

# Service Users' Experiences of a Brief Intervention Service for Children and Adolescents: A Service Evaluation

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Ten per cent of young people experience mental health difficulties at any one time. Prevention and early intervention leads to better prognosis for young people's mental well-being in the short and long term. Child and Adolescent Mental Health Services (CAMHS) must be able to provide swift and effective interventions for a range of difficulties to meet this need. This paper presents a service evaluation of the Brief Intervention Service in North Lincolnshire CAMHS. Nine young people and/or their families took part in semi-structured interviews that aimed to explore their experiences of receiving an intervention from the service. Template analysis was carried out to draw out themes from the interview transcripts. The three a priori themes were treatment outcomes, areas for potential improvement, and things that are working well; and an additional two emergent themes were emotional experience and managing practical barriers. In addition, all participants were asked about their satisfaction with the service and whether they would recommend the service to others. One hundred per cent reported feeling respected by their clinician when asked directly, and all felt that the service would be helpful for other young people and families. Overall, families were satisfied with the service and reported outcomes including improvements in symptomatology and family functioning. Specific recommendations as to how the service could be improved were made, which related to difficulties accessing the service, the content of the sessions, and communication within the service and with other services.

Keywords: Brief Intervention; Short-term Therapy; Child and Adolescent Mental Health; Qualitative

## Introduction

The importance of effective Child and Adolescent Mental Health Services (CAMHS) was emphasised in the UK government's 10-year strategy for mental health, "New Horizons" (Department of Health, 2009), which promoted laying the foundations for mental well-being in adulthood by working with young people and their families and carers. The document argued that prevention and early intervention lead to better prognosis in the short and long term, enable young people and their families to make a quicker return to mental well-being, and improve quality of life. One in 10 children and young people aged five to 16 years in the United Kingdom have a clinically diagnosed mental disorder at any one time (Green, McGinnity, Meltzer, Ford, & Goodman, 2004). A national review of CAMHS in 2008 highlighted the need for "swifter, more effective input from practitioners who are able to address the full range of needs", and argued that inequalities in accessing services and treatments must be addressed (Department of Health, 2008, p. 9). The young people and families involved in the review highlighted that they wanted services to offer help before crisis point was reached, as well as regular individual contact.

Locally, CAMHS manage severe, complex and persistent mental health difficulties in line with the four-tier strategic framework for planning, commissioning and delivery of CAMHS (Department of Health and Department for Education, 1995). From October 2007 to May 2008 a review of the Specialist CAMHS in North Lincolnshire CAMHS was carried out (Children and Young People Scrutiny Panel, 2008). This review highlighted long waiting times due to lack of resources and service provision. There was no service to work with young people and families presenting with less severe and complex disorders who were not considered high-risk cases and as a result were not prioritised. These clients were therefore managed within the same model, creating long waiting lists. The delays increased the risk of service users' difficulties becoming more severe and complex, and left families in distress for a considerable length of time.

To overcome these difficulties the Brief Intervention Service (BIS) in North Lincolnshire CAMHS was established in December 2009. BIS offered a maximum of six to eight sessions influenced by solution-focused and cognitive behaviour models. The short-term nature of the service meant that practitioners were required to be transparent about the process, and collaborative with the families to maximise outcomes in line with the features of effective services identified by young people and their parents and carers in the National CAMHS Review (Department of Health, 2009) and the partnership encouraged by the Children and Young People's Workforce Strategy (Department for Children, Schools and Families, 2008). The aim of this added branch to the existing CAMHS service was to reduce waiting times for those young people presenting with less complex, severe and longstanding mental health difficulties. The service would provide early intervention in order to prevent these difficulties escalating. The nature of the intervention varied. For some families the intervention was largely carried out with parents, and held a consultation

function, whereas for others the young person was more directly involved, and for others the young person attended intervention sessions without their parents.

