Six Month Service Evaluation for Greenwich Time to Talk 16-17 year old work stream.

Aims of the Report

In November 2014 Greenwich Time to Talk (GTTT hereafter) expanded its services to include referrals who were 16-17 years of age at the point of referral, in addition to its current 18+ service users. This six month evaluation aims to highlight referral, treatment, DNA rates and service user demographics of the 16-17 year age group. From this preliminary data, it aims to provide initial recommendations on current operational procedures, with the goal of bettering the service for a younger age group.

1 Referral Information

1.1 Referral rates and sources

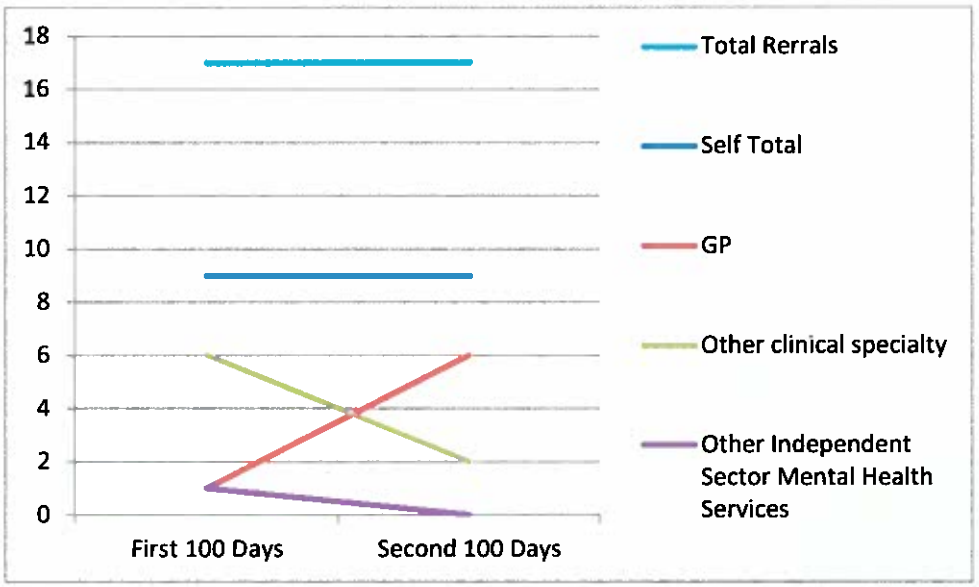


Figure 1: Referral rates and sources for the first and second 100 hundred days.

Referral rates have been consistent across the first 200 hundred days (6.5 months) of the service with a total of 17 referrals per quarter. 35 referrals have been received in total, but one referral was treated before the service was up and running as a trial case by the clinical lead of the service. Figure 1 highlights the majority of referrals have been self-referrals (54% overall) and this has remained consistent across the first two quarters. The number of GP referrals is increasing, however the number of referrals from other clinical specialities e.g. CAMHS directly, has reduced across the two quarters.

1.2 Referral Allocation

Overall, referral allocation has been appropriate across the two therapists' relative to their working hours, with the full-time therapist being allocated 57% of cases and the therapist working 3 days per week being allocated 37% of cases. The remainder of the cases were

allocated to the clinical lead (one case) or data was missing (one case example). However, when investigating referral allocation over time (see figure 2), the service and therapists struggled to accurately allocate referrals to both therapists in accordance to their working hours.

