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**Case note review of Community Mental Health Services for
Children and Young People in a UK Rural Location**

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Case note review of Community Mental Health Services for Children and Young People in a UK Rural Location

Abstract

This is a retrospective case note analysis that was conducted of 66 referrals to community mental health services for children and young people (CAMHS) serving a rural community of 132,000. The aim of the review was to investigate the reasons for referral to this CAMH service and determine whether these had been met by the service. Case notes were selected by the NHS CAMHS manager based on referrals during the pre-defined date set. Of the 66 referrals to CAMHS, 19 were not included in the analysis as they had not been accepted into the service. Data were analysed on the remaining 47 cases who were referred, accepted into the service and had been offered an assessment by the service. General practitioners represented the most frequent health care practitioner to refer to the service (n=33, 70.2%). Self harm, suicidal intent, thoughts or overdose represented the highest percentage of referrals to the CAMHS service (38.3%), whilst depression, low mood and sadness represented the next highest figure (19%), and anxiety and depression (10.6%) so broadly speaking 68% of referrals were related to low mood. Out of 44 cases examined, 14/44 (32%) were referred back to the GP and no specific intervention was given. Interventions provided to 5 cases were unspecified. A number of opportunities for developing the service that allowed for a focus on the core business of helping children and young people with low mood were identified. This informed a training strategy and resource allocation, as well as a redefinition of discrete roles within the service.

Introduction and background

Capacity for providing mental health services for children and young people (CYP) is becoming more challenging with a national increase in the demand for specialist child and adolescent mental health service (CAMHS) (NHS England 2016). Even Childline noticed a change in its reasons for accessing the service, with one in three Childline counselling sessions related to mental health and wellbeing, an 87% increase in young people reporting difficulties in accessing local support services and a 34% increase in dissatisfaction with mental health support services, where these had been accessed. Mental health is now the main reason CYP call Childline (Childline 2016). This increased demand coupled with a reduction on the workforce, such as 7% fewer psychiatrists between the period 2014-2017 (NHS Digital 2017), and an acknowledgment that a further 1700 trained therapists and supervisors are required in CAMHS by 2021 (Care Quality Commission 2017), it is unsurprising that individual CAMH services are struggling to see referred CYP in a timely manner and the volume of referrals seems overwhelming. The Care Quality Commission concluded in their 2018 review of CAMHS that staffing shortages were a significant barrier to high-quality care.

This paper reports on one aspect of a whole service review for a community mental health service for children and young people (CAMHS) in a rural community covering a population of 132,000. Demand for the service was increasing and recruitment of psychiatry and psychology was proving to be difficult. The service noticed the highest level of referrals they had experienced during January to March 2016.

A retrospective case note analysis was conducted on the paper based medical records of 66 referrals to the service to explore reasons and pattern of referrals to the service. This analysis formed part of an overall service review and re-design that was prompted by the increasing demand issues. There were difficulties recruiting psychiatry and clinical psychology, relying on locum cover. Due to the

rurality of the area, travel between clinical bases and to the homes of the referred CYP was time consuming and resource intensive, so alternate means of providing services apart from individual home visits were being explored. The impression of the practitioners and managers was that demand on the service was increasing, and the service had reached capacity. The service wanted to identify aspects of the service that were working well and opportunities for further development.

Methodology

The aim of the review was to investigate the reasons for referral to this CAMH service identified by the referring agent and determine whether these had been met by the service. The objectives were to

1. To identify the referring agents
2. To identify the main reasons for referral to the service
3. To explore performance data in relation to time between referral and assessment
4. To establish the appropriateness of any interventions offered

A case note analysis was conducted of the paper medical records of all referrals received between the period 1st February 2017 and 31st March 2017 (n=66). The sample had been requested by the service because this was the period of a particular spike in the referral rate over the previous year and suggestions were made that the volume of referrals might lead to more evidence of important themes in referral patterns. Three researchers (DO, MHT, NE) reviewed the notes. Two reviewers (NE and MHT) have clinical and management experience working in CAMHS and are experienced researchers in qualitative (NE) and quantitative methods (MHT). One reviewer (DO) is a senior midwife with experience in clinical governance. Both qualitative and quantitative data were mined from the records to populate a pre-designed framework (toolkit). This framework had been designed by criteria from the CAMHS management team.

