

# Evaluation of the Choice and Partnership Approach in Child and Adolescent Mental Health Services in England

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# Foreword

Children and young people with mental health problems represent some of the country's most vulnerable people. Their mental health and wellbeing is of paramount importance to the future health, wellbeing and prosperity of our society. However, many people in this position may find it difficult to access professional support services. This may occur for two main reasons; the lack of accessible mental health services, and the potential stigma attached to accessing them. Yet the ability of Child and Adolescent Mental Health Services to respond promptly and appropriately to the mental health needs of this population is key to ensuring the mental wellbeing of our population, both present and future.

Any clinical system that aims to improve the efficiency and applicability of Child and Adolescent Mental Health Services may potentially influence service provision for the better. However, there is a need for the systematic, pragmatic evaluation of these systems in order to provide evidence for their effectiveness in practice. This report outlines an evaluation of one such clinical system, the Choice and Partnership Approach, which aims to improve mental health services by attempting to increase service efficiency and by placing the needs of children, young people and their families closer to the centre of the decision making process.

We hope that the findings of this evaluation will provide a missing link to ensure that more families will experience better mental health care in the future.



Dr. Andrew McCulloch  
Chief Executive  
The Mental Health Foundation

# Executive Summary

Around one in ten children and young people will experience behavioural, emotional and mental health problems at some point. Child and Adolescent Mental Health Services (CAMHS) aim to provide support for children and young people who experience mental health problems, and to promote the mental health of children and young people.

The Choice and Partnership Approach (CAPA) is a clinical system that is being widely implemented across the UK, New Zealand and parts of Australia. The aim of CAPA is to provide services to young people that are user-friendly, designed around their needs, accessible, safe and effective. The system uses quality parameters combined with processes to facilitate pathways through the service, attempting to avoid unnecessary waits. In doing so, it attempts to place the needs of families at the centre of CAMHS. There is a shift in clinician stance from 'expert with power' to 'facilitator with expertise'.

As its name suggests, CAPA relies upon the principles of 'choice' and 'partnership'. New CAMHS users and their families are invited to an initial 'Choice appointment'. This appointment is a face to face appointment aimed at identifying what they want help with and reaching a shared understanding of the problems. From there a range of alternatives open to them can be offered, including other services, strategies they can use to help themselves, and any appropriate specialist CAMHS interventions. If the service user and family choose to be seen for further appointments within the service, then they are invited to book 'core Partnership appointments'. Here, the families will aim to work in partnership with the CAMHS professional. CAPA has 11 components, which revolve around the themes of management, Choice appointments, transferring families to Partnership appointments, conducting Partnership appointments, appropriate discharge (also known as 'letting go' of families), and the importance of team away days.

## How the evaluation was done

The Mental Health Foundation was commissioned by the National CAMHS Support Service to evaluate how CAPA has been implemented by CAMHS teams across England.

This report describes the evaluation. Information was collected in two phases. Phase 1 involved surveys that were sent out nationally to CAMHS teams across England. In Phase 2, the research team selected and visited six teams who had implemented CAPA and spoke to staff, service users and families in detail. The research team collected information through a combination of surveys and interviews.

Four hundred and forty two teams were sent a copy of the first survey (Phase 1a), 213 CAMHS staff responded. 97 teams were sent a copy of our second survey (Phase 1b), and 53 CAMHS teams responded. The 97 teams implementing CAPA were sent a third survey (Phase 1c), and 7 responded. Phase 2 involved conducting a group interview with staff in each of the six teams (a total of 62 staff) and individual interviews with 32 staff, 3 parents and 5 children. We also sent out questionnaires to 120 families, 7 young people and 7 carers responded.

## What the evaluation found

The report describes the following:

- 92% of the CAMHS staff who responded to our survey had heard of CAPA.
- 97 CAMHS teams who responded to our survey stated that they were implementing elements of CAPA into their practice.
- On average, the CAMHS teams who responded to our survey were implementing 6 of the 11 CAPA components. Of the six teams we visited for Phase 2, few were implementing job plans, full booking systems, and few were handling demand in the way recommended by CAPA. However, most were conducting Choice appointments within an appropriate framework.
- The first foundation component of CAPA details the significance of good management and leadership. The presence of facilitative, informed management was of utmost importance for teams to successfully implement CAPA.
- Few of the teams were fully implementing the system of 'full booking' to arrange appointments with families. This may be due to clinicians wishing to have more control over their individual diaries.
- The process of conducting a Choice appointment may be challenging for some clinicians, particularly those who are less experienced. Staff should be adequately supported and trained in this area.
- CAPA appeared to reduce waiting lists for families coming into the service, but CAMHS teams often experienced problems transferring families from their initial Choice appointment to follow up Partnership appointments because they had not set up necessary systems to do this. This may be due to a number of reasons:
  - Difficulties experienced by clinicians conducting Choice appointments.
  - Clinicians not developing goals with families, and not having a system to review outcomes.
  - Inaccurate capacity planning.
  - Inadequate resources
- Several of the CAPA components are likely to affect the service offered to clients and families in the following ways:
  - Planned discharge from the service.
  - The language used in consultation with professionals.
  - Formalised care planning.
- None of the clients and families who offered their views in this evaluation appeared to know about their own formal care plan. However they did have a good understanding of what help they were receiving and why.

## Benefits and challenges of implementing CAPA

Potential benefits may include:

- Improved access and reduced waiting times for families entering the service.
- Reduced demands on the service due to improved partnership working with community services and improved flow of families through the service.
- More efficient and more formalised mechanisms of team working.
- Better administrative and management infrastructure to plan services.
- Greater transparency within services, which may lead to improved relationships with service commissioners.
- Less referrals and bottlenecks to specialist clinics.
- Improved clinician skills through joint working.

Potential challenges may include:

- Active planning, monitoring and reviewing for families with complex needs
- Workers such as child psychotherapists and primary mental health workers may find it difficult to fit their work into the CAPA system due to their own understandings of their role in CAPA.
- Families may wait for long periods of time in between having a Choice appointment and a Partnership appointment if there is not enough capacity within the service or if full booking and job plan review systems are not in place.
- Less experienced staff may lack the confidence and skills required to conduct Choice appointments.
- Capacity planning requires robust service monitoring and a flexible workforce who are willing to extend capacity and roles where necessary.
- CAPA may require managers to be trained in capacity planning in order to implement CAPA. This may be a challenge for teams who do not have a formal capacity plan.

## Recommendations

There are key recommendations to be made at both national and local levels, both of which will be essential for successful implementations.

At a national level:

1. We recommend that CAPA is rolled out gradually, for teams to opt-in. Teams should be aware of the options available within their service, and aware of the benefits of CAPA. However, enforced adoption of CAPA amongst CAMHS teams is likely to lead to unsuccessful implementation.
2. A national support framework for CAPA should be established. Exploration of models of how this could work most effectively should consider:
  - How to receive and analyse information from teams implementing CAPA
  - How best to provide information for teams considering CAPA implementation



- Future approaches to quality assurance of CAPA training and or implementation
  - Identifying 'exemplar sites' which have implemented CAPA in different contexts These sites may need to be offered an incentive in order to help them share information with other teams who wish to observe and learn from them
3. An enhanced training package should be developed to facilitate successful implementation of CAPA. This should include training on conducting Choice appointments for clinicians, job planning and capacity planning for managers.
  4. A national online network and directory of CAPA implementers could be developed. This may provide a point of call for those who are interested in implementing CAPA, allowing professionals to share information and solve problems as a community.
  5. The CAPA implementation training and support package will need to be sensitive to commonly held misunderstandings of the CAPA model, particularly focusing on how the system can be applied to complex cases. This will help to ensure that the implementation process becomes more standardised across teams.
  6. The implementation of CAPA within a variety of contexts should be supported by the development of case studies which illustrate how the system can work in different types of services.

At a local level:

7. For teams to realise the benefits of CAPA the presence of facilitative team management is crucial. In line with the first component of CAPA there should be an informed manager, a clinical lead, and an administrative lead that should be well respected within the team, educated and trained in CAPA prior to implementation.
8. CAMHS teams implementing CAPA need more formalised mechanisms in place to facilitate effective team-working. Peer group supervision and regular away days may provide a good base for this, as outlined by components 10 and 11 of the CAPA model.
9. Children's Trusts should hold extensive, up-to-date directories of all local children's services. CAMHS teams should use these directories to enable them to engage in multi-agency work or to signpost families to appropriate services.
10. Successful implementation of CAPA should involve staff from a variety of roles within the CAMHS organisational structure, including clinical and administrative staff, managers and commissioners.
11. Monitoring and feedback are integral prior to, during, and after the implementation phase. Teams should engage in robust, transparent data collection and analysis processes that will allow them to monitor the following; outcomes for families, user experiences of the service, waiting lists, internal waits, capacity, flow and discharge.
12. Local service and regional support systems who wish to implement CAPA would be advised to appoint a number of local champions to help oversee and standardise implementation within an area. These champions should be a mixture of clinicians and managers with experience of implementing CAPA already.

# 1. Background

Around one in ten children and young people aged 5 to 15 years will experience behavioural, emotional and mental health problems at some point in their lives. The Government's vision for improving children's mental health outlined in Chapter 9 of the National Service Framework for Children, Young People and Maternity Services states that:

*All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders, have access to timely, integrated, high quality multidisciplinary mental health services to ensure effective assessment, treatment and support for them and their families.*

Child and adolescent mental health services (CAMHS) aim to promote the mental health and psychological wellbeing of children and young people. The services aim to deliver multidisciplinary mental health services to all children and young people with mental health problems. However, the recent CAMHS Review (CAMHS Review, 2008) has suggested that CAMHS may not be as child centred as they could be, and that services may be difficult for some to access. Also, the balance between the demands made on services with their actual capacity to deliver was identified as an area for improvement. The Choice and Partnership Approach (CAPA), which is the subject of this evaluation, aims to address these key issues.

In the 1990s, a four tiered model was used to describe the CAMHS system. Since then, this model has been used as a framework for commissioning and delivering services. As highlighted in the CAMHS Review there is some variation in the interpretation of this model between services and local areas, however it operates as follows:

**Tier 1:** Services such as schools, youth clubs and GP surgeries where staff are generally not trained mental health specialists. These services offer general support and advice and mental health promotion. They will refer families requiring further support up to the higher Tiers.

**Tier 2:** Services provided by staff who generally are trained mental health specialists and who work in community and primary care settings such as schools and GP practices. These services offer assessment, consultation and more specialist support for children and young people.

**Tier 3:** Multi-disciplinary mental health services such as community mental health clinics or psychiatry outpatient services. These services support children and young people with more severe and complex difficulties than lower tier services.

**Tier 4:** Highly specialist services such as psychiatric inpatient units or day units. These provide support to children and young people with the most serious difficulties.

More recently, some areas have been working with the definitions of 'universal', 'targeted' and 'specialist' services. These have been used in children's services more generally and have been applied to CAMHS.

## Choice and Partnership Approach

The Choice and Partnership Approach (CAPA; York and Kingsbury, 2009) is a clinical system that evolved in Richmond and East Herts CAMHS and is now being widely implemented across the UK, New Zealand and parts of Australia. The aim of CAPA is to engage young people and their families whilst managing supply and demand within CAMHS. In doing so, it places the needs of families at the centre of CAMHS. As its name suggests, CAPA relies upon the principles of 'Choice' and 'Partnership'. New CAMHS users and their families are invited to an initial 'Choice appointment'. They are offered a choice of day, time, venue, clinician and intervention. Following this, families are invited to book 'Partnership appointments'. Here, the families will aim to work in partnership with the CAMHS professional on mutually agreed goals. Until now, CAPA has not been independently evaluated to fully understand its benefits and scope of influence.

CAPA is rooted in the theory of Demand and Capacity, and is part of the modernisation agenda as outlined in the CAMHS Review (CAMHS Review, 2008). There are a number of similar clinical systems working within CAMHS services, including 'New Ways of Working'. CAPA itself arose from an initiative called the 7 'HELPFUL' Habits of Effective CAMHS (<http://www.camhsnetwork.co.uk>). It incorporates New Ways of Working, 10 High Impact Changes, You're Welcome Standards, Our Choices in Mental health Lean Thinking and other quality parameters.

The intention of CAPA is to allow CAMHS teams to put the young person and family at the heart of the service. One of the core principles is that the capacity of the service should extend to meet the demands of families waiting to be seen. There is an emphasis on how to 'let go' of families once they no longer need to use the service, instead of keeping families in the system unnecessarily. Within this framework, it is also important that the team manages time and human resources most effectively, and has a range of clinical skills. CAPA has 11 components, which its authors consider essential to its implementation (for further details please see <http://www.camhsnetwork.co.uk>); the components themselves are numbered below:

- 1. Management and leadership.** The CAMHS team should have three members of staff who take a lead on the following three domains – administrative work, clinical work, management. Staff from all three domains should meet on a regular basis. This is one of the two foundation items essential to the implementation of CAPA.
- 2. Language.** The CAMHS team should not use traditional language such as 'assessment' and 'treatment'. Instead, they should use alternative terms, decided locally, to describe the essence of 'choice' and 'partnership'. The aim of this component is to provide the basis for a new philosophy of working with families, a focus on appropriate skills rather than professional roles, and a more inclusive, less stigmatising environment for families.
- 3. Handle demand.** New referrals to the team should be screened as soon as they become known to the team. It is important to clear the waiting list for families who are waiting for their initial appointment with the service. The patient and family should be offered an initial appointment, which may typically be known as a 'Choice appointment'.

- 4. Choice framework.** This component relates to the initial appointment with the family (i.e., the 'Choice appointment'). The young person, family and clinician should develop a strategy for how to help. This should occur regardless of whether the patient is to be followed up with subsequent appointments. This strategy may include providing self-help information or helping the patient to access relevant help alongside or outside specialist CAMHS.
- 5. Full booking to Partnership.** A 'full booking' diary system should be in place when offering follow-up appointments to patients. Within each clinician's diary, the clinician should make a certain number of slots available for initial Partnership appointments. This diary should be available to other clinicians and administrative staff, who can then book families into these free slots. If chosen, the Partnership appointment should be booked straight after the Choice appointment. Unused Partnership and follow up appointment times in the diary are then made available for other patients.
- 6. Selecting Partnership clinician by skill.** The patient is matched to a relevant clinician. The information gained from the initial Choice appointment will help the clinician to guide this process. The decision should be made based upon knowledge of individual clinicians' own therapy styles and relevant skills.
- 7. Extended clinical skills in core work.** The CAMH team distinguishes between 'core work' and 'specific work'. In core work clinicians will use their 'extended clinical skills' and in specific work their 'specialist skills'. Clinicians are encouraged to ensure that families are engaged with core work first. Clinicians with relevant specialist skills are then added in as and when required.
- 8. Job planning.** All individuals within the team will have a job plan, which consist of various tasks. Clinicians will have time allotted for Choice appointments, follow-up 'Partnership' appointments, development and training, team meetings, and administrative duties. The team itself should also have a job plan, which is overseen by the team manager. Individual's workloads are seen to be flexible. This aims to ensure that staff members are working efficiently within their capacity.
- 9. Goal setting and care planning.** Formal care plans are produced for each patient, in consultation with the patient and family. Ideally, these care plans should be written down. Within the care plan, there should be discussion of goals and outcomes to facilitate engagement, effectiveness of the intervention and to review the progress of the work with each family. The process of letting go should help to increase the team's capacity to take on new patients.
- 10. Peer group supervision.** Members of the team should meet regularly in small, formal multi-disciplinary groups. These meetings should be used to discuss individual cases. Teams should also use these meetings to discuss how to let go of families by examining goals and outcomes.
- 11. Team away days.** CAMH teams should partake in quarterly team away days. The agenda for these days should be set by the team. These days serve the function of sharing clinical skills, maintaining staff relationships and planning for the future. This is the second of two foundation items and is essential for the implementation of CAPA.

These eleven components are further broken down into five subcategories:

- a. 'foundation items' (components 1 and 11),
- b. 'Choice items' (components 2, 3 and 4),
- c. 'transfer to Partnership items' (components 5 and 6),
- d. 'Partnership items' (components 7 and 8) and
- e. 'letting go items' (components 9 and 10).

According to the authors, 'Foundation' items are especially important to the implementation of the CAPA model. 'Choice' items relate to the process of meeting families for the first time, in an initial appointment. 'Transfer to Partnership' refers to the process of moving families from their initial screening into follow-up appointments with a suitable clinician. 'Partnership' items refer to the process of follow-up appointments themselves, and 'letting go' items enable families to leave the CAMHS team when ready.

The CAPA model is often misunderstood and is not implemented by services as originally intended by its founders. York and Kingsbury have identified 19 common misunderstandings of CAPA, or CAPA 'Myths' which are described in detail in the literature (York & Kingsbury, 2009; [www.camhsnetwork.co.uk](http://www.camhsnetwork.co.uk)). These include the view that CAPA is a limited session model (e.g. families can only be seen for a set number of appointments), that appointments have to take a fixed amount of time, and that CAPA places too much emphasis on discharge.

The Final Report of the National CAMHS Review (CAMHS Review, 2008) suggests that CAPA can have a positive effect on waiting lists, but may hide waiting times in between Choice and Partnership appointments for some services. However, this model of working has not been evaluated independently in pragmatic settings.

## 2. Aims

The aims of this evaluation are to:

1. Examine how well CAMHS in England have adopted the components of CAPA in their practice.
2. Assess the degree to which the intended outcomes of CAPA are being achieved.
3. Understand the impact of adopting CAPA for services and families.
4. Enable future decision making regarding the planning of further CAPA implementation.

## 3. Methodology

### 3.1 Design

This project drew upon quantitative and qualitative methods in order to explore the study's objectives, using a mixture of surveys, interviews and focus groups. The flexibility achieved from using multiple methods ensured maximum participation amongst different groups of participants; children, families and professionals who were working in CAMHS services.

The study was split into three discrete phases. Phase 1 was mostly quantitative. This consisted of audits that were targeted at professionals working in CAMH teams across England. The first audit (1a) used a generic questionnaire to assess CAPA implementation and some of its related aspects including whether implementing CAPA improved clinical outcomes and the working lives of staff in terms of levels of job satisfaction and stress. The generic questionnaire was established to help maximise participation from the CAMHS communities in this study, aiming to make the instrument more relevant to a wider range of people working in CAMH teams. The second audit (1b) used a questionnaire that was entirely centred on CAPA, and one that had higher face validity for all those who knew of CAPA already. A third audit (1c) collected data relating to the flow of families through the service pre and post the implementation of CAPA (e.g. waiting times, referrals, discharge rates etc).

Phase 2 of the evaluation employed qualitative methodologies, consisting of semi-structured interviews and focus groups with CAMHS professionals, service users and families. A questionnaire was also sent to carers and young people within the six selected sites.

### 3.2 Participants

#### Phase 1a

The first screening audit (1a) was sent to professionals in 442 CAMHS teams across the nine Government/NHS regions. Altogether, 213 responses were returned. However, there was substantial variation in the amount of responses across the nine regions (as shown in table 1).

