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RESEARCH ARTICLE

Adolescent Mentalization-Based Integrative Therapy (AMBIT):

A new integrated approach to working with the most hard to reach adolescents with severe complex mental health needs

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ABSTRACT:

Background:

'Hard to reach' young people are associated by virtue of their serious, multiple and complex needs, the difficulty of delivering effective help to them, and their poor long-term outcomes. There is a lack of published evidence relating to the effectiveness of interventions directed at this group.

Methods

We review these concerns, and the options available to service commissioners and clinicians seeking if not an evidence-based approach, then at least an evidence-oriented one. A mentalization-based multimodal intervention (AMBIT), is briefly described,

proposing a new kind of specialist practitioner and taking a radically different approach to treatment manualization.

Findings

A brief description is given of the different settings in which AMBIT is currently being developed, deployed and evaluated, and of lessons learned.

Conclusions:

AMBIT offers promise as an evolving 'open source' framework supporting development of evidence-based local practice in chaotic complex settings.

Key words:

Adolescence, “Hard to reach”, Outreach, Mentalization, Complexity

Practitioner Messages:

1. Mentalization-based approaches to treatment may offer promise for hard to reach, complex and comorbid youth, although formal outcomes evaluations and trials are required.
2. Mentalization-based practice can be applied not only to the index patient/family, but also towards the different (and often ‘dis-integrated’) parts of the multiagency network, and to support helpful interactions between team members.
3. A wiki-based (“co-constructed”) approach to treatment manuals is possible, expanding conventional notions of the manual, and marrying *locally-curated* accounts of implementation and other local expertise, with *centrally-curated* evidence-based material.

1. Introduction: the ‘hard to reach’ young person, needs and services.

‘Hard to reach’ young people with complex and severe mental health problems co-morbid with multiple social vulnerabilities present some of the highest risks, have amongst the worse prognosis, and are offered services often poorly equipped to provide for their needs (Kessler et al, 2010 ¹). They may be offending or on the verge of delinquency, they may have substance-use disorders in addition to an array of psychiatric disorders, but in addition to this they often have a care network or social ecology that is unable or unwilling to support them to access care or treatment in standard settings. From a service delivery

¹ See Bibliography in Electronic Appendix

perspective, this group often fall between the specific responsibilities of different welfare agencies and present challenges for the development of effective, inclusive, provision.

Pragmatic and proper concern about the cost and effectiveness of in-patient or out-of-area service provision mean it is imperative to consider what community services could engage multi-problem youth earlier, and reduce the likelihood of unnecessarily extended (and expensive, Beecham et al 2009, Ward et al 2008) admissions

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and institutional dependency. In the UK, developments in this area include services in Bradford (Rani et al 2009¹) and South Wales (Goel and Darwish, 2008¹). Internationally, Multi-Systemic Therapy (MST) is the most well developed model for assertive multimodal outreach (Henggeler et al, 2008¹), although some reviews (Littel et al 2009¹) have questioned its superiority to usual services. Results are awaited from a multicentre trial of MST across the UK..

Despite acknowledged paucity in the evidence for existing models of home-based treatment of adolescents, there is nonetheless an emerging consensus (Weisz and Simpson Gray 2008; Weisz and Kazdin, 2010¹; Bickman and Hoagwood, 2010¹; Garland et al, 2010¹; Kelley et al, 2010¹, Weisz et al 2011¹); that effectiveness of clinical practice is likely to be enhanced by a number of features, including:

- i. **A coherent overarching theoretical framework,**
- ii. **Manualization** of operational procedures

iii. **Measures to encourage and ensure fidelity** to the model.

iv. **Routine intensive evaluation of outcomes**

In this paper we describe a well documented (manualized) collaborative strategy for community based work with the 'hard to reach'. It involves a particular form of team organization, developed and successfully implemented in multiple teams, with strong emphasis on the above principles. It has, we believe, the potential to generate improved value by improving outcomes that matter for minimal investment of resources (Porter, 2010¹.) This initial report describes the team structure and functioning. Further papers will describe how the principles have been rolled out at several sites in England, Scotland and Northern Ireland.

