SHEFFIELD CITY COUNCIL

HEALTH AND COMMUNITY CARE AND CHILDREN AND YOUNG PEOPLE SCRUTINY AND POLICY DEVELOPMENT BOARDS

REPORT OF THE WORKING GROUP INTO YOUNG PEOPLE'S MENTAL HEALTH SERVICES

"CAN I JUST SAY I THINK IT'S GOOD THAT YOU'RE ASKING PEOPLE ABOUT THEIR OPINIONS BECAUSE I THINK THAT'S HOW IT ALL NEEDS TO BE DONE. I THINK THIS IS THE FIRST TIME THAT I'VE BEEN ASKED HOW I FEEL ABOUT THE SERVICES I RECEIVE".

(Comments from Focus Group 11/07/06)

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FOREW0RD

I would like to commend this report to you and at the same time say how much I have enjoyed the process. When this project started I had no idea of the issues we would be tackling, but it soon became very clear that this is an extremely important area.

It did prove challenging to remain focussed on the area of transition between Children and Adolescent Mental Health Services and Adult Mental Health Services. I was really pleased with the way this was achieved.

The project was a joint venture between the two Scrutiny and Policy Development Boards of the City Council and Sheffield Hallam University. This could have also provided challenges, but due to the professionalism and enthusiasm of all concerned I believe the project was enhanced.

I would like to especially thank Elaine Brookes, James Turner, Pat Day and Dr. Anne Hollows from the University for their help, support and dedication during the process.

I would also like to thank Councillor John Knight who was my Vice Chair, all the Members of the Working Group, the officers for both Children and Young People's Services and Neighbourhoods and Community Care.

Finally my special thanks to the officers from Committee Secretariat who have supported me throughout.

Councillor Clive Skelton,
Chair of the Working Group

WORKING GROUP INTO YOUNG PEOPLES MENTAL HEALTH SERVICES

1. INTRODUCTION

1.1 The purpose of this report is to set out details of the outcome of the scrutiny exercise undertaken by the Working Group on Young People's Mental Health Services established jointly by the Health and Community Care Scrutiny and Policy Development Board at its meeting held on 18th July, 2005 and the Children and Young People's Scrutiny and Policy Development Board at its meeting held on 20th July, 2005.

2. BACKGROUND TO THE SCRUTINY EXERCISE

2.1 In April, 2005, the Centre for Public Scrutiny invited bids for Year 2 of the Health Scrutiny Support Programme's Health Scrutiny Action Learning Project Funding.

2.2 The aim of the successful bids had to be to carry out a scrutiny review in response to the Government's White Paper "Choosing Health – Making Healthy Choices Easier" with a view to making recommendations which would seek to take forward locally a theme (or themes) from the White Paper, tackle health inequalities and improve the health of local people.

2.3 Bids had to recognise the wider determinants of health, the diverse partnerships that may be needed to improve health and the role that local authorities themselves can play in improving health and were encouraged around the White Paper's overarching priorities amongst which was "Improving Mental Health".

2.4 Following formal receipt of the invitation to bid, officers from Adult Community Care, Children's Services, Sheffield First for Health and Well-Being Partnership Board and Committee Secretariat, formulated a bid for a Scrutiny Action Learning Project which would consider Child and Adult Mental Health Services, with the particular emphasis on closing the transitional gap for young people with mental health problems who would be moving from the Child and Adolescent Mental Health Service (CAMHS) to the Sheffield Care Trust (SCT).

2.5 The project was viewed as an innovative and partnership based approach to using the scrutiny and overview function to improve health services and was deliberately focused on the Choosing Health Priorities and Themes which cut across the remit of the Health and Community Care and the Children and Young People's Scrutiny and Policy Development Boards.

2.6 It was proposed that the bid would utilise an advocacy and empowerment approach to engaging with young people with mental health problems, in particular those who had experienced the transitional period from 16 to 18, with this information being used to form the basis of case study evidence which would be collected together with the wider analysis of current service provision, current and projected needs, gaps and impact of not providing a

transitional service. It was also agreed that the funding for the bid would, in the main, be used to enter into a contract with an independent agency which would carry out the analysis and produce a final report and guidance suitable for national dissemination.

2.7 The aims of the project would be to test out a model of conducting a joint review where a focus was cross cutting the remit of two or more Scrutiny and Policy Development Boards and improving the mental health and well being of young people through reviewing the transitional service provision gap for young people with mental health issues from age 16 to 18 .

2.8 These aims would focus on the Choosing Health White Paper priority of improving mental health and the theme of children and young people.

2.9 The impact of the exercise was seen as being to (a) develop a model for joint scrutiny review, (b) develop a transitional support model for young people aged 16 to 18 with mental health problems, (c) develop a model for engaging vulnerable communities in Scrutiny, (d) achieve a reduction in the exacerbation of mental health problems and improvement in the quality of life of young people with mental health problems and (e) achieve a reduction in the numbers of young people with mental health problems entering the criminal justice system, becoming homeless etc.

2.10 In Sheffield, children and young people with acute mental health problems are provided with a support package through CAMHS until the minimum school leaving age of 16. This service is provided through the Children's Hospital Trust in partnership with the City's Primary Care Trusts and the City Council and there is also a set of partnership based service packages for adults with mental health problems provided by Community Care, PCTs and the Sheffield Care Trust.

2.11 The hypothesis which the review sought to test was that there was a gap in the transitional support for young people aged 16 to 18 and that without this support, young people were falling through the safety net. The provision of Adult Mental Health Services is very different to Children's Mental Health Services and without adequate interim preparation this experience can exacerbate young people's mental health problems and ultimately be a causal factor in young people becoming homeless, and entering the criminal justice system etc. it was also anticipated that this was a national issue.

2.12 The bid also saw many challenges in effective engagement of vulnerable communities in scrutiny reviews of relevant health related services. The approach which it sought to apply would add considerable value to the evidence collected in scrutiny reviews in that it would test the model of engagement which was sensitive to needs and which would facilitate the exploration of the experience of issues from a user perspective. The valuation aspect would include the identification of challenges and solutions in engaging vulnerable communities, in this case specifically young people with mental health problems, but it was also expected that these lessons

would be transferable to other groups.

2.13 The advantages of this approach were reflected in the well known benefits of engaging communities in health development highlighted in the Choosing Health White Paper. This approach was designed to provide detailed cases for this, tracking the experience of individuals, identifying common issues and gaining a detailed understanding of the needs and current experience of young people with acute mental health problems, particularly at the transitional ages of 16 to 18.

2.14 The bid would seek to use an opportunity to test an independent evaluation and reporting approach and would require a specific budget not normally available for scrutiny reviews but would also serve to highlight the benefits of independence when working through a scrutiny review topic, which cuts across many partners. In addition, this would provide a mechanism through which the learning from this review would be compiled into a report and guidance for national dissemination.

2.15 In conclusion, the bid set out proposed terms of reference for the review which would:-

"(a) examine through case studies, the experiences of young people with acute mental health problems, with a particular emphasis on those who, on reaching the age of 16 transfer to the Adult Mental Health System;

(b) determine from such case studies the extent to which the process of transition had a detrimental effect on the health and welfare of young people, and the impact of mental health problems and other aspects of children and young people's lives e.g. education, family life and admission to/leaving care; and

(c) bring forward recommendations to improve the service for young people with acute mental health problems."

3. MEMBERSHIP OF THE WORKING GROUP

3.1 In accordance with the decisions taken by the Health and Community Care Scrutiny Board and the Children and Young People Scrutiny Board at their meetings held on 18th and 20th July, 2007, respectively, Councillors Clive Skelton, Jane Bird, Keith Hill, Garry Weatherall, John Knight, Mary Lea and Helen Mirfin-Boukouris were appointed to serve as members of the Working Group.

3.2 Following the Annual Meeting of the City Council held on 17th May, 2006, Councillors Ian Saunders and Liz Naylor were appointed in place of Councillors Mary Lea and Helen Mirfin-Boukouris on the Working Group.

3.3 Meetings of the Working Group were also attended by John Randall (Head of Policy and Performance Unit, Neighbourhoods and Community Care), James White (Policy and Performance Manager, Children and Young Peoples Services), Roz Davies (Health Partnership Manager, Sheffield First for Health), Neil Garrett-Harris (Operations Manager, Employee and

Management Development Unit), Paul Robinson (Children's Scrutiny Policy Officer), Sarah Thomson (Administrative Assistant, Committee Secretariat) and Stuart Webb (Health Scrutiny Policy Officer) and the Consultants from Sheffield Hallam University Centre for Health and Social Care Research.

3.4 The City Council officers also comprised the membership of the Officer Steering Group which had been established to support the process and ensure delivery of the Project.

4. ROLE OF HEALTH SCRUTINY IN RELATION TO THIS INQUIRY

4.1 The Terms of Reference for the Health and Community Care Scrutiny and Policy Development Board, which had been approved by the City Council in May, 2005, were:-

"to exercise an overview and scrutiny function in respect of the planning, policy development and monitoring of service performance and related issues together with other general issues relating to adult and community care services, within the Neighbourhoods Area of Council Activity and Adult Education Services. It can also scrutinise the various local Health Service functions with particular reference to those relating to the care of adults."

4.2 Also at its meeting held in May, 2005, the City Council approved the following Terms of Reference for the Children and Young Peoples Scrutiny and Policy Development Board:-

"to exercise an overview of the scrutiny function in respect of the Planning, Policy Development and Monitoring of Service Performance and other general issues relating to learning and attainment and the care of children and young people within the Children's Services area of Council activity. It can also scrutinise the various local Health Services functions with particular reference to those relating to the care of children."

4.3 These functions were set out under new statutory powers included in the Health and Social Care Act, 2001 and the National Health Service Reform and Health Care Professions Act 2002, which empowered those local authorities with Social Services functions to appoint overview and scrutiny committees to review and scrutinise any matters relating to the planning and provision of Local Health Services and make reports and recommendations to local NHS bodies.

4.4 The aim of health scrutiny is to act as a lever to improve the health of local people. Its focus should be on health improvement in the widest sense, building on the power of local authorities to promote social, environmental and economic well being as well as the power to scrutinise local services provided and commissioned by the NHS.

4.5 It is not the role of overview and scrutiny committees to manage the performance of the NHS but to concentrate on ensuring the health needs of local communities are being met.

4.6 The Council power of well being conferred on Local Authorities in the Local Government Act, 2000, means that health scrutiny can look at any issue of service provision that impacts on the quality of life of residents of the City.

4.7 The remit of health scrutiny, its democratic mandate and its concerns with community well being, mean that health scrutiny can bring a wider dimension into an examination of services than, say, examinations which are undertaken on a narrower basis into individual service provision.

4.8 In the context of this scrutiny exercise, therefore, the Working Group were able to hear evidence and reach conclusions upon the services delivered by and impacting upon the Child and Adolescent Mental Health Services in the City and the Sheffield Care Trust.

5. APPOINTMENT OF CONSULTANTS

5.1 From the outset, it had been understood that the Working Group would not have access to a client group which comprised particularly vulnerable young people.

5.2 It was therefore necessary to engage specialist consultants to interview the Client Group and act as professional advisers to the Working Group and after lengthy detailed discussions between the Officer Group established to support the Health Scrutiny Policy Officer in his role as Project Manager for the exercise and colleagues of Sheffield Hallam University Centre for Health and Social Care Research, a contract was agreed between the City Council and the University to undertake these pieces of work.

5.3 The interviews with the client group were also the subject of detailed discussions between City Council Officers, colleagues from the University, the Sheffield Children's NHS Trust and the local Ethics Committee with a view to ensuring that all possible safeguards were put in place with regard to the welfare of the client group.

5.4 As a result of these discussions the University submitted a successful application to the Ethics Committee which was sponsored by the Children's Hospital NHS Trust and also submitted and gained approval for Advanced Police Checks.

5.5 It is the unique nature of this Scrutiny Exercise that has required a great deal of work to be undertaken by independent consultants to ensure the well being of the client group and therefore, unlike other scrutiny exercises, elected members were not involved in every aspect of the process.

5.6 Nevertheless, to enable the exercise to be conducted effectively, the Working Group have had access to detailed findings presented by the consultants and reflecting the views of the client group.

6. ACTION LEARNING

6.1 A significant part of the Scrutiny Exercise is its Action Learning Element.

6.2 After a great deal of consideration by the Officer Steering Group, it was agreed that the Action Learning Element should be undertaken by Neil Garrett-Harris, Operations Manager, Employee and Management Development Unit and a separate paper giving details of the Action Learning Exercise is set out as Appendix “B” to this report.

7. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES IN SHEFFIELD (CAMHS)

7.1 Child and Adolescent Mental Health Services in Sheffield are provided by the Sheffield Children’s NHS Trust which is the largest specialist provider of child and adolescent mental health services in the city.

7.2 CAMHS works in partnership to provide a comprehensive and high quality service to children and young people in Sheffield who are experiencing difficulties which are seriously impacting upon their mental health and emotional well being. The service aims to work closely with other professionals, agencies, families and carers and in doing this the service offers work with children their families and carers and, where appropriate, gives support to other workers by joint working, offering supervision, consultation and training.

7.3 CAMHS employs psychiatrists, nurses, psychologists and therapists working together to provide help for families who have a child with severe or longstanding mental health problems. At present they see children up to the age of 16 years and over the past three to four years, they have recruited staff to work in the community directly within a number of GP practices and providing mental health promotion in schools and identified areas of local need.

7.4 The service is organised into four teams with each team covering an area related to one of the former Primary Care Trust areas in the City.

7.5 Over the last few years the range of work done by CAMHS, Sheffield, has increased dramatically. Until four years ago the community based CAMHS teams offered to help families by seeing children and their carers, assessing the problems and issues and offering treatments. Each team now has staff who work with other professionals in the community, educational staff, social services staff, the voluntary sector and the general public and their remit is to provide education and training to children, young people and professionals and also to see families in community settings with problems

which are not so severe that specialist community teams need to get involved. The service hopes that by taking this approach, they can help other staff to feel confident in dealing with the children and young people they see and the service can help families before any problem has become severe.

7.6 For those children and young people with very difficult mental health problems, the service runs two day-patient and in-patient units.

7.7 As a service, CAMHS accepts referrals from GPs, qualified social workers, educational psychologists and other consultants in the Children's Trust.

7.8 Many CAMHS teams across the country are experiencing large rises in the rate of referral and in the City a great deal of work has taken place to train staff from all agencies who work with children and to offer them support via consultation and co-working. Nevertheless, even with this work there has been an overall rise in referrals to the Service from 1,168 in 2002-2003 to 1,305 in 2004/2005.

7.9 In addition to the work mentioned above, CAMHS also offers other services including a local community based Forensic Child Adolescent Mental Health Service which is a mental health service for young people who are subject to a legal order under the criminal justice system and including those who are placed in a secure children's home for their own welfare; support to children with disabilities through a dual diagnosis team which offers assessment, diagnosis and various interventions for children with moderate/severe learning disability and/or complex developmental problems including Autism, mental health problems and challenging behaviour; the provision of health promotion and prevention through Tier 2 Health Promotion and Prevention Teams which employ a brief solution focused approach providing an interface between CAMHS and primary care with an emphasis on community based accessible services in schools, GP practices and other community settings offering health education and promoting mental health; behaviour and education support teams which are multi-agency teams who work with targeted schools to promote emotional well being, positive behaviour and school attendance; multi-agency training through a training co-ordinator focused on the delivery of basic child and mental health training for workers in the community while providing a service to children and families experiencing mental health difficulties with the emphasis of the training being upon developing child and adolescent mental health awareness.

7.10 CAMHS also offers in-patient services at Shirle Hill Hospital and Oakwood Young People's Centre, both of which offer assessment and treatment facilities for children and young people between the ages of 5-16 years who present with emotional and behavioural problems as well as psychiatric disorders. Both facilities provide a residential and day service to the City, with additional contracts for residential services for districts surrounding Sheffield.

7.11 It is the view of the service that its development over the years has not been centrally led nor well funded. Services for children and adolescents emotional well being and mental health are now a central part of many of the reports which have emanated from Government and the development of CAMHS services are therefore guided by the following reports:-

- National Service Framework for Children, Young People and Maternity Services
- Green Paper – "Every Child Matters"
- The Laming Report
- Recent guidelines about support for adoptive parents.

7.12 In addition there are recent reports and recommendations concerning developments in the National Health Service which affect CAMHS including Foundation Trust status and the Government's policy of "Creating a Patient Led NHS".

7.13 Increasingly there are other reports which affect the clinical delivery of the service including

- National Service Framework Mental Health
- The Mental Health Act
- The Mental Health Bill
- NICE Guidance on Eating Disorders; Depression, Post Traumatic Stress Disorder and Obsessive Compulsive Disorder; and
- NIMHE report on violence and aggression.

7.14 CAMHS, whilst delivering a wide ranging service is still a relatively small service employing a total of 125 whole time equivalent personnel including 46 nurses, 11 doctors, 12 psychologists and 10 therapists as well as staff delivering service to primary care.

7.15 It is the view of the Service that the major gaps are, in particular, around the service for children and young people with learning disabilities and mental health issues with very little early intervention work being undertaken and no easy access to in-patient beds.

7.16 In support of this view the Service indicates that it is only now beginning to look at the development of mental health issues which arise when the child is pre-five, indicating that this is an area often enmeshed with maternal mental health issues and is often overlooked whilst services address very long waiting lists.

7.17 In addition, the provision of a liaison mental health service to the Sheffield Children's Hospital was prioritised for funding during the year but was not funded. This Service would enable children admitted to the Hospital (or seen as out-patients) to more easily have their mental health needs met.

7.18 The Government is also working towards people having a choice as to what therapy they can access (as clinically appropriate) and also who delivers the therapy and where; but within the constraints of such a small service, CAMHS is not able to offer all available therapies at all sites and is of the view that much more investment will be needed to enable this situation to be resolved.

7.19 The National Service Framework for Children and Young People states that mental health services for 16 to 18 year olds should be offered in an age appropriate environment; it also states however that young people should be offered a choice. If responsibility for delivery of services to this age transfers to CAMHS then the service is clear that issues of funding would need to be addressed. The service has no 24 hour support services such as crisis resolution services and no intensive care unit for very disturbed young people, two gaps which would need addressing as well as the expansion of the general service.

7.20 The Service believes that one of its biggest difficulties is the lack of continuing investment for a vastly under-funded service and a threat of a reduction of funding to the Service. Although over the last three years, CAMHS has received specified funding from the Local Delivery Plan (health monies) this is being incorporated into the PCTs overall budget and as a result of this and of a difficult budget position in the local health economy, CAMHS may have to make large cuts to the budget and consequently reduce its service. This is set against a background of adult mental health services nationally and locally spending as much as four times per head of population more than is available for spending on children with mental health problems.

7.21 CAMHS believes that this situation will impact dramatically on their waiting times which have fallen significantly and also on the services which they have developed in conjunction with Local Authority Social Services and Children and Young Peoples Services.

7.22 Services such as the Forensic and Looked After Children's Services have been identified by the multi-agency CAMHS strategy group and have had investment and leads from all agencies. In conclusion, the Service believes that if it is to maintain and build on its present services it needs secure funding, which is able to expand to meet gaps as identified by health services and partner agencies and to expand to deliver services as required by the NICE Guidance on Clinical Issues.

8. THE SHEFFIELD CARE TRUST

8.1 The Sheffield Care Trust is a large, integrated mental health and social care organisation with its staff being geographically dispersed and working in multi-disciplinary teams. Access to services depends upon geography, specificity and severity of problem.

8.2 Central to the provision of services is the engagement at all levels of users and their carers, in individual care, team governance, recruitment of staff and developing strategies. Partnerships with a wide variety of agencies are crucial and co-ordination of care is centrally dictated by adherence to the Care Programme Approach with much of the work of practitioners and teams being subject to targets and performance management.

8.3 The Trust provides services for people aged 16 upwards which is the age which Child and Adolescent Mental Health Services in the City cease. Young People enter SCT services through community teams, in-patient services or by contract from Children's services to specialist teams.

8.4 The Trust have agreed a protocol with CAMHS to follow at the transitional ages and believes that the protocol has been considered useful as a working document but does not provide for complexity, or mirror the increasing realisation of needs and successes in working together.

8.5 The Trust is of the view that there is a general consensus that the provision of services to young people through adult mental health services has considerable difficulties and can be unsatisfactory for young people, staff and families. Nevertheless, the Trust are constantly seeking to adapt and improve the experience of young people.

