

The tools have left the shed

One CAMHS experience of using outcomes
for service development

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**It's not easy and lets not get
carried away ...**

–“Indeed, the evidence suggests that that laudable goal [routine outcome measurement] has so far proven to be beyond the best efforts of any public mental health service.” (Rock et al., 2001, p.45).

...but was that so 2001?

“Outcomes measurement is of no use unless it is actually used” (Docherty &

Streeter, 1996, p.17)

- The outcomes for an *individual* client
 - Inform treatment decisions
 - Document progress of long-term cases
 - Overt change during treatment
 - Provide markers for reviewing progress
- The outcomes *aggregated* for many clients
 - Standardise assessment of strengths and difficulties
 - Document program or service effectiveness
 - Assess impact of procedures and policies
 - Highlight strengths and weaknesses in outcomes
 - Ground evidence based treatments locally
 - Guide decisions on training and policy changes

The challenge of aggregated data

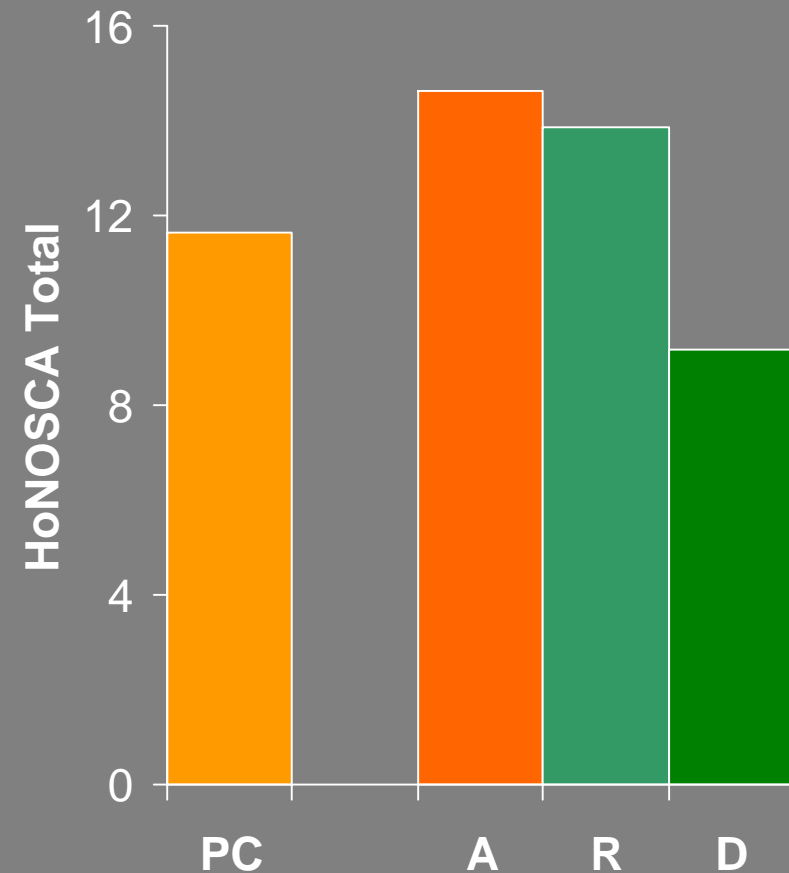
- Outcomes more likely to be seen as useful:
 - If for individual clients or research
- “The consideration of group or population outcomes is unfamiliar territory for many clinicians. Consequently the use of aggregated outcomes data for comparison between teams and diagnoses, or other such uses, may not be seen as useful to them.”
(Callaly & Hallebone, 2001, p.44).

Eastern Health CAMHS

- Long history of ROM
 - 1997 clinician based measure (HoNOSCA)
 - 1999 parent, carer, adolescent measure (SDQ)
 - 2000 qualitative satisfaction of parent and adolescent
 - 2003/4 NOCC
 - 3 Community teams
 - Intensive Adolescent Outreach Team (MAT)
 - Adolescent Inpatient Unit and ?Day Program?
- Feedback and use of the data still remains the biggest challenge across the programs

Informing conversations and beliefs

- The precious princesses, the chip on the shoulder and morale
- The unspoken emotional challenge
- Knowing the service makes a difference allows new questions
- Intake and primary consultations

