



## RESEARCH ARTICLE

# Factors Associated with Parental Satisfaction with a Pediatric Crisis Clinic (PCC)

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## Abstract

**Introduction:** Little is known about parental satisfaction with pediatric crisis clinics (PCCs) that provide a single consultation to families in need of urgent psychiatric care. Parental satisfaction may improve long-term adherence to physician recommendations. **Objective:** To explore parental satisfaction with a PCC. **Methods:** Parental satisfaction was ascertained by a structured telephone interview following crisis consultation at the PCC of an academic, tertiary care centre. **Methods:** Parents of 71% (n = 124) of 174 pediatric patients seen in the PCC from 2007-2008 participated in the post-consultation interview. Results: The majority of parents stated they were either somewhat satisfied (49/122, 40.2%) or very satisfied (49/122, 40.2%) with the PCC. Parental satisfaction correlated with time between referral and consultation (p<0.05), the degree to which parents felt listened to by the consultant (p<0.01), the amount of psychoeducation parents felt they received (p<0.01), and appointment length (p<0.001). **Conclusions:** Parents were satisfied overall with an urgent care service model. Satisfaction was correlated with the time between referral and consultation, degree to which they felt their consultant had listened to them, and the amount of information they received at the consultation's conclusion.

**Key Words:** child psychiatry, consumer satisfaction, referral and consultation, psychiatric emergency services

## Résumé

**Introduction:** Nous en savons peu sur la satisfaction parentale quant aux cliniques d'urgence pédiatrique (CUP) qui offrent une consultation unique aux familles nécessitant des soins psychiatriques urgents. La satisfaction parentale peut améliorer l'observance à long terme des recommandations du médecin. **Objectif:** Explorer la satisfaction parentale quant à une CUP. **Méthodes:** La satisfaction parentale a été évaluée par une entrevue téléphonique structurée par suite d'une consultation d'urgence à la CUP d'un centre de soins tertiaires universitaire. Les parents de 71% (n = 124) des 174 patients pédiatriques vus à la CUP depuis 2007-2008 ont participé à l'entrevue de post-consultation. **Résultats:** La majorité des parents ont déclaré qu'ils étaient soit plus ou moins satisfaits (49/122, 40,2%) soit très satisfaits (49/122, 40,2%) de la CUP. La satisfaction parentale corrélait avec le temps écoulé entre l'aiguillage et la consultation (p<0,05), le degré auquel les parents se sont sentis écoutés par le consultant (p<0,01), la quantité de psychoéducation que les parents ont cru recevoir (p<0,01), et la durée du rendez-vous (p<0,001). **Conclusions:** Les parents étaient généralement satisfaits d'un modèle de service de soins d'urgence. La satisfaction était corrélée avec le temps écoulé entre l'aiguillage et la consultation, le degré auquel ils ont senti que le consultant les avait écoutés, et la quantité d'information qu'ils ont reçue au terme de la consultation.

**Mots clés:** pédopsychiatrie, satisfaction des consommateurs, aiguillage et consultation, services d'urgence psychiatrique

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Submitted: September 13, 2013; Accepted: March 5, 2014

## Introduction

Increasing numbers of pediatric psychiatric patients are presenting to emergency departments (EDs) for psychiatric care (Ayliffe, Lagace, & Muldoon, 2005; Breslow, Erickson, & Cavanaugh, 2000; Edelson, Braitman, Rabinovich, Sheves, & Melendez, 2003; Page, 2000). Presenting complaints often include psychosis, suicidality, and self-harm (Lee & Korczak, 2010; Mattsson A, 1967; Nadkarni, Parkin, Dogra, Stretch, & Evans, 2000). As wait lists and referrals for consultations by child and adolescent psychiatrists (CAPs) increase, the ED may be utilized as a back-door entry point into mental health systems (Oyewumi, Odejide, & Kazarian, 1992). Sadka (1995) suggests that the emergency department is often the point of first contact with the mental health system for pediatric psychiatric patients.