**Table 1 – Responses to the screening audit by region**

Region	Proportion of total (%)
South West	20.2
South East	14.9
Eastern	14.4
Yorkshire and Humber	11.5
East Midlands	9.6
North West	9.6
West Midlands	5.3
North East	4.3
London	3.8
Unknown	6.2

As shown, the highest response was from services in the South West. There was also a good response rate from Eastern England and the South East. The lowest number of responses was received from London and the North East. The respondents came from a variety of mixed and urban areas; 39.4% described their CAMH teams as 'rural', 11.1% as 'urban' and 43.3% as 'rural and urban mixed'.

In addition to these regional variations, the sample included a variety of professionals in different roles. Table 2 describes the professions of those participants who responded to the questionnaire:

**Table 2 – Participants' professional occupation**

Profession	Proportion of total (%)
Manager	29.3
Nurse	19.2
Unknown	13.5
Psychiatrist	11.5
Psychologist	11.1
Primary Mental Health Worker	5.8
Therapist	3.8
Other	5.8

The largest single proportion of responses came from managers, either at the level of individual teams or at more senior 'service' level, encompassing several teams. In addition to this, nurses were well represented in the sample.

### Phase 1b

The second audit questionnaire (1b) was sent to all of the CAMHS teams who had responded to Phase 1a confirming that they had been implementing CAPA within their service and had given their contact details (n=97). A total of 53 teams responded to audit 1b, the greatest proportion of respondents were from the Eastern CAMHS region (n=10). There was a very low response rate from London (n=1) and the North East (n=1), this was likely to be because only a small number of teams in these regions responded to Phase 1a.

### Phase 1c

The third audit questionnaire was sent to the 97 teams that were implementing CAPA. A total of 7 teams responded.

### Phase 2

Phase 2 investigated six CAMHS teams who were implementing CAPA to varying degrees. All teams were selected based upon their responses to Phase 1b, which allowed the research team to determine the extent to which teams were implementing CAPA. Three teams were chosen as high-implementers, since they had implemented 8 or more of the components of CAPA. Two teams were chosen as medium-implementers, since they had implemented 5-7 of the components of CAPA. One team was chosen as a high-implementer that had completed their implementation of CAPA and was now in a 'post-CAPA' phase. These six teams presented a spread across the regions of England. The teams selected for site visits in Phase 2 have been identified in the following table:

**Table 3 – CAMH teams selected for Phase 2**

CAMH Team	Region	CAMHS Tier	How long since CAPA implemented	High/medium implementation
<b>Team 1</b>	Yorkshire and Humber	3	12 months	High
<b>Team 2</b>	South West	2 / 3	7 months	Medium
<b>Team 3</b>	South East	2	24 months	High
<b>Team 4</b>	West Midlands	3	12 months	High
<b>Team 5</b>	North West	3	30 months	Medium
<b>Team 6</b>	East Midlands	3	24 months	High / Post

In Phase 2, one focus group was conducted with staff at each of the 6 teams. The focus groups consisted of a total of between 7 and 16 people. In total, 62 staff members were interviewed in the focus groups, and 32 staff members were interviewed individually. Additionally, the research team attempted to run focus groups with service users and families in each of the six teams. 3 parents and 6 children and young people were interviewed. The age of the service users ranged between 10 - 16 years. In order to supplement these interviews, we asked each of the six selected teams to distribute 20 questionnaires to parents, children and young people. The response rate was low, with only 7 questionnaires from parents and 7 questionnaires from children and young people being returned.



## 3.3 Materials

### Phase 1

Two separate screening surveys were designed to identify teams who had implemented CAPA. The first of these audits (Phase 1a) was a national survey to identify those services that were aware of CAPA, and those services who were implementing elements of CAPA. This survey was to be completed by CAMHS professionals who may or may not have been familiar with CAPA. Therefore, the questions on this survey were designed to be universal to all CAMH teams. The survey included demographic questions and an 'opt-in' to allow the researchers to contact the teams to take part in Phase 2 of the study. See Appendix 1 for this questionnaire.

The second screening survey (Phase 1b) was more specific to the components of the CAPA model. This survey was designed to illustrate if and how each CAMHS team had implemented the 11 components of CAPA. The language used in this survey was therefore more specific to CAPA than in Phase 1a. See Appendix 2 for this questionnaire.

The third survey was an audit of services, collecting quantitative data from before the implementation of CAPA, data from 6 months following implementation, and recent data (from July 2009). Data collected related to waiting times, referrals, discharge rates, and DNA (Did Not Attend) rates. See Appendix 3 for this questionnaire.

### Phase 2

Three interview schedules were designed in order to guide the semi-structured interviews and focus groups. Separate schedules were written for carers, service users, and CAMHS professionals. These interview schedules included questions that related to the 11 components of CAPA. However, the carers and service users themselves were not likely to have heard of CAPA. Therefore, the interview questions were designed to probe areas that would be meaningful to the participants themselves, such as their observations about their local CAMHS, and their satisfaction with the service. See Appendices 6 – 9 for these interview schedules.

To maximise the number of families contributing to the evaluation two questionnaires were designed for young people (aged 10 years and above) and their carers (see Appendices 4 and 5 for these questionnaires). The questionnaires asked general questions around their views and experience of the service. These questions did not refer directly to CAPA, but were related several of its components. The questionnaire was particularly centred upon those components that would be noticeable from the family perspective; around 'Language', 'Choice Framework' and 'Goal Setting and Care Planning'. Questionnaires for young people were designed in consultation with the young person participation team.

## 3.4 Procedure

### Phase 1

In the initial stages of project planning, the research team set up an expert steering group. This group consisted of three senior managers of CAMHS within three different regions in England. All three of these managers had experience with service improvement, and two had clinical experience of working with CAPA. The expert steering group met once every six weeks to oversee the project. See Appendix 12 for details of the expert group.

The research team then created a database of CAMHS team managers in Tiers 2, 3 and 4 across England. This database included each of the CAMHS regional development workers, along with the team and service managers within the nine regions. A second database was built using the Children's Services Mapping website (<http://www.childrensmapping.org.uk/>). Using these two databases, the research team was able to build up a comprehensive database of CAMHS contacts in England.

The questionnaire used in Phase 1a was pilot tested with a CAMHS team in the East Midlands. The team's comments were assimilated into the questionnaire along with the guidance of the expert group.

Each member of staff on the contact database was contacted via email. In this email, contacts were asked to complete the first screening audit. Seven days later, all contacts were sent a reminder email to encourage a greater response. Fourteen days after the initial email, a targeted reminder was sent to contacts in those regions who had submitted the least responses. The responses were entered into a database and analysed using SPSS Version 16 for Windows (SPSS, 2007). The results of Phase 1a were used to calculate a CAPA 'score', which was comprised from questions in the questionnaire. This score was designed to provide an approximation of the degree to which CAPA had been implemented, consciously or not, by the CAMHS teams.

Following this, the second survey (Phase 1b) was piloted in consultation with the expert group. This survey was then sent out via email and post to all CAMHS teams who had claimed to implement CAPA in Phase 1a and had given their contact details (n = 97). Two reminders were then sent seven and fourteen days later in order to increase the response rate.

Following completion of Phase 2, a third survey (Phase 1c) was sent out to the 97 teams implementing CAPA and reminder was sent out 7 days later. During this phase, the research team collected data on waiting times from the Children's Service's Mapping database. Waiting times for services identified by Phase 1b as being high implementers of CAPA were compared with the average waiting times of all other services in the database.

### Phase 2

Using the results from Phase 1a and 1b, the research team selected six CAMHS teams who were suitable for further investigation, this was primarily based on the scores relating to the CAPA components as identified by Phase 1b and a full description of this process is given below. Following the identification of suitable teams, the research team contacted the team managers of the selected sites and provided them with information about the study. Individual and group interviews with staff

at each CAMHS team were arranged. The research team also arranged to conduct individual and group interviews with service users and families from each CAMHS team. All potential participants were given information about the study; along with consent forms where they could give consent to be interviewed. Easy-read consent forms and information sheets were produced using symbols and simplified vocabulary for younger service users.

The research team visited the six selected sites in between May and July 2009. Focus groups and individual interviews with CAMHS professionals took place at the CAMHS venue, with the exception of one interview, which was done via telephone. Data collection with service users and families took place in neutral, non-clinical community venues, such as youth or local community centres that were known to participants, with the exception of one interview, which was conducted on the telephone.

Typically, focus groups lasted between 35 and 50 minutes, whilst individual interviews lasted between 20 and 40 minutes. Focus groups and interviews with CAMHS professionals all took place within normal working hours, usually following a team meeting. Focus groups with clients and families took place after school hours in order to maximise the likelihood of participation and reduce burden on the participants.

The focus groups and interviews with service users and families followed a different format to the focus groups with CAMHS professionals. The focus groups with younger children included a mixture of activities designed to help participants engage both individually and as a group. Whilst planning these groups, the research team sought advice from a consultant who had previous expertise in the involvement of children and young people in research. Consequently, the design of the focus group with children and young people differed to the focus groups with families and professionals. A range of activities were set up to allow the children to share their opinions with the research team in a non-threatening environment. Each participant was asked to give informed consent to take part in the study and to have their comments used as quotations. For participants under the age of 16, consent from a parent/carer was also gained. Families were recompensed travel and childcare expenses as required, and were offered small incentives in the form of gift vouchers in appreciation for their time.

Focus groups with professionals were conducted in the presence of a facilitator and two co-facilitators. Focus groups with families were conducted with four or five members of staff. The extra staff members were required in order to conduct separate focus groups with children and their parents, and in order to support any children who may have become distressed during the group.

Additionally, the research team collected background information from each service, including promotional material, job plans and team capacity plans. This provided contextual information about the teams and allowed the research team to see how CAPA had been implemented in practice.

Questionnaires for children and young people, and their carers, were sent to each of the 6 CAMHS teams visited in Phase 2 of the research. Each team was sent 20 questionnaire packs and were asked to post these to families who had accessed their service. Questionnaire packs included a consent

form, information sheet and questionnaire for carer and young person and a freepost envelope so that questionnaires could be posted straight back to the research team anonymously.

The research team obtained ethical approval from the National Research Ethics Service, through the South West Research Ethics Committee. The research team followed local research governance procedures at each of six selected sites. All members of the research team had received enhanced CRB checks, and one had been trained by a nominated Child Protection Officer.

### **3.5 Data Analysis**

#### **Phase 1a**

Quantitative data were analysed using SPSS version 16.0 for Windows. CAMHS teams were given a score based upon their self-rated implementation of CAPA. This score was derived from answers to questions in Phase 1a and was compared across regional variations. The maximum possible score on this survey was 28.

Since Phase 1a also contained some open-ended questions these were analysed through using qualitative thematic analysis. One member of the research team examined the data and searched for themes arising from the comments. Another researcher then examined the data independently. Similarities and differences in the researchers' interpretations were discussed until reaching consensus.

#### **Phase 1b**

Teams that completed survey 1b were given a score which reflected their implementation of the 11 components of CAPA. One point was given for full implementation of each component, half a point was given for partial implementation of each component. The maximum score was 11, which would indicate full implementation of CAPA.

#### **Phase 1c**

Quantitative data were analysed using Microsoft Office Excel 2003.

#### **Phase 2**

The data from Phase 2 were analysed thematically. A coding framework was derived, which included the 11 components of CAPA and other important themes that had arisen during the data collection phase. Two researchers then coded the transcripts of the interviews and focus groups in accordance with this framework. The researchers then met at various points to discuss their coding. At these points, the coding framework was developed further, similar themes were merged together, sub-themes were created where appropriate. The findings were then written into the report and conclusions and interpretations were drawn. In order to supplement the data from families, themes from the service users' and families' questionnaires were analysed using the same approach.

## 4. Results

This section will present the findings of the evaluation. First, the quantitative data from Phases 1a and 1b will be presented. Second, the data from Phase 2 will be presented in relation to each of the 11 components of CAPA.

### 4.1 Spread of CAPA implementation

The results of Phase 1a revealed that the vast majority of respondents had heard of CAPA (n=194, 92%). Furthermore, the majority of the respondents claimed to have been implementing CAPA within their service (n=138, 68%, 97 CAMHS teams in total). Most of these teams were implementing it under the name of CAPA, rather than an alternative name. Of those respondents who stated that they were implementing CAPA, 92 (67%) had been on a CAPA workshop run by Steve Kingsbury and Ann York. Furthermore, 86 respondents (62%) had read the CAPA workbook, and 43 (31%) had seen the CAPA website. The CAPA score varied substantially from team to team, ranging from 25 at the highest to -6 at the lowest out of a maximum possible score of 28 (mean=12.9). Points were awarded or deducted for presence or absence of elements resembling CAPA, such care planning, offering Choice appointments, waiting lists, sharing knowledge within the team, and provision of away days. There were variations in the response rate to Phase 1a across the regions, as shown in the following table.

**Table 4 – CAPA implementation by region**

Region	No. respondents implementing CAPA	% of respondents implementing CAPA	Average CAPA score*
South West	40	95.2	13.0
Eastern	20	66.7	12.8
South East	18	58.1	12.2
East Midlands	16	80.0	12.1
Yorkshire and Humber	14	60.9	13.0
North West	9	45.0	13.3
West Midlands	7	70.0	12.7
London	4	50.0	12.8
North East	2	25.0	13.0

\* The CAPA score from Phase 1a does not relate directly to the 11 components of CAPA

Table 4 shows some interesting findings. A high percentage of respondents from the South West region appeared to be implementing CAPA. Of the remaining teams, the Eastern region also appeared to have a high proportion of teams implementing CAPA, in comparison to the South East, East Midlands, Yorkshire and Humber, and North West regions. Unfortunately the response rate for the remaining regions was too low to make meaningful comparisons.

Another notable finding from Table 4 was that there appeared to be very little regional variation in the degree to which CAPA has been implemented amongst services who claim to be implementing it. According to the results from Phase 1a, the 'CAPA score' was relatively even across all 9 regions.

## 4.2 CAPA and waiting lists

The data regarding the effect of CAPA on waiting times have been taken from several sources; the two audits conducted in Phase 1a and Phase 1c, the questionnaires received from families in Phase 2 and data from the Children's Services Mapping database.

According to the results of Phase 1a, there did not appear to be any differences between those teams who claimed to have been implementing CAPA and those who did not claim to be implementing CAPA. The average self-reported waiting time for both groups was 6.3 weeks. However, this result should be treated with caution; since there was great variability in the way these teams were likely to be implementing CAPA.

Complete sets of pre and post CAPA data on waiting times were collected from three teams responding to Phase 1c. Before implementation, waiting times ranged from 7 – 108 weeks and following implementation these had reduced to 5 – 12 weeks. These results too should be treated with caution due to the small number of teams responding to the survey with complete data.

Some information regarding waiting times was also given on the questionnaire for children and families. Five out of 7 carers responding to the questionnaire reported that they had waited more than 3 weeks for their initial appointment, there were also waiting times for Partnership; 4 carers waited less than 2 weeks to for their first Partnership appointment, 2 waited less than 4 weeks and one waited more than 2 months.

Data from Children's Services Mapping were used to gain some more detailed information about the effect of CAPA on waiting times.

**Table 5 – Waiting times from Children's Services Mapping**

	<b>4 weeks and under</b>	<b>4-13 weeks</b>	<b>13-18 weeks</b>	<b>19-26 weeks</b>	<b>More than 26 weeks</b>
<b>Average % of families waiting – all services (n=377)</b>	47	33	7	5	8
<b>Average % of families waiting – services who were high implementers of CAPA (n=9)</b>	53	39	4	3	1

Table 5 compares the average waiting times of services identified by Phase 1b as high implementers of CAPA with all other CAMH services that either did not respond to Phase 1a, or who responded and were not high implementers of CAPA. Information was only taken from services that had supplied complete sets of data. This mapping data suggests that CAPA does reduce waiting lists; there are a larger proportion of families waiting less than 4 weeks for support, and a smaller number of families waiting for more than 26 weeks.

### 4.3 Flow of families through services

Data collected in Phase 1c described the flow of families through 5 CAMH services, 4 of which were identified as high implementers in Phase 1b and 1 which was a low implementer. Only a very small number of services responded to this survey (n=7), and no services had complete data prior to implementing CAPA.

- On average there was a 10% decrease in the amount of referrals accepted per month for Choice appointments, and a 10% increase in the number of referrals that were not accepted following implementation of CAPA (n=2).
- Of the two teams which were able to provide pre-CAPA data regarding families referred elsewhere, one team showed no change in this number, whilst in the other team there was a 26% decrease in the number of families referred elsewhere.
- The low implementing team was the only one able to provide complete data regarding the number of families waiting for initial appointments, and saw an 80% decrease in this number following CAPA implementation.
- Four of 5 teams reported internal waits for follow-up work after CAPA had been implemented, waits ranged from 2 weeks to 5 months.
- Three teams were able to provide pre-CAPA data regarding families that did not attend (DNA) initial appointments. Two of these three teams saw, on average, a 47% decrease in DNA rate. The remaining team saw a 50% increase in DNA rate.
- Of the two teams that had complete data regarding discharge rates pre and post-CAPA, one saw a 59% decrease, whilst the other saw a 15% increase.

The data from Phase 1c are limited and varies significantly between teams; consequently it is difficult to form any solid conclusions about the effect of CAPA on the flow of families through CAMH services using this information.

### 4.4 Implementation of CAPA components

Table 6 shows the extent to which the respondents to survey 1b had implemented each of the 11 components of CAPA. It is difficult to make accurate comparisons across the CAMHS regions due to the low response rate from London and the North East. Yorkshire and Humber had an above average score for implementation of CAPA, implementing 7.3 components on average.

On average most of the components of CAPA were implemented to a similar level across the teams, however there were some differences; component 7 ('extended clinical skills in core work') was the most fully implemented component, whilst component 3 ('handle demand'), was the component that was least implemented.

There was a wide variety of scores within the CAMHS teams themselves. The highest implementing team had implemented 10.5 out of the 11 components of CAPA. The lowest implementing team had an implementation score of 1. Interestingly, although all teams identified themselves as using CAPA the average score for implementation was 6 out of a possible 11, indicating that most teams were only partially implementing CAPA.

**Table 6 – Average implementation of CAPA component by region**

Region	Component No.											Total	n
	1	11	2	3	4	5	6	7	8	9	10		
<b>East Midlands</b>	0.5	0.4	1	0.3	0.6	1	0.4	0.8	0	0.3	0.3	5.4	4
<b>Eastern</b>	0.4	0.6	0.9	0.3	0.6	0.8	0.6	0.9	0.6	0.5	0.5	6.4	10
<b>London</b>	1	0	0.5	0	1	0.5	0.5	1	1	1	1	7.5	1
<b>North East</b>	0.5	0.5	0	0.5	0	0	0	0	1	1	1	4.5	1
<b>North West</b>	0.5	0.7	0.7	0.6	0.5	0.4	0.1	1	0.6	0.7	0.8	6.6	7
<b>South East</b>	0.6	0.7	0.3	0.7	0.8	0.4	0.7	0.8	0.6	0.8	0.4	6.7	6
<b>South West</b>	0.6	0.3	0.6	0.3	0.6	0.3	0.6	0.8	0.6	0.4	0.8	5.8	9
<b>West Midlands</b>	0.5	0.5	0.5	0.3	0.5	0.1	0.8	0.8	0.6	0.4	0.6	5.5	4
<b>Yorkshire and Humber</b>	0.9	0.9	0.8	0.6	0.5	0.5	0.8	1	0.6	0.3	0.5	7.3	4
<b>Unknown</b>	0.1	0.2	0.7	0.4	0.6	0.7	0.4	1	0.4	0.4	0.3	5.4	7
<b>Total</b>	0.6	0.5	0.6	0.4	0.6	0.5	0.5	0.8	0.6	0.6	0.6		53

Table 7 shows the implementation scores for each of the four groups of CAPA components. There are no substantial differences in implementation between groups, however on average the 'Letting go' items were being implemented most, whilst the 'Foundation' and 'Choice' items were being implemented the least. It is interesting to note that on average the two Foundation items are not being fully implemented, since these items are considered essential for the implementation of CAPA. Again, this also suggests that that most teams were only partially implementing CAPA.

