of risky behaviours and have an impact on their educational performance. It is often the case that, despite the availability of effective and evidence based interventions, children and young people may not meet the threshold for services and subsequently might not receive the help they may need. At present, CAMH services are under significant pressure to provide timely access to effective and efficient care during a time of fiscal constraint with demand frequently outstripping service capacity to deliver.

The above challenges highlight the need for future workforce development to ensure that planning supports continued improvement in quality and delivers the best possible outcomes for service users; effectively screening when someone needs to be seen within CAMHS and when other agencies would be most appropriate to help. At present, no clear agreement exists in the literature as to how best to provide mental health support to children and adolescents. The national CAMHS referral criteria were developed following a need to be able to standardise access to Specialist CAMH services. The criteria are currently designed to define the boundaries of specialist CAMH treatment interventions with the aim that they will serve to improve the consistency of service delivery across Scotland.

The Delphi technique is a structured process that can be used to gather information and gain group consensus for areas where existing evidence alone is insufficient. It can be used as an exercise in group communication with the aim of exploring and understanding a complex problem among group members who are expected to have differing opinions. The proposed study aims to utilise the Delphi method to survey clinicians working in CAMHS.

The principal aim of the study will be to explore and identify, through expert opinion, how the nationally agreed CAMHS referral criteria have been implemented in the North of Scotland, and whether they are effectively managing the demand for services. In addition, the study aims to explore how to ensure that staff feel valued and supported in their work.

**Purpose of the study:**

Although a wealth of literature exists outlining the need for improved care, relatively little is known about how this should be operationalised in specialist CAMH Services. This study aims to inform future service development as well as national strategic and operational guidance in terms of good practice in implementing nationally agreed guidelines with a view to delivering effective, efficient and sustainable care.

**Why have I been asked to take part?**

You have been asked to take part as you are a clinician working in CAMHS.

**Do I have to take part?**

No, it is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect your legal rights.

**2. What will the study involve?**

Participation will involve being part of an expert panel for a Delphi Study comprising of 3 Rounds of questionnaires in the form of an online survey. The Delphi method aims to achieve consensus in an iterative structured manner. The key features of the method are to maintain anonymity between participants and to provide controlled feedback following each round.

The process has been designed to be as straightforward as possible and should take no longer than 15-30 minutes for each round. There are no right or wrong answers to the questions. This study is seeking your expert opinion.

The Delphi study comprises of three initial rounds. If you decide to take part, we ask that you agree to take part in all rounds. Depending on the level of consensus achieved, a further round may be required.

**What are the possible benefits of taking part?**

It is hoped that the results of the study will help to further the understanding of the feasibility of implementing national guidelines. In addition, it is hoped that the study will inform future workforce developments to support clinicians working in specialist services.

**What are the possible disadvantages and risks of taking part?**

It is not thought that there are any disadvantages of participating in this study

**What if there is a problem?**

In the unlikely event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against NHS Grampian but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

**Will my taking part in the study be kept confidential?**

All the information we collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. Participants' identities and responses will be made anonymous to other members of the panel.

You can request to leave the study at any point up until all the data has been collected.

To ensure that the study is being run correctly, we will ask your consent for responsible representatives from the Sponsor and NHS Institution to access your data collected during the study, where it is relevant to you taking part in this research. The Sponsor is responsible for overall management of the study and providing insurance and indemnity.

### **What will happen to the results of the study?**

The results of this study will be written up as a research paper for journal submission.

### **Who is organising the research and why?**

This study has been organised and sponsored by University of Edinburgh. The study will be written up as part fulfilment of a Doctorate in Clinical Psychology.

### **Who has reviewed the study?**

The study has been granted ethics approval by the University of Ethics Committee. NHS management approval has also been obtained.

### **3. Contacts**

Should you have any questions about the study you can contact the lead researcher directly by emailing: vera.elders@nhs.net

If you have any concerns about the study you can contact Dr Emily Newman on emily.newman@ed.ac.uk

If you wish to make a complaint about the study please contact Professor Charlotte Clarke, Head of School, Health in Social Science.

Email: Charlotte.Clarke@ed.ac.uk  
Telephone: 0131 650 4327

### **If you would still like to take part in the study please read the following before giving your consent:**

1. I confirm that I have read and understand the information sheet (as specified in this document header) for the above study and have had the opportunity to consider the information and ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
3. I understand that data collected during the study may be looked at by individuals from the Sponsor, from the NHS organisation or other authorities, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
4. I understand that my identify and my responses will be made anonymous to other members of the panel.