Case notes were selected by the NHS CAMHS manager based on referrals during the pre-defined date set. Data recording was completed using the toolkit variables provided which comprised of 41 data categories within an Excel spreadsheet. The range of data are displayed in Figure 1. Narrative data from case notes were entered into the categories outlined within the toolkit. This inevitably reifies essential and often complex information. For example, complex presentations from a referral may include information such as; *'this 16 year old girl is presenting with anxiety, self-harm, depression and challenging behaviour'*. This information was collapsed into one single category based on the most salient presenting issue of vulnerability. Variables included dichotomous responses such as yes/no and categorical data which included coding categories such as acceptance/non-acceptance. To ensure consistency in recording and reproducibility, types of interventions provided were categorised by the researchers within 21 different treatments offered (e.g. anxiety management, brief intervention by primary care health worker or referral to CAMHS wait list. Reasons for referral were categorised into 16 different mental health categories (e.g. depression and low mood, self harm and suicidal thoughts and voice hearing with anxiety or depression). This method also ensured the reliability of coding. Once all data had been retrieved and entered, one researcher (NE) checked the spreadsheet for accuracy. A coding frame for analysis of variables was constructed (Appendix 1) and data was entered onto SPSS® Statistics database version 23. Data entry was re-analysed on two occasions by reviewer MHT to ensure reliability of coding.

Figure 1: Data collected from patient notes during the retrospective case note review according to the pre-designed framework.

| |
|--|
| Initial Information (category) |
| 1. Case number |
| 2. Identifier |
| 3. Date of referral |
| 4. Date on referral case notes |
| 5. Case open at time of referral? |
| 6. Previously open? |
| 7. Case open at time of review? |
| 8. Area of referral |
| 9. Referral source |
| 10. Reason for referral |
| 11. Referral acceptance? |
| 12. Reason for non-acceptance: outline |
| 13. Referral routine/urgent? |
| 14. Sign posting? |
| Outcome of referral routine cases |
| 15. Category appropriateness (routine cases) |
| 16. Letter back to referrer (routine cases) |
| 17. ASD letter to referrer (routine cases) |
| 18. CAMHS team meeting (routine cases) |
| Outcome of referral urgent cases |
| 19. Category appropriate (urgent cases) |
| 20. Discussion with crisis practitioner or care co-ordinator? (urgent cases) |
| 21. Decision -not urgent sent meeting (urgent cases) |
| 22. Care co-ordinator to see (urgent cases)? |
| 23. Crisis practitioner to do 48 hour assessment (urgent cases)? |
| 24. Seen within 2 working days (urgent cases)? |
| 25. If not urgent, seen within 28 days? |
| 26. If not urgent, seen within 29-56 days? |
| 27. If not urgent seen over 57 days? |
| 28. Formulation at end of assessment? |
| 29. What is the working formulation? |
| 30. Initial intervention plan: outline |
| Intervention |
| 31. Intervention at end of 6 weeks: outline |
| 32. Ideal world intervention: outline |
| 33. What discipline? |

34. Date of plan?
35. Interventions offered?
36. If yes to intervention offered, what date?
37. Intervention offered within 28 days, 29-56 days or over 57 days?
38. Case seen by consultant psychiatrist?
39. Was this appropriate?
40. Date of discharge (if appropriate)
41. Any other comments or notes?

