Small Scale Service Related Project

An Evaluation of a CAMHS CAPA Service

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Brief Overview

The Child and Adolescent Mental Health Service Choice and Partnership Approach (CAMHS CAPA) is a clinical system that evolved 5 years ago in two services, now being introduced across the UK and world (www.camhsnetwork.co.uk).

A CAMHS service in the UK (Greenshire)[1] has been integrating CAPA for 2.5 years (Area A), 12 months (Area B) and 12 months (Area C). They are becoming involved in a national review. This evaluation will explore how closely CAPA is keeping to national guidelines (The National CAMHS Support Service, 2006; National Service Framework for Children, Young People and Maternity Services, 2006) by asking a sample of parents in Greenshire for their experiences and views of the service they received.

1) Service description and objectives, placing the current evaluation in context

[1] The name of the service under evaluation has been omitted throughout this report to protect anonymity. The term 'Greenshire' will be used to identify this service. The terms ' Area A', 'Area B' and 'Area C' will be used to represent three teams within the service.

CAPA begins with a Choice Appointment (CA), a one off contact session to discuss the relevance of CAMHS and its role in helping families. Ideas are generated around core and specialist skills, treatment, plus what can be done in the home until the family are seen again. Next, a Partnership Appointment (PA) involves further assessment, followed by core or specialist treatment selected by the family. Choice and Partnership sessions put service users and families at the centre of all work, facilitating flexible, user-led choice (Our Choices in Mental Health, 2006).

Greenshire CAMHS has been re-designing itself to fit with national principles (National Service Framework for Children, Young People and Maternity Services, 2006) and CAPA objectives (Box 1) that have been deemed essential by service users in other localities.

Box 1: CAMHS CAPA Aims and Objectives.

Improve the service user experience by seeing them quickly and involving them in choices

Improve the staff experience by managing capacity, increasing partnership with families and extending clinical skills into core capacity

Improve the flow through the clinical system

Reduce waiting lists (by offering CAs and PAs to determine treatment; by offering specialist work to be done in core work time)

Enhance partnership between multi-disciplinary teams and service users

This evaluation will examine whether Greenshire CAMHS is delivering a high quality service to families in line with frameworks. It will highlight that CAPA is about "doing the right things with the right people at the right time" ('The Choice and Partnership Approach,' n.d.). Nationally, CAMHS requires a model of service delivery that families and staff feel is effective.

2) Service related research and links to CAPA objectives

Due to the Choice and Partnership Approach being a new addition to CAMHS in the UK and being piloted by many services at the present time, there is a lack of empirical evidence to support the system. CAMHS services strive to create an evidence base by auditing their own methods and effectiveness. Therefore, this study acts as such a pilot. The current evaluation is based on two pieces of prior research carried out in local CAMHS services of Oaktown and Pinetown[2] (Kingsbury and York, 2006).

a) Improving capacity and effective flow through the clinical system:

The CAPA approach adopts Demand and Capacity Theory, in that CAMHS managers calculate their capacity in an attempt to reduce waiting lists and enhance delivery of core and specialist skills ('Capacity and Demand Modelling,' n.d.). Implementation requires the calculation of time available and referral rates.

[2] The names of the services that began the implementation of CAPA have been changed to 'Oaktown' and 'Pinetown'.

CAs are offered at various times and dates. It has been found that 95% of those offered a CA will attend, and 65% will continue to PA (www.camhsnetwork.co.uk).

In line with national standards, CAPA integrates the 7 Helpful Habits of Effective CAMHS that incorporates many of the Ten High Impact Changes for Service Improvement and Delivery (10 High Impact Changes, 2004). These include: extending capacity and redesigning clinical roles, using care plans, effective case closure, identification of bottlenecks, referral screening, administration time, advice for families while they wait.

b) Collaboration of treatment choice and enhancing empowerment:

Services should ensure choice and partnership, fitting with NHS developments ('Our choices in Mental Health,' 2006.). These include: life choices, access, engagement, improved care pathways. 'Out of the Shadows' (2008) is a review of young people's experiences of mental health facilities and recommends that services ensure all decisions are written into care plans and discussed with young people and families.

Research has also explored the importance of the therapeutic alliance and collaborative agreement to treatment, using a "non-expert" stance of facilitator (Carr and O'Reilly, 2007).

c) Reduction of waiting lists:

"Waiting lists remain one of the biggest barriers to accessing specialist services for children, young people and families", (Children and Young People in Mind, 2008, p. 59). CAPA has shown some improvement although waiting lists still exist beyond the optimum number of weeks. This review intends to note the value of CAs in reducing time from referral to treatment.