There has been very little evaluation of brief psychological talking therapies with young people to date outside the field of physical health. Wood, Harrington, and Moore (1996) reported a reduction in symptoms of depression following a short course of cognitive behavioural therapy (five to eight sessions) for young people. However, this finding was apparent in the clients' self-reports of symptoms, but not in the reports collected from parents. There have been a number of studies exploring the effect of a consultancy model of intervention based on solution-focused theory and problem-solving (Heywood et al., 2003; McGarry et al., 2008; Stallard & Sayers, 1998). This consisted of one assessment session plus two intervention sessions. The results of these have been positive, indicating reduced waiting times in services and improvement in symptoms. However, there have been a number of limitations to these studies affecting their scientific quality, including small sample sizes and incomplete datasets. A quantitative service evaluation was conducted by Worrall-Davies, Cottrell, and Benson (2004) exploring the nature of referrals to a brief-intervention Tier 2 team in Leeds, measuring the outcomes post intervention, and examining the impact of this service on the referrals made to the existing Tier 3 service. According to the four-tier strategic framework, Tier 2 professionals work in a uni-disciplinary team and serve a primary care function largely comprising of assessment and consultation. In contrast, Tier 3 professionals are usually based within a multi-disciplinary team in a specialist mental health service to work with young people with more severe, complex and longstanding difficulties. The results indicated that the addition of this service to the model of CAMHS practice addressed previously unmet need, and changed the nature of the referrals to the Tier 3 service, which was then able to address the chronic and complex presentations. This suggested that a brief intervention component can have positive effects in improving mental health and makes a significant contribution to service provision.

All of the studies exploring brief interventions for young people to date have been quantitative and have not explored service users' experiences. There is evidence to suggest that service users can make vital contributions to the evidence base regarding mental health as they provide an alternative perspective to professionals and value different components of treatment to service providers (Thornicroft & Tansella, 2005). There is a growing body of literature that reports service changes implemented due to service user feedback, yet there is a paucity of research or evaluation exploring the outcomes of these changes in terms of quality of care, satisfaction, or health of patients (Crawford et al., 2002). In relation to services for young people, Day (2007) outlines a number of objectives of children and young people's participation in service evaluation and planning, including improving the quality and effectiveness of provision, fulfilling the young people's right and obligations, empowering the young people, respecting their views as consumers and stakeholders, and developing their skills and competencies. Every Child Matters (Department for Education and Skills, 2004) recommends listening to young people and their families when assessing service provision.

This service evaluation involved young people and families who had received input from the Brief Intervention Service in North Lincolnshire CAMHS. There were many routes through BIS, as highlighted in Figure 1. The aim of the project was to explore young people's and their families' experiences of BIS, with a view to

making recommendations to improve the service, and to highlight the areas working well. Recommendations may also inform other services within the trust with regards to establishing similar teams elsewhere.

## Method

This evaluation was undertaken by a female trainee clinical psychologist as part of a doctorate in clinical psychology. No additional funding was provided.

## Participants

A list of all of the young people who had been referred to BIS branch of CAMHS since 2011 was provided to the author, who was external to the team. These 212 young people were then selected based on the following inclusion and exclusion criteria. The inclusion criterion specified that only those families who were referred to BIS for assessment and continued through the intervention period were selected, and BIS intervention must have been completed between January 2011 and June 2012. Assessment-only or consultation-only cases were not included, nor were families who

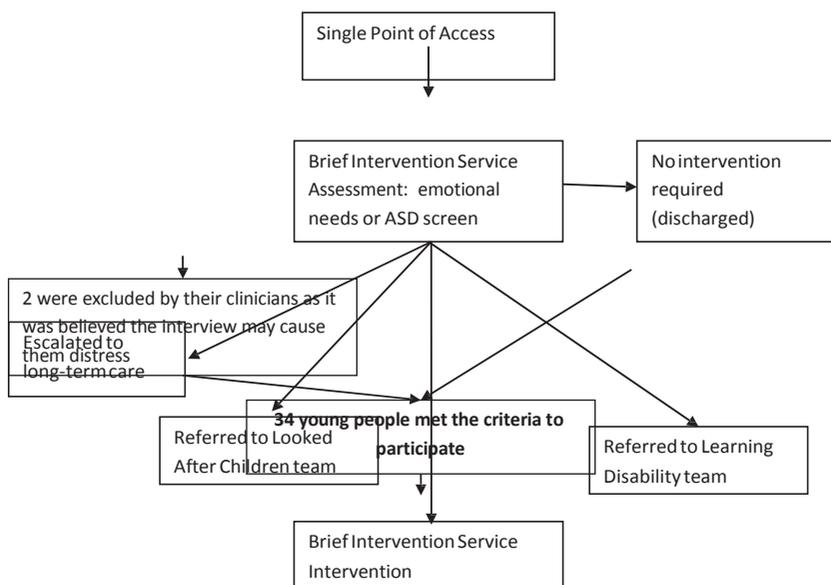


Figure 1 Routes through the Brief Intervention Service.

