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CAMHS Free from Waitlists

A. Mulligan[1,2]

1. HSE, Dublin North City and County Child and Adolescent Mental Health Services, Grangegorman, Dublin 7.
2. Department of Child and Adolescent Psychiatry, University College Dublin.

Abstract

This paper summarises a number of changes which have been made on a community CAMHS team which allow the team to function with little or no waitlist for many years. These changes include that (1) new cases are opened by 2 members of the team, (2) an evidence-based approach is used for each case, (3) new cases are allocated according to a rota, (4) new referrals are screened carefully, (5) help is accepted when it is offered – from trainees and from voluntary services, (6) "work bundles" are used help to streamline CAMHS work, (7) there are no internal waitlists, (8) a desk review of open cases occurs regularly at team meetings and (9) achievements are celebrated. Other CAMHS are encouraged to develop their own model within their team to improve efficiency.

Introduction

This paper describes the processes which were adopted within a community CAMHS team which allowed the team to function with little or no waitlist for many years (pre COVID). There have been many small changes to how the team works; this paper outlines these changes and encourages other teams to develop their own model within their team which leads to a service without a waitlist.

This community CAMHS team had a long waitlist in 2008, and a team meeting was held that year to discuss possible methods to approach the long waitlist. The book "7 Helpful Habits of Effective CAMHS" was reviewed by a number of team members; the team committed to making a number of changes, many of which have shaped our team today. Initial changes made by the team at that stage include the introduction of an urgent rota, two disciplines (one psychiatry) opening urgent/emergency cases, and the introduction of a Team Co-ordinator. "Team Review" meetings were planned to occur 4 times per year, to review the progress of these changes, and to plan further changes.

These regular team review meetings have continued, but now instead of reviewing waitlist statistics, we can look at the number of new cases seen per month, or the number of new cases seen per Whole Time Equivalent per year. The year following the introduction of the early changes, the team reported a 36% increase in the number of new cases seen; a small reduction in the waitlist was reported while there was a 36% increase in referrals (in 2009 in comparison to 2008).

Since then there have been many challenges to this CAMHS team, such as a change in the management and governance of the service, the transfer of responsibility for mental health services for 16 and 17 year olds to CAMHS, and the introduction of the HSE CAMHS Standard Operating Procedure and more recently the HSE CAMHS Operational Guideline (COG). There have also been many changes in team members, times when one or more disciplines or roles were vacant on the team, a change in the work location, and a change to the catchment area of the team. Through this we have maintained a high throughput of cases and for many years we have been working without a waitlist, with referrals processed quickly and offered an appointment shortly after triage of the referral. The following is a summary of the current system within the team which has evolved over time, which allows for referrals to be processed in a timely manner and has allowed a long period of management without a waitlist.

New cases are opened by 2 members of the team

One person from psychiatry and one other team member, usually from psychology, social work or nursing. The psychiatry trainee or consultant brings the skill of making a diagnosis, risk assessment and management of risk while the other team member brings various recovery-focused skills, such as management of family communication, de-escalation techniques, or perhaps recommends local services which may be accessed by the young person and their family. There is also the “added bonus” that team members have an opportunity to learn new skills from each other.

An evidence-based approach is used for each case

Information about the most *effective* treatments for the various conditions seen in CAMHS is available in NICE guidelines and similar treatment guides. By making a clear diagnosis and following these guidelines carefully it is likely that we will use the quickest and safest way to treat the young person and thus achieve discharge quickly. All members of the team are encouraged to keep an evidence-based perspective in their treatment. Best medical evidence may be discussed at team meetings and team members are encouraged to take up opportunities to participate in further training and education.

New cases are allocated according to a Rota

Team members are on a rota to see new cases, and each week new cases are allocated to team members according to this rota. The non-psychiatry therapist is automatically listed as the Keyworker, though there may be a change in key worker at a later stage. There is a Team Co-ordinator who allocates cases on this rota.