Kingsbury and York (2006) demonstrate how extensive changes made in Oaktown and Pinetown have enhanced user and staff experiences. This has been achieved by incorporating the 7 Helpful Habits of Effective CAMHS. In Oaktown, CAs were offered almost immediately after referral. Time to treatment was then 2-6 weeks. In Pinetown, they managed a 4 week wait from referral to CA.

d) Service users to have a positive experience of CAPA:

A 'CAPA Experience Questionnaire' was completed by children and parents in Oaktown and Pinetown, the majority reporting that their CA was useful. They felt involved in agreeing outcomes and understood the nature of the service. Almost 70% felt they gained new ideas about the problem and what they might do to help themselves. 'Experience of Service Questionnaires' (www.chai.org.uk) were also administered, illustrating an overall positive experience of the CA, more so by parents.

A national CAPA review is underway and this evaluation aims to analyse a small subset of data from Greenshire (parents views only), as a starting point for future research.

3) Relevance to the service

Greenshire would benefit from replicating the success of the services that introduced CAPA (Oaktown and Pinetown). CAMHS services in Greenshire have historically experienced long wait times (averaging 6 months), which are to be shortened, following practice guidance (York, Anderson and Zwi, 2004). A smoother pathway from referral to treatment would reduce the anxiety of staff in a system that is experiencing rising referrals and funding reductions. Greenshire CAMHS would also benefit from greater clarity around staff roles.

4) Aim of the evaluation

To investigate the effectiveness of CAPA for service users in Greenshire.

Method

Participants

The sample was opportunistic and consisted of parents who had recently attended a Choice Appointment with their child at Greenshire CAMHS. Each

parent was given a questionnaire and asked to complete it if they wished. To ensure anonymity, nothing was recorded about participants' age, gender, socio-economic status, or nature of the problem. Details of the Choice Appointment facilitator were also absent. Twenty-five parents returned their questionnaire.

Materials

The Greenshire CAMHS CAPA Parents' Questionnaire (Appendix 1) was adapted from the 'CAPA Experience Questionnaire' (www.camhsnetwork.co.uk), designed to fit with materials being devised for national review. Each of the 20 original items were formatted alongside a likert scale of 5 possible responses (questions 1-6) or 3 possible responses (questions 7-20). For item 3, the wording was altered from "How helpful was today's session" to "How helpful was the initial session", to account for those who had attended more than one CA, or those who were completing the questionnaire on a different day. Included was an 'Information Sheet' detailing the purpose of the evaluation along with participants' rights (Appendix 2).

To ensure anonymity, nothing was recorded about participants' age, gender, socio-economic status, or nature of the problem. Details of the facilitator they were seen by were also absent.