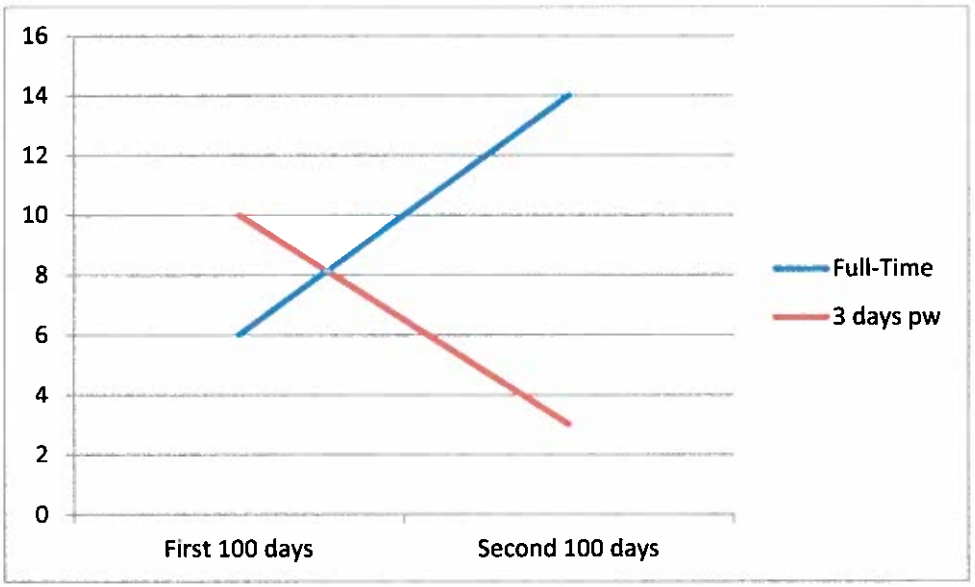


Figure 2: Referral allocation to the full time and part time therapists across the first two hundred days.

1.3 Service User Status

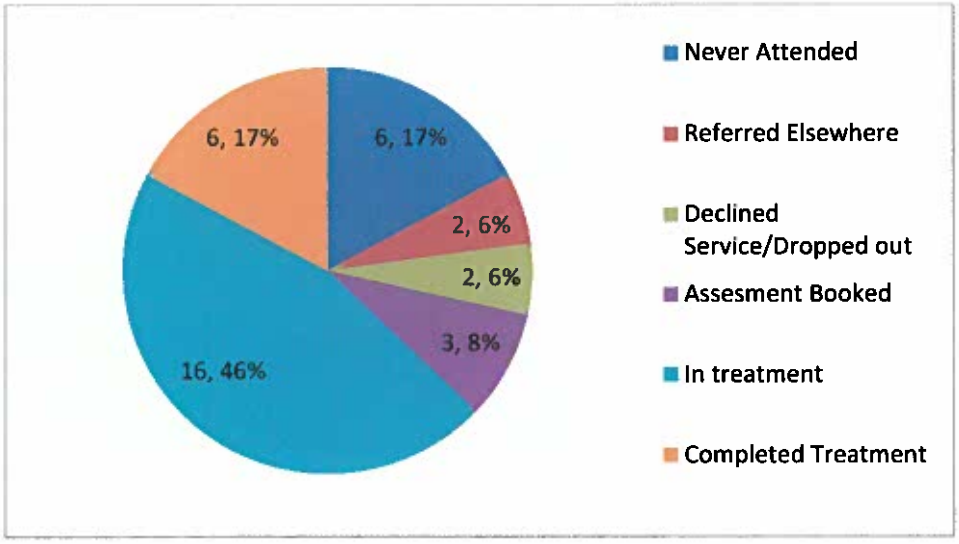


Figure 3: Service user status 6 months into the new service.

In the first six months six individuals representing 17% of all referrals did not attend their first session and have been discharged from the service in accordance with the service's DNA policy. One service user declined the service and one dropped out. Three service users have assessments booked and 16 are currently in treatment. Six have been discharged who have completed therapy.

