



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH PAPER

Improving the timeliness of mental health assessment for children and adolescents in a multidisciplinary team

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Abstract

Background: The waiting list for outpatient Child and Adolescent Mental Health Service (CAMHS) appointments exceeded 12 months. This paper discusses the development and implementation of a bespoke mental health assessment process that improved the timeliness of assessments for referred children and adolescents.

Aim: To introduce a new system of managing referrals to reduce the waiting list for children and their families.

Methods: Action research methodology was used as an approach to engage practitioners and facilitate change within a multidisciplinary CAMHS in the UK. The methods used to generate data about the intervention were semi structured interviews with families referred to the services and with practitioners working in the team, as well as an examination of waiting list data and a survey of referrers to the service.

Findings: As a result of the implementation of a triage approach, the waiting time for a referred child to receive an initial CAMHS assessment was reduced from 12 months to all children being assessed within one month of referral. Referrers to the service and families involved valued the quick response from CAMHS.

Conclusions: This was a bespoke process that combined a brief clinical interview, the use of psychometric measures and a team review meeting to create an effective mechanism for conducting brief, robust mental health assessments.

Implications for practice:

- It was possible to glean sufficient detail about the nature of a child's mental health difficulties from a brief assessment or triage process
- A brief assessment process might be useful in a number of mental health fields to enable screening, triage or a gateway assessment to be conducted
- Action research was a useful approach to engage practitioners as collaborating partners during organisational change in a way that promoted sustainability for that change

Keywords: Action research, brief assessment, child and adolescent mental health, triage

Introduction and rationale for a change in practice

Policy context

The problem facing CAMHS in the UK was an increased demand relative to the service provision capability, causing lengthy waiting lists for referred children and adolescents to receive an initial assessment (Department of Health, 2008; 2009). One of the most debilitating aspects of developing a mental disorder for a child or young person is that they fail to maintain progress in psychological development in relation to their peers and thus are disadvantaged both by the distress of the disorder and by impaired psychological development (Hewson et al., 2003). This combination of factors highlights why children need to have their mental health needs met in a timely manner. The current prevalence of diagnosable mental health disorders among five- to 15-year-olds in the UK, according to the Office of National Statistics, is 10% (Green et al., 2005). Evidence suggests a significant link between emotional and psychological difficulties in childhood and ongoing mental health problems in adult life (Fombonne et al., 2001). It therefore makes sense, from a humanitarian and an economic viewpoint, that timely, effective interventions are targeted at children and young people who present with a mental health disorder (Hewson et al., 2003); sound evidence exists to support the efficacy of early interventions for many such disorders (Carr 2000; Fonagy 2002). The NHS in the UK has acknowledged the significance of this, emphasising that the mental health needs of children and young people should be accurately identified and met by appropriately located services without a significant delay (Department of Health, 2008; 2009) as this reduces the likelihood of chronic mental health conditions (Moss, 2008).

This paper describes how action research methodology was used to introduce an assessment clinic into a CAMHS outpatient clinic in the UK. The study was supported by funding from the Health Foundation and approved by the local research ethics committee.

Practice context

The research context

In the UK, the organisation of CAMHS is based on the tiered system (Health Advisory Service, 1995). This study was located at an outpatient clinic that offered mental health assessment and intervention to children and young people up to school leaving age. The CAMHS clinical team was multidisciplinary, with one consultant child and adolescent psychiatrist, three social workers who were in therapist roles, one part time clinical psychologist, one full time nurse therapist and one training psychiatrist. The service was located in a semi-rural town, serving a population of 100,000. There were approximately 400 new referrals to the service each year and these, although largely initiated by GPs, also originated from school educational psychology services, social services departments, paediatricians and other health services.

Rationale for change

Before the implementation of the intervention, referrals were made in writing to the consultant psychiatrist in the team, who would review them on a weekly basis and decide what action needed to be taken. As there was a significant waiting list predating this study, only cases deemed to be urgent were given immediate appointments. Others were allocated sequentially in the order that they were received. Before the introduction of the triage process, there were 176 children who had been waiting between two and 12 months since referral to be assessed by CAMHS.