Ethics

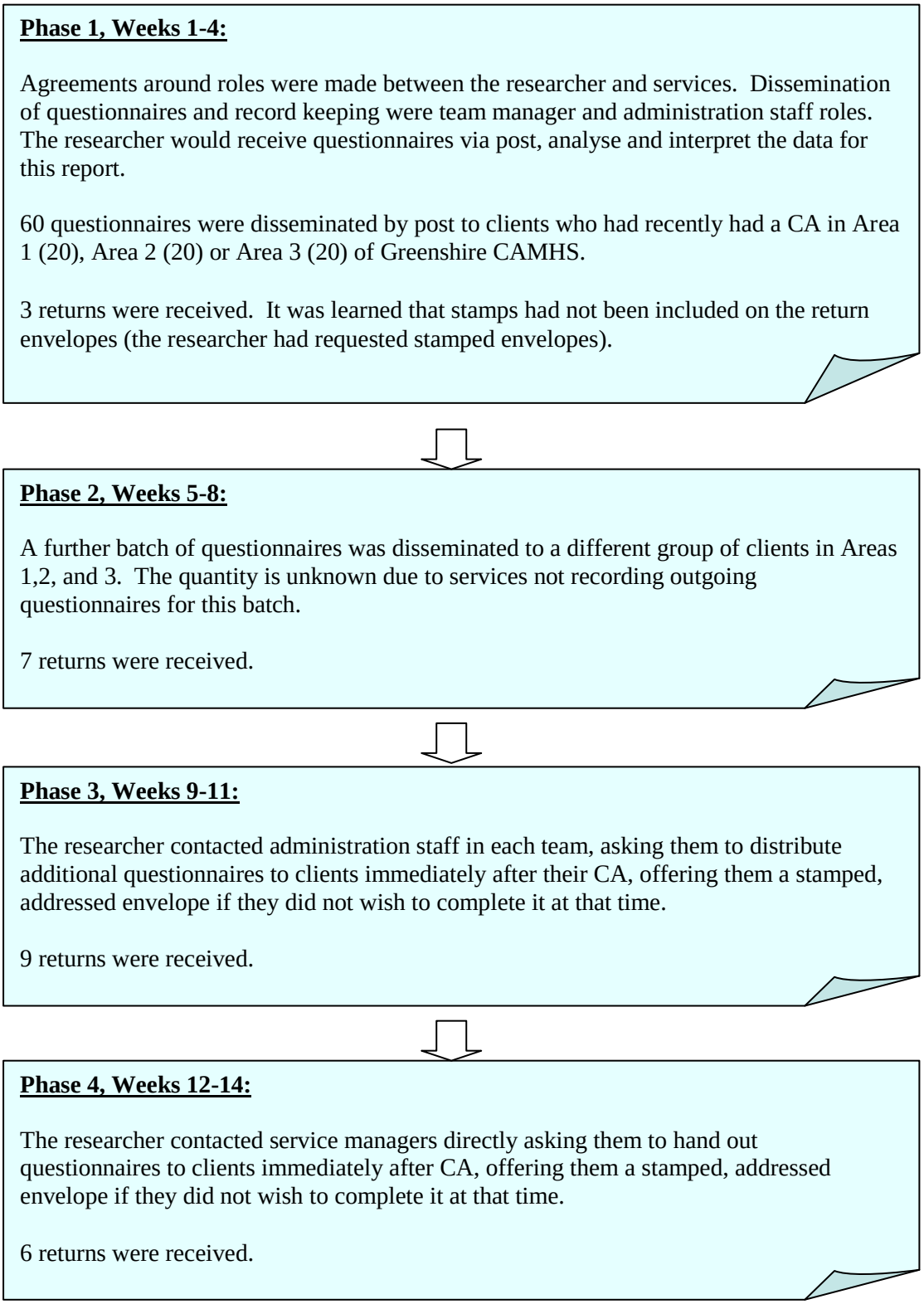
As CAs were a part of routine clinical practice, formal ethical approval was not required. However, to maintain good ethical standards, questionnaires contained a 'unique identifying number' (rather than participant names) and an opt-out slip enabling participants to withdraw at any time (Appendix 3). Contact details of the researcher and service leads were provided.

Procedure

Questionnaires are often constructed for a specific research topic (Coolican, 2004), being time efficient and simple, particularly when gathering participants' views. The researcher wanted to use a method that would cause least disruption and inconvenience to participants. Should respondents have required additional information, full contact details were supplied for the researcher, plus two CAMHS CAPA service leads for Greenshire. By using a unique identifying number for each questionnaire, anonymity was ensured and participants had the choice to opt out at any point. This questionnaire, based on one used in previous research, appeared to be the most effective way of gaining opinions about the CAPA system.

Initially, 60 questionnaires were distributed equally to Areas 1, 2 and 3, who disseminated to clients that had recently attended a CA. The researcher had no access to identifiable information. Unfortunately there was a poor response rate and the researcher made additional attempts of gaining data. A flow diagram (Figure 1) illustrates this.

Figure 1: The Data Collection Process.



Of the 25 returns, it is not discernible which came from Areas 1, 2 or 3. The researcher requested the area to be noted alongside each unique identifying number, however, this was not completed by all teams. It is possible that the data is skewed due to an uneven split. A larger sample and a more rigorous procedure would be required to address this.

Results

Analysis of the data shows that parents responded mostly with extremely positive answers (Table 1), suggesting that they viewed their CA to be helpful and the CAPA service to be effective. This is illustrated by the percentage who responded with the highest positive rating for each question (Table 2). The exception was question 6, related to generating new ideas, which did not yield such extreme positive scores. This appears to be a weakness within the service. Nonetheless, examining the raw data and percentages (Appendices 4 and 5), it is noted that most parents still responded in a positive rather than negative direction, to this item.

Table 1: Descriptive Statistics of Parents Responses to Each Question.