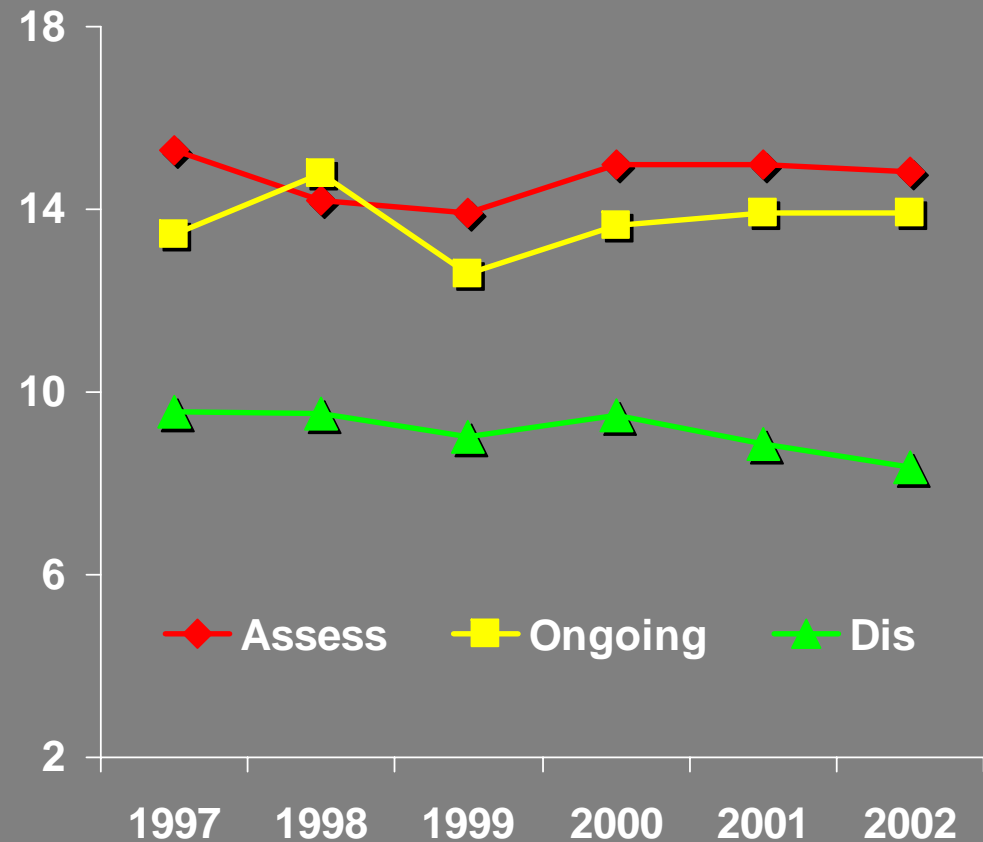


Why is it feeling harder? The workload conversation

- Clinicians experiencing increasing burden

- Changes in clients?
- Not severity, but complexity of the task

- The data informs the perceptions



Verifying referrers decisions-the GP Project

- An assessment proforma - PLOTS and SPACES
 - A referral pathway
 - On-site CAMHS brief assessment
-
- Significant difference in severity by who GP referred child to (HoNOSCA totals)
 - CAMHS 16.7 (sd=4.2)
 - Other professionals 11.3 (sd=5.0)
 - Not referred on 9.6 (sd=4.0)
 - Impact on perception of GPs decisions, and on average, congruence



Clinical Processes, Audits, Training,... and the Unexamined Life

The sword cuts both ways...

Clarity of documentation



Clarity of assessment & treatment



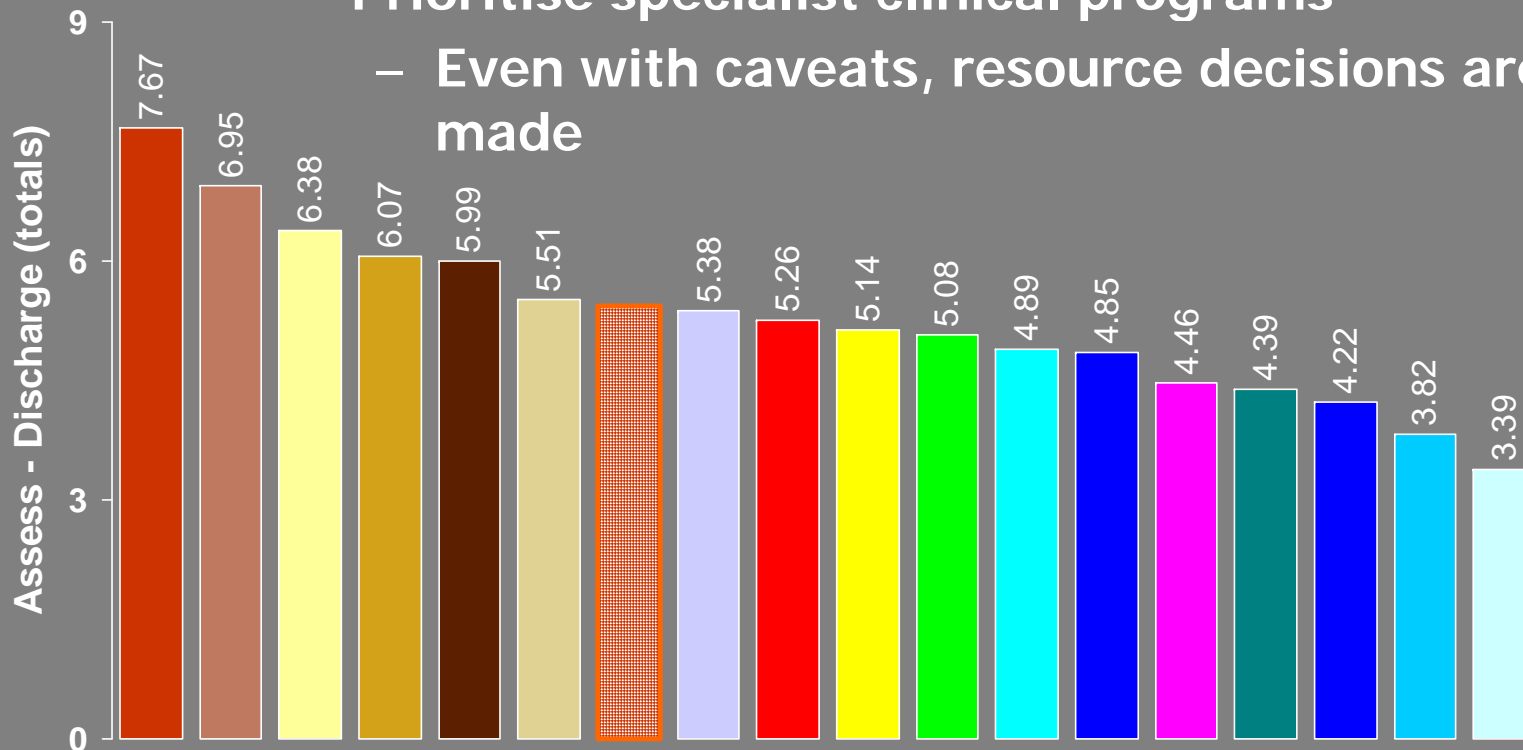
Better & more consistent outcomes

Keeping Big Brother in perspective

- Much time spent on CQI
 - Clinical file audits seen as addressing clinical quality
 - ?unlike routine outcome measurement?
 - Advantage of routine system was that time consuming examinations of procedures reflected upon and put in perspective
 - Suggesting: **A neat file is a neat file, is a neat file, is a neat file, is a neat file...**