8.6 Providing for such needs demands a familiarity with issues of psychological development which the Trust's staff will all have met whilst training but which they are not currently practising and this can lead to considerable difficulties for the young people.

8.7 Statistics from the Trust indicate that, from April to November, 2005, 561 people up to 19 years of age were seen across all teams in Adult Mental Health and during the same period five young people were admitted as in-patients, two aged 16, one aged 17 and two aged 18 and the rehabilitation services are working with four people who are longer term patients (that is admitted before April, 2005).

8.8 The aim of the services offered by the Trust is to work with people at home for as long as possible. To that end people now have the opportunity of assessment and home treatment from newly configured and dedicated teams. Increasingly admission to hospital would be for a minority of people at times of severe crisis or with exceptional presentations or under other difficult circumstances.

8.9 The Trust accepts that placing under 18s on adult wards has obvious problems which increase with the decreasing age of the young person and in such circumstances the Mental Health Act Commission is obliged to visit staff.

8.10 The focus of staff during an in-patient stay is now to provide respite and security for the person, to assess their needs and their psychological and mental health problems and to provide treatment in the context of any continuing care in the community, or to create that care for when they leave.

8.11 An intensive treatment service also supports the general acute wards by providing extra expertise on a more containing environment for behavioural and emotional difficulties. It is a relatively small service, eligible to all for care by the adult services and there have been at least two young people aged 16 to 18 who spent several months on ITS because there was no other service either in the City or externally who were able to admit them. This situation is considered by all practitioners as being far from the ideal.

8.12 In addition to in-patient services, the Trust has Community Mental Health Teams (Sector) who deal with increasingly complex mental health and social care needs for the adult age range with young people being likely to be referred into these teams by GPs and other community staff when they are experiencing symptoms such as those of depression, anxiety, obsessive compulsive disorders or who have harmed themselves and approximately 235 people have been referred this year at ages under 16 to 19; Community Mental Health Teams (Continuing Needs) specialise in people who present with psychosis and similar difficulties and, typically, have longer contact with individuals who are established on the Care Programme Approach.

8.13 At different times, people may also receive help from Assertive Outreach Teams if they have repeated hospital admissions and are not engaging with services and achieving recovery.

8.14 The Early Intervention Service is managed alongside the Continuing Needs Service Teams and is a new and pioneering development in the City which is now part of the National Service Framework development and which works with people from 14 to 35 years of age with a recent onset of a psychotic illness.

8.15 These individuals are often those who will develop the most severe and intractable forms of illness and few develop psychosis younger than 14 years and from the point of view of maturity it appears to the Trust to be a reasonable age when they can think of them as young people rather than children.

8.16 Early intervention experts work jointly with CAMHS from 14 to 16 years of age with the psychosis expertise resting within Adult Services. Key to provision in this area is that children should not suffer discontinuity in the team treating them in those early stages when the diagnosis may be unclear. The caseload of the team is around 120 and the average age of

clients is around 21 with four people being under 16 years of age who are being cared for jointly with CAMHS. There has been involvement in transition with about four other clients who are subsequently taken on by other parts of the Trust's services.

8.17 The Trust estimates that a probable total of 12 people have had some contact with CAMHS at some point before presenting to the Early Intervention Service. These numbers are towards the end of first year of EIS set-up across the City and the fully developed EIS (hopefully by the end of 2007) is likely to have a caseload of 360 clients and therefore these other figures are likely to increase proportionally.

8.18 The Trust believes that much has been learned about the differences between adult and child services through joint working with particular issues being dealt with by the Eating Disorders Services and Art Psychotherapy and Clinical Psychology.

8.19 Joint working between the Early Intervention Service and CAMHS has, the Trust believes, illustrated differences in speed, flexibility and prioritisation. EIS seeks to work in an assertive outreach model of community care and CAMHS are at the opposite end of a spectrum and are often an appointment and building base service. The Trust is of the view that the one service holds the expertise in psychosis and the other in systematic and developmental work. The slowing of joint working to the lowest speed of response to equalise the joint working can risk young people being excluded from receiving a service. The Trust is of the view that early intervention in the course of the illness is highly beneficial to outcome.

8.20 The Care Co-ordination that exists for adults does not, again in the view of the Trust, appear to be there for children where there is no alternative mechanism to structure care from multiple agencies. This can lead to a vacuum, putting pressure on EIS staff to intervene which again could be dangerous without the child expert. The Trust believes that shared training and mutual learning, with support from senior practitioners and leaders/managers is a way through this joint learning exercise where each team needs to be able to access the expertise of the other, with equal respect.

8.21 The Trust indicate that there are very fundamental differences in the approach between Continuing Needs Service Teams and CAMHS in working with young people who have a high level of needs. The Approved Social Worker has a responsibility to consider the least restrictive option to admission whilst at the same time ensuring that the person receives the appropriate treatment and care and they would routinely consider intensive community options.

8.22 It is also the view of the Trust that intensive support to families of children in crisis does not seem to be available as it is with adults although it may well be preferred to in-patient admission. Children may have to be admitted because there is a lack of support worker resource and training to support

them at home.

8.23 In addition there are no approved social workers in CAMHS and this is perceived by the Trust as a gap in terms of that particular area of specialist knowledge within their multi-disciplinary teams. The Trust also believes that when the new Mental Health Act is applied, it will be essential that CAMHS ensures that they have a sufficient number of approved Mental Health Practitioners from whatever profession.

8.24 Adult mental health services have developed in recent years in response to the National Service Framework for Mental Health. Areas within which standards should improve include access to services at the primary level and improvement of services at the secondary level.

8.25 The Trust indicates that policy directives abound across the whole area of provision and specific to certain services with the most important emphasising recovery, social inclusion and integration of services across all agencies to achieve the multiplicity of services which people need.

8.26 Policy frameworks for provision are around direct payments in the Social Care White Paper, “Choosing Health” and care for people outside hospital.

8.27 In conclusion the Trust offer the view that choice, practice based commissioning and payment by results will affect service organisation with the quality of service being monitored by health care standards. Central to feedback are the experiences of users of the Trust’s services and their carers with practice becoming increasingly into line with guidelines for conditions, such as depression, anxiety, schizophrenia, self harm, obsessive compulsive disorders and eating disorders.

9. INTERVIEWS BY THE MEMBER WORKING GROUP

9.1 As referred to earlier in the report, it was understood that the Working Group would not have access to the client group and therefore so far as obtaining evidence through interviews was concerned, the Working Group concentrated upon seeking the views of Practitioners and Professionals who work with young people with mental health issues.

9.2 Over a three week period, the Working Group gathered evidence from a wide cross section of individuals involved in young people’s mental health services and including persons from the voluntary sector.

9.3 Whilst being presented with a range of professional perspectives and views, it soon became clear to the Group that a number of common views were held by the majority, if not all of the interviewees with regard to the means by which the transitional process could be improved; and it is these views which have led to the conclusions reached by the Working Group and which, together with the conclusions reached by colleagues from Sheffield Hallam University following their interviews with the client group, have formed the basis of the final recommendations in the report.

9.4 There was a widely held view that, whilst lines of communication existed between the two Services, communication was often fragmented and this led to inconsistencies and lack of cohesion in the transitional process.

9.5 It was also recognised that whilst a protocol for transition existed its application was also inconsistent. This situation was viewed by the Working Group as both a cause and symptom of the lack of communication referred to in 9.4 above.

9.6 So far as the transition process itself was concerned there appeared to be an arbitrary "cut off" age of 16 for clients to move away from CAMHS to the Care Trust. In this regard, the Working Group accepted the opinions expressed by a majority of the interviewees that decisions upon the point of transition should be taken with due consideration being given to individual circumstances and needs and that, if an arbitrary age were to be applied, then transfer to adult services should be at 18 years of age in line with national guidelines.

9.7 The arbitrary nature of transition concerned all parties and there was a general view that more support should be offered to clients during the course of the process.

9.8 There was a sense that clients and/or their carers had "nowhere to go" in times of difficulty and whilst acknowledging the financial constraints on both Services, the Working Group nevertheless concurred with the widely held view that a support structure should be established which used individual staff in a "buddy system" to support clients through transition.

9.9 Expanding upon the theme of increased support most interviewees also believed that the CAMHS philosophy of involving parents and carers of clients should be adopted by the Care Trust, particularly in those circumstances where CAMHS were of the view that such continued involvement would be to the benefit of the client.

9.10 The Working Group also held the view, again expressed by the majority of interviewees, that continuity was a major factor in the successful transition experiences of clients and that increased dialogue between the Services with regard to diagnosis and treatment be introduced.

9.11 This element of continuity should not only flow from CAMHS to the Care Trust but should also be encouraged to move in the other direction with, for example, consideration being given by CAMHS to adopting, in consultation with the Trust a Care Pathway Approach.

9.12 Turning to the role of the Early Intervention Service, the Working Group was struck by the high regard in which the Service was held by all interviewees.

9.13 It is the view of the Working Group that increased support should be given to the Early Intervention Service to enable it to participate in all stages of

transition and to expand its remit of dealing only with psychosis.

9.14 Nevertheless, the proposed expansion of the Service towards a projected capacity in 2007 under the auspices of the National Service Framework is welcomed by the Working Group as a vital contribution to service provision in the City.

10. YOUNG PEOPLE FROM BLACK AND MINORITY ETHNIC COMMUNITIES

10.1 A number of respondents from both Social Services and Health backgrounds had suggested to the Working Group that, because of cultural differences, young people from the Black and Minority Ethnic Communities had experienced particular difficulties with the transitional phase from CAMHS to the Care Trust and in light of these views it was suggested that interviews be held with persons involved with young people from the BME communities with mental health issues.

10.2 Strenuous efforts were made by officers to make arrangements to hold such interviews; but, whilst indicating a willingness to be interviewed, none of the prospective interviewees could recall any instances of particular difficulties being experienced by young people in transition as a result of their ethnicity.

10.3 Interviews with practitioners and with a representative from the Voluntary Sector did however lead the Working Group to the view that there were cultural and sociological problems impacting upon questions of access and attitude with regard to young people from BME communities who were experiencing mental illnesses.

10.4 This situation had been highlighted in a report published by the South West Child and Adolescent Mental Health Team of the Children's Hospital Trust in November, 2005 and which inter alia found that "(a) there were low referral levels from all GP practices in the area, (b) GPs had a misconception about waiting list times (for referrals), (c) GPs believed that they had to pay for CAMHS services, (d) GPs ability to recognise mental health difficulties when presented as physical symptoms was often limited, (e) a proportion of BME families did not access their GPs regarding mental health issues, (f) cultural barriers to accessing services and information; stigma associated with mental health; not being aware of the service or what it does; concerns that cultural needs, including religious and spiritual ones would not be met, (g) spoken and written language was a barrier in accessing services and information; some BME families had English as a second language; some BME families spoke no English and (h) there was a lack of appropriate cultural competence within Sheffield CAMHS."

10.5 The Working Group did not doubt that these questions had to be addressed as a matter of some urgency but within the narrow parameters of this scrutiny exercise and its examination of the transition process, felt unable to either conduct meaningful enquiries or to bring forward informed recommendations.

10.6 Nevertheless they do recognise, in broad terms, the difficulties experienced by young people from BME communities and their families in the area of mental illness and the need for early and appropriate treatment.

11. SHEFFIELD HALLAM UNIVERSITY RESEARCH

11.1 The work of the Consultants from Sheffield Hallam University Faculty of Health and Well-Being was predicated on the view that transition to adulthood is difficult for all young people, but particularly traumatic for young people with mental health problems who have to move between services. Many young people were "lost" to services and those who did receive them were often not happy with the support given.

11.2 One in ten children will develop a mental health problem and the numbers increase with age. One in five 16-25 year olds suffer from a mental health disorder. This population's health and education are adversely affected by poor mental health. As a result, there was a significant impact on life chances in adulthood. There was also a high cost to society. Suicide was the main cause of death of young men aged 15 to 24 and there was a high suicide rate among young Asian women.

11.3 The methodology used by the University was designed to provide detailed case studies tracking the experience of individuals, identifying common issues and gaining a detailed understanding of the needs and current experience of young people with acute mental health problems, particularly at the transitional ages of 16-18.

11.4 The component methods of the study included:

Focus group interviews which were undertaken with young people who have experience of using mental health services while aged between16-18. The purpose of these interviews was to gather first hand experience and to understand the shared and discrepant experiences of young people who have experienced services designed to respond to their mental health needs.

In-depth case studies from the participants in the focus groups, with a small number of individuals being selected for in-depth case study research, in which the views of the young person and associated stakeholders (parents/carers, school or college tutors, professionals involved in the case etc) were sought with the young person's explicit consent. This provided more detailed information and understanding of the processes and

experiences, reflecting the wider range of stakeholders in the experience of service provision.

Review of administrative data, with administrative data regarding referrals and treatment of 16-18 year olds over the past 3 years both to CAMHS and the Adult Care Trust being examined to identify trends and to relate issues raised in the interviews to the frequency of instances. Due to time constraints this form of data collection was minimal.

Participants for this study were gleaned from two main routes:

- Through support from CAMHS via key workers

- Through analysis of Insight, the data base for the Sheffield Care Trust and Sheffield Children's Hospital

11.5 CAMHS provided a list of 12 clients who had been approached by their key workers to be involved in the study. Of these clients eight were male and four female. Seven of the males were included in the study and the consultants were able to interview one with his mother. Of the seven males, two were included in the interviews of parents, one extensive recorded interview the other a short telephone conversation.

11.6 Some clients were unable or declined to take part in the project, and the final numbers of interviews were:

- 3 individual client interviews
- 3 focus group clients
- 6 parents
- 2 General Practitioners
- 5 key workers (plus the EIS team for South East)

In total 17 separate pieces of data were gleaned for analysis. As this study has an action research element there was also a reflective practice piece transcribed, which are the reflections on the focus groups by the two researchers facilitating this group.

11.7 Many positive comments and observations were made by the participants within the project:

- There was general support for the changing from CAMHS to adult services, given some persuasion from the GP. This process was maturational in that the young people considered adult services to be the more appropriate location and had the skills to help their mental health problem, for example self harm. However, there were drawbacks in there being a less accessible range of services in adult compared to CAMHS.

- Value of GP – GP’s were very important to the parents and the clients, being seen as a bridge and advocate of the clients' needs.

Participants talked of ‘excellent support from my GP’. GP’s have the ability to track clients longitudinally through their notes and have longer term involvement with the family.

- Mental Health staff - CAMHS was generally accepted as a flexible, compassionate and organised service for the clients. However there were some comments about the CAMHS orientation being seemingly over weighted to the younger age group, rather than adolescents. Never the less, relationships were important for participants which has a bearing on the client's response to transition. Once in adult service there was generally a sense of the staff seeking to understand the young persons, albeit sometimes in an exploratory way in terms of finding an appropriate treatment modality.

- Protocols - specialist services like Eating Disorders and Early Intervention Service seemed to have a protocol of transition where meetings and information sharing took place. This practice was not apparent across all aspects of the service.

11.8 There were unhelpful aspects of transition across services commented upon and shared between participant groups, most importantly about reasons for transfer, information sharing, changing staff and a perceived change of culture between services

- Reasons for transfer: most young people were transferred because of their age at 16 and were perplexed that this should be an automatic cut off. One family felt their transfer was highly inappropriate and based more on their child's behaviour and physical appearance rather than clinical need. A further two clients were discharged from CAMHS because at the time they were perceived to be ‘doing all right’ but subsequently deteriorated within a few months of discharge and had therefore to re-engage with adult services as a ‘new starter’ rather than having transferred appropriately.

- Information exchange: CAMHS and the Sheffield Care Trust are separate services under their own management structures, with different provision for case note access, although they both currently share the same information data base. Consequently the researchers felt that it might be expected for there to be some complexities with the transfer of notes from one service to another. A general lack of information (except with regard to specialist services) was however noted, information about services, about timescales and process of transition, about mental health problems affecting young people and about support services/groups for both parents and young people. A theme among the parents was a lack of information about adult services.

- Cultural differences between the Services which were best relayed through the following quotations:

- Expectations on attendance from adults without necessarily assertive outreach – *"it's a big responsibility making all your appointments and things like that, that's the sort of thing that you learn as you grown up. It's a big responsibility to turn up for appointments; you only get so many chances"*.

- Access to services – *"give young clients more chances and send them more appointments to give them more chances to attend, The overall difference in philosophy of engagement seems to have more of an arms length people it is about people have to show willing to come to the service, make appointments and things like that. Opposed to our more outreach, keeping in contact*".

- Adult services have less scope to offer multiple workers than CAMHS - other than individual work it seems as if other services, like day services, would be inappropriate for young people. *"But certainly there's nothing for us to refer that's age appropriate at all - there's nowhere for them to go"*.

11.9 Caring for carers was seen as a significant target for adult mental health services and as such it was felt that there needed to be some attention drawn to the experience of the parents in this study. Carers collectively felt that they were often managing alone, lacked information, lacked respite and generally were left holding risk whilst services made their mind up about interventions and treatments.

Parents' needs can be summed up as follows:

- Support groups
- Individual support
- Respite
- Respite information and feedback

11.10 So far as contact between services and clients was concerned, clients and others found both the written word and verbal dialogue to be an expectation of communication between services. Clients definitely did not want services to contact them via text.

11.11 The researchers summarised the general findings into 10 key aspects which reflected an ideal model of transition from CAMHS to adult mental health services:

1. Age appropriate service: There was virtually unanimous support for a young person's mental health service that was located in the adult mental health service. This location would enable there to be no third transfer if it was necessary to an older age group. The general position being early intervention and appropriate treatment options to reduce the opportunity for long term ill health. Staff would be trained and familiar with the need and treatment approaches effective with

this potential client group. Significant anxiety was located in young people being admitted to adult secure wards and this intermediate model would have its own small admission unit. Key points:

- 15-20
- Community based
- Child and parent support groups
- Information essential
- Small admission unit for this age group
- Staff trained to manage this group
- (All clients commented in favour, plus key workers, GP and parents)

2. Planned transition following a clear pathway of care

3. Bridging : this was mentioned by 80% of clients, 100% of GP's, a number of parents and key workers. Essentially this means having at least one meeting prior to transfer to introduce new workers and the service and one after transfer to make sure all relevant steps have been taken.

4. Empowerment of young people : 'I think to be asked what I wanted really' or self determination through being heard - All participants felt it important to involve the key stakeholders in the configuration of services and in particular the clients and parents found this an emancipatory exercise.

5. Recognition of the role of parents in the ongoing support and management of their children. Three themes emerged from parents:

   - Respect for non involvement of parents in consultations but some communication with parents with young person's collaboration (all clients commented)

   - Client and parent support groups - A few parents commented on their isolation and lack of support, for both respite and in general for their mental health hoping for some individual support or age appropriate group support.

   - Uninformed as to the nature of the services and the nature of their child's mental health problem.

6. Information : encapsulated in observation of a GP but reinforced by all clients was the need for 'as smooth as you could the transfer between child to adult and passing on the notes and talking to each other'

7. No time lag between services: it is of concern that three of the clients in this study, who were vulnerable, had significant time lags without a

specialist service, the maximum time being 2 years for a psychotic young man.

8. There should be an assessment of risk by services of the client's future needs, as care needs to be taken when discharging clients.

9. Early engagement and continuity of service is prized by the young people, their carers, key workers and GP's.

10. An audit trail should be established for each client as they pass from one service to the other.

11.12 The Research Team reached the concluding view that fundamental to the issue of transition is the tension inherent in all work with young people between children's and adult services. While many of the participants rejected the overt aspects of a children's service (the cuddly toys, child-friendly interviews and environment) and resented sitting in a waiting room with much younger children and their parents, they still sought the 'containment' and security offered by those services. While they wanted to be consulted about changes and developments in their treatment they were far from able to deal with the choices inherent in the approach of adult services.

11.13 One of the strongest criticisms of the children's services was apparent in their sense of being patronised and 'talked down to' while in adult services they felt that discussions and conversations sometimes took place above their heads. This was even more vividly expressed when discussing their experiences with Accident and Emergency Services - an obvious concomitant of mental health services where self harm is the visible symptom of mental distress.

11.14 An approach consistent with respect for the rights of these young people would go some way towards remedying some of these problems.

11.15 The full report of the Research Team is set out at Appendix “A”.

12. CONCLUSIONS

12.1 Mental health is a government priority target and the National Service Framework for Mental Health emphasises the development of effective interventions to promote mental health. Children’s mental health is an increasing concern and is a developing theme within the Children’s National Service Framework. Standard nine relates to the access of all children and young people to integrated, high quality mental health services. Continuity of care between child and adult services should be ensured using a 'care programme approach'.