Many models of emergency psychiatry exist (Breslow et al., 2000; Feiguine, Ross-Dolen, & Havens, 2000; Gillig, 2004; Larkin & Beauvais, 2010; Parker et al., 2003; Sullivan & Rivera, 2000). In a traditional model, pediatric patients deemed appropriate for psychiatric assessment following assessment by a pediatric emergency physician (PEM) are referred for emergent psychiatric assessment by an on-call psychiatrist or CAP. Emergency assessments are completed and disposition decisions made entirely within the ED. This model may be accompanied by some disadvantages including: 1) prolonged data gathering, often during evening and weekend hours when sources of collateral information such as family members, pediatricians, or other health professionals are frequently unavailable and (Dennis, Beach, Evans, Winston, & Friedman, 1997; Nadkarni et al., 2000); and, 2) child and parent fatigue, leading to potential omission of key data by weary parents or lengthier interviews with drowsy children (Nadkarni et al., 2000).

An urgent referral model is one alternative that addresses the aforementioned disadvantages (Parker et al., 2003). Within this model, patients presenting to the ED requiring urgent, but not emergent, psychiatric assessment are provided a follow-up CAP appointment within 24-72 hours of discharge from the ED (Lee & Korczak, 2010; Parker et al., 2003). One group found that implementation of this “rapid response model” in Kingston, Ontario, shifted consultations from weekends and evenings to weekdays, improving psychiatric and nursing staff satisfaction (Parker et al., 2003). For patients presenting in crisis, this urgent care model offers an alternative to immediate on-call assessment, or the other previous alternative – that of a costly admission (Breslow et al., 2000) – while ameliorating the challenges associated with data-gathering during weekend and evening call-shifts. Blumberg (2002) found that the initiation of a crisis program significantly decreased the average number of hospital beds utilized, and generated savings of approximately \$20,000 per year. Of the 726 children referred for crisis intervention, none harmed themselves or others after starting treatment. Of the 465 that were deemed at risk of

hospitalization, 11 (2.4%) were referred for hospitalization and 27 (5.8%) were referred for outpatient treatment. However, to our knowledge, few studies have explored direct benefits to patients with this model of care.

It is now believed that 50% of adult psychiatric disorders have their onset in adolescence (Belfer & Saxena, 2006). A positive interaction with psychiatric professionals and adequate adherence may decrease morbidity in later years (Hawley & Weisz, 2005; Kazdin, Whitley, & Marciano, 2006). As parents are usually responsible for bringing pediatric patients to appointments (Nock & Ferriter, 2005), parental satisfaction may: (i) impact patient attitudes regarding future psychiatric care; and, (ii) influence the degree to which young patients adhere to treatment recommendations. Though previous work has explored factors associated with parental satisfaction in the context of inpatient psychiatric consultation (Kitts et al., 2013) and outpatient community care (Garland, Haine, & Boxmeyer, 2007; Hart, Kelleher, Drotar, & Scholle, 2007) little is known about parental satisfaction with an urgent referral model. Parent-provider communication (Hart et al., 2007; Kitts et al., 2013), provision of impressions and recommendations (Kitts et al., 2013), and greater number of outpatient sessions (Garland et al., 2007) have all been associated with enhanced parental satisfaction. In a sample of hospital-based psychiatric consultations to patients admitted to medical and surgical floors, high parental satisfaction was strongly correlated with high ratings of consultant-participant communication and working relationship, provision of impressions and recommendations, and helpfulness of the consultation intervention (Kitts et al., 2013). We know of no studies that have examined parental satisfaction in the context of an urgent referral model. The objective of the present study was therefore to explore parental satisfaction with a pediatric psychiatric urgent referral service using a retrospective telephone survey. We hypothesized that parents would be satisfied with crisis consultation services and that their satisfaction would be associated with perceived consultant attentiveness, amount of information provided, and greater consultation length.

## Methods

### Participants

Approval for this study was obtained from the Research Ethics Board of the Hospital for Sick Children (HSC), Toronto, Ontario. The Pediatric Crisis Clinic (PCC) is situated within an urban, academic, tertiary care centre that serves roughly 50,000 pediatric patients and their families annually. Patients referred for consultation by pediatric emergency physicians (PEM) for psychiatric assessment are given an appointment to be seen within 72 hours, and frequently within 24-48 hours of referral. Parental attendance at the consultation is required. All patients seen from May 2007-April 2008 and the parent who had accompanied

them to the PCC were included without exclusion within the study. Parents received a mailed letter describing the study. Parents were subsequently invited to participate by telephone by one of the authors (JL). At the time of telephone contact, a structured description of the purpose of the study, including the goal of ascertaining parental satisfaction or dissatisfaction with the PCC, was described (script appended). Parents were given the opportunity to ask any questions they had about the study, the responses to which were non-standardized, prior to providing their informed verbal consent to participation.