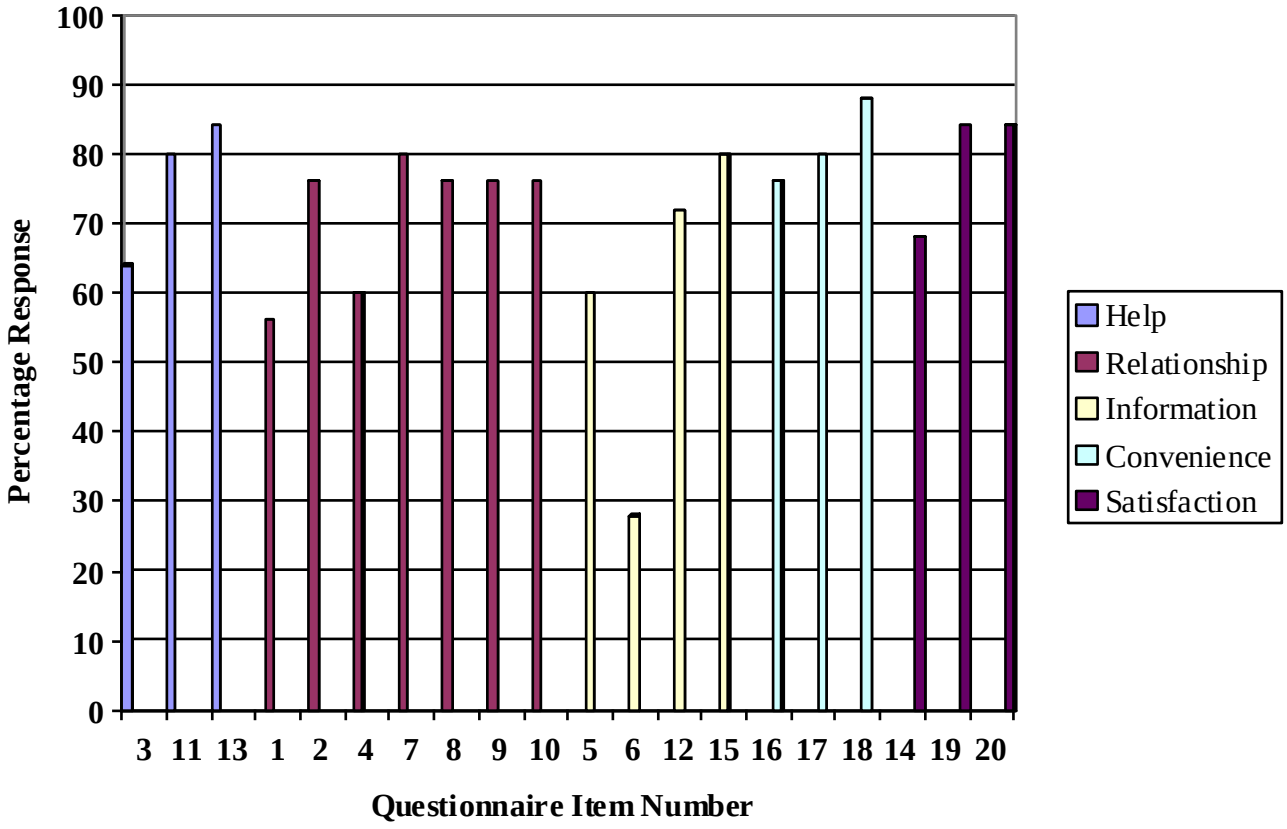
Questions	Central Tendency			Dispersion
	Mean	Median	Mode	Stand. Dev.
1	4.24	5	5	0.93
2	4.68	5	5	0.63
3	4.4	5	5	1.04
4	4.2	5	5	1.00
5	4.28	5	5	1.10
6	3.56	4	3	1.23
7	2.8	3	3	0.50
8	2.76	3	3	0.44
9	2.76	3	3	0.44
10	2.72	3	3	0.54
11	2.76	3	3	0.52
12	2.68	3	3	0.56
13	2.8	3	3	0.50
14	2.6	3	3	0.65
15	2.76	3	3	0.52
16	2.72	3	3	0.54
17	2.84	3	3	0.37
18	2.92	3	3	0.28
19	2.8	3	3	0.50
20	2.76	3	3	0.60

Note: For questions 1-6, the response scale ranged from 1-5 (1=most negative; 5=most positive) and for questions 7-20, the response scale ranged from 1-3 (1=most negative; 5=most positive).

For most items, the highest percentage of parents responded with the most positive answer in the scale. Even though question 6 shows only 28% of parents gave the most positive response, if the next most positive response were to be included, then this figure would rise to 52% (Appendix 5).

