Child and Adolescent Mental Health Services in Laois/Offaly: A One Year Perspective of Services

(July 1, 2008 to June 30, 2009)

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Abstract

Objectives: To examine the Laois/Offaly Child and Adolescent Mental Health Services (CAMHS), focusing on new referrals and trends in the service.

Methods: Data was collected over a one-year period from July 1, 2008 to June 30, 2009 using the computer system MAISY (Medical Audit Information System) and through chart reviews. A Client Satisfaction Survey was administered to both parents and children.

Results: The Laois/Offaly CAMHS team provides service to a total population of around 140,000, of which around 32,000 are less than 16 years old. In this one-year period, 303 referrals were received with 167 offered an assessment, of which 150 availed of an appointment. Forty-six percent were offered appointments within one week of receiving the referral with 87% being assessed within one month. A further 41 were assessed from a previous waiting list, compiled prior to the actual study period, thus resulting in a total of 191 assessments.

Thirty referrals required assessment only. Behavioural/Emotional difficulties and Attention Deficit Hyperactivity Disorder (ADHD) were the most common reason for referral. During this time the ADHD waiting list was suspended due to staff constraints. Seventy-six percent were diagnosed with an Axis I disorder with 34% given medication treatment. Of the return appointments over the year, eight percent of patients did not attend (DNA). Both parents and children reported being satisfied with the service, according to the Client Satisfaction Survey.

Conclusions: The Laois/Offaly team services a catchment area of approximately three times the number recommended by *A Vision for Change*, with a staff equivalent less than the number recommended for one whole team. The team was able to provide a rapid service for assessment of new referrals, with the ADHD waiting list suspended. Axis I pathology was often diagnosed among those assessed (around 75%), with about one-third being treated with medication. Follow-up appointments achieved a high attrition rate, with only around eight percent not attending. Patient satisfaction with the service rated high by both parents and children.

Key words: Child and Adolescent Mental Health Services (CAMHS) Referrals, CAMHS Diagnosis, *A Vision for Change*, Annual Report on Child & Adolescent Mental Health Services, Client Satisfaction Questionnaire (CSQ-8).

Introduction

The first annual report on Child and Adolescent Mental Health Services (CAMHS) in Ireland was completed in 2008. It was an audit on current CAMHS services and it took into consideration recommendations from *A Vision for Change* (2006). The report identified many different parameters such as the total number of CAMHS teams, inpatient beds, caseload and total clinical workforce by profession. We looked at the Laois/Offaly CAMHS over a one-year period (July 1, 2008 to June 30, 2009) to evaluate the services with regard to recommendations in *A Vision for Change* and the first annual CAMHS report.

The Laois/Offaly CAMHS team provides services to the two counties of Laois and Offaly, which consist of a total population of about 140,000 people. According to the 2006 Census from the Central Statistics Office Ireland (2006), the population of Laois was 69,012, while Offaly's population was 70,868. Of the total 139,880 population, close to 41,000 were under the age of 20, with approximately 10,000 distributed among five year intervals. Estimating from these statistics, about 32,000 are under the age of 16. Approximately one in ten children and adolescents suffer from a mental health disorder that is severe enough to cause some level of impairment (Green, McGinnity, Meltzer *et al*. 2005); consequently, about 3,200 children and adolescents in Laois and Offaly will suffer from a mental health disorder by the time they are 16. In *A Vision for Change*, it is recommended that one team should service a population of 50,000. The Laois/Offaly CAMHS team provides services to nearly three times more than this recommendation. It has also been recommended that a day hospital be available to the catchment area; currently, such a hospital does not exist.

The Laois/Offaly CAMHS team was officially set up in 1995 and has been led by a Consultant Psychiatrist. The clinical workforce has changed throughout the years. During this one-year study period, the average staff whole time equivalent (WTE) was 12.3 staff members (10.1 clinical and 2.2 administrative) with psychiatrists dominating the percentage (4.5 WTE = 36.6%). There was no social worker or occupational therapist on the team during this year, with other disciplines such as psychology, speech and language therapy, nursing and administrative staff forming the remainder of the team. The recommendation in *A Vision for*

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Change calls for each CAMHS team to have 11 WTE clinical staff and two WTE administrative staff per population of 50,000. The Laois/Offaly team had 10.1 WTE clinical staff and 2.2 WTE administrative staff for a population of 140,000, which is nearly three times less than the recommendation in *A Vision for Change*.