**Table 7- Average implementation of CAPA component group by region**

Region	Foundation Items (1 and 11)	Choice Items (2 – 4)	Transfer to Partnership (5–7)	Letting Go (8 – 10)
<b>East Midlands</b>	0.45	0.63	0.73	0.2
<b>Eastern</b>	0.5	0.60	0.77	0.53
<b>London</b>	0.5	0.50	0.67	1
<b>North East</b>	0.5	0.17	0.00	1
<b>North West</b>	0.6	0.60	0.50	0.7
<b>South East</b>	0.65	0.60	0.63	0.6
<b>South West</b>	0.45	0.50	0.57	0.6
<b>West Midlands</b>	0.5	0.43	0.57	0.53
<b>Yorks. and Humber</b>	0.9	0.63	0.77	0.46
<b>Unknown</b>	0.15	0.57	0.70	0.36
<b>Total</b>	0.52	0.52	0.59	0.6



Table 8 below shows the extent to which the six selected teams for Phase 2 have implemented the 11 components of CAPA. These data were generated from Phase 1b. Teams score 1 for indicating that they were fully implementing the component, 0.5 for partial implementation, and 0 for non-implementation.

**Table 8 – Implementation of the CAPA components for the six teams selected for Phase 2**

	Component No.											Total
	1	11	2	3	4	5	6	7	8	9	10	
<b>Team 1</b>	1	0.5	1	0.5	1	1	1	1	0.5	1	0.5	9
<b>Team 2</b>	0.5	0	0.5	0	1	0.5	0.5	1	0	1	0	5
<b>Team 3</b>	0.5	1	0.5	1	1	0	1	1	1	1	0	8
<b>Team 4</b>	1	0.5	0.5	0.5	1	0.5	1	1	0.5	1	1	8.5
<b>Team 5</b>	1	1	0.5	0.5	1	0	0.5	1	0.5	0	1	7
<b>Team 6</b>	1	1	1	0.5	1	1	1	0	0	0.5	1	8
<b>Total</b>	5	4	4	3	6	3	5	5	2.5	4.5	3.5	

As shown in Table 8, the six selected CAMHS teams were implementing CAPA to varying degrees. However, it is especially notable that very few of the teams were implementing CAPA component 8 ('job plans'), component 5 ('full booking to Partnership') and component 3 ('handle demand'). Other components, such as component 4 ('choice framework') were much more fully implemented.

Based on the results to Phase 1a, the six teams identified for Phase 2 had received varying amounts of training. All six teams had at least one member of the team who had been on a workshop run by Steve Kingsbury and Ann York. Four of the six described that they owned a copy of the CAPA workbook, whereas two had used the CAPA website. One team had received service improvement training.

The following section of the report will focus on the meaning of the 11 components of CAPA, and how they have been implemented. The benefits and problems with each component will be presented using data from the interviews, focus groups, and the qualitative responses to Phase 1a.

#### 4.4.1 Management and Leadership

This was one of the two foundation components of CAPA, and was likewise revealed to be one of the most important of all. Our site visits with all teams revealed that facilitative, informed leadership was essential:

*"Well our manager is really good. She is very structured she is very clear on what we do and I think she understands the model, she understands how it is supposed to work, she understands our roles. I think we are very lucky to have somebody like her to be honest."*

*Clinician, Team 3*

The managers and leaders of the team should without doubt, be able to understand the CAPA model in order to implement it successfully. In order to do this, managers discussed how they had educated themselves about CAPA. In most cases, this included attending a workshop run by Steve Kingsbury and Ann York. In some cases the whole team had been on the workshop, in others only the managers had been involved and in general it appeared to be well received:

*“Because we hadn’t had the training for the whole team. It’s been me and the old clinical lead that’s gone, more recently the new clinical lead went on a Solutions one, but the whole team hadn’t had the all singing all dancing CAPA workshop.”*

*Manager, Team 4*

An additional source of education was the CAPA workbook, which was often used as an adjunct to the workshop, rather than as an alternative:

*“In theory having read the book, spoken to the CAPA founders and seen their delivery, it looked like a very effective way of addressing chronic resource problems in CAMHS, some of which were due to inefficiencies and some failure to practice.”*

*Clinical lead, Team 2*

The education of managers and clinical leads provides a valuable theoretical framework for understanding CAPA. However, it must be supplemented by an understanding of what each of the members of the team contributes within the overall structure:

*“Basically our consultant is quite forward thinking, I don’t have a lot of time for the formal structures in terms of ‘I am a consultant I am important’. They have an important role in the team but it is one of many.”*

*Manager, Team 5*

Therefore, service managers should have the ability and credibility to liaise effectively with all of the members of the team. It would appear that a clinical background was useful for managers who wanted to facilitate this process:

*“Fundamental is the service manager’s relationship with the consultant. . . because without your consultant on board you are absolutely stuffed because of the kind of hierarchy. . . As a manager trying to implement, trying to force change doesn’t seem to work. If you have clinical credibility that seems essential in getting clinicians to change their ways of thinking”*

*Manager, Team 5*

As in accordance with the CAPA model, it would appear that the combination of service manager and clinical lead is essential to lead the success of the implementation. Furthermore, the manager must also be responsive and flexible to less experienced members of the team:

*"[Our manager] is very supportive so if we have got any issues we can always feel that we can speak to her and that makes a big difference because it stops you holding things and thinking you are doing something right or wrong, you are more confident in your approaches, you are more confident in how you are dealing with families, knowing that there is that support available."*

*Clinician, Team 3 (focus group)*

The benefits of positive leadership can easily be contrasted with the problems associated with poor leadership:

*"I would say that, I feel really disappointed that a model that seemed like a reasonable idea has just been mismanaged and not managed. If you are setting up a new system then you should be looking at attention to detail and monitoring closely and that has just not happened. I feel really frustrated about that."*

*Clinician, Team 2 (focus group)*

This quote comes from an employee of a medium-implementing team. The interviewee appears to show faith in CAPA itself; however, in the opinion of this interviewee, poor management has caused the implementation to fail. From that team, there was a desire for a more facilitative style of leadership:

*"In terms of the positive leadership, where somebody is kind of looking and wanting to make it work and adapting things to make it work better and teasing things out and that kind of thing."*

*Clinician, Team 2*

Naturally, those who have leadership roles within the team need to have a well informed understanding of the CAPA model. They need to be able to understand it well enough to know how to adapt it for the demands of their own service:

*"The difficulties of CAPA need to be considered within a much wider organisational context around commissioning, planning, good management."*

*Manager, Team 1*

This implies that robust management networks need to be in place before implementing CAPA successfully. Managers therefore must take this on board when planning to make changes within the service. Teams agreed that more than time to prepare, teams needed internalised decisions to make changes:

*"I think if we'd had two years to prepare I think it would have gone off the boil really. No I think there was something about needing to do it as quickly as was possible and that in a way, the February start point was kind of decided by us really so it was what seemed workable to us"*

*Clinician, Team 6*

*"I think what we needed was the decision to do it really. I think the time that we needed was from when we said we were going to do it to the doing really."*

*Manager, Team 4 (focus group)*

Within this framework, communication and feedback about the success of the model should be constantly cascaded to frontline staff; otherwise problems are likely to arise:

*"I guess that one of the other problems is that we don't know anything about how CAPA is being implemented because there is no feedback, there's nothing to evaluate how we've done and there's no target or plan or objectives against which we wanted to show change so I think it is very hard for anyone really to know exactly what is happening with CAPA to be honest."*

*Clinician, Team 2 (focus group)*

Ideal implementation of this component seems to focus on clinically sensitive management. The whole organisational structure needs to be motivated to implement the change, from higher-level management to clinicians at the ground level. This way, team managers may gain appreciation of how CAPA fits into commissioning strategies. Therefore, an ability to connect the theoretical elements of CAPA to practice was essential:

*"We wanted to put pressure on commissioners to read to evidence."*

*Manager, Team 4 (focus group)*

*"I think there needs to be more work done with the managerial operational people who have a job to implement these things to actually understand some of the difficulties that will arise. So it's a combination of theory practice link."*

*Manager, Team 1 (focus group)*

Aside from management and clinical direction, the importance of administration in CAPA cannot be underestimated:

*"I had seen CAPA somewhere else before I came here and it was terrible. That was one of the reasons why I didn't want to do it that I wasn't that keen was because that was a lot to do with admin who were not returning families' phone calls, double booking, it was a nightmare. I do think here we are lucky because we have got a very efficient admin team but I have been in a place where it wasn't like that. It really didn't work."*

*Clinician, Team 6 (focus group)*

The CAPA model also recommends that the team nominate a person to lead on administrative duties, to help organise the infrastructure for implementation. This person may be in place already within the teams, or may be recruited. This position was not in place for all of the teams that we visited:

*"The preparation work wasn't done which is to do with having a good sound admin system in place, having the capacity to do the work, and its just not managed, its just not been managed well."*

*Clinician, Team 2*

In the teams that had appointed someone to this role, it was variously described as 'business manager' or 'project manager':

*"We hired a project manager for two days a week, and she was employed for one year. She worked across the three teams. The first three months she spent implementing CAPA, and the following nine months were spent tweaking and adapting it"*

*Manager, Team 1*

*"There is an over arching business manager who looks at the Admin processes and each clinical lead"*

*Service improvement lead, Team 6*

The task of the administrative manager was complex during the implementation phase, and it goes beyond the regular administrative procedures undertaken by the majority of CAMHS administrative staff:

*"I wasn't going to give that job to any of the other secretaries to add on to their workload because I don't think they'd have wanted to and I think it would have just been too much really on top of being a medical secretary. We're quite short on admin and I think it just would have been unfair with losing an office manager and then recruiting another one. That stalled us really and I think she's now getting on to sorting some of the bits out and she has to look after all our admin so she's got quite a job on really."*

*Manager, Team 4*

One of the duties of the administrative manager could be to ensure that the IT systems are capable of handling the demands of the CAPA model. From visiting the six teams, it was evident that expensive new IT systems were not essential for the implementation of CAPA:

*"I think the only thing you need is a relatively good information retrieval system so it's that bit about keeping track of appointments but most of that doesn't have to be expensive equipment, you should be able to do it on an Excel database for instance."*

*Manager, Team 5*

However, some team managers expressed a desire for more sophisticated, integrated IT systems, which at present they did not appear to possess:

*"I think our IT system leaves a lot to be desired, and we could've done with a better one. What we're trying to do in the future, although we're quite a long way off, is to do an e-job plan, we have a paper plan already. We hope for eventually that we can be able to link the job plans into the diary on the IT system. My ambitious hope is that for us to have those as living documents. I hope to put that as an appendix into the workforce development plan for the service, so what we have is ideally a monthly doc that we can update."*

*Manager, Team 1*

*"It would be really nice to have a software package that booked the Choice and the Partnership, at the moment we have got a diary. All the clinicians put their diary time into the choice diary and then input their diary time into the Partnership. So it's based on pen and paper, there is no programme developed that we can find, that will be a real asset."*

*Service improvement lead, Team 6*

Although no sophisticated IT systems were seen in the evaluation, there may be room for a standardised system of the type described above. The administrative side of planning in CAPA is something that could be delegated to the administrative manager. The introduction of this role at a certain stage during the implementation provides another tier of management, and this person should allow the service manager or team manager to concentrate on the management of demand and capacity.

#### 4.4.2 Language

Four out of six teams were fully implementing the change in language as suggested within the CAPA model such as the use of 'Choice' and 'Partnership' instead of 'assessment' and 'treatment', or the use of other locally determined terms. One team was partially implementing it. The use of the CAPA language was often debated:

*"The team here have all just adopted 'Choice' and 'Partnership' and I think there has been some debates within the teams. Some people have really liked the word 'choice' and explained that to families, to take it away from the assessment phase but some people like to do an assessment and have struggled with that first appointment so I don't think it really matters what you call it as long as you stick to what the principles are behind it. I personally like the language I wouldn't change it. I think it explains exactly what's in the box."*

*Service improvement lead, Team 6*

However, this component was not universally popular. As stated previously, some clinicians were sceptical about the language:

*"It has that air of business modelling. I am struggling with the words, clinicians are not generally well meaning towards that sort of approach."*

*Manager, Team 1*

Furthermore, some interviewees felt that the shift from 'assessment' and 'treatment' to 'choice' and 'partnership' or other locally determined terms would be confusing to service users and families:

*"I think families are kind of puzzled a little bit by the language. Talking about choice and partnership, what do they mean?"*

*Clinician, Team 2*

*"When you say choice and partnership, people are like what? That doesn't make sense."*

*Clinician, Team 2*

It appeared that some teams were using the terms when talking to other professionals, but tended to use more traditional terms such as 'assessment' and 'treatment' when talking directly with families.

*"I wouldn't use 'Choice and Partnership Approach' with families because I don't feel particularly comfortable with that. If I was talking to our consultant I would say oh lets take a CAPA approach on this and he knows exactly why, he has read through it and he knows"*

*Manager, Team 5*

*"Obviously at the minute she's at the assessment process with my son"*

*Parent, Team 6*

These quotes imply that professionals may not be adopting the new language because they may feel unsure about using it. They also wanted to avoid confusing the families by using the new terms. However, other interviewees said that they thought the language changes tended not to make much difference to families' experiences:

*"I know it was meant to become more user-friendly so it wouldn't put families or service users off but when people come into our service some of them can be pretty desperate and I don't think they are too worried about the words assessment or treatment they just need something from us. I don't know that it makes that much difference actually."*

*Clinician, Team 2*

*"Semantics are relatively immaterial its how the message gets to the family and we are very clear about saying that to families"*

*Manager, Team 5*

However, aside from the words 'choice' and 'partnership', there was evidence that using friendly, or plain language terms helped facilitate communication with the families, as shown in the following extracts:

*"I tend not to say I'm a Social Worker as I think it can get people's back up. I say I'm a worker at CAMHS. I mean often I will say I'm a Social Worker but people generally have a very dismal view of Social Workers."*

*Clinician, Team 5 (focus group)*

*"[The service] use basic English... purely and simply because even though I work in a hospital I don't begin to say that I know everything there is to know."*

*Parent, Team 4*



Significantly the children and young people who accessed services that had adopted the CAPA language had not heard of 'choice' and 'partnership', and only 2 out of the 7 the young people surveyed were familiar with CAPA language suggesting that these terms were not something that they particularly identified with or found important. Despite this, there was some evidence from a parent that the new language was useful and positive, regarding 'choice':

*"Choice, erm, Choice I would say is that you're given a choice as to whether you want to process the information that they give you or whether you don't basically. They give you choices like, we could do this course with you next or we could try that course. We could try this route or we could try that route."*

*Parent, Team 4*

And later on in the same interview, regarding partnership:

*"I class me and the service as a partnership, because if there is a problem that I know that I cannot handle or I cannot deal with it in a way that I feel is needed, then I'll speak to our therapist about it"*

*Parent, Team 4*

Therefore, there seems to be both benefits and concerns to using the language required by CAPA. However, it is important to mention that one medium-implementing team had decided not to use the word 'choice' because they felt it was misleading to families:

*"I don't like the word 'choice' particularly because it implies the family are free to choose anything and actually they are not. There is a limited number of options that are available to them, so I kind of don't like the word 'choice' because it implies a freedom that they don't have."*

*Manager, Team 5*

This section needs to be interpreted with care. It is reasonably clear that the push to change the language of CAMHS has begun, fitting the spirit of modernisation of services. However, the CAMHS workforce will need to be sensitively supported to actually appreciate this. This needs to be embedded in the staff and the service culture before service users will fully feel the differences.

#### **4.4.3 Handle Demand**

According to the results of Phase 1a, this component was implemented less frequently than any other. Many teams scored less highly because they still indicated on the survey that they had a waiting list. However, on closer inspection during Phase 2 many of the teams appeared to understand the principles of handling demand.

*"CAPA is a sensible way of looking at demand and capacity within the system."*

*Clinician, Team 4 (focus group)*

The need to handle the demand of families coming into the service was a primary motivation for implementing CAPA. One of the most often quoted examples of this was when teams wished to reduce external waiting lists for families to be seen by the service:

*“CAMHS historically has had quite a long waiting list and this was seen as a new process that might actually speed the process up in terms of children and families getting access to a CAMHS service.”*

*Clinician, Team 2*

*“Our waiting list is so much shorter for that first appointment. Before if people had been on a waiting list for a year or nine months it really felt difficult saying actually this is the wrong place you need to go to”*

*Clinician, Team 6 (focus group)*

*“I went to my doctor and that was in 3 weeks. Also I got a letter from her saying they would see him and you know obviously then he was put under the clinician so I know for me it's been quite a short process to be honest.”*

*Parent, Team 6*

The perceived impact of CAPA on waiting lists was seen as one of the primary benefits of CAPA. All children and young people accessing services which appeared to be managing their waiting lists said that they felt that staff enjoyed being at work. And in a well managed team, CAPA appeared to be more popular:

*“We don't have a waiting list and I have capacity, I have bookable slots but I know other people in the team don't have them because they don't have capacity so that must mean that I am in line with the model I suppose.”*

*Clinician, Team 2*

*“We often get surprise from families saying ‘gosh we didn't know you would be so quick.”*

*Clinician, Team 6 (focus group)*

*“CAPA seems about the best way to manage a workload where you, most CAMHS services across the country are at 50% capacity of what they should be in terms of resource against population.”*

*Manager, Team 5*

The management of demand to resources can only be achieved if there are suitable screening criteria for families entering the service, which is based upon the capacity of the service. In the following example, a team appears to try to keep a 60/40 ratio following the Choice appointment; 60% of families will enter the service for Partnership appointments for every 40% that don't:

*"Initially when CAPA first came in it was probably we saw about 60% and signposted 40% because referrers weren't really up to speed and we didn't have a local community service at that time with Primary Mental Health workers."*

*Service improvement lead, Team 6*

This ratio should be managed and monitored by the team manager, whose job it is to ensure that an optimum number of families are entering the service:

*"For us pretty much the screening is the diagnostic bit, so my role is to try and ensure that we hit the Trust targets, the national targets and holding that in mind with being clinically effective and patient centred."*

*Manager, Team 5*

*"There is a whole process in CAPA that it goes through, and it is all recorded and there is a book that says how many people were taken in, how many people were referred to a counselling service"*

*Service improvement lead, Team 6*

Unless new service users and families are adequately screened after the Choice appointment staff can become overworked. It is important to note that with CAPA, there is a potential problem of waiting lists being transferred into internal waits if other key components are not in place. Families are seen for their Choice appointment, and then many of them are transferred to Partnership appointments. For several teams, there had been a build-up in waiting times from Choice appointment to Partnership appointment:

*"Internal waiting lists for Partnership were widened so it moved the wait from one place to another..."*

*Clinician, Team 2 (focus group)*

The internal waits are widened because families are seen for a Choice appointment and then booked into a series of Partnership appointments. However, there may be a difficulty in booking Partnership appointments because of the lack of slots available:

*"That's the waiting list for people waiting to be seen or to be offered a Choice appointment, but the internal waiting list is for specialist therapy which we have always had, so that's when somebody has had a Choice [appointment] and possibly then some Partnership appointments and then they need some more work but there's somebody else booked into that slot because you have given your appointment."*

*Clinician, Team 1 (focus group)*

The lack of bookable slots for Partnership appointments represents a bottleneck in the flow of the system. This was seen in both medium and high implementers of CAPA. The perceived success of CAPA on waiting lists was often based upon the prior expectations of the process amongst staff. For those who were led to believe that there would be no waiting list, CAPA implementation could lead to disappointment amongst professionals:

*"I think we were led to believe that there would be no waiting and that's kind of the part that I think is frustrating."*

*Clinician, Team 2*

In teams where CAPA implementation was motivated by members of the team themselves, expectations seemed to be somewhat more realistic. One advantage of CAPA was that it could be used to facilitate relationships with commissioners:

*"The stresses are still there, they're just not all over the place, you know. It is a lot easier to talk to the commissioners and you can also see where we want to develop things, you know, we're thinking about opportunities, we've been able to see where some of those might lie as well."*

*Clinician, Team 1*

*"CAPA was a very easy model to present to the commissioners, the joint PCT and Local Authority Commissioners, so myself and the Director of CAMHS went to the commissioning group, presented it as a way of resolving waiting times"*

*Service improvement lead, Team 6*

One clinician espoused a sympathetic view for the problem of internal waits:

*"I felt a bit sorry that sometimes CAPA is criticised for the problem of internal wait but actually CAPA could never solve that, CAPA is a way of new referral processing system and can't invent new staff, I feel a bit sorry when CAPA gets the blame for something it was never designed to sort."*

*Clinician, Team 6*

One of the main concerns about handling demand within CAPA was the formation of bottlenecks at various points in the system, such as when families are transferred from their Choice appointment into a Partnership appointment. There are a number of reasons why bottlenecks may occur here. Many services calculated their capacity based on offering families a set number of Partnership slots which were allocated for core work, however clinicians may not let go of families after their specified number of Partnership appointments. There may be inadequate staffing resources. Clinicians may feel under-confident to make a judgement after a single Choice appointment and they may use their bookable Partnership slots in order to conduct further second Choice appointments or assessments with families who have already had a Choice appointment. Furthermore, team managers may experience difficulties in capacity planning, which may lead to them making incorrect assumptions about the demand and capacity of the service. All of these issues will be addressed underneath the sections relating to the relevant components.