The existing assessments were thorough, eliciting developmental, educational and medical history, and details about family composition, as well as information about the child's social, relationship and developmental functioning. Each initial assessment took just over one hour; this was an embedded assessment process that had been used by the service for more than 20 years. The quality of information provided in referral letters was variable and the content reflected the referrer's professional orientation. This has been found to be an inaccurate mechanism for making a decision about the appropriateness of the child's referral (Potter et al., 2005).

Methodological approach

Action research is a multidisciplinary, multi-method, contextual and holistic approach to social research that respects the complexity of problems people (stakeholders) face in their everyday lives (Greenwood and Levin, 2007). It is founded on a research relationship in which those involved are participants in the change, and involves a cyclical process in which research, action and evaluation are interlinked (Waterman et al., 2001). Its strength lies in its focus on generating solutions to practical problems and its ability to empower practitioners – getting them to engage with research and subsequent development or implementation activities (Meyer, 2000). Nichols and colleagues (1997, p 36) argue that the evolution of action research as a methodology directly addresses the ‘persistent failure of research in the social sciences to make a difference in terms of bringing about actual improvements in practice’ by rejecting the concept of a two-stage process of research then implementation in favour of a more integrated approach. What is distinctive about action research as an overall research strategy is the iterative cycle of identifying a problem, planning to address the problem, intervention and review in order to plan subsequent intervention (Cassell and Johnson, 2006). In action research, multiple methods of data-gathering may be employed in a systematically evolving process that becomes evident through the life of the project. Therefore, there need be no gap between theory, research and practice, as the three can be integrated.

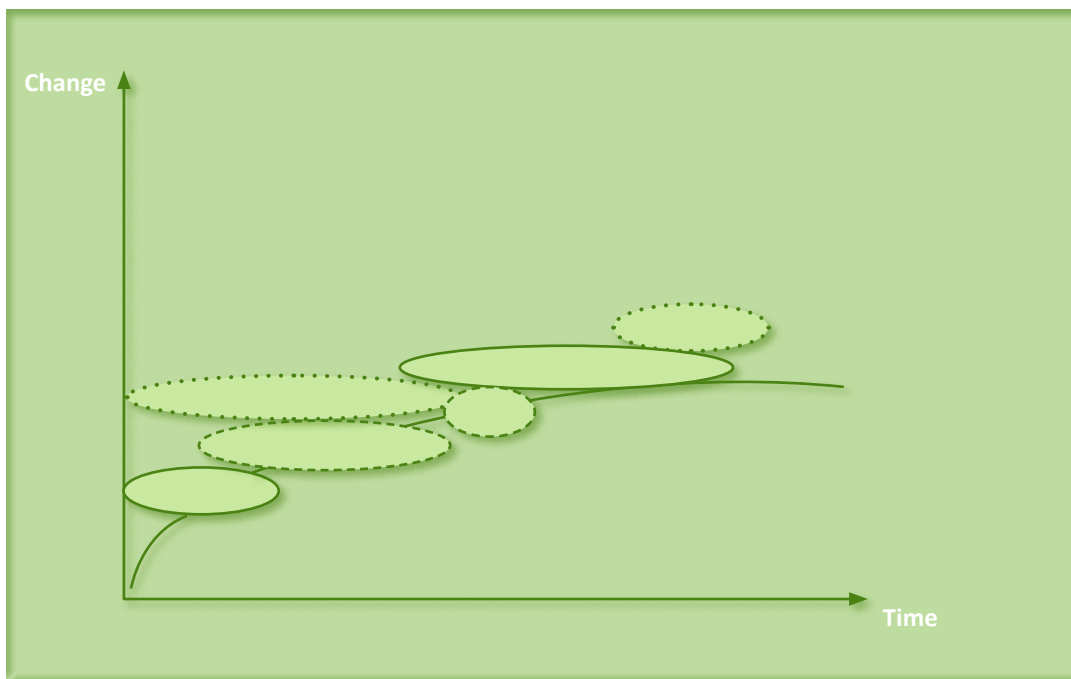
The action research spiral or cycle

Lewin (1946) introduced the idea of a continual spiral of activity of reviewing and acting to effect change in an organisation. The cyclical nature of action research involves what Winter (1989) referred to as the four elements of planning, acting, observing and reflecting – not as discrete, single entities but as an overlapping process of which these may be components, or ‘moments’ in a spiral, (Kemmis and McTaggart, 1988, p9). Where these occur in a ‘spiral’ and are embedded within practice, the changes that result are more likely to be sustained (Argyris, 1985).