These data were further illustrated to show more clearly how clients felt about their CA. For this purpose, responses were grouped into the 5 areas relating to service effectiveness (Figure 2).

Figure 2: Percentage Responses as a Function of Five Categories of Effective Service.



Summary of the five categories:

Help: The CA appeared successful with the majority of participants reporting that the facilitator and CAMHS team knew how to help their case.

Relationship: Most parents reported that they could be open about their problems, finding the facilitator easy to talk to. They agreed with statements like,

"Do you feel that your concerns were listened to?" Ninety-two percent felt that most or all of their concerns were listened to.

Information: The largest proportion of respondents stated that they understood the nature of the service, feeling informed about what would happen next. The majority felt that they generated at least some new ideas.

Convenience: The majority of parents found the service to be very convenient in terms of time (80% strongly agreed), venue and accessibility (88% strongly agreed).

Satisfaction: Most participants were satisfied with the outcome of their CA and would recommend the service to others. The current evaluation found that 92% of parents "strongly agreed" or "somewhat agreed" with the statement "I am happy with the outcome of my initial meeting".

By creating these groups, it is easier to examine outcomes and make more meaningful recommendations.

It should be noted that the data must be treated with caution, as the sample size is small and potentially skewed toward clients who experienced the service positively. Clients who had negative experiences may have chosen to assist the service in their evaluation.

One of the service leads offered additional information about waiting lists, stating that families in Areas 1 and 3 were waiting an average of 2-4 weeks (at the time of writing this report), compared to 24+ weeks prior to the implementation of CAPA. This improvement is in line with national frameworks, as described earlier.

Implications, relevance to the service and relevance to Clinical Psychology

From the analysis of results, it appears that facilitators have appropriate clinical skills to assist clients. Greenshire, therefore, are implementing appropriate strategies in line with national standards (10 High Impact Changes, 2004). Building a relationship with parents seemed to be a strength of the service. Carr and O'Reilly (2007) propose the importance of such a therapeutic alliance and collaborative agreement in relation to service effectiveness. It is important that parents felt they were given appropriate information in order to know what to do next for their child. Kingsbury and York (2007) found almost 70% of their sample to have gained new ideas about helping themselves. Perhaps Greenshire CAMHS could expend more resources into empowering service users to facilitate their own positive change. This could potentially reduce the number of people needing to continue with treatment. Kingsbury and York (2006) found an enhancement in both user and staff experiences upon implementation of the 7 Helpful Habits of Effective CAMHS. It is assumed that parents who felt most satisfied would be more likely to continue to PA and treatment (www.camhsnetwork.co.uk). The question is: what can be done for the remaining service users who did not feel satisfied?

The CAPA service appears to be working in line with Capacity and Demand Modelling (n.d.) and how CAMHS teams organise themselves through careful planning of job roles and referrals. It also ties in with NHS targets to reduce waiting lists and offer a more client led service. This includes building in time for Choice and Partnership appointments, producing slots for clients to have a real choice around when they are seen and who by. Any service implementing CAPA would need job planning and a 'blank diary' approach to include sufficient sessions each week for Choice and specialist appointments, administration time (meaning extra staff or hours), and extended clinical flexibility (decreasing queues into specialist streams). Managers would need to remain aware of how staff spend their time, in order to assess whether the team is in balance or whether job plans need to be reviewed. A realistic assessment of capacity should also be conducted.

Careful implementation ensures that CAPA is in keeping with the changing role of Clinical Psychologists. There is a sense of a filtering and narrowing process, whereby CAPA acts as a screening tool for workload, so that referrals are quickly funnelled to appropriate clinicians. This would certainly reduce wait times although not all clients would necessarily be passed on to the right worker. This may be due to a lack of understanding of job roles, as some staff have limited awareness of what Clinical Psychologists offer. With recent developments of increasing CBT training, it is possible that Clinical Psychologist's time can be freed up for specialist work. However, there is a potential for clients to be lost in a

system that is filtering them away from specialist care when they could benefit from it.

In terms of team gains, the CAPA approach is designed to increase a sense of support, enhancing staff morale and increasing communication. In addition, staff activity is better planned and monitored, including multidisciplinary peer group supervision.

The data revealed that parents found the CA to be effective. This points to a requirement for funding in order to develop the CAPA system further. Additional evaluation in similar services and a follow up study in Greenshire would offer useful comparisons that can be used to inform the national review of CAMHS CAPA that is currently underway.