#### 4.4.4 Choice framework

Choice appointments represent one of the key features of CAPA, distinguishing it from the more traditional CAMHS system where a waiting list is prioritised to determine who will be seen. One team manager explains the problems associated with the old approach:

*“So you had a lot of people who weren’t seen as clinical priority and actually didn’t get a service, you kind of look at it and go ‘well clinical needs should take priority’, those often came back as an increasing clinical need, two years later they come in as a crisis, so we were struggling to find a way of managing that.”*

*Manager, Team 5*

In CAPA, families are given the choice to be seen immediately after referral. The choice framework aims to empower families by allowing them to make decisions about the kind of support they want to access and who they will receive this support from. It also means that families can choose the time and place of their appointments to suit. A Choice appointment should involve the families as much as possible, and all the children and young people who were interviewed felt that they had been listened to by staff. The following extracts from carers show this:

*“We were given options of times of appointments. They were quite flexible which is obviously good when I am at work and things. Then they weren’t pushing anything on us either. Everything was an option if you wanted to yes, if you didn’t then no.”*

*Parent, Team 3*

*“He immediately made good contact with myself and my daughter and was very sensitive to her illness. He assured her he would help her as much as he could, and at the same time, agreed to see her on appointments, as she wished, at home.”*

*Parent, Team 5*

However, in practice services may find it difficult to offer this range of choice. Some of the children and young people interviewed did not feel that they had been given any choices about their care. Forty percent of families surveyed were given a choice of day for their appointment, but there was limited choice of place and time for the appointment. Those who were given choices said that talking to staff helped them to decide what support they should have. Others felt that writing letters to staff would be a good way of letting them know what support they would like.

According to CAPA, the family should be seen for a Choice appointment as soon as they are referred, meaning that there is no external wait for the service. Therefore, the Choice appointment represents one stage of a screening process, where families are seen to determine their suitability for the service; goals are determined and preliminary support offered. Evident from the interviews with staff was the fact that Choice appointments required a lot of experience, confidence and skill to conduct.

*"There is an awful lot of information that you have to give and receive. You have to make sure all the details of their child and the family with you are correct. You have to look at the various outcome sheets of which there are three and fill those out with the service user. You have to look at the very and quite tricky issue of confidentiality so you know the child as well as the parent understands all the quite complex and difficult issues about confidentiality that those are in place. Also you have to, of course, get the information out of the child and out of the parents; what are the presenting issues, what are the contexts of these problems, make some recommendations and explain the process in terms of what happens next. There is a hell of a lot you have to pack into an hour and I have to check myself to be quite kind of disciplined really in getting my point across"*

*Clinician, Team 5*

A Choice appointment is therefore daunting for people who are less experienced, and professionals discussed the difficulties of making judgements about care within the context of one appointment:

*"People were saying the Choice appointment is not an assessment, it's a solution focussed interview, that really freaked a lot of staff, they were really anxious about this and I think we need to be really subtle about how we help people to use their expertise widely"*

*Clinician, Team 2*

*"I wouldn't embrace it as something I would really want to be involved in. I found it too difficult really. I found with the Choice appointment there was so much information that you had to sort of plough into this hour as well as the family of the clients you are having to see. I personally found that completely overwhelming."*

*Clinician, Team 2*

There appeared to be a need to receive training in conducting a Choice appointment:

*"We've never had skills training in kind of carrying out the Choice assessment"*

*Clinician, Team 2*

However, if less experienced staff were being adequately supported and assisted then they proved to be capable of doing Choice appointments. For some, it was useful to do Choice appointments jointly, with two staff present:

*“Choice gets done in twos; it’s given the people that have been newer or maybe feeling less confident more confidence in their Choice appointment skills.”*

*Clinician, Team 4*

*“I think it’s because the Choice gets done in twos, it’s given the people that have been newer or maybe feeling less confident more confidence in their Choice appointment skills.”*

*Manager, Team 4*

Team managers and clinical leads needed to be aware of the potential anxieties that staff may have experienced in doing Choice appointments. This was an issue that required careful handling:

*“I mean we have people that we think of as being very skilled and they’re all in Choice because we think that’s quite a skill to be in Choice. We don’t think, oh, they’re only here for an hour, we’ll put all our junior staff in because I don’t think that’s fair on anybody.”*

*Manager, Team 4*

In order to conduct a successful Choice appointment, the clinician was also required to possess detailed knowledge of the local area:

*“Well I have actually had a very complex Choice assessment where I have had to do extensive research because I have no experience for the area. So I have spent a lot of time kind of just researching what might be available”*

*Clinician, Team 2*

Ideally, this local area research should be developed into individuals’ job plans, since it may take large proportions of staff time to gather this information. Managers should therefore be aware of this:

*“This is a new patch, a new central locality so none of us knew what was here, like what the ethnicity was, or who the agencies were, or any of the community services. So, we started just learning, as fast as we could, like, it was almost like we just kept eating information and patch sharing information between each other and then what we did do was um, we started attending local events and local groups and churches and schools and just really liaise with them”*

*Clinician, Team 3*

*"When we first started doing the first step [Choice] appointments we all put together a folder that everybody had so that they had leaflets about other agencies or sports services or more of the tier one, tier two type stuff which was really useful and quite often even if families were staying we would still give them the information saying in the meantime here is something for you to do as well"*

*Clinician, Team 4*

A potential outcome of under-confidence at performing Choice appointments was manifest in clinicians offering second Choice appointments:

*"I tend to do Choice plus because I have wanted time to go away and possibly talk with other agencies, professionals that are working with the family. It may be that it presents with something different each time, where the parent might want us to talk further without the child present, or may have brought a little toddler along. It just seems to be something that crops up quite regularly that requires at least one more interview."*

*Clinician, Team 2*

In principle, the idea of doing second Choice appointments is reasonable. There is provision within the CAPA model for this; however it may create extra demand on the CAMHS capacity since it equates to reduced numbers of clinicians who are free to offer Partnership appointments. Therefore, it makes it more likely that bottlenecks will develop at this part of the system.

Despite the challenges reported by staff conducting Choice appointments, all of the families who were surveyed found this initial appointment with the service useful, and felt that staff had listened to what they had to say. The young people that responded to the questionnaire found that they had an increased understanding of their problems, and valued the space to talk about these issues. The young people found staff informative with regards to their future concerns, and also expressed that the session had helped them to develop their confidence by encouraging an open approach.

*"They helped me understand my problems and let me tell them about things that are troubling me. They tried to help me with my thoughts and feelings."*

*Male, 17, Team 1*

*"They explained what is happening and why they think it is happening, giving reassurance to my daughter by explaining how they can help and what is going to happen next."*

*Parent, Team 1*



#### 4.4.5 Full Booking to Partnership

The Choice appointment is conducted to help the family and professional come to a decision about the action needed, such as whether and how to transfer the family to a Partnership appointment. Families will then have some understanding of how long they will be seen by the service:

*“In the first appointment I think that was purposefully to get all the information from us and then they went away and defined it and by the second appointment when she came round the house and spoke to me she brought round what was appropriate information for us to have. It was obvious that they weren’t going to be doing that much for him which was fine.”*

*Parent, Team 3*

In CAPA, each Partnership appointment should come with adjunctive follow ups. It is possible that the client may see more than one clinician in parallel through a set of Partnership and follow-up appointments. A well organised system could arrange for a family to visit and see several clinicians on the same day:

*“At the Choice appointment, or the very first Partnership appointment, which is the assessment partnership, that partnership person should be planning, they need to see that person, that person which could happen all at the same time, which makes the families time in the service probably much quicker”*

*Service improvement lead, Team 6*

Each Partnership appointment is booked into a diary, where clinicians indicate available slots in advance. The number of follow-up appointments attached to each Partnership appointment could be based upon the needs of each team:

*“What I don’t think works so well is how much time you have got and CAPA gives a 6 or 7 session follow up. If you look at all the guidelines and choosing what’s best for you and all the other group work it doesn’t fit into 6 or 7 and that’s the bit by the specialist bit that isn’t very well explained in the CAPA book. What this team have done is adapted it and said a Partnership gives you 10 follow up appointments”*

*Service improvement lead, Team 6*

In this team, each client is booked in to ten follow up appointments. They have decided that this number is appropriate based on local needs. A more recent version of the CAPA book has sought to clarify these matters (York & Kingsbury, 2009; page 69). Some may need fewer appointments, freeing up slots for others:

*“We swap between the people and if you only need two follow up appointments at Partnership you have got 8 in the bank, and that goes back into the team bank. Its like a banking account.”*

*Service improvement lead, Team 6*

These free slots can then be used to offer families a choice of dates and times that would be most convenient for them:

*"She always said, you know, can you make it on this date and this time, but if not I'm willing to change it and you tell me what time will suit you"*

*Parent, Team 6*

However, from our site visits it appeared that many of the teams were not implementing this system in this way. Some noted that there was a need for very robust administration in booking Partnership appointments into a diary:

*"I'm not sure our electronic diaries have been robust enough to really manage that at the minute, so we've been a bit hesitant on that, but that's the next step"*

*Manager, Team 4*

*"People's Partnership is kind of booked out several weeks ahead and have personally never been in a position where I have actually been able to make use of that. The admin system has not just been established well enough and it's all been confusing, everything has been in a muddle"*

*Clinician, Team 2*

Conversely, it may be possible to implement a similarly effective system without a Partnership diary. This was seen in one relatively small team who appeared to have a good sense of team cohesion:

*"We should don't particularly use the Partnership diary so we tend to have informal discussions with people oh I saw this person in Choice they would be great for you and then it forms like that. The fact that the team is really cohesive does mean that you can have that conversation and then if you don't want to take on one case then it works OK."*

*Clinician, Team 6 (focus group)*

Therefore, the process of 'full booking' was applied inconsistently across the teams. This may be due to the fact that clinicians occasionally experienced difficulty in transferring service users from Choice appointments to Partnership appointments. Clinicians may lack confidence in making judgments following a Choice appointment. If a clinician did not feel confident to book a Partnership slot, it may be because they wanted to discuss their case with colleagues first.

*"I think because the Choice team come together at the end, they feel like they want to have that bit of a discussion but also because we're not entirely sure where all the Partnerships are to be able to say"*

*Clinician, Team 4*

More than any of the other components, the full booking system required clinicians to embrace a cultural shift towards a more team-orientated way of working. Clinicians were required to make their diaries available to all other clinicians within the team, so that Partnership appointments could be booked with suitable and available clinicians. This way of working required a certain degree of openness:

*"I think [CAPA] attracts the teams that work together and want to develop their skills together and I think that when they have a group of autonomous workers that are called a team, then I'm not sure it's quite so attractive for them."*

*Manager, Team 4*

A potential benefit of full booking is that it may represent a more egalitarian system, since clinicians could not pick the cases they wanted to work with at the expense of more difficult cases:

*"Before we used to go to the drawer and to a certain extent there was a certain amount of cherry picking I guess because you would go through and think ah that's my sort of case I'll take that one which meant really difficult cases could sit there for a while"*

*Clinician, Team 6 (focus group)*

However, one barrier to implementing full booking was that clinicians may be sceptical of the idea of opening up their personal diary systems to other clinicians. One medium-implementing team and one high-implementing team were consciously not implementing full booking because of how it affected clinicians' personal diary systems:

*"Fully booking works really well for general hospitals in the sense that it doesn't really matter who you see, whereas in CAMHS for us, I prefer to set my own diary with my families, partial booking works quite well where we have slots in our diaries, people ring in and then slot into it. I have some flexibility around that but I wouldn't want someone else to manage my diary for me because there are families that I want to be flexible around."*

*Manager, Team 5*

*"We don't need the traditional model of full booking system. That is managed by the two clinicians that are actually allocated the case work so we don't use the booking system in that manner. That is totally between a family and that clinician in the rest of their diaries."*

*Manager, Team 3*

From the site visits, it would seem that teams were not always doing full booking, and that teams could implement elements of CAPA successfully without implementing this component. Some teams appeared reticent to move towards full booking, which may be related to the reticence of having a shared diary system and a preference to retain some personal autonomy. More than any of the other components, full booking requires a cultural shift in attitudes, and requires good teamwork and communication, and co-ordination through the team manager and administrative lead.

#### 4.4.6 Selecting Partnership clinician by skill

Under the CAPA model, once a Choice appointment has been completed, the Choice clinician should be able to refer to a clinician within the diary who would be well suited to working with the service user. Theoretically, a person should be selected based upon their skills, rather than because of their job role. However, job role and skills often go hand in hand, as the following extract shows:

*"Background is integral to skills to a certain extent so part of the psychologists and the mental health nurse backgrounds are the ones that are CBT practitioners. If you have complex family dynamics and you want a co-worker the first person you tend to go to is the social worker, not because of the title just because they naturally have those skills because of their background. So yes, there's more to it than the skills are related to the job title."*

*Clinician, Team 5 (focus group)*

There is widespread recognition that job role and skills reinforce each other. Still, CAPA encourages CAMHS teams to resist rigidly thinking in terms of job role and to think about which clinicians may be able to conduct each task in order to meet the demand, as shown in the following quote:

*"Historic roles which have been filled by medics can now be done by other people, diagnostic assessments, autistic spectrum disorder can now be done by other people so its about thinking about what's the skills needed for the team to meet the demand and how best and how economically you can do that without always relying on its historic role."*

*Service improvement lead, Team 6*

The ability to select clinicians who will be suited to cases means that the team must be suitably aware of each others' skills. This means that the team must work cohesively, of which we saw several examples:

*"They kind of know each other's foibles and they know who's quite interested in certain conditions and you know, you know the people who maybe need some support dealing with something and they're quite happy to say some of those things. I think there's been, you know, there's a lot of respect"*

*Manager, Team 4*

*"She is a learning disabilities nurse and if the coding and the issues are around a disability and say, autism for example, then she might get that case or if the issues are more, I don't know, more mental health based, kind of things, in terms of what I'm used to like depression or stuff or addiction, um, I might get that case so it's according to our specialty, but it doesn't always work that way either, it depends a lot on our caseloads"*

*Clinician, Team 3*

*"So Choice appointment happened, formulation was reached with the family, I was identified as the Primary Mental Health Worker, it was a level 2 piece of work and I went out to meet the family. They were very appropriate pieces of work that I had the correct skills and was able to carry out the piece of work, it just felt that it was very much as it should be"*

*Clinician, Team 2*

*"we have got two teachers on our team and also we have got somebody who has done a lot with special needs as well so it's really good"*

*Clinician, Team 3*

As can be seen in the above quotes, a good mix of skills within the team is essential for getting this to work properly. This typically included members from a variety of backgrounds such as social work, occupational therapy, psychology, nursing, psychotherapy and psychiatry. Some teams however felt that there was not a place for the work of Primary Mental Health Workers (PMHWs) within the CAPA model, and there was some confusion about what their specific role should be within a team who has implemented CAPA. Within some teams Primary Mental Health Workers conducted Choice appointments and did Partnership work, however some clinicians felt that this may not be the best use of their skills:

*"I think if primary mental health workers worked doing Choice and Partnership like the rest of us, I think that would be a great loss of their skills and it would be much better I think to keep them freed up but also have them very clearly connected to Choice in terms of, kind of Tier 2 work where there's some concerns about mental health but the child doesn't need a clinic based service but it would be nice to have a mental health check of a bit of consultation or a bit of support to that worker."*

*Clinician, Team 6*

Some clinicians also felt that following implementation of CAPA the work that the PMHWs would normally do to engage families and support them to access the service was no longer happening. This may have been because there was a lack of understanding within the team of the role of PMHWs and of the skills they possess:

*"Beforehand we always used to engage people and do that a lot to get them to here because they would never make it here, but now CAPA doesn't really allow for that to a certain extent, that surely should come from the CAPA process but it doesn't and it's only the management who are screening those referrals that have that knowledge. The others they don't seem to grasp what we do."*

*Clinician, Team 2*

Some clinicians however highlighted that PMHWs have in depth knowledge about local services and links with these services, and so could play an important role in the implementation of CAPA.

*"Finding out what's available locally on the ground, a really, really important job in setting this up was making sure we had up-to-date resources, you had relationships for those resources; primary mental health workers"*

*Clinician, Team 6*

The dynamic of the team and of the workers within the team appears to be of vital importance to the success of the implementation. One of the teams (Team 3) had been newly set up, alongside CAPA implementation. Therefore the team members were handpicked based on what they could bring to the service.

