Making Hillingdon fit for the future

Report of the Transition from Child to Adult Mental Health Services Working Group

A Working Group established by the External Services Scrutiny Committee

Members of the working group:

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Cllr Mary O'Connor
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Cllr Janet Gardner
Cllr John Hensley
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Chairman's Foreword

Children and young people can suffer from a wide range of behavioural and psychiatric problems and need the best help that our society can provide for them. A young person with problems will become an adult with problems unless they are dealt with effectively.

The Working Group on the Transition from Child to Adult Mental Health Services therefore presents this review as a contribution to the improvement of both the Child and Adolescent Mental Health Service and Adult Mental Health Services in Hillingdon. We undertook this review as a consequence
of a discussion with service providers about mental health services provision in Hillingdon, where Members expressed concerns about the problems faced by young people during the transition from child to adult mental health services.

During this review, Members were pleased to learn that all the agencies involved in the transition protocol are engaging in its implementation, and that the protocol is generally having a positive impact on the process for the small number of service users going through transition.

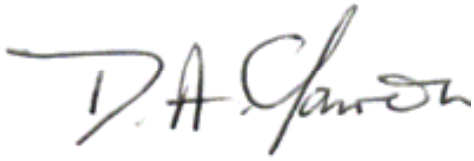
However, the findings of our review indicate that transition does not always provide a seamless service, and that there are particular problems where adolescent service users do not meet the higher thresholds for Adult Services.

As we carried out our research, we became very conscious of the issue of stigma around mental health. Whereas the stigma of physical conditions such as cancer has declined, mental health problems remain as one of the most stigmatised areas of illness. Despite the fact the mental health problems of some form may affect as many as 1 in 4 of the population over their lifetime, there are widespread public misconceptions about mental illness. As a result, people with mental health problems may experience isolation, discrimination and a lack of acceptance by society. For adolescents, who are the focus of our review, stigma is a particular problem and a major barrier to the use of mental health services.

This has not been an easy review to carry out. For some scrutiny reviews, residents and service users are only too willing to give us their opinions and contribute to our work, but for the reasons outlined above, this has not been the case with this review. We are therefore indebted to those service users who were willing to speak to us about their experiences.

We hope that our work and the recommendations that flow from it will help to improve service provision in the borough. We also hope that this report will help to raise public awareness more broadly about the need for mental health services. On a broader canvas, discrimination towards individuals with mental illness can affect the provision of health services and in the competition for resources in health and social care, mental illness, with its stigmatised image, may lose out to "physical" medicine, with little danger of a public outcry.

A number of health professionals, council officers and voluntary sector staff also contributed to our work. On behalf of the Review Group, I would like to thank all the witnesses who gave their time to this review and provided us with information. I commend this report to the Executive as Scrutiny's contribution to addressing some of the issues in these services which are so essential to the health and wellbeing of children and young people in Hillingdon.



Cllr David Yarrow

Introduction

1. This report presents the findings of the Transition from Child to Adult Mental Health Services Working Group: a policy overview & scrutiny working group established by the External Services Scrutiny Committee (POC) to review the transition from child to adult mental health services for young people with mental illness in Hillingdon.

2. Given the complex range of services and organisations involved in the provision of child and adolescent mental health services and the Committee's focus on the transition to adult mental health services, the working group set up by the External Services Scrutiny Committee to undertake this review involved representation from relevant Policy Overview Committees (POCs), including Adult Health, Social Services, Health and Housing POC, the Education and Children's Services POC and the Residents' and Environmental Services POC.

Background

3. Increasing numbers of young people are presenting with mental illness problems owing to a variety of factors (better diagnosis, greater family and societal awareness, drug and alcohol problems and the pace of modern life), which puts pressure on services. Cause for concern is the difficulties some young people experience in the transition from child to adult mental health services, which is a priority area for the Department of Health and has been highlighted in a number of influential reports. For example, the latest, the National CAMHS Review Interim Report produced in July 2007, noted that "Transition issues will be an area of comment for the Review because of ongoing challenges faced by young adults in accessing services and experiencing poor transition to adult services." [1]

4. The consequences of failure to deal adequately with young people's mental illness can be seen in rates of suicide for young men and in the prevalence of mental illness among young people and young adults in prisons or on probation. The cost of getting these services wrong falls not just on the young people and their families but also on society.

5. Mental health services for those up to the age of 18 years come under the auspices of the Child and Adolescent Mental Health Service (CAMHS) London. Local provision includes the Child, Family and Adolescent Consultation Service (CFACS), Hillingdon, which offers therapy services to those aged 0-18 years with emotional, behavioural and other mental

[1] Improving the mental health and psychological well-being of children and young people, National CAMHS Review Interim Report, July 2007, para. 2.5

health problems and their families, and education services, e.g. educational psychologists.

6. Once over 18 years old, mental health service provision becomes the responsibility of the Central and North West London (CNWL) NHS Foundation Trust, and the services provided are those available to adults.

7. In addition, both Hillingdon PCT and the Council commission a range of services from voluntary organisations. [2]

Why review the transition from child to adult mental health services?

8. The origins of this review lie in a discussion that the Committee held on 10th January 2008 with service providers about mental health services provision in Hillingdon. Members expressed concerns about the problems faced by young people during the transition from child to adult mental health services.

9. There is surprisingly little general information available about the smoothness or otherwise of the transition from child to adult mental health services for residents in the borough.

10. The Committee therefore decided to set up a Working Group under the chairmanship of Councillor David Yarrow with the following terms of reference:

    i. To map and review the provision of mental health services on both sides of the transition from child to adult mental health services for young people with mental illness in Hillingdon.

    ii. To investigate service users', their families' and advocates' views on the transition from child to adult mental health services.

    iii. To investigate disparities in services to different groups of young people with mental illness, and whether these are appropriate.

    iv. To investigate whether improvements are needed in relation to the transition from child to adult mental health services.

[2] Details of these can be found in Chapter 3 of the Hillingdon Strategy for Adult Services for Mental Health and Wellbeing 2008-13.

Our review

11. The main method for collecting evidence for this review was through a series of witness sessions, in which we talked to and questioned commissioners of service and providers (in both the statutory and voluntary sector) to obtain a clear picture of the child to adult transition in mental health services and the pressures and issues involved in this field. We also talked to a national expert in child and adolescent mental health services, and met with service users to hear directly about their experiences.

12. We are hugely grateful to the following people who gave up their time to attend our meetings and advise us on the key issues:

- Kevin Mullins, Executive Director of Strategic Commissioning, Hillingdon Primary Care Trust
- Tracy Gallagher, Project Manager working for Central and North West London NHS Foundation Trust and Hillingdon Social Services
- Noreen Rice, Community and In-patient Services Manager, Central and North West London NHS Foundation Trust.
- Amynta Cardwell, Clinical Strategy Manager, Child and Adolescent Mental Health Services (CAMHS) in Central and North West London NHS Foundation Trust.
- Jill Patel, Director, Hillingdon Mind.
- Lynn Hawes, Service Manager, Hillingdon Youth Offending Team.
- Dr Kami Saedi, Consultant Psychiatrist, working with young asylum seekers locally.
- Dr Yvonne Anderson, the lead director for child and adolescent mental health services at HASCAS.
- Christine Robson, Consultant Child & Adolescent Psychotherapist, lead clinical advisor for CAMHS Hillingdon within Central and North West London NHS Foundation Trust.
- Dennis Ball, Team Manager for Sorted Young Peoples Drugs & Alcohol Team, based at Fountains Mill, Uxbridge
- Julian Wooster, Deputy Director, Education and Children's Services, London Borough of Hillingdon.
- Nav Johal, Democratic Services Officer, London Borough of Hillingdon.