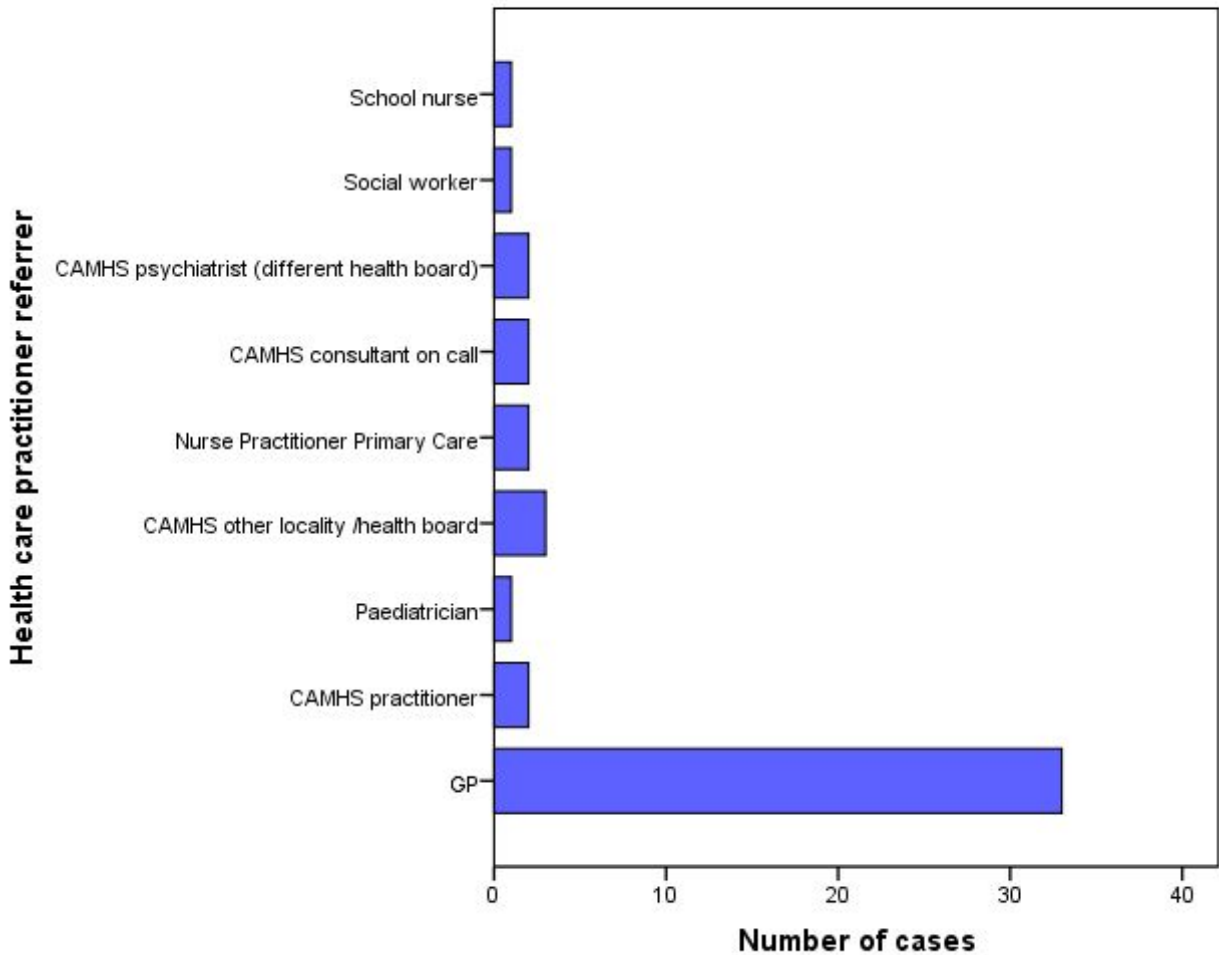
Results

Of the 66 referrals to CAMHS, 19 were not included in the analysis as they had not been accepted into the service. Data were analysed on the remaining 47 cases who were referred, accepted into the service and had been offered an assessment by the service. Out of the 47 cases there are missing data within some variables for 7 cases. The exclusion of these missing cases in some parts of the analysis was due to non-attendance, improvement before assessment or discharge after team meeting discussion and before assessment. Thirty cases were referred as routine, 15 urgent and 2 were unspecified.

Descriptive statistics were explored for all level of data. For scaling variables, the means and standard deviations were used. Nominal data was explored using percentages, ranges, minimum and maximum values.