2. A new approach: Adolescent Mentalization-Based Integrative Therapy (AMBIT)

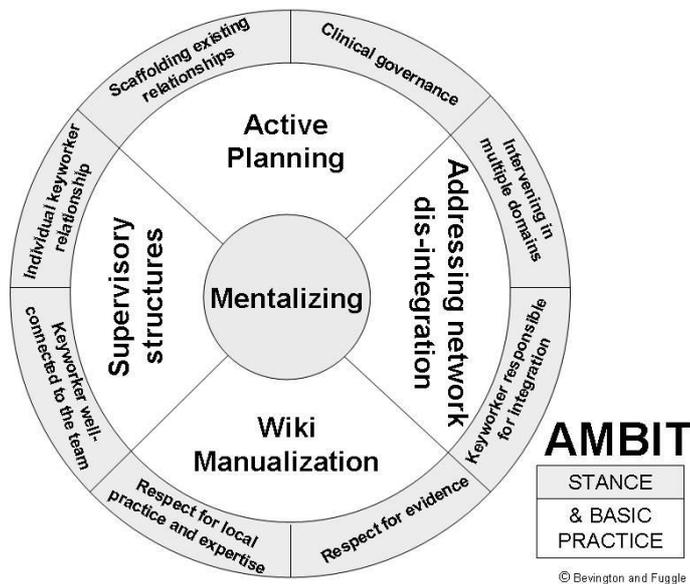
AMBIT uses mentalization (see below) as an organising framework (Bevington and Fuggle, in press¹) for integrating a range of specific techniques and practices derived from different evidence based modalities of intervention (Asen and Bevington, 2007¹). Integration is principally achieved through a focus on delivery of multiple modalities through a single worker, and mentalization-based practices developed to enhance team and network functioning. These support work in exposed community settings in which practitioners are, at times likely (appropriately) to experience high levels of professional anxiety. An innovative approach to treatment manualization supports outcome evaluation, maintenance of treatment fidelity, and the adaptation of the approach to local conditions.

2.1 The core AMBIT Stance and Practice

The **core stance** for AMBIT practitioners has eight components and is designed to shape practice, articulate values, and to function as memorable "grab-rails" for those times when

professional anxiety threatens the capacity to deliver systematic and structured interventions. The stance supports **4 Key Components of Practice**, with Mentalizing as central to the whole. This is summarized in Figure 1.

Figure 1.



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2.1.1 Mentalization

We use the term mentalization in the sense used by both neuroscience (Frith, 2007) and psychological therapy (Bateman & Fonagy, 2011), to refer to a form of imaginative mental activity about others or oneself, namely, perceiving and interpreting human behaviour in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons). Mentalization offers an integrative theoretical framework for the approach that is easy to train and can be applied to practical advantage across individual, family, social-ecological and inter-professional domains. It is axiomatic to mentalizing theory that well functioning (accurate) mentalizing in individuals or families makes for improved relationships, a reduction in the negative impact of misunderstandings, and, within the

individual, more effective meta-cognitive abilities (Sharp & Fonagy, 2008¹). More pertinent to AMBIT, we assume that failures of mentalizing undermine interpersonal relationships, tending to generate social environments where actions are rarely considered accurately in mental state terms (e.g. prisons, gangs, street crime). Mentalization based treatment (MBT) for borderline personality disorder is a relatively well evidenced intervention (Bateman and Fonagy 2011) and a randomized controlled trial of an adaptation for self-injurious adolescents for is nearing completion.

Mentalization is primarily (in its developmental origins and its functional significance) *relational*, placing great emphasis on the therapeutic relationship between worker and client. Fonagy et al (2003¹) assume that there is a mutually facilitative relationship between the attachment and the mentalizing social systems - a sense of security creates opportunities for seeing actions in mental state terms, and, conversely, accurately understanding the actions of others in terms of their likely thoughts and feelings appears to trigger an affiliative reaction. This explains the AMBIT emphasis on fostering an individual therapeutic relationship to an extent that contrasts somewhat with behavioural and/or social-ecological approaches.