We would also like to thank Maureen Colledge, Scrutiny Advisor, who started the plans for the review, and Tim Young, Scrutiny Advisor, who undertook the work for the review and drafted the final report.

13. In addition to questioning people with an interest or expertise in the issue, we also reviewed a range of relevant literature. Documents of particular interest were: *"CAMHS to Adult Transition - A Literature Review for Informed Practice"* produced by the Health and Social Care Advisory Service (HASCAS); the Department of Health's *"Getting it Right",* dealing with the transition of young people with long-term conditions needing health services (although this publication is not restricted to mental health); and the National Service Framework CAMHS standard.

14. The Committee was also able to draw on work in progress in developing local mental health strategies for both children & young people and adults – 'A Commissioning Strategy Towards Improving The Emotional Wellbeing And Mental Health Of Children And Young People In Hillingdon, 2008/9-2011/12' and 'A Strategy For Adult Services For Mental Health And Wellbeing, 2008-2013'. Both draft strategies address the question of mental heath need, which is essential for putting the provision of services into context.

15. We also looked at a selection of overview & scrutiny reviews into the transition from CAMHS to Adult Mental Health Services undertaken by other local authorities, and in particular an extensive scrutiny by Sheffield City Council of young people's mental health services, and researched some examples of best practice.

16. We are grateful to Christine Robson, Consultant Child & Adolescent Psychotherapist and lead clinical advisor for CAMHS Hillingdon within Central and North West London NHS Foundation Trust, for providing two longer case studies and several examples of 'case vignettes' of how services had been provided in specific circumstances and the outcomes. In addition, we sought at first hand the views of young people who have or are using mental health services in the borough, by talking to a number of users, both in a small group setting and individually.

17. One of our concerns as a working group is the stigma associated with mental health needs and the barrier this presents to seeking and receiving treatment. Overcoming this stigma would benefit from greater promotion of the need to talk about mental illness, wider societal awareness of the different forms of mental illness and easier access to diagnostic services.

18. We were therefore delighted that Chris Longhurst, Chief Reporter of the Uxbridge Gazette, accepted our invitation to join the Working Group and provide media advice and assistance. In addition to contributing to the debate at meetings, Chris was able to include an article in Gazette informing people of the review and inviting those with relevant experience to contribute.

19. As a Committee, we took the opportunity to contribute our early findings to the Department for Children, Schools and Families' Call for Evidence to the CAMHS Review: Next Steps to Improving the Emotional Well-Being and Mental Health of Children and Young People. The CAMHS Review produced an Interim Report just after we had concluded our evidence gathering. Our report develops those early insights that we contributed to the CAMHS Review and presents our full findings from all the sources of

evidence on which we drew, making reference where appropriate to the National CAMHS Review Interim Report.

20. Below we set out the recommendations from our review that address the main issues that arose in the course of this work.

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Summary of Recommendations

21. The evidence for the following recommendations can be found in the following sections of the report and its appendices.

22. The lead organisation(s) which would be responsible for implementing each recommendation are shown in italics.

Recommendation 1

We recommend therefore that the evidence base for the needs assessment on which the new Hillingdon CAMHS strategy is based is as up-to-date and robust as possible. (para. 26) *(Cabinet, Hillingdon PCT)*

Recommendation 2

The Committee recommends that the CAMHS Joint Partnership Group should examine Case Study 3 to see if there are any lessons to be learned in general about how to improve CAMHS services for Hillingdon residents, and in particular how well the protocol works in practice and how the transition might be improved from the point of view of those receiving the service, including parents and carers. (para. 41) *(Cabinet, Hillingdon PCT)*

Recommendation 3

The Committee recommends that consideration is given in the new CAMHS strategy to increasing that flexibility so that more young people who are existing CAMHS clients and need to continue using CAMHS services can do so, up to their 25th birthday. (para. 50) *(Cabinet, Hillingdon PCT)*

Recommendation 4

The Committee recommends that commissioners and providers keep a close eye on the issue of a potential growth in dual diagnosis cases among young people. (para. 54) *(Cabinet, Hillingdon PCT, Central & North West London NHS Trust)*

Recommendation 5

The Committee recommends that Leeds Information for Mental Health and other best practice examples are investigated in order to see how Hillingdon's provision of information in this field might be improved. (para.64) *(Cabinet, Hillingdon PCT, Central & North West London NHS*

Trust)

Recommendation 6

The Committee therefore recommends that in addition to reviewing the scope for better local provision of information about local service provision in Hillingdon, service commissioners and providers (both statutory and voluntary) should explore the potential for better networking amongst themselves. (para.66) *(Cabinet, Hillingdon PCT, Central & North West London NHS Trust)*

Recommendation 7

We recommend that training for staff who work with children and families but are not part of the mental health workforce should be improved (along the lines of the new training initiative for teachers), so that they might be able to identify mental health needs earlier, involve parents or carers and know where to make referrals. (para. 68) *(Cabinet, Hillingdon PCT, Central & North West London NHS Trust)*

Recommendation 8

The Committee therefore recommends that the need for a family-centred approach, with specific support for parents and carers, balanced with the need for information sharing protocols to protect young people's confidentiality, are fully addressed by the new Hillingdon CAMHS strategy. (para.71) *(Cabinet, Hillingdon PCT)*

Recommendation 9

We recommend that the new Hillingdon CAMHS strategy also fully addresses the need to ensure that there are effective systems and processes to obtain user feedback. (para. 72) *(Cabinet, Hillingdon PCT)*

Recommendation 10

We recommend that Cabinet consider supporting the call by MIND for measures such as supporting people with mental health problems to provide good evidence, allowing people to report incidents to an independent third party and offering patients a safe place to tell their story, in order that they may access and use the new unified complaints system for health and social care in England. (para.77) *(Cabinet)*

Recommendation 11

We further recommend that the new Hillingdon CAMHS strategy should

consider how such advocacy systems might be used to enable children and adolescents and their families to make appropriate use of the new unified complaints system for health and social care. (para.78) *(Cabinet, Hillingdon PCT)*

Evidence and findings

23. In this section we first provide some background about mental health needs and services, for both children and adolescents and adults, before presenting our findings from the witness sessions and the research that we undertook, including discussions with users of services.

What are mental health problems?

24. In the case of children and young people, the starting point is the definition of mental health problems in children and adolescents taken from the National Service Framework CAMHS standard:

> *Mental health problems may be reflected in difficulties and/or disabilities in the realm of personal relationships, psychological development, the capacity for play and learning and in distress and maladaptive behavior. They are relatively common, and may or may not be persistent.*
>
> *When these problems (conforming to the International Classification of Diseases criteria) are persistent, severe and affect function on a day to day basis they are defined as mental health disorders.* [3]

25. Appendix 1 contains three case studies which illustrate the sort of mental health problems that young people may experience. The first two, written from a CAMHS perspective, exemplify how CAMHS can help them to have a fuller life and experience what every young adult should have the opportunity to do, as one of the case studies puts it, while the third, written from the perspective of a young person and their family, shows the difficulties that they may face when help is not provided in the right way or at the right time.