The CAMHS team serving Laois and Offaly is located on the grounds of the Midland Regional Hospital in Portlaoise. It provides services for these counties for children and adolescents under the age of 16, both for initial assessments and subsequent treatment. The child/adolescent may be followed up by the service until the age of 18 if clinically indicated. In addition, the team provides a liaison service to the Paediatric Ward in Portlaoise Midland Regional Hospital and to the Accident and Emergency Departments in Portlaoise and Tullamore Hospitals. Referrals are accepted from general practitioners (GPs) and paediatricians.

Initial assessments are carried out on a designated day with urgent referrals given appointments as needed throughout the week. Two team members take part in the assessment. The assessment is divided into an interview with the parents/young person, followed by a discussion among the interviewers with the consultant. Feedback and recommendations are then provided to the family. The assessment takes approximately two hours to complete. A report is written and sent to the GP and other relevant agencies. Follow-up appointments are given if clinically indicated, with transparent treatment plans. There are treatment packets in the department for the various presentations. There is a review of the case at three months at the team meeting or earlier if there are concerns. The aim is for each young person to be receiving active treatment with transparent plans.

Aims

The aim of this audit was to evaluate the Laois/Offaly CAMHS service over a one-year period from July 1, 2008 to June 30, 2009, focusing on new referrals and trends in the service. A Client Satisfaction Survey was conducted during this time, in order to assess global satisfaction of parents and children with the service.

Methods

The data was collected by using the computer system MAISY (Medical Audit Information System) and through chart reviews. The data was analyzed using Microsoft Office software. A one-year review of new and existing patient information, clinical workforce and trends in the service was collected. The Client Satisfaction Questionnaire (CSQ-8) was administered, which is a measurement of general satisfaction with services developed for use in a wide variety of service settings.

Results

Referrals

Referrals Received

During this time, the criteria for acceptance of referrals were as follows: the young person must be under the age of 16 and must live in Laois or Offaly County, with the exception of the liaison service provided to the hospital paediatric ward where the young person would be seen regardless of their home address. The clinical criteria for acceptance consisted of a suicide attempt or suicidal ideation (SI), deliberate self-harm (DSH), symptoms suggestive of an Axis I disorder and school refusal with associated psychiatric difficulties.

In April 2008 there were approximately 140 people on a waiting list for assessment of Attention Deficit Hyperactivity Disorder (ADHD), with an estimated waiting time of up to four years, due to staffing constraints. As a result, the list was therefore closed and general practitioners along with community psychology personnel providing primary care were often involved in these cases. Throughout this one-year audit period, the waiting list did not reopen and referrals were not accepted for assessment of ADHD. However, previous existing ADHD cases continued to be followed up in the clinic.

In this one-year period, there were a total of 303 referrals. Of those, 167 (55%) were accepted and 150 availed of an appointment. However, 43 more assessments were carried out from referrals received prior to July 1, 2008; therefore, a total of 193 assessments were completed. Thirty appointments were for assessment only and did not require follow up by child psychiatry personnel. (See Table 1 below)

Reason for Referral

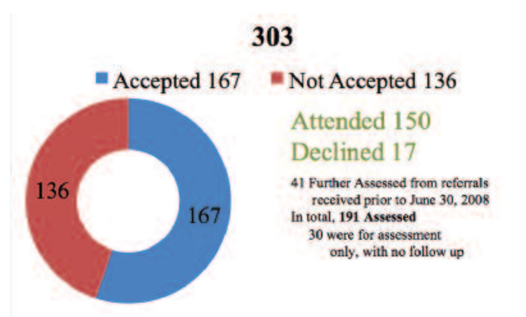

Table 1

In each case, the main reason for referral was extrapolated from the letters sent in by the general practitioners/paediatricians. The main reasons for referrals were behavioural difficulties, ADHD, SI, DSH and affective symptoms. Other Axis I disorders were represented in smaller numbers. For the purpose of the audit, only one disorder was entered for each case. (See Table 2)

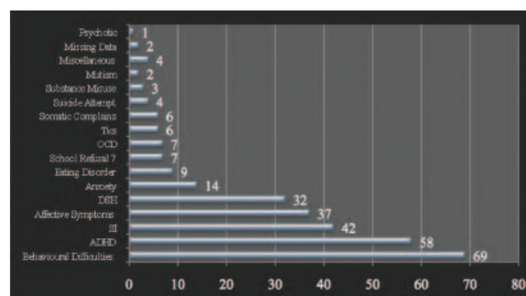

Table 2

Interval between referral received and first appointment

Of 150 appointments attended, 69 (46%) were offered an assessment within one week and 130 (87%) were offered an appointment within one month from receiving a referral. The rest were all seen within six months, except for one referral. (See Table 3)

