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Service-user evaluation in two outpatient CAMHS teams

Emily Taylor & Fiona Duffy

EDINBURGH has two sector teams (North and South) within its Child and Adolescent Mental Health Service (CAMHS) covering a total population of 489,000. The teams comprise a multi-disciplinary mix of professionals totalling 24.1 WTE including temporary staff, serving children and young people aged 0-18 years. Referrals come from varied sources including GPs, Community Child Health Workers and schools.

At the time of this evaluation, in June 2009, outpatient CAMH teams in Edinburgh were one year into the implementation of a new model of service delivery, based on the Choice and Partnership Approach (CAPA). This introduction was with the intention of improving patient choice, reducing waiting lists, making service provision more transparent and managing capacity. As well as outcome and evaluation data gathering being integral to CAPA, the teams were also participating in national peer review through QINMAC, for which service-user opinions were a necessary component. The data gathered in this evaluation was therefore timed to coincide with the peer review.

Methodology

Design

The evaluation of service-user satisfaction used a cross-sectional design with a questionnaire measure gathering quantitative and qualitative data.

Measures

The Child Evaluation of Service Questionnaire or CHI-ESQ (Attride-Stirling, 2002) is a self-report questionnaire designed for use by children and parents/carers. There are three versions: 9–11 years; 12–18 years; and parents/carers.

The questionnaire has 12 statements (to which the participant is invited to respond with one of four options: yes/only a little/not really/don't know), three open-ended questions and a short section asking for demographic information including age, gender, ethnicity and disability.

The CAMHS Outcomes Research Consortium (CORC) report the following criteria for selecting all their measures: free; completed in less than 10 minutes; tested for validity and reliability; acceptable to users and practitioners; easy to complete and interpret; widely used; and culturally sensitive.

Procedure

The CHI-ESQ was posted out to 825 young people/families open to a CAMHS clinician in May 2009. This list was generated from the administrative database (PIMS) and

included open and active cases, recently closed cases that had not yet been discharged from PIMS and cases for which a first appointment had been offered but who had not yet been seen, either because of cancellation, failure to attend or because the date had not yet arrived. Where possible, people who had not yet been seen by a clinician were excluded.

The questionnaire was accompanied by a cover letter inviting people to participate and asking them to respond within one month using a supplied stamped addressed envelope. A labelled box was also kept in the reception area of our main clinical bases for hand delivered questionnaires.

According to the age of the referred child or young person, the following questionnaires were issued:

- 0–8 years: Carer questionnaire;
- 9–11 years: 9–11 questionnaire and carer questionnaire; and
- 12–18 years: 12–18 questionnaire and carer questionnaire.

Results

Sixty-one responses were received from 47 families in the North and 126 responses from 86 families in the South. This constituted a 14 per cent return rate for North and 17 per cent for South. South team’s child-respondents were a mean 1.2 years older and parent-respondents’ children a mean 1.8 years older than North Team’s. No other significant differences were found for demographic or questionnaire data so the data was merged for all further analysis.

Demographics of sample

Although demographic data was collected and is reported below, this cannot be compared with the overall clinical population as this data was not available from PIMS at the time.

Table 1: Age and Gender of Children/Young People

| Respondent | N* | Age of child | | Gender of Child (%) | |
|------------|-----|--------------|-----|---------------------|--------|
| | | Mean | SD | Male | Female |
| Parent | 103 | 11.4 | 3.4 | 61.2 | 38.8 |
| Child | 76 | 13.9 | 2.6 | 48.7 | 51.3 |