### Measures

Data regarding parental satisfaction with the PCC were explored with a 17-item structured telephone interview of patient's parents 4-12 months following PCC assessment. The questionnaire was adapted from the Quality of Care Parent Questionnaire (Ygge & Arnetz, 2001), a 63-item instrument used to measure parental views of pediatric hospital care that includes questions about receipt of information about ward routines and illnesses, accessibility of care, medical treatment, caring processes, and staff attitudes. As our study involved parents of outpatients seen for a single consultation, using a brief telephone interview, we adopted a subset of items regarding the receipt of information-illness, treatment provision, caring processes, and staff attitudes for inclusion that were most relevant to the study sample. Parents were asked to rate their experiences of time between referral and consultation, consultant professionalism, appointment length, the degree to which they felt their consultant listened, the amount they learned, and overall helpfulness and satisfaction of the consultation on a 5-point Likert scale. Anchors varied depending on specific questions, but ranged from 1 = very negative to 5 = very positive. For example, when asked about their global satisfaction, parents responded 1 = very dissatisfied, 2 = somewhat dissatisfied, 3 = neither dissatisfied nor satisfied, 4 = somewhat satisfied, to 5 = very satisfied. Parents were also asked whether they had "followed through" with the recommendations made by the consultant in the time since consultation. Psychometric properties of the questionnaire are unavailable. Demographic data and consultation visit data, including PEM reasons for referral, Axis I, and disposition (admission to hospital, referral to community agencies, outpatient psychiatric follow-up), were collected and subsequently verified by hospital chart review by one of the authors (JL).

### Analysis

Descriptive statistics (means and proportions) were used to determine the prevalence rate of psychiatric illness within the study sample and to report age, sex, mean satisfaction and helpfulness ratings, and participant disposition following assessment. Categorical definitions of psychiatric disorder were utilized for descriptive comparisons.

To explore parental satisfaction, multiple regression analyses were conducted for parental ratings of wait time between emergency and PCC consultation, the degree to which they felt their consultant had listened to them, the amount they felt they learned, whether at least one recommendation post-consultation was followed, and the length of their appointment. Appointment length was entered as a dichotomized variable into the regression. Participant variables of age, sex, psychiatric diagnosis, and disposition following assessment were included as covariates. In order to increase the power to detect differences between groups, and limit the number of independent variables tested within the regression analysis, psychiatric diagnoses were categorized as follows: mood and anxiety disorders were considered "internalizing disorders" whereas attention-deficit hyperactivity disorder, oppositional defiant disorder, and conduct disorder were considered "externalizing disorders." Data were analyzed using SPSS v.16.

### Results

One hundred and seventy-four (174) patients were referred for CAP consultation and seen at the PCC during the study period. No discrepancies were found between data in the database and information contained in patients' charts upon review. Of the 174 patients assessed, 124 (71%) parents consented to participate in the follow-up telephone interview. Demographic information, reasons for referral, and mean satisfaction ratings are presented in Table 1. Data describing the psychiatric diversity, comorbidity, and disposition of the study sample have previously been reported (Lee & Korczak, 2010). The mean age of patients was  $12.2 \pm 3.2$ . Sixty three percent of the referred patients were male ( $n = 110$ ). The most frequent reasons for referral were suicidality and aggressive behavior (Lee & Korczak, 2010). Factors associated with parental satisfaction are presented in Table 2. The majority of parents stated they were either somewhat satisfied (49/122, 40.2%) or very satisfied (49/122, 40.2%) with a minority stating they were somewhat dissatisfied (8/122, 6.6%) or very dissatisfied (7/122, 5.7%). Two parents declined to give an opinion regarding their satisfaction with PCC services.