*"We are a very multidisciplinary team and I think that's partly through interview process and looking at team and local needs and I have had the luxury of being part of all the interviews and actually selecting people that would [fit] for our team"*

*Manager, Team 3*

The other five teams were already established, and CAPA was being implemented to replace an older system. In considering the variety of staff within a team, it is also important not to understate the value of a good gender mix, due to the nature of the problems sometimes faced by service users:

*"We could do a swap if necessary and then there was a case a while back where I tend to see boys more than girls, I do see girls but I think on that occasion there were two of us in to do Choice. I have got the girl and she got the boy and it just seemed more natural just to swap it round because of the gender issues"*

*Clinician, Team 6 (focus group)*

Furthermore, it is important to ensure that members of staff are adequately supervised in order to develop and maintain their skills. In multi-disciplinary teams this may be difficult, since there may be a lack of senior staff from each discipline within the team. One potential solution to this problem was buying supervision from outside the team, where necessary:

*"She's a very senior Family Therapist; we don't have anybody more senior than her, so we buy supervision for her from another supervisor. I manage the more senior O.T.s, I have an O.T. background so I can do their supervision and then they do the supervision for the more junior O.T.s in the team"*

*Manager, Team 4*

If the team is communicating and functioning well, then this method of selecting clinicians to work with families during the Partnership phase appeared to work well, one clinician remarked that it was better than their previous system:

*"We allocate them to a more appropriate professional so that once they are with them that person can then talk to them through, whereas before it could have just been a bit arbitrary really they were just given anybody and then that person would inevitably have to get a referral to somebody else who was appropriate to do the work"*

*Clinician, Team 4*

This process may reduce complications further along in the process, since the most suitable clinician available will be working with the family as part of their care plan. The importance of this component was corroborated by the children and young people we interviewed, all of whom felt that they had received suitable support from professionals who they were working with:

*"Making the book about anger...really helps me know about happiness and peace"*

*Male aged 10, Team 4*

*"They made me realize things were not so bad in life. It helped me gain a little more confidence, and helped me to go out more. Loads."*

*Male aged 15, Team 5*

*"They encouraged me and talked to me to help me with my life"*

*Female aged 13, Team 3*

*"I loved it!"*

*Female aged 13, Team 3*

Skill matching a clinician to a family for Partnership work appears to be an effective way of providing appropriate support and saving time. However, this component requires good team communication and knowledge of each others skills in order to be implemented properly. Therefore, a skills audit may be necessary at the outset, which may be done formally through the manager but may be better done collaboratively through team away days.

#### 4.4.7 Extended clinical skills in core work

In order to implement CAPA fully, families should have been matched to clinicians who have the necessary skills during the Partnership phase. Therefore, those clinicians would be best placed to help the families with their problems. This allows clinicians to use their own specialist skills within their Partnership slots, without needing to refer to other specialists. Thus, during the 'core' Partnership phase, clinicians are able to use their 'extended clinical skills' to help families move through the system more efficiently. This mechanism allows clinicians to work more flexibly:

*"If you really don't know about something about autism then it's a training opportunity, so that's our model so it's not 'oh I don't know anything about that', you say 'OK that's fine I'll come and do it with you' and I do the same if it's my turn to pick somebody up. So that's our core culture."*

*Clinician, Team 5*

In this model, as demonstrated by a medium-implementing team, clinicians may learn the skills through working with others who already possess them, which may be an effective method for reinforcing skills learnt in more formal training scenarios. It is interesting to see the use of the word 'culture' in the above extract, this again implies that CAPA requires a cultural shift for staff. Staff must be flexible and responsive in their approach to working with families, rather than referring to specialists as soon as they encounter difficulty, which may take time.

However, one problem arose from the principle of extended clinical skills in core work. There were problems in deciphering Partnership, core input and specialist input. Interestingly, this occurred in some high-implementing teams:

*"We need more thinking around what is specialist and what is general and I am not sure we have got it quite right."*

*Clinician, Team 1*

*"One of the things I want to find out from people is knowing the difference between what's Partnership and what's specialist because we are being encouraged to timetable, to do our job plans and I am not exactly sure where the sticking point is. Some people aren't sure where there's a bit of a grey area between what's generic what's Partnership work and what goes into the specialist again"*

*Clinician, Team 4*



Some clinicians voiced the opinion that specialist skills were being devalued within the CAPA system, and that resources were directed away from specialist time into core Partnership work. This was particularly a worry for psychotherapists, who were called upon most often in a specialist capacity to help more complex cases:

*“My team are working long term with very complex children who we sometimes see a few times a week. Well the CAPA model doesn’t fit at that point. That’s not Partnership, that’s post Partnership so we are specialist provision post Partnership. So if the 7 sessions or whatever they’ve offered in Partnership leaves those clinicians thinking, you know I’m not touching this problem, this is really deep seated, extends to early trauma, so then they would refer to the psychotherapy team.”*

*Psychotherapist, Team 4*

Within CAPA, there was some debate about how the work of very specialist workers, particularly psychotherapists, could fit within the model. In some cases, the work of psychotherapists may be preserved away from doing Choice and Partnership appointments:

*“I think my team felt that my specialist time had to be preserved as much as possible. So I would do something like an hour every two weeks.”*

*Psychotherapist, Team 2*

*“I think the danger of the model is it can pull people away from their specialism so they only do generic work and I think that’s actually quite good here that there’s been a recognition that they don’t want psychotherapists doing all generic work because then we’d lose the psychotherapy.”*

*Psychotherapist, Team 4*

The provision within CAPA for more complex cases and specialist working was a concern. Regarding the CAPA model, this was something that teams felt they needed more help and explanation around. Therefore, teams often felt unsupported in these cases. There appears to be a need for further explanation about how CAPA could be implemented to support more complex cases:

*“I think if the model can try and think and introduce something additional that helps services deal with more complex families then I think that would be an important theoretical contribution.”*

*Manager, Team 1 (focus group)*

#### 4.4.8 Job Plans

The idea of job planning was one of the most tangible components of CAPA, and most staff could relate to it directly. CAPA recommends initiating job plans for individuals and capacity plans for whole teams (examples of individual and team plans can be found in Appendices 10 and 11). These plans mapped out the weekly activities of the staff. For some professionals, job plans were a welcome addition:

*"I actually feel quite helped by my job plan and it has been a relief to have that come in. Before the job plans came in we were inundated and would hold extraordinary amounts of cases and it was just not being managed properly and now it feels very firmly managed."*

*Clinician, Team 2 (focus group)*

In this extract, the interviewee suggests that CAPA job plans have given more certainty and control surrounding the workload. From a management perspective, job plans were a way in which clinicians could liaise with non-clinical staff about how to manage workload effectively:

*"I am very keen for job plans even before CAPA because I think they are a tool or a focus by which actually there is a dialogue between clinicians and commissioners and managers around what is doable, what is achievable"*

*Manager, Team 1*

*"What's CAPA offered me? I think it's offered me job plans for individuals and a team job plan so we've got a notion of what we're offering, who's offering it and what we'd like to offer or other people think we should offer"*

*Manager, Team 4*

Interestingly, one clinician described how having a job plan had helped to legitimise her workload, particularly regarding administration time, which may otherwise be left undone:

*"I liked the idea of having a much clearer job plan because I think the pressure was so high that it gave us a little space, it may be admin time or time to make phone calls and we would feel guilty about using that time for those kind of things when there is somebody quite urgent to see."*

*Clinician, Team 2*

However, not everyone agreed with the positive views about job plans. Some argued that they seemed too rigid:

*"There isn't any flexibility because people are stuck with their job plan; it's very hard to move things around isn't it."*

*Clinician, Team 2 (focus group)*

*"It just feels a bit complicated and inflexible whereas before I think I would have just got on with it, it's a bit like have I got this kind of sorted there and it just feels a little bit rigid whereas I don't think it necessarily needs to be."*

*Clinician, Team 1 (focus group)*

It is difficult to say whether this is a criticism of CAPA or a criticism of local implementation. However, from the quotes it would seem as though it is more of a criticism of the local implementation. This is because our experience of visiting other professionals and teams revealed more positive views on staff job plans:

*"I think the absolute key to it all is flexibility and putting families first. The families need to be the focus of it; actually it's not to fit around us. That means putting structures in place to be flexible for other people. That's how it has been managed really. You need those structures to actually make a service manageable"*

*Manager, Team 3 (focus group)*

It would appear that job plans can be implemented as effectively in medium-implementing teams as they can in high-implementing teams. Once more, it is the overseeing from management that determines how well this is implemented. Alongside individual job planning, there was evidence that managers were employing team job planning, or 'capacity planning':

*"What we work for contacts is a 42 week working year, six weeks leave, that gives you 48 weeks, two weeks study which takes you to 50 weeks and you have got two weeks flexible. So everybody would normally have two weeks study leave, we will not necessarily always have money for that but a lot of courses are free so that's how we structure people's time."*

*Manager, Team 5*

Interestingly, only 17 of the 53 respondents to Phase 1b claimed to have been doing capacity planning formally. It is possible that this kind of capacity planning was often done less formally:

*"They might not see it as job plans necessarily but somebody who is doing two days a week can't come in and do a whole day Choice appointments and then manage case loads so you have to be careful of what the case load is and their experience and training needs and I think that's important too really."*

*Manager, Team 3*

Having a capacity plan or team job plan allows the team to be more transparent in extending the capacity of the service to meet the demands when needed, which in essence relates to the benefits of CAPA:

*“Being able to modify the capacity in order to meet the demand that was coming into the service. In my view as a service manager it has been successful and we have seen a big drop in our waiting list.”*

*Manager, Team 1*

Capacity planning appears to be a useful mechanism by which demand into the service can be handled. However, the lack of formal capacity planning in some cases indicates that teams may benefit from a more structured approach.

#### **4.4.9 Goal setting and care planning**

*“Generally I mean, we go, we talk, discuss and she’s always writing notes down so but I believe she’s got a plan.”*

*Parent, Team 4*

In order to implement CAPA fully, formal care planning with families needs to begin in the initial Choice appointment and then needs to continue throughout Partnership appointments, as illustrated with the following quotes:

*“We begin from the family’s perspective; it is actually looking at a goal from the initial meeting. So the family determines the goal and then that kind of focus is held, so actually it is supporting them to realise that we won’t solve everything for you but we will work on those bits to support you to be able to take control back of your lives yourselves and move to the next bit.”*

*Manager, Team 3*

*“At the Choice appointment, you asked what happens afterwards and how we determine a care plan. That is done with the family so at the appointment we pull out what we call our consultation tool, screening tool recently and it’s basic assessment. From there we determine a summary and we begin to set the goals with the family at that point, and some of it might be that we are going to actually refer this to somewhere else, so we have a document for actually processing those sort of things. It might seem like a big paper trail but it really helps hold things together, it’s quite tight”*

*Manager, Team 3*

Here, the process of planning is shown in its entirety. The care plan also needs to empower the family to make their own choices with their care:

*"She explained that we'd been referred from the Doctor and in order for the process to go through he would need to be seen x amount of times, conversations between the O.T.s and Doctors and my son himself but they wouldn't go to that point until they really felt that they'd got as much information as they could"*

*Parent, Team 4*

Within the plan is the need to consider how the family will leave the service when appropriate, in other words, how they will be 'let go', or be discharged once they no longer require help. The principle of 'letting go' presented difficulties for staff, for both emotional and practical reasons:

*"They come to the end of six slots, actually more work is needed and a review has been done and actually still more work is needed and actually they just continue"*

*Clinician, Team 1 (focus group)*

*"What feels certainly to me is a fairly arbitrary figure if you will see them eight times in Partnership and by then they will be ready to be discharged For some cases that's fine and for some cases it's two Partnerships but for others you might very legitimately see them for a year"*

*Clinician, Team 6 (focus group)*

The complexity of some cases meant that people were being seen for longer or shorter periods of time. In a sense, it would appear that the number of Partnership appointments is adaptable to the situation. In other cases, it appeared as though clinicians' lack of confidence was preventing them from letting go:

*"We are not getting rid of enough families because we tend to keep hold of quite a lot of them and we don't know whether that's because people aren't confident enough to say 'go', or whether we just don't know what else is out there, or whether there aren't things out there or whether they really are complex enough, serious enough to keep them into Tier 3."*

*Clinician, Team 4*

The capabilities required to let go of families, as required by CAPA, were challenging for some members of staff. Similarly, for one of the parents that we interviewed, this early discussion of discharge seemed puzzling:

*"I can't remember the exact date when he started but it may not have even been four months, it was a very short period and I was shocked to think well three appointments and now they are saying they are going to discharge him already but my only guess is they feel that we don't need the help."*

*Parent, Team 3*

From this quote it appears that the CAPA system of discharge is surprising for this particular parent. This process shows how families can be seen quickly and signposted away from the service if it is felt that they no longer need the help.

One of the medium-implementing teams that we visited appeared to have consciously prolonged the discharge process, and was putting less emphasis on letting go:

*"It is very un-CAPA-like is our discharge process. Much more, it is reviewed against the management plan and our outcomes and we try and review things depending on how long they're open and periodically we will sort of highlight cases that have been open a certain length of time, usually it's a year."*

*Manager, Team 5*

Early discussion of care planning allows carers to be prepared for discharge from the beginning. Therefore, this sets a precedent for the relationship between the service and the families. However, it would also reasonably seem that teams did not want to feel pressurised into letting go of families too early:

*"Bottom line is it's difficult to let go of family sometimes and yes part of that may be to do with clinicians own stuff but also that there are some families where actually either it would be unsafe or judiciously and very, very carefully, with careful thought actually it is more time cost effective and efficient just to keep things bubbling along sometimes."*

*Manager, Team 1*

Teams were aware of the problems of becoming too focused on discharge. The care plan therefore needed to be flexible enough to be able to cope with potential problems surrounding service user safety. Care planning also served to facilitate teamwork on individual cases, especially if the care plan has been written down:

*"We are beginning to have care plans and the rationale for that has been; I am team coordinator, if you are away and your case pops up I have to field it. Therefore if you could put plans at the end of your write up I have a better chance of being able to be helpful to the family that I don't know, because it is clear what you are doing, where you are going, so from that the next stage is why are your discharging now, why didn't you discharge before."*

*Manager, Team 5*

Care planning appears to be good practice for teams, although we found evidence that it takes place at varying degrees of formality. The team needs to be able to formulate plans for individuals. Within CAPA, the family must be involved in helping to develop that plan. Interestingly enough, none of the children and young people who were interviewed, and only 2 families surveyed had heard of a care plan. However the young people who responded to the questionnaire felt that the staff had given them a good understanding of the help they would be receiving. They were given clear explanations of the issues involved, and discussions with parents/carers were facilitated.

*"They explained it carefully and I was able to understand."*

*Male, aged 17, Team 1*

*"They've helped me understand tremendously, absolutely loads, they always explain – it is perfect!"*

*Parent, Team 4*

Several of the young people interviewed had seen more than one person whilst in contact with CAMHS, and understood why this was necessary. The staff's suggestion of a goals system was also seen to be valuable by the young people.

*"They gave me 10 goals to do and meet by my next appointment."*

*Female, aged 15, Team 5*

One young person however felt that they needed greater clarity on the treatment they would be receiving in terms of how it worked and helped, in order to have a full understanding.

*"They could have been more open with treatment options."*

*Male, aged 17, Team 1*

#### **4.4.10 Peer group supervision**

*"All the clinicians meet prior to seeing their clients and meet following seeing the clients as well and that's a brilliant way of supervising each other and really discussing if there are any problems."*

*Clinician, Team 6 (focus group)*

Peer group supervision was important because it allowed the team to get together and get a greater sense of each others' strengths and specialism. Gaining knowledge through regular, weekly small-group meetings enabled clinicians to more confidently conduct Choice appointments, and then be able to transfer families to Partnership appointments.

*"I see people on a Tuesday morning and I do their initial Choice appointment, then what we do is on the Friday meeting we talk about that,"*

*Clinician, Team 3*

*“Supervision is a strong key element. We don’t actually call it supervision we call it a team meeting, but it is kind of like a supervision and clinical discussions happen regarding the family.”*

*Manager, Team 3*

CAPA clearly distinguishes between peer group supervisions, which are small multidisciplinary events, and larger team meetings. However, it should be noted here that Team 3 were a small, multidisciplinary Tier 2 team, and thus the team meeting was similar in style to peer group supervision. The act of discussing cases in small groups helps facilitate team working, care planning, and in transferring families onto Partnership appointments.

However, not all CAMHS teams showed evidence of having regular small-group supervision meetings. The absence of this may have been causing problems when less experienced staff members were required to conduct Choice appointments:

*“We didn’t have a multi disciplinary discussion. People weren’t giving their thoughts about this girl’s development or state of mind or anything like that”*

*Clinician, Team 1 (focus group)*

*“I think we should meet more. I think about people from other teams, the clinicians often left feeling isolated in their Choice appointment, we planned to build in consultation time, we planned to build in peer support time, we planned all sorts of things for people a) for the individual clinician to feel supported in that process, b) for us as a service to be able to audit and get to the baseline of where we were functioning and those things haven’t happened.”*

*Clinical lead, Team 2*

These quotes show that without peer group supervision, staff may feel inadequately supported. Peer group supervision can therefore be viewed as essential to the successful implementation of CAPA. Whether group supervision needed to be formalised or not was debated, with some discussing the merits of informal discussions with groups of colleagues. However, one clinician from a medium-implementing team appeared to see some extra merit in a more formal structure:

*“We do it on an ad hoc basis not in a formal setting. We can bring cases that we are struggling with to the team but sometimes it does feel daunting when there are 20 people and you think ‘God am I being silly, are people going to think she should know what to do with that.’ So yes that would be helpful actually yes. But a more formal structure might be, you know sort of peer supervision might be a good idea.”*

*Clinician, Team 5*



Regardless of how peer group supervision was done, it appeared to be a useful process. Teams could work together to help families, where individual clinicians could discuss ideas and feel supported within the team structure. If more formalised peer group supervision was to be initiated, then the decision on how to do this needs to come from the team themselves. Therefore, it could be an ideal discussion topic for a team away day, which is the next and final component of CAPA.

#### 4.4.11 – Team away days

Away days are of foundation importance in CAPA, since they allow the team to come together and discuss any outstanding issues relating to service delivery. They should act as a mechanism to ensure that the CAMHS staff members are being looked after properly within the team:

*“It is a workable model, it’s auditable and it’s about staff care, making sure that people have away days so the actual success feature is within the model itself and the framework itself.”*

*Service improvement lead, Team 6*

As an extension of this, away days could be seen as a way of ensuring continuing ensuring professional development of the team, helping them to update their skills and knowledge:

*“We have had some on eating disorder, we have had days on depression, we look at a particular topic. We have got one coming up on creative therapies which we are really excited about because it’s thinking about therapeutic tools that we use”*

*Clinician, Team 6 (focus group)*

*“We get a certificate for being so that they keep it in their portfolio to say that they have attended the away day”*

*Clinician, Team 6 (focus group)*

As we found out in the evaluation, it was also helpful if these away days could be used to discuss the progress of how CAPA was being implemented, and whether any adaptations were required:

*“I think this is the other thing that we want to talk about on the away day next week with the whole team CAPA is very high on the agenda and one of the things I want to find out from people is knowing the difference between what’s Partnership and what’s specialist”*

*Manager, Team 4*

The practice highlighted in the above extract shows how the away day can be used effectively within the context of CAPA. Here, a problem with the implementation of CAPA has been identified by the team, and they will use the away day to discuss it. The following quote shows the problems of teams that do not have regular away days:

*"Following the implementation of CAPA we haven't had team days looking at CAPA. We have had team days in which it has been a moan session about how awful people are feeling but there is a sense of hopelessness that anything we say is going to make managers do it differently."*

*Clinician, Team 2*

This member of staff feels strongly about how CAPA has been inadequately implemented, however, the team have not been given the chance to discuss the problems and adapt the model to their own needs. This has led to less positive strategies.