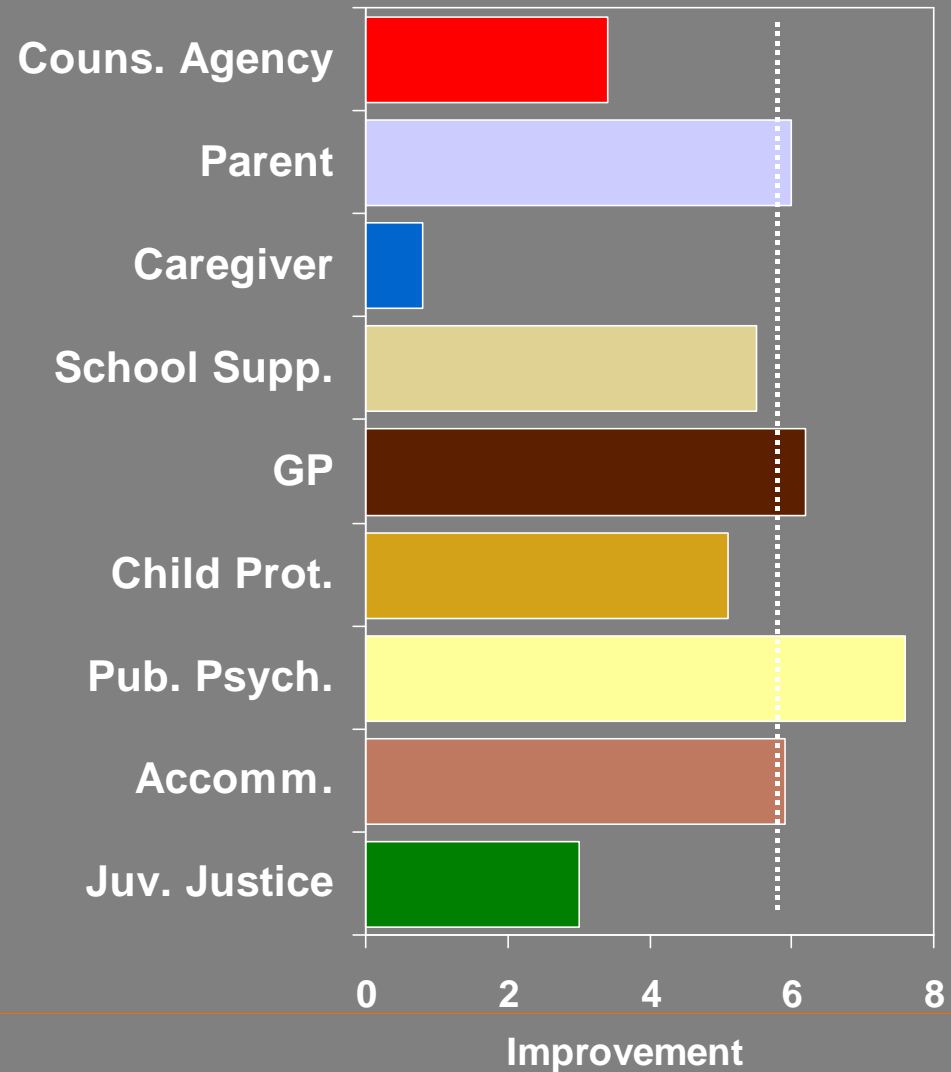
Why do we do better with some than others?

- Shape professional development
- Provoke CAMHS executive discussion
- Prioritise specialist clinical programs
 - Even with caveats, resource decisions are made



The community plan

- Forming priorities with limited resources
- At risk groups for CAMHS and Who are caregivers?
- Saying yes and no to consultations



A Routine Infrastructure Supports Learning

The background of the slide is an abstract composition of wavy, liquid-like patterns in shades of orange, brown, and gold. The top half features a solid orange band with the title text. The bottom half is a darker, more complex pattern of flowing, metallic-looking shapes.