One of the difficulties with this particular aspect of action research is to represent this three dimensional activity within a linear report such that it reflects its complexity but is easily understood.

This study, rather than comprising a series of sequential stages forming a spiral of logically ordered work, appeared to consist of a collection of overlapping and interconnected cycles of planning, action, observation and reflection, with different sizes and timescales that created a forward trajectory. The idea of action research being a messy methodology (Coghlan and Brannick, 2005) is a useful contrast to the ordered sequencing of a typical experimental design study, but conceptually it is difficult to represent in advance how an action research study might unfold. An attempt at a visual representation of this is shown in Figure 1, where the curve of the graph represents the trajectory and each circle represents a discrete cycle or spiral of planning, action, observation and reflection within the study.

Figure 1: Overlapping and interconnected cycles of action research



The change in practice

Spiral 1 of the action research process: identification of the problem and collaborative solution-seeking

An examination of the relevant literature about assessment in CAMHS was conducted with the research collaborators. In the preliminary discussions with key stakeholders at the research site, we agreed to undertake an initial review of the literature to map the field and identify brief initial assessment protocols for use in a CAMHS context. The results of this process informed the development of the initial proposal that was submitted for ethical approval and funding. A more in depth review of both research and professional literature continued as a part of the first spiral of the action research process and was integrated with the planning of the new practice.

Review of the literature

The literature was examined initially to identify specific strategies that had been employed to manage waiting lists in CAMHS and was then broadened to consider triage or brief assessment processes in other specialties. The literature offered a number of models that have been introduced to address the waiting list problem specifically in CAMHS. Jones et al. (2000) described a process in which the team met in advance of seeing the referred child to hypothesise about the presentation. This was followed by two practitioners conducting a clinical interview lasting one and a half hours and a team review. A similar model was used by Parkin et al. (2003), which included a validated psychometric screening measure – the Strengths and Difficulties Questionnaire (Warnick et al., 2008). This questionnaire was sent to families in advance of the appointment and the clinical interview was reduced to one hour. Other approaches identified in the literature included the brief ‘two plus one’ consultation model (Heywood et al., 2003) and a specifically devised set of prioritisation criteria based on likely success from treatment (Woodhouse, 2005). None of these approaches used a brief clinical interview, although aspects of them were thought to be useful, such as the use of psychometric measures and a post triage meeting.

In Australia, there has been a small number of studies exploring decision-making and effectiveness of triage systems (Grigg et al., 2007; Creaton et al., 2008; Broadbent et al., 2010). However, these studies were not designed to address demand management for services, were not child-specific and did not contain protocols that would have been helpful to address the work.

Given there was no brief CAMHS assessment available in the literature to inform a decision on the appropriateness and priority of a child referral to outpatient CAMHS, the focus of the study became to develop a bespoke assessment process that met the specific needs of the research site, and evaluate the impact.

The development of the intervention

The researcher met with the CAMHS team as an action researcher on a consultancy basis on an increasingly regular basis over a year to explore the prospect of developing a strategy to manage the long waiting list. This CAMHS team saw 400 new cases each year and at that time there were 176 children waiting for their initial assessment. The researcher attended the clinical team meeting on a monthly basis with the 'waiting list/triage clinic' as a standing item on the agenda. Incorporating the intervention into the team meeting agenda helped to establish this project as part of the normal working function of the team. The regular meetings were critically important in understanding the team and building relationships. Initially, members of the team seemed put out by the researcher's presence in that it was taking time away from the core business of that clinical team meeting, which was to review clinical cases, as can be seen in the data extract below.