Additionally, one team mentioned the fact that part of an away day could be dedicated to fun activities, a time in which staff could build team morale:

*"We take it in turns to plan our activities. We discuss it as a team, people come with ideas and then we make a decision about what we're going to do from the ideas that come. We have been doing some things that have been sort of more focused on the team but then we also seem to like to have some time to have fun together and interact together as a team. So last time we had the first morning we had an external facilitation, we did some study and then we did some drumming with African drums."*

*Clinical lead, Team 5 (focus group)*

In relation to this, some families also noted the team spirit, high morale and lack of stress amongst staff in their service:

*"They always seemed happy and worked well together and were always on time and organised"*

*Male, aged 17, Team 1*

*"They are so happy always. They are kind and understanding, not mean, stressful and bossy"*

*Female, aged 15, Team 5*

*"They always seem like they enjoy working with you and together because they make it as comfortable as possible, a bit like a family friend unit, a very calm atmosphere."*

*Parent, Team 5*

Team away days appear to be a useful mechanism for teams to get together and discuss potential problems and pitfalls, and to plan the future of the service. More importantly, they are important for the successful implementation of CAPA, since they allow teams time to reflect and build upon their experiences. This is vital if teams are going to adapt CAPA to their local demands.

## 4.5 Results summary

CAPA is a wide reaching model amongst CAMHS teams in England; however, there were significant differences in how the model had been applied across different teams. If well managed and implemented, CAPA appears to provide teams with structured, formal planning mechanisms and it encourages flexible team working. CAPA recommends a sensible structure of management and leadership, emphasising clinical and administrative duties as well as service management. The importance of doing this correctly was emphasised by all six visited teams. Furthermore, CAPA also requires careful monitoring and facilitative leadership in order to manage demand and capacity within the team. If this is done correctly, CAPA can reduce waiting lists for families coming onto the service, which was commented by both staff and families. CAPA also has an impact on how long families stay in the service. 'Letting go' was an important element of managing capacity and demand, but this was being done inconsistently across teams.

Regarding individual CAPA components, CAPA language was viewed with mixed results, some families and staff responded positively whilst other staff members were less positive. Choice appointments could be challenging for clinicians, and capacity planning may present challenges for managers. Job plans could be a useful tool care planning and goal setting appears to be done less explicitly and less collaboratively than recommended in the CAPA model. Supervision and away days may help to build team cohesion and develop staff skills. The process of selecting appropriate clinicians to work with clients was well received, although there may be difficulties for more specialised members of staff to fit within CAPA.

## 5. Discussion

This section of the report will discuss and interpret the findings presented in the previous section. The first sub-section will map out how teams appeared to be implementing CAPA, and will describe what is likely to be the necessary infrastructure for successful implementation. The following sections will provide a guide for how much implementing CAPA could be expected to cost in terms of time and financial investment. The strengths and limitations of this evaluation are discussed, along with suggestions for useful future research.

### 5.1 The implementation process

In Phase 1a of our evaluation, we found that a large number of CAMHS teams in England were stating that they were implementing CAPA. It appeared as though CAPA had no noticeable beneficial effects on waiting lists. On further inspection in Phase 1b, the majority of those teams that were implementing CAPA were not fully implementing all 11 components. In Phase 1c, data provided from a small number of teams, in conjunction with data from the Children's Services Mapping indicated that high implementers of CAPA did benefit from shorter waiting lists.

Phase 2 revealed how CAPA was perceived by staff. One benefit of implementing CAPA was that it allowed teams to track demand, capacity and flow easily, allowing teams to become more aware of these processes. This meant that the teams often had better links with commissioners and could provide evidence for more resources. CAPA effectively improved the transparency of the service through consistent job plans and Partnership diaries.

At all times, it was important for teams to be aware of the problems in developing an internal wait for Partnership and specialist appointments. The cause of these bottlenecks appears to be multi-faceted. One reason could be due to large numbers of new referrals being transferred for Partnership appointments when they could be signposted elsewhere. The internal wait may also be due to the fact that many of the teams tended to place more emphasis on the 'Choice' elements of the CAPA model at the expense of the 'Partnership' elements such as full booking, thus hindering the transfer from Choice appointments to Partnership appointments. Alternatively, this problem could be due to staff feeling unconfident in transferring service users to Partnership appointments following the initial Choice appointment, and wanting to do further assessment. Accurate, formal capacity planning by managers could help to prevent bottlenecks from occurring. However, problems may occur if managers do not have access to the resources and training needed to plan capacity accurately.

These findings did not appear to relate to the degree by which services were employing high fidelity to the CAPA model. We saw evidence of good organisation and benefits in medium-implementing teams, and we also saw evidence of poor organisation and negative consequences in high-implementing teams. If implemented poorly and without adequate management, then CAPA can cause confusion and overwork amongst staff. There were particular concerns around the confidence of less experienced staff who were being asked to conduct Choice appointments, and how the work of primary mental health workers and specialist psychotherapists could fit into the CAPA model.

The evaluation suggests that there is no obvious 'tipping point' at which CAPA can show benefit to CAMHS teams. Implementation in relation to the 11 components varied substantially from team to team, and CAPA appeared to show benefits and problems in both medium and high implementing

teams. Some clinicians thought that CAPA could be improved if it offered more suggestions for how to work with more complex cases. The information collected from Phase 2 suggested that there were a number of conditions that facilitated the use of CAPA.

### 1. Team management structures

Our investigation found the presence of facilitative team management to be absolutely crucial. This is in agreement with the first foundation component of CAPA, which recommends that there should be an informed manager, a clinical lead, and an administrative lead.

The presence of these three roles appears to recognise the fact that the implementation of CAPA is likely to be a complex process, requiring input from various disciplines within the team. The manager's role within the team is crucial. In the most highly functioning teams that were visited, the manager was also a clinician by background. This suggests that the leadership roles within CAPA require a good understanding of clinical issues. Because of this, the importance of having a clinical lead cannot be understated. The clinical lead should preferably be someone senior within the team, and often it was a consultant psychiatrist. However, it appeared that the most important attributes of the clinical lead were approachability, the desire to work as part of a team, and effective management skills.

In some services, an administrative lead had been appointed in order to facilitate the implementation of CAPA. This person's role was to manage the administrative team and to facilitate the implementation of administrative structures needed in order to implement CAPA, such as Partnership diaries. In one medium-implementing team, we saw that this role had been exchanged for a Band 6 nurse, who was responsible for helping to facilitate change within the clinicians. It would therefore seem that at least three members of staff would be needed in order to implement CAPA; these usually would be existing members of staff within the team.

Of great significance was the fact that this management structure must be respected within the team itself. We saw instances where commissioners and external senior management had put pressure on teams to implement CAPA from above. We also saw evidence of a 'bottom-up' approach to management, where the team manager, clinical lead and administrative manager had constant rapport with the team members, and were motivated to implement CAPA within their team.

If senior service-level management and/or commissioners were to think of implementing CAPA in their services, a useful process would be to work in partnership with team managers and clinical leads. If these two people have not been educated and trained in CAPA prior to implementation then it is likely to hinder the process. In summary, teams that had well organised management at the team-level were likely to reap the benefits of CAPA, which increased team cohesion and allowed clinicians to work more flexibly within an organised system. Teams that had been ordered to implement CAPA from top-level management risk implementing a model without adequately prepared management staff.

## 2. Good team cohesion

Equally essential to successful implementation of CAPA was a strong sense of team cohesion. This was especially important in transferring families from Choice appointments to Partnership appointments. As mentioned by several of our interviewees, CAPA requires teams to work together more transparently than traditional CAMHS approaches. This is manifest in the components surrounding shared diaries for appointments, and team and individual job plans. Furthermore, CAPA could be said to openly foster team cohesion through emphasis on peer group supervision and team away days.

If carefully implemented, CAPA may provide a facilitative environment for clinicians to develop skills from working with their co-workers, and to discover the strengths of others within the team. The background of each team member (including their skill mix) needs to be well understood by all team members. Skills auditing could be a topic for team away days. If necessary skills are missing from the team, then the manager needs to be able to address this through identifying the problems and reaching solutions, either through further staff training or through outside supervision. This approach appears in line with a recommendation from the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004).

Whilst CAPA could be argued to improve team cohesion, its initial success is dependent upon existing team cohesion. Again, this relates to good management and leadership. If those in senior positions do not promote a culture of working openly and jointly, then CAPA will fail to generate greater team cohesion. In fact, from one team, we saw that CAPA appeared to have an adverse effect, since the pressures on staff had increased through inadequate support for Choice appointments. However, within an existing facilitative team environment, CAPA can help teams to improve further, and to work more efficiently.

In terms of implementation, it is recommended that teams and individuals partake in reflective practice focused on team cohesion prior to implementing CAPA, for example, teams should examine how well they communicate, whether staff have sufficient support, supervision, and understanding of colleagues' roles and workloads. This should be reported back to commissioners or service managers who wish them to implement, to help gauge how well the team is likely to embrace CAPA once it is in place and to determine any additional support required for successful implementation. This is especially important if a team wishes to implement a diary system that supports the process of full booking, since individual clinicians will then be required to make their diaries available for others to book into. CAPA appears to be an attractive option for those CAMH teams with good team cohesion, and may be less attractive to teams that do not.

## 3. Knowledge of local services

Since part of the flow management in CAPA relies on engaging with and signposting to other relevant services, it requires staff to have an extensive knowledge of what other services and activities are available for young people in the local area. This knowledge should include tertiary sector community organisations and activities. Several members of seemingly highly functioning teams described how managers had encouraged clinicians to take time to visit local services. These activities

should be built into a comprehensive induction plan for new staff, but should also be part of ongoing training and development for more established staff. Therefore, it should to some extent be built into individuals' job plans and discussed within the team, either in peer group supervision or team away days.

It seemed as though this local area knowledge was especially important in the one Tier 2 service that we visited, although it was also useful to Tier 3 teams. Good local knowledge allowed staff to feel more confident when conducting Choice appointments, since they were more able to signpost to relevant places outside of the services. This also had implications for capacity and demand on the team, since clinicians in the Choice appointment were less likely to take cases that were not relevant to their services.

#### **4. Regular monitoring**

Monitoring and feedback were essential in order to find out the 'teething problems' of implementing CAPA. This allowed the model to be shaped and to become more useful for the teams. The greatest benefits of CAPA were reserved for teams who had been able to adapt the model to their own purposes, making it relevant to their own specific demands. However, such adaptation of the model required those in positions of management and leadership to possess sound theoretical understanding of CAPA.

Team away days presented a mechanism to discuss problems and plan improvements. The team should be encouraged to set the agenda of the day, and team issues should be discussed. The success of the implementation of CAPA becomes responsibility shared within the team. Therefore, team members are likely to increase their stake in the implementation, and are more likely to be motivated to facilitate change.

Regular monitoring of outcomes needs to be done constantly by the team manager, and these should be formally written up and reported each quarter, and fed back to the team during away days. The most tangible outcomes of CAPA include shorter waiting lists, shorter waiting times in between Choice appointments and Partnership appointments, the ratio of service users taken onto the service in comparison to those being signposted to other services, the number of Choice appointments and Partnership appointments conducted by each clinician. Another potential tangible outcome that could be measured was the rate of discharge of families; however we were unable to obtain enough data to be able to make a solid conclusion. However, there should be a caveat in that more complex service users may continue seeing the service for longer, and some service users may be seen over much longer periods of time. It is important that these monitoring requirements are treated within the context of providing a sufficient service for service users.

## 5. Adequate preparation

During our site visits, we found some teams that had been inadequately prepared for implementing CAPA. This preparation included a lack of time and/or resources. Usually, this indicated pressure from senior management outside of the team to implement CAPA, which in turn may have caused resistance from the teams themselves.

There was evidence to suggest that team managers and clinical leads needed significant amounts of preparation time to implement CAPA. This time needs to be allotted in order to conduct a skills audit of staff, plan the development of staff, conduct a waiting list blitz, and begin to plan capacity. The overall feeling was that hasty implementation of CAPA would cause problems. We recommend that CAPA be implemented steadily over a period of at least six months. This allows teams time to internalise the new processes and to reflect upon any problems that arise. Some teams described the process of a waiting list 'blitz'. This requires teams to see any outstanding families who were on an external waiting list. One team manager described how the commissioner had offered them extra funds for extra staff time in order to accomplish this.

At some point over the implementation period, the team should have the opportunity to see a system like CAPA in action. Ideally this could be done both formally and informally. A formal mechanism could be through a CAPA workshop from Steve Kingsbury or Ann York. An informal mechanism could be through visiting other teams in the local area who had already implemented elements of CAPA. There is certainly room for a peer mentoring system with CAPA, where teams can get together and compare their implementation processes, and learn from each others mistakes.

Regarding specific infrastructure, the results showed that many less experienced clinicians could have difficulties conducting Choice appointments. Therefore it is essential that less experienced clinicians be adequately supported through Choice appointments in order to build confidence. Joint Choice appointments with other staff members may help, but ideally all members of the team should receive training on how to conduct a Choice appointment, which should be part of a clinician's core skills. Formal peer group supervision sessions may also provide an ideal platform for clinicians to share their experiences and improve the skills needed to conduct Choice appointments.

In this evaluation, the needs of IT infrastructure did not appear to be great and most teams were using their standard systems. More sophisticated systems may have added value, but this was not explicitly shown in our evaluation.

## 6. Strategy for dealing with complex cases

One limitation teams found with their implementation of the CAPA model was that it seemed difficult to fit more complex cases within the Partnership framework. Particularly difficult cases such as those seen in Tier 3 CAMHS were often seen over several years by specialist psychotherapists. Successful teams had developed a strategy for working with complex cases, such as rolling Partnership appointments, or intermittent follow up appointments over a number of years.



## 7. Misunderstandings of the model

Many of the teams visited in this evaluation were not fully implementing CAPA as originally intended by its founders, who have identified the common misunderstandings which have been implemented by services (York and Kingsbury, 2009). This has meant that some of the issues identified by teams in this evaluation are not directly related to the CAPA model, but to its implementation. For example, teams described difficulties keeping to a set number of Partnership appointments where the CAPA model is in fact not time limited.

The significant level of misunderstanding of the CAPA model within CAMHS highlights the need for a clear and comprehensive training package for senior staff planning on implementing CAPA. It would also be useful if additional support and advice was available for teams during the implementation period. The founders of CAPA have made themselves available to answer queries via email, and further guidance could also be accessed by setting up an online forum of services who have successfully implemented the model. It is however important to note that if a large number of services plan to implement CAPA a more structured and accessible source of support and guidance would be required to ensure that it is implemented successfully, such as an online community resource.

### 5.1.1 CAPA implementation checklist

The following checklist describes conditions that would be advisable for CAMHS teams to follow to facilitate successful implementation of CAPA:

Factor	Responsibility
Clinical lead in place	Manager, clinical lead
Team manager in place	Manager, clinical lead
Provision of capacity planning tools	Manager
Demonstration of capacity planning ability	Commissioner, manager
Peer group supervision system in place	Team
Funding to recruit administrative lead	Manager, clinical lead
Project plan for implementation	Manager, clinical & admin leads
Budget for implementation	Manager
Willingness to implement CAPA	Team
Motivation to reduce waiting lists	Team
Team skills audit	Manager, team
Local services directory	Team
Regular discussions with commissioner	Manager, clinical lead
Partnership diary	Administrative lead

## 5.2 Cost of implementing CAPA in CAMHS teams

From our evaluation and site visits, we recommend individual teams spend at least 6 months dedicated to the implementation of CAPA to ensure that the relevant infrastructures are in place, including a project plan for how CAPA could be implemented. The staff will also need to feel comfortable working within the system that requires a significant cultural shift.

Regarding specific resources needed to implement CAPA, it is recommended that each team should have a manager, a clinical lead and an administrative lead responsible for overseeing implementation of the new system. Team managers and clinical leads should be at least at Band 7 level and should commit one day a week to the task of implementing CAPA. These tasks would include:

- Assessing demand, capacity and flow management within the service
- Attending and delivering CAPA training
- Agreeing on the CAPA protocol and procedures for implementing CAPA, in consultation with frontline staff
- Regularly reviewing the system

There should be a preparation period prior to the six month implementation period. An estimated twelve days for the clinical lead and manager over a period of 6-12 months would be sufficient for preparation. It may be possible that this time could be used as part of Continuing Professional Development (CPD). During this time, the clinical lead and manager should familiarise themselves completely with CAPA and the literature surrounding capacity and demand. This education may include attending relevant training such as the founder's workshops, reading the CAPA workbook, undertaking a skills audit within the team, planning the deployment of the workforce, and visiting other local teams who have already implemented the system. Team managers and clinical leads should draft an implementation plan. This should be done in consultation with frontline staff, who should be involved in the process throughout. Senior management also need to be involved and informed at all points, in order to approve of any changes that need to be made.

Based on our observations of CAPA implementation from the six teams, the administrative lead would seem to be at the level of Band 5 (or above). If this post is not already filled within the team or service, then it may be sensible to appoint an administrative lead following the preparation period. If the person is already in post, then the administrative lead could be involved during the preparation period. During this time, they could assume administrative planning tasks and thus reduce the amount of preparation time required by the manager or clinical lead. Whichever model is followed, the administrative lead will be responsible for setting up any necessary administrative processes. This role requires a person who has the ability to understand and manage aspects of the CAPA protocol, such as coordinating job plans. This person may be accountable to the team manager and should spend approximately two and a half days per week assimilating the lessons they have learnt from the CAPA model into their regular practice gradually. During the six month implementation period, it is assumed that these CAPA duties will be assimilated into the person's daily role. Duties would include drafting all invitation and follow-up letters, tracking the waiting list, producing tools for conducting Choice appointments, and implementing an electronic diary system, if required. In larger teams, this person would be required to manage an on-site administrative team. In teams with fewer staff and less demand, this person could be shared across several teams.

During the 6 month period of implementation teams it would be advisable that the team come together for at least two away days, the first of which could take place during the first month of implementation. Away days could then occur at least three times per year. Money for team away days should come from the training budget. The second away day should be conducted in the final month of the implementation phase and should be used to ensure all staff are comfortable following the CAPA protocol including:

- Screening assessment tools
- Protocol for Choice appointments
- Selecting Partnership clinician
- Signposting
- Job plans
- Administration procedures

The overall costs of implementing CAPA are difficult to calculate because the teams we visited had implemented CAPA in different ways over different periods of time. However, using the information provided above, it is possible to estimate based upon the amount of staff time and days spent on CAPA-related duties. It is likely that these staff members may already be in place within the teams. Therefore, the staffing costs listed below reflect a full cost recovery model, which accounts for the amount of non-patient contact time that is likely to be required for implementation. These figures should not be seen as absolute for implementing CAPA in each team, as it is possible that services may already have apportioned time for employees to engage in service development activity such as this. All staff costs are calculated using the mid-points for each NHS Band, and 19% of the salary is added automatically for on-costs (e.g., pension, national insurance):

Staff costs, service manager (Band 7)	£5,460
Staff costs, clinical lead (Band 7)	£5,460
Staff costs, business (administrative) manager (Band 5)	£5,556
2 team away days	£1,500
Training costs (1 day workshop)	£1,500
<b>Total</b>	<b>£19,476</b>

Therefore, we would estimate that the total costs of implementing CAPA for a CAMHS team over a 12 month study period and a six month implementation period are £19,476. This figure will increase if the clinical lead is employed at higher than Band 7 level, which is frequently the case when consultant psychiatrists act as clinical leads. The cost of any software has not been included, since the evaluation revealed that this was not always necessary. The costs of training and of 2 team away days within the six month implementation period have been added. Following implementation, the costs of CAPA are assumed to be assimilated into the teams' regular running costs.