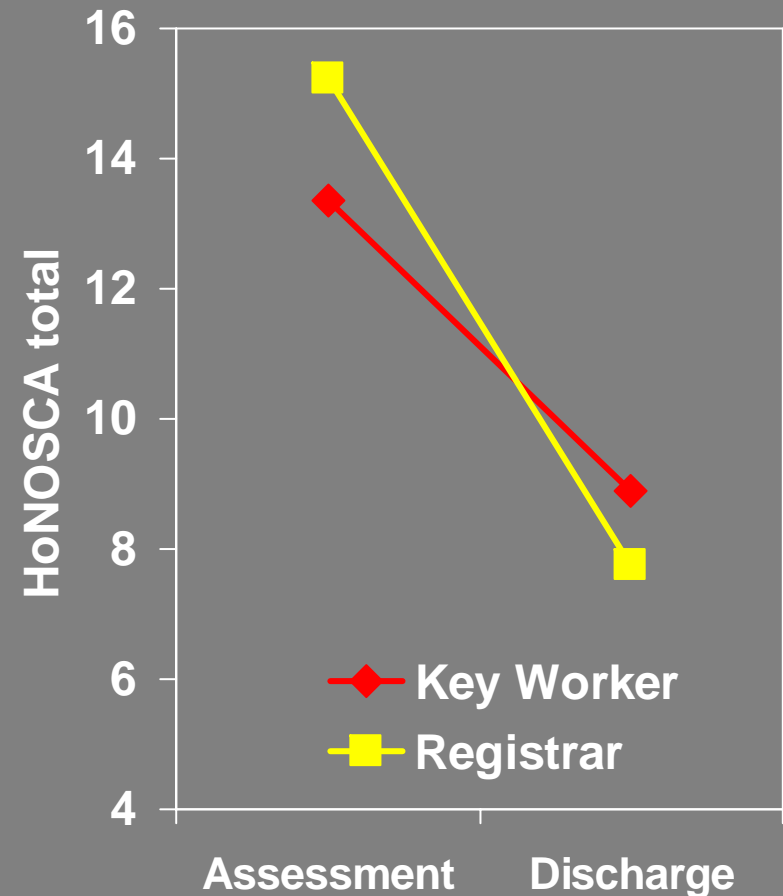
The Adolescent In-Patient Unit

Dr Lanka Cooray and Peter Brann

- Effective or Containing?

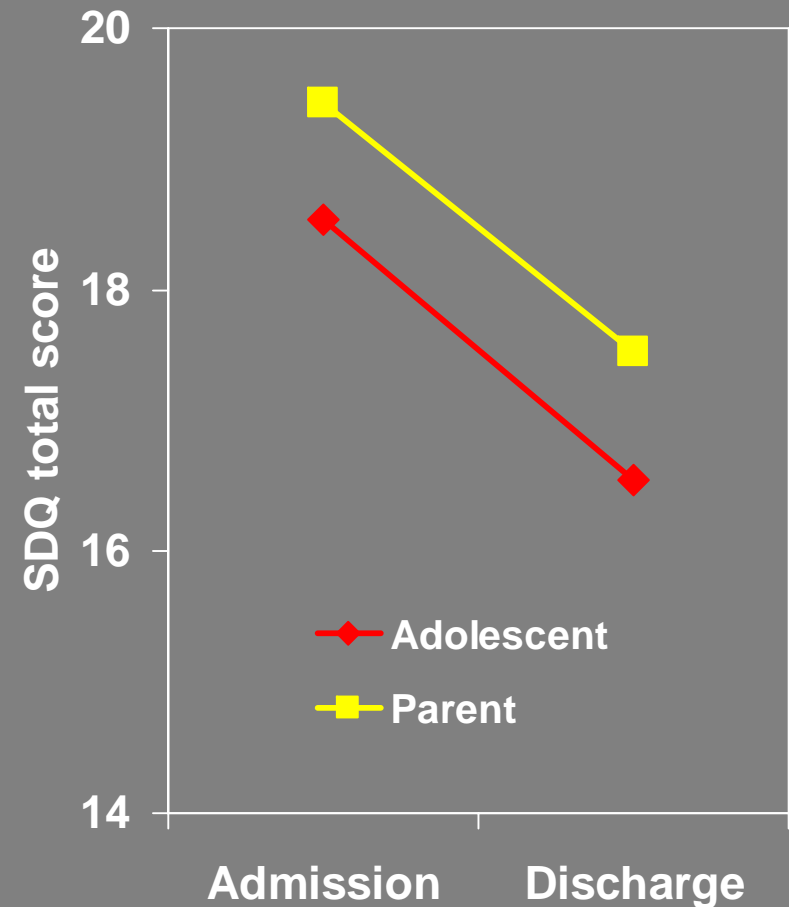
- 98 consecutive admissions
- Mean length 14 days
- Mean age 16
- 81% female

- Significant decrease in symptoms on HoNOSCA and CGAS
- But overtaken one set of symptoms where key workers and registrars diverge



Changes from adolescents and parents perspective

- Significant decrease
 - Adolescents
 - 49% admission
 - 37% discharge
 - Parents
 - 53% admission
 - 43% discharge
 - All SDQ scales changed with the exception of Peer and Prosocial



The Adolescent Day Program

Nicola Kennair and Peter Brann

- An important yet chronically under-funded program
 - (approx 2 EFT)
- Is it worth the resources?
 - Examined 110 participants
 - Mean age 15
 - 60% male
- Significant Changes in HoNOSCA
 - Disruptive
 - Non-accidental self-injury
 - Emotional
 - Peer relationships
 - Family life & relationships
 - School attendance
 - Total difficulties

Parents, Adolescents and the SDQ

- Significant improvements for parents, adolescents and staff
 - Total
 - Emotional
- *Staff* saw no change in conduct and hyperactivity, but *parents* and *adolescents* did
- Matched outpatient reference group
 - age, sex, diagnosis, treatment duration, initial HoNOSCA total
- Both ADP and O/P produce improvement
 - Trend for ADP greater improvement
- Commitment to staffing and ADP enhancement!!!

finally

Aggregated data can make a difference to service development...

- **Modifying the service**
 - Diagnostic and Referrers
- **Increasing commitment to expensive marginal programs**
 - ADP and AIPU
- **Questioning departmental assumptions**
 - Clinical File Audits
- **Questioning our own assumptions with data**
 - Primary Consultations, GP project and Workload

...but, only if its used

2. Outcomes of EHCAMHS' ADP HoNOSCAs (1999-2004)

- N=110 adolescents
- Age; $m = 15$ yrs old
- Gender (60% male, 40% female)
- Program length; $m = 10$ wks

HoNOSCAs - ADP

Significant Improvements

- Disruptive
- Non-accidental self-injury
- Emotional
- Peer relationships
- Family life & relationships
- School attendance
- Total difficulties

No difference

- Overactivity/attention
- D & A
- Scholastic/language skills
- Physical illness/disability
- Hallucinations/delusions
- Somatic
- Self-care & independence

