



Consumer satisfaction with private child and adolescent mental health services in Buenos Aires



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ABSTRACT

The assessment of consumer satisfaction (CS) in child and adolescent mental health services (CAMHSs) is becoming more important due to the increasing emphasis on consumer involvement in mental health services. The majority of the research has been carried out in high income countries (HICs), such as the UK, however, and there is a distinct lack of similar research in low and middle income countries (LMICs), such as Argentina. This is typical of mental health research more generally (the so-called 10/90 Gap, e.g. Saxena, Paraje, Sharan, Karam, & Sadana, 2006). The aims of this study were as follows: 1) Test the viability of carrying out a CS study outside of the HIC context by transferring the methodology of a UK based study (Barber, Tischler & Healy, 2006) to Argentina. 2) Introduce an original Spanish version of the self-report, English Experience of Service Questionnaire (Commission For Health Improvement, 2001). 3) Generate findings about CS in Argentina, of relevance to this context. Specifically, to explore the relationship between young persons' symptoms and their satisfaction with three private CAMHSs in Argentina, and examine the relationship between CS and the age of the children and adolescents, the types of problems with which they presented, and the impact of these problems. Data were elicited from participants using the new Spanish ESQ. In the three CAMHSs which participated, the practice of seeking user feedback was found to be viable, with sufficient data gathered for analysis to provide meaningful results. The Spanish ESQ was also found to be a viable measure, with satisfactory internal reliability and no difficulties for participants in completing the instrument. Specific findings about CS in the Buenos Aires CAMHSs showed that while high levels of CS were reported for all groups, they were significantly higher for parents than for children and adolescents. There were no significant differences found in CS for different age groups. Children and adolescents who reported behavior problems were less satisfied with CAMHSs, as were those who rated their problems as having a significant impact on their lives. Also, those parents who reported their child as having behavioral problems and lack of pro-social behaviors showed lower levels of CS. The results highlight the viability of CS research in LMIC CAMHSs, the viability of the Spanish ESQ, and the need to address those areas of lower satisfaction revealed by the study by exploring further the needs and expectations of young people and their parents who present behavioral problems in order to improve the quality of CAMHSs. Further research should also extend this small sample of the Argentine child mental health services by carrying out similar studies in other private sector services, other geographical regions and also in the public sector, where findings (along with the expectations of users) may differ.

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1. Introduction

Worldwide, mental health problems affect around 10–20% of children but only a relatively small proportion of cases receive appropriate intervention, suggesting that there is an urgent need to improve

services targeting this age group (Kessler et al., 2005; Kieling et al., 2011). This is particularly so in low and middle income countries (LMICs) (Kieling et al., 2011; Patel, Flisher, Nikapota, & Malhotra, 2008; WHO, 2005, 2009a, 2012). The assessment of consumer satisfaction (CS) in the field of child and adolescent mental health services (CAMHSs) is an important part of this agenda. It fits within the remit of heeding the views of the child or young person when planning services that affect them, a concept articulated in the UN's Convention on

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the Rights of the Child (1989). Moreover, measuring CS is a low cost way of generating opportunities for change in services. This makes it an ideal candidate for exploring in LMICs.

High levels of CS have been linked to positive clinical and social outcomes, including subsequent use of services and adherence to treatment (Fitzpatrick, 1993; Mahin, Attari, & Mokhtari, 2004), and predicted therapeutic alliance (Hawley & Weisz, 2005). The evidence for a link with sociodemographic variables is scarce (Barber, Tischler, & Healy, 2006; Holmboe, Iversen, & Hanssen-Bauer, 2011). Just two studies show that satisfaction tends to decrease with age (Shapiro, Welker, & Jacobson, 1997; Stuntzner-Gibson, Koren, & Dechillo, 1995). The findings are mixed for CS and psychological variables. Regarding problem type, young people with behavioral difficulties reported lower satisfaction with CAMHSs compared to those with emotional difficulties (Barber et al., 2006). Symptom severity and satisfaction were negatively correlated in some studies (Barber et al., 2006; Garland et al., 2000; Godley, Fiedler, & Funk, 1998; Noser & Bickman, 2000), while the others did not find such a relationship (Rosen et al., 1994; Shapiro et al., 1997; Stuntzner-Gibson et al., 1995); and a highly significant relationship has been found between CS and child- or adolescent-rated impact of problems on life (Barber et al., 2006). Parents tend to report a higher CS than their children (Barber et al., 2006; Copeland, 2004; Godley et al., 1998; Kotsopoulos, Elwood, & Oke, 1989; Marriage, Petrie, & Worling, 2001) and, like the young people themselves, the parents of children who externalize have been found to report lower levels of satisfaction than those whose children present with internalizing disorders (Bjørngaard, Wessel Andersson, Osborg Ose, & Hanssen-Bauer, 2008). Additionally, parent's reports on CS with CAMHSs may be a reliable source of data for the between-provider comparisons (Brown, Ford, Deighton, & Wolpert, 2014). For a complete review see Biering (2010).