Table 2: Representation of Ethnicity and Disability of Children/Young People

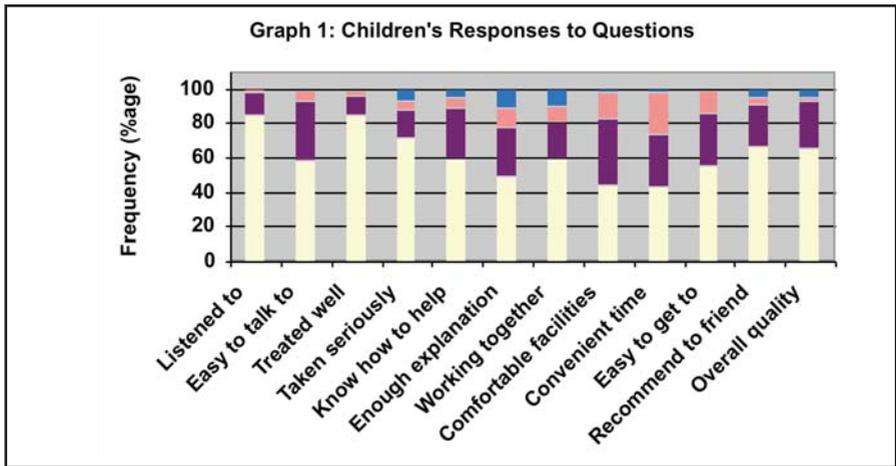
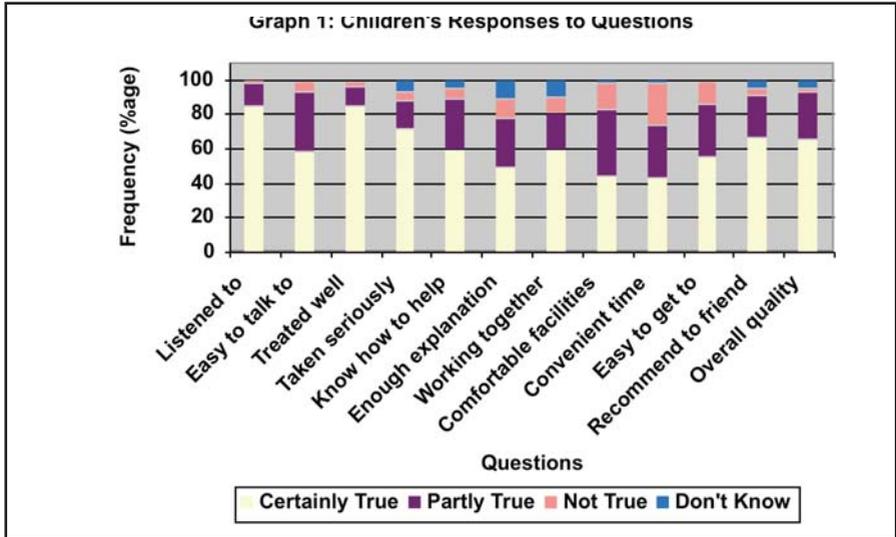
| Respondent | N* | Ethnicity (%) | | | Registered Disability (%) | |
|------------|-----|---------------|---------------|-------|---------------------------|------|
| | | White | Asian British | Other | Yes | No |
| Parent | 106 | 4.3 | 1.9 | 3.8 | 7.5 | 92.5 |
| Child | 77 | 96.1 | 3.9 | 0 | 6.5 | 93.5 |

* Some participants declined to answer

Satisfaction with service

The respondents were generally positive in their evaluation of the services provided to them. All statement showed more than 70 per cent satisfaction (responding with certainly or partly true).

Children’s responses are shown in Graph 1 and parents/carers’ in Graph 2. There was no significant difference between the two groups on any item.



Qualitative comments were gathered by asking three questions:

- What was really good about your care?
- Was there anything you didn't like or anything that needs improving?
- Is there anything else you want to tell us about the service you received?

Generally, respondents showed a high degree of appreciation for the service delivered to families:

'I personally think you provide a wonderful service and I always tell others about the help and hope I have received!'

'I got lots of help with getting my life back on track. All the staff were great with supporting me. I feel lucky to have received the supportive care that I and my family have been given. Staff were approachable – and helpful, giving guidance and advice without being judgemental or patronising.'

However, comments also highlighted specific problem areas. Comments were made about failings in communication; phone calls not being passed on or returned and specifically breakdown in communication between the outpatient and inpatient teams.

'Moving between inpatients/outpatients/day patients was always quite difficult because the handover between these doesn't always happen or sometimes took weeks. Also moving therapist/doctor/dietician, etc. between departments wasn't ideal for me as I found it hard to confide in people and benefit from their help when I had to keep switching professionals it made everything quite disjointed'

Parents commented on problems with contacting staff, leading to them feeling demoralised about the level of care they were receiving. Families complained about little happening in the way of interventions, cancelled appointments without new ones being made, interventions ending without knowing why, and feeling unsupported following discharge. There also seemed to be a lack of clarity about people's roles and expectations of the service, leaving people feeling disgruntled:

'I would have liked to have known more about CAMHS before I went, because I didn't know a lot about the service I was scared not knowing what to expect or what I might receive from this service'

A recurring theme was the time that people waited to be seen, and the time spent waiting for appointments once being seen:

'Would like to have more frequent appointments. But understand budgets are limited.'