SDQs

	Clinicians <i>n</i> = 61	Parents <i>n</i> = 25	Adolescents <i>n</i> = 40
Emotional	*	*	*
Conduct		*	*
Hyperactivity		*	*
Peer Problem	*	*	
Prosocial	*	*	
Total	*	*	*

* = Sig., $p < .05$

HoNOSCA- Comparison Group

CAMHS outpatient Rx (not inpatient or ADP)

- Matched ($N = 84$)
 - Gender
 - Collection period
 - Diagnoses
 - Age
 - Initial HoNOSCA severity
 - Duration of Treatment ($M = 17.5$ weeks)
- Limitations
 - Random allocation treatment group
 - ? Length of treatment

HoNOSCAs – Outpatient Rx

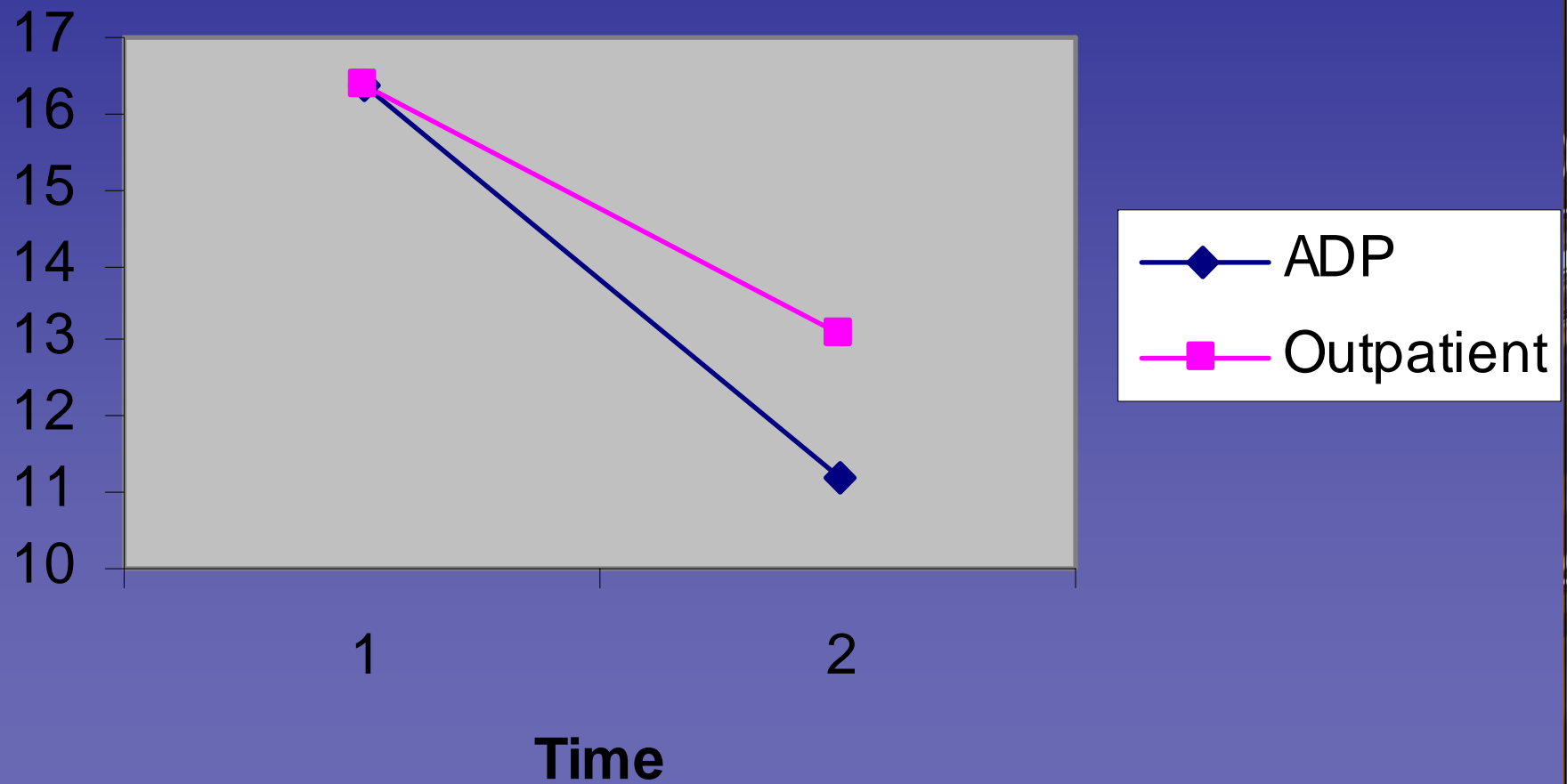
Significant Improvements

- Disruptive
- Non-accidental self-injury
- Emotional
- Peer relationships
- School attendance
- Total difficulties
 - Somatic (outpatient only)
 - Family life & relationships (ADP only)