**If you do not wish to continue with the study at this time, please indicate this by clicking 'no' below.**

If you do wish to continue, please confirm that you agree to the statements above by clicking 'yes' below and you will be taken to Round 1 of the questionnaire for completion.

1. Please indicate whether you wish to participate in this study below: \*

Yes

No

## 4. Demographics

2. Sex \*

Male

Female

3. How many years have you been qualified? \*

4. How many years have you worked in Child and Adolescent Mental Health Services? \*

5. What is your job title? \*

6. Email address : (The email address you provide will be used to send Round 2 and 3 of the survey) \*

## 5. Section 1 - Moving towards good clinical practice

### The Nationally Agreed CAMHS Referral Criteria state –

“A referral is deemed appropriate for a specialist CAMH assessment for treatment where both of the following two conditions are met:

Condition 1

**(basic threshold)**

- **A child/young person has or is suspected to have a mental disorder or other condition that results in persistent symptoms of psychological distress.**

**Condition 2**

**(complexity and severity threshold)**

**There is also the existence of at least one of the following:**

- **An associated serious and persistent impairment of their day to day social functioning.**
- **An associated risk that the child/young person may cause serious harm to themselves or others.**

**However, any threshold definition is likely to be subject to a degree of interpretation and no amount of supplementary information, qualification or guidance is going to be sufficient to completely eliminate the existence of geographical variance.”**

**Based on the above information**

7. How closely aligned is your service to following these guidelines? \*

8. How do you feel the current criteria meet patient needs? \*

What is important in order for your service to be able to implement the nationally agreed CAMHS criteria? \*

9. What has been helpful in your experience of adhering to the referral criteria? \*

10. What are some of the barriers in adhering to the referral criteria? \*

11. In what ways have you modified the guidelines to suit your service? \*

12. Thinking of your service, what are examples of good practice of implementing the nationally agreed guidelines? \*

13. Are there any additional areas that should be included in the referral criteria? If yes, please indicate what else should be included? \*

## **6. Section 2 - Supporting Staff**

14. What do you need to feel personally valued and supported in a specialist CAMH service? \*

15. In what ways are, or could, the values and support needs you identified above be best met?

#### *4.6 Appendix F.Reminder Email*

##### **Reminder Email**

Dear #FirstName#

I am a trainee clinical psychologist at the University of Edinburgh. Two weeks ago you received an email message inviting you to be part of an online expert panel as part of my research exploring how the nationally agreed CAMHS referral criteria have been implemented in the North of Scotland, and whether the criteria are effectively managing demand for services.

I recognise that you are extremely busy and that you may not wish to participate; however, if you have time, I would greatly appreciate your participation. Overall, participating in the Survey should take no longer than 15-30 minutes.

**If you would like to take part in this study or would like further information, please go to:**

#SurveyLink#

**If you do not wish to respond to this survey, please click on the link below to decline:**

#DeclineLink#

With thanks,

Vera Elders  
Trainee Clinical Psychologist  
DClinPsychol Programme  
**University of Edinburgh**

4.7 Appendix G. Categories and Themes from content analysis

<b>Section 1</b>				
	<b>Category</b>	<b>Sub-category</b>	<b>Codes</b>	<b>Theme</b>
<b>1</b>	Barriers to implementing the referral criteria	15	112	Access to Services
<b>2</b>	Service requirements	10	90	Implementation
<b>3</b>	Modification of guidelines	7	20	Implementation
<b>4</b>	Additional areas for the guidelines	7	20	Meeting Patient Needs
<b>5</b>	Examples of good practice	6	63	Access to Services
<b>6</b>	Consistency	4	12	Access to Services
<b>7</b>	Person centred care	3	5	Meeting Patient Needs
<b>Section 2</b>				
	<b>Category</b>	<b>Sub-category</b>	<b>Codes</b>	<b>Theme</b>
<b>1</b>	Support needs	5	50	Staff Needs
<b>2</b>	Meeting Support needs	14	80	Staff Needs

#### 4.8 Appendix H. Example of content analysis

The following provides an example of how the coding was implemented using a response from Participant 10 to the question “What are some of the barriers in adhering to the referral criteria?” who gave the response:

*“The definition of serious as used within the criteria. This definition being interpreted differently by different clinicians within the service, lack of clarity of service managers understanding of this. Feelings of guilt that those in need may not be receiving a service as they don’t meet the criteria and managing other’s expectations of the service.”*

In line with the coding strategy, the above response was divided into four units of meaning and assigned to three different categories and four sub-categories:

1. The first meaning unit: *“This definition being interpreted differently by different clinicians within the service”* was assigned to the category Barriers in the sub-category “Open to Interpretation”.
2. The second meaning unit: *“lack of clarity of service managers understanding of this”* was assigned to the category Implementation under the sub-category of ‘Leadership’.
3. The third meaning unit was considered to be: *“Feelings of guilt that those in need may not be receiving a service as they don’t meet the criteria”* and was also placed in the category Barriers in the sub-category “Discomfort with set threshold”.
4. The fourth meaning unit was considered to be *“managing other’s expectations of the service”* and was placed in the category ‘Implementation’ and the sub-category “Realistic expectations”.