*Note:* Autism Spectrum Disorder (ASD).

may have been distressed by participating in an interview at CAMHS, as based on a clinical judgement by their practitioner. Figure 2 displays the sampling process.

## Procedure

Young people and their families were given the choice as to whether they all wanted to be interviewed, and whether they wanted to be interviewed together or separately. Written consent was obtained from the parents and young person over 16 years who participated in the evaluation; parents gave written consent for their children under

16 years to participate. The participants had not met the author prior to being interviewed. They were informed that the data would contribute to a doctoral qualification, and that the findings would be fed back to the team in an anonymous format for the purpose of service evaluation and improvement.

Approval to conduct the evaluation was obtained from Research Governance in the Trust.

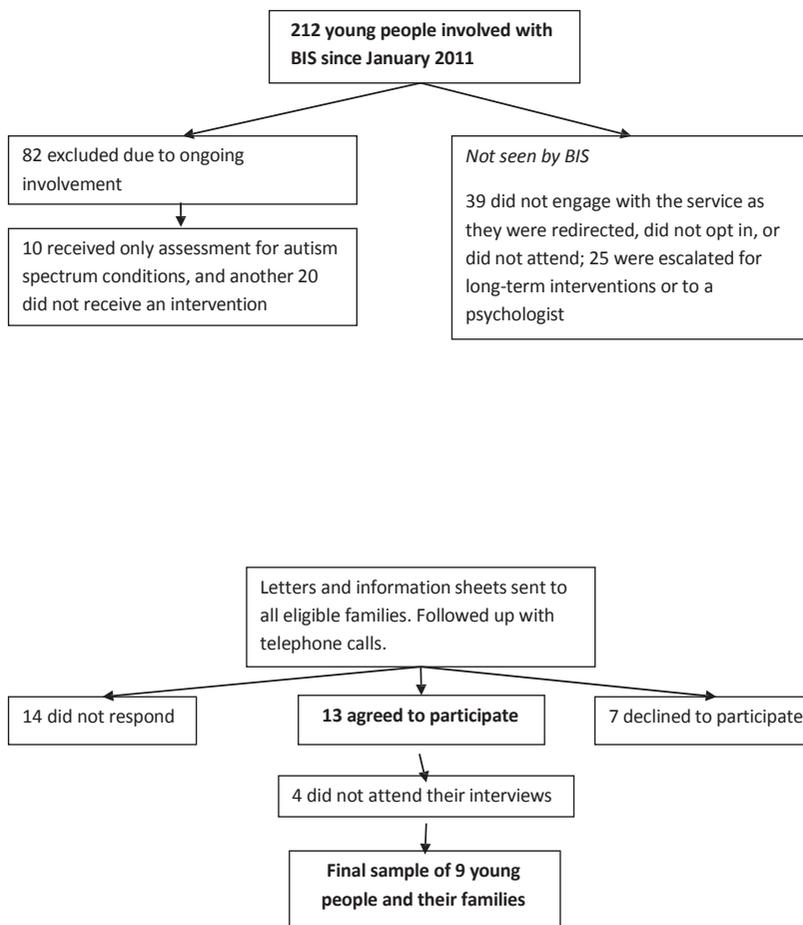


Figure 2 Study Recruitment Process.

### *Data Collection*

The semi-structured interview lasted from 15 to 90 minutes. The schedule was developed to cover a number of areas recommended for service evaluation, and more specifically in services working with young people and families (Bailey et al., 2008; Department for Children, Schools and Families, 2010; Kennedy, 2010; pH Associates, 2012). The recommended areas of evaluation were captured in three *a priori* themes outlined below. All interviews were conducted by the first author, took place at the CAMHS where the families had received their interventions, and were digitally recorded.