'It's not clear to me how it all evolved, you know, I can kind of remember initially you coming to talk and me connecting "oh yes I'll be quite interested in that" and then it kind of felt it was like this, you know, sort of evolved before we knew it really' (Practitioner A4, pre-intervention interview).

As time went on, the team became accustomed to the idea that this was an action research project that had a place as a standing agenda item at team meetings. The important consideration from a resource perspective was that this was to be a change in practice that entailed no additional resources apart from a researcher leading the development. Thus, through this collaborative 'thinking' process, the team created a specifically designed approach to assess referrals and address the waiting list. This became known as the triage clinic.

Planning stage

The idea of a brief assessment model was floated early in the discussions and the researcher took the role of researching the literature and presenting the findings for discussion at subsequent team meetings. The team was therefore able to contribute to the thinking about the intervention without having to take on additional work. Anxieties about conducting brief assessments or triage were raised from the outset by practitioners within the team and by stakeholders outside the team. Fears were expressed that an incorrect clinical decision could be made for a child and that practitioners would become burned out from regularly taking part in a stressful work activity as suggested by Sands (2009) in her examination of the Australian triage system. One of the most challenging aspects of initiating this project was capturing the range of ideas from the collaborators in way that enabled a shared sense of decision-making about the introduction of the triage model. Not all practitioners were available at all planning meetings so there was a degree of repetition during the discussion phase. On balance, this approach of repeating and rehearsing discussions was effective as it allowed all collaborating members to feel included in decisions.

A recurring theme that emerged during triage planning meetings was how to make clinical decisions more robust and how to increase the individual practitioner's experience of feeling supported through this new way of working. A post-assessment review process that we had discovered in the literature (Jones et al., 2000) had been described as a strategy to manage both the anxiety that individual practitioners felt and the quality of clinical decision-making from a risk management perspective, so this was adopted.

One of the key tasks of the planning stage was an application for ethical approval. There are particular considerations when conducting research with children and with people with mental health issues due

to their vulnerabilities and ability to consent to participation. In this study, children who were looked after by the local authority were excluded from the evaluation aspect because of the complexities of securing consent. Given this group of young people are at a high risk of mental health issues, excluding them is a weakness of this study.

Since the value of action research is collaboratively to develop, in an evolving process, a solution to a clinical problem in the field, it can be difficult to predict safely the exact nature of the intervention to be developed. In the research proposal submitted for ethical approval, it was therefore difficult to specify the exact nature of the intervention and also of the tools to be used to evaluate its impact. This lack of certainty resulted in a delay to approval being given, and further approval had to be sought when adjustments to the protocol were made to include data generation from non-clinical staff.

Spiral 2 of the action research process: the implementation of the new practice

The practicalities of how such a clinic would operate – such as timing, frequency, who would take part and what format the assessment would take – were established through trial and error and refined during a three month pilot phase testing out the triage process. In addition to the required demographic details such as name, address, GP and school, the team developed a brief interview schedule that addressed the following:

- An overview of the symptoms causing the main problem
- The degree of impairment to the child
- An assessment of any issues of risk
- A brief formulation with a plan for intervention or discharge

The clinical interview was consolidated by asking the family to complete two psychometric measures in advance, a recommendation drawn from the review of the literature. Some of the CAMHS practitioners were accustomed to using psychometric measures to support the individual assessments that they had made under the existing system. The key one of these was the Strengths and Difficulties Questionnaire (Goodman, 2001), alongside the Mood and Feelings Questionnaire (Angold et al., 1995) – a self-report measure of mood.

The assessment clinic operated once a fortnight and all referred children were given appointments within one month of referral. The team administrator performed reception duties for this clinic, meeting families and distributing the self-report measures to families to complete in the waiting room. Between two and five practitioners were available to see families. Appointments were scheduled 45 minutes apart to give practitioners time to conduct the 20 minute brief clinical interview, score the psychometric measures and write brief notes. Initially, it was commonplace for families to be seen by two practitioners when the intervention was being established and practitioners were becoming skilled in conducting brief assessments.

All referrers were informed by letter of the change in process for conducting initial assessments. This was followed by a brief standardised letter summarising the key decisions about a referred child made at assessment, that was sent to the referrer and copied to the child's GP if the referral had been initiated elsewhere.