26. National prevalence studies suggest that between 10% and 20% of children and young people are suffering from mental health problems at any one time. This a wide band Applied to the Hillingdon population this would equate to between 6,369 and 12,738 children and young people. This is in a resident population of Hillingdon (based on the 2001 census figures) of 243,006, of whom 63,691or 26% are aged under 19 years. The

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[3] *National Service Framework for Children Young People and Maternity Services: The Mental Health and Psychological Well-being of Children and Young People: Standard 9,* Appendix 1 (Department of Health, Department for Education and Skills, 8 February 2007)

school age population is increasing (there are 1,000 more children in Hillingdon schools now than 6 years ago) and also becoming more diverse: in 2001, 21% of the school age population was of a non-white ethnic background and by 2007 this had increased to 40%.

27. The width of a 10 to 20% band of incidence of mental health needs among children and adolescents would make planning and resourcing services very problematic if need were actually to be located nearer 20% than 10%. We note that the draft Hillingdon CAMHS strategy cites another way of looking at the incidence of mental health needs of this group in Hillingdon, which is to extrapolate from a survey published in 2000 of a large sample of children in Great Britain. This study found that overall 10% of children aged 5-15 years had some type of mental health problem or disorder, and suggested prevalence rates for different types of disorders, which are set out in the table below, with the expected rates applied to the Hillingdon population aged 5 – 15 years.

Type of disorder	**Prevalence in National study – ages 5-15yrs**	**Applied to Hillingdon population, 5-15 yrs**
Clinically significant conduct disorders	5%	1,767
Emotional disorders (anxiety and depression)	4%	1,413
Hyperactive	1%	353
Overall rate for mental health problems	10%	3,533

28. The draft Hillingdon CAMHS strategy also examines the risk factors for mental health problems. Family characteristics, individual characteristics, health and education problems are all associated with the likelihood of developing a mental health problem, and the risk factors overlap to a great extent with those identified more generally for social exclusion. These factors were outside the terms of our remit but it is worth noting the incidence of some of those factors in Hillingdon:

- Some wards show higher rates than both the national and London averages for lone parent households with dependent children, for example Yiewsley (9.2%) and Botwell (9.3%) (National Statistics 2001 Census).

- According to the index of multiple deprivations three wards in Hillingdon (Botwell, Yiewsley and Townfield) are in the top 25% most deprived wards in England (DETR, 2000).
- The child poverty index (DETR, 2000) shows that six wards (Yiewsley, West Drayton, Wood End, Townfield, Botwell and Yeading) are amongst the 25% most deprived in England on indices that measure children living in low income families.
- As a consequence of Heathrow airport being within the Council's boundaries, the borough has responsibilities for high numbers of unaccompanied minors and former asylum seeking families who have remained in the area (families and adults are now dispersed through the National Asylum Support Service).

29. However, it is also worth noting that much of this data is seven or eight years old, and we would agree with the CAMHS Review Interim Report's emphasis [4] on the need for every area to have a clear and robust analysis of the mental health needs of their local population as part of their Children and Young People's plan, in order to plan appropriate service provision. ***We recommend therefore that the evidence base for the needs assessment on which the new Hillingdon CAMHS strategy is based is as up-to-date and robust as possible.***

Provision for children and young people

30. To meet the mental health needs of children and young people in Hillingdon, we found that CAMH services are organised into the orthodox four tiered service model:

Tier 1 refers to non-specialist services for children that contribute to meeting their health needs such as schools, nurseries, children's centres, community settings and health centres. In Hillingdon these include GPs, health visitors, school nurses, teachers, SENCOs, Healthy Hillingdon, social workers and Connexions advisors.

In addition to these are the Community Access and Support Teams (CAST), with a remit for improving child and adolescent mental health which focus on providing integrated, preventative services; and Link Counselling Service (LINK), a counselling service by appointment for people aged 14-25 who live, work or study in Hillingdon.

Tier 2 refers to services provided in community settings by single CAMHS practitioners for example, Primary mental health workers/Counsellors/psychologists working in GP practices, paediatric

[4] See para. 8.12

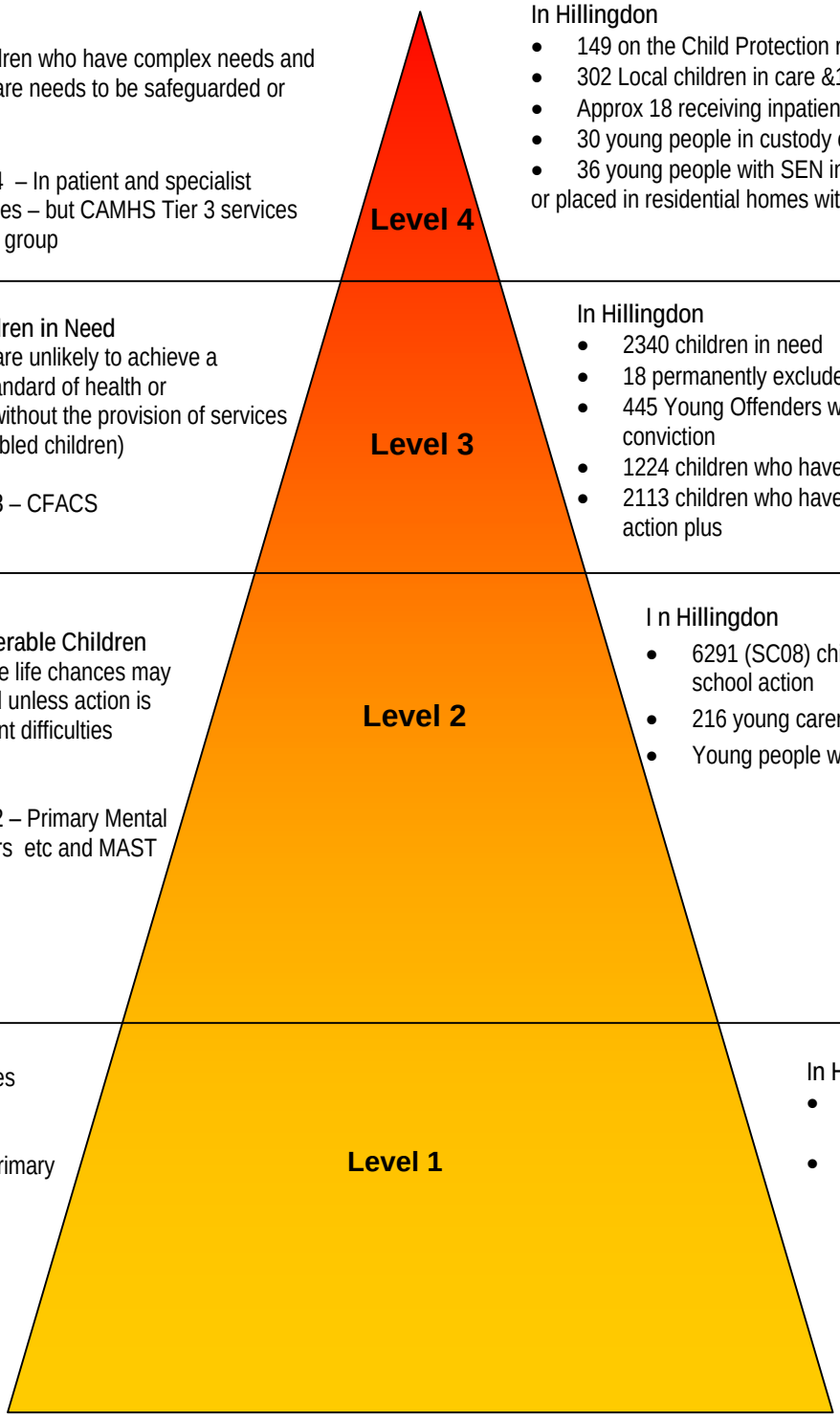
clinics e.g. Child Development Centre (CDC), schools and youth services. In Hillingdon distinct services are Marlborough Project and the multi-agency support team (MAST).