Objective 1: *To explore the sources of referrals to the service.* Figure 2 is based on 47 health care practitioner referrers.

Figure 2: The source of referral as identified by practitioner



Outcome: General practitioners represented the most frequent health care practitioner to refer a CYP to the service (n=33, 70.2%).

Objective 2: *To explore the reasons of referral to the service*

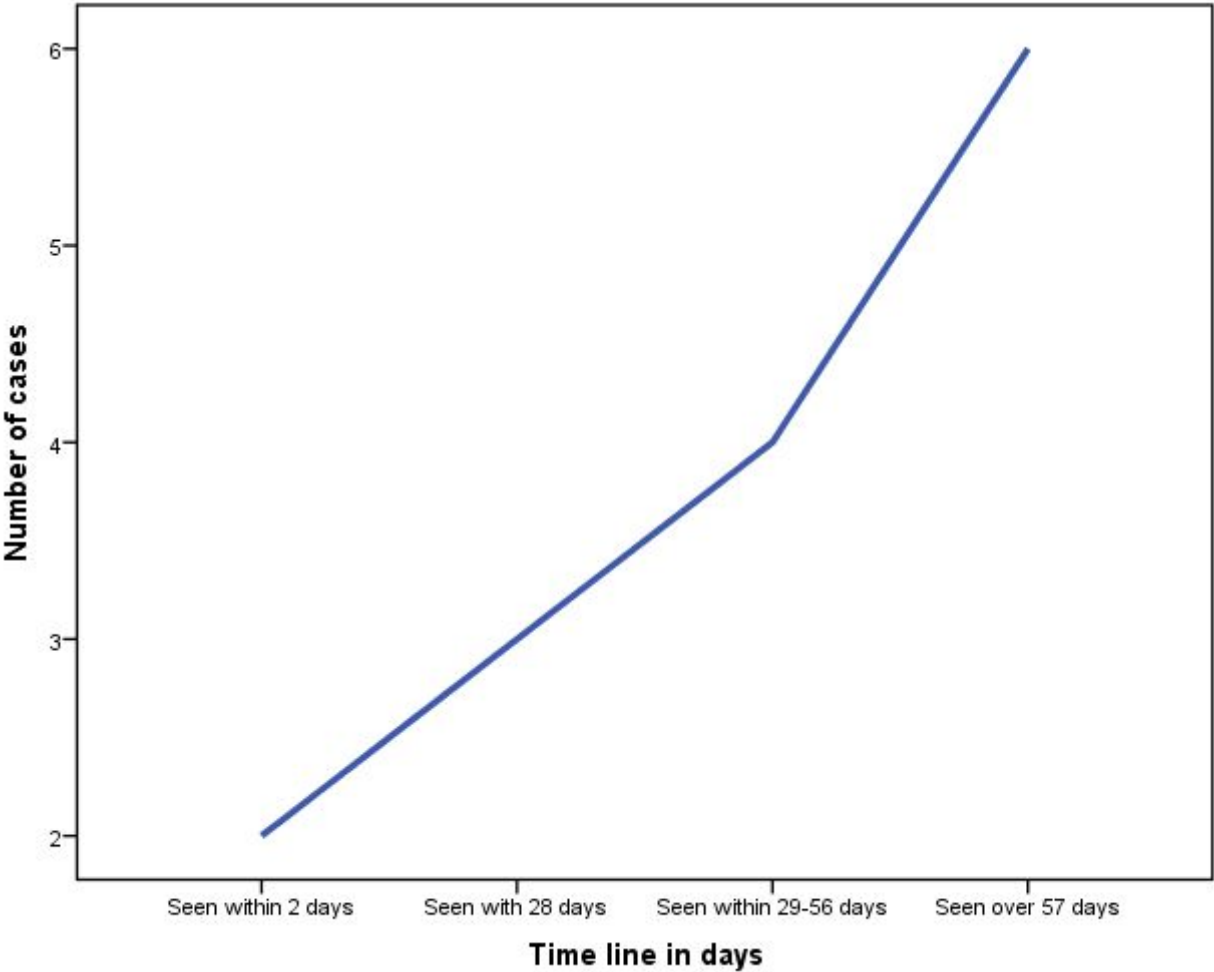
Figure 3: The percentage of referrals according to each mental health category (based on 47 cases)