The table below provides an exemplar of the categories and subcategories that mapped on to the theme: “Implementation”.

Theme	Implementation	
Category	Modifying the Guidelines	Requirements
<b>Sub-Category</b>	<ul style="list-style-type: none"> <li>• Accepting repeat referrals</li> <li>• Triage appointments</li> <li>• Reject with support from managers</li> <li>• Agreed criteria for all tiers</li> <li>• Urgent criteria</li> <li>• Accept referral for training reasons</li> <li>• More detailed criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Clear referrals</li> <li>• Staff training</li> <li>• Sufficient resources to meet demands</li> <li>• Realistic expectations</li> <li>• Leadership</li> <li>• Experienced team</li> <li>• Skills mix</li> <li>• Tier 1 – 2 specific services</li> <li>• Availability of other agencies</li> <li>• Good working relationships with other agencies</li> </ul>
<b>Example of codes</b>	<ul style="list-style-type: none"> <li>• Offering triage or screening appointments</li> <li>• Use of CAPA model</li> <li>• Accept multiple re-referrals</li> <li>• More detailed guidelines</li> <li>• Clear definitions</li> </ul>	<ul style="list-style-type: none"> <li>• Managing expectations</li> <li>• Good leadership</li> <li>• MDT working</li> <li>• Having other services to refer to</li> <li>• Training to screen referrals</li> </ul>

#### 4.8 Appendix I. Round 2 Questionnaire



# THE UNIVERSITY *of* EDINBURGH

Implementing nationally agreed guidelines in Child and Family Mental Health Services: A Delphi Study

### Welcome to Round 2 of this study

Firstly, thank you for continuing to take part. The Round 2 questionnaire is based on the content analysis of the information provided in Round 1. This stage invites you to rate your agreement of the statements that were identified by the panel in round one. In addition, you will be asked to rate statements about your values and support needs for working in a CAMH service.

It is estimated that this stage should take no longer than 10–15 minutes.

If you have any questions or comments about the study please contact me directly by emailing me on [vera.elders@nhs.net](mailto:vera.elders@nhs.net)

If you wish to continue, please click to the next page.

Many thanks,

Vera

### 2. Consistency

Thinking about applying the National CAMHS referral criteria in a consistent way, please rate the following statements:

1. Guidelines should be open to interpretation and allow for clinical judgement.

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly disagree

Do you have any comments or suggestions for the revision of this item?

2. Guidelines should be consistently applied across all CAMH services. \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly disagree

Do you have any comments or suggestions for the revision of this item?

3. There should be clarity on what the core work of the service is \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

4. There should be clear service priorities \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly disagree

Do you have any comments or suggestions for the revision of this item?

3. Examples of good practice

Thinking about examples of good practice in implementing referral criteria, please rate the following statements

5. There should be regular referral consensus meetings \*

- Strongly Agree
- Agree

- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

6. There should be opportunities to discuss referrals with colleagues \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

7. There should be close working relationships between primary and secondary care \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

8. There should be opportunities to network with partner agencies \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

9. There should be good access to third sector services \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

10. CAMH services should provide a stepped model of care \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

11. Patient needs should be prioritised \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

12. CAMH services should dedicate their time to those most in need of a service \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

13. CAMH services should offer triage / screening appointments for referrals which do not clearly meet the referral criteria \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

14. CAMH services should offer CHOICE appointments for all referrals \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

15. CAMH services should offer consultation clinics to reflect on complex cases with other professionals \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

16. Referrals should be screened by experienced clinicians \*

- Strongly Agree
- Agree

- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

17. A regularly updated resource directory with appropriate resources for children and young people should be available to all health professionals \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

18. CAMH services should seek to educate referrers on the CAMHS referral criteria \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

19. Specialist treatment should be available for developmental disorders \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

20. Referrals should contain information regarding any previous input \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

4. Working together as a team

Thinking about working together as a team, please rate the following items:

21. There should be regular team discussions about service priorities \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

22. Multi-disciplinary teamwork is an essential prerequisite for an effective CAMH service \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

23. There should be a range of disciplines in a CAMHS team \*

- Strongly Agree
- Agree

- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

24. Staff should feel supported by the service management \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

25. There should be defined responsibilities for each team member \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

5. Barriers

Thinking about some of the barriers that may arise when applying the referral criteria, please rate the following items:

26. Children and young people's mental health should not have to deteriorate before being eligible to receive input from CAMHS \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

27. Addressing children and young people's psychosocial health is as important as addressing their medical needs \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

28. There shouldn't be a distinction between medical, psychological and social difficulties. \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

29. There should be a clear agreed definition of 'Mental Health' \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

30. There should be a clear agreed definition of 'Psychological Distress' \*

- Strongly Agree

- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

31. There should be clear guidance from management on how to apply the referral criteria \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

32. Clinicians should not feel pressured to accept referrals due to pressure from Government targets \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

33. Clinicians should not feel pressured to accept referrals due to pressure from referrers \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

34. There should be sufficient time to read through referrals \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

35. There should be a well resourced team \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

36. It is important to take the geographical area of the health board into account when screening referrals \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

37. The guidelines should be specifically used to reduce government waiting times \*

- Strongly Agree

- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

38. There should be a focus on early intervention \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

39. There should be adequate numbers of primary care health professionals to assist in the recognition and management of Tier 1 and Tier 2 cases \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

40. There should be specific services for Tier 1 and Tier 2 cases within CAMHS \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

41. There should be staff training on how to apply the referral guidelines \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

42. Referrals should contain clear information to be able to determine whether it meets the referral criteria \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

43. Resources should be matched to capacity \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

6. Modifying the referral criteria

Thinking about modifying the Nationally agreed CAMHS referral criteria, please rate the following items:

44. There should be specific guidelines for each Tier \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

45. There should be additional guidelines for CHOICE appointments \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

46. Repeat referrals should be automatically accepted for triage / screening / CHOICE \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

---

47. Referrers should always receive information about other services or options when a referral is not accepted \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

48. Referrers should be signposted to other services on a regular basis \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

7. Additional areas

Thinking about additional areas that could be included in the National CAMHS referral criteria, please rate the following items

49. There should be criteria for Looked After and Accommodated Children \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

50. Children and young people should consent to a referral being made to CAMH services \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

51. There should be agreed criteria around assessing risk \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

52. There should be an indication of the child or young person's motivation to attend \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

53. There should be guidelines for developmental disorders \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

54. There should be guidelines for conduct disorders \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

55. There should be guidelines for somatic and physical disorders \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

56. There should be guidelines for urgent / emergency criteria \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

## 8. Implementation

Thinking about implementing the National CAMHS referral criteria, please rate the following items

57. Services should be equitable for patients \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

58. There should be robust outcome monitoring \*

- Strongly Agree

- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

59. Effective implementation of the guidelines should be evidenced \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

60. There should be strong leadership within the service \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

61. There should be sufficient administrative support \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

62. There should be strong links with social work \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

63. There should be strong links with education \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

64. There should be strict referral criteria for accessing specialist services \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

65. The National criteria should be used to screen all referrals across Scotland \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

66. There should be sufficient IT systems \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

67. There should be effective communication between primary and secondary care \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

68. There should be effective communication between key stakeholders \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

69. There should be an increase in health promotion \*

Strongly Agree

- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

#### 9. Section two - Supporting Staff

Thinking about your support needs, please rate the following items

70. There should be opportunities for CPD / training \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

71. There should be opportunities to develop innovative services \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

72. There should be a clear and coherent service vision \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

73. There should be transparency between managers and clinicians \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

74. Professional opinions of all team members should be recognised and respected \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

75. Everyone's contributions should be valued \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

76. Individual skills should be recognised by the team as well as managers \*

- Strongly Agree
- Agree

- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

77. There should be a supportive culture in CAMHS teams \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

78. There should be regular MDT supervision \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

79. There should be regular individual supervision \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

80. There should be opportunities to progress within the service \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

81. It is important to understand one's role within the service \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

82. It is important to have trusting relationships with your colleagues \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

83. It is important to function within your own discipline \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

84. It is important for other team members and managers to be aware of what I do \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

85. It is important to get feedback from patients and families \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

86. It is important to get feedback from management \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

10. Meeting support needs

Thinking about ways to meet your support needs, please rate the following items:

87. There should be a focus on team processes \*

- Strongly Agree

- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

88. There should be a reduction in pressures from the top down \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

89. There should be opportunities for non-work related discussions \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

90. There should be a culture of respect \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

91. There should be regular face to face contact between clinicians and managers \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

92. There should be a clear management structure \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

93. There should be meaningful line management \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

94. Achieved goals should be acknowledged and celebrated \*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

95. There should be an effective appraisal process \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

96. There should be an acknowledgement of hard work \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

97. There should be time to meet patient needs rather than just meeting waiting times \*

Strongly Agree

Agree

Neither Agree nor Disagree

Disagree

Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

98. There should be regular and clear communication between clinicians and managers \*

\*

- Strongly Agree
- Agree
- Neither Agree nor Disagree
- Disagree
- Strongly Disagree

Do you have any comments or suggestions for the revision of this item?

#### 11. Final thoughts

Do you have any other comments or suggestions about any of the items that you have rated?



# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

0%

### Participant Information (1)

Study Information

#### **Welcome to the final round of this study**

**Firstly, thank you for continuing to take part. Round 3 will display the overall panel consensus percentage for each item that reached consensus (a rating between 51-75%).**

**Please use your participant number from your email to see what rating you gave each item in the previous round. Round 3 will involve re-rating items from Round 2.**

**It is estimated that this stage should take less than 10 minutes to complete.**

**If you have any questions or comments about the study, please contact me directly by emailing me on: [vera.elders@nhs.net](mailto:vera.elders@nhs.net)**

**If you wish to continue, please click the next page.**

**With thanks,**

**Vera**



Save and Continue Later

Next Page

# THE UNIVERSITY *of* EDINBURGH

## (Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services

12%

Examples of good practice

**Thinking about examples of good practice in implementing referral criteria, please re-rate the following statements**

**1. Original item:**

**CAMH services should dedicate their time to those most in need of a service**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
61.5% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	1	P8	2	P15	2		
P2	1	P9	3	P16	3		
P3	4	P10	4	P17	2	P22	2
P4	2	P11	1	P18	1	P23	3
P5	1	P12	3	P19	3	P24	2
P6	3	P13	1	P20	3	P25	2
P7	2	P14	2	P21	3	P26	2

**Summary of Comments:**

- **CAMHS should dedicate some of their time to those most in need, however, a range of skills are required across the service. Skills should be used where they are required.**
- **Within a tiered system there is also a role in early intervention and prevention**
- **There needs to be a balance, both prevention and early intervention are also important and skilling up those in Primary Care to recognise early signs of mental health problems and respond to appropriately.**
- **There needs to be a balance between most severe cases and early intervention.**
- **Only working with people who meet the national CAMHS criteria does not allow for early intervention.**
- **Early intervention is an important role and a strong driver for service development**

**Revised item for re-rating:**

**It is important for CAMH services to balance their time between the most severe cases and early intervention**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**2. Original item:**

**Specialist treatment should be available for developmental disorders**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**73.1% (Median = 2, IQR = 2)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	3	P8	2	P15	2		
P2	2	P9	3	P16	1	P22	2
P3	1	P10	1	P17	1	P23	2
P4	1	P11	3	P18	2	P24	2
P5	3	P12	1	P19	1	P25	2
P6	1	P13	3	P20	1	P26	3
P7	2	P14	4	P21	2		

**Summary of Comments:**

- **Contingent upon the presenting difficulty, and the availability of alternative resources**
- **Depends on what 'specialist' means**
- **Depends on whether assessment is included in 'treatment'**
- **Where there is a co-morbid mental health difficulty**
- **Treatment needs to be delivered in the most appropriate contexts**
- **This will come at a cost**

**Revised item for re-rating:**

**CAMHS should only offer post assessment contact for patients with developmental disorders when there is a co-morbid mental health condition**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?



# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

25%

### Barriers

**Thinking about some of the barriers that may arise when applying the referral criteria, please re-rate the following items:**

#### **3. Original item:**

**Children and young people's mental health should not have to deteriorate before being eligible to receive input from CAMHS**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**65.4% (Median = 2, IQR = 2)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
-------------	--------	-------------	--------	-------------	--------	-------------	--------

P1	3	P8	1	P15	1		
P2	1	P9	3	P16	1	P22	2
P3	1	P10	1	P17	2	P23	1
P4	1	P11	3	P18	3	P24	2
P5	3	P12	3	P19	1	P25	2
P6	2	P13	3	P20	1	P26	3
P7	3	P14	2	P21	2		