12.2 Within this framework, the importance of the seamless transition of teenagers to adult mental health services has come under increasing scrutiny.

12.3 The Working Group would wish to recognise the high levels of service offered by CAMHS and the Sheffield Care Trust in the treatment of young people with mental health issues and the undoubted commitment and professionalism of staff in both organisations.

12.4 The purpose of this, as with all other scrutiny exercises is, however, to seek to improve service delivery by bringing forward recommendations following an examination of the issues and the seeking of views from providers and clients. In this context, the Local Authority's role is that of the "critical friend" and it is this philosophy which has underpinned this scrutiny exercise.

12.5 Over a period of time, comments from professional colleagues had indicated the need for an examination to be undertaken of the transitional arrangements for young people moving from CAMHS to the Care Trust and further detailed enquiries led to the decision to put forward a bid to the Centre for Public Scrutiny.

12.6 It is the view of the Working Group, having now completed the scrutiny exercise that these initial judgements were entirely justified. Significantly, although many of the conclusions reached by both the Working Group from interviewing professionals and providers and the team from Sheffield Hallam University from interviewing clients had common ground, the two groups of interviewees perhaps, not surprisingly, brought different perspectives to bear in putting forward proposals for service improvements.

12.7 Whilst recognising the need to improve the client experience, the professionals and providers views leant markedly towards structural change whilst the clients saw a lack of consultation with regard to their views and in many cases a perceived lack of empathy.

12.8 It is both sets of views which have informed the recommendations of the Working Group but in setting out these recommendations, the members of the Working Group would wish to make it abundantly clear that they are not in any way, to be seen as a critique of the services which perform a vital role in the care and treatment of young people with mental health issues in the City, but rather as a series of proposals for improving that care and treatment.

12.9 Finally, the Action Learning Element of the exercise which the Centre for Public Scrutiny saw as a significant factor in the bid, particularly with regard to the use of outside consultants and their interaction with the Working Group and the Officer Support Team, assumed a further dimension with the need to receive consent from the Local Ethics Committee for the consultants to interview the client group and there is no doubt that the lessons learnt from this element of the scrutiny exercise will be of considerable value to future pieces of work following the dissemination of these lessons by the CFPS.

13. RECOMMENDATIONS

13.1 A Joint Working Group between CAMHS and the Care Trust be established to (a) examine the effectiveness of the existing protocol for transition and to make any amendments and evaluate as it deems necessary;

(b) monitor the consistent application of the protocol; and

(c) ensure that the transition process is effectively managed.

13.2 An age appropriate service for young people, located in adult services but designed for young people and with the following characteristics be established:

- 15-20
- Community based
- Information essential
- Small admission unit for this age group
- Staff trained to manage this group
- Respect for non involvement of parents in consultations but some communication with parents with young persons collab oration (all clients commented)
- Client and Parent support groups - A few parents commented on their isolation and lack of support, for both respite and in general for their mental health hoping for some individual support or age appropriate group support.
- Parents informed of the nature of the services and the nature of their child's mental health problem.

13.3 The age of transition to be raised to 18 but with in-built flexibility to take account of individual client needs.

13.4 Planned transition following a clear pathway of care with "Bridging" an expectation of this transition.

13.5 Both Services involved in the transition process to ensure the involvement of young people, their carers and other stakeholders in developing and reviewing services.

13.6 Both services to enter into urgent discussions with a view to implementing an advocacy and support system for clients in transition and on a one to one basis to enable clients to enjoy support throughout the transition process.

13.7 The SCT to involve the parents and carers of clients more, thereby building upon the work of CAMHS in this area and if, in the opinion of CAMHS, the well-being of the client is benefited by the involvement of parents and carers, the Care Trust should be prepared to give favourable consideration to building upon this element of care by continuing to involve parents and carers.

13.8 Transition should include no time lag between closure in CAMHS and admission to Adults/Young Persons service.

13.9 An audit trail should be established for each client as they pass from one Service to the other.

13.10 More effective exchange of information, with notes transferring to the referred service at an appropriate time before transfer and supported with dialogue between the services. Increased consultation between CAMHS and SCT with regard to diagnosis of clients leading to consistency of diagnosis and treatment thereby ensuring all aspects of the clients mental health are identified and addressed. Early engagement and continuity of service is prized by the young people, their carers, key workers and GP's.

13.11 Risk assessment by Services of clients' future needs before they are closed to CAMHS.

13.12 CAMHS to consult with the SCT with a view to adopting a CPA to ensure effective care co-ordination in the Transition process.

13.13 Increased funding support and expansion of the E.I.S at every stage through transition in addition to its existing remit of dealing with psychosis only.

13.14 CAMHS be requested to examine the question of access to and responsiveness of their Service with regard to the BME community.

Sheffield Hallam University

Faculty of Health and Wellbeing

Full Project Report:

Sheffield City Council Scrutiny Study:

Review of the arrangements for transition from CAMHS to adult mental health services

Produced by:

Faculty of Health & Wellbeing
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Authors:

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Date: August 2006

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'Can I just say I think it's good that you're asking people about their opinions because I think that's how it all needs to be done. I think this is the first time that I've been asked how I feel about the services I receive.'

(Comments from focus group, 11/7/06)

'I did think that when she came to you it was good for her because maybe I felt as though she had quite enjoyed the experience. She came back quite positive and perhaps made her feel as having some power of the situation'

(client 3 parents interview)

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- Lastly but most importantly all the clients, parents, key workers and GP's who gave their valuable time and rich experiences to enable this document to be produced. We wish you all the best on your continuing journeys.

Sincerely and with best wishes

James Turner, Pat Day and Anne Hollows.

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Section 1 Background to the study and relevant literature

1.1 An Outline of the Health Scrutiny Function

- Local Government Act 2000 – established the two separate roles of Executive and Overview & Scrutiny within (most) local authorities.

- The Council sets the budget and the overall policies of the local authority.

- The Executive (i.e. Cabinet) is responsible for taking decisions which are required to be made to implement Council policy.

- Overview and Scrutiny Committees (OSCs) scrutinise and hold the Executive to account publicly for their decisions – they have no decision-making powers, but make reports and/or recommendations to the Council or Cabinet as appropriate.

Process

- The two main roles of Overview and Scrutiny relate to reviewing policy outcomes and advising on policy development (the overview role) and holding the Executive to account for its decisions and performance (the scrutiny role).

- In terms of scrutiny, OSCs can call-in for reconsideration decisions made, but not yet implemented by the Cabinet; question the Cabinet, Cabinet Members and officers in relation to the performance of the Council or in relation to particular initiatives or projects; and scrutinise the performance of other public bodies delivering services in the area.

- In terms of overview, OSCs can assist the Council and the Cabinet in the development of its budget and policy framework by undertaking in-depth analysis of policy issues, gathering appropriate evidence/research and consulting with all relevant stakeholders, service users and/or the wider public as part of that process; OSCs can appoint advisers and assessors to assist their deliberations, can conduct site visits, public surveys, public meetings, commission research etc, and may ask witnesses to address them on any matter under consideration.

- In addition to exercising the overview and scrutiny roles in relation to the discharge of any of the local authority's functions, OSCs can consider any matter affecting the local authority's area or its inhabitants – this reflects the community leadership role of local authorities.

Overview and Scrutiny of Health

Role and Responsibilities

- Health and Social Care Act 2001 – built on the community leadership role of local authorities and their duty to promote the well-being of their citizens by empowering those authorities with social services responsibilities to have an OSC that can respond to consultations by local NHS bodies on substantial variations or developments of health services and can take up the power of overview and scrutiny of broader health issues.

- That Act provided OSCs with a statutory right to be consulted on proposals for substantial variations or developments to health services in their area (effectively the scrutiny role) and specific powers to review any matter relating to the planning, provision and operation of local health services (the overview role) and placed corresponding duties on NHS bodies to consult their local health OSC and co-operate in their reviews.

- Health overview and scrutiny is viewed as an important part of the Government's commitment to place patients and the public at the centre of health services and is seen as a fundamental way by which democratically elected community leaders may voice the views of their constituents and require local NHS bodies to listen and respond – thereby "closing the democratic deficit".

- The primary aims of health overview and scrutiny are to ensure that: health services reflect the views and aspirations of local communities; all sections of local communities have equal access to services; and all sections of local communities have an equal chance of a successful outcome from services.

Process

- The Regulations and associated guidance on health overview and scrutiny do not define substantial variations or developments, nor prescribe how the health OSCs powers should be exercised, but leave them to local determination – accordingly, the City Council and the local health bodies have developed a protocol for the scrutiny of health in Sheffield and agreed a definition of substantial variation or development.

- Again, health OSCs have no power to make decisions or to require that others act upon their suggestions, but hold NHS bodies to account publicly for their activities and performance. They can make reports and recommendations to local NHS bodies on any matter reviewed or scrutinised (and publish those reports), and can require those bodies to respond to the recommendations made.

- The OSC's report would generally include an explanation of the issue addressed, a summary of the evidence considered, a list of the participants involved in the review or scrutiny, and any recommendations on the matters considered.

- If required to respond to a report of an OSC, the NHS body(s) is required to do so within 28 days and its response should set out the views of the NHS body on the OSC's recommendations, and proposed action or reasons for inaction in relation to the recommendations. Again, the response would generally be published.

So, as regards the health scrutiny action learning project relating to mental health services to young people:-

- The Project is being conducted as part of the health overview role relating to the arrangements made by local NHS bodies to secure and provide hospital and community health services to Sheffield's citizens;

- The views of patients and service users will be considered by the OSC and, in turn its recommendations have to be considered by the relevant NHS bodies;

- Key aspects for achieving a positive outcome to the exercise are evidence-based recommendations for service improvement and public accountability.

1.2 Background to the study - Aims and Objectives

In Sheffield Children and Young People with acute mental health problems are provided with a support package through CAMHS until the minimum school leaving age of 16. This service is provided through the Children's Hospital Trust in partnership with the PCT's and Sheffield City Council. There is also a set of partnership based service packages for adults with mental health problems provided by Community Care, PCT's and the Sheffield Care Trust.

There are complexities in the transition for all patients from CAMHS to adult services, as there are in all transitions between services. This project is seeking to investigate the transition process for positive and problematic factors, to then inform practice and enable them to look at their interfaces and systems and adjust as necessary, to facilitate positive transitions between the services concerned.

A key question for the scrutiny review concerns the effectiveness of transitional arrangements for the care of young people age 16-18 with mental health problems. If these arrangements are not effective, vulnerable young people will fall though the safety net. The provision of adult mental health services is very different to children's mental health services and without adequate interim preparation the experience of different services can exacerbate young people's mental health problems and ultimately be a causal factor in young people ending up homeless, entering the criminal justice system or self harming. With 10% of children overall having moderate to severe mental health problems and associated psycho-social difficulties, the risk of self harm increases. Loss and deprivation are causative factors in self harming behaviour, the loss of a trusting relationship, during the transition process, is therefore significant (Ryan 1999).

It is generally understood that risk increases in the two weeks following discharge from services or when a client is in the transition between services. Fostering and developing a working alliance between staff and service users has direct impact on outcomes for service users with mental health problems (Onyett 2000). It is therefore essential in managing clients that these relationships and alliances are considered in transition.

This project is an innovative and partnership based approach to using the scrutiny and overview function to improve health services. It is deliberately focused on Choosing Health priorities and themes, which cuts across the remit of the Health and Community Care and the Children and Young People Scrutiny and Policy Development Boards.

Sheffield will be using an advocacy and empowerment approach to engaging with young people with mental health problems, in particular those who have experienced the

transitional period from age 16-18. This information will be used from the basis of case study evidence, which will be collected together with a wider analysis of current service provision, current and projected needs, gaps and impact of not providing a transitional service. The evidence will be presented to the joint scrutiny group for review and a draft final report will then be presented to both Scrutiny and Policy Development Boards for approval.

Partners will have the statutory 28 days to respond to findings and will present their responses to the Health and Community Care and Children and Young People Scrutiny and Policy Development Boards for final consideration prior to agreement on the terms of the final document and the implementation of its findings.

Aims:

- To test out a model of conducting a joint review where a focus is cross-cutting the remit of two or more Scrutiny and Policy Development Boards.

- To improve the mental health and well-being of young people through reviewing the transitional service provision gap for young people with mental health issues from age 16-18 and by investigating the impact of mental health issues on other areas of concern in children and young people's services, such as school exclusions and admission to local authority care.

These aims focus on the Choosing Health White Paper priority of improving mental health and the theme of Children and Young People.

Objectives:

1. To set up a joint scrutiny working group between the Children and Young People and the Health and Community Care Scrutiny and Policy Development Boards
2. To take a service user engagement approach to gathering case study evidence for a scrutiny review through an empowerment and advocacy approach
3. To use an academic approach to independent analysis for evaluating evidence and recording the action learning findings
4. To use the strategic partnerships (Sheffield First for Health and Well-being and Sheffield 0-19+ Partnership Boards) to support the delivery of this model.
5. To work with regional and national agencies to disseminate the findings of this action learning model, e.g. NICE, Yorkshire and Humber Public Health Observatory and the Regional Public Health Team

Impact:

1. Development of a model for joint scrutiny review
2. Development of a transitional support package model for 16-18 young people with mental health problems
3. Development of a model for engaging vulnerable communities in Scrutiny
4. Reduction in the exacerbation of mental health problems and improvement in the quality of life of young people with mental health problems
5. Reduction in the numbers of young people with mental health problems entering the criminal justice system, becoming homeless etc

1.3 Rationale and scope of the project

In Sheffield Children and Young People with acute mental health problems are provided with a support package through CAMHS until the minimum school leaving age of 16. This service is provided through the Children's Hospital Trust in partnership with the PCT's and Sheffield City Council. There is also a set of partnership based service packages for adults with mental health problems provided by PCT's and the Sheffield Care Trust.

A hypothesis which this scrutiny review will test is that there is a gap in the transitional support for young people age 16-18 and without this support young people are falling though the safety net. The provision of Adult Mental Health Services is very different to Children's Mental Health Services and without adequate interim preparation this experience can exacerbate young people's mental health problems and ultimately be a causal factor in young people ending up homeless, entering the criminal justice system etc. It is expected that this is a national issue.

There are many challenges in effective engagement of vulnerable communities in scrutiny reviews of relevant health and related services. This approach will add considerable value to the evidence collected in scrutiny reviews in that it will test a model of engagement, which is sensitive to needs and which will facilitate the exploration of the experience and issues from a user perspective. The evaluation aspect will include the identification of challenges and solutions in engaging vulnerable communities, in this case specifically young people with mental health problems, but it is expected that these lessons will be transferable to other groups.

The advantages of this approach are reflected in the well known benefits of engaging communities in health development highlighted in the Choosing Health White Paper. This approach is designed to provide detailed case studies tracking the experience of individuals, identifying common issues and gaining a detailed understanding of the needs and current experience of young people with acute mental health problems, particularly at the transitional ages of 16-18.

Sheffield would like to use this opportunity to test the independent evaluation and reporting approach. This requires a specific budget not normally available but will also serve to highlight the benefits of independence when working through a scrutiny review topic, which cuts across many partners. In addition this provides the mechanism through which the learning from this review will be compiled into a report and guidance for national dissemination.

1.4 Review of the literature

One in ten children will develop a mental health problem and the numbers increase with age (Meltzer, Ford and Goodman, 2000). One in five 16-25 year olds suffer from a mental health disorder. This population's health and education are adversely affected by poor mental health. As a result, there is a significant impact on life chances in adulthood (Collishaw, Maughan , Goodman and Pickles, 2004). There is also a high cost to society, suicide is the main cause of death of young men aged 15 to 24.

The Audit Commission report Children in Mind (1999) found that many children presented to CAMHS with more than one condition, and in some cases up to five complaints. Co-morbidity is common in children (more than one mental health disorder present, e.g. attention deficit hyperactivity disorder (ADHD) and depression, or ADHD and conduct disorder). This increases the complexity of the care and treatment required for children and young people in the community.

Behaviour problems account for 30-40% of referrals to child mental health services and involve many agencies (Audit Commission, 1999). Fewer than 10% of young people who need treatment for conduct disorders ever receive it (Webster-Stratton, 1991). This has costly implications for society. Many of these young people are at risk of social exclusion, poor academic achievement and membership of anti-social peer groups (Webster-Stratton, 1991).

Unresolved childhood problems become unstable and more serious over time (Reid, 1993). ‘There are virtually no subjects with adult antisocial personality disorder who did not also have conduct disorder as children’ (Moffitt, 1993). Correlation has been found between aggressive behaviour at the age of three to later childhood conduct disorder and then to police arrest as a teenager (White, Moffitt, Earls, Robins and Silva, 1990). Inadequate CAMHS services for teenagers with behaviour problems become non-existent in the adult services.

The prevalence of severe mental health disorder in children and young people is significant though rare. It includes severe eating disorders, psychoses and major depression, with incidence increasing during adolescence (NSF,2004). Long term outcome of severe psychiatric disorders is poor (Roth and Fonagy,2005), 50 -100% of these young people show disorders for many years after initial diagnosis. Disorders with particularly poor outcome are autism, childhood schizophrenia and ADHD. Depression usually resolves in the short term but often recurs.

Mental health is a government priority target (DoH, 1999a, 2001) and the National Service Framework for Mental Health emphasises the development of effective interventions to promote mental health (DoH, 1999b). Children’s mental health is an increasing concern and is a developing theme within the Children’s National Service Framework (DoH, 2004). Standard nine relates to the access of all children and young people to integrated, high quality mental health services. Continuity of care between child and adult services should be ensured using a 'care programme approach' (DOH, 2004).

Within this framework, the importance of a seamless transition of teenagers to adult mental health services has come under increasing scrutiny (DH, 2006). Transition to adulthood is difficult for all young people, but particularly traumatic for young people with mental health problems who have to move between services. Many young people are lost to services (DOH, 2004). Those who do receive care are often not happy with the support they are given.

Continuity of care is difficult to achieve because of different care plans, care teams and funding arrangements (While et al, 2004). Adult and child mental health services have different philosophies and client groups (Association of Directors of Social Services in Dartington and Sheffield, 2006). 'Adolescents sit poorly between the family centred, developmentally focused, paediatric paradigm and the adult medical culture' (Viner, 1999, p.271). Within adult mental health services the focus is on clients with severe, enduring

illness. Children's services work within a more preventative model and include families, schools and the wider community. Flexibility in the delivery of care is essential for children and adolescents and engagement with services may take some time (DOH, 2004).

The difficulties of young people with mental health problems and learning difficulties or substance misuse are compounded by the lack of effective responses to their needs (Association of Directors of Social Services in Dartington and Sheffield, 2006). They complain about over-reliance on medication, being treated in a punitive way and the lack of talking therapies.

The views of service users should always be sought in relation to service provision (DOH, 2004). They say 'you get really fed up of other people making the decisions because it is your body, and you want a say in it' (DOH, 2006, p.16). Young people should be encouraged to take responsibility for their own health (DOH, 2006). They deserve the right to be 'expert patients' and influence their care.

Good transition arrangements increase the likelihood of better outcomes (DH, 2006). Communication is key to young people. They expect specialists to have an awareness of teenage health issues such as sexual health. Transition can be a time of great stress if familiar services are withdrawn and there is a lack of attention to their particular needs (While et al, 2004). It is probable that 16 year olds will have not completed their physical or emotional growth and adult services are unlikely to take this into account (Viner, 1999). Transition should not happen until teenagers are able to cope with an adult clinic.

Few models of good practice exist. There is no "right" time for transition and a flexibility of approach is important. Timing should depend on the developmental readiness and health status of the individual as well as the capabilities of the adult providers (Viner, 1999). Services tend either to concentrate on the safe transfer to adult services or adopt a developmental model which considers personal growth (While, Forbes, Ullman, Lewis, Mathes and Griffiths, 2004). However, there is a lack of evidence about the effectiveness of service models.

1.5 Background statistical information

In terms of the numbers of clients involved in this study they represent a small part of the adult mental health services numbers of young people with mental health problems. The

following tables give some indication of the demographics of current clients between the ages of 16 and 20 .