| Reason for referral | Number of cases | Percentage |
|--|-----------------|------------|
| Depression /sadness | 9 | 19.1 |
| Self harm, suicidal intent/ thoughts or overdose | 18 | 38.3 |
| Gender identity dysphoria | 2 | 4.3 |
| Anxiety and depression | 5 | 10.6 |
| Hearing voices/psychosis | 4 | 8.5 |
| Post-natal depression | 1 | 2.1 |
| Spectrum disorders /or ADHD | 1 | 2.1 |
| Moderate / severe anxiety | 4 | 8.5 |
| Other: deterioration in mental and physical health not specified | 1 | 2.1 |
| Challenging behaviour | 1 | 2.1. |
| Look after child: complex presentation | 1 | 2.1 |
| | N=47 | 100% |

Outcome objective 2: Self harm, suicidal intent, thoughts or overdose represented the highest percentage of referrals to the CAMHS service (38.3%), whilst depression, low mood and sadness represented the next highest figure (19%).

Objective 3: To explore the performance waiting times between date received to the service and assessment date for urgent cases as specified by referrer

Figure 4: The waiting times to be assessed for urgent referrals as specified by referrer categorised as within 2 days, within 28 days, between 29-56 days and over 57 days (based on 15 cases).



Objective 3: Based on the 15 urgent referrals as specified by referrer, 2 referrals were seen within 2 days (13.3%), 3 were seen between 28 days (20%), 4 (27%) were seen between 29-56 days and 6 (40%) were seen over 57 days.

Objective 4: Appropriateness of intervention

This objective was to determine the appropriateness of interventions. In order to establish this, we examined the records to establish if there was a formulation written on completion of the initial assessment. The inclusion of a clearly outlined formulation was mixed. Some practitioners offered a formulation (e.g. incorporated into a risk assessment). Thirty practitioners (64%) offered the formulation as a way of making sense of the child's /adolescents' difficulties in the context of their relationships, social circumstances and life events. Other practitioners offered only the most cursory of information. There was no formulation present or a formulation was poorly conceptualised and vague within 11 assessments (23%). In some cases, an impression was offered without a formulation. Six CYP were not assessed for various reasons (12.8%).