Tier 3 refers to multidisciplinary community CAHMS teams. In Hillingdon this provision is the Child, Family and Adolescent Consultation Service (CFACS), which Hillingdon PCT commissions from the Central and North West London (CNWL) NHS Foundation Trust. The CFACS offers services for infants, children, adolescents and families with emotional, behavioural and other mental health problems.

Tier 4 refers to specialist services such as in-patient provision. There is no service located physically in Hillingdon. More than 50% of provision is commissioned through consortium arrangements via NHS and independent providers. All eight PCTS in the former North West London sector commission from Collingham Gardens (CNWL) and The Priory, a private organisation. Herts Partnership is commissioned on a consortium basis with Hounslow, Harrow and Hertfordshire PCTs.

31. The diagram below represents this model as a pyramid of services, with an indication of the level of current (2008) need in Hillingdon.

Pyramid of Need – Hillingdon 2008 & CAMHS Services



Level 4 - Children who have complex needs and or whose welfare needs to be safeguarded or protected

CAMHS Tier 4 – In patient and specialist regional services – but CAMHS Tier 3 services also serve this group

In Hillingdon

- 149 on the Child Protection register
- 302 Local children in care &184 UASC in care
- Approx 18 receiving inpatient mental health care
- 30 young people in custody or at risk
- 36 young people with SEN in residential schools

or placed in residential homes with education on site

Level 3: Children in Need
Children who are unlikely to achieve a reasonable standard of health or development without the provision of services (including disabled children)

CAMHS Tier 3 – CFACS

In Hillingdon

- 2340 children in need
- 18 permanently excluded young people
- 445 Young Offenders with final warning or conviction
- 1224 children who have SEN statements
- 2113 children who have needs met by school action plus

Level 2: Vulnerable Children
Children whose life chances may be jeopardised unless action is taken to prevent difficulties continuing

CAMHS Tier 2 – Primary Mental Health Workers etc and MAST etc

I n Hillingdon

- 6291 (SC08) children who have needs met with school action
- 216 young carers
- Young people who received reprimands

Level 1
Universal Services including Health promotion
CAMHS Tier 1 Primary

In Hillingdon

- All families & Children receiving universal services
- In Hillingdon: 63,691 children in the borough aged 0-19

32. Our focus as a Committee, however, was on the transition from Child and Adolescent Mental Health Services to Adult Mental Health Services, rather than the general need for CAMHS in the growing population of Hillingdon children and young people. Before we look at the distinct needs of young people at the phase of transition, we need to briefly outline the provision of Adult Mental Health Services (AMHS) in Hillingdon.

Provision for adults

33. According to the draft document, ' A Strategy For Adult Services For Mental Health And Wellbeing 2008-13', provision for adult mental health services is divided into three main sectors:

Main Health Providers (through Service Level Agreements /Contracts)	**Consortium**	**Other**
Central & NW London NHS Foundation Trust Inpatient Unit o Frays Ward o Crane Ward Psychiatric Intensive Care Unit (PICU) o Colne Ward o Shannon ward Day Services & Community Mental Health Teams (CMHTs) o Pembroke Centre o Mill House o Mead House Assertive Outreach Team Crisis Resolution and Home Treatment Team Rehabilitation Services o Colham Green Road Primary Care Counselling Services Psychological Therapies Mother & Baby NHS funded Continuing Health Care	**North West London Forensic Consortium, West London Mental Health Trust** **Mental Health Services for Deaf People** **Specialist Psychotherapies** **North West London Eating Disorders Consortium** **Gender Dysphoria** **Specialist Personality Disorder Service**	**South London & Maudsley NHS Foundation Trust** **West London Mental Health Trust** Glynn Ward Mental Health Services those people registered with a Hillingdon GP but living in WLMHT catchment area **Priory Hospitals Group** Low secure challenging behaviour services **Ealing PCT** High Secure Services

34. With regard to CAMHS, the draft AMH Strategy notes that " a local CAMHS strategy … will include ensuring provision of enough CAMHS beds to ensure age appropriate services for under 18's, transition from CAMHS to adult services and joint provision across CAMHS and Adult services of Early Intervention Services for first episode psychosis." [5]

Categories of need in the transition from CAMHS to AMHS

35. A key national study funded by the Department of Health and undertaken by the Health And Social Care Advisory Service (HASCAS) indicates three distinct categories of need in young people at the transition stage:

"1. Those young people who make a transition to AMHS from CAMHS because they meet the AMHS eligibility criteria. These young people need adequate preparation for the transition from CAMHS and an age-appropriate service from AMHS.

2. Some young people who have severe and enduring mental health problems but who do not meet the eligibility criteria for AMHS. This group includes young people who have attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder (ASD). These young people need to be recognised and require services to be developed jointly between CAMHS and AMHS.

3. A large number of vulnerable young people are known to a range of statutory and voluntary services, though not necessarily to CAMHS. They do not meet the criteria for a specialist mental health service, but are likely to make heavy use of other service provision. Some may come to the attention of AMHS later in life through substance misuse, homelessness, criminal justice. They need joined up, inter-agency responses over a sustained period of time. " [6]

Current transition arrangements

36. The Committee found that in dealing with the first group of service users - young people who make a transition to AMHS from CAMHS because they meet the AMHS eligibility criteria – locally there have been two key organisational improvements in recent years:

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[5] *A Strategy For Adult Services For Mental Health And Wellbeing 2008-13*, Hillingdon Primary Care Trust and London Borough of Hillingdon, draft 3 March 2008, para. 3.5.4.
[6] *The transition from Child and Adolescent Mental Health Services to Adult Mental Health Services,* Health And Social Care Advisory Service (HASCAS), June 2006.

- the bringing together of local adult and children's services providers within a single management organisation – Central and North West London NHS Foundation Trust; and

- the drawing up of a protocol setting out the timetable and stages for those transferring from child to adult mental health services.

37. As a result, a small number of young people now have a more structured transition. These changes, particularly the introduction of a protocol, has primarily benefited a small number of high-need children (those within tier 4), which in the context of this borough number about 6 young people a year transferring from child to adult services.

38. Included as Appendix 2 are three case vignettes which illustrate what can happen at the age where a transfer to Adult Mental Health services may be appropriate. The first two vignettes are examples where a transfer to AMHS was not required, while the third provides an example of transfer for a young person who has required Tier 4 services.

39. However, the transition from child to adult services is not always smooth and without problems, as shown by the following two case vignettes supplied to the Committee by the CAMHS service (and written from their viewpoint). These illustrate a problem that can occur with transfer between CAMHS and AMHS, where the two services do not for some reason work together to provide a seamless service.

Case vignette A: problematic transfer to Adult Mental Services – lack of seamless service

A. was an inpatient in Tier 4 for 3-4 months and within days of her eighteenth birthday, transfer to Adult Services was required; but prior to discharge follow-up services needed to be in place. Adult Services were informed about the forthcoming Care Programme Approach (CPA) meeting and requested to attend for discussion and planning. They declined, saying that they must make their own independent assessment of suitability, thus ensuring anxiety and indecision which was detrimental to the patient's confused state of mind.

Case vignette B: problematic transfer to Adult Mental Services – lack of seamless service

B. has moderate learning difficulties and a complex presentation of behaviours, social functioning and emotional needs. He has visited A&E over 70 times in emergency presentation for uncontrollable behaviour.