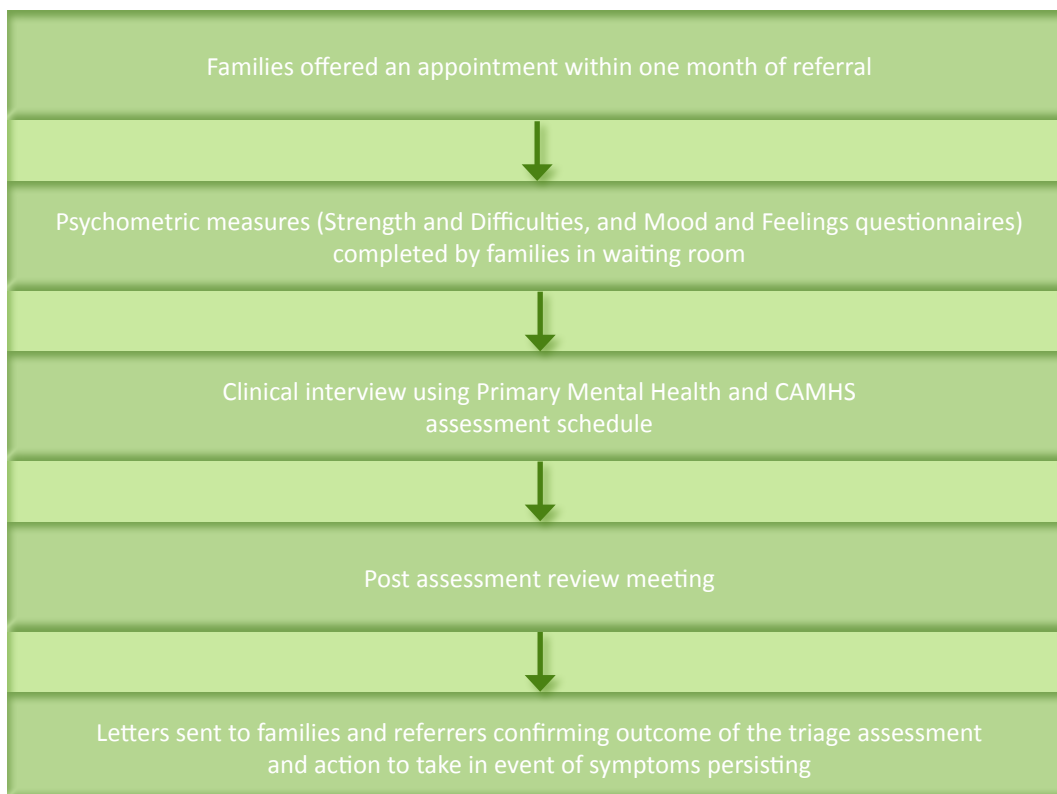
Decision-making

Decisions about the child's needs and level of priority were based on a synthesis of the two sources of information: the brief clinical interview and the information generated from the psychometric measures. There were five possible outcomes from the assessment that the practitioners could decide on and then discuss with the families (see Table 1).

Table 1: The five possible outcomes of initial assessment	
1	To accept the child as meeting the criteria for CAMHS and offer an outline of an intervention for them as a routine, non-urgent case
2	To accept that the child needed either an urgent further assessment and/or intervention, and appoint accordingly
3	To accept that the child would need a further specific assessment, for example if there was an indication that the child had a specific diagnosis or difficulty that required a particular and detailed assessment
4	To determine that the child's needs did not fall within the CAMHS remit so discharge with information or with signposting to another service
5	Where the CAMHS practitioner(s) were unable to make a decision on the available information, to invite the child and their family to return for a further, more in-depth general assessment

At the end of the clinic, all practitioners would meet for the post assessment review, during which all children seen would be discussed by the team. An hour was set aside for all cases to be presented. Individual practitioners were given the opportunity to reflect on the decision they had made for each child and for their colleagues to provide comment. After this point, letters would be sent to the families and the referrer to confirm the decision that had been made at the assessment. For those children discharged, families and referrers were reminded that if symptoms persisted, the child could be re-referred to CAMHS. For ease of understanding, a flowchart of the assessment process can be found in Figure 2.