2 Service User Information

2.1 Demographics

Of the 16-17 year olds referred to the service 66% were female and 34% male. The ethnicity of the young people seen by the service was broadly similar to the borough of Greenwich's adult census data (see Figure 4). Of note the number of white British 16-17 service users was slightly higher than the census data. The majority of referrals did not have contact with social services (82%) although two had current contact (one was in foster care) and two had historical contact with social care. Of the service users assessed, 48% of them were currently attending college/school, 22% were not attending school and 4% were at university. In 26% of cases this data was not recorded and highlights a large gap in the data set. Furthermore, the map of the service users' addresses (see Appendix 1) shows that participants are being accessed from all parts of the borough.

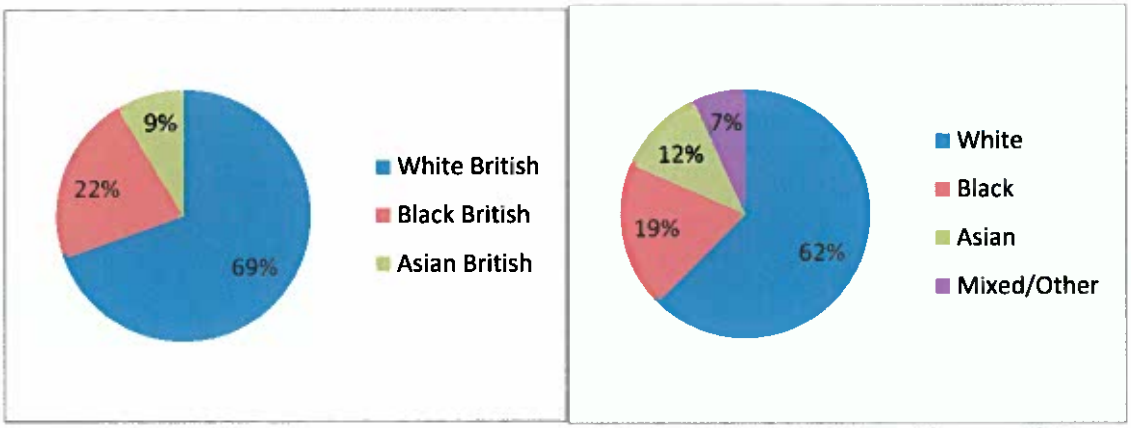


Figure 4: Left GTTT Service user ethnicity profile. Right: Royal Borough of Greenwich census data.

2.2 Clinical Presentation

The majority of service users presented with depression as their primary difficulty (60%; see Figure 5) with PTSD and Social Anxiety making up just over a quarter of the remaining presentations collectively. Of those who were assessed, the majority did not have a secondary presenting problem (56%) although, if a secondary problem was identified (apart from one case of depression) it was always an anxiety disorder (see Figure 6.). Of those assessed, 50% were deemed to be low risk and 42% showing medium risk levels. The remaining two cases were equally divided between no risk and high levels of risk. Importantly, the case identified as high risk was not treated within the service, but referred onto secondary care.