Insofar as mentalizing theory suggests that most effective therapeutic methods (from psychoanalysis to systemic therapy, by way of cognitive behaviourism) actually stimulate and sustain mentalizing, in AMBIT, it functions as the 'lubricant' which oils the interface between theoretically diverse interventions. Most crucially, mentalizing techniques are applied not only in face to face work with clients but also between team members; thus responsibility for supporting colleagues' capacity to mentalize is a core team task.

2.1.2 Individual Keyworker Relationship

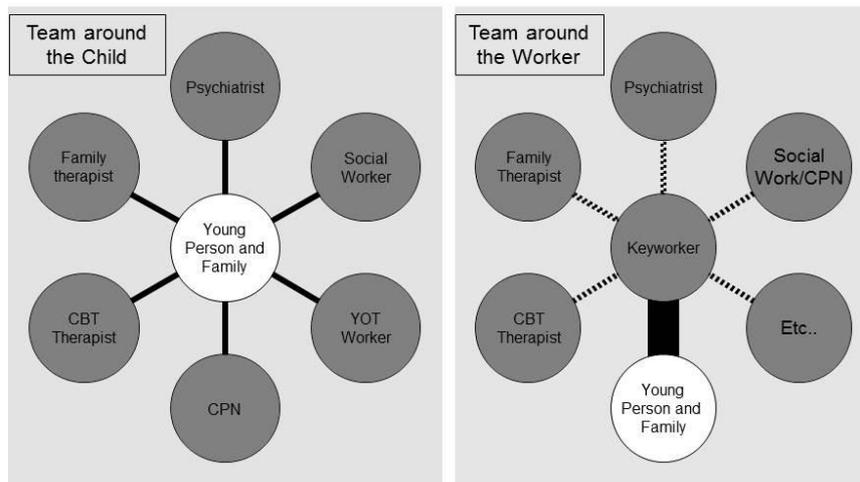
As stated above, AMBIT emphasises the importance of developing a ‘therapeutic attachment’, accepting that the activation of the attachment system in ‘hard to reach youths’ and in their families in relation to the professional may be an essential component of the treatment. In most cases a single keyworker works with the youth, the family and the wider network, so as to reduce the opportunities for families to feel overwhelmed by the multiplication or duplication of workers, or to be distracted by the different emphases, or frank disagreements, of different workers. Workers aim to activate something of the “secure base” phenomenon in their clients, who can then start to explore not so much the external world, but their own internal narratives, which through the generation of a continuity between past, present and future in terms of subjective experiences is one of the helpful features of successful mentalizing.

2.1.3 Keyworker is well-connected to the wider team

AMBIT is a **team-based** approach, adopting an alternative position to the conventional notion of the “Team around the Child” – instead creating a “Team around the Worker” (see Fig 2). Interaction with these young people and their families can challenge the most empathic professional, causing them to act rather than think, to make dramatic generalizations, or think in circles ‘fantasizing’ about mental states in a meaningless way. To avoid teleological (solely outcomes-focused) or pseudo-mentalizing responses (apparent thoughtfulness, though lacking real affective congruence to the moment) in these challenging settings, the support of a team that demands mentalized accounts is essential.

Figure 2.

AMBIT: A shift of emphasis



**Actively stimulating and sustaining Mentalization
IN THE WORKER COLLEAGUE as a core team task**

2.1.4 Scaffolding *existing* relationships.

As with other systemic approaches, AMBIT looks to nurture and support existing constructive family or peer relationships and resiliencies in the young person's life. In addition, AMBIT explicitly aims, wherever possible, to scaffold *existing relationships* within the professional network rather than to replace these. A 'common sense approach', eschewing jargon, and ensuring that the young person's or the family's predicament is expressed in mental state terms facilitates broad based collaboration between the services.

2.1.5 Clinical Governance.

Local risk management and clinical governance structures are expected to be implemented to a high standard. AMBIT requires a clear structure of local clinical accountability, in which roles, authorities and responsibilities are made explicit, rather than held implicitly.

2.1.6 Intervening in multiple domains.

Because of the multiply determined, and highly co-morbid presentations typical of hard to reach youth, interventions in a single domain (biological, psychological, social-ecological, educational) are likely to be less effective than multi-domain interventions in this population (Hogue et al 2006 ¹). In addition to Mentalizing techniques, practitioners are deliberately trained to carry out basic interventions which are drawn from a broad range of modalities (e.g. Systemic, CBT and attachment-based techniques, as well as health-promotion and harm-reduction) equipping them for active, flexible, non-clinic-based, “frontline” or “street-level” work.