Figure 2: The assessment process



Spiral 3 of the action research process: evaluation of the new practice

Pilot of the intervention

The three month pilot phase allowed for the assessment process to be tested. During the pilot, appointments were offered for 114 children (some multiple referrals within same family), 95 children were seen, nine did not attend (DNA), and six cancelled. Nineteen children (20%) were discharged directly from assessment and for only two children was it not possible to make a clear decision about their care needs based on the bespoke assessment. A total of 47 children were allocated a follow-up appointment for a specific intervention, 25 were referred to specific CAMHS clinics for assessment of attention deficit hyperactivity disorder or autistic spectrum disorder, one was referred to primary mental health care and one was referred to a specialist CAMHS community intensive care team. The pilot therefore demonstrated that the bespoke assessment process enabled a decision to be reached for 98% of referred children within that period.

Research methods

Data were generated through a number of methods:

- A specifically designed postal questionnaire was used to survey a sample of referrers who had accessed CAMHS in the year prior to the study. This questionnaire contained nine sections with questions using a Likert (1932) scale to rate aspects of the assessment, alongside open ended questions to invite further comment. The questions were designed to elicit referrers' perceptions of any strengths or weaknesses of the intervention and suggestions for how the intervention could be further developed. A total of 107 referrers were invited to complete the postal survey at six and 12 months into the intervention. The response rate was 20.56%. These data were analysed using IBM's [SPSS](#) software
- Semi structured interviews were conducted with the families of 17 children seen in the assessment clinic to elicit their views on the process. These interviews were audio-recorded and transcribed verbatim. A computer assisted qualitative data analysis software package [Atlas-ti](#) was used to manage the data
- Data were generated from CAMHS practitioners in the team through participant observation. The post assessment review meetings were also audio-recorded and transcribed. Atlas-ti was used to manage the data
- Semi structured interviews were also conducted with CAMHS practitioners before and after the intervention to elicit views on the new assessment process
- Waiting list data were examined post-intervention to establish impact of the intervention

As this was an action research study, findings were fed back into the continual development of the project and, as a result, collaborative decisions about refinements were made periodically. The results from the referrer survey were discussed with the team, as can be seen in the extract below.

Researcher: 'The feedback from the questionnaires from referrers suggests that holding the triage clinic one and half days a month is not enough? We know it's enough but the referrers have the impression it's not.'

Practitioner A12: 'What they mean is they need to be seen sooner... they have that feeling if they miss the day they'll have to wait for a month.'

Practitioner A1: 'When they have a family coming in, in distress, for a GP that's an emergency isn't it?'

Practitioner A12: 'For the GP it's an emergency... perhaps what we should do is have fortnightly half-days?'

Practitioner A9: 'Because you can tell people... they wouldn't have to wait any longer than a fortnight. In fact, that would be the maximum wait, a fortnight, when you think that people used to be waiting 18 months and now they can wait two weeks' (Clinical team meeting, 8 June 2006).

In this extract, it can be seen that three practitioners were engaged in the discussion of the meaning of the survey results, offering their own interpretations of the findings and their views on how the triage clinic could be adjusted based on the feedback.

Findings from the study that are relevant for practice in CAMHS

Impact on waiting list and rates of non-attendance

CAMHS routinely collected information about the date and source of referrals, first appointment and discharge data. Before the start of the study, the number of referred cases on the waiting list for this CAMHS service was 176, of whom 93 had waited more than three months.

An analysis of the appointment data held by the NHS trust showed that before the introduction of the triage, the DNA rate for first appointments was 18.7%. During the data collection period September 2005 to August 2006, there were 17 assessment clinics and 211 families were seen. All children were seen within one month of referral. There was no waiting list for initial assessment at the end of this period. An analysis of the appointment data held by the NHS trust for a comparable period of April 2005 to March 2006 showed the DNA rate for first appointments to have reduced to 0.08% during the time the triage model was operating.