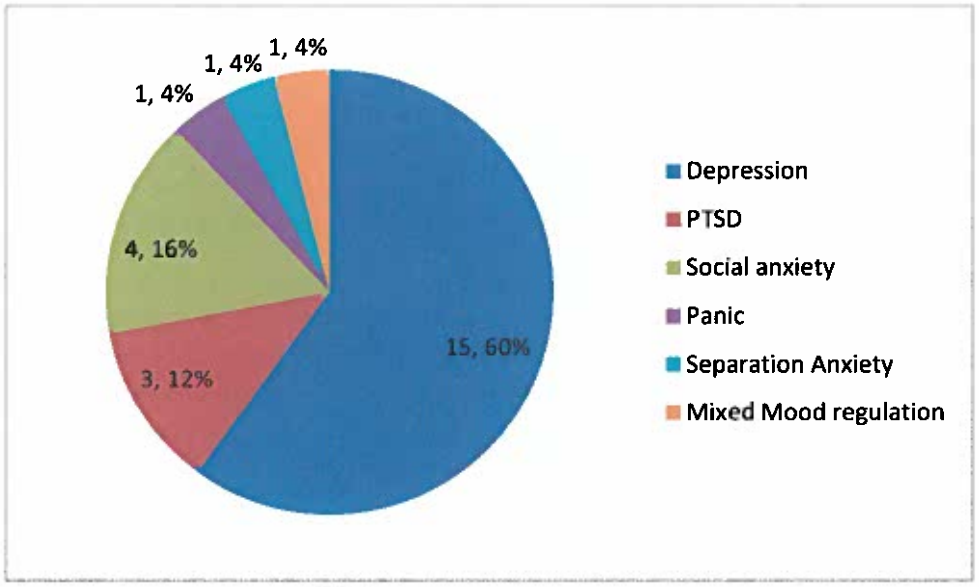


Figure 5: Service users' primary presenting problem.

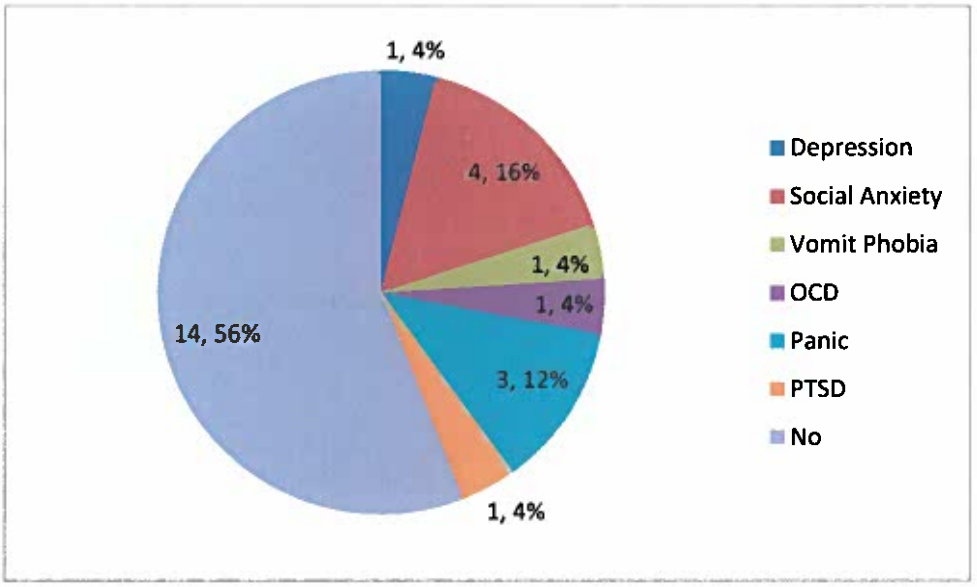


Figure 6: Secondary presenting problems at assessment.

3 Discussion points and recommendations

3.1 Referrals, pathway and procedures:

Referral rates of 16-17 year olds are currently not at expected levels and, while the work stream is still in a pilot phase, a strategy to increase referrals of this age group should be put in place. The data suggests that G.P referral rates of 16-17 year olds to the service are increasing. Awareness is likely to be improving therefore, however targeted marketing at G.Ps would be helpful and a young person friendly leaflet has been designed and is currently with the communications department to facilitate this. Self-referral has shown to be important to this age group and especially where relations with the G.P are not harmonious. Finally, further developing relationships with CAMHS, and defining when CAMHS might choose to refer on to GTTT would be helpful in ensuring a steady flow of referrals without over burdening the service. The current allocation procedure is currently not working for the emerging branch of the service and needs to be reviewed in light of the findings. Similarly, the collection of school data needs to be a priority in the registration/assessment process.

The DNA rate is likely to be related to a number of potential factors including presentation, motivation, distance to travel (see map of service users), timing of appointment and/or the strictness of the current policy. Currently, individuals are discharged if they DNA their initial assessment, which is where all participants (bar two) have been lost to the service so far.