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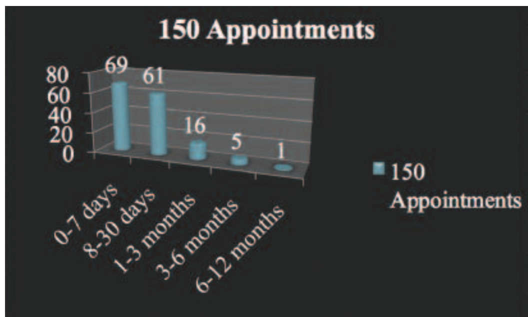

Table 3

Monthly Distribution of Referrals.
It appeared that there were peaks in the number of referrals in November, March and May. The months of June, July and August accrued the least amount of referrals. (See Table 4 below)

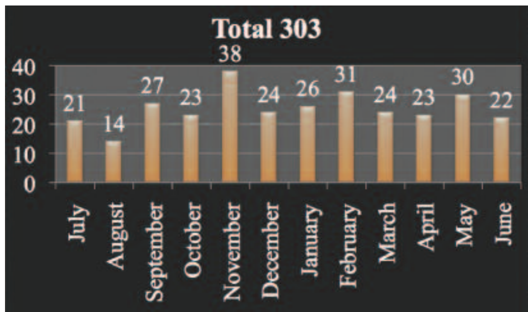

Table 4

Geographical Distribution of Referrals
There was a Laois predominance of 59% compared to Offaly's 41% for new referrals. However, it should be noted that any liaison work in Portlaoise Hospital, if originated in other counties (aside from Offaly), would have been recorded under Laois. In cases that were already open, there were a total of 1,921 appointments scheduled over the year, of which 1,125 were from Laois and 796 were from Offaly, which equates to the same figures as above, in which 59% of return appointments came from Laois and 41% came from Offaly. (See Table 5)

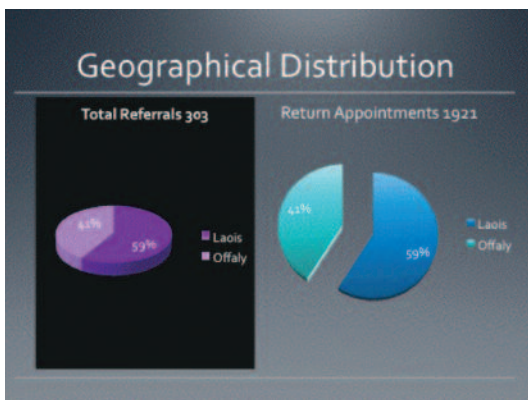

Table 5

Referrals not Accepted
There were 136 referrals not accepted. Sixty-nine did not meet the acceptance criteria. Fifty were due to the waiting list for ADHD being suspended. Seven were outside the catchment area and ten were over the age of 16. The main reason for these referrals not being accepted was due to behavioural difficulties, with no indication of a psychiatric co-morbidity. (See Table 6)

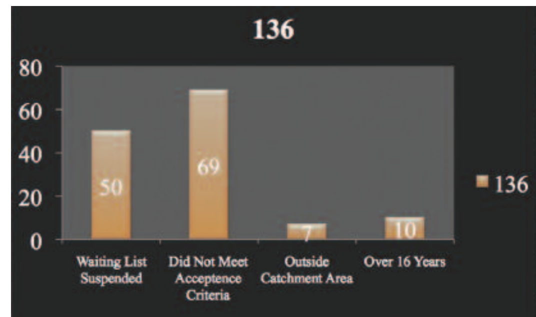

Table 6

Age Distribution
The age distribution was divided according to five-year intervals: Under 5, 5-10 years old, 10-15 years old and then over 15 years old, which was then subdivided into under 16 and over 16. The age group 10-15 years old dominated most of the referrals received (149 = 49.2%). However, the age group of 15 years old only accounts for a one-year period of time, as opposed to the other age groups; yet it yielded 50 referrals (16.5%). Those over the age of 10 were more likely to be accepted for assessment. (See Table 7)