> Our Service want to facilitate his transition to the Adult Learning Disability Service. However, prior to a Care Review Meeting, the referrals contact in the Adult Service has requested that we produce copies of all previous interventions. With a very thick file this would take a considerable time and we believe it would be more helpful for the AMHS to read the file available which would facilitate understanding of the complexities prior to a meeting and thus facilitate the process of transfer.

40. With regard to the first instance of not providing a seamless service, we noted that Christine Robson, the lead clinical advisor for CAMHS Hillingdon within Central and North West London NHS Foundation Trust who very helpfully supplied the vignettes, has explained that the case was in CAMHS's experience unusual, "as transfer of young people with a serious mental presentation has been supported by our colleagues in AMHS and we have on the whole managed to work well together in the best interests of the patients." Nevertheless, any such cases must be very stressful for young people and their parents or carers.

41. With regard to the second instance, we learned that CAMHS always worry that there may be a rejection and want to try and prevent that wherever possible, for example by providing for a "reading in period" by the Adult service. However, the young person in question presented many times at A& E with 'behaviour' associated with their diagnosis, which can sometimes be problematic in fitting with AMHS criteria. Overall, though, according to Christine Robson, CAMHS are "hopeful that with gradually increasing contact now between services we can solve many difficulties in the future. We now have one rep from one of the AMHS teams who has undertaken to come to our team meetings at regular intervals to discuss ways of working and referrals and … hope we can build more of this into our protocols and practice."

42. The Committee welcomes these efforts to address this problem of how to provide a seamless service. In addition to the examples in the vignettes, we also received evidence from a young person and their parent about their experiences of the transition to adult mental health services, during which they had experienced many problems, with it taking over a year to regain continuity of service (see Case Study 3 in Appendix 1).

43. Their case appears to bear out the National CAMHS review's concern about gaps in securing effective, evidence-based service provision for some children, particularly those with complex needs, and for ensuring that those children actually get the service they need, when they need it. In sum, their needs and experiences bear many similarities to what

parents, carers and children and young people said when asked by the National CAMHS review what they would wish for in local services: [7]

- the need for advice, support and help quickly
- easier access to information on what is available to help and what different services can offer
- continuity of staff and professionals, as far as is possible
- earlier intervention to avoid crises and better aftercare support
- the need for appropriate emergency services to be available at appropriate times

44. While this is only one case, nevertheless ***the Committee recommends that the CAMHS Joint Partnership Group should examine Case Study 3 to see if there are any lessons to be learned in general about how to improve CAMHS services for Hillingdon residents, and in particular how well the protocol works in practice and how the transition might be improved from the point of view of those receiving the service, including parents and carers.***

45. The Committee notes that the June 2008 draft of Hillingdon's Child and Adolescent Strategy being developed by the Hillingdon CAMHS Joint Partnership Group (which reports to the Children and Young People Strategic Partnership Board) has acknowledged that there are issues to be addressed to ensure that transition is properly provided for and efficiently managed:

> "Transition into adult mental health services needs to be closely monitored given the increase in incidence of severe mental illness in late adolescence. Managing effective transition will require long term planning and it may be necessary to scope the equity and appropriateness of existing provision and transition arrangements. There needs to be clear agreements and pathways for the referrals of young people between 16-18 years and for transition to adult services." [8]

[7] *National CAMHS Review Interim Report*, July 2007, para. 7.2.
[8] *A Commissioning Strategy Towards Improving The Emotional Wellbeing And Mental Health Of Children And Young People In Hillingdon, 2008/9-2011/12, DRAFT June 2008*, pp38-39.

46. The Committee welcomes this commitment in the draft strategy, particularly the last point about the need for clear agreements and pathways for referrals and for transition to adult services.

47. The draft strategy also notes that while protocols on the admission of adolescents to adult wards and on the transfer of adolescents to adult services have been updated, there needs to be further updating to include how the needs of those not accepted into services for a range of reasons would be addressed.

48. The Committee also welcomes this commitment. We noted that there are much higher service thresholds for adult services – post 18yrs – that work against the continuation of treatment for those with moderate or lower needs. The adult service threshold of "severe and enduring mental health problems" results in a group of children with less severe mental health needs falling through a service gap, as they become adults, unless CAMHS can find an alternative service. The evidence that we took indicated that while service provision exists for severely mentally ill young people, with about 6 such young people transferring to adult services each year, for the 90% of young people with less severe mental illness there is little provision after 18 years old.

49. Currently, mild to moderate mental health needs (Tier 1 and Tier 2-type needs) in young adults are picked up – if at all – by voluntary organisations or statutory bodies such as the Youth Offending Team or drug and alcohol services. The Adult Mental Health Service's 'Well Being Project' for looked-after unaccompanied asylum-seeking young people may help to fill some of this gap but clearly there is a need for continuing help for young adults with mental health needs after 18 years. A number of witnesses confirmed that adult mental health services seem to work well for acute cases, but there are gaps for those with less serious mental health needs until a crisis pushes them over the threshold.

50. The CAMHS team itself in particular identified a difficulty for young people on the autistic spectrum and young people with mild to moderate (but often chronic) presentations which do not meet the threshold for AMHS. But interestingly the team was unable to produce case examples of these categories of difficulty in transition and concluded that this was because it has learned to work within the constraints and do not plan for transfer to adult services but rather trying to find alternative services wherever possible. Through taking part in the Committee's review, the CAMHS team has acknowledged that "one useful outcome for us from this process is that in our future audits we will try to track these cases to help us to clearly identify the issues and factors involved."

51. The Committee appreciates these efforts by CAMHS to provide services and welcomes this commitment, but we also considered two structural options for addressing this problem of discrepancy between the threshold of services for young people and services for adults:

- changing the age threshold for transfer to adult services; or
- building in greater flexibility so that CAMHS services might retain existing clients and continue to support those young people who need its services, post age 18.

52. Both these options have resource implications, with the latter potentially costing less since not all young people using the services would continue to be supported.

53. While we acknowledge that the CAMHS service, in line with the National Service Framework (NSF), already provides some flexibility in its provision of care for young people past their 18th birthday, ***the Committee recommends that consideration is given in the new CAMHS strategy to increasing that flexibility so that more young people who are existing CAMHS clients and need to continue using CAMHS services can do so, up to their 25th birthday.***

Gaps in meeting lower-level needs through CAMHS

54. While the Committee has considerable concerns about the loss of service provision for many young people in the transition to adult mental health, Members are also concerned about gaps in meeting lower-level needs through CAMHS. The evidence we took from a range of professionals indicated that there is a lack of provision and support for those with lower level mental health needs – especially at Tier 1 and 2. A consequence of insufficient provision for low level needs is that young people in effect have to get worse before they can access services.

55. This is compounded by pressures among specific groups of people and in specific service areas.

Youth offending

56. Youth offending service are finding increasing numbers of young people presenting with mental health needs and needing assessment and help. For example, the Youth Offending Team's (YOT) primary care mental health worker took 96 such referrals last year.

Substance use and misuse

57. Drug and alcohol services are assessing and providing services for those needing both specialist substance misuse treatment and mental health services. These services reported an increasing number of adults presenting with such dual needs and a sense that this was probably permeating into younger age groups. Firmer evidence of the hypothesis that dual diagnosis cases are spreading into younger age groups would enable commissioners to plan how to deal with this potential pressure. ***The Committee recommends that commissioners and providers keep a close eye on the issue of a potential growth in dual diagnosis cases among young people.***

Children and young people with learning disabilities

58. According to the draft CAMHS strategy, one of the risk factors associated with mental health needs is having a physical or learning disability. Research studies have shown that children with mental disorder are three times more likely than those without to have recognised special educational need.