Recommendations

- Distribute young person leaflets to G.P surgeries and colleagues throughout the borough.
- Staff to visit key referring schools and feedback to CAMHS staff working in such schools regarding drop in referral rates.
- Staff to visit CAMHS services to raise awareness of the service, suitability of referrals and facilitate fluid transition between CAMHS and adult services for service users.
- When patients are registered their school data should be entered onto the IAPTUS system.
- Administration staff to log referrals and register them as per the adult protocol. Assign patients to 'waiting allocation'. Therapists to then review referrals assigned to this stage on a weekly basis and allocate according to current case load and location of participant/clinical availability. Following allocation, administrative staff to book appointment with allocated therapist.
- The current DNA policy should be updated for young people. If a patient DNAs then they should be called within the therapy hour. If a legitimate excuse is provided then they should be given another appointment. If they do not answer, a voicemail should be left and an opt-in letter should be sent with an alternate appointment date in two weeks time, giving the young person two weeks to respond. A 'patient delay' tab should be added to such cases. If they DNA a second time then they should be discharged.
- To run a service user focus group to better understand patient experience of new service (use of adult outcome measures etc.) considering ethnic minorities experience in particular to continue to increase access to in line with population ratios.

3.2 Clinical presentation

The clinical presentation of the sample so far suggests a tendency for depression to be the primary presenting problem with 60% of service users having significant difficulties with low mood. The National Institute for Health and Care Excellence (NICE) guidelines for depression in youth, when the presentations are moderate to severe suggest that individual CBT,

interpersonal therapy or shorter-term family therapy should be recommended. When cases are mild then group CBT should be offered. Only trials with 18+ participants have shown the effectiveness of mindfulness based cognitive therapy for individuals with multiple episodes of depression/recurrent depression. However, this approach is gaining evidence for younger participants. Social Anxiety was the second most prevalent difficulty for the service users evaluated suggesting a need to develop increased capacity to support such individuals as the service grows. One service user has enquired about a social anxiety group for young adults, and group treatments may be one way of increasing access to the service with regards this presentation, in addition to responding to service user feedback. Of the young people who have presented with depression a clinical observation noted amongst the team is that difficulties are often related to relationship problems with partners/family/friends. In these circumstances CBT has not always felt the "best fit" with regards treatment. This perhaps further highlights a need for potential training in systemic/interpersonal approaches for this age group, in keeping with NICE recommendations.

Recommendations

- Increase staff capacity e.g. lower band therapist, to jointly offer group CBT for service users with mild depression with a behavioural focus. Similarly, there is growing evidence for group therapies to treat Social Anxiety in adolescents, which would enable an increase in service delivery for these service users also.

