Mental Health Triage in CAMHS

Connecting Research & Practice in Children & Young People's Mental Health

University of Manchester
Rationale for change in practice

- Waiting list felt at an unacceptable level for CAMHS practitioners
- Illustrative cases levered an emotional response
- Scattergun practice of local referrers
- Opportunity as an insider/outsider researcher & funding
Process

1. Family opt-in
   - Measures completed in waiting room

2. 20 min clinical interview
   - PaCTS

3. Post triage discussion (whole team)
PaCTS

• Demographics

• Presenting problem
• Symptoms/behaviours causing concern

• Level of impairment (family, social & school)
• Risk to self & others
• Brief formulation

• Plan of action agreed
  – Discharge,
  – refer elsewhere,
  – specific intervention (routine),
  – specific intervention (urgent),
  – further assessment
Rating Scales

Anticipated
• CGAS
• Mood & Feelings
• SDQ
• Spence
• CHOC1
• Impact of Events
• Conners

Used
• Mood & Feelings
• Conners
• SDQ
• Spence
Pilot

Over 6 triage sessions

Patients selected from waiting list

No emergency referrals

Pairs to develop competence

Appointments offered = 114
Number attended = 95
DNA = 9 [3 sibs, 2 cons]
Cancellation = 5 + 1

• Discharged = 19 (20%)
• Referred to PMH & CITT = 1+1
• Allocated with Rx plan = 47
• ADHD/ASD assessment = 25
• Decision unclear = 2
• Total followed up = 76
Nature of problem: pilot only

(n=95)
Evaluation findings

• Eliminated the waiting list for initial assessment in one locality (population 100,000).
• The DNA rate for first appointments reduced from 12% to 6.8%
• Fears that clinical decision making would be flawed and rushed were disproven.
• Families seen in triage clinic were pleased with the speed of their first appointment
• Referrers found improved access to CAMHS (but poor response rate 22%)
<table>
<thead>
<tr>
<th></th>
<th>April 04 - March 05 Pre-intervention</th>
<th>April 05 - March 06 Intervention period</th>
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</thead>
<tbody>
<tr>
<td>New first appointments seen</td>
<td>262</td>
<td>470</td>
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<tr>
<td>New appointments DNA</td>
<td>76 (18.7%)</td>
<td>46 (0.08%)</td>
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<tr>
<td>New appointments cancelled</td>
<td>67 (16.5%)</td>
<td>40 (0.07%)</td>
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<tr>
<td>Total new appointments offered</td>
<td>405</td>
<td>556</td>
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<tr>
<td>Follow up appointments seen</td>
<td>1453</td>
<td>1876</td>
</tr>
<tr>
<td>Follow up appointments DNA</td>
<td>257 (13.2%)</td>
<td>242 (10%)</td>
</tr>
<tr>
<td>Follow up appointments cancelled</td>
<td>234 (12%)</td>
<td>275 (11.5%)</td>
</tr>
<tr>
<td>Total follow up appointments offered</td>
<td>1944</td>
<td>2393</td>
</tr>
<tr>
<td>Total appointments offered</td>
<td>2349</td>
<td>2949</td>
</tr>
</tbody>
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Challenges & remedies

- Child at risk
- Junior doctors
- Admin
- Anxious about decisions
- Allocation of case
- Signposting

- Build in some ‘slack’
- ?
- Standardised letters
- Post-triage discussion
- Team meeting agenda
- Bank of websites, RCPsych info sheets
Junior Psychiatrists

• I mean you’d expect medics because of their training, to be able to pick out what was relevant in what a patient is presenting you and decide whether this was an appropriate case or not. Perhaps it was because the medics coming through, you know, didn’t have such a long experience of child psychiatry although the staff grades would have had a few years.

  [Practitioner A5, post intervention interview]

• You’ve got to change your mind and think of a problem-solution rather than a diagnosis orientated assessment …its very difficult…What if you get somebody psychotic, really unwell, which could well happen that requires a good full psychiatric history with mental state examination and may require maybe sectioning which could potentially happen and you’re in triage…The question is if you can do triage in 20 minutes then why would a full psychiatric history needed to be done in an hour.

  [Practitioner A6, pre intervention interview]
Decision making

- Despite people’s concern about the risk, it was, I felt it was actually a well managed risk because if there was any doubt about risks and uncertainty after assessment, [the patient] just came back for a full assessment. After a bit of reassuring about that to [practitioners] I think people felt that much easier about it.

  [Practitioner A5, post intervention interview]

- It’s not clear where we’re going with that other one, we need more information, I think. Mood and Feelings at that level suggests he may well have a depression of some kind.

  [Post triage meeting]

- The other thing is that I think individual therapists are making the decisions there and then in the room, so the decisions are made before we get to the de-brief...it’s the security blanket though

  [Clinical team meeting]
Families

• But when you've got a child with problems, well they need to be sorted straight away because that issue will affect that child for the rest of their life and you'll always have problems then.

  [F13 family interview, mother of 12 year old girl]

• I had [a questionnaire] to fill in initially while we were waiting to be seen …the initial referral … was querying Asperger's syndrome, but during the triage appointment, the therapist picked up on [child’s] lowness of mood and she explained that …depression was assessed as being present and quite significant …and in fact then, the outcome of that was that the therapist felt that, that the depression actually took priority.

  [F8 family interview, mother of teenage girl]

• I thought it was fine, I thought it was very good actually from start to finish…the initial appointment was to see whether he was suitable and the kind of service they could offer…It was decided during that interview actually that certain sessions would be offered… followed up with an appointment fairly quickly.

  [F12Family interview, mother of teenage boy]
Admin support

• She’s the one who is in control of it all really. She is aware of appointments sent out and who is coming and who is not coming. She physically sets up, in terms of the waiting room and families and questionnaires and who’s due next and who is seeing who. She just organises it basically. You notice the difference when [administrator] isn’t here, put it that way I think!

[Practitioner A1, post intervention interview]
Adoption of triage locally

I assume that you are aware that we in [neighbouring CAMHS] have flagrantly copied the triage system used in [Study site]. I thought I would give you some feedback.

First I am glad you have not patented the idea because we have found it very useful.

We have reduced the waiting list by two months over the last three months and fantasies of catastrophe have not happened, (yet.)

As there is a system for all to go through it feels more coherent and the waiting list pressure is less, with the prospect of reducing it ultimately to a few weeks.

I seem to be forming the impression that a long list is now taboo and that the response to this of just allocating large numbers of waiters to individual people's work loads … results in severe workload and personal stress. The triage system as set up with us shares that and does not overwhelm individuals

[Email correspondence from a consultant psychiatrist in Neighbouring CAMHS, 31 July 2006]
Dissemination further afield

- Bournemouth & Christchurch CAMHS
Overseas:
Malta & Toronto
Further information

• Evans N (2014): Improving the Timeliness of Mental Health Assessment for Children and Adolescents in a Multi-disciplinary Team, International Practice Development Journal, 4(1) 7
• Evans N (2016): Vulnerable young people with mental health issues: How to ensure timely access to services and for those young people requiring hospital care how to help them keep in touch with life outside hospital, Observations of mental health services for children and young people in Canada, Malta and Australia, Florence Nightingale Foundation Travel award http://www.florence-nightingale-foundation.org.uk/content/page/803