Parental satisfaction was associated with the degree to which parents felt listened to by consultants ( $p < 0.01$ ), the amount learned from the consultation ( $p < 0.01$ ), time between referral and consultation ( $p < 0.05$ ), and appointment length ( $p < 0.001$ ) (Table 2). Patient age, sex, diagnosis, and disposition (hospitalization, return to primary care physician, academic child psychiatrist, community psychiatrist, private therapist, community agency, or none) following psychiatric assessment were unrelated to parents' ratings of the satisfaction with the consultation. Satisfaction with the CAP consultation was associated with adherence to treatment recommendations ( $p < 0.05$ ; Table 2). Fifty-two (41.9%) of the parents stated they had implemented at least one recommendation made by their consultant. Of the 63

**Table 1. Descriptive analysis of patients seen in the PCC during the study period and parental ratings of satisfaction**

	Mean (SD)
Age	12.2 (3.2)
Satisfaction	3.4 (1.4)
	N (%)
Male	110 (63.2)
Referral for suicidality	45 (25.8)
Internalizing d/o <sup>a</sup>	60 (34.5)
Externalizing d/o <sup>b</sup>	36 (20.7)

<sup>a</sup> Internalizing d/o – mood or anxiety disorder  
<sup>b</sup> Externalizing d/o – disruptive behavior disorders

(50.8%) parents who did not, 19 (30.2%) stated they were still on a waiting list, three (4.8%) stated they felt the recommendations would not be useful, 12 (19.0%) stated they had trouble accessing the recommended resources, three (4.8%) stated they had tried what was recommended but did not find it helpful, 11 (17.5%) stated they found something other than was recommended, five (7.9%) stated the patient got better on his/her own, and 25 (39.7%) had other reasons for non-adherence (for example, the family decided to continue seeing a previous therapist). Nine parents declined to respond to whether they had implemented recommendations.

## Discussion

Seventy-one percent of parents seen in the PCC during the study period consented to being interviewed. With regard to our first hypothesis that parents would be satisfied with this model of care, we found that the majority of respondents were satisfied with the consultative process. It is possible that the non-respondents represented a non-random subset of the sample and might have responded less favorably. Nonetheless, some work has suggested that achieving lower non-response rates does not necessarily result in significantly different estimates (Groves, 2006).

The degree to which parents felt their consultant had listened to them was predictive of their satisfaction with service. It is possible that parental responses to this question reflected a measure of therapeutic alliance. This finding that degree of parent-rated listening predicted ratings of satisfaction agrees with previous research with adult patients with bipolar disorder (Sylvia et al., 2013), unipolar depression (Klein et al., 2003), and schizophrenia (Fenton, Blyler, & Heinssen, 1997), that found patient satisfaction and a good patient-provider relationship improve adherence to treatment recommendations and outcomes. In addition, work with pediatric patients undergoing family therapy

has found that higher therapist-parent alliance is associated with greater reductions in problem behavior among youth (Hogue, Dauber, Stambaugh, Cecero, & Liddle, 2006). More recent work with children participating in a treatment program for oppositional behavior (Kazdin et al., 2006), and those receiving care in a general outpatient clinic (Hawley & Weisz, 2005), has also suggested that the parent-provider relationship is independently implicated in treatment outcomes. These studies, however, have focused on longitudinal relationships with therapeutic alliances constructed over time, in comparison to the present study, in which psychiatric care consisted of a single point of contact at the time of consultation. In contrast to previous work in pediatric rheumatology clinics that has suggested parental satisfaction correlates with diagnoses given (Aasland, Flatø, & Vandvik, 1998) parental satisfaction in the present study was associated with neither diagnosis nor disposition, but rather parental ratings of CAP communications. It is possible that parents of children in this sample were more interested in specific advice regarding how to improve their child's circumstance than specific diagnoses.

In addition to feeling as though their psychiatrist had listened to their concerns, this study finds that the amount of information gleaned from the consultation was also predictive of parental satisfaction. These data are in keeping with those reported by Kitts et al. (2013) in an inpatient setting who found that the satisfaction of young adults and parents seen by a psychiatric consultation service was significantly associated with the receipt of psychiatric impressions and recommendations. Thus, apportioning time at a consultation's conclusion specifically for psychoeducation of patients and their families regarding their diagnoses and suggestions for further care may augment the parent-provider alliance and improve adherence to treatment recommendations.