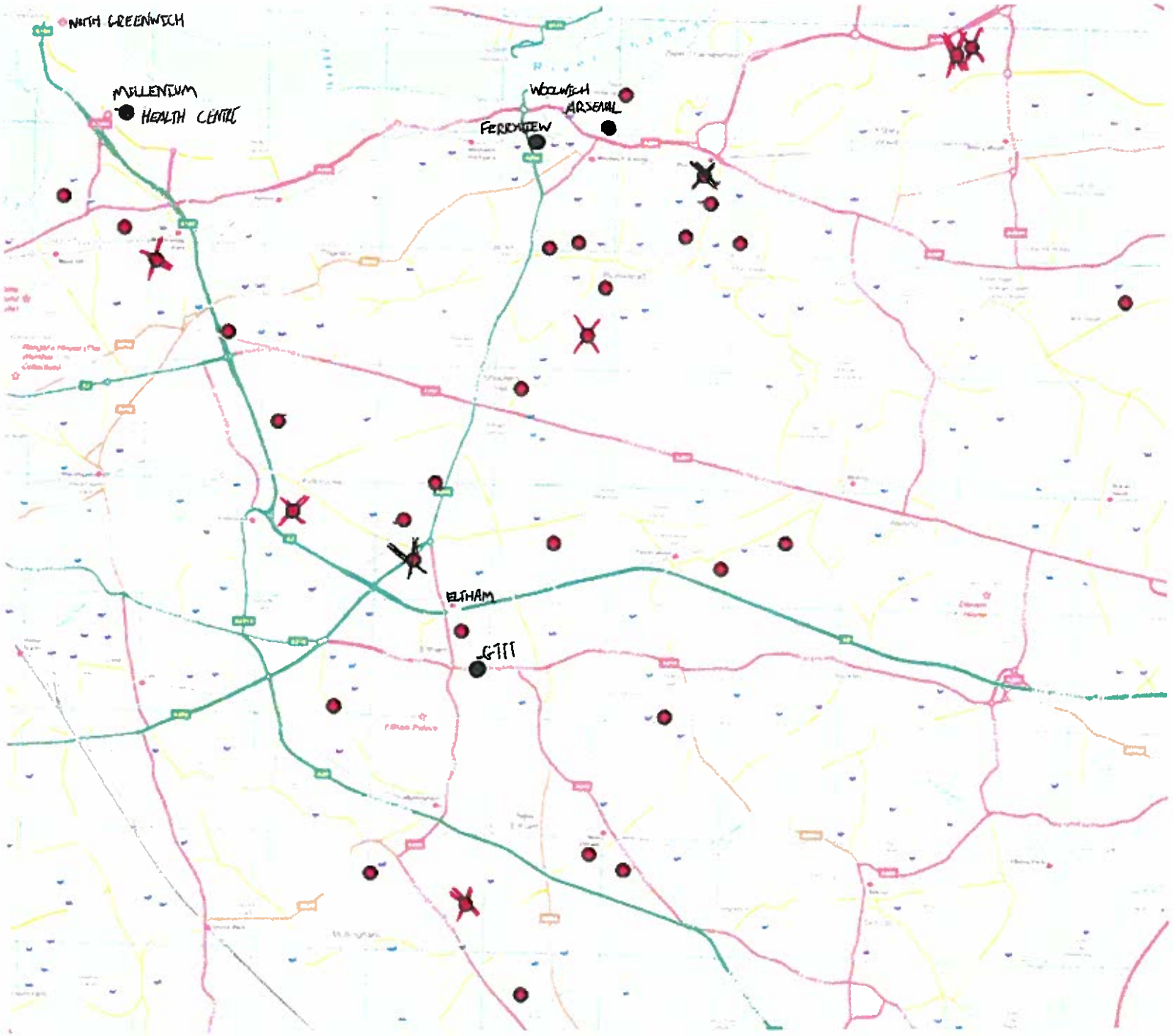
- To set-up young adults (16-21) mindfulness based cognitive therapy group for service users who have experienced multiple episodes of depression and/or have already been seen by CAMHS for treatment of the depression using CBT or other evidence based approach.

- Increase staff competency to offer alternative models of individual intervention other than CBT e.g. IPT.

- Greater liaison with family therapists within the EIT CAMHS team to support therapeutic interventions as systemic formulation is key part of NICE recommendations for depression in youth. Cases to be prioritized where systemic interventions would facilitate individual work or without it individual work would be consistently undermined.

3.3 Limitations

The current evaluations main limitation is sample size. The reduced numbers limit the confidence with which future directions can be argued. Without additional access to the IAPTUS system it has also been difficult to assess severity of presentation at baseline, age at referral, number of cancellations/DNA during treatment, response rates (meaningful change in outcome measures) and recovery rates. However, only six patients have been discharged so far so forming any conclusions regarding outcomes of treatment would be difficult to generalise to other service users at present. Furthermore, this report has not examined the number of young people being referred who have additional diagnoses of ASD / ADHD and whether these diagnoses should affect treatment plan / be considered with respect to use of measures goals and recovery rates.



X = Never attended.

X = Dropped out / Declined Service

● = G.P surgery / GTTT base.