### 5.3 National implementation strategy

For CAPA to be implemented successfully, it will require a national strategy. From our findings it is evident that there needs to be a facilitative link between the theory and practice of CAPA. Teams and services need to be aware of the theory of capacity and demand, but they also need the opportunity to see the processes in practice. This could form part of an action research loop whereby learning from teams practicing CAPA can be fed back to the founders. This could inform the development of the model and ensure that it remains directly relevant to current practice in CAMHS.

The theoretical elements of CAPA could be learned through workbooks and workshops. The practical challenges of implementing CAPA into a live service could be developed through a mentoring system for CAMHS teams. This would allow potentially interested teams to interact with teams who have already implemented CAPA successfully. Mentors, or 'beacon sites' could be selected by an advisory committee. This committee should consist of experts from around the country, who will be able to visit potential beacon sites and gauge their appropriateness for the role. Sites will need to be selected in each region in order to minimise journey times between teams.

It may be advisable to have CAPA champions in each region, the job of whom may involve organising regional workshops, distributing learning material, develop contacts with successful implementers, auditing beacon sites, and visiting teams who are interested in implementing CAPA.

### 5.4 Strengths and limitations of the evaluation

This report has presented the findings from the pragmatic, real-world evaluation of CAPA. The methods used were appropriate to determine the extent to which CAPA had been implemented by CAMHS teams across England. The surveys in Phases 1a and 1b garnered an excellent response rate. Phase 1a was inclusive enough to find out how extensively CAPA was spread across the country. Phase 1b enabled us to discover the extent to which CAPA was being implemented in relation to the individual components themselves.

The results from Phase 2 provided rich, detailed information of how CAPA had been implemented in a variety of different CAMHS teams. The six selected sites provided a wide-ranging geographical sample of regions across England. The combination of interviews and focus groups allowed staff to discuss the benefits and problems of CAPA in a variety of forums. The interview schedules asked relevant questions to complete the aims of the evaluation.

There were a number of limitations with the evaluation. In Phase 1, we did not achieve an even geographical spread of responses. Some regions provided many more responses than others. This made it difficult to determine how CAPA had been implemented in some of those regions, such as London for example. There were limitations with the CAPA score as calculated in Phase 1a, which may not provide an accurate reflection of how CAPA components were being implemented. This is

because Phase 1a was targeted at a wide group of potential respondents who may not have heard of CAPA, so fidelity to the CAPA model needed to be compromised in the interests of obtaining a larger sample. It does provide some indication of the extent to which CAPA was being implemented, and provides useful information especially when taken in conjunction with the results of Phase 1b.

There was also a problem in obtaining capacity plans, job plans and balance sheets from the teams for analysis. In many cases no formal document appeared to exist. This made it difficult to compare throughput and discharge rates for the six selected teams. It was also difficult to determine the ratios by which teams were transferring families to Partnership appointments or signposting them to other appropriate services, because no data were readily available from the teams visited in Phase 2, and very limited data from the responses to Phase 1c.

However, the main difficulty encountered was related to accessing the views of families. We were unable to speak to as many families as we had intended. It is possible that the topic area did not seem relevant to families, and so they did not attend focus groups in the numbers that we would have wished. This suggestion is supported by the fact that none of the families we interviewed had heard of CAPA. A further difficulty was due to the fact that the research team were unable to contact families directly, which was a condition of gaining approval from the Research Ethics Committee. In spite of this, the evaluation did receive some useful feedback from families, which helped to provide some insight into how the CAPA process feels regarding waiting lists, care plans and discharge.

## 5.5 Suggestions for further research

We do not believe that a clinical trial comparing client outcomes for CAPA services with those for non-CAPA services would provide value for money in this case. This is because the present study has shown that there are large regional and composition variations from team to team. It has also shown that CAPA is a complex system that is implemented in a variety of ways, to a variety of degrees. This would make it difficult to draw adequate comparisons in outcomes between the teams.

However, it would be useful to conduct smaller scale quantitative research to measure clinical outcomes for families who have visited a team which has implemented CAPA. Patients could be measured at baseline before entering the service, and then again post discharge. It may also be useful to conduct a quantitative survey to measure levels of staff stress within teams who have been implementing CAPA. This could be measured pre-implementation, during implementation and post-implementation to provide an indication of the impact of implementing CAPA on staff. It may also be useful to conduct qualitative research to further explore how primary mental health workers and specialist child psychotherapists could fit within the CAPA model.

## 5.6 Conclusion

A large number of CAMHS teams across England appear to have heard of CAPA and appear to be adopting components of CAPA into their practice. However, many teams appeared to have been doing this informally, rather than implementing all 11 components. CAPA works well for teams with a strategic plan to implement CAPA, with facilitative management and support from clinicians. It reduces waiting times for families coming into the service, although without fully implementing all 11 components it may produce internal waits when families are being transferred from Choice appointment to Partnership appointment. If appropriately managed and implemented, CAPA may facilitate cohesive team working and foster good relationships with commissioners. However, implementation of CAPA should be recognised as a complex, challenging process. Teams may experience problems in adapting to the new system. These problems can be lessened by ensuring adequate prior preparation and infrastructure.

## 5.7 Recommendations

There are key recommendations to be made at both national and local levels, both of which will be essential for successful implementations.

At a national level:

1. We recommend that CAPA is rolled out gradually, for teams to opt-in. Teams should be aware of the options available within their service, and aware of the benefits of CAPA. However, enforced adoption of CAPA amongst CAMHS teams is likely to lead to unsuccessful implementation.
2. A national support framework for CAPA should be established. Exploration of models of how this could work most effectively should consider:
  - How to receive and analyse information from teams implementing CAPA
  - How best to provide information for teams considering CAPA implementation
  - Future approaches to quality assurance of CAPA training and or implementation
  - Identifying 'exemplar sites' which have implemented CAPA in different contexts These sites may need to be offered an incentive in order to help them share information with other teams who wish to observe and learn from them
3. An enhanced training package should be developed to facilitate successful implementation of CAPA. This should include training on conducting Choice appointments for clinicians, job planning and capacity planning for managers.
4. A national online network and directory of CAPA implementers could be developed. This may provide a point of call for those who are interested in implementing CAPA, allowing professionals to share information and solve problems as a community.
5. The CAPA implementation training and support package will need to be sensitive to commonly held misunderstandings of the CAPA model, particularly focusing on how the system can be applied to complex cases. This will help to ensure that the implementation process becomes more standardised across teams.
6. The implementation of CAPA within a variety of contexts should be supported by the development of case studies which illustrate how the system can work in different types of services.

At a local level:

7. For teams to realise the benefits of CAPA the presence of facilitative team management is crucial. In line with the first component of CAPA there should be an informed manager, a clinical lead, and an administrative lead that should be well respected within the team, educated and trained in CAPA prior to implementation.
8. CAMHS teams implementing CAPA need more formalised mechanisms in place to facilitate effective team-working. Peer group supervision and regular away days may provide a good base for this, as outlined by components 10 and 11 of the CAPA model.
9. Children's Trusts should hold extensive, up-to-date directories of all local children's services. CAMHS teams should use these directories to enable them to engage in multi-agency work or to signpost families to appropriate services.
10. Successful implementation of CAPA should involve staff from a variety of roles within the CAMHS organisational structure, including clinical and administrative staff, managers and commissioners.
11. Monitoring and feedback are integral prior to, during, and after the implementation phase. Teams should engage in robust, transparent data collection and analysis processes that will allow them to monitor the following; outcomes for families, user experiences of the service, waiting lists, internal waits, capacity, flow and discharge.
12. Local service and regional support systems who wish to implement CAPA would be advised to appoint a number of local champions to help oversee and standardise implementation within an area. These champions should be a mixture of clinicians and managers with experience of implementing CAPA already.

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## **7. Appendices**

### **Appendix 1**

#### **Audit 1a**

##### **Audit of the Choice and Partnership Approach in CAMHS**

The Mental Health Foundation is an independent UK charity with a research team that conducts service improvement and public mental health projects. We have been commissioned by the National CAMHS Support Service to undertake an audit and in-depth evaluation of the Choice and Partnership Approach (CAPA) in CAMHS in England.

You may already know that CAPA is a clinical system that places the needs of families at the centre of CAMHS, and enables clinical and non-clinical staff to manage capacity and demand more efficiently. Some teams may not be using the term CAPA and know it as New Ways of Working, Lean, or Capacity and Demand Service Improvement work. This short questionnaire is relevant for all CAMHS teams and services to complete.

The aims of this audit are to examine the extent to which CAMHS team and services in England have adopted the key components of CAPA. A further research stage will assess the degree to which CAPAs intended outcomes are being achieved, along with understanding the impact of adopting CAPA for services and families.

Please complete this short questionnaire. It should take around 10 minutes. If you do not know some answers please complete as much of it as you can. All responses will be kept strictly confidential and in accordance with the Data Protection Act.

**The Mental Health Foundation is very grateful for your participation in this research**



**1. Have you heard of the Choice and Partnership Approach (CAPA)**

Yes  No

**2a. Has CAPA been implemented within your team/service?**

Yes  No  Don't know

**b. How long has CAPA been implemented within your service? \_\_\_\_\_ months/years**

**3. Some teams may have adopted something similar to CAPA under a different name, such as; New Ways of Working, Lean, or Capacity and Demand. Do you think your team may be using any of these terms instead?**

Yes  No  Don't know

*If you answered 'Yes' to question 2 or 3 then please go on to question 4. If you answered 'No' or 'Don't know' please skip to question 8*

**4. To what extent has CAPA improved clinical outcomes for your service users?**

Substantially improved  Improved  Neither improved nor worsened   
 Substantially worsened  Worsened

**Please explain your answer in 2-3 lines**

**5. What impact has CAPA had on your own level of work stress?**

Significantly less stress  Less stress  No difference   
 More stress  Significantly more stress

**Please explain your answer in 2-3 lines**

**What impact has CAPA had on you own level of job satisfaction?**

- Substantially improved       Improved       Neither improved nor worsened   
Substantially worsened       Worsened

**Please explain your answer in 2-3 lines**

**7. What training have you or your team/service had to help implement the components of CAPA? (please mark all that apply)**

- Attending Steve Kingsbury and Ann York’s workshop       Attending closely related Service Improvement training   
Using the CAPA website (www.camhsnetwork.co.uk)       Other (please specify) \_\_\_\_\_  
Using the CAPA workbook

**8. How are new referrals screened to ensure they meet the eligibility criteria (please mark all that apply)**

- Assessment of referral letter       Initial assessment with family   
Other (please specify): \_\_\_\_\_

**9. How often are clients placed on a waiting list before their initial appointment with your service?**

- Always       Often       Sometimes       Never       Rarely

**10. On average, how long do people wait for an initial appointment? \_\_\_\_\_**

**11a. Do you have a system for allocating the following types of cases? (please mark all that apply)**

- Urgent       Emergency       Priority

**b. On average, how long will the following types of cases wait for an appointment? (please state in hours, days or weeks)**

- Urgent       Emergency       Priority

**c. Please give any further comments**

**12. Who usually conducts the initial appointment with clients? (please mark all that apply)**

- Whoever the family chooses
- The team member with the most relevant skills
- Whoever is available at the time
- The rostrad/allocated team member for assessment
- A designated team member, who conducts all initial appointments

**13. Are families offered the following choices for their initial appointment? (please mark all that apply)**

- Choice of time(s)                       Choice of date(s)
- Choice of location(s)                       Choice of therapist(s)

**14. Do you prepare written care plans with your clients?**

- Yes                       No                       Sometimes

**15. To what extent are clients and carers involved in developing care plans?**

- Always                       Often                       Sometimes                       Never                       Rarely

**16. Do you produce information for people of the following ages? (e.g. information about your service, about clinical disorders etc) Please mark all that apply**

- Under 10                       11-13                       14+15                       16+

**17. How are cases matched to clinicians for follow-up appointments? (please mark the appropriate option for each statement)**

Based on...	Always	Often	Sometimes	Rarely	Never
An individual clinician's capacity on their caseload					
Matching clinicians' specialist skills to client need					
Client preferences for a particular clinician					
Care pathway/ referral from specialist clinic (e.g. from an ADHD clinic)					

**18. Are families offered the following options for their follow-up appointments?  
(please mark the appropriate option for each statement)**

Based on...	Always	Often	Sometimes	Rarely	Never
Choice of time(s)					
Choice of location(s)					
Choice of date(s)					
Choice of therapist(s)					

**19a. How often do you share knowledge to help other team or service staff with their cases?**

Always       Often       Sometimes       Never       Rarely

**b. How often do other team or service staff share knowledge with you, to help you with your cases?**

Always       Often       Sometimes       Never       Rarely

**c. How is this done? (Please mark all that apply)**

Informally

As part of a clinic (e.g. a routine clinic)

Formally, through weekly meetings

Formally, through monthly meetings

Other (please specify):  
\_\_\_\_\_

**20a. How often does your team or service have 'away days' for staff? \_\_\_\_\_**

**b. What proportion of staff attend these team/away days? \_\_\_\_\_%**

**21. Please complete if you are a team manager: Which of the following capabilities can your team/service offer? (please indicate the number of staff you have who are able to offer each capability)**

ADHD assessment	<input type="checkbox"/>	Mental state examination	<input type="checkbox"/>
Art therapy	<input type="checkbox"/>	Parenting Programmes	<input type="checkbox"/>
Autistic Spectrum Disorder assessment	<input type="checkbox"/>	Eye Movement Desensitization and Reprocessing (EMDR)	<input type="checkbox"/>
Behavioural Therapy	<input type="checkbox"/>	Group therapy	<input type="checkbox"/>
Child psychotherapy	<input type="checkbox"/>	Play therapy	<input type="checkbox"/>
Family therapy	<input type="checkbox"/>	Psychometric assessment	<input type="checkbox"/>
Cognitive Behavioural Therapy (CBT)	<input type="checkbox"/>	Systemic psychotherapy	<input type="checkbox"/>
		Other (please specify)	<input type="checkbox"/>
		_____	

**22a. What core skills does your team/service provide?**

**b. What specialist skills does your team/service provide?**

**c. What proportion of your time do you spend using these skills?**

<b>Core skills</b>	%
<b>Specialist skills</b>	%

Please fill in the following as best describes you:

**23. What is your role?**

Nurse	<input type="checkbox"/>	Primary MH worker	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>	Psychologist	<input type="checkbox"/>
Support worker	<input type="checkbox"/>	Service manager	<input type="checkbox"/>
Team manager	<input type="checkbox"/>	Art therapy	<input type="checkbox"/>
Therapist (e.g. Occupational Therapist)	<input type="checkbox"/>	Please specify type of therapy _____	
Other			
_____			

**24a. What is the age range of the children and young people accessing your service?  
(Please mark all that apply)**

Under 5       5-10       11-13       14-15       16+

**b. How many staff are there in your team?** \_\_\_\_\_

**25. Which of the 9 national CAMHS regions do you work in?**

Eastern	<input type="checkbox"/>	South East	<input type="checkbox"/>	North West	<input type="checkbox"/>
East Midlands	<input type="checkbox"/>	South West	<input type="checkbox"/>	West Midlands	<input type="checkbox"/>
London	<input type="checkbox"/>	North East	<input type="checkbox"/>	Yorkshire and Humber	<input type="checkbox"/>

**26. How would you describe the area that you work in?**Mainly urban Mainly rural Mixed rural and urban **27. Please give details of your service**

Name of team: \_\_\_\_\_

Address of team: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_

Contact email address: \_\_\_\_\_

**28. In the next phase of this study we will be investigating further how CAPA might impact children, young people and their carers and CAMH workers. We will be selecting teams and conduct some interviews and focus groups. We will take an action-learning approach that will not only enable us to conduct the research but will also give CAMH service/team members opportunities to reflect, learn and improve their service. If you would be interested in taking part in this stage please mark below.**

Yes No 

Please return to Karen James, Research Officer: [kjames@mhf.org.uk](mailto:kjames@mhf.org.uk) or for postal questionnaires to FREEPOST RLSU-XKXG-RKZX, The Mental Health Foundation Sea Containers House, 20 Upper Ground, London SE1 9QB. If you have any questions, or to find out more about the research you can contact Karen on 0207 803 1155.

**Thank you for taking the time to complete this questionnaire**

## Appendix 2

### Audit 1a

#### Audit of the 11 Components of CAPA

Thank you for completing our first audit of the Choice and Partnership Approach (CAPA) in CAMHS. We are asking services who are implementing CAPA to complete a second short survey. The aim of this survey is to identify more precisely to what extent services are implementing the 11 components of CAPA.

This survey should take around 10 minutes to complete. All responses will be kept strictly confidential as before. If you have any questions about this audit please contact Karen James, Research Officer, on 0207 803 1155, [kjames@mhf.org.uk](mailto:kjames@mhf.org.uk).

**The Mental Health Foundation is very grateful for your participation in this research**

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#### Management and Leadership

**1a. In your team do you have someone who leads on the following CAPA duties?**

	Yes	No
<b>Administrative</b>		
<b>Clinical</b>		
<b>Management</b>		

**b. Do you have regular CAPA meetings between admin, clinical and management staff?**

Yes

No



## Language

### 2a. What do you call the initial appointment with families?

Initial appointment  Triage

Assessment appointment  Choice appointment

Other (please specify):

---

### b. What do you call follow-up appointments with families?

Follow up appointments

Treatment appointments

Partnership appointments

Other (please specify):

---

### c. How to you select which clinician will meet with families?

Based on their skills  Based on the family's goals

Based on their job role/discipline  Based on whoever is available

## Handle Demand

### 3a. What is the first thing you do if you are unsure whether a family meets the eligibility criteria for your service?

Seek further information from the referrer

Seek further information from the family

Arrange to meet with the family appointments

Other (please specify):

---

### b. Do you have a waiting list?

Yes

No

### Choice Framework

#### 4. During the choice appointment with families do you work with the family to:

- Discuss alternative sources of support outside of your service
- Identify what the family could do to support themselves
- Identify a set of goals to be achieved whilst they are using your service

### Full Booking to Partnership

#### 5a. Are you using the 'full booking' system when arranging follow-up appointments for families? (i.e., do you have a number of appointments to offer families)

- Yes  No

#### b. Do you have a diary system to facilitate the 'full booking' process?

- Yes  No

### Selecting Partnership Clinician by Skill

#### 6. Following choice appointment, how do you select the clinician/s who will be working with the family?

- Based on the goals of the young person/family
- Based on the therapy style identified in the initial assessment/choice appointment
- Based on the clinicians extended core skills

### Extended clinical skills in core work

#### 7. Does your team operate with a general principle of core work first with specialist work added if required?

- Yes  No  Unsure

**Job Plans**

8a. Do individuals in your team have a job plan? Yes  No

b. Does this vary according to the capacity of your team? Yes  No

c. Does this job plan include:

Choice activity

Administration time

Partnership targets for each quarter

Defined specialist and specific time

d. Is there a job or capacity plan in your team? Yes  No

**Goal Setting and Care Planning**

9a. Do you prepare written care plans with families?