**Summary of Comments:**

- Patients who do not meet the threshold should receive support from universal services at Tier 1 and 2 and if this does not work then tier 3 services are required
- Should not have to be at a crisis point before being seen
- CAMHS is tiered. Specialist CAMHS (Tier3+) are for children and young people who have clear deterioration in functioning. So Tiers 1 and 2 should have preventative and health promotion components
- Early intervention is therefore very important
- PMHW support should be available to all children and young people, in their communities

**Revised item for re-rating:**

**If a referral does not meet threshold criteria for specialist CAMH services, there should be clear referral pathways for lower intensity services**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**4. Please re-rate the following item:**

**There should be a clear agreed definition of 'Mental Health'**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**65.4% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	1	P8	1	P15	2		
P2	2	P9	3	P16	2	P22	2
P3	4	P10	2	P17	2	P23	4
P4	2	P11	3	P18	3	P24	2
P5	2	P12	3	P19	2	P25	2
P6	3	P13	2	P20	1	P26	1
P7	3	P14	3	P21	2		

**Summary of Comments:**

- **Impossible to come to a consensus on a definition**
- **There already is a distinction between mental health and mental well-being**
- **The World Health Organisation already have a definition of Mental Health**
- **Would be difficult to arrive at a consensus as it is too big and broad a term**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**5. Please re-rate the following item:**

**There should be a clear agreed definition of 'Psychological Distress'**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
57.7% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	2	P8	2	P15	2		
P2	2	P9	3	P16	2	P22	3
P3	4	P10	2	P17	2	P23	3
P4	2	P11	3	P18	4	P24	2
P5	3	P12	3	P19	2	P25	2
P6	3	P13	2	P20	1	P26	1
P7	3	P14	3	P21	2		

**Summary of Comments:**

- **Cannot operationalise a subjective experience**
- **Not possible to come to an agreed definition**
- **We have to recognise individual differences in the experience of psychological distress/coping and how this manifests**
- **Better to focus on how we define psychological distress that requires CAMHS: This is more focused and pragmatic (applied rather than essentialist)**
- **Definition should be applied from a person-centred point of view**

**\***

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**6. Original item:**

**There should be clear guidance from management on how to apply the referral criteria**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
73.1% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	4	P8	3	P15	1		
P2	2	P9	3	P16	1	P22	2
P3	3	P10	2	P17	2	P23	2
P4	1	P11	5	P18	2	P24	2
P5	2	P12	2	P19	2	P25	2
P6	3	P13	2	P20	1	P26	1
P7	3	P14	2	P21	1		

**Summary of Comments:**

- **Management may be non-clinical**
- **Some managers do not have any clinical experience and do not necessarily understand what our service does.**
- **Clinical decisions should not be made by non-clinical staff**
- **Applying the referral criteria must be a clinical consensus rather than management. However, it is helpful if the management are clear about what is not CAMHS business such as grief work, ASD assessment or anything to do with risk for example**
- **Managers need to be guided by clinicians who often have more robust understanding and knowledge of the day to day work**
- **Requires bottom up and top down discussions to achieve team ownership of the criteria**

**Revised Item for re-rating:**

**There should be clear guidance on how to apply the referral criteria, this guidance should be informed by clinicians**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**7. Original item:**

**It is important to take the geographical area of the health board into account when screening referrals**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**73.1% (Median = 2, IQR = 2)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	2	P8	2	P15	1		
P2	4	P9	3	P16	1	P22	1
P3	2	P10	3	P17	2	P23	2
P4	3	P11	1	P18	2	P24	2
P5	2	P12	1	P19	3	P25	2
P6	1	P13	2	P20	1	P26	3
P7	2	P14	4	P21	1		

**Summary of Comments:**

- Whilst there may be locally based services available to remote geographical areas, a CAMHS assessment should be the baseline for any intervention
- Should not impact on decision making about whether a referral meets criteria
- Geography shouldn't impact on services available to patients
- All patients should be treated equally, regardless of geographical location

**Revised Item for re-rating:**

**Geography should not have an impact on whether a referral meets threshold criteria**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**8. Please re-rate the following item:**

**There should be specific services for Tier 1 and Tier 2 cases within CAMHS**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
57.7% (Median = 2, IQR = 2)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
-------------	--------	-------------	--------	-------------	--------	-------------	--------

P1	3	P8	1	P15	2		
P2	4	P9	3	P16	1	P22	1
P3	3	P10	1	P17	1	P23	1
P4	1	P11	5	P18	2	P24	2
P5	4	P12	3	P19	1	P25	2
P6	3	P13	3	P20	3	P26	4
P7	1	P14	2	P21	1		