Time for initial appointment

The team administrator had an important role in identifying the full impact that the intervention had not only on the waiting list itself but on the wider issue of managing demand for the service. The administrator observed the fundamental organisational difference in managing new referrals through the new process, both for its value in reducing the existing waiting list and for proactively managing future excessive demand.

'We would have a waiting list soon enough if we didn't have triage... The therapists couldn't possibly see 21 kids in a week, with their own workload. We had... 14 referrals were being done on that day. That apart they should never have been allowed to build up. They were hanging around. But they'd built up since last Thursday. So you can see Thursday to the Tuesday, 14 referrals in half a week. So you imagine that building up, we would be back to square one' (post-intervention interview).

Cases were allocated to individual practitioners at post assessment review meetings. During the semi structured interviews with CAMHS practitioners, it was ascertained that no internal waiting lists for treatment had been created as a consequence of this new process.

The experience of a brief assessment

Despite the clinical interview in the assessment lasting just 20 minutes, families reported that this allowed sufficient information to be gained to appreciate the nature of the child's difficulties.

'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' (F12 family interview, mother of teenage boy).

Despite initial anxieties expressed by CAMHS practitioners about making sufficiently robust assessments with the time constrained triage assessment, they reported increasing confidence and competence with the assessment process.

'I suppose the other thing I think with triage is that over the year I'm more confident about actually saying to that family today 'you don't need to come to this service' – I would never have done that a year ago' (Practitioner A1, post-intervention interview).

'Despite people's concern about the risk, 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... I think people felt that much easier about it' (Practitioner A5, post-intervention interview).

The CAMHS practitioners were a mixed professional group with a range of experience. The factors that appear to have increased their competence and confidence in conducting brief assessments include working in pairs initially and meeting for a post assessment review at the end of the clinic.

Discussion of the implications for CAMHS practice

The development and implementation of a bespoke assessment process was a useful strategy in addressing the increased demand relative to available resources within this outpatient service. The impact on the waiting list itself was significant and has been sustained. An unexpected feature of this innovation was a reduction in DNA rates for first appointments. The absolute reason for this reduction has not been fully explained by the data from this study, but a possible conclusion is that families did not have to wait too long for an intervention and therefore were motivated to engage with CAMHS. Under the previous system, when families waited months for an initial CAMHS assessment, they may have been seen sooner by another agency, or the problem for which they were referred may have improved.

There was no evidence in the research or professional literature for a brief psychological assessment schedule for routine use with children and young people before the development of this initiative. Despite initial anxieties expressed by CAMHS practitioners about their ability to elicit sufficient information about a child's needs and priority for intervention within a brief clinical interview, this was not found to be problematic. By honing in on specific areas such as risk and where and how the child experienced impairment, and by using supplementary psychometric measures, the significant information was elicited. Therefore, this model may have utility in other CAMHS internationally, as well as in adult mental health or older person's services, if appropriate psychometric measures could be established to supplement the clinical interview.

Discussion of the use of action research to effect a change in practice

The collaborating team reported that the impact of having developed and introduced this new way of working had unforeseen benefits. They described additional benefits from working together more frequently and in a more integrated way. There was a greater understanding of one another's professional orientation as a result of conducting the triage assessments as a shared process. Professional assumptions that were aired at the outset of the study were challenged by the experience of working more closely with other disciplines during the triage clinic.

'To be honest I think they've got ideas but medics in the team, I don't think that they really know what social workers do. [laughs] That's not a criticism of anyone but there's not a lot of co-working in the team' (Practitioner A1, pre-intervention interview).

Working together more intensively and frequently appeared to add a greater sense of team belonging. The triage clinic became a symbol of genuine teamworking, where practitioners had the opportunity to work alongside colleagues they would not usually work with. The shared lunch on triage days, although brief and busy, became an important opportunity to socialise with one another and enhance working relationships.

'I enjoyed the triage because you are working as a team, I think, aren't you...You're learning from each other and I just think it's a pulling together thing so I think its valuable in that way: doing things together because sitting in these rooms can be quite isolating, can't it? You get together at team meetings and whatever at other times but you know you're not working together more often than not' (Practitioner A4, post-intervention interview).