2.1.7 Keyworker responsibility for integration

At the point of delivery the AMBIT practitioner takes responsibility for integrating different interventions and explanatory models, rather than leaving this to the client. Where the keyworker is not personally delivering a particular modality, he or she assumes the role of interpreter;

[Figure 2]

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researching, explaining and contextualizing the approach of other professionals for the young person.

2.1.8 Respect local practice and expertise.

In an attempt to avoid the effects of negatively biased feedback that often colours inter-agency attitudes in the professional network (for instance, clients often seek to engage a worker through accounts of the failure of other agencies), and consistent with a mentalizing stance, a team culture of explicit sensitivity and respect towards the existing

local service ecology, and existing local expertise, is promoted. The stance of the 'expert' is eschewed.

2.1.9 Respect for Evidence

Wherever possible, AMBIT aims to incorporate and promote evidence-based techniques and practice. Robust outcomes measurement is expected as a core part of practice, and an adaptation of the Hampstead Child Adaptation Measure (Target & Fonagy 1992 ¹) is integrated within the manual as the 'AMBIT Adolescent Integrative Measure' (AIM) (available at www.tiddlymanuals.com). A goals-based approach to routine outcomes monitoring using the AIM is underway in Cambridgeshire Child and Adolescent Substance use Service (CASUS) with some preliminary promising results. An uncontrolled pilot evaluation of 63 key problems identified at treatment start in 15 cases indicated that 79% showed improvement at discharge, with 9 cases rated as having occasional or no use of alcohol or drugs at case closure.

2.2 Key practice components of AMBIT.

2.2.1 Active Planning: Using the stance laid out above, the practitioner aims to develop an accurately mentalized understanding of the young person's/family's difficulties in order to deliver evidence-based interventions across the range of functional domains. Formulations following a mentalizing approach require a systemic understanding which entails no theoretical language and attempts to state the young person's and family's problems *in terms of their respective subjective experiences* of their social and family contexts. All AMBIT interventions and interactions (with clients and with colleagues) should have an explicit plan directly linked to the mentalizing formulations. From brief practitioner case discussions, through individual sessions, to longer term care plans, workers practice the discipline of defining tasks/intentions/desired outcomes *explicitly* (in

conversation or in writing) and justifying these plans in terms of the presumed understanding of others' experience, as opposed to engaging in activity with implicit (or non-mentalized) plans. This focus on making explicit ("broadcasting") one's intentionality encourages planning, and supports mentalization and effective practice.

2.2.2 'Addressing Dis-integration': Experience suggests that between institutions of social 'care', non-mentalizing interactions (responding to the other without considering the impact on their subjective experience) are common. Rules and procedures may be implemented without regard to how others in the system are likely to experience the actions, mirroring contradictions ('dis-integration') within the family systems they aim to organize. AMBIT *anticipates* the likelihood of dis-integration between workers or agencies; in (a) the way the problem is *conceptualized*, (b) the *pragmatic* solutions proposed and (c) in assumptions about role responsibilities within the wider *system* of care. Explicitly and proactively mentalizing and checking the differing perspectives of the main people/agencies involved allows identification of difficulties in the network, and the selection of 'connecting conversations' between elements of that network that might repay facilitation. A simple 'Dis-integration Grid' has been developed for this purpose (figure 3.) This offers a structured process for an individual worker or team looking for ways to support a complex network by encouraging mentalization of the different parts of that network. It can also be used collaboratively with a young person or family members.

2.2.3 Supervisory Structures: AMBIT has a very specific model of mentalization-based peer or team supervision, using mentalizing techniques at the core of all case

Figure 3.

DIS-INTEGRATION GRID (Add / Subtract elements of the network as required)								
DOMAINS LEVELS <i>of Dis-integration</i>	Young Person	Family	Drugs worker	Social Worker	School	Youth Offending team	Psychiatrist	Others
CONCEPTUAL "What's the problem?"								
PRAGMATIC "What to do?"								
SYSTEMIC "Who does what?"								