Table 1 Current Adult Mental Health Clients aged 16-20 / use of CAMHS Services

	CAMHS Flag		
Last Yr	CAMHS	None Recorded	Grand Total
2000	5		5
2001	13		13
2002	18		18
2003	20		20
2004	33		33
2005	22		22
2006	18		18
(blank)		208	208
Grand Total	129	208	337

Table 2 Current Adult Mental Health Clients aged 16-20 / geographical location

	Sex		
PCT	Female	Male	Grand Total
5EE North Sheffield PCT	32	25	57
5EN Sheffield West PCT	34	43	77
5EP Sheffield South West PCT	39	33	72
5EQ South East Sheffield PCT	43	68	111
Non-Sheffield	8	9	17
Not Known		3	3
Grand Total	156	181	337

Table 3 Current Adult Mental Health Clients aged 16-20/ ethnic origin & gender

	Sex		
Ethnic Origin	Female	Male	Grand Total
White British	116	120	236
White Irish		1	1
White other	1		1
White (old PsyMon category)	1	5	6
Asian or Asian British Pakistani	4	5	9
Asian other		2	2
Black or Black British African		2	2
Black other		1	1
Mixed White & Asian	2	1	3
Mixed White & Black African		1	1
Mixed White & Black Caribbean		1	1
Mixed other	2		2

Somali	3	3	6
Yemeni		1	1
Other		4	4
Not Known	27	34	61
Grand Total	156	181	337

Section 2 Methodology

2.1 General methodological approach

A case study approach was applied. Robson (1993) suggests that the 'defining characteristic' of a case study is that it concentrates on a particular case 'studied in its own right'. It is an appropriate strategy for this study because:

- It involves gathering empirical data
- It is about a particular case
- It is about a 'phenomenon in context'
- It involves using a range of data collection methods

There are different types of case studies, but in this study the case is used as 'an example of phenomena occurring more widely in the belief that a detailed study of the case i.e. a group of CAMHS service users and associated stakeholders, will support a better understanding of issues for CAMHS users in general. Punch (1998) describes this type of case study as a 'collective case study' in which several cases are examined to 'give insight into an issue' and to learn more about a particular phenomenon.

The component methods of the study were as follows:

Focus group interviews: a group interview was undertaken, comprising of young people who have experience of using mental health services while aged between 16-18. It is intended to develop a maximum variety sample Patton (1990) to ensure coverage of all the critical groups of service users noted above, as well as reflecting those who have experienced both CAMHS and adult services as well as those who were referred directly to adult services. The purpose was to gather first hand experience and understand the shared and discrepant experiences of young people who have experienced services designed to respond to their mental health needs.

In-depth case studies: From the focus group interview and by communication through key workers, participants were selected for in-depth case study research in which the views of the young person and associated stakeholders (parents/carers, school or college tutors, professionals involved in the case etc) were sought, with the young person's explicit consent. This provided more detailed information and understanding of the processes and experiences, reflecting the wider range of stakeholders in the experience of service

provision. The sampling strategy for this part of the study will again focus on obtaining the maximum variety of experiences, including gender and ethnic origin as variables.

All interviews were carefully recorded on tape and tapes destroyed at the end of the study. Tapes, together with materials generated in the focus group e.g. data collected on flip charts was also transcribed for analysis.

Review of administrative data: Administrative data regarding referrals and treatment of 16-18 year olds over the past 3 years both to CAMHS and the Adult Care Trust was examined to identify trends and to relate issues raised in the interviews to the frequency of instances. Due to time constraints this form of data collection was minimal.

2.2 Methodology of focus groups

Consultation with clients is a key theme in government policy (DoH, 2004, DoH, 2006). This includes listening to the views of children and young people about services (DfES,2004, DoH, 2004b). Participation of young people in decisions which affect them is a right. Article 12 of the UN rights of the child (1989) states that 'children have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinions taken into account'. The Children Act (2004) re-iterates this principle and forms the legal basis for the shaping of children's services in Every Child Matters (DfES, 2004).

Young people want to be consulted about the delivery of services (DfES, 2006), 19,000 young people responded to the consultation on the Green Paper 'Youth Matters'. Placing teenagers at the centre of policy is seen as empowering and a vehicle to produce 'lasting change' (DfES, 2006, p. 6). Knowledge and understanding of young people's needs is likely to lead to improved services and better outcomes.

The implementation of a child and young person centred approach has only been slowly adopted (Morgan, Gibbs, Maxwell and Britten, 2002). However, the evidence base for consultation with children and young people is growing. Focus groups with children and young people can provide an understanding of their views and ideas (Kennedy, Kools and Kreuger, 2001). Group based discussions can be more equalising than an individual interview with an adult. They can be used to discuss sensitive topics. Groups should be homogeneous to allow for shared experiences but also embrace diversity.

They can be useful in reaching the views of marginalised groups (Kidd and Parshall, 2000). They can enable discussion of 'taboo' subjects (Kitzinger, 1994). More confident members of

a group can encourage quieter members to share their experiences. These experiences may be considered deviant from mainstream culture, but are de-stigmatised through the mutual support of group members (Kitzinger, 1994). This can enable the unspoken and hidden worlds of marginalised populations to be given a voice within an accepting environment. Experiences can be articulated which 'break away from the clichés of dominant cultural constructions' (Kitzinger, 1994, p. 112).

Recruitment to groups can be difficult. Groups made up of strangers can have a disinhibiting effect (Morgan, Gibbs, Maxwell and Britten, 2002). However, friends can gain mutual support from each other. Issues of confidentiality can arise if young people know each other.

Recommended practice is that there should be a moderator and co-moderator to run groups and maintain the level of interest (Morgan, Gibbs, Maxwell and Britten, 2002). Moderators need to be experienced in running focus groups and have the skill to allow everyone's opinion to be heard (Kennedy, Kools and Kreuger, 2001). They should be able to provide the framework for each young person to share their opinions on their own terms and to their own agenda (Kitzinger, 1994). Co-moderators have an important role in supporting young people, observing and occasionally interjecting to seek clarity. Probing and clarifying is essential if meaning is uncertain (Morgan, Gibbs, Maxwell and Britten, 2002). It is also important to saturate the data so that there is nothing left to add.

The setting of groups is important. A school environment has been shown to promote a test taking mentality and create competition between peers (Morgan, Gibbs, Maxwell and Britten, 2002). A clinical setting could also influence discussions. It is important to have a neutral and informal venue. In this instance , the Sheffield Hallam Student Union building.

Groups contain four components: beginnings, openings, discussion and wrap up (Kennedy, Kools and Kreuger, 2001). Structuring groups is important, but should also allow free expression (Kidd and Parshall, 2000). The context of a young person's experience should be included by allowing them to introduce themselves and tell their story. It is important to ensure informed consent has been given and that teenagers understand the limits of confidentiality.

Young people should be aware that if they are distressed or worried, they can withdraw at any time. The challenge is knowing when to pursue a line of questioning, even though it may be difficult and when to abandon it because it is too painful (Morgan, Gibbs, Maxwell and Britten, 2002).

Commitment to feedback on the findings should be re-iterated by the moderators. Young people say they often do not get feedback. It should be ensured that their views will influence practice.

Focus groups are not a stand alone method and should be triangulated with other evidence (Kidd and Parshall, 2000). It is also important to conduct multiple groups to ensure reliability (Kidd and Parshall, 2000).

2.3 Methodology of interviews

Interviewees for this study were gleaned from two main routes.

- Through Support from CAMHS via key workers
- Through analysis of "Insight": the data base for Sheffield Care Trust and Sheffield Children's Hospital

Through Support from CAMHS via key workers

CAMHS provided a list of 12 clients who had been approached by their key workers to be involved in the study. Of these clients 8 were male and 4 female. 7 of the males were included in the study and we were able to interview one with his mother. Of the other 7 males, two were included in the interviews of parents, one extensive recorded interview the other a short telephone conversation.

Through analysis of "Insight": the data base for Sheffield Care Trust and Sheffield Children's Hospital

A morning was spent with John Wolstenholme at Sheffield Care Trust, who helpfully managed a number of searches and combinations, interrogating "Insight" for data. Eventually a list of 32 names was developed with particular characteristics:

- involvement with adult service in the last year
- involvement with CAMHS prior to adult services
- +20 contacts with CAMHS
- within ages of 16-20

Interviews generally followed the semi structured interview schedule organised for the focus groups. However, there was an element of organic development in that some questions were framed based on information previously obtained from other participants. This felt reasonable in terms of the approach of the study as it enabled themes to be followed.

2.4 Communication process and description of sample

A letter was sent out to all key workers identified on the list, either they contacted the researcher or the researcher contacted them, in total 24 key workers were spoken to.
Of the 24 potential participants, 5 were not suitable for the study, 8 declined to take part, 4 were uncontactable in the timescales of the interviews and focus groups. This left 7 clients who could be included. Three of these clients were too ill to be interviewed so parents were interviewed or their key workers.

Breakdown of client and stakeholder sample:

- 3 individual client interviews
- 3 focus group clients
- 6 parents
- 2 GP's
- 5 key workers (plus the EIS team for South East)

In total 17 separate pieces of data were gleaned for analysis. As this study has an action research element there was also a reflective practice piece transcribed which represented the reflections on the focus group by the two researchers facilitating this group.

Table 4 Clients involvement in the study

Client	Focus group or 1:1	Parent	GP	Key worker
2	Focus group	Client did not want them contacting	Dr M - On leave	TE - Interviewed
1	Focus group	Parent interviewed	Dr N interviewed	HS Interviewed
9	Unwell	Parents interviewed	Not contacted	Not contacted
3	Focus group	Parent interviewed	Dr F - On leave	Not allocated

5	Individual interview	No contact	DR McA - interviewed	MY interviewed
10	Individual interview with mother present	Parent interviewed	No contact	No contact
4	Individual interview	Arranged but DNA	No contact	No contact
12	DNA individual interview, subsequently declined to take part	No contact	No contact	AW discussion
6	Too ill/vulnerable to take part	No contact	No contact	LM interviewed
13	DNA individual interview, subsequently declined to take part	No contact	No contact	AW discussion
7	Too ill/vulnerable to take part	Parent AD interviewed	No contact	CA interviewed (EIS Team)
8	Too ill/vulnerable to take part	Parent JW interviewed	No contact	JR interviewed (EIS Team)
11	Too ill/vulnerable to take part	DNA interview, telephone interview instead	No contact	No contact

Table 4 indicates the range of responders. One complete 'set' of data was collected on client 1.

Table 5 Demographic data

Client	Diagnosis	Transition status	Gender	Age
2	Self harm and depression	In transition	f	17
1	Depression and self harm	transferred	f	17
9	Schizophrenia	In transition	m	15
3	Depression and OCD	transferred	f	17
5	Depression and eating disorder	transferred	f	17
10	Autism and ADHD	Preparing for transition	m	15

4	Depression	In transition	f	17
12	Eating disorder	transferred	f	17
6	PTSD	transferred	m	20
13	Eating Disorder	transferred	f	18
7	Paranoid Schizophrenia	In transition	m	19
8	Paranoid Schizophrenia	In transition	m	16
11	Schizophrenia	Preparing for transition	m	15

Section 3 Data Analysis

Presentation of the data generated for this study will be described using the main fields of analysis by groups i.e. 3.1 Young Person, 3.2 Parent, 3.3 GP, 3.4 Key worker comments. The findings will be interpreted for each of these groups then further developed within the discussion section for coherence and clarification. Tables will be used where necessary and the rich data interviewees gave, used to support key points in the text in the form of quotations.

The fields for analysis, were developed based initially on suggestions from the literature and the interview questions used to cover the scope of the project. Each section of interview was coded using these overall interview and literature fields. Subsequent nodes of information were analysed and combined, development of sub nodes illuminated a particular point made by a number of clients or others. For example, within hospital treatment there were a number of observations from a few client interviewees about their experience of the in-patient services, crisis team, and A&E. So these became sub nodes of the node Hospital treatment.

All names and identifying information have been removed from this analysis. Hence clients become clients 1-10; patients become ‘P client 1’ and ‘GP client 1’, etc. Bases are either set in italics in free text or non italicised if the text is in italics. So ‘CAMHS Community Team’ is a service within CAMHS, and ‘Sector Team’ is an adult service in the city etc.

3.1 Young persons' views

3.1.1 Vignettes

Five clients altogether commented on their experiences within CAMHS and subsequently adult services. Below are the words they used to describe themselves, this will help frame their subsequent comments:

Client 1 - I'm 17. It started when I was about. I don't know, I started at a CAMHS Community Team, I had problems with my dad, he got cancer and everything and a lot of stuff with me and my life. I blame myself for most of it and I started with self-harming, regularly tried to commit suicide once a month or twice a month. Mum found out and then she referred me to someone at CAMHS Community Team and I saw the counsellor for a couple of months and then I was getting more depressed and more suicide attempts followed. So then they referred me to Beighton an actual psychiatrist who started me on

anti-depressant medication. Then when I was about 16 or 17 my doctor thought that they weren't doing any more for me because they were only doing it on a child basis so she referred me to the Abbott one and that's where I am now. Client 1 was on the verge of committing suicide, she made all the signs, she withdrew herself totally, she locked herself in her bedroom, she wore black constantly, she was writing all these suicide notes, she didn't look after herself, she wouldn't eat. She was absolutely totally gone, her mental state was terrible. She lay awake all night, crying all night long.

Client 2 - I started self-harming when I was about 14 because I got bullied badly but nobody did owt about it really. I saw my doctor about everything and he referred me to Centenary House and then he referred me to Lockwood and now I'm with Adult service

Client 3 - depression and OCD, complex family history.

Client 4 - I've been suffering with depression for about two and a half years, so I was referred to be seen by a psychiatrist and I started going every so often and then I started getting quite bad so I was going every week until they referred me to the Crisis Team and they put me into Adult Services. I'm 17. I had quite a rough time at school, I don't know how it really came on but it just came on all of a sudden. It wasn't the school; it was just that I didn't like school. I weren't getting bullied or anything. I had a lot of friends; it's just overall the fact that I just wasn't happy at all. That's why, I don't know, the depression just came on all of a sudden.

Client 5 - Well I was in CAMHS because I had constant depression, seeing the psychiatrist but I didn't see him as often but I stopped going because I got severely unwell, I know it sounds a bit backwards but I just became so unwell I have depression and I suffer from social phobia and the last time I saw them they came barging into my house and asked for me to go to Adult Services, because I wasn't attending, I hadn't been attending counselling for at least six months. Then recently I can't remember why but now I've gone back into the mental health services to try and sort things out, things with eating. Some things have got better but other things seem to have got worse. So it was a bit complicated because it wasn't just a smooth transition from one service to another...I think they had a brief idea but mainly because of my mum but it was fairly quick. I was expecting it to be much slower.

3.1.2 Transition - general thoughts

The comments made by clients in the focus group and individual interviews about their transition to adult services, indicated varying degrees of success and planning. Two clients were transferred with some "bridging" and meetings with clinical staff on both sides. Of the remaining three one was discharged and re presented, the other two were loosely transferred over to adult services via a referral process. Three of the clients were relieved to go to the adult services and two wanted to remain in the CAMHS service because of the flexibility and compassion exhibited there.

The client who wished to transfer to adult services commented on a dissatisfaction with CAMHS by treating them as a child with a, perceived child orientation to the service. For example client 1 states:

> "I was relieved to go to the adult services because I was fed up of them treating you on a child basis and the methods that they went through...just simple things, like one of my counsellors was using mood cards and you had to match which set was the same as depressed and it just doesn't do anything for anyone who's about 15 or 16 because they already know about it. So I was relieved to go to the Adult one where they treated you more on an adult basis, that you knew more about the condition you were in and things like that."

Overall the process does not sound as organised as one would hope with the experience of client 2:

> "my doctor decided that there weren't anything else he could do and I was 16 so we went to adult services..... he read my review and because they decided there wasn't anything else they could do so he just mentioned about other things and talked about it and said 'do you want to go"

Generally, a strong sense of the unknown was experienced, this was polarised in comments from client 5 who stated:

> "I think probably it would have been better if I'd been vaguely aware of the service so it wouldn't have been having to sort of start from - I wasn't starting completely again - but it just started getting a bit stressful. I find it very difficult the thought of going into the adult, I just feel slightly intimidated because I don't really understand it and also because there's lots of older people and there's some really severely unwell people at *CMHT day service* and I feel a bit frightened. "

3.1.3 What helped you?

Clients commented on the individual support they received from key workers in CAMHS, their psychiatrist and their GP's. Client 1 had excellent support from her GP mid transition, as she was initially referred and not accepted by the adult services because she was still on a caseload with CAMHS. Commenting:

> "It was my GP who actually got it for us because my GP's great, she'll do anything for us and first they couldn't accept me because I was still in the child one and she said 'well that's stupid' so she sent about three or four letters and eventually they accepted me"

Clearly here there is a strong relationship between with the clients and their GP (a GP interviewed for this study GP1) and this coherence of primary care spanning the services came across particularly well in this case of a GP who has mental health issues high on their agenda.

Client 2 noted that coming into adult services was supportive in that the staff were familiar with dealing with self harm, experiencing this as a form of acceptance when she mentions

> 'Everyone's self-harming really so that's helped - maybe the problem isn't as bad and just working on my confidence and everything'.

3.1.4 What hasn't helped?

More comments were made regarding the barriers to transition, this section has been sub divided into the referral process, information exchange and the differences in service.

- **Referral Process**

Table 6: Referral Process

Client	Transition planned	Discharged then to adult services
1	**no**	**Yes (couldn't get accepted in adult services whilst in CAMHS books)**
2	**Yes (joint meetings and handover between services – very quick)**	
3	**no**	**Yes (seemed to be OK so closed to CAMHS, accepted easily into adult services later)**

4	**Yes (Transferred through involvement with Crisis home treatment team)**	
5	**no**	**Yes (case closed having considered she was 'better' by CAMHS but significant issues present)**

Two of the five clients were transferred to adult services, with two receiving a planned transfer over. However one of three planned transfers was less than satisfactory for the client. Client 4 comments on the process:

> "Not really, it's ok. I would have preferred for the Child to just stop seeing me when I got transferred over to the Crisis Team, but they thought it might be helpful if we bring you into the Adult Services so we can tell you a bit about you, which I think is a good idea but it's not very nice for me then because I'm left like in August, that's it then, they're going to stop seeing me.....I'm in two different minds really about what I thinks best. I suppose in a way it's better to bring you in slowly."

This comment is generally echoed by others, although client 2 and 4 just wanted the transfer to happen.

There were some issues in relation to acceptance into the adult service with perceptions of the clients reflecting the following:

> "You cannot get into the adult service at *sector team* unless you've been on medication for six months already, otherwise they won't accept you. That's what I was told."

> "It was the *sector team* that didn't want me in.....because I was still with another service; it took about two months once accepted to seeing someone."

It is worth noting the phenomenon of "transition within transition" which sometimes occurs in services. Client 3 experienced a transfer to adult services where her worker has subsequently left and not been replaced, she commented:

> "Well I'm seeing a guy he's just left so I've got to wait about six weeks to get a new person he referred me to other services but they said I'm not suitable when I got there so I'm kind of waiting to see where to go".

- **Information exchange**

Information is key to all aspects of managing risk and patient care in health service settings. In terms of this study we looked at the process of information sharing as part of the transition. One of the intentions was to audit case notes, but due to circumstances beyond our control, this was not possible. However, current case notes were used in other areas of this data analyses to track progress of referrals and contact

Two clients commented on this area, client 1 and client 3. Client 1 noted that her key worker had the files from CAMHS, but there was no verbal dialogue between services and between key worker and GP. Client 3 explained that she was aware her file was sent across but again there was no dialogue between services. There had been an expectation amongst the researchers that when transferring complex cases between services, there would be some verbal dialogue, as exhibited in the transfer of client 4 for example.

- **Difference in the nature of service**

Transition between services has inherent anxieties; one of the principal factors expressed by the clients was knowing there was someone there for you. There appeared a perceived difference in culture between the services, with CAMHS being described as 'patronising' and also 'flexible and compassionate' with adult service being 'scary'.

3.1.5 What can you suggest would make services better?

Many comments were received here and they fall into a number of categories best outlined in tablature.

Table 7 Views of clients on improving services

Nature of improvement	No. of comments	General sense of comments
Bridging service	3	- A service more aimed at adolescents rather than the younger age groups. - Something that looked a little less like it was for kids. - Ensuring there was someone there for you. - Just would feel that they were dealing with people who were the same as you and had the same kind of issues.
Information	3	- Need for information about services but not necessarily self help books. - Perhaps some key questions to help frame your first session in the new service

Instillation of hope	2	- You do want to think that there is some hope out there, that there is something that can be done for you but when you've got your social worker saying 'I don't know what to do now' it's a bit daunting. - As long as you get somebody - as long as there's somebody there at the end of the phone!'
Compassion and flexibility in adult services	3	-"They seemed to be more on the ball if you know what I mean more helpful, just more on the ball, like they'd sort things out straight away, they didn't leave stuff, if you wanted them they were there". - If I'm feeling depressed I can just call for her if I get desperate

Three of the clients felt that some of the approaches in CAMHS were not geared up to teenagers, which is why they welcomed the move to adult services. Feeling that the service was patronising:

Client 1 comments:

> "I felt that she was used to talking to children and I didn't have the same problems as them...they were too patronising...it would be better if they were separate things because you're sort of stuck at the age of 15 or 16.