**Summary of Comments:**

- **Within CAMHS, but not within specialist CAMHS**
- **Having Tier 1 and 2 services within CAMHS can create a blur on role of specialist CAMHS. Close links are essential to improve patient experience**
- **Cannot be specialist and see all children and young people**
- **Should be embedded in schools and communities rather than in hospitals**
- **Having a tiered system doesn't always work as it is not easy to define what Tier 1,2,3 do**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**9. Original item:**

**Resources should be matched to capacity**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
73.1% (Median = 2, IQR = 2)**

Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	1	P8	3	P15	2		
P2	1	P9	2	P16	1	P22	2
P3	3	P10	3	P17	1	P23	2
P4	1	P11	5	P18	2	P24	2
P5	1	P12	2	P19	3	P25	2
P6	3	P13	1	P20	2	P26	2
P7	2	P14	3	P21	2		

**Summary of Comments:**

- Question is unclear
- Is capacity the same as resource?
- Matched to demand rather than capacity
- Resources should be matched to capacity demand

**Revised Item for re-rating:**

**Resources (e.g. staffing) should be matched to meet service demands**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

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# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

38%

Modifying the referral criteria

**Thinking about modifying the Nationally agreed CAMHS referral criteria, please re-rate the following items:**

**10. Item for re-rating:**

**There should be specific guidelines for each Tier**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
73.1% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	4	P8	2	P15	2		
P2	1	P9	3	P16	2	P22	2
P3	2	P10	2	P17	2	P23	2
P4	2	P11	5	P18	2	P24	2
P5	3	P12	2	P19	2	P25	2
P6	3	P13	2	P20	3	P26	1
P7	4	P14	2	P21	2		

### Summary of Comments:

- Tiered system may not be helpful in practice
- Specific, but not micro-managed

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

### 11. Item for re-rating:

**There should be additional guidelines for CHOICE appointments**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**57.7% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	4	P8	3	P15	2		
P2	2	P9	3	P16	1	P22	2
P3	2	P10	2	P17	2	P23	3
P4	2	P11	5	P18	4	P24	2
P5	4	P12	3	P19	3	P25	1
P6	1	P13	2	P20	2	P26	1
P7	4	P14	2	P21	4		

**Summary of Comments:**

- **Additional to what?**
- **There are guidelines available already**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

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# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

50%

Additional areas

**Thinking about additional areas that could be included in the National CAMHS referral criteria, please re-rate the following items**

### **12. Original item:**

**There should be criteria for Looked After and Accommodated Children**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**73.1% (Median = 2, IQR = 2)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	4	P8	1	P15	2		
P2	1	P9	3	P16	1	P22	1
P3	3	P10	2	P17	2	P23	3
P4	1	P11	3	P18	2	P24	2
P5	4	P12	2	P19	2	P25	2
P6	1	P13	1	P20	2	P26	2
P7	3	P14	2	P21	1		

**Summary of Comments:**

- **LAAC should not be a reason to discriminate**
- **There should be criteria for all children and young people**
- **Mental illness is mental illness whether in Looked after children or not but there is up to 80% more possibility of LAC having mental illness than the general population**
- **Yes, given corporate parenting responsibilities that have now been widened beyond councils to include health boards**
- **Need to take into account other services involved, and stability / security to engage with CAMHS**

**Revised item for re-rating:**

**There should be separate criteria for Looked After and Accommodated Children**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

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# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

62%

### Implementation

**Thinking about implementing the National CAMHS referral criteria, please re-rate the following items**

#### **13. Original item:**

**There should be strict referral criteria for accessing specialist services**

**Average percent of Strongly Agree (1) or Agree (2) ratings:**

**69.2% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	2	P8	3	P15	1		
P2	2	P9	3	P16	3	P22	2
P3	3	P10	2	P17	4	P23	2
P4	1	P11	4	P18	4	P24	2
P5	1	P12	2	P19	2	P25	2
P6	2	P13	1	P20	2	P26	2
P7	3	P14	2	P21	2		

**Summary of Comments:**

- Fair referral criteria
- **Everything in life needs flexibility. Mental disorders may fit in clear cut boxes but real life patients do not.**
- 'clear' not 'strict'

**Revised item for re-rating:**

**There should be clear referral criteria for accessing specialist services**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

**14. Item for re-rating:**

**The National criteria should be used to screen all referrals across Scotland**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
57.7% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
-------------	--------	-------------	--------	-------------	--------	-------------	--------