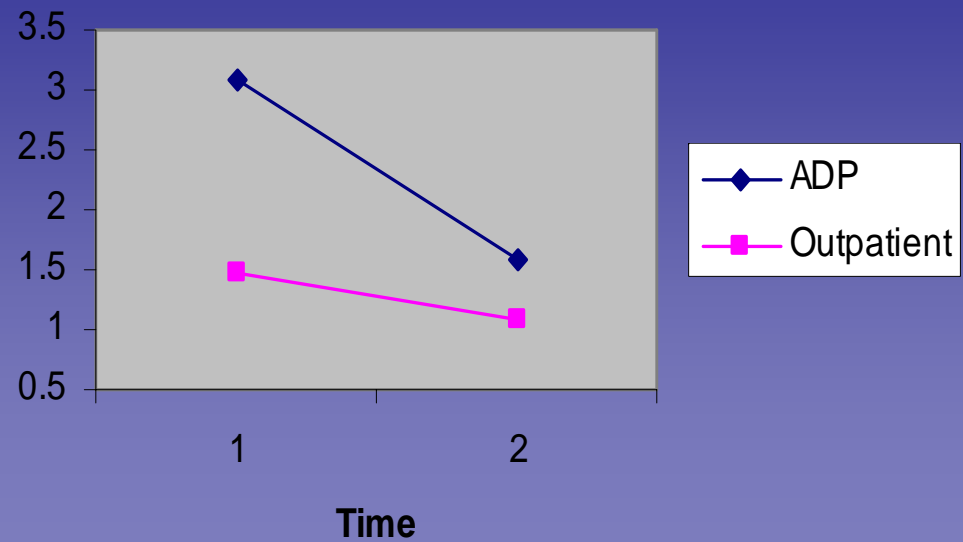
No difference

- Overactivity/attention
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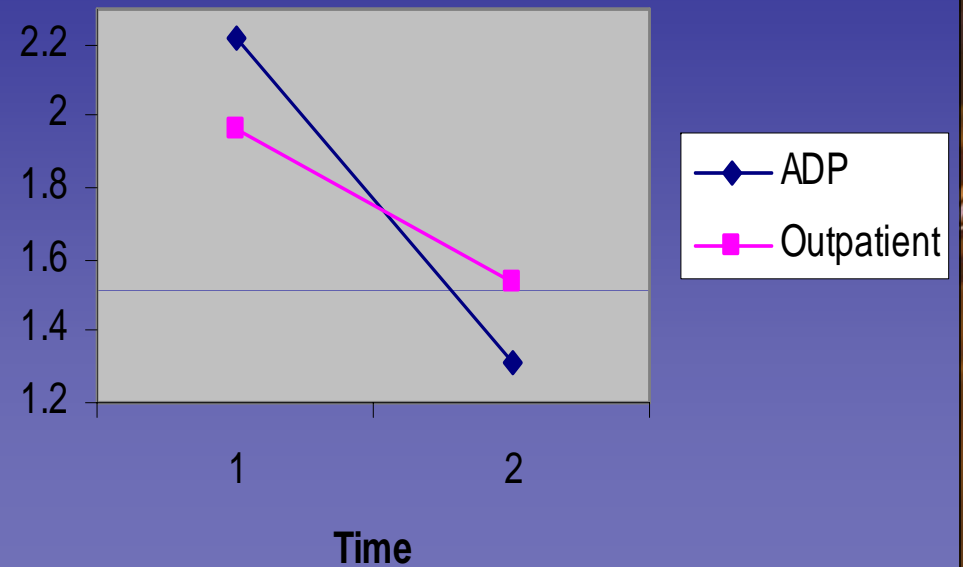
Total Difficulties - HoNOSCA



Poor School Attendance



Problems with Peer Relationships



Summary

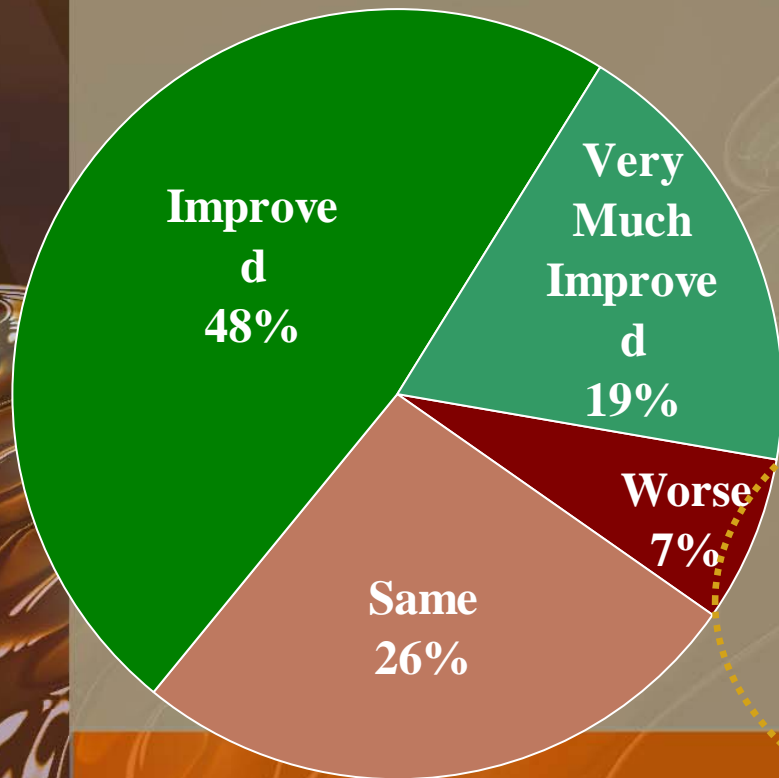
- ? EHCAMHS typical Australian ADP
- ? Specific program for specific difficulties
 - Family life and relationships
 - Peer relationships, school attendance, total difficulties
 - Non organic somatic symptoms

Future Research

- Follow-up
- Cost effectiveness (length of Rx, intensity)

Follow up in the GP Shared Care Project

How was the child at follow up? •Further treatment:



- »26% CAMHS
- »15% Paediatrician
- »11% GP only
- »8% Private therapy
- »7% School