Client 3 comments:

> "When I was 14 the first time I went they had charts and things and they were asking me to draw pictures and asking what my favourite colour is. They treat you like you don't know how to express yourself in words - they skirt round it"

.

Client 2 comments:

> "They ask stupid questions...you have to write things down and draw things.

3.1.6 What part do you want your parents to play?

Parents are in a complex and difficult place when supporting young people with mental health problems. The NSF for adults and the NSF for children have both recognised the need for attention to this area of care delivery. The young people in this study had varied experiences of their parent's involvement with services and their wellbeing. The researchers recognise this as a dilemma for both service and the young people in terms of their safety and confidentiality.

The young people commented:

> "I didn't want my parents there but my psychiatrist said to my mum and dad that I didn't and I wasn't just being bad but he told my mum and dad and I didn't want him to."

> "Well when I was younger we did a series of family therapy sessions ..that did help a little because it explained to them that I didn't want them like constantly over me...and it did give me a bit of space and a bit of freedom which did actually help."
>
> "It would be a good idea to send progress reports to parents through the post or something or have a separate meeting."
>
> "You don't want to go with them together because you're less likely to tell them things when your parents are in the same room."
>
> "Key worker did say do you want me to tell your mum and dad things and I said no."
>
> "My mother has met my key worker on the one occasion...I don't know, I'm a bit funny about that, I think I'd rather sort it out by myself."

3.1.7 How would you want services to contact you?

We were interested in the methods of communication with this client group to support their ongoing therapeutic response and engagement with the service. There was a loose hypothesis in the research team that clients would like electronic contact, but this was not born out in the testimony of the young people. They preferred a formal contact either through letter, telephone or by e-mail, but not by text which they preferred to keep for their friends/personal life.

3.1.8 If you had to go into hospital, how would you feel about being on an adult ward?

The researchers were surprised in the range of opinions the young people gave in relation to their hospital experiences. Although these comments do not completely fall within the remit of this study into transition it was felt important to capture them, in order to facilitate the services understanding of the nature of the clients experiences as user of their services.

- **Hospital admission into an adult ward**

Three of the clients had experienced in-patient care, one on a general medical ward the other two on acute psychiatric admission wards. Their annotated quotes speak for themselves:

> **Client 1** - "I went on an adult ward when I had my operation and that was fine.... I don't mind in my hospital I had an old woman, a girl a couple of years older than me, this middle-aged woman on the other side, I didn't mind, I had my TV. ....I suppose if you've got really younger kids and then a really older person like 30, 40 you kind of seem stuck in the middle. I think in a children's

setting you feel too old for them all and in an adults' setting you seem too young and they're all looking down on you, its weird being in between".

Client 3 - "Well I don't think I'd like to be in with children because if I was with children and I needed help I think I'd say help them because you can look after yourself. I had to go to hospital in an adult place which was a bit strange, I thought they'd take me to the children's and they wouldn't like call my parents for me or anything so I didn't like that really....I went in for the day, I took an overdose. I was at *in patient Unit*; I just thought I was treated really badly there. I asked them to call my mum and they wouldn't call anybody.....I ran away from the hospital after a few hours because they just left me and I just thought there was no point me even being here, there just ignoring me".

Client 4 - " I think now I would probably have referred to go on a ward, I'd have felt safer. But I didn't think much at the time.....Absolute nutters - people with schizophrenia and stuff like that. I don't think there'd be anybody as young as me, hardly anybody. I reckon it would be quite intimidating, I think that's why I was preferring to have home treatment.....I just wanted some help. I did feel as if I needed it - but I obviously didn't get enough!"

- **Accident and Emergency**

The researchers are aware, through their experiences of working in mental health settings and with mental health clients, that sometimes the experience of service users in adult acute settings is less than satisfactory. Again these stories speak for themselves:

Client 3 - "I thought the services were good when you actually got to see the person who dealt with it but it took about 15 hours. Alex - I was like really run around. I had to sit on my own, it was really horrible because I was throwing up everywhere and they wouldn't get me another sick bowl. I was at A & E I saw a doctor. I saw him straight away and I was left, they said do you want me to call your mum and I said yes. That happened after about 8 hours and I was just sitting in a waiting room for 8 hours with nobody there.....It was really horrible. I don't mean to be disgusting but there was like sick everywhere and I was shouting to a woman to get me another bowl and then they just shouted at me for being sick on the floor".

Client 1 - My mum ..took me to hospital after waiting three hours to actually see someone because it was at night and it was emergency service and they said 'Well you better talk to your GP about it because we do have a psychiatrist here but he's very busy at the moment'... It is horrible because it's bad enough to take an OD in the first place and then they just leave you on your own. You thought nobody cared in the first place and then you're just left like that and you're thinking 'What's the point?' They treat it like it's your own fault and you deserve what you get....When they were treating me when I had to have stitches for self-harm the nurse was so horrible to me. If somebody had fallen over and needed stitches she'd have been a lot nicer, I know it. It's because it was my own fault and I did it to myself.....Just give them more training, or maybe somebody who has done it to themselves. A lot of the time they don't know what's going through your head when you're in that state. It is their mental health that's affected. They do need the same care and attention as anybody else".

- **Crisis home treatment team**

Client 3, client 1 and client 4 had been seen by the crisis team.

Client 1 saw a junior doctor first, then the crisis service. Her experience was one of being assessed to 'make sure that I was mentally stable to go back home'. Client 1 felt this experience as very pressurised.

> "they ask too many questions... I know they just wanted to see if you're alright but you've just tried to kill yourself and they're on you and it's just too much".

Client 4's experience was different in that the adult service felt she was too young to be admitted to an acute ward and that home treatment would be more beneficial commenting:

> 'they came twice a day if needed every day to see me....it was horrible....I just didn't find them very helpful. I didn't really like some of the people that come. I just hated it.....I saw loads of different people who just basically asked me if I were alright and if I said no they didn't really do much anyway, just gave me tablets really'.

She was asked what she hoped for in the service

> 'I don't know. I was just really ill. Really suicidal. I couldn't really do anything and they didn't give me much reassurance...at CAMHS it was more helpful to me, more understanding, they had a bit more compassion...I just felt 'Well I might as well go and top myself now'. I got no help from anybody really. All they were doing was just drugging me up all the time.....So that's it; I didn't find them really helpful at all. Sometimes the people had no compassion, if I was really upset - no compassion whatsoever. This one particular day this lady came, I don't know what she were, but she came and said 'How are you feeling?' and I said 'I'm suicidal' and she said 'Have you had a wash this morning?' and I said 'Yeah' and she said 'Oh, well you're fine then.'

Client 3 however had a positive experience of the crisis team commenting:

> 'I thought the Crisis Team were quite good but I was probably just relieved because everybody else had been so clueless'.

3.1.9 If you felt unwell who would you want to see?

Forming and maintaining a therapeutic relationship is an important skill and one in evidence across the care spectrum. For the young people in this study they commented on the importance of this relationship and some factors which contributed to their sense of safety during transition and subsequent support in managing their mental health problems. As termination approaches indirect expressions of fear and anger often take the form of

recurrence of original symptoms (Ryle & Kerr, 2002). Therefore closure of these relationships contributes a special consideration as termination; of a therapeutic relationship can be a profound and moving experience for both client and therapist but its reality can still be experienced by patients as a desertion or betrayal (Ryle1995). Accurate and appropriate management of the closure will enable the client to internalise the worker as 'replacement or substitute for earlier ambivalent object' so separation become more of an adult maturational event (Mann 1973).

With this in mind the young people in this study noted a number of key factors that support the need for a 'conscious transfer':

They might be really comfortable with and have formed a strong relationship between the key worker and to break that might cause more problems. The issue of being passed on to someone unfamiliar needs to be recognised and worked with to ensure planned separation.

> **Client 2** "For a lot of people there's trust issues, for me it was. It took me a long time to tell the first person that I went to things that I wouldn't normally tell other people because I do have a lot of trust issues".
>
> **Client 1** "I think when I first start working with someone at first they can't do anything because it takes quite a while for me to open up to them".
>
> **Client 4** describes a strong example of transition (despite her experiences in crisis in the adult services) as being 'held by her psychiatrist and also by her key worker in adult services', one feels if joint working it had not been apparent there might have been a serious incident.

Many of the clients felt the meeting with their new workers, being in a place away from home, was constructive and recognised them as adults, despite some of their reservations about the age and complexity of the other adult clients they encountered.

3.1.10 What would be your ideal for transition and most important things in transfer?

- **Age appropriate service** and environment both in waiting areas for services and hospital admissions facilities (all clients commented in favour).

- **Bridging** - "I just think somebody being with you during the transfer who you can regularly go and see if you need help either regular collaborative sessions with key workers in both services (80% of clients) or 'regular sessions, maybe every week, with your GP".

- **'I think to be asked what I wanted really'.** "They know what they've been offering me and they know how to help. Just seeing my psychiatrist and he'd know what to do, that's who I prefer to work with".

- **Flexible transfer time between 15 and 18-20 (60% of clients)** – 'But the decision should be the actual patient's themselves.... because different people are ready at different times. However it may depend because some people at 15 might not be ready in themselves to go to an adult service'. This was a strong perception from the young people came in the form of a service appropriate to young people that had a degree of separation from adults. It must be noted that we asked this as a specific question which may have contaminated the responses in favour of a 'young person's service'. The young people felt that this service should be hosted in adult services so there was not another 'transfer' needed if required at a later stage.

  Client 4 describes this well:

  > "Because there's more people your age group and I think that if you go into Adults and they're used to dealing with people who are 40-odd, you're not the same as a 40-odd year old person. You're 16 - you're a lot different and I think that's why the Crisis Team didn't have a lot of compassion - I think because I was so young and I think they're used to dealing with people a lot older than me, so.. I just didn't think it was very appropriate really because I think I was one of the youngest ones.....They just didn't understand me"

- **Parents** - Respect for non involvement of parents in consultations but some communication with parents with young persons collaboration (all clients commented)

- **Information** - "I'd say make it as smooth as you could, the transfer between child to adult and passing on the notes and talking to each other. Because how many times I've had to repeat my life story I can't remember. Even within the adult services, *my key worker* when I last saw her I saw my *Psychiatrist* afterwards and she had no idea so I had to repeat it all to her again. It just wastes time. (80% clients commented)

- **No Time lag-** ‘Just not really having a time gap in between. I don't mind explaining things again because I felt like they took it more seriously here’.

3.2 The parents' views

Eight parents were interviewed for this study. Two parents were interviewed on the telephone (client 11 and 12), one of which had agreed to a face to face interview but declined to attend at short notice, as she was feeling stressed (client 11) and six face to face interviews took place. Of the six interviews, three more clients were added to the overall list of clients included in this study (see vignettes below). One of the clients was present for the interview with his mother (client 10) and the other three clients were aware of the study and agreed to participate through their parents, but due to the nature of their mental health problems and their current mental state declined to be interviewed themselves. The final 2 parent interviews related to clients 1 and 3. Client 4's mother had agreed to be interviewed, but unfortunately had to work at short notice.

One of the client's parents (client 9) had particular issues in terms of involvement with services in Sheffield, but their child was receiving inpatient care in Rotherham. It was decided to include this information in the study as an example of one young persons experience in inpatient settings and the complexities involved. It is important to make clear that it is not the Sheffield in patient services they are commenting upon. Never the less this interview was important as their experience may be one that is similar to client's resident in Sheffield given similar circumstances.

3.2.1 Vignettes

These vignettes have been built from the words of the parents interviewed. Client 7's vignette is particularly poignant of a male coping alone with a child who possesses a number of risks to himself and potentially others. The researchers are cognsanti with the evidence from homicide and suicide enquiries that the nearest relative is often the person most at risk. Therefore this case has particular poignancy as this young person displays a number of risk factors noted in the literature which include; a history of violence; paranoid delusions; poor medicine compliance; young male; social demographic group; unemployment (Doyle 1996, Hawton 1987, Royal College of Psychiatry 1998). This clients fathers words are some of the most powerful heard in all the interviews conducted

Client 7 - Since he were born he has had problems, he couldn't keep still as a kid, screaming shouting at night nightmares when he were about six months, twelve months. We couldn't take him out, he attacked kids and just literally run riot, sit down and stuff like that. We had him to different people and that took really 5 to 6 years before they really

started to look at him…they came up with ADHD when he was about 8/9 year old he was on special drugs and that takes long enough everything seems to take forever. You know when you are looking for help and he went to 'special school', a lot of people have seen him over the years, he managed to get actually kicked out of school when he was 15 for violence. Its just put down as psychosis , I mean he was hearing voices when he was bout 13/14 which was a shocker He very rarely goes out now because of his paranoia he did actually go out for a couple of days the other day. He is 6 ft and 16 stone and if he says he don't wanna do something then he won't do it and then I'll get myself in a tangle arguing with him about it, so I can't can I? When aroused makes threats 'I will kill you and I will kill me and I will kill my brother I hate him'. I have heard it all before. And when he has calmed down and then you can actually talk to him. He was cutting himself about 6 weeks ago, slashing his arms and I looked at him like went in room and he was sat on settee, first time he has ever done it he was cutting his hands, blood all over and I went in back in kitchen got him a cloth and walked back out again I thought what do I do? He sat there absolutely fuming face like thunder…he hasn't done that since. Yeah, I mean prior to that about 2 months before he was sat there where you are and he had a knife to his throat I am going to kill myself, so I get all upset which anybody would and said, so I phoned his brother and his brother walked through door looked at him, said what are you doing? He says I am going to cut my throat, so his brother says, cut you're fucking throat then! I think that is the first time he has ever seen him like he was…he just stood there but there were no one I could pick phone up to and say apart from coppers….I more or less got to that point yesterday with key worker to say well I can't keep a lid on it so much now and I didn't go as far to say well can't you take him away and you know for a week to make sure he does take some medication and find out a bit more about him and how he reacts – I don't know if that would be good or bad though. I am thinking fuck off – do sommat just say we can try this or we can try that or whatever they can do and I wish they would, lets find out lets get on with it but no….it can get really hairy at times, there isn't that back up, there is no quick backup for people like me anyway just to phone and say can you get out here and see if you can sort him or what have you I suppose you could phone an ambulance but then you get the same reaction from them, you know he has mental health problems what do they do, they probably bring coppers in as well'

Client 8 *- Client is 15 and under the care of EIS. His father noticed a change in his behaviour around age 14 started off with him coming home drunk, he started to do things which he has never done before. He says that he was raped. But he didn't tell us. We only find it out after. I think that what his problem is now, he still hold it, he won't tell nobody what really happened. But when it happened it was about a year ago. He was fourteen then and I think he lose all his trust in people and his bit of pride and I think that is his main problem at this moment in time. He thinks a lot and he don't laugh a lot, only when something come and grasps him then he will laugh. He doesn't laugh and he doesn't talk a lot and he has stopped mixing with all his friends. He has cut them all off, he don't mix with them anymore. Because they are getting into a hell of a lot of trouble. Now he hasn't that much friends. So you know where things are concerned now, it's not bad. His diagnosis is Schizophrenia. But until this day they have never taken any proper tests to prove that's the main problem. Myself I think the main problem is what happened to him when he was fourteen. Currently spans services with psychiatrists in CAMHS and a CPN in adult.*

Client 9 *– Has a diagnosis of Paranoid schizophrenia. He was diagnosed at 15. When it first came on he thought that his dad was the devil and that we were aliens and we were made up with superglue and all sorts, and he was getting paranoid and suspicious about us and everything. It was very difficult. It was coming on over a period of a few months he just started changing, there were odd little things and we just thought, well we knew he was messing about with stuff and we though it was that that was altering him. Then just one night, it was terrible, we'd been prescribed Diazepam to give him to knock him out for 48 hours until we could see a child psychiatrist. So we'd basically got to keep him in here dosed up. It was actually the police that we called out and they sent for somebody from Adult services, a social worker, to come out and assess him and he said he thought he was very poorly but could we keep him here rather than take him to Adult services for 48 hours. So they sent me up to the doctors and gave me the Diazepam, knocked him out and every 10 minutes from 8 o'clock at night till 2 o'clock in the morning he was screaming and hurling abuse at us and then crying, and this was like going on for every 10 minutes changing like that, up and down, up and down, it was a nightmare, an absolute nightmare. Then he saw this child psychiatrist and she said that he should have been referred to her months ago. I tried three times at the doctors and they sent me away. Currently in patient in Secure unit in Northampton. It used to break my heart when we used to go in, you're stood there and he's stood at the back of this locked door and window waving at me. I thought this is not right, he's not a criminal. Why's he being treated like a criminal? His only crime is having a mental illness. You get treated like a criminal when you've got a mental illness.*

Client 10 *- Has Asperser's Syndrome and ADHD he was diagnosed at the age of 6. Mother (I) separated and had to go out to work to support us both and started getting feedback from there that he was very unsettled and wouldn't join in stuff and I just put it down to family circumstances. So I went to see my GP who was brilliant and she informed me to ring the Education, you know the Steps service direct and I got straight through to a wonderful Educational Psychologist and subsequently diagnosis with Asperser's Syndrome and ADHD. At that point they were going to 'secure children's hospital' for ADHD and 'children's psychiatric Hospital' for his Asperger's. He gets quite upset about changes he can throw quite violent tantrums, quite violent behaviour. We've had some hair-raising moments (at school) and he's been excluded from school on numerous occasions for being violent but Joe's not violent as in just lashing out at people, something or someone would have pushed him in to that situation where he can't cope, he just lashes out.*

Client 11 *- Client has Psychosis and is being cared for by one of the early intervention services Client academically behind, cognitions have reduced since back at school. Mother thought the experience of him going to Adult Services was a very difficult concept as they had no idea what the services were like. He has been poorly all through his adolescence*

3.2.2 Transition – general comments

Client	Transition planned	Discharged, then to adult services
7	**Transferred into EIS**	
8	**Transferred into EIS still under CAMHS psychiatrist, 16 in Sept.**	
9	**Complex transfer to adult service before the age of 16 ****	**Closed on discharge from young person's admission unit to care of adult team. Some transition evidenced**
10	**Coming up to transition, no dialogue as yet**	**No information as yet as to process of transfer**
11	**Yes**	**Transferred into EIS**

****Client receiving adult services from Rotherham.**

Four parents made an observation about transition. Comments were:

- **Not wanting to be treated like a child anymore** – Feeling that the CAMHS service was not suited to adolescents and wanting to engage with adulthood. 'she was coming into a teenager and dealing with teenage thoughts and things like this that they were treating her as a child (client 1).

- **He's big enough** – no 'transition, parents felt that the young person was transferred because his behaviour was complex to manage in CAMHS and as he was a 'large' person he would be able to 'handle' adult services. Adult service unfortunately was less than reliable (client 9).

- **He's well enough** - Felt that client's behaviour and mental health had improved and was subsequently closed to CAMHS. Client left for 2 years before being picked up by adult services as there was a steady deterioration. This client had a number of complex needs and one wonders about the wisdom of discharge without a transition plan (client 7).
- **No preparation/information** – A theme among the parents was a lack of information about adult services and the process of transfer. Al parents felt they needed more information about the 'problems' they were managing and the expectations of what was available/style of service in adult mental health (client 10)

3.2.3 What helped you?

Two main themes emerge in this section:

- **Value of the GP** – GP's were very important to the parents and the client, three parents commented directly as to how positive they felt the GP's role was (client 1, 3 and 10). They noted the importance of the GP to act assertively in securing place in adult services based on client's wishes; having a good GP; support with medication management and the GP acting as a bridge between CAMHS and adult services. There was one comment about the interface financially between the prescribing of complex psychiatric medications and a sense that there was an issue with respect to the cost of the medications needing management by a psychiatrist rather than a GP.

- **Value of the Psychiatrist / key worker** – The psychiatrists in CAMHS (and some key workers) were generally held in high regard for their compassionate, supportive, flexible and encouraging response. There was an exception in the case of client 10 whose parent's experiences were very negative. Trust was a fundamental issue.