Yes

No

Sometimes

b. To what extent are families involved in developing care plans?

Always

Often

Sometimes

Never

Rarely

**Peer Group Supervision**

10a. Do you have peer group supervision sessions? Yes  No

b. If yes how often? Weekly  Monthly  Other

c. Is group supervision:

	Yes	No
<b>Conducted in small groups</b>		
<b>A multidisciplinary activity</b>		
<b>Used for case discussion</b>		
<b>Used to let families go</b>		

**Team away days**

**11a. Do you have team away days?**

Yes

No

**b. How often?** \_\_\_\_\_

**c. Who sets the agenda for team away days?**

The team members

The manager

**d. What is the focus of your team away days?**

Clinical learning

Team relationships

Business issues

Other (please specify):  
\_\_\_\_\_

## Appendix 3

### Audit 1c

	Before you implemented CAPA	6 months after implementing CAPA	At end of July 2009
<p><b>1. On average how many referrals did your service receive in a month?</b> Please give source of information eg. RIO system</p>			
<p><b>2. Of these referrals, on average how many were accepted in each month?</b> Please give source of information eg. RIO system</p>			
<p><b>3. Of these referrals, on average how many were declined in each month?</b> Please give source of information eg. Register</p>			
<p><b>4. On average, how many were referred elsewhere?</b> Please give source of information eg. Register</p>			
<p><b>5. What was the waiting time in weeks for a first appointment?</b> Please give source of information eg. RIO system</p>			
<p><b>6. How many families were waiting for a first appointment?</b> Please give source of information eg. RIO system</p>			
<p><b>7. Post assessment were there any internal waits for specific follow up appointments clinics/therapies?</b></p>			
<p><b>8. What was the Did Not Attend rate for first appointments?</b></p>			
<p><b>9. What was the Did Not Attend rate for follow up appointments?</b></p>			
<p><b>10. What was the discharge rate per month?</b></p>			

## Appendix 4

### Questionnaire for young people

#### Survey for Children and Young People - Version 4 – 10.06.09

Our names are Dan and Karen. We work at a place called the Mental Health Foundation, which is a charity doing a lot of different types of work to look after people's mental health and emotional well-being.

We have been asked to write a questionnaire to find out about whether children and young people have enough information, and are able to make enough choices about how they are helped at [SERVICE]. If you would like to give us your answers by phone then please call Karen on 0207 803 1155 or Dan on 0207 803 1116.

We will not share your answers with anyone who helps you. What we will be doing is gathering all the answers we get from children and young people across the country and then using those answers to try and make sure that children and young people all have the chance to make choices about the help they get, when they need it.

Your answers to the following questions will help us to do that. Although your answers will be useful to us, filling in the questionnaire is your choice. If you do not want to, that is also completely fine.

#### 1. Were you given any information about [SERVICE] before you had your first appointment?

Yes  No

*If you answered 'Yes' please go to 1a, if you answered 'No' please go to 2.*

#### 1a. What kind of information were you given? Please tick

Leaflet  Spoke to someone on the phone

Information sheet  Website

Other (please specify):  
\_\_\_\_\_

#### 2. What choices were you given for your first appointment with [SERVICE]? Please tick

Choice of day  Choice of place

Choice of time  Choice of person you had the appointment with

**3. How long did you have to wait before your first appointment with [SERVICE]?** *Please tick*

1 week       2 weeks       3 weeks       More than 3 weeks

**4. Who did you see in your first appointment with [SERVICE]?** *Please tick*

Nurse       Therapist

Psychiatrist       Psychologist

Support worker       Don't know

Primary Mental Health Worker       Please tell us what kind of therapist (e.g. Family Therapist)  
\_\_\_\_\_

Other (please specify):  
\_\_\_\_\_

**5. Were they helpful?**

Yes       No

**6. What did they do that was helpful?** *Please write all the things below:*

**7. What could they have done better?** *Please write all the things below*

**8. Do you feel that they listened to what you said?** *Please tick*

Yes       No

**9. Did the staff at [SERVICE] tell you about other places where you could get help?**

Yes       No

**10. Were any of the following words used by any of the staff at [SERVICE]? Please tick**

- |                         |                          |                         |                          |
|-------------------------|--------------------------|-------------------------|--------------------------|
| Assessment              | <input type="checkbox"/> | Follow up visit         | <input type="checkbox"/> |
| Choice appointment      | <input type="checkbox"/> | Partnership appointment | <input type="checkbox"/> |
| Choice-plus appointment | <input type="checkbox"/> | Specialist appointment  | <input type="checkbox"/> |
| Treatment               | <input type="checkbox"/> | First-step appointment  | <input type="checkbox"/> |

**11. After your first appointment, how long did you have to wait for the next appointment with [SERVICE]? Please tick one**

- |                               |                          |                    |                          |
|-------------------------------|--------------------------|--------------------|--------------------------|
| Less than 2 weeks             | <input type="checkbox"/> | Less than 4 weeks  | <input type="checkbox"/> |
| Less than 2 months            | <input type="checkbox"/> | More than 2 months | <input type="checkbox"/> |
| I never had a 2nd appointment | <input type="checkbox"/> |                    |                          |

**12. Were you given a choice of who you would see for the next appointment? Please tick**

- Yes                       No                       Don't Know

**13. Did they tell you about things that you could do in between appointments, which might help?**

- Yes                       No

**14. Do you think the staff enjoy working at [SERVICE]?**

- Yes                       No                       Don't Know

**14a. Please explain your answer the box below:**

**15. Do you understand why you are getting the type of help you are getting?**

- Yes       Please go to question 15a
- No       Please go to question 15b



**15a. If yes, how have staff at [SERVICE] helped you to understand this?**

**15b. If no, how could staff at [SERVICE] help you to understand this better?**

**16. Do you have a care plan?**

Yes

No

Don't Know

**17. Were you involved in deciding what your care plan says?**

Yes

No

**18. How would you describe what a care plan is?**

**19. In total, how many appointments will you have with the people at [SERVICE]?**

*(if you are unsure how many appointments you will have, please write "don't know")*

---

**20. Is there anything else you would like to tell us about [SERVICE]?**

**Please fill in the following as best describes you:**

**21. Age:** \_\_\_\_\_ years

**22. Sex:**

Male

Female

**23. Your Ethnicity**

**White**

British

Irish

European

**Mixed**

White and Black-Caribbean

White and Black-African

White and Asian

**Asian/Asian British**

Indian

Pakistani

Bangladeshi

Chinese

**Black/Black British**

Black-African

Black-Caribbean

**Other**

Other (please state): \_\_\_\_\_

**24. Your Religion:**

Protestant

Catholic

Sikh

Buddhist

Church of England

Christian

Jewish

Muslim

Hindu

Agnostic (not sure)

None

Other (please state): \_\_\_\_\_

**25. Is English your 1st language?**

Yes

No

## Appendix 5

### Questionnaire for carers

#### Survey for Parents and Carers - Version 4 – 10.06.09

#### 1. Were you given any information about [SERVICE] before you had your first appointment?

Yes  No

*If you answered 'Yes' please go to 1a, if you answered 'No' please go to 2.*

#### 1a. What kind of information were you given? Please tick

Leaflet  Spoke to someone on the phone

Information sheet  Website

Other (please specify):

---

#### 2. What choices were you given for your first appointment with [SERVICE]? Please tick

Choice of day  Choice of place

Choice of time  Choice of person you had the appointment with

#### 3. How long did you have to wait before your first appointment with [SERVICE]? Please tick

1 week  2 weeks  3 weeks  More than 3 weeks

#### 4. Who did you see in your first appointment with [SERVICE]? Please tick

Nurse  Therapist

Psychiatrist  Psychologist

Support worker  Don't know

Primary Mental Health Worker  Please tell us what kind of therapist (e.g. Family Therapist)

---

Other (please specify):

---

**5. Were they helpful?**

Yes

No

**6. What did they do that was helpful?** *Please write all the things below:*

**7. What could they have done better?** *Please write all the things below*

**8. Do you feel that they listened to what you said?** *Please tick*

Yes

No

**9. Did the staff at [SERVICE] tell you about other places where you could get help?**

Yes

No

**10. Were any of the following words used by any of the staff at [SERVICE]?** *Please tick*

Assessment

Follow up visit

Choice appointment

Partnership appointment

Choice-plus appointment

Specialist appointment

Treatment

First-step appointment

**11. After your first appointment, how long did you have to wait for the next appointment with [SERVICE]?** *Please tick one*

Less than 2 weeks

Less than 4 weeks

Less than 2 months

More than 2 months

I never had a 2nd appointment

**12. Were you given a choice of who you would see for the next appointment?** *Please tick*

Yes

No

Don't Know

**13. Did they tell you about things that you could do in between appointments, which might help?**

Yes

No

**14. Do you think the staff enjoy working at [SERVICE]?**

Yes

No

Don't Know

**14a. Please explain your answer the box below:**

**15. How have staff at [SERVICE] helped you to understand the situation of the child/ young person in your care?**

**16. How could staff at [SERVICE] help you to understand this better?**

**17. Does the child/young person in your care have a care plan?**

Yes

No

Don't Know

**18. Were you involved in deciding what this care plan says?**

Yes

No

**19. How would you describe what a care plan is?**

**20. In total, how many appointments will you have with the people at [SERVICE]?**

*(if you are unsure how many appointments you will have, please write "don't know")*

---

**21. Is there anything else you would like to tell us about [SERVICE]?**

**Please fill in the following as best describes you**

**21. Age:** \_\_\_\_\_ years

**22. Sex:**

Male

Female

**23. Your Ethnicity**

**White**

British

Irish

European

**Mixed**

White and Black-Caribbean

White and Black-African

White and Asian

**Asian/Asian British**

Indian

Pakistani

Bangladeshi

Chinese

**Black/Black British**

Black-African

Black-Caribbean

**Other**

Other (please state): \_\_\_\_\_

**24. Your Religion:**

- |            |                          |                   |                          |                       |                          |
|------------|--------------------------|-------------------|--------------------------|-----------------------|--------------------------|
| Protestant | <input type="checkbox"/> | Church of England | <input type="checkbox"/> | Hindu                 | <input type="checkbox"/> |
| Catholic   | <input type="checkbox"/> | Christian         | <input type="checkbox"/> | Agnostic (not sure)   | <input type="checkbox"/> |
| Sikh       | <input type="checkbox"/> | Jewish            | <input type="checkbox"/> | None                  | <input type="checkbox"/> |
| Buddhist   | <input type="checkbox"/> | Muslim            | <input type="checkbox"/> | Other (please state): |                          |

---

**25. Is English your 1st language?**

Yes

No

## Appendix 6

### Focus group schedule for CAMHS professionals

#### Questions

1. **Tell us what you understand about CAPA**
2. **So how did you find the process of implementation?**
  - When did it begin?
  - Did you experience any difficulties with this process?
  - What helped? (e.g. training, away days)
  - What didn't help?
3. **How has CAPA changed the way you work as a team?**
  - Has it improved communication?
  - Do you meet more regularly?
  - Are you more aware of the skills your team has to offer?
4. **We're interested in how CAPA helps or hinders the way services manage capacity and demand.**
  - What affect has CAPA had on waiting times?
  - How has this changed over time?
  - Some teams have reported that they have an internal waiting list for follow-up work, have you experienced this?
  - How do you discuss 'letting go of families'?
  - How do you use your job plans?
5. **Has CAPA changed the way in which you manage your time? How?**
6. **Do you think CAPA is a good way of working?**
  - How has it changed the experience of families?
7. **Are there any things you would like to change about CAPA?**
8. **Is there anything else you would like to share with us about CAPA**



## Appendix 7

### Interview schedule for CAMHS professionals

#### Questions

#### 1. How did you find the process of implementing CAPA?

- How long was this process?
- What training/support did you receive?
- Do you have team members of staff who lead on CAPA clinical, admin and management duties? Does this work?
- What are the good things about the process of implementing CAPA?
- Did you experience any difficulties with this process?

#### Manager

- *We are trying to understand the costs of implementation, what was required to implement CAPA? (e.g. away days, job plans etc)*
- *Tell us about CAPA and IT resources, any specific issues?*
- *Have you has any difficulties implementing CAPA?*

#### 2. CAPA involves changing the way that staff use language, what do you think about this?

- Is this helpful?
- Has it improved the experience of families using your service (e.g. more collaborative working, better understanding of support?)
- How was it implementing this change?

#### 3. How has CAPA helped you to manage your workload?

- Has CAPA changed the way in which you manage your time? How?
- Do you have a job plan?
- How is this useful?

#### 4. How has your first contact with families changed since implementing CAPA?

(change from assessment to choice appointment?)

- How has this affected the quality of support that families are receiving?

**5. What do you think about the 'full booking' system when arranging follow-up appointments with families?**

- Has this reduced waiting times?
- What are the benefits to using this system?
- Have you had any difficulties implementing this system?

**6. How does CAPA affect the way you work with families (in Partnership)?**

(e.g. work with clinician with the most appropriate skills to meet their needs, more goal focused)

**7. Has your team working changed since implementing CAPA?**

- Any change in the way you communicate?
- Do you meet more regularly?
- Do you have a team job plan?

**8. Do you work with the general principle of core work first and specialist work added if required?**

- Any change in the way you communicate?
- Do you meet more regularly?
- Do you have a team job plan?

**9. Which components of CAPA work well for your team?**

**10. Which components don't work so well?**

**Manager**

**11. Based on your experience of CAPA so far will you continue to use the system?**

- Will you change anything?

**12. Do you have any of the following information that we could take away with us?**

- Pre and post CAPA data (e.g. Outcomes for service users, waiting times, discharge numbers)
- Details of the flow through your service
- Information about care bundles
- Team and individual job plans
- Partnership diaries
- Care plans
- Guidance for choice appointments

## Appendix 8

### Interview schedule for carers

#### Questions

1. **When did you first access [name of CAMHS team]**
2. **Did you have to wait long for an initial appointment?**
3. **What was the initial appointment like?**
  - Was it helpful?
  - Did you have a choice of time/location?
  - Were you given some ideas about how to help the child/young person you are caring for at home?
  - Were you told about other places you could go for help?
  - Did you feel listened to during the appointment?
  - Did you have a say in what support you accessed?
  - Anything that could be improved?
4. **Did you have to wait for a follow-up appointment?**
  - If yes, how was this wait?
5. **Do you feel you are receiving the kind of support from [name of CAMHS team that you need]**
  - Do you understand why the people you are working with were chosen to support you?
  - Do you feel the staff listen to what you have to say?
  - Do you feel the staff listen to what the child/young person you are caring for has to say?
6. **Does the child/young person you are caring for have a care plan?**
  - Do you understand this?
  - Do they understand this?
  - Were you involved in writing it?
  - Is it reviewed regularly?

**7. Do you know when you will be discharged from the service?**

- Have staff spoken to you about this?
- Do you feel prepared for it?

If anyone has already been discharged ask the following:

**8. What was it like being discharged?**

- How did it feel?
- Did you feel ready to go?
- Would you come back to [name of CAMHS team] if you needed more help?

## **Appendix 9**

### **Interview schedule for children and young people**

#### **Questions**

- 1. Have you heard of 'Choice' and 'Partnership'?**
- 2. Have you ever heard of a care plan?**
- 3. Who can tell me what one is?**
- 4. Have you had a say about your care plan?**
- 5. Is your care plan helpful?**
- 6. Has anyone been discharged? If so:**
- 7. Did you feel ready to go?**
- 8. Was it useful to come to [service]?**
- 9. Would you come back if you needed to?**

## Appendix 10

### Example of a team capacity plan

DAY	Name 1	Name 2	Name 3	Name 4	Name 5	Name 6	Name 7	Name 8	Name 9
<b>Monday</b>									
am				PM	ADHD	Admin Part x 1	Part x 2	FT x 2	Choice x 2
pm		Choice x 1 Part x 2	Choice x 1 Part x 2	PM	ADHD	Spec x 2	OD cover (fortnightly) Spec	Part x 2	OD cover (fortnightly) Admin Supervision
<b>Tuesday</b>									
am	FT/3Di			FT x 2	OD cover (fortnightly) Spec x 1	Part x 2	Choice x 1 Part x 1	FT x 2	Spec.
pm	Team Meeting: Admin/Apts	Team Meeting Spec x 2	Team Meeting Spec x 2	Team Meeting Spec x 1	Team Meeting Spec x 1	Team Meeting Spec x 1	Team Meeting Admin	Team Meeting OD Cover (fortnightly) Admin	Team Meeting Admin
<b>Weds</b>									
am			Choice x 1 Part x 1 Training (2)	Part x 3	Spec	FT	Part x 1 Spec	FT	Part x 2
pm			apts) OD Cover (fortnightly) Spec x 1	OD Cover Admin	Spec	Choice x 2	Admin	FT x 2 (Hols)	ASD or Paed Psychology supervision
<b>Thursday</b>									
am	Spec x 3	Spec. Admin	Spec. Admin	PM	Part (fortnightly) Spec (fortnightly)	FT		FT x 2	Part x 2
pm	Supportive work	Spec x 3	Spec x 3	Part x 3	Choice x 2 (fortnightly) Part x 2 (fortnightly)	OD cover (fortnightly) Admin		FT x 1 Choice x 1	Spec.
<b>Friday</b>									
am	Admin	Spec.	Spec.	PM		Part x 3 (Bideford)		Choice x 1 Part x 1	Spec.
pm	Spec x 3	OD Cover Admin	Admin	PM		Admin		Part x 1 Admin	Spec.

## Appendix 11

### Example of a job plan

	Monday	Tuesday	Wednesday	Thursday	Friday
<b>A.M</b>	Client contact x2 9:00-12:00	Team meeting 9:30-12:30	Supervision 9:00-10:00  Admin 10:00-12:00	Family therapy 10:00-1:15	Client contact x2 9:00-12:00
<b>P.M</b>	Client contact x2  Admin	Self harm rota	Screening 1:00  Screening 2:30	Client contact x2	Client contact and admin 1:00- 5:00

## Appendix 12

### The project team

#### The evaluation team

1. Dr Kam Dhillon, Head of Research, project manager, Mental Health Foundation
2. Dan Robotham, Senior Researcher, senior project worker, Mental Health Foundation
3. Karen James, Research Officer, project worker, Mental Health Foundation
4. Kim Penketh, Young Participation Officer, project adviser, Mental Health Foundation
5. Carly Raby, Young Person Participation Manager, project adviser, Mental Health Foundation

#### The CAPA expert steering group

1. Angie Pullen, Development Projects Manager, National CAMHS Support Service (NCSS)
2. Jo Paul, CAMH Service Improvement Lead, NCSS, Eastern region.
3. Gill Walker, Associate Regional Development Worker, NCSS, East Midlands region.
4. Roz Rospopa, Regional Development Worker, NCSS, Eastern region.



# Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121.

Visit [www.mentalhealth.org.uk](http://www.mentalhealth.org.uk) for free information on a range of mental health issues for policy, professional and public audiences, and free materials to raise awareness about how people can look after their mental health.

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