An unexpected opportunity that arose from the depth of discussion around clinical decisions following triage assessments was that this became a rich source of sharing knowledge about different treatment modalities. There was opportunity and time for practitioners to ask one another about specific approaches or medication, or to arrange specific training and supervision in a therapeutic approach, as can be seen in the data extract below.

'I learned from the debriefings about illness, therapy or whatever... I felt a bit like a sponge in it... either I didn't know about it and I had to go and look it up or, you know, we did learn about it from other people... I took it with me to other therapy sessions with other people, you know' (Practitioner A2, post-intervention interview).

Role of researcher during the action research process

Conducting action research in one's own area of clinical practice offers strength to the project due to credibility in the clinical field (Meyer, 1993) alongside a challenge about where to draw the boundary between researcher and practitioner. This uncertainty about the boundary between the two roles has already been acknowledged in the literature (Waterman et al., 2001; Williams et al., 2006). In this action research study, the development of the practice was driven by the researcher's understanding of the clinical problem and insights into possible workable solutions. Immersion within the clinical work of developing the triage model was an integral part of leading the change in practice, but there were occasions when there was a dilemma over the divide between the need for clinical leadership and the role of researcher.

The following field note extract highlights one such occasion, when a family was being interviewed but their presenting unmet clinical needs were so evident that the researcher's decision was to focus on addressing those rather than attend to the data generation to inform the evaluation of the project.

'Present was a mother, the index child and a younger preschool child with profound learning and physical disabilities... The index child struggled to keep still even though I was playing with him. He talked incessantly and was very busy; the mother commented this was his usual pattern of behaviour. She showed me the educational psychologist report, which indicated their concern for his lack of ability to concentrate and attend in comparison with his peers... Had I seen this child in my capacity as a CAMHS nurse, I would be conducting a specific assessment for ADHD... I found myself asking clinically relevant questions within this interview instead of focusing on the evaluative questions planned in my interview schedule. That left me feeling uncomfortable as I was supposed to be generating evaluation data. This was a one parent family where the index child had quite high needs, the mother was struggling. The child probably met specific diagnostic criteria but was undiagnosed... After the interview I contacted the CAMHS team secretary to pursue an appointment for them' (F10 family interview).

Such role conflicts frequently presented themselves during this study. On occasion, it was useful to discuss these openly with the collaborating team. The team was interested in exploring how to manage when a conflict arose, usually offering suggestions to address the clinical issue. It was also helpful to have conversations with a 'critical friend' (McNiff and Whitehead, 2002), who could help explore the interpersonal difficulties that arose. This critical friend was outside the study itself and was not familiar with the field but was familiar with qualitative research approaches and thus understood the nature of the potential conflicts between researcher and practitioner roles.

Conclusion

The development of a CAMHS triage clinic was facilitated using action research methodology, which combined the development of practice with a systematic inquiry into the process of that change. The qualitative data generated to investigate both CAMHS practitioners' experience of using the triage and families' experience of being assessed by this process demonstrated that the process itself

was acceptable and effective in determining children's needs. Waiting time for initial assessment was demonstrably improved. The engagement of referrers in the development of the triage and its subsequent evaluation could have been improved by using an alternative method to engage them, such as a focus group, or telephone rather than postal survey.

Implications for practice

- This assessment process worked well in addressing the waiting list issue for this service at this time. It was found that a brief assessment conducted by CAMHS practitioners enabled sufficient information to be collated to determine the necessity of CAMHS involvement and associated priority for a referred child
- A brief assessment process might be useful in a number of mental health fields to enable screening, triage or a gateway assessment to be conducted, to determine either the severity of symptoms causing the problem or whether the referred person meets the service criteria. In this study, the combination of the brief clinical interview and the use of psychometric measures (questionnaires), followed by a review meeting proved to be effective in ensuring effective clinical decision-making and for managing practitioners' anxiety about conducting time constrained assessments
- Action research methodology as an approach to introducing organisational change enabled a collaborative approach to developing practice, while allowing the opportunity simultaneously to examine the impact of that change

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