Finally, parents who found the length of the appointment acceptable were also more satisfied overall with their consultation experience. Parents may have interpreted appointment length as a measure of CAP caring, reflecting a genuine wish on the part of the CAP to understand, listen to, and care for their child. Simply having their expectations of appointment length be met may also have contributed to parental satisfaction. Gerkenmeyer, Austin, and Miller (2006) developed a consumer satisfaction model for parents of pediatric psychiatric inpatients and outpatients. Within this framework, meeting parental expectations (what parents anticipated over the course of their care), but not necessarily their desires (what parents wanted and hoped to see from their providers), was predictive of parental satisfaction. This research suggests that providing parents with information regarding the consultation objectives prior to the appointment may augment parental satisfaction by setting tenable expectations before a crisis consult.

Although many parents reported difficulty with implementing recommendations made by their consulting CAP,

**Table 2. Multiple regression of patient age and sex; parental ratings of time to consultation, degree of consultant listening, and degree of psychoeducation (amount learned during consultation); patient diagnoses; and disposition on overall parental satisfaction with urgent psychiatric consultation. N = 124.**

	B	SE B	$\beta$	p
Age	0.04	0.04	0.07	0.67
Sex	0.11	0.26	0.03	0.67
Time to consultation	0.65	0.38	0.30	0.04*
Degree to which consultant listened	0.91	0.30	0.25	<0.01*
Appointment length	1.30	0.26	0.44	<.001*
Psychoeducation	1.37	0.27	0.45	<0.01*
Internalizing d/o <sup>a</sup>	0.01	0.23	0.001	0.96
Externalizing d/o <sup>b</sup>	0.19	0.40	0.03	0.55
Adjustment d/o	0.22	0.32	0.04	0.58
Disposition	1.16	0.68	0.14	0.09
Adherence <sup>c</sup>	1.06	0.52	0.35	0.04*

R<sup>2</sup> = 0.453  
 \*p<.05  
<sup>a</sup> Internalizing d/o – mood or anxiety disorder  
<sup>b</sup> Externalizing d/o – disruptive behavior disorders  
<sup>c</sup> Adherence – follow through with one or more recommendations post-consultation

parents who were satisfied with the consultation were more likely to follow through with the recommendations suggested. Of those who had not implemented a suggestion a large proportion stated they were either on a waiting list or had had trouble accessing the resources suggested. These data point to systemic influences in addition to satisfaction effects that each affect treatment adherence. A small proportion of parents felt the recommendations made would not be helpful or that the CAP was unclear. It is possible that adherence among this subset of parents could have been augmented with time addressing parental concerns and providing psychoeducation.

This study has a few main limitations. First, child or adolescent sex and sociodemographic factors (Godley, Hedges, & Hunter, 2011; Rossi et al., 2008) may influence satisfaction with psychiatric services. In a study reporting satisfaction with a community based mental health program, Godley et al. (2011) found that male, African American adolescents were significantly more satisfied than Caucasian adolescents despite being comparable in days absent from school, psychiatric burden, and rates of substance abuse at follow-up. In contrast, however, Kitts et al. (2013) found no influence of age, race/ethnicity, gender, or living situation on overall satisfaction level with an inpatient psychiatric consultation service. As the present study did not collect data on participant race or ethnicity, we are unable to comment on their potential impact in this context. However, given the multicultural composition of the Greater Toronto Area from

which the emergency department receives children and adolescents, it may have been useful to ascertain whether ethnicity influenced global satisfaction.

In addition, once adapted, the questionnaire utilized in this study can no longer be presumed to have the reliability and validity properties of the original measure. Moreover, while the original questionnaire was developed for inpatients, a subgroup of patients exposed to multiple therapeutic contacts and educational opportunities over time, the present study sample was restricted to patients and family members seen by a CAP on one occasion. Thus, extrapolation of the population sample to the present study may not be reflective of the original validation sample.