'Again, please increase resources and recruit more psychologists. Mental health should matter as much as physical health!'

Specific comments about the facilities all highlighted areas that could be improved including:

'The rooms looked old. It looked like a dump. That was my first impression.'

Many comments highlighted inconveniences such as distance to appointments:

'Too far away so have to miss school for appointments and take two buses which is expensive.'

Discussion

The responses to the evaluation show a high level of satisfaction with the service provided by the two teams, tempered by some specific complaints and concerns. Several people reported feeling listened to, receiving good quality advice, feeling that their clinician had made an extra effort to help them and in response expressed gratitude. However, there were also reported incidences of people feeling patronised, not listened to, being rudely treated (albeit not by clinicians), receiving interventions of a

quality which did not meet expectations, and poor communication. It was clear that waiting times, as experienced by families, still feel very long, despite the implementation of CAPA. Clinicians also seem hard to access at times both formally and informally. Clinicians' ability to respond quickly to telephone calls and offer sufficiently frequent appointments is often impeded by carrying over-large caseloads. York and Kingsbury (2009) explain how efficiency drops as caseloads grow so that clinicians are less able to offer effective interventions with clear endings; preliminary data from an audit of 214 services showed reduced waiting times following implementation of staff capacity management compared to teams without capacity management (York & Kingsbury, 2009).

Shortcomings

This evaluation had some shortcomings. The method by which people were excluded was not fail-safe. The questionnaire pack was sent to people who had, in some cases, only had a first appointment. They would have been less likely to respond and would have had less experience upon which to base their comments. Attride-Stirling (2002) recommends against use of this questionnaire at such an early stage in engagement. It was also apparent that there was a substantial amount of misinformation in PIMS, for example some potential respondents were no longer making use of the service or had never made use of the service. This meant that the response rate appeared lower than was actually the case.

The evaluation was conducted in isolation from any treatment outcome measures and therefore could not be linked in with such data. However, it was conducted as part of a national (QINMAC) peer review, and this meant that we achieved a staff and service user qualitative evaluation simultaneously.

It should also be noted that the survey was only in written format, potentially excluding families with significant literacy problems.

Recommendations and plan

As a result of this evaluation, a number of action points were identified. Some of these have already been implemented:

- More community-based clinics are needed. Attempts are being made to locate the North Edinburgh team base to the North of Edinburgh.
- A quota system is being introduced across outpatient teams to help guide clinicians as to appropriate caseload size. The need for increased numbers of staff continues to be highlighted to commissioners.
- There have been a number of strategies to improve facilities, for example redecorating clinical areas, providing artwork and supplying more age-appropriate materials in waiting areas.

Further strategies are planned or are already in place to address gaps in communication and information:

- Team information leaflets for families have been standardised and are now included with initial correspondence.

- A CAMHS-wide group is putting together an information pack for young people and families.
- Letters are being standardised across the service. There have been discussions more broadly about what information to include in letters, and how to write letters that are comprehensible to those with lower literacy levels.
- Administration staff have been reminded about the protocol for reporting telephone calls.
- A working party is in the process of developing a protocol for transition to adult services to improve communication between these services.
- Difficulties in communication between CAMHS teams and tiers have been highlighted to the CAMHS Executive. The new Intensive Treatment Team has a clear role in addressing this problem.
- The PIMS system is being upgraded to provide more accurate and richer information.

Conclusions

This year's service evaluation demonstrates high levels of satisfaction with the service, with the caveat of a low response rate. The results show that the teams could focus on communication to improve quality of service delivery over the coming 12 months. The evaluation has highlighted that the introduction of a new model of service delivery can bring challenges as well as opportunities to the team and that staff training and supervision should be prioritised along with communication between clinicians and service users. It is hoped that routine service evaluation can be rolled out to all outpatient and specialist teams using a similar model to this one.

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