### *Design and Data Analyses*

All participants were asked whether they were satisfied with the service, and whether they would recommend it to a friend. The responses to these questions are summarised.

Qualitative methodology was used to explore the participants' experiences of the service. Template analysis, a hierarchical qualitative method, was used to extract themes from the interview transcripts (Brooks & King, 2012). Template analysis is a style of thematic analysis developed within the field of organisational psychology. It forms a middle ground between the qualitative approaches of grounded theory and interpretative phenomenological analysis in that it offers the option to work within a realist framework, aiming to discover underlying truths, or the option to take a contextual constructivist approach, accepting that there may be multiple interpretations of the meaning of the data, and allowing flexibility around the themes that emerge (King, 2012). The author must consider their position prior to conducting the interviews and analysis, which then influences the method of coding.

In template analysis the investigator develops a template, which is a list of codes that represent the themes in the data (Brooks & King, 2012). Prior to beginning the project, the investigator must decide on one of three positions (Waring & Wainwright, 2008):

- a. have pre-defined *a priori* codes based on the theoretical position of the study and intended to guide analysis;
- b. develop codes after initial exploration of the data; or
- c. a middle ground between options a and b where the investigator begins with some initial codes and adds to and modifies these as data are explored.

Option c was selected for this project due to a clear aim to produce specific recommendations for the service and explore three areas of interest for them, in addition to exploring emergent themes from the data. In this sense, the epistemological position taken was that there would be information and truths based on the questions asked that could be captured within the *a priori* themes, but also additional data to be interpreted to give further insight into the families' experiences of working with BIS.

*A priori* themes are tentative and, like emergent themes, may be redefined or removed in the process of analysis. The three *a priori* themes developed based on the service's aims for the project and existing evidence included the following:

1. Treatment outcomes.
2. Areas for potential improvement.
3. Things that were working well.

In template analysis codes are developed with a hierarchical order, so that similar codes cluster together to produce higher-order codes (King, 2004). The initial template was produced by combining the *a priori* themes with emergent themes from a subset of the data (two interviews). This was then revised as more interviews were analysed, to ultimately produce the themes and sub-themes outlined in the Results section.

Transcription and analysis were undertaken by the first author with supervision from the second author and a course tutor.

## Results

Table 1 presents the demographics of the young people included in the study. All nine young people had been referred to CAMHS by their general practitioner. Eight participants reported waiting one month or less for their first appointment; one participant reported waiting five months. The nine clients worked with three clinicians from BIS team. The self-reported length of contact with the team ranged from two to 10 months (mean 4.33 months). Two of the young people had worked with CAMHS before. Data were not available on the waiting time of those who did not opt in to the study.

## Satisfaction

Clients were asked about their satisfaction with the service. One hundred per cent of those interviewed reported that they felt respected by their clinician. Eight of the nine interviewed said that they would recommend the service to a friend, and two already had. The young person who responded that she would not recommend the service

Table 1 Demographics of the Young People Included in the Study

Family	Age of child	Gender	Referral reason	Family members interviewed
A	11	Male	ASD assessment	Father
B	14	Male	Anger	Mother and child
C	5	Male	ASD assessment	Mother and father
D	16	Female	Anxiety	Child
E	13	Female	Behavioural difficulties	Child
F	16	Male	Anger	Mother
G	11	Male	ASD assessment	Mother and child
H	13	Female	Complicated grief	Mother and child
I	9	Female	Anxiety	Mother

Note: ASD, autism spectrum disorder.

felt that others would find it helpful, but thought she lacked the confidence to make a recommendation because she would find it anxiety-provoking.

### A Priori Themes

#### *Treatment outcomes*

The interview included a number of questions surrounding treatment outcomes observed by the families, including changes in the young person's development and behaviour, family life, family relationships, and meeting the family's needs and expectations. All nine families reported noticeable improvements in the child and/or the family.