Finally, the interval between PCC consultation and interview was not standardized. Therefore the potential exists for recall bias to affect patients differentially based on time from consultation. In addition, it is possible that some respondents were influenced by an acquiescence or social desirability bias, such that their responses were unduly favorable in order to please the interviewing study author (Groves, 1990). Previous work has found that patients underreport symptoms when interviewed by telephone in comparison to mailed surveys, possibly as the result of a social desirability bias (Brewer, Hallman, Fiedler, & Kipen, 2004). Therefore, it is possible that these findings overestimate the overall satisfaction with care. Nonetheless, the lack of an ongoing relationship with the service of inquiry may diminish this likelihood somewhat.

This study suggests that parents of pediatric patients are satisfied with an urgent care model. It is, to our knowledge, the first study to explore parental satisfaction with service delivery for children and adolescents referred for urgent crisis consultation. Several key variables associated with parental satisfaction were identified including: reduced wait time to consultation, the degree to which consultants were perceived to be listening to parental concerns, and the amount of information provided during the consultation. Parental satisfaction was correlated with adherence to CAP recommendations. Awareness of these factors may be important for clinicians in order to enhance the effectiveness of crisis consultation.

## Conclusion

Parental satisfaction was associated with the degree to which parents felt their psychiatrist listened to them, the amount they learned from the psychiatric assessment, and the amount of information they gained from the PCC consultation. Our finding that the amount parents felt they learned from the consultant was an independent predictor of overall satisfaction highlights the importance of incorporating a psychoeducation component to the emergency child and adolescent psychiatric assessment.

## Acknowledgements/Conflicts of Interest

Mach-Gaensslen Foundation Scholarship for Research in Psychiatry. Liz Gillespie Award for Best Resident Paper in Child Psychiatry. This paper was presented as a poster at the Institute on Psychiatric Services, New York, New York, October 4-7, 2012. The authors have no financial relationships to disclose.

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## Appendix. Pediatric Crisis Care Clinic Telephone Questionnaire

Hi, this is Jonathan Lee, a medical student working in the Psychiatry Department at Sickkids Hospital. May I speak to Mr. or Mrs. (family name of patient) please?

Hi Mr/Mrs. (family name of patient). We sent you a letter recently about a follow-up study of children seen in our Crisis Clinic. Have you received it?

Yes – Is this a convenient time for us to chat for a few minutes? [Go to next question]

No – Can I check your address so that I can make sure you receive it? I'll send it out today and call back in a week or so. When is a good time to talk for a few minutes about your visit to the crisis clinic? [record]

Ok thanks very much. I'll call back on [date], then. Goodbye.

We have in our records here that you were the parent who accompanied (name of patient) to the Crisis clinic – is this true?

Has anything big or major happened in the life of your family or in the life of your child since that time?

Yes – could you tell me about it please?

No – [go to next paragraph]

The reason for my call today is that I'm currently doing a research study with Dr. Daphne Korczak, a staff psychiatrist here who regularly sees patients in the Crisis Clinic referred from the emergency department. We're trying to learn more about the experiences patients and families have had in the clinic, for example what went well or what could be better for patients and families, and what patients and parents find helpful or not so helpful about coming to our clinic. Any input you have could change the way we see and help kids and their families in the future. Our records show that (name of patient) came to the Crisis Clinic in (month of visit). I have a few questions I would like to ask you and was wondering if it would be possible for me to talk to you for about 15 minutes about what you thought and how you felt about the clinic.

No – Ok, thanks very much for your time. Goodbye.

Yes – Ok, so just some housekeeping issues regarding this study. Some people find it hard describing their illness experiences or children's experiences, but you don't have to answer any questions you don't want to and you can ask me questions about the study at any time during our talk. Also, if you feel like you want to talk to someone after we are finished, I can arrange for someone to call you back to help as well. Any suggestions or comments you make will be kept confidential and separate from any identifying information about you and your child, and will not influence [name of [patient]'s care here. Only myself and Dr. Korczak, will be able to access your responses. If you choose to participate we will send you a copy of the summary of results we find at the end if you like.

Does this study sound like something you might want to participate in?

Yes – ok, let's get started.

No – ok then. Thanks for your time. Goodbye.

[Note, for all questions, if parent states out a number before you are finished reading the anchor points, always go back and confirm with them that the number they are giving corresponds with what they think]

1. How satisfied were you with the length of time between the ER visit and your appointment in the psychiatry clinic? Were you:

- 1) really dissatisfied
- 2) somewhat dissatisfied
- 3) neutral
- 4) somewhat satisfied, or
- 5) really satisfied with the amount of time it took to get an appointment with us?