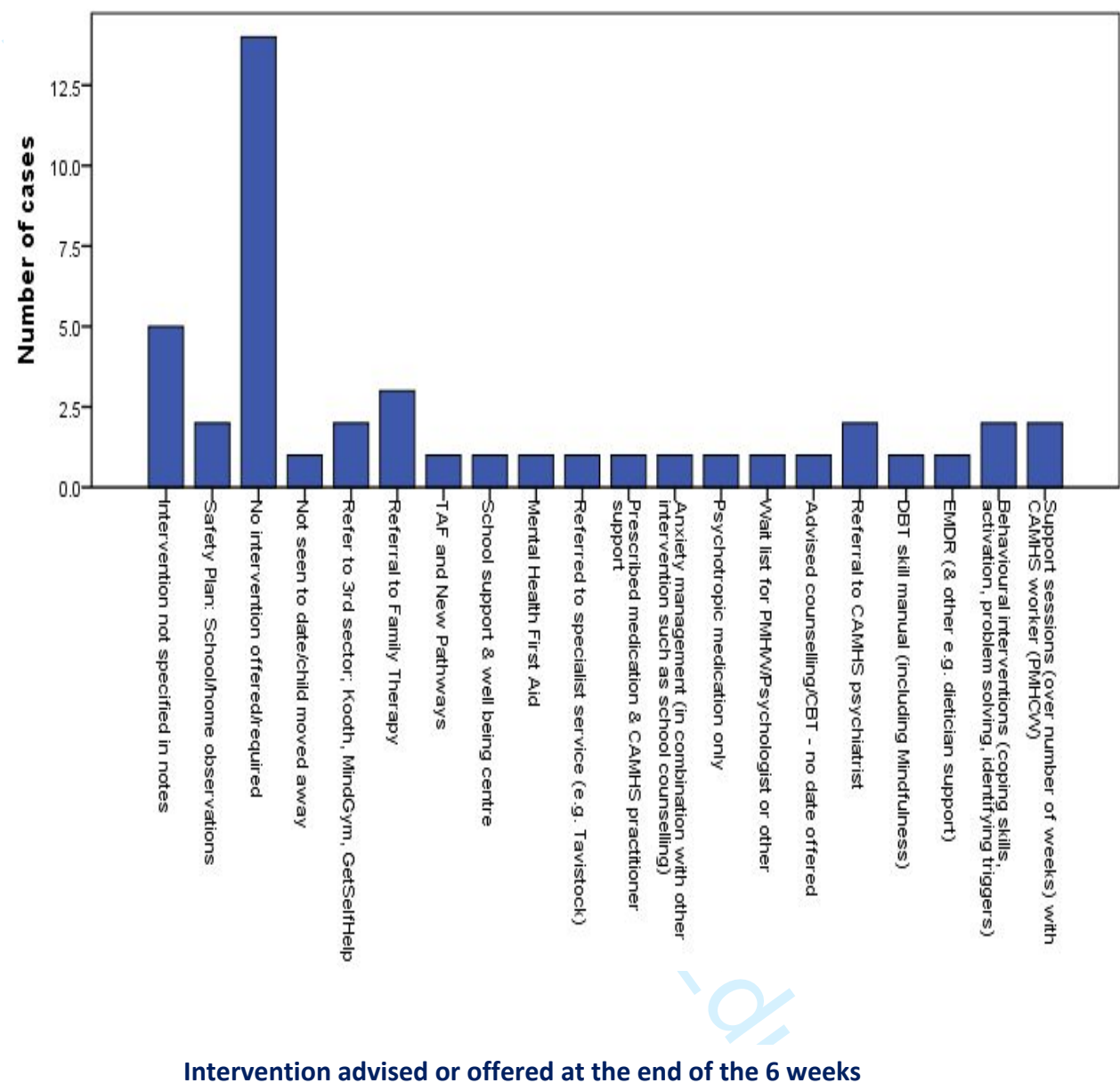
Psychosocial interventions advised and received post assessment.

We explored what therapeutic interventions were advised (for referral) after assessment. Based on 46 case notes, interventions advised came broadly under the umbrella of what the referrers conceptualised as 'supportive interventions' by CAMHS or more specific interventions by CAMHS specialist practitioners. Supportive interventions were broad and included; risk reduction, teaching of coping skills, school nurse, counselling, psychoeducation, implementing behavioural strategies, brief interventions with a PMHW, mental health first aid and other (non-specific) psychosocial support. More specialist interventions advised were EMDR, CBT, CBT and medication combined and family therapy. The majority of cases (13/46) were referred to specialist CAMHS worker (including EMDR and clinical psychologist). It was difficult to ascertain from the notes in 6 cases, 3 cases were discharged or referred back to the GP and 4 cases were referred to the psychiatrist.

When we examined the types of interventions received at the end of 6 weeks, there were a broad range of interventions within 20 different categories (see figure 5). Out of 44 cases examined, 14/44 (32%) were referred back to the GP and no specific intervention was given. Interventions provided to 5 cases were unspecified. The other case received a range of interventions under the umbrella of supportive interventions. Only one case received a specialist intervention which was EMDR.

Nineteen referrals were not included in the analysis as they were not accepted into the service. One child that was included for analysis was outside the date range (referral received 25/7/17). Most CYP (14/44, 32%) were referred back to the GP and no specific interventions were offered. It was also difficult to ascertain whether an intervention was offered or provided within the case notes in 5 /44 cases.