New referrals are screened carefully

Referrals are accepted where a Psychiatry-led mental health service is required. If the young person could be treated in primary care or by therapists who are not linked to a psychiatry-led service, then other services are suggested. A detailed 1-page list of other services in the catchment area, and their contact details has been generated and is sent to the GP with a letter of guidance regarding non-accepted cases, with a suggestion that the case can be re-referred to CAMHS if symptoms remain after the child has had a primary intervention. There is psychiatry involvement in the screening and triaging of new referrals, and more urgent referrals are offered appointments before routine appointments. The HSE Standard Operating Procedures and the CAMHS Operational Guideline are used to guide the screening of new referrals.

Help is accepted when it is offered – from trainees and from voluntary services

Trainees and students of various disciplines are welcome on the team – they take on various roles, ask questions and energise the team. They can contribute a vast amount of therapy time to the team, and often work in a manner which is very much informed by current guidelines and evidence. We will also work closely with local services - some voluntary agencies working in the area can provide services which are not readily available in CAMHS such as individualised parenting support in the home, or the mentoring Big Brother Big Sister intervention. We often try to co-work a case, with local services.

"Work Bundles" are used to help to streamline CAMHS work

An ADHD medication clinic was set up within the team in 2008, with streamlined paperwork to create efficiency. Appointments were initially offered 45 minutes apart one Monday per month, with a case-list managed on a central database. The names of young people offered appointments at the next ADHD clinic are discussed at Team Meeting, to allow other team members to plan appointments the same day and provide integrated care. Other services are similarly offered in "work bundles" where possible eg group Parenting programmes, group Occupational Therapy.

No Internal waitlists

Multidisciplinary working is used from the time the case is opened until closure, often with more than one therapist working with a family at the same time. The team makes a conscious effort to deliver co-ordinated care to families - if 2 therapists are working with a family, they will co-ordinate their work or appointments so that appointments may be simultaneous or dove-tailed so that both appointments occur on 1 day. Cancelled or missed appointments are discussed weekly at Team meetings, so that the alliance of the family with the service can be supported.

Desk Review of open cases regularly at Team Meeting

A list of all open cases in alphabetical order is maintained, and 6-10 charts are brought to each weekly team meeting, in alphabetical order. A desk review of each chart is performed by the team. The focus of desk reviews has changed over time – initially we looked for cases which were not attending regularly or who had missed appointments; currently we are reviewing the care planning process. When the complete open caseload has been reviewed, the process begins again with the first chart in the list.

Achievements are celebrated

Positive re-inforcement of team achievements is considered very important. Local CAMHS statistics are shared with the team so that the impact of their work can be seen. The team has consistently opened a high number of new cases per Whole Time Equivalent in the sector area for some time, and this has been communicated to the team.

Discussion

The overall plan for each referral is that there is a clear diagnosis, clear communication to the GP and to the family and that patients/families are supported early in the treatment process to find their own solution to the difficulties they present with, if possible. The team attempts to "harness" the energy the family has at the point of referral to CAMHS, to support the family to create change from that point onwards.

Many of these strategies were previously described in a relevant text[1] and many are found in other CAMHS in Ireland. However, there are also many waitlists in CAMHS in Ireland, with a recent report of 2,606 young people on CAMHS waitlists[2]. Similarly, there are long waitlists in CAMHS in the UK, with an increase in the rate of referral to CAMHS noted[3]. We need to continue to develop ways of working in CAMHS in Ireland which are effective and efficient, in order to meet the challenge of current long waitlists *and* the challenge of increasing numbers of referrals to mental health services. Easy access to team statistics or measurements such as the number of new cases per Whole Time Equivalent opened and closed per month (which indicate the flow through the service) will help the development of efficient practices in each CAMHS. However, changes in CAMHS may not be enough to meet the increased need for mental health services for young people - we also need a societal change which will reduce the overall need for CAMHS.

Declaration of Conflicts of Interest:
Professor Mulligan has no conflicts of interest to declare.

Corresponding Author:
Professor Aisling Mulligan MD DCH MSc (CBT) MRCPCH MRCPsych
UCD Clinical Professor in Child and Adolescent Psychiatry
Email: aisling.mulligan@ucd.ie

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