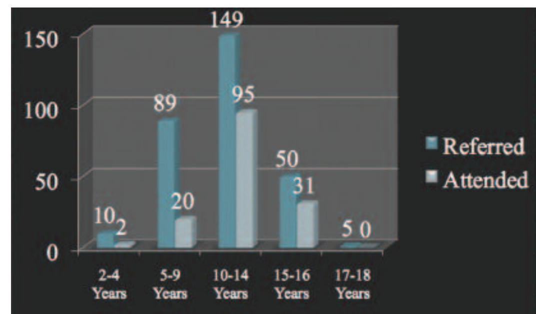

Table 7

Gender Distribution
Overall, there were 126 females and 177 males referred. Of the females, 83 referrals were accepted (66%). Of the males, 84 referrals were accepted (47.5%). (See Table 8)

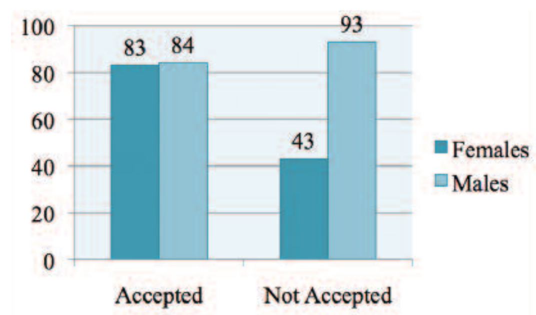

Table 8

Clinical Assessment
The Portlaoise Child Psychiatry Service uses the ICD-10 multi-axial classification for diagnosis. Preliminary diagnosis is made after each new assessment. Of the 150 assessed, 114 (76%) met the criteria for an Axis I diagnosis after the initial assessment. Thirty-three (22%) did not meet the criteria for an Axis I diagnosis, with the remaining three requiring ongoing assessment for establishing a diagnosis. (See Table 9)

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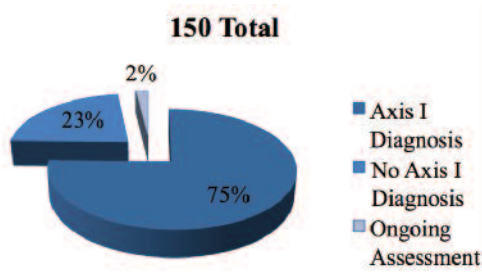

Table 9

Axis I distribution

Of the 150 assessed, Adjustment Disorder and Emotional/Behavioural Difficulties formed the majority of Axis I diagnoses. Conduct disorder was the most common emotional/behavioural difficulty. Although child psychiatry does not provide a service specifically to those with pervasive developmental disorders (PDD), it was diagnosed in 10 cases. (See Table 10)

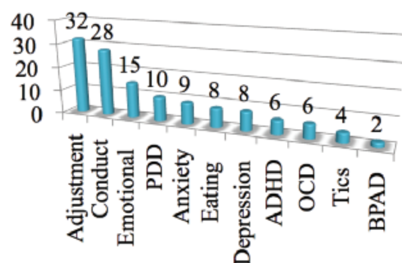

Table 10

Interventions

Of the 150 assessed, 91 had a combination of treatments with the remainder having one treatment modality. In total, 34 received medication treatment (37%).

Open Cases

Return Appointments

In total, 1,921 return appointments were offered. Of those, 1,423 were attended. In 280 (about 15%) of the cases, the patient cancelled. In 155 (about eight percent) of the cases, the patient did not attend (DNA). In 54 cases, the clinic rescheduled. (See Table 11)

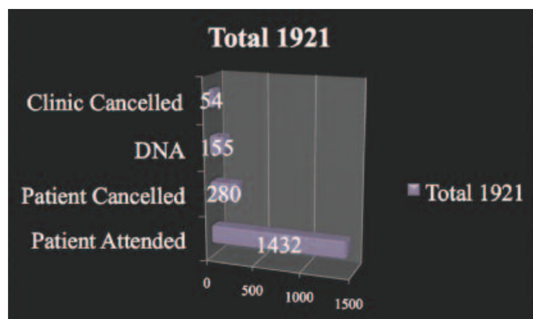

Table 11

Cases Closed

In total, 176 cases were closed. The main reason for closing a case was due to a mutual agreement between the clinician and young person/guardian that the treatment was complete. Twenty-one cases were closed due to not attending. We used the computerised system for this information, which accounts for the category, 'data not recorded'. (See Table 12)