59. The importance of provision for this group is underlined by the fact that under the Public Service Agreement (PSA) arrangements, one of the four proxy measures used to check if improvements in CAMHS are being secured and maintained by Primary Care Trusts (PCTs) and local authorities is: *'Is a full range of CAMHS for children and young people with learning disabilities being delivered?*

60. The Hillingdon rating in 2006/7 against the question *'Has a full range of CAMHS services for children with learning disabilities been commissioned in your area?'* was 'Poor but making good progress'. Mental health services for children with learning disability are therefore targeted in the draft CAMHS strategy as a major area requiring significant improvements.

Black and minority ethnic groups, including young asylum seekers

61. Another group that is also identified as requiring significant improvements in service is black and minority ethnic groups. Owing to local patterns of migration and immigration the population is becoming more diverse. In 2001, 21% of the school age population was of a non-white ethnic background and by 2007 this had increased to 40%. The CAMHS draft strategy identifies the need for improvements in monitoring of service take-up by ethnicity.

62. In particular, the Committee heard evidence from both adult and child mental health service providers of increasing pressures from asylum seekers with mental health problems, raising questions about the adequacy of provision of mental health services for young asylum-seekers.

63. Young asylum seekers are estimated at about a thousand locally, many of whom are very vulnerable as they do not have the support of families and have experienced traumatic events in their lives. While the government provides funding for a mental health support service for 16-17 year old asylum seekers, there is uncertainty over its continued funding and no support for young asylum seekers aged 18 years or over. The Committee therefore endorses the draft CAMHS strategy's proposal to secure longer-term funding resources and develop a linked approach to ensure integration.

64. Clearly there are resource implications in trying to fill existing gaps by providing extra services, as well as the longer-term issues raised by the growing population of children and young people and possibility of a disproportionate increase in need for mental health services if current trends continue. These are matters for strategic planning and budget decision-making in the future.

Improving information, networking and signposting

65. In the meantime, the Committee believes there may be scope for improvement through better information, networking, and signposting. We were interested to explore the perception of Jill Patel of Hillingdon MIND that communications between local agencies, both statutory and voluntary are such that they are not sufficiently aware of each other's services and activities. The mental health needs of young people are often picked up and provided for in a variety of settings – schools, GPs, the Youth Offending Team, drug and alcohol services, etc. With staff turnover and other changes, there can be a problem of keeping up to date on the range of service provision and exactly who does what.

66. Currently, in compliance with one of the targets from the 2001 National Service Framework for mental health, the Council's website does have information on mental health services, with a link to access a mental health directory of services and organisations at www.hillingdonmhd.org . There are, however, examples of best practice that illustrate what can be done in terms of more comprehensive provision of information and resources.

67. One such example is Information for Mental Health, a partnership between Leeds MIND and Leeds Social Services, which won a National Institute for Mental Health in England Positive Practice Award in November 2005 for the development of Leeds Mental Health Directory. ***The Committee recommends that Leeds Information for Mental Health and other best practice examples are investigated in order to see how Hillingdon's provision of information in this field might be improved.***

68. Directories, whether published or on-line, are of course no substitute for agencies directly communicating with each other. Locally, we should aim to achieve both greater awareness and familiarity with the range of services provided locally (and sub-regionally) and recent research, as well as improving the signposting for those people with mental health problems who need help, especially where they do not meet the eligibility criteria for statutory services.

69. ***The Committee therefore recommends that in addition to reviewing the scope for better local provision of information about local service provision in Hillingdon, service commissioners and providers (both statutory and voluntary) should explore the potential for better networking amongst themselves.***

70. Pursued in tandem, both these initiatives could assist not only those in need for services but also those people who in the course of their work find themselves required to help with signposting towards the services which can provide assistance to those in need.

71. The Committee also supports the commitment set out in the Adult Mental Health and Wellbeing Strategy for Hillingdon that "everybody working with people with mental health problems and with their carers – whether in a voluntary capacity or as part of their employment will be helped to develop their skills." We welcome the new initiative that is training teachers to recognise and refer mental health needs, and ***we recommend that training for staff who work with children and families but are not part of the mental health workforce should be improved (along the lines of the new training initiative for teachers), so that they might be able to identify mental health needs earlier, involve parents or carers and know where to make referrals.***

Balancing confidentiality and a family-centred approach

72. We noted that one of the conclusions of the *CAMHS Review Interim Report* was that "given the importance of the role that parents and carers play in children's lives, support for parents particularly during the referral

processes, which can be lengthy, is seen as particularly important" [9] and we would agree. In our review we were concerned to note that adult mental health services do not recognise a role for parents or carers in the way that child mental health services do. While recognising a young person's legal right to decide their treatment after reaching age 18, a more family-centred approach, recognising the continuing role many parents and carers have in young people's lives, could be beneficial for young people with mental health problems.

73. This issue is also interwoven with the concern that young people have about the need for their confidentiality to be respected, and we concur with the CAMHS Review Interim Report recommendation that "information sharing protocols and practice need to reflect their views and their consent to share information should always be sought unless there are overriding child protection concerns." [10]

74. ***The Committee therefore recommends that the need for a family-centred approach, with specific support for parents and carers, balanced with the need for information sharing protocols to protect young people's confidentiality, are fully addressed by the new Hillingdon CAMHS strategy.***

User feedback

75. One of the commonly accepted features of what makes the provision of services successful is the engagement of users – in this case young people and their families. While in other services it is now standard to build in targets and assessment mechanisms for gaining user feedback, this appears not to be the case in services for young people with mental health problems. We regard this as essential, since it can aid monitoring and evaluation to focus on effectiveness and outcomes rather than processes and structures which research has found is generally the case for mental health services. [11] ***We recommend that the new Hillingdon CAMHS strategy also fully addresses the need to ensure that there are effective systems and processes to obtain user feedback.***

[9] Op. cit., para.7.4
[10] Op. cit., para.7.2
[11] See *National CAMHS Review Interim Report*, July 2007, para. 6.5.

Dealing with complaints

76. Sometimes user feedback may need to take the form of a complaint. But users of health and social services often feel too vulnerable to make a complaint about the service that they receive, and when they do so, they may encounter barriers. The Healthcare Commission's recent publication, *Spotlight on complaints: A report on second-stage complaints about the NHS in England,* [12] which sets out the Commission's work on reviewing complaints made by patients or their representatives about NHS services, observed that among the key issues complained about was a lack of help for mental health service users.

77. While we note that the Health Care Commission congratulated Central and North West London NHS Trust as one of a small number of NHS Trusts with a "consistently high standard of responses" [13]to the complaints that the Commission reviewed, we endorse the Commission's concern that NHS trusts should learn from patients' complaints and improve complaints handling.

78. In February 2008, the government unveiled a new unified complaints system for health and social care in England aimed at making it easier for people to complain. This will involve a local resolution stage followed by, in the case of unresolved complaints, a Health or Local Government Ombudsman investigation.

79. We note that MIND nationally has expressed concern that the proposals will not address serious complaints on mental health wards and has called for 'special measures' to be put in place.

80. **We recommend that Cabinet consider supporting the call by MIND for measures such as supporting people with mental health problems to provide good evidence, allowing people to report incidents to an independent third party and offering patients a safe place to tell their story, in order that they may access and use the new unified complaints system for health and social care in England**.