CS research for CAMHSs is a relatively recent field and consequently has not been studied extensively (Biering, 2010) still less so in LMICs. A literature search by the authors of this study encountered no CS studies from LMICs despite finding 142 studies from HICs (search string (Satisfaction) AND ("mental health") AND ("child") OR ("adolescent") inclusive of all languages run in PubMed, Ebsco, Scielo, PsychInfo and Latindex). This may be partly because service user involvement in mental health services in LMICs is low scarce (WHO, 2009b) but is also in line with the general under-representation of LMICs in mental health research (Patel & Kim, 2007; Patel & Sumathipala, 2001; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). We cannot assume that the same results will be found and the same measurement tools will be viable in a LMIC context. CS is a fluid, multi-faceted concept that will vary across contexts (Stacey et al., 2002). We need to extend our understanding of CS with CAMHSs in LMICs.

The current study aims to extend our understanding of CS by studying it in Buenos Aires, Argentina, a Middle Income Country (MIC). It provides an interesting example of LMICs because it is relatively well resourced: it is one of only 12 of 58 LMICs without a shortfall in availability of mental health professionals (Bruckner et al., 2001; though see Moldavsky, Savage, Blake, & Stein, 2011 for further discussion). This provides opportunity to attempt to transfer some service user feedback procedures from the HICs to the MIC with a realistic chance of success. Argentine children's rights legislation sets the precedent for seeking children's feedback on their experiences of services, specifically naming the right to "express his/her opinion as a user of all public services" (translated from Law 26.061, 2005, Article 9c).

In Argentina, the public health sector co-exists with three types of private sector funding: social insurance schemes ('Obra Sociales'); private insurance plans; and up-front treatment payments (Anderson, 2000; Moldavsky et al., 2011). In this study, we take the design used by Barber et al. (2006) to study CS for public sector CAMHSs in the UK and apply it to three private sector CAMHSs in Buenos Aires (treating patients funded by all three types of private provision). It is not intended as a direct comparison. 'Like-with-like' comparison across these two countries would be very difficult because of the marked differences in

their health systems. Forms of provision are not equivalent between the countries and the populations treated by the same sector likely differ. In Argentina, over 60% of the population is covered by some form of private health insurance (INDEC, 2010) versus 11% in the UK (King's Fund, 2014). Seen in this light, it becomes clear why studying private CAMHSs is meaningful in Argentina, given that they represent those which majority of the population may access, a role that is occupied by the public sector in the UK. In this, Argentina is representative of LMICs more widely, where the private sector provides a substantial proportion of health care to low-income groups (e.g. Berendes, Heywood, Oliver, & Garner, 2011; Montagu et al., 2011).

The current study explores which aspects of CAMHSs are valued as positive and/or negative by consumers; whether there are any differences the CS reported by children, adolescents and parents; differences in CS according to age; or type of problem; or problem impact. Alongside these specific questions, it aims to explore the viability of CS research in a LMICs and of the use of the new Spanish ESQ, while generating findings about the specific patterns of CS in the CAMHSs in question, as a starting point for future research in Argentina and a point of reference for CS studies in other LMICs.

2. Method

2.1. Participants

A total of 382 individuals participated, made up of 208 parents, 83 adolescents, and 91 children (see Table 1 for sociodemographic characteristics). The sample was composed of 91 parent–children dyads, 83 parent–adolescent dyads, and 34 parents whose children (aged older than 4 years of age) did not participate. All participants were attending, or were parents of those who were attending, one three CAMHSs in the city of Buenos Aires. These three services were private institutions, constituting a convenience sample from among multiple similar services in the city and nationwide. The participants were recruited by the receptionist of the CAMHSs they were attending, who provided an information sheet about the study. Participation was voluntary, anonymous and signed consent was given by the young people themselves and their. Questionnaires were delivered in a close envelop. The participants were informed that they were free to withdraw at any time. This study was approved by the Institutional Review Board of Buenos Aires School of Psychology.

2.2. Measures

Two self-report questionnaires were used. The Spanish (Rio de la Plata) Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2005) is a 25 item questionnaire that measures positive and negative behavioral and psychological attributes across five subscales: 1. Peer problems, 2. Behavior problems, 3. Emotional symptoms, 4. Hyperactivity and 5. Prosocial behavior, and a total difficulties score. Scores indicate possible child behavior problems by designating 'caseness' and 'non-cases' (Goodman & Scott, 1999), and the impact of problems. The instrument has good demonstrated reliability and validity (García Cortázar, Mazaira, & Goodman, 2000; García et al., 2000).

The Experience of Service Questionnaire (ESQ) is a 15-item, self-report measure designed to provide feedback about service user experience with CAMHSs, developed in 2001 by the UK's Commission for Health Improvement (CHI; Commission For Health Improvement,

Table 1
Sociodemographic characteristics.

	Children (n = 91)	Adolescents (n = 83)
Sex, males % (n)	75.8 (69)	67.5 (56)
Age X (SD)	9.8 (1.15)	14.6 (2.1)
Age range	9–11	12–18

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