3.2.4 What hasn't helped?

- **Referral process:** Transition either faltered or was facilitated for a number of reasons; age of acceptance being too young for EIS (client 11); no real 'transition' because already has key workers in adult service (client 8); non acceptance in adult service because already on the books of CAMHS (client 1); transfer based on need for inpatient services and perceived inability for CAMHS to manage the behaviour (client 9); discharge from CAMHS and no transition because the client was deemed to be mentally well (client 3 and client 7). Both these client were left in the competent hands of their GP's; and no planned transition, as yet, despite their being a 16th birthday in a few months (client 10).

- **Information exchange and confidentiality: n**umerous comments were made about a lack of dialogue and in particular, a lack of information (clients 8, 1, 3, 9, and 10). Notably:
  - information about **medications**
  - leaflets about **mental illness** in adolescence
  - I've had to research everything, '**Young Minds'** recommended as a resource.

- information about **adult services**. 'I don't know what kind of service they provide or what kind of support they provide, how regularly they would want to see anybody, I don't know…. If they produced a booklet and it were automatically given at say 14, 15 about Adult Mental Health Service with frequently asked questions etc. I don't even know where Adult Mental Health Services are (Client 10)
- information about **Further Education** Training Programmes
- information and **confidentiality**, two parents commented about a potential lack of knowledge that adult services may have if they rely on the testimony of the young person only. Because parents no longer intrinsically involved much anxiety on their part about the nature and scope of information they (the client) are telling their new workers in adult services, for example 'Client 3 - I wonder whether they know the family history in terms of useful information.'

- **Difference in the nature of service:**

There was recognition of a difference between adult and CAMHS, in that CAMHS might be more flexible and responsive and adult services having a different threshold.

> 'Well when the doctor tells you it's hard to get them in, it must be hard to get them in. …It's obviously because there are so many adults with depression and under stress with society as it is I suppose'
>
> (client 1)

> 'I don't know what to expect,…What I don't want is because they're classed as adult, even though I don't think they are adult, to be a bit more dismissive with them, as much as they should stand on their own two feet, oh come in, sit down, here's your prescription, off you go'
>
> (client 10)

3.2.5 School/college

It was interesting to note the number of positive comments, from parents, about the experience of learning mentors in school supporting the young people in their studies.

Positive:

- Home tutoring,
- Support to return to school,
- Discussions (health promotion mental health aspect) with one clients class to help them understand potential behaviours,

- The statementing process being in place for one client with a full package of educational support,
- College was also noted as a good experience as the young person had an ‘adult learning expectation’.

Negative:

- One parent felt that special needs schools ought to be reinvested in as putting complex children in mainstream education. in his view ‘didn’t work' commenting ‘you know put them with an ordinary kids and they will learn from them but it don’t work like that with kids like him’ (client 7).
- Also noted was a lack of helpfulness 'only offering leniency with her coursework deadlines and things like that’.
- There is also a perceived change in support needed when moving from junior to secondary education as junior school retain a ‘class’ structure’ whereas secondary schools operate a subject structure which means more complex health promotion activities are needed to reduce stigma and promote inclusion.

3.2.6 Support for parents/carers

Numerous comments were made about the support parents received both generally and in relation to transition. They fall into a number of headings:

- **Support groups** - There are specific support groups for individual problems but seemed a lack of general support for adults caring for young people with mental health problems. (client 10, client 9, client 1).

- **Individual support -** Client 7 father has arranged individual support from the Carers Centre in the city but parents were interested in being consulted and involved with their child's workers in some way. Some recognition that they might be managing stress and mood problems themselves because of the nature of the childs mental health problems and demands/anxieties (client 1, client 7, client 3, client 9, client 11).

- **Respite** - "I did ask once to key worker is there any chance they could take him away for a few days just to give me a break and they said no so I never mentioned that anymore" (Client 8)

- **Information and feedback**- No information from services about conditions and management of conditions. (client 9, client 7, client 3, client 1, client 10). Concern

that often service is a bit like politics, 'they answer your question with a question. I came out thinking that I didn't get what I wanted to know….we lived with the situation, we lived with all the negative things that were going on…I mean you're talking about a girl's life here' (client 1).

3.2.7 If your child had to go into hospital, how would you feel about them being on an adult ward?

Hospital services – There were a number of views express about the use of adult in-patient services by young people. In particular there were a few comments captured about experiences in 'young person's admission units' and adult in-patient services.

One comment about 'young persons admission unit:

> **"**They send all the other teenagers home and from Friday to Sunday he was left totally on his own on a unit, the only one on the unit, all the others went home, because he was so unwell because of his illness. He was just left. (client 9).

Most comments were about adult acute wards:

- Emotional comments from staff which were overheard like ''He shouldn't be here, he's only a baby'. Doctors, staff, patients, it used to upset patients actually to see him on there (client 9) and the level of containment

- Structure and containment – recognition that containment can be positive, but that adult forensic units for young people in particular were inappropriate, not only because of the threat posed to the young person but the potential to learn maladaptive behaviour, 'if you put a lamb amongst wolves'. (client 9). But that sometime hospital can be necessary to ensure treatment (client 7).

- anxiety over young persons safety – recognition of the nature of acute ward and potentially exacerbating behaviour of a young person, but also young people being threatened by older clients (client 9, client 3)

> 'You can imagine a typical 16 year old, 3/4 length trousers on, sports gear, Walkman on, boom boom boom up and down the corridors, bouncing off the walls. So obviously there all older mentally ill patients in there and it used to irritate them, you know he used to be like that in their face, so that caused a lot of friction'.
>
> (client 9)

"There was some sort of sense that if he ended up in Adult Services on an acute ward he wouldn't be able to leave when he wanted to" (Client 11)

- Concerns over deterioration of mental health (client 8)

Accident and Emergency

Client 7's parent made observations about A&E commenting on how there were a number of seemingly mentally ill people there just milling about on a Saturday night (he had gone there for a physical problem with a relative). He was surprised at the number of people, in distress and felt that this indicated a lack of funding for mental health services with this level of impact on general medical services.

3.2.8 Forming relationships facilitating safety

Three parents commented on the importance of long term relationships with clients. In particular much praise was placed generally at the door of CAMHS with some obviously dedicated psychiatrists and staff who have supported clients over the years. Client 10's parents had difficulty with transition because of this noting: 'you're dealing with another total stranger where you've got to start all over again from rock bottom, explaining everything and going through everything and building a relationship with someone'. Relationships are fundamental to mental health work and we have seen how damaging they can be also with client 9's family's experience of trying to help their son. However, client need often is a lever to forming a good relationship as client 1's parents note a change in her overall behaviour based on the regular (weekly/fortnightly) sessions and the relationship the client has forged with her key worker in adult services.

3.2.9 What would be your ideal for transition?

A number of themes emerged from the parent interviews:

- **Client and parent support groups** - Some parents commented on their isolation and lack of support, for both respite and in general for their mental health. Feeling that even in CAMHS they were left to manage on their own at times and were ignored at client meetings. There seems to be a need for support groups for parents of younger children with mental health problems as most support groups seem to be, in their view, for older clients. Client 8's father felt that there should be some support

for young people with mental health problems that were more specific to their type of problem based on a social model.

- **The value of an intermediate/young persons service -** a number of comments were made here, however it is important to note that the researcher did ask a specific question on this area based on the review of the literature. Comments circulated around teenage years being a transition in emotional development in terms of relationships and coping skills (client 3, client 10) and anxieties regarding involvement in adult services, particularly admission wards. The main essence of a desirable service would be:
    - 15-20
    - community based
    - child and parent support groups
    - Information essential
    - Small admission unit for this age group
    - Staff trained to manage this group

    (client 3, 10, 7, 9, 1, 11)

    However, client 1 parents were also unsure as to the value of a service because there would then be two transitions 'I don't know if that would work or not because then they're going to three different stages. That could do more harm than most people like the continuity of getting to know people, especially when they are in stages of mental illness because they can't adapt very well' (client 1). However there was a sense that the service should be hosted in adult mental health, like the EIS service is so there would not be another change of 'provider'.

- **Self determination through being heard -** Client 3 feels it important to have 'power over their circumstances and that has got to be a positive thing' based upon being involved and having ones voice heard (client 7).

- **Speed - "**I would have liked things to have happened sooner, which obviously they don't at times but what I would have liked is perhaps when she was patting me on back, telling me how well I had done and all that is to say here are some numbers, phone numbers that if things kick off**"** (client 7)

- **Bridging** – "Helpful for parent/carer and the person who needs the adult mental health services to have at least two meetings, one meeting where the people from the adult mental health services come to CAMHS and share an appointment with the

child psychiatrist, for instance psychiatrist, parent and client and then the next appointment for us all to go to the adult mental health services, parent client and psychiatrist" (client 10)

- **Planned transition** – Needless to say parents felt that there should be a planned transfer between services with it being a 'natural process' (client 1) based on evaluation of needs.

- **Recognition of the role of parents in the ongoing support and management of their children –** Many parents felt uninformed as to the nature of the services and the nature of their child's mental health problem, especially when they entered adult services with confidentiality issues changing. Understandably there is a lot of anxiety held by parents as one comments:

'Just in some ways that parents don't necessarily want to interfere and let their teenagers be teenagers but at the same time they are completely out of the loop and completely isolated…It's no good them (the service) just turning round and saying, you know if anything goes wrong, you're the one that is responsible' (client 1)

3.3 General practitioner views

Two GP's were interviewed for this study, Client 1 GP and Client 5 GP. One GP was from the South East sector of Sheffield the other from the West sector. The researchers were unable to include other GP's, for clients who had agreed to their involvement, due to time constraints and circumstances of the clients GP's, for example one was on holiday the other on maternity leave. Never the less important observations by the two GP's interviewed were made about transition and their sense of transition.

3.3.1 What helped you?

Individual and referrals: Client 1 GP felt the active involvement of the client in requesting a change of service helped in the momentum for change, an awareness of the client wanting transition because she wanted to be treated as a young adult so GP agreed.

3.3.2 What hasn't helped?

Referral process: Client 1 GP referred on her request, but community mental health team would not accept her since she was already on someone's caseload in CAMHS. There was a perception that she wanted to be under two consultants, but this was not accurate. This misconception delayed the process. The GP commented:

> 'You have to write again and again and everyone gets a bit shirty…and a wait of 8 months not unusual. Referrals can be mislaid and then because of information transfer the client has to start again as if they are a new patient'

Client 5 GP, commented how their client was discharged from CAMHS because she was apparently 'well' and the closure letter included 'copies of our leaflets for information'. The client subsequently became ill with a time lag of 12 weeks before being seen. The client had to return an 'opt in' slip to the service and responded on the second letter which stated as she had not replied they would not be following her up. There seems to be an element of risk involved in this process of managing referrals with vulnerable young people and perhaps their might be a transparent system of assessing referrals for follow up should a risk profile be apparent in the referral information.

Client 5 GP comments on whether there was a transition or not:

> "I think the answer is isn't it that if she had, let us suppose they had done that assessment at 15 years old they wouldn't have closed the case on her would they at that point, it is because she was going to become an adult that they decided they would close the case because she was doing well. She had

> only been doing well a couple of months. I am sure, well I can't speak for them but I would guess that if she had been remaining under that team they would have said lets see you in six months and see how you are doing"

Information exchange: This section builds on the risk management issues identified above, where one GP commented:

> 'Children's service has got to recognise there's a problem, they've got to bridge it…a lot of kids are quiet sometimes around 16 and then suddenly it breaks forth and who do you belong to, you know'.

Suggestions for 'bridging' include liaison between the two services which has both written and verbal communication included. A complex communication system might answer the perception that referrals are taken up in the adult service on a 'bit hit and miss' basis. Client 5's GP supports the 'formal referral I suppose, that's what I would expect' and further was able, due to the good written communication between both CAMHS, adult and the GP to fully track the progress of client 5's transfer. Suggesting that there was a strong written communication system between primary and secondary care, in this case.

Difference in the nature of service: The GPs commented that there could be an advantage in treating clients as a new patient, since new information might come to light depending on different questioning/assessment procedures. However concern was expressed about the option of admission to an adult acute ward, with its complexities and age spread, stating it might be 'Too shocking' (GP client 5).

3.3.3 What can you suggest would make services better?

A number of helpful comments were made here and include:

- Adult services should relax rules for 16-18 year olds.

- Care should be taken in discharging clients too early by CAMHS based on age and current mental health status. For example client 5 had 'only been doing well a couple of months and should have been seen in 6 months to check progress was still being made.

- It seems as if there is no audit trail for these clients

3.4 Key worker views

Seven key workers were interviewed for this study. Two of whom pertain to clients in the focus group (client 1 and client 2), one from eating disorder specialist services (client 5) one from a sector CMHT (client 6) and three staff from early intervention covering two clients (client 7 and client 8). These later two clients we met in more depth through their parents' interview in section 3.2. Staff were mostly interviewed individually, except the early intervention workers who were interviewed as a group, since they all had a strong awareness of the two clients they were discussing as part of their team ethos.

There are two strong examples of good practice, both of which offer highly specialised mental health services. These are the eating disorders service and early intervention team for psychosis. It may be that the focus of these services is on prevention of chronic disorders and early improvement of outcomes. Their development of protocols and care pathways appears to lead to a more effective transition.

Four clients are discussed in this section a new client, client 6 and clients 5, 7 and 8 who we have discussed previously. Client 6 was unfortunately unable to be interviewed, because of his work patterns. However, his case is important and provides complex information as to the nature of service for one asylum seeker.

Client 6

Seen in the Child and Family service and the art therapist there got in touch with me about a potential referral even before she'd finished the work…he was left on the waiting list to be seen here for assessment and he didn't get any sort of input at all. He didn't have a social worker - he had had a social worker in Child and Family. By the time I saw him there was a huge back log of things. I think the problem there for me was about who co-ordinates the client's discharge from Child and Family to here, with all the bits they had there at the end and to say 'ok does he need therapy any more, he's got a CPN and he's got a social worker' but he just came through in a kind of blind way.

He's got post-traumatic stress disorder. He's an asylum seeker from Macedonia and he left the country when he was about 16. His parents were murdered. He arrived here and he was in some holding place where he didn't have any services - he didn't know there was an interpreter available.

He didn't physically see them get killed but he was at home and police were coming and his father told him to run into the woods at the back of the house. His mother was in the house and he heard as he was running, he heard his father being beaten up and his father's screams and cries and then he heard a shot and then he saw smoke rising from the house - the house was set on fire. There is an assumption I suppose that they were killed but it certainly sounds like his father was definitely killed, whether his mother was in the house or not. So he then spent several days, I think not quite 48 hours but the best part of that, in this mountainous area wandering around. He'd come across dead bodies and then eventually he found a track and a man found him and took him to the next village who said 'I can't stay here but I'll help you' so he was put on a train.

I think the whole village, they used the hay to set the houses on fire, I don't know why. That's how he ended up here. The Home Office didn't really believe his story, they thought it was unbelievable…at the moment there's an appeal going on, and he should have left the country on 31st January.

3.4.1 What helped you?

Individual and referrals:

Client	Transition planned	Discharged then to adult services
Client 6	**Not really, referred to adult services then waited for assessment**	

Client 2 key worker comments on a few aspects of transfer both positive and potentially negative, there is evidence that a transition occurred albeit a quick one with little communication between services and the client:

> I'm quite surprised she did because I think there's lots of people wouldn't have done, to come to a place like this when you've gone to a school like '*young persons admission services'* where it's very young and very young-orientated - sitting in the waiting room downstairs it's full of adults, to a woman that you don't know at all, you've only met once.
>
> She didn't have a clue what to expect at all…I think she was quite brave to come I think'.
>
> 'So in a way it's quite good at 16 to go on to adult services because I think sometimes that brings out more mature behaviour anyway and a realisation that 'Hang on a minute', which I think has happened to client 2'.

For client 5 there was also a transition in evidence, but there was a significant time lag between referral and being accepted into a service. This client was included in the specialist services, and it seems there is evidence of the development of a care pathway in eating disorders, based on testimony from the key worker.

> ' Her transition was stop start but in actual fact from eating disorders we've developed a shared protocol…working group over the past two years to develop guidelines on the management of eating disorders in the under 18 year old age group….It's a protocol whereby two teams would meet together and agree how the transfer would take place'.

The protocol normally includes a meeting if a young person has an eating disorder, and access to case notes. Reflections on the relationships formed in CAMHS was also commented upon:

'the fact of the matter is people who are transferred from CAMHS have usually already had quite a good service from CAMHS. They're usually happy with the service they got because eating disorders are quite prioritised in CAMHS and very often the families might have had some family therapy and so they're already half better if they're transferred usually and so we have less work to do and so my issue is more the issue of young people with eating disorders in general'.

3.4.2 What hasn't helped?

Referral process: was varied for the clients discussed by key workers, client 6 was referred by an art therapist and languished on a waiting list and had no input despite needing early intervention with a social worker. Client 2 was referred and transferred in a week. Client 1 had to be discharged first before adult services would accept her and clients 7 & 8 were introduced to the early interventions teams at an appropriate juncture. However all these referrals lack suitable supporting information and risk information.

Particular comments worth noting are:

‘I think the problem there for me was about who co-ordinates the client's discharge from Child and Family to here, with all the bits they had there at the end and to say 'ok does he need therapy any more, he's got a CPN and he's got a social worker' but he just came through in a kind of blind way… He was so traumatised by the time I started seeing him ' (client 6 key worker)

'I literally went to the review, in fact I'm sure the review was on the Monday and she was being discharged on the Friday…I knew nothing about her and they were trying to get us to say what we could offer which obviously you don't know until you've met them anyway and I think that she was really quite anxious about it. I think that she's adapted quite quickly to it, but she was really, really anxious that week...I didn't get to see any of her notes. All I got was the last couple of reviews to read through' (client 2 key worker)

Information exchange: CAMHS and SCT are separate services under separate management structures with different provision for case note access, although they both currently share the same information data base, 'Insight'. So it might be expected for there to be some complexities with the transfer of notes from one service to another. This experience was born out in practice . It seems that there are a number of issues of note:

- No passing over of information takes place before transition (client 1 key worker)

- 'Then still often it’s the point where they get to the appointment rather than us meeting them before' (client 2 key worker)

- Access to notes difficult (client 5 key worker)

- 'Shocking communication. There seems to be a clear difference in working philosophy from CAMHS, their expectations of us and us of them' (clients 7&8 key worker)

- 'They (CAMHS) are so unused to work with people at risk with psychosis they don't see the risk therefore they don't see the necessity to pass on the notes' (Client 7&8 key worker)

All five comments suggest a need for improved communication systems both verbal and written. It is important to note the comments from clients 7&8, suggesting an element of risk to others due to the nature of the clients mental health problem and presentation. Especially in the case of client 8 whose behaviour is impulsive, aggressive and threatening to others. There is a heightened risk of harm to others, normally nearest/closest relative with clients suffering paranoid schizophrenia and therefore risk assessment is essential in all aspects of working, both for clients and for staff (Hawton 1987, Blom-Cooper et al 1995, DoH 1999). In fact, for client 7, there was a potential risk not divulged in relation to the client's attitude toward male workers, which placed the member of staff at risk when he first met the client, a risk which could have been minimised given appropriate levels of information:

> "Some of the stuff we've found out late after we would have changed things as we did as we had already seen this lad and found this information. I can think of one instance where we had of done something different - one client it turns out that he's got a thing about males in general it can be from he found males really threatening, this is a standing and the case on the ward as well, the second time we went round he wouldn't come down so I went upstairs to talk to him. So if I had known that before would I have done that? Probably not "
>
> (Client 7 key worker)

Difference in the nature of service: There is an active recognition of the transitional experience from the key workers and reflection in their work of the differences between adult and CAMHS services. A strong sense of difference is reflected in the change from a service where you might have multiple workers who are responsive and flexible to being tied into a system that is less flexible and puts the emphasis on client responsibility. Also the role of parents in adult services is less acute than in CAMHS. Some key workers view this as a maturational process and it seems reasonable for the clients to have an awareness of this difference before they become part of the adult service. These points are reinforced by the following comments:

Client 1 and client 2 key worker need to be **adult enough to make appointments** and turn up for them:

> 'I think young people - clients fully have to engage themselves because it's a big responsibility making all your appointments and things like that, that's the sort of thing that you learn as you grown up. It's a big responsibility to turn up for appointments; you only get so many chances'.

Need to be able to access service:

> **'give young clients more chances and send them more appointments to give them more chances to attend**, but beyond that there's an expectation that if you want it you've got to be able to come and get it'. Adult services not proactive in accessing those that are hard to reach. 'That overall difference in philosophy of engagement seems to have more of an arms length, people, it is about people have to show willing to come to the service, make appointments and things like that. Opposed to our more outreach, keeping in contact'.