81. We also note that one of the objectives of the draft Hillingdon CAMHS strategy is to "develop systems to ensure service user involvement in planning of services, including development of advocacy systems". **We further recommend that the new Hillingdon CAMHS strategy should consider how such advocacy systems might be used to enable**

[12] *Spotlight on complaints: A report on second-stage complaints about the NHS in England,* Healthcare Commission, April 2008
[13] Op.cit, page 16.

children and adolescents and their families to make appropriate use of the new unified complaints system for health and social care.

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Closing word

82. Finally, we note that a major challenge to be overcome in delivering effective mental health services is the impact of stigma. Overcoming stigma and the barrier this presents to seeking and receiving treatment would benefit from greater promotion of the need to talk about mental illness, wider societal awareness of the different forms of mental illness and easier access to diagnostic services. We hope that this report makes a contribution to breaking down this barrier and enabling children and young people to receive the services that they need, whether in childhood, adolescence or the transition to adulthood.

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Appendix 1

Case Studies

These three case studies which illustrate the sort of mental health problems that young people may experience. The first two, written from a CAMHS perspective, exemplify how CAMHS can help them to have a fuller life and experience what every young adult should have the opportunity to do, as one of the case studies puts it, while the third, written from the perspective of a young person and their family, shows the difficulties that they may face when help is not provided in the right way or at the right time.

We are indebted to Christine Robson, the lead clinical advisor for CAMHS Hillingdon within Central and North West London NHS Foundation Trust who very helpfully supplied the first two of these case studies and the 'case vignettes' in Appendix 2.

Case Study 1

X. has lived in hostels from the age of 18. She moved in to the Uxbridge YMCA as a direct access client in 2005 and progressed from an excluded licence to a licence agreement and then an assured short hold tenancy within the hostel, before moving in to a property through Locata.

X. has struggled with many things such as budgeting, healthy living, job hunting, confidence and coming to terms with mental health issues. In her words, she was lost and sleeping rough before she moved to the YMCA and found a new beginning with help from staff. With constant support from the same support worker, she has overcome being a victim of bullying and has grown in confidence. She was able to complete a Business Studies National Diploma Level 3 with encouragement from staff, attended self esteem classes and has gone from part-time work to full-time employment. X. cannot see all her achievement and puts it all down to the YMCA, but she is being encouraged to give herself more credit and see the good things she has done and is doing now.

Staff have supported X. with her confidence and self-esteem by providing basic counselling daily to build herself up for the day ahead and gradually decreasing the amount of time to zero. She was supported to become a resident representative, which in turn gave her training and motivation to be more confident and try new things. We aided her to set up coping mechanisms to do with bullying and supported her on taking up a self-esteem course. She is a lot more confident, and with the support of staff has come to terms with the fact she is a manic depressive who self-harms. To cope with this she has been supported with seeing a professional counsellor, whom she now sees weekly at the YMCA, and gaining help and advice from her GP, Hillingdon Hospital and Mill House.

X. has gradually learnt to budget and shop. She made monthly budgets with staff and shopping lists. She was encouraged and shown by staff how to be fit and healthy – this included setting up exercise sessions and meal plans. She has overcome large debts running in to thousands and has learnt to be in credit with her rent and council tax. At one point she wanted to give up work but she has learnt that with support things are not always bad as they first seem. She is no longer isolated and has a full social and working life. To combat her isolation she was encouraged to take up training courses and full-time employment. She has completed a course in basic counselling and works full-time in Tesco in Ealing. She now has a fuller life and is experiencing what every young adult should have the opportunity to do.

Case Study 2

Y. is a current social services client with learning disabilities (Asperger's) and a mental health condition, Obsessive Compulsive Disorder (OCD). He came to the YMCA from a residential care home for those with disabilities. Y. had many issues on moving in and was worried the hostel would not be clean and safe. He was introduced by his support worker to the staff team and other residents. To support his OCD he was taken to Argos on his move-in day to purchase new bedding, even though the YMCA had clean and new bedding. This was done to engage him from the start and gain his trust. Y. has never worked well with professionals. This has changed at the YMCA, and he engages daily rather than weekly with the support offered by staff.

His type of OCD is severe and was not diagnosed until he moved to the YMCA. He was just tagged as having a hygiene problem. He would never wash and had not cut or washed his hair for a year when he moved to the YMCA. He was encouraged on a regular basis to wash his hair but his support worker soon realised he was too scared and could have OCD. Eventually it came to light he would not use bathroom facilities others had used, even if he saw the housekeeper clean them. This was why he would not wash. He is being supported to progress on his appearance, but his Asperger's makes any progress slow.

Y. has special needs but has found the YMCA a safe place to live and to progress in life. He was advised on how to clean his room and was given cleaning products to help with this. He was supported by weekly checks which he agreed to be part of his support plan to help maintain his licence to occupy. This has been taken out of his support plan and he now has spot checks each month instead. The room is not perfect but is good for his ability and progress: he no longer needs to be told or encouraged to clean his room.

Y. made a new support plan in March and he is being supported to achieve each of his goals. He was advised to make it a realistic plan for himself and not for others as he has done in the past. He has recently washed his hair for the first time in 1 ½ years as part of his plan and was supported by the YMCA in purchasing a shower head for the sink, so he would not have to use the bath. He also went to the hairdressers that day with staff and had his hair washed again and then cut.

He has made progress in all areas of his life and now listens to others. He refused to apply for Disability Living Allowance at the beginning of his stay as he said he would not get it. After much advice and support he made a claim and was awarded benefit. In his words, he says he now realises he should trust people more. He is a completely different resident to the one that moved in, in August. He talks to other residents and has overcome fears of visiting the GP, assisted by staff. He is no longer isolated as he has been over the past 18 years of his life, and has tried to take part in mainstream education. He is trying this again in September 2008. He now smiles, jokes and has started to understand body language and people's faces more. He still has a long way to go, but these improvements in his life have been big for him and he wants to continue this with the YMCA.

Case Study 3

Z. suffers from epilepsy, which was diagnosed at 11, but also Attention Deficit Hyperactivity Disorder (ADHD) which was not diagnosed until age 16, and dyspraxia.

Z.'s epilepsy, which at its worst could make him have a fit every day, has taken 6 or 7 years to bring under control and is still problematic for him. The effects have at times caused him to self-harm, to feel suicidal, and to run off, leading to the police needing to be involved to find him.

The first prescription to treat his epilepsy was Epilim which unbalanced Z. and he had to spend 6 months in Collingham Gardens (a Child and Family Psychiatry Unit, run by CNWL NHS Trust, providing in-patient treatment for young people), only coming home at weekends. After seeing an epilepsy consultant, Z. was put on a quieter regime of tablets and allocated a Social Support Worker, but this support was later withdrawn and Z.'s parents had to argue with Social Services to have this support restored. Z. and his family felt that an opportunity was lost when he came out of Collingham Gardens but found that the facility's efforts were not followed through.

At 15, Z. was put onto a new medication, Keppra, which made Z. suicidal. There

had been no warning given to the family that this was a possible side-effect of the drug. C's clinician wanted to persist with the medication, but Z.'s parents objected and Z. was weaned off this drug and onto Tegretol, which has helped to stabilise him, although he still has fits, especially at times of stress. A referral by Social Services to Kids Can Achieve has also considerably helped Z. and his family, but at the upper age limit of 18 this service had to be withdrawn.