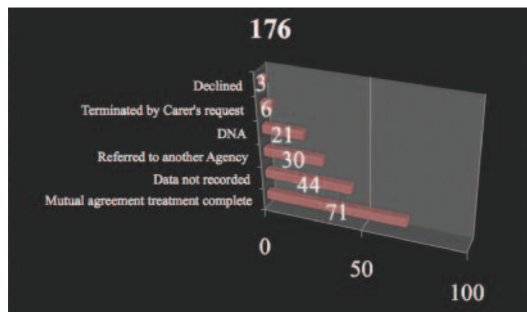

Table 12

Client Satisfaction Questionnaire

In 2009, a Client Satisfaction Questionnaire (CSQ-8) was administered and 100 people participated. Parents completed 65 surveys and the children completed 35. The mean age of the responding children was 14.7 (range 12-18). It utilised a four point Likert scale containing eight questions, with an opportunity for the respondent to volunteer comments. An Answer of 1 indicated low satisfaction, with high satisfaction indicated by an answer of 4. Examples include, 'How satisfied are you with the amount of help you have received?' and 'If you were to seek help again, would you come back to our service?' Overall satisfaction reported by parents was 3.6/4 (range 1.9-4) and children 3.2/4 (range 1.1-4). Question 4 yielded the highest score in both parents (3.8/4) and children (3.4/4). This question asked: 'If a friend were in need of similar help, would you recommend our service to him or her?' Children reported the lowest score (3.1/4) in the question: 'Did you get the kind of service you wanted?' Parents reported the lowest score (3.4/4) in the question: 'To what extent has our service met your needs?'

There were a wide variety of comments by both parents and children. Some positive comments made by parents regarding what they found helpful were as follows: "Contact, continuity, availability.", "The time I was given as a parent and the support.", "When I phoned there was always somebody to talk to and listen and help if at all possible.", "We were told what was going on and we could understand our child's problems more clearly.", "Support, talking, and books.", "It was a friendly atmosphere, made me feel welcome.", "We got in straight away within one week…was very happy with the services.", "Attention from the staff, information received regarding problem, follow-up appointments including parents very helpful.", "That when one thing did not work, there was always another option for us to try, no one gave up.", "Kind and respectful manner in which my family was dealt with.", Some of the comments parents made as suggestions for improvement were as follows: "Inpatient unit.", "A support group for parents.", "More feedback after child's one-to-one sessions.", "More child-centered therapy.", "More discussion with the parents about home-life.", "Same doctors each visit.", "Better communication between the schools and the service.", "Getting an answer about what is wrong earlier.", "A more intense psychological examination.", "Tea and coffee available to help people relax.", "Not challenging the parent in front of the child during disagreements.", "More regular sessions.", "More follow-up appointments.", "More rooms in Tullamore."

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Children's comments regarding what they found helpful were: "The advice and art therapy.", "The staff is very kind.", "The Psychiatry was extremely helpful in dealing with my difficulties." Children's comments regarding suggestions for improvement were as follows: "Spend more time in sessions.", "Have the doctors listen to the child more.", "Decrease time between appointments.", "Sky Sports in the waiting room.", "Hot chocolate in the waiting room."

Discussion

Over this one-year period, 193 assessments were completed. Forty-three were from the overflow of a waiting list that had closed in April 2008. This averages to about 3.7 assessments per week. Two team members participate in each assessment with the consultant overseeing all assessments. This equates to around seven to eight team members participating in assessments per week on a team with an average WTE of 10.1, including consultants who are often not part of the assessment.

Overall, 136 referrals were not accepted. During this time, the ADHD waiting list was closed and 50 of those referrals were for assessment of ADHD. Sixty-nine referrals did not meet the criteria for acceptance. Most of these referrals were for behavioural difficulties with no co-morbid psychiatric difficulties. The remaining referrals not accepted were either outside the catchment area or for assessment of a young person over the age of 16.

During this one-year period, 303 referrals were received and 167 were offered an assessment, with 150 appointments attended. Approximately 90% of those offered an initial assessment availed of an appointment. The remainder either did not attend or felt symptoms had improved enough that an assessment at that time was not warranted. Sixty-nine (46%) were offered an assessment within one week and 130 (87%) were offered an appointment within one month from receiving a referral. The rest were all seen within six months, except for one referral. The reason for any delay in seeing referrals was primarily due to the case requiring further information prior to assessment. This is in contrast to the national average, according to the first annual report on child and adolescent mental health services, 45.6% of new referrals were seen within one month after receiving a referral. During this time, the ADHD waiting list had been closed, which afforded more time to the team for assessments of other psychiatric problems. Therefore, a time-efficient service was provided for those with a psychiatric disorder other than ADHD.