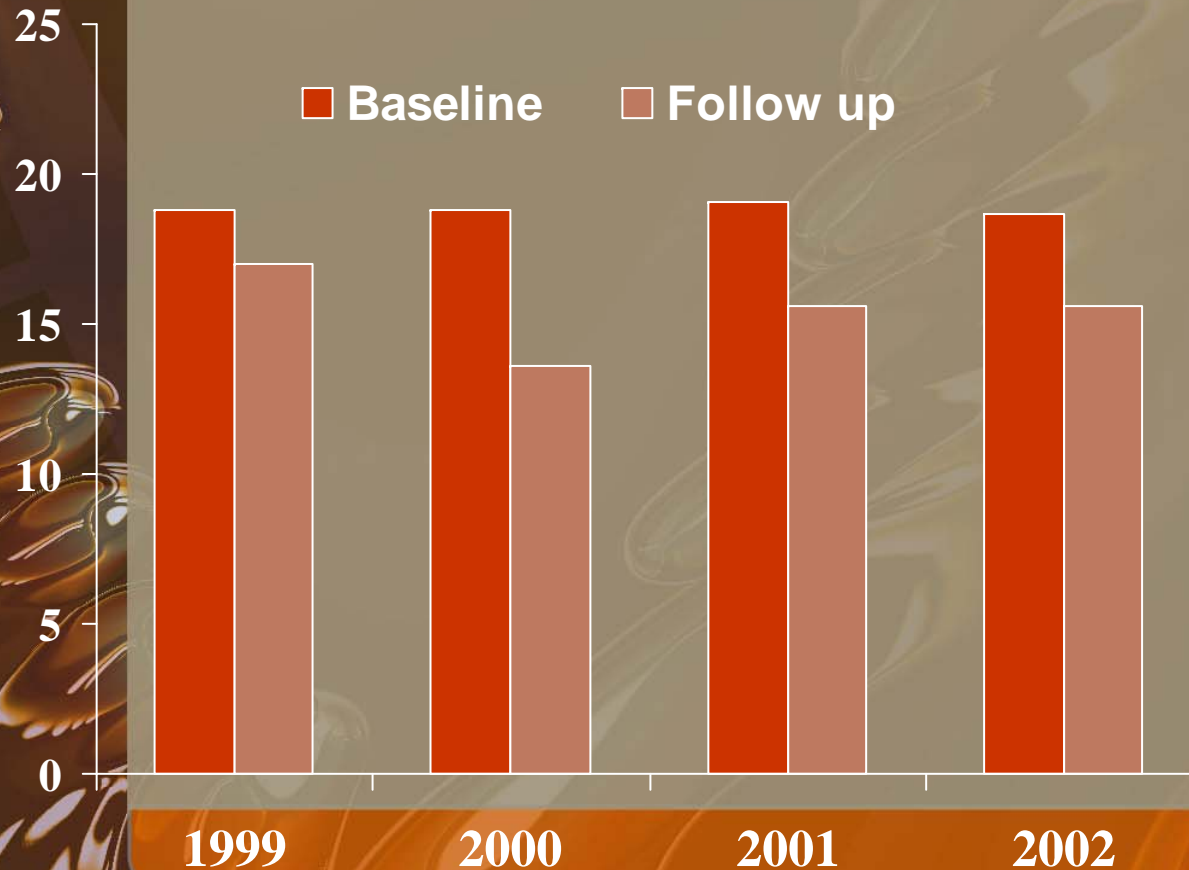
•Significant difference in severity by referral status (HoNOSCA totals)

- »CAMHS 16.7 (sd=4.2)
- »Other professionals 11.3 (sd=5.0)
- »Not referred on 9.6 (sd=4.0)



What Use Is Routine Outcome Measurement? Use it or lose it!

Changes From Parents and Adolescents Perspective, Also!



–Note similarity of parent and adolescents SDQ to HoNOSCA

–Adolescents tend to rate themselves as less severe

•Now to the outliers

Original Expectations of the Mobile Adolescent Team

- Target group - “high risk” adolescents, 12-18yrs with
 - Multiple agency involvement
 - Mental health disorder
 - Unable to be engaged in less intense responses
- Intensive case management & Assertive outreach
- Flexible and responsive model which enhances access to specialist services for the high risk group
- After hours response capacity
- Inter-service collaboration
- Consultation, liaison and education
- But does the rhetoric match the actuality

Satisfaction and Symptom Change

–Change in registrars
HoNOSCA related to:

- SDQ total (Ad & Pa)
- Emotional SDQ (Ad)
- Conduct SDQ (Pa)
- Hyperactivity SDQ (Ad & Pa)

–But not to satisfaction
for parent or
adolescent

•SDQ change for
adolescents not
related to adolescent
or parent satisfaction

•However parents
satisfaction appears
related to perceived
conduct SDQ change

–Parents & adolescents
more satisfaction
agreement than with
staff

Quantitative Data: Who, What, Where and

With What Effect?

- **Average HoNOSCA score for clients referred to MAT is 18 at assessment and 13 at discharge**
 - O/P CAMHS assess. approx. 12-13 and discharge 8-9
- **Significant difference in areas of:**
 - Disruptive behaviors
 - Concentration
 - Self harm
 - Non organic Somatic
 - Emotional
 - Self care
 - Family Relationships

In what areas is there change from the staff perspective?

- Most impaired areas at admission
 - Emotional
 - Family Life
 - Self-injury
 - School Attendance
- Least
 - Non-organic
 - Self-care
 - Peer relationships (Reg)
 - Scholastic (KW)
- Both key workers and registrars perceived improvement on all HoNOSCA scales except:
 - Non-organic somatic symptoms
 - Self-care and Independence
 - Scholastic and Language skills (No change for key workers)
- Overall key workers and Registrar very similar

Satisfaction for clients

- Availability
 - Easy to reach
 - Speed of help
 - Assessment and Treatment
 - Participation
 - Play part in treatment
 - Say in running of unit
 - Unit
 - Responsiveness, range of activities
 - Staff
 - Attitude, Time, Skills
- Majority of adolescents satisfied
 - Availability (66% cf 9%)
 - Assess and Treatment (53% cf 20%)
 - Participation (40% cf 25%)
 - Unit (51% cf 19%)
 - Staff (62% cf 19%)
 - Overall (69% cf 17%)