*Noticeable changes in the young person.* Noticeable changes in the young person included gained skills, and a reduction in previously problematic or distressing behaviours and emotions:

He's gained a lot of confidence, and that confidence has stayed. (Father of Young Person A)

It really helped me get back on track. I was getting mad every day. I couldn't sleep. (Young Person B)

All my friends and my family have seen a difference in me ... I'm more outgoing. (Young Person D)

Now she knows that she can speak out she feels now that she can get herself understood. (Mother of Young Person I)

*Noticeable changes in the family.* Those changes reported in the wider family included increased positive emotion and reduced negative emotion:

We're happy! ... We're a lot more content, a lot more happy. A lot nicer, a lot more relaxed, a lot more laid back, we have a lot more fun. (Mother of Young Person C)

We sit and talk more. We do more things together. Because I [mum] haven't got all that tension. (Mother of Young Person D)

It's given me an answer because we always knew and we were always fighting for [young person] ... It was a big relief getting that diagnosis. (Mother of Young Person F)

We didn't [think about the future] before. We had no end of problems. (Mother of Young Person B)

None of the clients included reported negative outcomes from the intervention. However, one parent reported his disappointment with the extent of the improvement he noticed:

He's now enjoying going out, but when all's said and done he's going out to play with 4, 5, and 6 year olds and he's 11 ... He is enjoying it ... so yes it's improved his quality of life but to be honest it's not the development of an 11 year old. (Father of Young Person A)

### *Areas for potential improvement*

Areas for potential improvement were directly explored through questions related to whether the family felt that they had received the service they needed, challenges or difficulties that the family faced during their engagement, whether the service was helpful, and direct suggestions for improvement. In addition, themes emerged from reports of unpleasant experiences of the service that may have emerged from other questions in the interview. The sub-themes included problems with access to the service (reported by eight clients), feeling that the focus of the work was unhelpful (two clients), poor communication (three clients), ongoing support (five clients), and environmental factors (two clients).

*Problems with access.* When asked about their referral into the service, clients reported difficulty finding out which service they should access and how to do so:

I didn't know about the service until somebody else said "Go to the doctors" ... I think you need advertising to let people know that this service is available for people with problems with young children ... In the doctors', when you go to the midwives or the children's unit. (Mother of *Young Person F*)

They reported difficulty with having their concerns taken seriously or obtaining a referral due to restrictions on which services were able to make referrals to CAMHS:

I remember saying "why do we have to go to the doctor? This is ridiculous" ... the doctor hadn't seen all the things that [the autism support worker] had seen ... but they weren't allowed to refer. (Mother of *Young Person F*)

Since [young person] was born we always knew there was something there. We took him to the doctors and we got fobbed off, and we talked to school and got fobbed off ... We finally got the diagnosis but we had to fight for that through CAMHS as well. (Mother of *Young Person F*)

*Feeling that the focus was unhelpful.* The families were asked about what their goals and expectations for the service had been, as well as what they had found helpful and unhelpful. Some clients reported their disappointment in the focus of their work with BIS:

There was too much emphasis put on post-traumatic stress and the things that had happened in the past ... these problems are more deep rooted and a lot more years ago. (Father of *Young Person A*)

They blamed us for bad parenting ... They said we had marital issues ... They said I had mental health issues. (Mother of *Young Person C*)

*Poor communication.* Communication was not directly raised during the interview; however, when considering the relationship between the clinicians and the families, and potential improvements that could be made, some clients felt that clinicians should have made explicit efforts to maintain communication with them throughout the process:

I think that there wasn't enough contact through the whole process ... us having to ring them all the time ... there could have been more contact between appointments just to check how things were. (Mother of Young Person C)

I think there should be more time for parents to discuss what's going on ... things were changing each week ... but I didn't get much chance to explain that because [young person] was going in for his one-to-one. (Father of Young Person A)

Other clients felt that there were wider problems with the communication between BIS and wider health and education services working with young people:

The problems are a lot more deep rooted than what we've got in this building ... it's the full structure. (Father of Young Person A)

*Ongoing support.* A number of clients expressed their wish to have had some ongoing communication with the service following their discharge. For some, this was because their therapy felt too short:

I felt with [clinician] I was getting all the support I needed, but I needed more than I was able to get in that six week period. (Young Person H)

However, others simply felt that keeping the channels of communication with the service open would have been beneficial in the longer term:

I wish there'd been a follow-up ... he [young person] could have made an appointment just for an informal session. Just to chat to somebody, just to help him out. (Mother of Young Person B)

I think it would be nice to have a follow-up ... A few months down the line just to have a little visit to see how they think she [young person] has changed ... Just to look back at all the bits she's done from then to now. (Young Person D)

*Environmental factors.* Two clients made suggestions for how the environment of the service could be improved:

Some things on the wall ... to make it a bit more friendly. (Young Person D)

It would be nice instead of being in a room every time if you could walk outside sometimes. (Young Person H)

### *Things that were working well*

The things that were working well were targeted through questions that explored whether the families agreed with their referral reasons, the relationship between the clinicians and the families (e.g. whether the family felt understood and respected by their clinician), things that the families found enjoyable or easy, and things that families were able to identify as helpful about the service. The results could be divided into two sub-themes: positive experiences of the service; and useful components of the work. The factors that contributed to positive experiences of the service are presented in Table 2. The useful components of the interventions that were highlighted by the clients are indicated in Table 3.

Table 2 Positive Experiences

Factor	Example
Enjoyment	"He [young person] did enjoy coming and he did enjoy talking about it ... he used to love coming" (Father of Child C)
Feeling heard	"I felt like I could tell her [clinician] anything. If I wasn't happy about something I could tell her ... she knew when I wasn't happy" (Child H)
Good relationship with the clinician	"She [clinician] didn't speak to me like she was an expert. She just spoke to me like somebody who would listen to whatever I had to say" (Child H)
Environment	"I didn't imagine it [CAMHS] being so open. I expected her [clinician] to be at a desk ... It's nice and casual ... With the children's toys and the comfy chairs you don't feel tense or uncomfortable. It's a family atmosphere" (Child D)

Table 3 Useful Components of the Work

Component	Example
Books	"We did the books ... he's [young person] still got them at home and if he needs them we have a look through" (Mother of Child B)
Talking	"You could just let out your feelings. It's not like you had to talk to a parent or something" (Child D)
Opening doors to other services	"I went on a course ... and it opened my eyes up ... and that has had a big impact on me" (Mother of Child F)
Learning skills	"Amazing ... they've sort of taught him [young person] his emotions ... he couldn't understand expressions on people's faces" (Mother of Child C)
Having goals and structure	"She [clinician] explained every week what we were going to do in future weeks and that was good" (Child D)

### *Emergent Themes*

In addition to the *a priori* themes, the following themes emerged from the interviews.

#### *Emotional experience*

Three clients expressed that participating in an intervention was a difficult emotional journey:

It was quite an emotional rollercoaster ... It was quite tough ... Sometimes you don't want to re-live what's happened. (*Mother of Young Person C*)

It was a journey. It was like a rollercoaster, I did have ups and downs. But luckily ... I'm on an up now and hopefully that can help me in the future. (*Young Person D*)

These comments emerged when participants were asked to summarise what happened while they were engaged with the service, and also when they were asked to consider what had been challenging or difficult about the experience.

### *Managing practical barriers*

When asked what they had found easy and enjoyable about the service, four clients spoke about being faced with and overcoming practical barriers to attending sessions:

Just being able to ring up and change appointments if necessary [was easy].  
(Mother of Young Person G)

I thought at the time that I would get in trouble with school ... but then [clinician] explained that because it was CAMHS school were ok ... then I didn't worry anymore. (Mother of Young Person I)

### Discussion

The young people and families reported feeling satisfied with a number of their experiences of the service, and also made specific recommendations for how it could be improved. In line with the aspirations detailed in "New Horizons" (Department of Health, 2009), families reported developing a better understanding of their child, and improved functioning for the young person and their family. Families and young people reported noticeable changes in the young person themselves, such as increased confidence, increased skills, and decreased symptoms, as well as noticeable changes in the family as a whole, including improved communication, increased understanding of their child, and increased happiness. These findings are consistent with the existing literature exploring short-term therapy with young people (Heywood et al., 2003; McGarry et al., 2008; Stallard & Sayers, 1998; Wood et al., 1996) that indicated a reduction in difficulties as a consistent outcome.