2. How did you find the length of your appointment at the clinic? Was it:

- 1) too short
- 2) a bit short
- 3) the right amount of time
- 4) a bit long or
- 5) too long?

3. Ok, I'm just going to read you a few statements now, and I'll ask you to tell me whether you *strongly* disagree, disagree, agree, *strongly* agree, are *neutral*, or just *not sure* about how you feel about them, ok?



- a) "when we visited the clinic the nurse/doctor treated us with *respect*". Do you
- 1) strongly disagree
  - 2) disagree
  - 3) feel neutral about it
  - 4) agree, or
  - 5) strongly agree with this statement?
- b) "the nurse/doctor was professional". Do you:
- 1) strongly disagree
  - 2) disagree
  - 3) feel neutral about it
  - 4) agree, or
  - 5) strongly agree with this statement?
- c) "the nurse/doctor was sincere". Do you:
- 1) strongly disagree
  - 2) disagree
  - 3) feel neutral about it
  - 4) agree, or
  - 5) strongly agree with this statement?
- d) "the nurse/doctor was interested in the problems we were having". Do you:
- 1) strongly disagree
  - 2) disagree
  - 3) feel neutral about it
  - 4) agree, or
  - 5) strongly agree with this statement?
4. How well did you feel that the doctor in the clinic listened to you on a scale of 1-5 with: 1 meaning you were not listened to, 2-3 meaning you were listened to a bit and 4-5 meaning you were listened to a lot?
5. Did you feel you talked enough about what you wanted to talk about? In other words, how satisfied were you with what was discussed? Were you:
- 1) really dissatisfied
  - 2) dissatisfied
  - 3) neutral
  - 4) satisfied or
  - 5) really satisfied with what was discussed?
6. Did the doctor at the clinic *tell* you the name of the condition your child had?
- No – go to question 7
- Yes – Do you remember what the name was?
7. How much do you feel you learned about the problems your child was having? Was it:
- 1) nothing at all
  - 2) or 3) a little bit or
  - 4) or 5) a lot?
8. Did you receive enough information about the problems your child was having?
- 1) No, not at all
  - 2) No, too little information
  - 3) Adequate information
  - 4) Yes a lot of information
  - 5) Yes, more than expected?

9. What recommendations did they give you for what your child needs and/or what you should do? For example, did they recommend that you visit a community agency, subspecialist, private therapist, family doctor of pediatrician, or community psychiatrist?

Yes – Go on to 10

No – Ok thanks. [Skip to 11]

10. Have you tried any of these?

Yes – Which ones? When did you go? For how long? Are you still going?

No – What was the main reason you could not attend? [Code based on response, not to be read out] 1) waiting list was too long, 2) felt the recommendations given weren't useful or right, 3) had trouble accessing services, 4) tried it once but hated it, 5) found something else on own, 6) patient got better him/herself or 7) any other reason (record on sheet)]

11. Since your visit have you taken your child to see another psychiatrist, psychologist, social worker, or therapist?

12. Have you taken your child to another hospital ER for psychological concerns?

Yes

No

13. Has your child started a therapy?

Yes

No

14. How is [name of child] doing compared to your visit on a scale of 1-5 with:

1) being much worse

2) being a bit worse

3) being about the same

4) being a bit better and

5) being much better?

15. Is there anything the doctor could have done to make you happier with your visit?

No – go to 16

Yes – What would it have been?

16. Overall, how helpful did you find the clinic? Was it:

1) not helpful at all

2) you're not sure how helpful it was

3) a little bit helpful

4) somewhat helpful or

5) very helpful?

17. Finally, how satisfied were you with the appointment overall? Were you:

1) very dissatisfied

2) somewhat dissatisfied

3) neutral

4) somewhat satisfied, or

5) very satisfied with the overall appointment?

Thanks so much Mr./Mrs. [family name of the parent]. Do you have any questions for me at this point? [answer the questions]

Would you like us to send you a copy of the summary of results? [record answer]

Thank you again very much. Good bye.