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discussion. A mentalizing focus on supervision ensures that a collaborative stance is taken between supervisor and supervisee. Rather than the supervisor addressing the supervisee's 'problems', guided by a shared model of four simple steps, they work jointly and explicitly to (i) mark the task, (ii) narrate the case succinctly, (iii) *starting with the worker's state of mind*, to identify present understandings of all the protagonists involved ('mentalize the moment'), and (iv) return promptly to the original pragmatic purpose (intentions) of the conversation. In addition, a team culture of immediate access to phone supervision with peers is promoted, so that all team members are responsible (via these tightly defined patterns of communication) for supporting their colleagues to mentalize in high stress situations.

2.2.4 Wiki-Manualization: Despite some negative practitioner perspectives (e.g. Addis et al, 1999 ¹), there is support for the use of treatment manuals (Langer et al, 2011); AMBIT is a manual-based intervention, but it takes a radically different approach from conventional paper manuals, and extends the definition of a treatment manual. The manual is located on a freely available web site and the content is written in a novel format of a “Wiki” (this is a collection of linked and user-editable web-pages around a subject.) New open source software actively supports the team in owning and proactively *adapting* a local version of the manual, *co-constructing* a web-based ‘marriage’ between AMBIT core content and locally-generated protocols and adaptations for the local context. We hypothesize that this enactment of our ‘stance’ of “respect for local practice and expertise” increases engagement with, and exposure to manualized content. The current AMBIT manual and existing local adaptations can be found at www.tiddlymanuals.com, and more information is included in the electronic appendix to this paper.

3. Lessons Learned:

- Formal feedback about the AMBIT training from around 150 front line UK practitioners has been very positive. The model deploys simple language and theory, with high face-validity, and the emphasis on relational aspects of practice appears to promote worker and client satisfaction.
- Training of 10 UK-based teams to date has led to increasing emphasis on the development of the *organisational* (team-working) aspects of this approach. The need to provide clear and practical mentalization based methods of handling high professional anxiety has become increasingly central to the whole approach.
- Existing teams (from statutory and voluntary sector services) using the AMBIT approach are working with different client groups (see www.tiddlymanuals.com for

brief description of teams.) Despite these differences, the AMBIT approach encourages these teams to adopt systematic and evidence-based practice whilst developing effective local adaptation that is relevant to their client group and service ecology..

- Working primarily in outreach settings, such teams run the risk of becoming marginalised within larger organisational structures – analogous, perhaps, to the fate of many of their clients. Senior managerial support for such teams is essential in order for them to function effectively.
- New services replacing old ones inevitably incur a cost in terms of conflict around the loss of cherished predecessors; it is important to predict and manage this proactively.
- Professional relationships must also, to some extent, be re-drawn. There is likely to be a mix of experienced staff (who are expected to share their expertise and be available and active ‘on the ground’) and less experienced newcomers. The adoption of new multimodal outreach skills for individual practitioners used to working in a single modality is another potential stress for workers. Improved peer-to-peer communication in the context of a shared team language (mentalization) can counterbalance this.

4. Conclusion

AMBIT is a mentalization–based approach which encourages and supports local adaptation appropriate to the client group and local service arrangements. Current teams who have been trained in the AMBIT approach include an adolescent substance use service, a social services intervention for children on the edge of care, four CAMHS teams for severely psychiatrically ill youth at risk of hospitalization and five non-statutory street-level agencies for vulnerable youth. The description of these implementations will be the

focus of future communications. It is an example of a “deployment-focused model” of treatment development (Weisz and Simpson Gray, 2008) aiming to provide a coherent theoretical and practice based model which can underpin services organized in very different ways (Weisz & Kazdin, 2010¹). The model is supported by the developing ‘open source’ web-based manualization at www.tiddlymanuals.com. A real priority is now to gather more robust evaluative evidence of effectiveness. . The overarching goal is, of course, to divert desperate developmental and psychopathological trajectories towards more adaptive pathways, with a view to reducing the frequency and intensity of those outcomes that are most costly in terms of suffering and the financial implications of later treatment options.

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There is an electronic appendix which includes an extended bibliography.