Limitations

Only a small amount of data was yielded, even though the researcher attempted to gather a larger number of questionnaires using different methods (Figure 1). Perhaps due to the nature of CAPA, the questionnaires caught clients before they had been given the chance to infiltrate into the service, thus eliciting a weak response rate.

Due to the researcher working outside of the CAPA system, it was difficult to ascertain how it was being implemented on a service level, therefore, direct

comparisons to the data collected by Oaktown and Pinetown CAMHS is not viable. External factors could have influenced the current evaluation, including the data gathering process and nature of questions, as discussed. The researcher had a lack of control over how and when questionnaires were disseminated and a limited amount of data was yielded. There may also have been a sampling bias, in terms of clients only participating if they felt satisfied with the service. Clients who were dissatisfied may have not felt comfortable to raise their concerns via questionnaire. Alternatively, the items were quite leading in nature, for example, "I am happy with the outcome of my initial meeting" eliciting a positive response. In addition, the changes during the data collection process may have affected results. Indeed, participants offering their opinions about a service would be likely to give different responses with staff around them, compared to being alone. Perhaps there was an effect of having little time to reflect upon the CA, when being asked to complete a questionnaire immediately after the session (Phases 3 and 4, Figure 1).

Conclusion and Future Recommendations to Overcome Limitations

Greenshire CAMHS appears to be implementing some of the main standards of effective service for their clients, when CA ratings of effectiveness and satisfaction are examined. However, the data needs to be treated with some speculation and there is much that can be done to improve future research. In addition, there are areas that Greenshire can develop, such as generating more ideas with families about how to help themselves at home.

Suggestions for Greenshire CAMHS to continue evaluating their service are as follows:

1) Disseminate the questionnaire to parents after the PA rather than the CA to get a more accurate reflection of whether the service has been effective.

2) Enhance understanding of what works for whom by gathering demographic information about service users and additional details around the referral and facilitator.

3) Ensure stringent data collection with one member of the CAPA team managing this process. Maintain full records of participants who have been contacted and have responded, including who they saw for the CA/PA.

4) More audits are required in local services. To supplement parents' views, children and young people must also be asked for their experiences. Moving forward from questionnaires to alternative methodologies such as interviews or focus groups would yield useful, qualitative information. Indeed, the current evaluation struggled to obtain sufficient data for complex analyses to be performed, therefore a follow up study or comparison work is required.

This report will be disseminated to the teams that took part in order to communicate the outcomes and offer guidance for future audit and research. Staff can reflect upon their developments and action further positive change for their service users.

References

10 high impact changes for service improvement and delivery: a guide for NHS leaders. (2004). *NHS Modernisation Agency.* London: Department of Health Publications.

Capacity and Demand Modeling, Implementation of Choice and Partnership Approach. (n.d.).Downloaded from www.newwaysofworking.org.uk

Carr, A. and O'Reilly, G. (2007). Interviewing and report writing. In: Carr, A. O'Reilly, G. Noonan Walsh, P. and McEvoy, J. (Eds). *The handbook of intellectual disability and clinical psychology practice.* Hove: Routledge.

www.chai.org.uk/_db/_documents/04017626.pdf

Children and young people in mind: the final report of the National CAMHS Review. (2008). London: Department of Health Publications.

Coolican, H. (2004). *Research Methods and Statistics in Psychology.* London: Hodder Arnold.

National Service Framework for Children Young People and Maternity Services: The Mental Health and Psychological Well-being of Children and Young People: Standard 9 (2006). Retreived August 12, 2009, from

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4090560.pdf

Our choices in mental health: Improving choice for people who use mental health services and their carers. (2006). *The Sainsbury Centre for Mental Health.* London: King's Fund.

Out Of The Shadows?: Progress needed to meet Government's pledge on children's mental health. (2008). *Children's Commissioner for England.*

The Choice and Partnership Approach. (n.d.). Retrieved August 13, 2009, from http://www.camhsnetwork.co.uk/Childlayer1pages/CAPA.htm

The National CAMHS Support Service: Learning Perspectives from the National Child and Adolescent Mental Health Service Improvement Programme (2006), Retrieved August 12, 2009, from http://kc.csip.org.uk/viewdocument.php?action=viewdox&pid=0&doc=34225&grp=1

www.camhsnetwork.co.uk

York, A., Anderson, Y. & Zwi, M. (2004). Eight months to eight weeks: Reducing waiting times in a child and adolescent mental health service. *The Mental Health Review*, 9, (2), 15-19.

Appendices