Adult services more **geared to individual than family:**

> 'People receiving the service from the Child and Family Therapy Service have had this quite a bond - generally when you see people here it's very hard on the individual, if it's not massively obvious at the assessment that the carer's got a big role. It goes from being a systems thing to an individual'.

Adult services have little to offer young people (client 2 key worker):

> 'Well I think there's nothing for us to offer people until they're about 20 really. Obviously there's a Day Centre which is totally inappropriate because they've got to be with a lot older people. I think we've got quite a few young people that's come here now, a lot more since I started to now, we've got a lot more younger people coming through. I think some of that's maybe because they've not got the right services early on. But certainly there's nothing for us to refer that's age appropriate at all - there's nowhere for them to go.'

Managing stigma:

> 'They've put her into Mental Health Services at 16 years old and I think that's a big taboo for her to have and how does she get rid of that really. It must be very difficult for her to say that's where she's going'.

3.4.3 What can you suggest would make services better?

Overall workers within adult services express a perceived inadequacy of their services for young people. They make useful suggestions for improving them. The need for a teenage service has been highlighted. There is an urgent need to address the management of risk for vulnerable teenagers, as they are sometimes left to fend for themselves in ' no man's land'.

- Transition should start earlier, especially when there are complex needs involved (client 6 key worker)

- Transition should have a period of joint working. It just makes it more flowing and appropriate' (client 7 & 2 key workers):

  'I think it would have been easier if I could maybe have met with some of the people who had been working with her as opposed to getting it over the phone because I think sometimes that's difficult as well'.

- Transition should involve a handover of clients and assessment by services of their future needs (client 1 & 6 key workers). Client 6 key worker notes:

  'have a sort of discharge meeting…because you're not finishing a bit of work are you, the client's coming to an age where they're finishing with your service so perhaps at that point you could perhaps have a discharge meeting with whoever else is involved in your team and you should know that because you'll have been communicating with them won't you, and just check with each other'. This comment primarily concerns clients who have multiple workers in CAMHS, like social workers, art therapy and psychiatry. Joint referrals being the hoped for outcome.'

- Should be assessment of risk (client 6 &7 key workers)

- Expectations of services for clients who need interpreting and have issues of integration into a different culture. (client 6 key workers)

- Should be clear pathway of care (client 7 & 8 key workers)

  'it should be somewhere between the services of an adult to clearly identify a pathway and clear information going through'.

- There is a lack of resources in eating disorders service which hinders the work they can offer. 'We just have a lot of people waiting for therapies in this service because the service is small'.

3.4.4 What part do you want your parents to play?

It seemed that in the EIS service parents were intricately involved with the support for parents and the support of the client. Although it is useful to reflect back to client 7's father, who, in hoping for some support for respite, received no response and so did not pursue the issue. The main reference in these interviews with key workers comes from client 2 key worker who comments:

> "This is the other big problem, because client 2's parents were involved quite a lot at '*young persons in patient unit'* and told everything that she did and because she's classed as an adult here that's much more difficult for us to do. So she says she doesn't want her parents to know, we're having a discussion

about it at the minute about what you do really. I've seen her mum a few times but I've never met Dad'.

3.4.5 If you had to go into hospital, how would you feel being on an adult ward?

Hospital services

Client 1 key worker comments on potential admission to an adult acute ward:

> 'I wouldn't have thought it would be fantastically nice - quite scary possibly and an opportunity to get exploited maybe, or maybe set up expectations about what their mental health problems are going to be in the future. Maybe pick up unhelpful coping mechanisms from other people - yeah, I think it would be very scary'.

Client 5 key worker discusses a gap in suitable inpatient facilities for clients with specialist needs:

> 'I think we're all very comfortable working with the younger age group but our problem is that if they need to be admitted we haven't got anywhere dedicated to admit them to because they're too old for '*young persons in patient unit'* they're too old for the Children's Hospital, they're too young for Leeds where we refer people to. That's the nearest NHS specialist unit and they don't take people under 17. So we've got a gap there, a big gap in the middle'.

3.4.6 What would be your ideal for transition?

The key workers generally supported the principle of a young person's service. Client 2's key worker makes three good points, noting:

> 'I think there should maybe be a specific service set up for maybe 16-20 year olds that can deal with young people. '

> 'I think it's very difficult working with young people to working with adults, definitely. I think they need a different approach.'

> 'I think they're brought into a service that they could remain in until they're quite a lot older so something more specific and more time-limited, you could probably do a bit more work and not have to give them that badge of being in Adult Mental Health Services.'

Section 4 - Discussion and summary

This study asked the question 'Is there a recognisable care pathway for transition from CAMHS to adult services?

There seems to be no clear model of transition as a process, confirming the findings in the literature review. From the initial focus group to the analysis of other interviews there appeared no clear pathway of transition. The move to adult services was either initiated by the young person, CAMHS service by closing a case or the GP. In one case, transfer was not accepted and only the persistence of a GP resulted in a successful outcome. Without a strong advocate, this young person would not have received the service they needed. As a result some young people's outcomes are poorer. Some are actually left in limbo while others have to be discharged and then re-admitted.

There is some evidence of planning in the transfer of care for some clients, but in a few cases there is evidence of closure of a case that has developed into a complex mental health problem in late teenage years, which might have been better managed with a transition rather than a closure. Multi-agency meetings have only taken place for a few clients. Young people and their parents do not always seem to be involved in the transfer process, with concerns expressed about the nature of the service they are transferring into and the suitability of admission wards should their child need intensive in-patient care.

Young people perceive a lack of communication between workers about transition:

> 'They don't talk to each other. There's not much connection between my GP and my key worker either' (client 1).

There is a sense that when a service can do no more, they pass on a young person:

> 'And then my doctor decided that there weren't anything else he could do and I was 16 so we went to adult services (client 2)'.

This is likely to have an impact on a teenager's self esteem and lead to a feeling of rejection, resulting in potential alienation from services.

4.1 Helpful aspects of transition and service

A number of key comments can be drawn out of participants observations relating to the young person as a teenager, but wanting to be seen as a young adult, the value of GP's and the value of supportive mental health staff:

Not wanting to be treated like a child anymore – participants noted that there was support for the changing from CAMHS to adult services, with a little persuasion from the GP. This process could be thought of as maturational, in that the young people considered adult services to be the more appropriate location and had the skills to help their mental health problem, for example self harm. However, there were drawbacks in there being a less accessible range of services in adult compared to CAMHS.

Value of GP – GP's were very important to the parents and the clients, being seen as a bridge and advocate of clients needs. Participants talked of 'excellent support from my GP'. GP's have the ability to track clients longitudinally through their notes and longer term involvement with the family. There is also an opportunity for further study here as GP's have an opportunity for an audit trail with the correspondence they hold on behalf of their clients.

Mental Health staff - CAMHS was generally accepted as a flexible, compassionate and organised service for the clients. However there were some comments about the CAMHS orientation seemingly overly weighted toward the younger age group, rather than adolescents and the role of parents in the support of their children and inclusively in terms of support and dialogue with CAMHS workers. Never the less, relationships were important for participants which has a bearing on the client's response to transition. Once in adult service there was generally a sense of the staff seeking to understand the young person, albeit sometimes in an exploratory way in term of finding an appropriate treatment modality. There were a couple of comments here also about wanting adult mental heath staff to 'make decisions' and act rather than reflect back a question with a question. One sensed the frustration and anxiety of the parent's role here in managing day to day potentially volatile and dangerous behaviours.

Protocols - Specialist services like eating disorders and EIS seemed to have a protocol of transition where meetings and information sharing took place. This practice was not apparent across all aspects of the service.

4.2 Unhelpful aspects of service and transition

There were unhelpful aspects of transition and services commented upon and shared between participant groups, most importantly about reasons for transfer, information sharing, changing staff and a perceived change of culture between services

Reasons for transfer: Most young people were transferred because of their age at 16 and were perplexed that this should be an automatic cut off. One family felt their transfer was highly inappropriate and based more on their child's behaviour and physical appearance rather than clinical need. A further two clients were discharged from CAMHS because at the time they were perceived to be ‘doing all right’ but subsequently deteriorated within a few months of discharge and had therefore to reengage with adult services as a ‘new starter, rather than having transferred appropriately. It was suggested that there be a risk assessment and a planned follow up for CAMHS clients with complex needs who appear to be doing well and are not therefore transferred.

Information exchange - CAMHS and Sheffield Care Trust are separate services under individual management structures with different provision for case note access, although they both currently share the same information data base, 'Insight'. So it might be expected for there to be some complexities with the transfer of notes from one service to another. A general lack of information (except with regard to specialists services) was noted, information about services, about timescales and process of transition, about mental health problems affecting young people and about support services/groups for both parents and young people. A theme among the parents was a lack of information about adult services. In particular we would like to draw your attention to:

- No passing over of information takes place before transition.

- Access to notes seems difficult between services.

- Managing risk - there seems a perception that CAMHS manages a different level of risk to adult services and as such may not be as familiar with some risk assessment strategies. This might be a misperception as there are a number of complex clients well managed in CAMHS from the author's experience. Never the less it requires some consideration. Perhaps the main issue is the management of psychosis and familiarity with this mental health problem as noted by some key workers

'They (CAMHS) are so unused to work with people at risk with psychosis they don't see the risk therefore they don't see the necessity to pass on the notes'

In managing risk the main conclusions from the interviews were to have an early transfer, adequate information and a 'bridging' phase where clients who pose a risk are handed over appropriately through planned meetings. One GP noting with clarity:

"Children's service has got to recognise there's a problem, they've got to bridge it…a lot of kids are quiet sometimes around 16 and then suddenly it breaks forth and who do you belong to, you know'.

There was a sense that better coordination was required:

'I think the problem there for me was about who co-ordinates the client's discharge from Child and Family to here, with all the bits they had there at the end and to say 'ok does he need therapy any more, he's got a CPN and he's got a social worker' but he just came through in a kind of blind way… He was so traumatised by the time I started seeing him'
(client 6 key worker)

Culture – It seems as if there is a perceived difference in culture between a CAMHS and adult service, with CAMHS being able to have clients with multiple workers inputting and adult services only managing a one person intervention. But importantly there needs to be a transparency between what is available in adult services as compared to CAMHS and how the service is configured. It was mentioned by a number of participants how difficult it was to 'get into' adult services. Two key workers noted:

'There seems to be a clear difference in working philosophy from CAMHS, their expectations of us and us of them' (clients 7&8).

There is a sense that CAMHS and adult services have a different threshold and a different approach. The researchers feel that these approaches are appropriate, since young people need a specific approach to engagement and with adults there is an expectation of volition in engaging with the service with the caveat being that is if the person poses significant risk then there will be a more assertive approach to inclusion.

Some key points arose from the interviews about the perceived difference in culture, both positive and negative:

- Expectations on attendance from adults without necessarily assertive outreach 'it's a big responsibility making all your appointments and things like that, that's

the sort of thing that you learn as you grown up. It's a big responsibility to turn up for appointments; you only get so many chances'.

- Access service. **'give young clients more chances and send them more appointments to give them more chances to attend**,' the overall difference in philosophy of engagement seems to have more of an arms length people it is about people have to show willing to come to the service, make appointments and things like that. Opposed to our more outreach, keeping in contact'.

- **Individual work rather than family work**. 'It goes from being a systems thing to an individual'.

- **Adult services have less scope to offer multiple workers than CAMHS -** other than individual work, it seems as if other services, e.g. .day services, would be inappropriate for young people. 'But certainly there's nothing for us to refer that's age appropriate at all - there's nowhere for them to go'.

- **Managing stigma** - always a complex issue but doubled by the perspective of young people potentially entering a system that has people with perhaps more severe problems and for longer timescales. This can lead to a despondency amongst the young, instillation of hope was a core concept in relationship formation from the interviews and this hope might be challenged if young people were to be immersed in a system not suitable for their needs. There was recognition of a difference between adult services and CAMHS, in that CAMHS might be more flexible and responsive and adult services having a different threshold. Evidence of work being undertaken in schools to reduce stigma is encouraging and should be supported for specific cases and more generally as a health promotion target.

Transition between services has inherent anxieties; one of the principal factors expressed by the clients, was knowing there was someone there for you. There appeared a perception in culture between the services with CAMHS being described as 'patronising' and also 'flexible and compassionate' with adult service being 'scary'.

The GP's commented that there could be an advantage in treating clients as a new patient, since new information might come alight depending on different questioning/assessment

procedures. However concern was expressed about the option of admitting to an adult acute ward with its complexities and age spread, stating it might be ‘Too shocking’ (GP client 5).

4.4 Parent's involvement

Caring for carers is a significant target for adult mental health services and as such there needs to be some attention drawn to the experience of the parents in this study. They collectively felt that they were often managing alone, lacked information, lacked respite and generally were left holding risk, whilst services made their mind up about interventions and treatments. Recognising the changes in confidentiality from CAMHS to adult services, one must also recognise the complexities of moving to adulthood and the emotional and physical changes that occur. For a number of the male clients in this study, there were aspects of their mental health problems and behaviour which posed a potential risk, not only to staff, but to the carers. One suggests that including the parents, with due respect to confidentiality, as much as is possible would be a worthy enterprise in minimising this risk.

Again specialist services were better placed in their communication with relatives, however even they were commented upon as to their level of support and responsiveness.

Parents' needs can be summed up as follows:

- Support groups
- Individual support
- Respite
- Information and feedback

Parents are in a complex and difficult place when supporting young people with mental health problems. The young people in this study had varied experiences of their parent's involvement with services and their wellbeing. The researchers recognise this as a dilemma for both service and the young people in terms of their safety and confidentiality.
The young people commented:

> "I didn't want my parents there but my psychiatrist said to my mum and dad that I didn't and I wasn't just being bad but he told my mum and dad and I didn't want him to."

> "Well when I was younger we did a series of family therapy sessions that did help a little because it explained to them that I didn't want them like constantly

over me...and it did give me a bit of space and a bit of freedom which did actually help."

"It would be a good idea to send progress reports to parents through the post or something or have a separate meeting."

"You don't want to go with them together because you're less likely to tell them things when your parents are in the same room."

"Key worker did say do you want me to tell your mum and dad things and I said no."

"My mother has met my key worker on the one occasion...I don't know, I'm a bit funny about that, I think I'd rather sort it out by myself."

4.5 School/college

It was interesting to note a number of positive comments about the experience of learning mentors in school supporting the young people in their studies.

Positive:

- Home tutoring.
- Support to return to school.
- Discussions (health promotion mental health aspect) with one clients class to help them understand potential behaviours.
- The statementing process being in place for one client with a full package of educational support.
- College was also noted as a good experience as the young person had an ‘adult learning expectation’.

Negative:

- One parent felt that special needs schools ought to be reinvested in as putting complex children in mainstream education, In his view ‘didn’t work” commenting ‘you know put them with ordinary kids and they will learn from them but it don’t work like that with kids like him’ (client 7).
- Also noted was a lack of helpfulness only offering lenient with her coursework deadlines and things like that’.
- There is also a perceived change in support needed when moving from junior to secondary education as junior school retain a ‘class’ structure’ whereas secondary schools operate a subject structure which means more complex health promotion activities are needed to reduce stigma and promote inclusion.

4.6 Contact with services

Clients and others found both the written word and verbal dialogue to be an expectation of communication between services. Clients' definitely did not want services to contact them via text.

4.7 Hospital admissions

A number of positive and negative comments were received about admissions to adult acute wards and some experiences in young person's admissions units.

- **Hospital admission to an adult ward**

Client 1 comments on potential admission to an adult acute ward:

> 'I wouldn't have thought it would be fantastically nice - quite scary possibly and an opportunity to get exploited maybe, or maybe set up expectations about what their mental health problems are going to be in the future. Maybe pick up unhelpful coping mechanisms from other people - yeah, I think it would be very scary'.

Client 5 discusses gap in suitable inpatient facilities for clients with specialist needs:

> 'I think we're all very comfortable working with the younger age group but our problem is that if they need to be admitted we haven't got anywhere dedicated to admit them to because they're too old for '*young persons in patient unit'* they're too old for the Children's Hospital, they're too young for Leeds where we refer people to. That's the nearest NHS specialist unit and they don't take people under 17. So we've got a gap there, a big gap in the middle'.

- Emotional comments from staff which were overheard like ''He shouldn't be here, he's only a baby'. Doctors, staff, patients, it used to upset patients actually to see him on there (client 9) and the level of containment

- Structure and containment – recognition that containment can be positive but that adult forensic units for young people in particular were inappropriate not only because of the threat posed to the young person but the potential to learn maladaptive behaviour, 'if you put a lamb amongst wolves' (client 9). But that sometimes hospital can be necessary to ensure treatment (client 7).

- anxiety over young persons safety – recognition of the nature of acute ward and potentially exacerbating behaviour of a young person, but also young people being threatened by older clients (client 9, client 3)

> 'You can imagine a typical 16 year old, 3/4 length trousers on, sports gear, Walkman on, boom boom boom up and down the corridors, bouncing off the walls. So obviously there all older mentally ill patients in there and it used to irritate them, you know he used to be like that in their face, so that caused a lot of friction'. (client 9)

- There was some sort of sense that if he ended up in Adult Services on an acute ward he wouldn't be able to leave when he wanted to (client 11)

- Concerns over deterioration of mental health (client 8)

Three of the clients had experienced in-patient care, one on a general medical ward the other two on acute psychiatric admission wards. Their annotated quotes speak for themselves:

> **Client 1** - "I went on an adult ward when I had my operation and that was fine.... I don't mind in my hospital I had an old woman, a girl a couple of years older than me, this middle-aged woman on the other side, I didn't mind, I had my TV. ....I suppose if you've got really younger kids and then a really older person like 30, 40 you kind of seem stuck in the middle. I think in a children's setting you feel too old for them all and in an adults' setting you seem too young and they're all looking down on you, its weird being in between".
>
> **Client 3** - "Well I don't think I'd like to be in with children because if I was with children and I needed help I think I'd say help them because you can look after yourself. I had to go to hospital in an adult place which was a bit strange, I thought they'd take me to the children's and they wouldn't like call my parents for me or anything so I didn't like that really....I went in for the day, I took an overdose. I was at *in patient Unit*; I just thought I was treated really badly there. I asked them to call my mum and they wouldn't call anybody.....I ran away from the hospital after a few hours because they just left me and I just thought there was no point me even being here, there just ignoring me".
>
> **Client 4** - " I think now I would probably have preferred to go on a ward, I'd have felt safer. But I didn't think much at the time.....Absolute nutters - people with schizophrenia and stuff like that. I don't think there'd be anybody as young as me, hardly anybody. I reckon it would be quite intimidating, I think that's why I was preferring to have home treatment.....I just wanted some help. I did feel as if I needed it - but I obviously didn't get enough!"

- **Accident and Emergency**

There were three overall experiences of A&E in the study:

One parent was attending A&E and found there to be a number of obviously mentally ill people there and he wondered about their needs and what kind of service they might/ought to be receiving. The researchers are aware of the development with crisis home treatment and their liaison with A&E and hope that the improvements to the experience of mental health clients in A&E continue.

One client was a recipient of Crisis Home treatment from A&E and felt 'the services were good when you actually got to see the person who dealt with it but it took about 15 hours'. The main concern of her experience was being left for so long and a perceived negative attitude from A&E staff towards her because she had self harmed (overdose).

Another client went to hospital after overdosing and waited three hours to actually see someone because it was at night and it was emergency service

> 'It is horrible because it's bad enough to take an OD in the first place and then they just leave you on your own. You thought nobody cared in the first place and then you're just left like that and you're thinking 'What's the point?' They treat it like it's your own fault and you deserve what you get....When they were treating me when I had to have stitches for self-harm the nurse was so horrible to me. If somebody had fallen over and needed stitches she'd have been a lot nicer, I know it. It's because it was my own fault and I did it to myself.....Just give them more training, or maybe somebody who has done it to themselves. A lot of the time they don't know what's going through your head when you're in that state. It is their mental health that's affected. They do need the same care and attention as anybody else".

Watts and Morgan (1994) talk eloquently in their paper about how clients who deliberately harm themselves can become unpopular with staff who are trying to help them and in being unable to help can inadvertently reinforce the negative assumptions the clients have of themselves. It seems as if this observation was born out by two of the clients in this study.