Exploring families' positive experiences of the service led to them describing enjoyment of the work, feeling heard by the clinician, developing a good relationship with the clinician, and the positive aspects of the environment, such as reduced formality. These factors contributed to their feelings of satisfaction, and their sense of feeling respected by the clinicians.

In relation to the outcomes of the national CAMHS review Children and Young People in Mind (Department of Health, 2008), the time between referral and the first appointment was short (the majority of first appointments being within one month), indicating an improvement in internal waiting times. In addition, the families commended the way in which practical barriers were managed by the service, such as negotiating time away from school, and flexibility with appointments, both of which made the service more accessible. However, the areas for potential improvement reported by the families included problems accessing the service, such as a lack of awareness in external services about the nature of BIS or CAMHS, and potential referrers declining to make a referral. This indicates that there are still improvements which can be made to ensure that the service is swiftly accessible so that it can serve a preventative and early intervention role. This may also indicate that there could still be inequalities in accessing the service depending on whether families are persistent, whether their local services, such as general practitioners, are up to date on referral

criteria, and whether they access services that are able to make direct referrals to CAMHS.

Some families reported feeling that the focus of the work was unhelpful; for example, it dwelled too much on past difficulties, or focused too heavily on parental well-being.

Finally in relation to the CAMHS review recommendations, families reported regular contact involving a number of components of the work that they had found useful, including the use of books, talking about feelings, opening doors to other services, learning new skills, and having goals and structure within the work. Parents felt that this could be improved by increasing communication between the parents and the clinician when a young person was having individual work. Existing research on parental involvement in therapy for young people reports the impact of parents as collaborators and co-therapists in terms of better adherence to intervention (e.g., Mendlowitz et al., 1999; Nock & Ferriter, 2005; Nock, Phil, & Kazdin, 2001), and greater reduction in psychopathology and longer term improvement (e.g., Kendall, 2006; Mendlowitz et al., 1999), but that parental involvement can also impact upon therapeutic alliance positively or negatively (e.g., Shirk & Karver, 2003).

One emergent theme was the families' emotional experience of BIS. Families described the therapeutic process as a "rollercoaster", with very difficult times. This may reflect a common experience of the journey through therapy. Indeed there is evidence to suggest that recovery is a non-linear process involving peaks and troughs (e.g., Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

### *Clinical Implications and Future Research*

The feedback from the families made it clear that communication both within the service and with external services needs to be considered. In particular, referral pathways need to be clarified to ensure that appropriate referrals are not lost, and to ensure that appropriate external services refer to CAMHS. In addition, it may be beneficial to provide publicity in the local area regarding the service offered by CAMHS for the attention of health and education professionals as well as parents and young people. Whilst BIS aimed to improve access to services for low-risk clients, this lack of communication in the referral pathway may undermine this.

One challenge facing modern services is a lack of resources. Whilst there is evidence from this evaluation that short-term therapy can help to alleviate psychological difficulties, participants also reported disappointment related to a lack of ongoing support, including both follow-up and availability for less formal contact.

Clients reported struggling with the therapeutic process, including the peaks and troughs of their recovery, ending the work, and a desire for follow-up or extended work. Whilst the beginning and ending of therapy is often challenging, this raises clinical implications for the beginning of therapy—such as the importance of providing clear information in order to gain informed consent and to prepare the young people and their families as to what to expect, and contracting processes surrounding the information that will be shared between the clinician and parent(s)

(British Psychological Society, 2006), and implications for ending therapy, such as the need to prepare for the ending early on in a short piece of work (Haworth & Gallagher, 2005). This feedback may be helpful for the service in considering whether their current methods of providing information are sufficient.