Figure 5: Type of intervention the CYP received or were advised at the end of 6 weeks (based on 44 cases)



Discussion

Four areas of particular interest in this review: referral sources; nature of demand on service; waiting times for urgent referrals; making decisions about planning care.

GPs represented the most frequent health care practitioner for urgent referrals of CYP for self-harm, suicidal thoughts or following overdose, suggesting that either families access their GPs rather than other agencies when worried about these issues, or that GPs themselves seek specialist support when faced with these worrying presentations and may benefit from increased training in supporting CYP with mental health issues (Sharon et al, 2017). There is a suggestion that increased training for GPs might also help reduce the burden of CAMHS assessment for sub-threshold presentations, if the GPs were to be able to assess and then manage the care of these CYP (Sharon et al, 2017). In a study looking at GP perceptions of CAMHS referral processes, Hinrichs et al (2012) found that GPs would refer if they felt the CYP was at risk of major harm, required medication, access to further therapy, and a further diagnosis or specialists' opinion. The GPs in this study reported that the detection and treatment of mental health issues in CYP was too specialised for their knowledge base.

The majority of CYP (32 out of 47, 68%) were referred to CAMHS for assessment of self-harm behaviour, suicidal thoughts and /or behaviour, low mood and depression. This proportion was double that reported in a larger study by Smith et al (2018) where just 31% were for emotional and behavioural difficulties. As this was a small study, in one location, this might in part explain referral patterns or thresholds. However, the high proportion of new referrals with low mood was essentially the common factor illustrated to the service that this was in fact their core business, the assessment of mood and subsequent risk to self. Therefore noticing this pattern was pivotal for the service in considering how to organise its staffing resource, invest in training and consider improved ways of working with the referring agents.

Cases deemed as urgent by their referrer (15 cases) were required to wait for an appointment. Only two CYP were seen before or at two days after referral. Some CYP waited over 57 days to be seen despite assumptions that waiting list issues were problematic only for routine referrals (Care Quality Commission 2017). This delay has been shown to have a negative impact on the young person's engagement with the therapeutic process, with longer waiting times for initial appointment associated with higher drop-out rate from therapy (Oruche et al 2014). Of those cases referred as urgent, all were referred to the multi-disciplinary team meeting. Only 5/15 urgent cases (33%) were assessed by the crisis practitioner and 2/15 were seen by the care co-ordinator. It is noted however that out of the 15 cases eligible for analysis, there was missing data from the notes or the information was unclear from some cases.

The inclusion of a clearly outlined formulation was variable. Often, a formulation was absent although the practitioner included 'an impression'. Some practitioners offered a clearly outlined formulation (incorporated into a risk assessment). In some cases however, the risk assessment was left blank despite indication of evidence of risk from vulnerability. Follow up interventions at six weeks demonstrated that for the majority of cases, no intervention was in place and the CYP was discharged home. There was a sense of lack of clarity about specific evidence-based interventions offered despite the Future in Mind report (Department of Health 2015) advocating that the use of evidence-based interventions in CAMHS with a focus on measurable outcomes. It was unclear from the retrospective case note review what the different roles of primary mental health worker,

specialist CAMHS worker and the crisis team were in relation to assessments and therefore treatment planning.

Limitations

One of the limitations of this retrospective review was the time frame selected because it had been identified as a particularly high period for referral into the service and may not have been representative of the usual trend. It might have been useful to compare the trend during 2017 to previous two years, to establish what the pattern of referrals is over the year, and whether there is any discernible shift (timing or volume) this year.

Also in order to understand the pattern of how referrals were being managed, some categories of intervention were collapsed to artificially create a homogenous group, which is called in the analysis ‘discharged to GP’. This in fact is a summary of those cases discharged to GP and/or referred to other mechanisms in primary care.

Conclusion

Having examined the data, analysed them and discussed the initial findings with the service, reflecting on both the data and our observations and discussions, collectively we identified a number opportunities for developing the service that allowed for a focus on core business. This informed a training strategy and resource allocation, as well as a redefinition of discrete roles within the service.

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