Z.'s schooling has suffered during these years, since at the lowest point he was only able to attend one day a week. In Year 10, when he was 14, he was statemented and was allocated some 1:1 support in his last year. Overall, though, Z. felt that there was not enough support through his school years and found himself isolated in the school environment. He would have wanted to stay an extra year at school by dropping a year and taking his GCSEs a year later than usual, and this had been agreed by a meeting of all concerned, only for the decision to be reversed by the school a few weeks before GCSEs started.

At 16 Z. was referred to Great Ormond Street and assessed by the National Centre for Young People with Epilepsy, which graded his epilepsy as 'severe and aggressive'. His family also had to fight to get a Social Worker for Z. at 16, with the help of the Epilepsy Centre. Once accepted onto the 16-18 team's caseload, the social workers in the team were very good, and Z. received the support of a worker until he was 19, beyond the normal cut-off point for service.

Between his 16th and 17th birthdays, Z. began the transition to Adult Services. Meetings between CAMHS and the Pembroke Centre (an adult mental health centre also run by CNWL NHS Trust) took place but neither C nor his parents were involved. The transition actually took over 2 years to complete on all sides, psychiatry and social services. The delay seemed to be on the Social Services side, in terms of allocating a care co-ordinator which C did not get until just past his 19th birthday.

Post-transition, Z.'s experience has been that he has not received as much support as he did with CAMHS. He finds that there is not as much support regarding his epilepsy and his ADHD has been 'pretty much ignored' by Adult Services – he has been told that he will 'grow out of it. His parents found out that the Maudsley Hospital in South London deals with ADHD and asked the Pembroke Centre to refer him, which it did, but the PCT would not pay. Z.'s parents' appeal against this decision was unsuccessful.

Z. has also experienced a lack of continuity in staff. The family was very appreciative of C's first consultant in Hillingdon who used to see Z. every three months and kept Z. as one of his patients until he retired. In Neurology, however, Z. has never had a settled doctor. Now 20, he has had 2 doctors in the last 18 months.

Z.'s experiences of the emergency treatment that he has required have not been

positive. At times when he has been taken to hospital by ambulance and admitted after a seizure, staff have not been familiar with the need to make an adjustment to his dosage. On other occasions, when Z. was 16, the assumption by staff (other than those at Great Ormond Street and Hillingdon Hospitals) was been that Z. needed to be placed in a mental health unit rather than be treated as a patient with epilepsy.

Z.'s first experience of college was stressful and after an episode of self-harming brought on by stress, he was excluded, but he has managed to continue his studies with the help of a Connexions worker and a worker allocated by Kids Can Achieve (KCA) specially funded by Hillingdon Social Services, since KCA is funded to serve Harrow residents. He has also been strongly supported by the LINK counselling service, which can provide a service for young people from 14 to 25. Z. finds the college is also more sensitive about the way it handles any episode of fitting that he has, whereas the school's response was to automatically call an ambulance. Z. is now in his third year at college. He is now doing a B. Tech course. He hopes to do well at his studies, go longer periods without fits and manage his life with some longer-term support.

Appendix 2

Case Vignettes

Case Vignette (C)

Transfer to Adult Mental Services of an adolescent who has required Tier 4 services

C. is now just turned 18. He is a boy who has had schizophrenia from early adolescence and has responded variably to various anti-psychotics. Additionally, he has moderate learning difficulties, attending a Special School with a Statement of Special Educational Needs, and is also intermittently depressed, with obsessive compulsive tendencies too. A final complication is a dysfunctional family background with possible physical and sexual abuse.

Eventually, after several years of effort by all concerned and with a positive therapeutic alliance, CAMHS asked for referral to the Maudsley/Bethlem Adolescent In-Patient Unit for assessment and consideration of a trial of Clozapine. This is the ultimate resource and very hazardous from the viewpoint of side-effects, requiring daily monitoring in an in-patient setting. The admission lasted for about six months and much beneficial psychological/family therapy was also provided.

At discharge, although he was only 17, CAMHS negotiated with adult services to undertake his Clozapine monitoring and itself provided continuing psychotherapeutic support. This was a beneficial, complementary approach by CAMHS services. He is now just turned 18 and CAMHS has a final review booked to complete the transfer, at which loss as well as hope will be important considerations.

Case Vignette (D)

Transfer to Adult Mental Services not required

D. is a male – referred at 15½ by a counsellor because of severity of presentation (anorexia, self-harming).

Seen for critical assessment by Consultant Child & Adolescent Psychiatrist and Consultant Child & Adolescent Psychotherapist. Then offered Specialist assessment by Consultant Child & Adolescent Psychotherapist.

The outcome of this assessment was that D. could benefit from “individual

psycho-analytic" psychotherapy. Supportive, gradual approach needed to help D. engage and to feel ownership of the process, but three months after initial referral was able to engage in 1 x weekly treatment.

Severity of symptoms increased and 2 x weekly sessions offered.

D. able to engage fully, very committed to process. As a result, able to speak about past experience of abuse and isolation within family and feelings of worthlessness.

Ongoing monitoring offered by Consultant Child & Adolescent Psychiatrist as well as regular 2 x weekly individual psychotherapy. Physical condition deteriorated as D. tried to mask anorexia. Prescribed anti-depressants. Distress led to physical crisis, and risk of breakdown of immune system and need for admission to Tier 4.

Physical symptoms monitored, leading to referral to Hillingdon Hospital and close liaison. When D. was too weak to attend appointments, Consultant Child & Adolescent Psychotherapist telephoned D. at home. As D. improved, became physically stronger, in tandem with increasing emotional strength and stability. Therefore less need for recourse to anorexic control of eating. At age 17, sessions reduced to once weekly.

D. able to plan and hope for future.

Care Plan to end at 18th birthday with no need to transfer to Adult Services.

Case Vignette (E)

Transfer to Adult Mental Services not required

Referred by his GP at seventeen years of age, E. was seen in at Child, Family and Adolescent Consultation Service (CFACS) by a Consultant Child & Adolescent Psychiatrist who recommended treatment by a clinical psychologist.

E.presented with Obsessive Compulsive Disorder (OCD), which was complex and long-standing. He was ambivalent about treatment as he had significant concerns about managing his anxiety, if he were to begin to challenge his ritualistic behaviours.

The intervention therefore consisted of a process of engaging E. and exploring his motivation to make changes in his life at a time of many transitions. The OCD had become particularly problematic during final year exams, and this had

coincided with uncertainty for E. about what choices to make in his life.

Through treatment, E was able to modify his behaviours and to find ways to prevent the OCD dominating his life. He continued to have periods of time when it became more intrusive, and strategies for dealing with these times were discussed.

By the time he was eighteen, the OCD was much more controlled, although still present. Options for further treatment, such as a referral to Adult Services, were discussed. However, E. felt confident enough to want to have a period of trying to cope without help, and was aware that he could contact his GP if he wished for a further intervention in the future. His case was therefore closed to CFACS.

Appendix 3

Glossary, references and further reading

Glossary

A&E	Accident and Emergency
AMHS	Adult Mental Health Services
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CDC	Child Development Centre
CFACS	Child, Family and Adolescent Consultation Service
CNWL	Central and North West London NHS Foundation Trust
DETR	Department of the Environment, Transport and the Regions
DCFS	Department for Children, Schools and Families
HASCAS	Health and Social Care Advisory Service
MAST	Multi-agency support team
PCT	Primary Care Trust
POC	Policy Overview Committee
SEN	Special Educational Needs
SENCOs	Special Educational Needs Co-ordinators
WLMHT	West London Mental Health Trust
YOT	Youth Offending Team

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