The majority of the feedback was hugely positive, and predominantly focused on the attitudes of the clinicians and their relationships with the clients. It is important that the noted flexibility and the non-threatening environment of the service are maintained to ensure that it remains accessible to clients. Further exploration should be conducted into what it is that helps clinicians to maintain their positive work ethos. For example, is this supported by resources offered by the service (e.g. the size of case loads, supervision), supported by the atmosphere within the workplace (e.g. respect, peer support), or due to individual qualities of the clinicians? Exploring this will enable the service to maintain such factors to ensure ongoing high-quality interventions by maintaining the level of resources currently provided in the pertinent areas. This is particularly important because, at the time of publication, significant changes have been made to the structure of the service which means that clinicians may be working across multiple pathways. This will result in changes to their teams, changes to the nature of their clients' presenting problems, and physical moves around the building in which they are situated.

In terms of implications for research, it is evident that participants were able to identify and articulate the components of the work and the service that were important to them and that they wish to be maintained or improved. There was also evidence in support of Thornicroft and Tansella (2005) that these priorities differed in part from those held by the clinicians; for example, families felt frustrated with the focus of the work and concerned about ongoing support. This demonstrates the value of service user participation in service evaluation and planning.

### *Limitations*

The issues surrounding representativeness of the sample were as follows: because interviews took place at CAMHS, it is possible that those service users who did not have a pleasant experience of working with the team may not have wished to return to be interviewed, potentially leading to a skew towards more positive feedback. It was hoped that this would be reduced by the interviewer being external to the service, and this was made clear in the information sheet. Only families who completed an intervention were interviewed, and thus it was not possible to ascertain reasons for non-completion. This may have been a useful source of information regarding what is not working well in the service. Data were also not collected regarding the demographics of those participants who were eligible to participate but did not opt into the evaluation. Therefore it is not possible to comment on the representativeness of the final sample.

Willig (2008) emphasises the importance of personal reflexivity in qualitative research, encouraging the investigator to think about how their involvement with the study impacts on their interpretation of the data. This project involved a team that

the interviewer worked alongside during training. This positive experience may have led to a confirmation bias in which the positive feedback was attended to more readily than negative feedback despite attempts to work objectively with the data. Additional quality control procedures would have added to the quality of this evaluation. For example, it would have been helpful to double code the transcripts in order to be able to assess inter-rater reliability. The results of the evaluation were fed back to the clinicians in the whole CAMHS service by a presentation and a report. The clinicians felt that the themes had face validity as they reflected their own experiences of the challenges and benefits of the brief intervention service, as well as the experiences of their clients. It may also have been helpful to incorporate quantitative measures of symptoms and well-being to compare any change in these with the themes. However, because this was an evaluation after the time of therapy, routine outcome measures were not available.

The use of a semi-structured interview with direct questions regarding service users' experiences of the service may have led to a bias in their responses due to social desirability effects and constraints imposed by the wording. For example, asking the question "What were your hopes for working with the service?" evokes an answer exploring goals and expectations. An alternative method may have been interpretative phenomenological analysis, which uses broad questions in the interviews enabling the emergence of themes whilst following a similar method of analysis (King, 2004; Smith & Osborn, 2008); however, this would not have enabled the direct exploration of questions pertaining to the service's interests. Alternatively a postal questionnaire that enables anonymity to the investigator may have yielded a wider range of responses, although this method is also vulnerable to social desirability effects and low response rates. Another alternative may have been to use a mixed-methods approach that incorporated quantitative data routinely collected by the service, such as satisfaction ratings and attendance records.

## Conclusion

This evaluation demonstrated that, from a user perspective, brief intervention can lead to high satisfaction and positive treatment outcomes for young people and their families.

In relation to their experience of a brief intervention for a range of presenting difficulties, families reported noticeable changes in the young person's well-being and their family functioning. All families reported feeling respected by their clinician and reported noticeable changes. Positive feedback related to when communication did work well and relationship-building with clinicians as well as the flexibility and accessibility of the service and some specific components of the interventions. Areas that were unsatisfactory predominantly related to communication between the family and the service, and between the service and external services. Whilst participants reported positive and enjoyable experiences, they also acknowledged that the journey through the intervention could be emotionally challenging.

Overall this article provides support that a brief intervention service for early intervention and less severe and complex mental health difficulties can reduce waiting

times and lead to positive clinical outcomes, and should continue to have a place in community mental health services for young people.

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