The main reason for referral was for behavioural difficulties (22.8%) and ADHD (19.1%). This coincides with the First Annual Report in which the two most frequent primary presentations were hyperkinetic category (29.1%) and emotional/behavioural disorders (26.3%). This was followed by symptoms of SI, DSH and affective symptoms. Other Axis I disorders were represented, but in lesser amounts. The suspected reasons for less ADHD referrals than the national average is that there is a community psychology service and that it was made aware to the referrers that the ADHD waitlist was closed.

Of those assessed, around 76% were diagnosed with an Axis I disorder. The remainder of cases often had elements of DSH/SI in the absence of an Axis I disorder, all of which are appropriate reasons to provide psychiatric input. It was more common to have multiple interventions. Medication treatment was used in only 37% of cases, despite 76% of cases receiving Axis I diagnoses.

Among open cases in the clinic, 1,921 return appointments were offered during the year. In 15% of the cases the patient cancelled their appointment. Approximately eight percent of patients did not attend. This is lower than the national average during this time of about a 15.9% DNA rate.

In total, 176 cases were closed in this one-year period. One hundred and ninety-one were assessed with 30 requiring assessment only, therefore 161 were followed up for treatment. This figure represents a service maintaining equilibrium. Active treatment is the aim for all the young people, with ongoing team discussions and reviews of cases.

Peak referral periods were identified in November and February. This was associated with school-related difficulties that exacerbated symptoms. More males than females were referred for assessment (177 vs. 126). A higher percentage of females were accepted for assessment (66% vs. 47.5%). Males were more likely to have been referred for behavioural difficulties and ADHD with no co-morbid psychiatric problem, rather than females, which accounts for the discrepancy in the acceptance rate. Referrals received for children under 10 were less likely to be accepted for assessment. Many of these referrals were for ADHD and behavioural difficulties with no co-morbid psychiatric difficulties, which would not have been accepted for assessment. Referrals for children over 10 were more likely to have SI, DSH and more identifiable psychiatric pathology. Therefore, these would have been accepted for assessment.

The results of the Client Satisfaction Survey indicated that both children and parents were satisfied with the services, with parents being more satisfied (children = 3.2/4 vs. parents 3.6/4). We would see children often less inclined to attend psychiatric service in general than the parents.

Since the time period of this audit, a second annual report has been published on child and adolescent mental health services (2009-2010). The structure of the Laois/Offaly team is changing, with the addition of a full-time consultant now providing one consultant per county in December 2010. There is a plan to commence assessing ADHD referrals and to offer appointments to those who had been referred during the period of the waiting list suspension. With a change in team structure and the addition of opening the ADHD waiting list, it would be interesting to re-audit the Laois/Offaly team structure to identify changes.

We did not look at re-referral rates and the average length of cases remaining open. This would be important as the Laois/Offaly service operates using active treatment and sets treatment goals with estimated discharge dates. Keeping cases open for extended periods of time for general reviews after the presenting problem has settled is not common. An examination of our turnover and re-referral rate would provide an idea of whether or not this ethos is effective.

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Conclusion

The Laois/Offaly service, during the period of July 1, 2008 to June 2009, was working with a team that had a WTE staff of less than had been recommended for one team, yet it was providing a service to a population nearly three times of that recommended by *A Vision for Change*. Under these circumstances, the ADHD waiting list was suspended to provide adequate service for core psychiatric problems; consequently, this provided a minimal waiting time for assessments (87% seen within one month). Of those seen, three-quarters fulfilled Axis I disorder criteria, with the remaining one-quarter exhibiting problems that were appropriate for assessment by a psychiatric service.

The number of cases closed was nearly equivalent to the number of cases that were assessed and followed up for treatment, which points to a service working at equilibrium. Patients were in active treatment with appropriate transparent plans working towards a discharge date, which promotes high turnover and the ability to take on new cases. Of the returning cases, DNA rates were remarkably low at about eight percent, indicating the value of the service to the Laois/Offaly community. Patient satisfaction rated high among both the parents and children attending the service.

Conflict of interest

None.

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