- **Crisis home treatment team**

Three clients had experience of the recently developed crisis home treatment team their experiences are varied and worth repeating here from the data analysis section:

Client 1 saw a junior doctor first, then the crisis service. Her experience was one of being assessed to 'make sure that I was mentally stable to go back home'. Client 1 felt this experience as very pressurised 'they ask too many questions... I know they just wanted to see if you're alright but you've just tried to kill yourself and they're on you and it's just too much'.

Client 4's experience was different in that the adult service felt she was too young to be admitted to an acute ward and that home treatment will be more beneficial commenting:

> 'they came twice a day if needed every day to see me....it was Horrible....I just didn't find them very helpful. I didn't really like some of the people that come. I just hated it.....I saw loads of different people who just basically

> asked me if I were alright and if I said no they didn't really do much anyway, just gave me tablets really'. She was asked what she hoped for in the service 'I don't know. I was just really ill. Really suicidal. I couldn't really do anything and they didn't give me much reassurance...at CAMHS it was more helpful to me, more understanding, they had a bit more compassion...I just felt 'Well I might as well go and top myself now'. I got no help from anybody really. All they were doing was just drugging me up all the time.....So that's it; I didn't find them really helpful at all. Sometimes the people had no compassion, if I was really upset - no compassion whatsoever. This one particular day this lady came, I don't know what she were, but she came and said 'How are you feeling?' and I said 'I'm suicidal' and she said 'Have you had a wash this morning?' and I said 'Yeah' and she said 'Oh, well you're fine then.'

Client 3 however had a positive experience of the crisis team commenting:

> 'I thought the Crisis Team were quite good but I was probably just relieved because everybody else had been so clueless'.

4.8 The importance of a therapeutic relationship

Forming and maintaining therapeutic relationship is an important skill and one in evidence across the care spectrum. For the young people in this study they commented on the importance of this relationship and some factors which contributed to their sense of safety during transition and subsequent support in managing their mental health problems. As termination approaches indirect expressions of fear and anger often take the form of recurrence of original symptoms (Ryle & Kerr, 2002). Therefore closure of these relationships contributes a special consideration as termination; of a therapeutic relationship can be a profound and moving experience for both client and therapist but its reality can still be experienced by patients as a desertion or betrayal (Ryle1995). Accurate and appropriate management of the closure will enable the client to internalise the worker as 'replacement or substitute for earlier ambivalent object' so separation become more of an adult maturational event (Mann 1973).

With this in mind the young people in this study noted a number of key factors that support the need for a 'conscious transfer':

> 'They might be really comfortable with and have formed a strong relationship between the key worker and the person that they're talking to that they've got and to break that might cause more problems to be passed on to someone that they have no idea who they are - so this needs to be recognised and worked with to ensure planned separation.'

> Client 2 "For a lot of people there's trust issues, for me it was. It took me a long time to tell the first person that I went to things that I wouldn't normally tell other people because I do have a lot of trust issues".
>
> Client 1 "I think when I first start working with someone at first they can't do anything because it takes quite a while for me to open up to them".

Many of the clients felt that the meeting with their new workers being in a place away from home was constructive and recognised them as adults, despite some reservations about the age and complexity of the other adult clients they were meeting there.

Three parents commented on the importance of long term relationships with clients. In particular much praise was placed generally at the door of CAMHS with some obviously dedicated psychiatrists and staff who have supported clients over the years. Client 10's parents had difficulty with transition, because of this noting:

> ‘you're dealing with another total stranger where you've got to start all over again from rock bottom, explaining everything and going through everything and building a relationship with someone’.

Relationships are fundamental to mental health work and we have seen how damaging they can also be with client 9’s family’s experience of trying to help their son. Often a client's need is a lever to forming a good relationship as client 1 parent’s note a change in her overall behaviour based on the regular (weekly/fortnightly) sessions and the relationship the client has forged with her key worker in adult services.

4.9 Ideal aspects of a model of transition

Collective comments form 10 key points:

1) Age appropriate service: there was virtually unanimous support for a young person’s mental health service located in the adult mental health service. This location would enable there to be no third transfer if it was necessary to an older age group. The general position being early intervention and appropriate treatment options to reduce the opportunity for long term ill health. Staff would be trained and familiar with the need and treatment approaches effective with this potential client group. Significant anxiety was located in young people being admitted to adult secure wards and this intermediate model would have its own small admission unit.

Key aspects:

- covering an age range of 15-20 years
- Community based
- Child and parent support groups
- Information essential
- Small admission unit for this age group
- Staff trained to manage this group

2) Planned transition following a clear pathway of care – a strong sense from all groups was the need for a planned transfer between services.

3) Bridging – was mentioned by 80% of clients, 100% of GP's a number of parents and key workers. Essentially this means having at least one meeting prior to transfer to introduce new workers and the service and one after transfer to make sure all relevant steps have been taken.

4) 'I think to be asked what I wanted really' or **self determination through being heard** - All participants felt it important to involve the key stakeholders in the configuration of services and in particular the clients and parents found this an emancipatory exercise.

5) Recognition of the role of parents in the ongoing support and management of their children. Three themes emerged with parents:

a) Respect for non involvement of parents in consultations but some communication with parents with young persons collaboration (all clients commented)

b) Client and parent support groups - a few parents commented on their isolation and lack of support, for both respite and in general for their own mental health, hoping for some individual support or age appropriate group support.

c) Uninformed as to the nature of the services available and the nature of their child's mental health problem.

6) Information – encapsulated in an observation of a GP, but reinforced by all clients was the need for ‘as smooth as you could the transfer between child to adult and passing on the notes and talking to each other’

7) No time lag- not having a time gap in between services. It is of concern that three of the clients in this study, who were vulnerable, had a significant time lag without access to a specialist service, the maximum time being 2 years for a psychotic young man.

8) There should be an assessment of risk by services of clients future needs, as care needs to be taken when discharging clients. For example client 5 had only been 'doing well' a couple of months and should have been seen in 6 months to check continued progress.

9) Instillation of hope - early engagement and continuity of service is prized by the young people, their carers, key workers and GP's.

10) An **audit trail** should be established for each client as they pass from one service to the other.

Section 5 Conclusions

Fundamental to the issue of transition is the tension inherent in all work with young people when they move between children's and adult services. While many of the participants rejected the overt aspects of a children's service (the cuddly toys, child-friendly interviews and environment) and resented sitting in a waiting room with much younger children and their parents, they still sought the 'containment' and security offered by those services. While they wanted to be consulted about changes and developments in their treatment they were far from able to deal with the choices inherent in the approach of adult services.

One of the strongest criticisms of the children's services was apparent in their sense of being patronised and 'talked down to' while in adult services they felt that discussions and conversations sometimes took place above their heads. This was even more vividly expressed when discussing their experiences with A and E services - an obvious concomitant of mental health services where self harm is the visible symptom of mental distress.

An approach consistent with respect for the rights of these young people would go some way towards remedying some of these problems. It is not for this study to identify the specific staff development needs of A&E staff in work with this age group, but the recognition of critical learning needs here is clear.

Staff development issues

Because of the nature of the transitional process, staff in both CAMHS and adult services, need to have skills in communication with young people and in the important areas of values and children's rights that are central to practice. Training and staff development needs are wider than this, however, and the significance of self harm/overdose behaviours among this group is an immediate pointer to the need for staff development among all A&E staff. Education services have a mixed review in this study. There are clearly some schools which have developed a better organisational approach to responding to children and young people's mental health needs and it may be that careful scrutiny would reveal which schools have the best approaches. Of particular significance for schools is the need to recognise and respond to the reality of transition - that it may be a bumpy and uncertain ride for many young people. If adult services have long waiting times and gaps between appointments, then it is often the schools who are left carrying the responsibility of an unwell young person, combined with the anger felt at the confusion as service provision changes. One participant

suggested that the involvement of some young people in the design and delivery of such staff development might be a positive step:

> 'Just give them more training, or maybe somebody who has done it themselves. A lot of the time they don't know what's going through your head when you're in that state. It's [your] mental health that's affected. We do need the same care and attention as anybody else.'

Section 6 Recommendations

1) Consideration be given to an age appropriate service for young people, located in adult service but designed for young people with the following characteristics:

- 15-20
- Community based
- Child and parent support groups
- Information essential
- Small admission unit for this age group
- Staff trained to manage this group

2) Planned transition following a clear pathway of care and that "Bridging" is an expectation of this transition.

4) Involvement of young people, their carers and other stakeholders in developing and reviewing services.

5) Recognition of the role of parents in the ongoing support and management of their children. Three themes emerged with parents:

a) Respect for non involvement of parents in consultations but some communication with parents with young persons collaboration (all clients commented)

b) Client and Parent support groups - A few parents commented on their isolation and lack of support, for both respite and in general for their mental health hoping for some individual support or age appropriate group support.

c) Uninformed as to the nature of the services and the nature of their Childs mental health problem.

6) More effective exchange of information, with notes transferring to the referred service at an appropriate time BEFORE transfer and supported with dialogue between the services.

7) A transition should include no time lag between closure in CAMHS and admission to Adults/Young Persons service.

8) Risk assessment by services of clients' future needs before they are closed to CAMHS.

9) Early engagement and continuity of service is prized by the young people, their carers, key workers and GP's.

10) An audit trail should be established for each client as they pass from one service to the other.

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APPENDIX B

WORKING GROUP INTO YOUNG PEOPLES' MENTAL HEALTH SERVICES

ACTION LEARNING

Purpose

This appendix is to record and report on the Action Learning Element of the Working Group's Scrutiny Exercise.

It will describe:

1. why such an approach was taken
2. what constitutes action learning
3. how it was undertaken in this particular set of circumstances
4. what has been learnt from including it in this scrutiny exercise and
5. what might be the considerations for the future.

1. Why include Action Learning?

The primary reasons for using Action Learning, as part of the approach to the exercise, were:

a) to test it as a means of helping all parties learn from the experience;
b) to ensure what was learnt, as the exercise was progressing, was fed back into subsequent decisions and actions taken and
c) to record the lessons learnt as a summary, both for future, similar scrutiny exercises and as part of the scrutiny process in general.

2. What is Action Learning?

Action Learning is based upon the notion of learning by reflecting on actual experience and drawing worthwhile and practical conclusions, which are then implemented and tested for their accuracy and validity.

The approach was first developed by Reg Revans (1982) and used within industry as a means of helping managers:

i. reflect on their experience of doing things;
ii. draw conclusions;
iii. decide the consequences and
iv. test if their conclusions were accurate.

3. How was it undertaken?

At an early stage of the Working Group's exercise, the purpose of Action Learning and its planned incorporation were explained, understood and accepted. The following short note was circulated to Members of the Working Group:

ACTION LEARNING

Why is it important?

It allows for learning to be captured effectively to:

a) ensure individual learning through participating in the process
b) inform and adjust the process as it develops and
c) summarise key lessons for participants and others to learn from

What is action learning?

A way of actively learning and implementing the consequences, it was originally developed as a means of getting coal board managers to take control of their own learning and support each other in translating the learning into practical applications.

How does it work?

There are a variety of ways in which it is now applied. In this instance, it is intended to ensure the benefits, mentioned above, are effectively achieved.
This will be done by a combination of methods:

i) build in review times at the end of every meeting
ii) review sheets filled in for consideration of relevant actions in response
iii) use of notebooks so as to 'don't let a good idea get away'
iv) option of additional discussion(s) with facilitator of the process

What happens from here?

In line with the intention to capture ongoing learning, so as to 'inform and adjust the process as it develops', the actual process may well change and develop over the life of the scrutiny exercise!
In any eventuality, a report will be compiled, at the end, to summarise the key lessons. This will be included in the report to the project sponsors, which is likely to be the subject of national acknowledgement and dissemination.

To help the Members of the Working Group record what they learnt, they were provided with:

- a pocket notebook, in which to write anything of relevance at any time it came to mind and
- at the end of meetings, a sheet on which to record their answers to a number of questions about that meeting.

This sheet included space for them to write their answers to:

- what worked and what have you learnt from that?
- what could have worked better and what have you learnt from that?
- what do you want/recommend for the future?
- the action I intend to take and
- the action I would like taken.

At the end of the meetings, the sheets were passed to the facilitator, who typed them up and returned the originals to their authors. In addition, any points raised in relation to the comments made in answer to 'the action I would like taken' were raised for further discussion and decision as the exercise proceeded.

In addition to reviews taking place at the end of meetings, a series of discussions took place with all participants (with the exception of the people consulted by the team at Sheffield Hallam University). This allowed all to have recorded both their experience of the process and the lessons they considered important to take from it.

From these elements, a story was built up of the whole process, from the perspective of all involved.

4. Lessons from this scrutiny exercise

All of the points made in Section 4 are from a combination of notes either of meetings with a range of individuals or those made by people during their reflections at the end meetings of the Working Group.

4.1 Exercise start-up

The choice of area to scrutinise was a brave one, as there is a sense of 'no man's land' for service users between the ages of 16 and 18. This could often take the form of either a lack of consistent or an inappropriate institutional response to users' needs. As such, it was felt that scrutinising the area was likely to 'flush out' the degree to which there was a problem/gap. In addition, there was likely to be both public and national interest in the findings. Whilst this was felt to be a risk, it was considered worth taking, as it was shown likely to be well managed and a potential 'feather in the cap' for doing so. This would be particularly so as improving this area of service provision would

increase the trust from external assessors that there was a willingness to deal with 'difficult' subjects.

Essential to be clear about the focus and boundaries of the scrutiny process.

In line with the above point it was important to be absolutely clear who was being consulted and why, e.g. service users/their carers/service providers/other stakeholders.

Regardless of who was to be consulted, it would be critically important to make explicit, the principles upon which the consultation would be undertaken. A general learning point is that consultation with service users should be undertaken in an ethical manner. Guidelines of good practice may be helpful, including guidelines for researchers. In this context, for example, the National Children's Bureau principles of good practice would be good to be considered.

It would be of the utmost importance, in one expert's view, to be clear, for future scrutiny projects, about the distinction between research and service evaluation. They pointed out that the research governance procedures in health and in social care are different and considered that difficulties might arise in terms of different definitions of what constituted research.
They had emphasised that they believed it was important, in this project, to be clear about the distinction between what would constitute research in health service systems, namely 'the attempt to derive general stable new knowledge by addressing clearly defined questions with systematic and rigorous methods', whereas they understood the purpose of this exercise to be to collect information, in order to inform local practice.

There was some concern that the term 'scrutiny' might, of itself, create an unfortunate expectation in the minds of those being scrutinised.

A series of meetings took place, to establish the relevancy, legitimacy, competency and credibility of scrutinising this area of service delivery. That series of parallel meetings, with various partners, ensured their engagement and allowed for them to contribute effectively to preparatory work.

Ethics' Committee involvement had been an unknown in Council Officers' previous experience. It was fortunate that expert opinion and support for undertaking this element was available and timely.

Earlier involvement of providers could have helped deal with the ethics' considerations sooner

It was felt that the establishment of good working relationships had created a degree of trust amongst the partners involved.

4.2 Contracting

The Health Partnership Manager (HPM) drew up a specification, in consultation with the Officer Steering Group. This was used as a discussion document with both Sheffield Hallam University (SHU) and the University of Sheffield (UoS).
It was originally expected that the two universities would collaborate in providing two elements of the process. The first was to act as interviewers of service users and the second, to act as expert adviser to the Scrutiny Working Group.
UoS decided it was inappropriate for them to continue and SHU confirmed they were willing to perform both functions.
SHU were then invited to submit a statement of their intended methodology and a cost to provide their input. The statement of methodology was evaluated by the HPM, in conjunction with the Head of Policy and Performance Unit, Neighbourhoods and Community Care and the Performance Development Officer, Education.
It was recognised, when going through this, it is essential that such a specification is detailed and clear about what is wanted.
Good working relationships helped adjust and clarify the expectations and outcomes wanted from the interviewers/expert advice.
It was also an opportunity to confirm that the interviewers were all fully 'police checked' for having substantial access to this 'vulnerable' group of people.

4.3 Ethics/Governance Arrangements

Due to the nature of this work, there was a need to be in contact with service users. This inevitably brought into question whether what was being undertaken was research or service evaluation. The distinction is critical in determining the relevant governance arrangements to be incorporated.

With the service users also being from a 'vulnerable' group, there was unsurprising caution, on the part of service providers, about the level and type of governance that was needed, to ensure adequate protection of the service users' interests. As an example, the Child and Adolescent Mental Health Services (CAMHS) required that the individuals from Sheffield Hallam University (SHU), who would be making direct contact with some service users, had a Criminal Records Bureau check no more that 3 months old.

Staff from SHU, along with Members and Officers of the City Council, considered the work being undertaken as service evaluation. However, the Children's Hospital Trust, considered it to be research. Consequently, a full submission was needed to a relevant Ethics Committee. If the work had been agreed as service evaluation, a different approach could have been taken to establish appropriate governance arrangements. After a lot of time and effort went into fulfilling the procedural and information requirements, associated with making a submission to a local Ethics Committee, it was accepted that this work was indeed service evaluation.

In future instances of this type of work, it would be extremely useful to have readily available and easily understandable pathways for each of the different types of endorsement needed.

To fulfil legal requirements, the staff from SHU were issued with honorary contracts.

In fulfilling the procedural requirements of both CAMHS and the Sheffield Care Trust (SCT), each insisted on having their particular forms filled in. This meant a degree of duplication by the staff of SHU, due to a perceived unwillingness, on the part of the service providers, to accept information already endorsed by the other. This seemed to reinforce the view, expressed by some service users, of a lack of communication and sharing of information between the service providers.

What helped the work proceed was a dedicated project manager, to keep things on track, an enthusiastic team and the local contacts one of the team members had.

4.4 Other factors

The Local Authority perspective on children issues is probably different from that of Child and Adolescent Mental Health Services (CAMHS) when it comes to confidentiality, i.e. where mental health issues exist, there needs to be a recognition that people don't always want to be explicit about the issues.

An awareness of the National Service Framework and its potential implications were considered critical in the process.

There is a great deal of difference in the range of services on offer from CAHMS as opposed to Adult Services.

The reflective process undertaken added legitimacy and focus for ensuring lessons were learned, recorded and acted upon.

5. Considerations for the future

Considering the work from a wider, longer-term perspective, there were other factors to note for future reference.

The following points were taken from notes of meetings with a range of individuals (5.1) and comments made at a meeting of the Working Group that considered the draft report (5.2).

5.1 This area of scrutiny

In order to ensure the best expertise is available for this type of investigation, it would be useful to establish a programme of scrutiny 12 – 24 months in advance. This would allow for the organisations, nationally recognised as having the greatest expertise in the areas concerned, to be contacted, sufficiently in advance, for them to be available to do the work needed. This would need to be balanced against the fore-warning of providers, giving them time to 'paper over any cracks'.
In addition, there is worth in exploring a greater use of secondments between relevant organisations. This would not only facilitate the dissemination of knowledge and expertise in very specialised areas, but would help develop greater capacity, within social care organisations, to undertake this type of investigation.

5.2 Scrutiny in general

This particular exercise has shown what can be achieved when working effectively in partnership with other agencies and a lot was learnt about working in such a way.

With the exercise being a long series of meetings, it would have been easy to lose focus and become sidetracked. Having a time of reflection, at the end of each meeting, avoided this happening. The approach would be applicable to a much wider range of meetings, where they occurred as a sequence over time.

Reflecting at the end of each meeting meant that it was still fresh in the memory. It could be enhanced further by an additional reflection 1 or 2 days later.

It allowed for a record of what still needed to be done and not get forgotten about.

Helped reflect on own practice and plan improvements.

The exercise showed that people from an academic perspective did have a real part to play, both in terms of the particular area being scrutinised and in feeding the outcome into future education of practitioners.

The fact that it was undertaken as a joint exercise gave added strength to it.

There was a good focus of attention on clients' needs, rather than purely the providers' perspective.

Facilitation of the process helped focus the reflective time effectively. It would be good to do this at the beginning in order to embed it as an approach.

It helped legitimise taking time out to reflect.

GLOSSARY OF ABBREVIATIONS

A & E	-	Accident and Emergency
ADHD	-	Attention Deficit Hyperactivity Disorder
B.M.E	-	Black and Minority Ethnic
CAMHS	-	Child and Adolescent Mental Health Service
CFPS	-	Centre for Public Scrutiny
CPA	-	Care Programme Approach
DfES	-	Department for Education and Skills
DoH	-	Department of Health
E.I.S	-	Early Intervention Service
G.P.s	-	General Practitioners
NICE	-	National Institute for Clinical Excellence
NSF	-	National Service Framework
PCTs	-	Primary Care Trusts
SCT	-	The Sheffield Care Trust