P1	2	P8	3	P15	1		
P2	1	P9	3	P16	3	P22	3
P3	3	P10	2	P17	3	P23	2
P4	2	P11	4	P18	2	P24	3
P5	1	P12	2	P19	3	P25	2
P6	2	P13	1	P20	3	P26	1
P7	3	P14	2	P21	2		

**Summary of Comments:**

- **The National criteria assumes a good level of primary care or tier 1 provision.**
- **Depends on the CAMHS remit when the service was commissioned**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

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# THE UNIVERSITY *of* EDINBURGH

## **(Round 3) Implementing nationally agreed guidelines in Child and Family Mental Health Services**

75%

Meeting support needs

**Thinking about ways to meet your support needs, please re-rate the following items:**

### **15. Original item:**

**There should be a reduction in pressures from the top down**

**Average percent of Strongly Agree (1) or Agree (2) ratings:  
53.8% (Median = 2, IQR = 1)**

**Please see your response to this question from Round 2 below (your participant number can be found in your invitation email to Round 3)**

Participant	Rating	Participant	Rating	Participant	Rating	Participant	Rating
P1	2	P8	2	P15	2		
P2	2	P9	2	P16	2	P22	3
P3	2	P10	3	P17	2	P23	3
P4	1	P11	3	P18	4	P24	4
P5	2	P12	3	P19	3	P25	2
P6	3	P13	2	P20	2	P26	3
P7	3	P14	3	P21	2		

**Summary of Comments:**

- **Pressure is an individual thing and also depends on what is going on in ones personal and social life**
- **Pressure should move in both directions**
- **If the purpose of the pressure is clear and in keeping with the service values, mission and vision, then - yes. Pressure from top down is helpful. Anything from a less clear cause will produce decreased morale, animosity and disengagement.**

**Revised Item for re-rating:**

**There should be a reduction in demands coming from the top down**

\*

- Strongly Agree (1)
- Agree (2)
- Neither Agree nor Disagree (3)
- Disagree (4)
- Strongly Disagree (5)

Do you have any comments or suggestions for the revision of this item?

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4.10 Appendix K. Letters of ethical approval



SCHOOL of HEALTH IN SOCIAL SCIENCE  
CLINICAL AND HEALTH PSYCHOLOGY

The University of Edinburgh  
Medical School  
Doorway 6, Teviot Place  
Edinburgh EH8 9AG

Telephone 0131 651 3969  
Fax 0131 650 3891  
Email [submitting.ethics@ed.ac.uk](mailto:submitting.ethics@ed.ac.uk)

Vera Elders  
Trainee Clinical Psychologist  
Young People's Department  
Lower Garden Villa  
Royal Cornhill Hospital

04 February 2016

Dear Vera,

**Application for Level 1 Ethical Approval**

**Reference:** CLIN254

**Project Title:** Clinical Priorities for a 0-18 CAMH Service: A Delphi Study

**Academic Supervisor:** Emily Newman

Thank you for submitting the above research project for review by the Department of Clinical and Health Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 3<sup>rd</sup> February 2016.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

Kirsty Gardner  
Administrator  
Clinical Psychology

**Research and Development** Foresterhill House Annexe  
Foresterhill  
ABERDEEN  
AB25 2ZB



Ms Vera Elders  
NHS Grampian  
Young Peoples Department  
Lower Garden Villa  
Cornhill Road  
Aberdeen  
AB25 2ZH

Date 21/06/2016  
Our Ref 2016MH002  
Enquiries to Lynn Massie  
Extension 53846  
Direct Line 01224 553846  
Email grampian.randdpermissions@nhs.net

Dear Ms Elders

**STUDY TITLE:** Implementing nationally agreed guidelines in Child and Family Mental Health Services: A Delphi Study  
  
(Previously Clinical Priorities for a 0-18 Child and Adolescent Mental Health Service: A delphi study)

**PROTOCOL NO:** Version 2 dated 10/05/16  
**R&D REF:** 2016MH002  
**NRS REF:** NRS16/192255  
**AMENDMENT NO:** Dated 31 May 2016

We are in receipt of a copy of the amendment to the above project relating to changes to the following documents:

- Protocol V2 10.05.16
- Initial Invitation Email V2 31.05.16
- Consent Form V2 31.05.16

We also note change of title of the study, as documented above.

This letter is confirmation that this amendment does not alter local NHS Grampian R&D management permission of the project.

Yours sincerely

A handwritten signature in black ink, appearing to read 'S. Ridge', with a long, sweeping underline.

Susan Ridge  
Non Commercial Manager

cc. Jo-Anne Robertson, Sponsor, Edinburgh University