Satisfaction for the grown ups

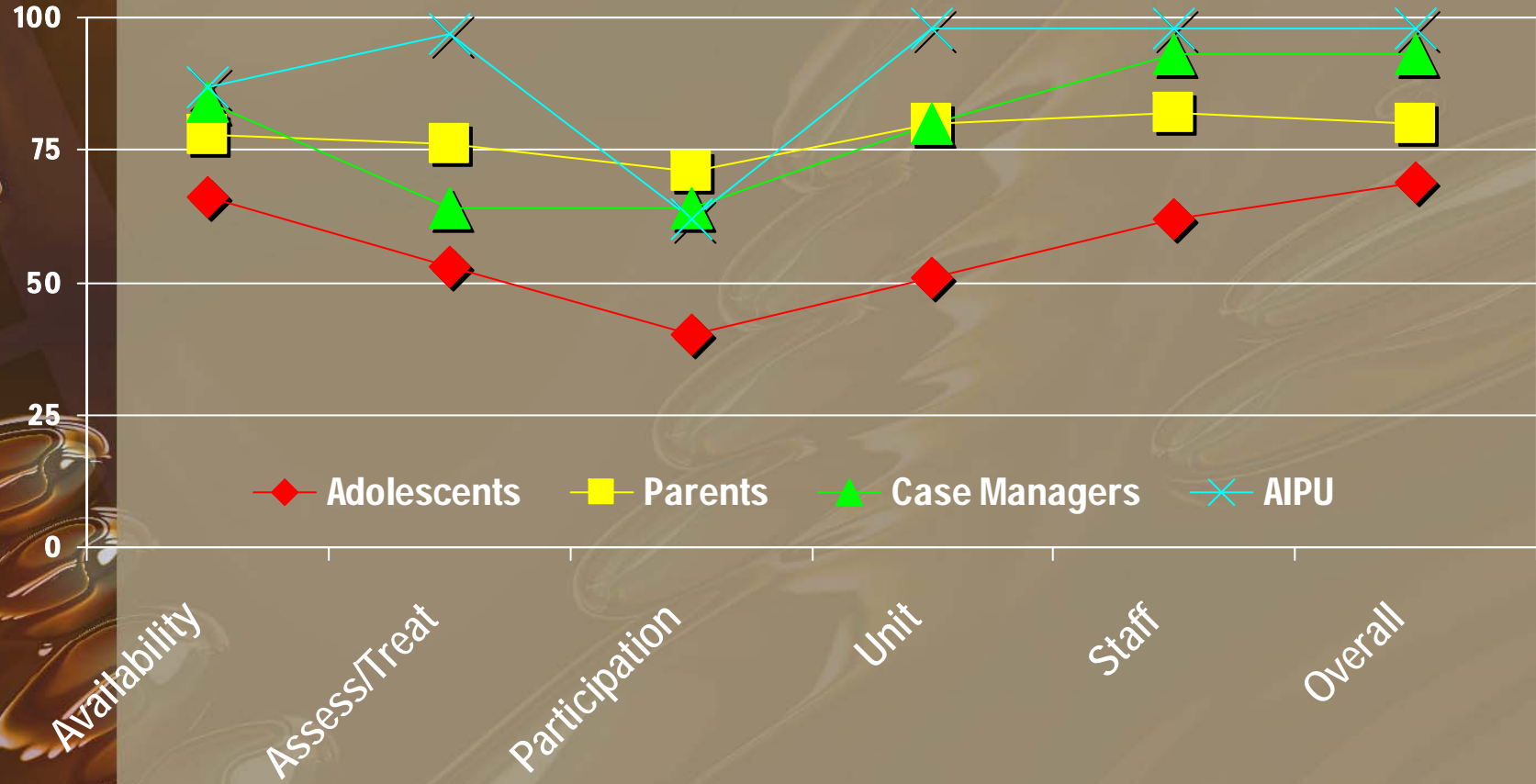
- Parents

- Availability (78% cf 8%)
- Assess & Treat (76% cf 8%)
- Participation (71% cf 14%)
- Staff (80% cf 9%)
- Unit (82% cf 8%)
- Overall (80% cf 9%)

- Case Managers

- Availability (84% cf 5%)
- Assess & Treat (64% cf 3%)
- Participation (64% cf 3%)
- Staff (93% cf 0%)
- Unit (80% cf 1%)
- Overall (93% cf 1%)

Satisfied to Very Satisfied



Comments & satisfaction index

– Very few written comments

- Admission too brief
- Not clean enough
- Limited communication about progress
- Too much travelling time
- Not aware of unit activities
- Unclear responsibilities
- Locked doors unfriendly
- Communication patchy
- Place of psychotherapy

–Satisfaction index correlated significantly between adolescent, parent , case manager and AIPU clinician with the exception of :

- No correlation between Case Managers and Adolescents Satisfaction

Does satisfaction relate to change in symptoms?

- Change in Registrars HoNOSCA related to:
 - SDQ total (Adol & Parent)
 - Emotional SDQ (Adol)
 - Conduct SDQ (Parent)
 - Hyperactivity SDQ (Adol & Parent)
- But not to satisfaction for parent or adolescent
- SDQ Change for adolescents not related to adolescents/ parent satisfaction
- However parents satisfaction appears related to perceived Conduct SDQ change
- Parents & Adolescents have more satisfaction agreement

So what...

- We now have systematic evidence that the AIPU makes a difference to symptoms and functioning from multiple perspectives
- Overall, adolescents, parents, case managers and clinicians were satisfied
- Participation in both treatment planning and the way the unit runs may be the area to explore further
- Satisfaction and change in symptoms are different things