Child and adolescent mental health and social care services in Cambridge and Peterborough:
A quantitative mapping exercise

A Report for the Cambridge & Peterborough Child and Adolescent CLAHRC theme

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Executive Summary

This mapping document forms part of a programme of research carried out under the Child and Adolescent theme of the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) initiative for Cambridge and Peterborough. The primary interest in the theme is the ‘transitional care for adolescents requiring mental health care’. There is a large cohort of adolescents who develop serious mental health problems in late adolescence and who are also not being treated by transitional services. The reasons for referral and acceptance into adult services are not yet fully understood nor is there a gold standard model of transition within the NHS. There is, however, discussion as to the future nature and form of mental health services for adolescence given the imminent completion of the National Service Framework for Children. In some quarters it is argued that a youth mental health service should become a specialty in its own right whereas for some it is argued that a youth service would be unnecessarily complicated, fragmented and would likely increase transition problems. Our stepped programme of research aims to understand more about the transitional process for groups of adolescents vulnerable to developing serious mental health disorders including children and young people in out-of-home care. Specifically, the programme involves several key stages including:

1. Mapping out existing mental health services
2. Describing the characteristics of the target populations
3. Cross-sectional measurement of associations between variables of interest in groups of young people at the point of transition.
4. Tracking groups through the transitional period using longitudinal designs.
5. Testing alternative ways of providing services using among other methods, randomised controlled trials.

Therefore the primary aim of this quantitative mapping exercise is to provide a platform of knowledge that can inform the theme programme of research by laying the foundations for subsequent research. Here we outline and describe the extant mental health services available to children and young people in Cambridge and Peterborough posing questions such as: ‘what are the primary presentations for child and adolescent services in the area?’ ‘what is the caseload like?’ and ‘what are the usual sources of referral?’

Given that Looked after Children are likely to have significant and complex mental health needs, the transitional process for this group of young people, from child mental health services to adult, and also from care to independent living, is particularly important and features amongst our proposed future studies. For this reason, part of this mapping exercise was designed to describe more about children in care in general terms and specifically when considering their mental health needs.

Finally, as an initial step this exercise reported on any national or Trust specific policy that is pertinent to the transitional process.
CAMHS Services

Cambridge and Peterborough NHS Foundation Trust (CPFT) is the mental health service provider for the area and is one of 129 Foundation Trusts currently in operation across England. Consisting of three localities (South, Central & North), the CPFT is organised into 27 care pathways, six of which form the Child and Adolescent Mental Health Services (CAMHS). The six child and adolescent care pathways largely correspond to the 4-Tier structure of NHS CAMH services nationwide. The first pathway is Early Intervention and corresponds to Tier 2 CAMHS. The second pathway is the Choice and Partnership Approach care pathway and is equivalent to Tier 3. Care pathways 3 and 4 are sub-pathways (Attention Deficit Hyperactivity Disorder (ADHD); Autistic Spectrum Disorder (ASD)) within the Neurodevelopmental pathway. The fifth care pathway provides for children with Learning Disabilities, while the sixth care pathway represents the local Tier 4 services. These include Complex eating disorders (The Phoenix Centre), complex adolescent eating disorders (The Darwin Centre) and complex child development problems (The Croft). In total, 17 core service teams were identified ranging from CAMHS - Central, Fenland, North and South (multidisciplinary) to Butterfly (learning disabilities), CABS (behaviour problems), YOUS (drugs and alcohol) to the Primary Mental Health Worker Team providing support and advice to professionals who may have concerns about the mental health of children or young people.

Referrals to CAMHS are encouraged to be made with reference to the Children’s Global Assessment Scale (CGAS). A score on the CGAS should be at 60 or below to warrant a referral to CAMHS. The CGAS 51-60 score range indicates: “some noticeable problems in more than one area. Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.” A copy of the CGAS can be found in the Appendix.

The biggest source of referral for CAMHS is Primary Health Care (usually GPs), which accounts for 42% of all referrals. Child Health (18%), Internal Referrals (12%), Social Services (9%) and Education (9%) combine to explain the majority of the remaining referrals. Few referrals stem from the Youth Justice system (1%), Learning Disabilities (1%) or the Voluntary Sector (<1%). Young people seldom make self-referrals (2%).

The vast majority of CAMH Service Users (SUs) have a white ethnic origin (95%) where 44% are female and 56% male. CAMHS usually see children and young people across the whole spectrum of ages from 0 to 17 or 18, where the most frequent age range is between 10 to 14 years (approximately 43%). Interestingly, there is an interaction between age and gender in that more males than females are seen in the early age ranges up to 14, whereas the reverse is true from age 15 and onwards. Of particular interest to this mapping exercise was an estimation of the volume of young people in the CPFT at the age of potential transition to adult services. It is expected that approximately 300 young people are on the CAMH caseload for any given year.

Young people present to and indeed can be referred to CAMHS with a variety of mental health problems. The most common presentations are with emotional disorders (32%), followed by hyperkinetic disorders (17%), conduct disorders (12%), autistic spectrum disorders (9%), developmental disorders (8%) and eating disorders (7%). Other presentations include self harm,
habit disorders, psychotic disorders, substance abuse and a further 5% whose primary presentation is unspecified.

In terms of total volumes of SUs on Service Books, the multidisciplinary teams in South Cambridgeshire (358), Huntingdon (374) and Fenland (198) along with the Specialist CAMH team in Peterborough (195) are the Trust’s largest. When considering the staff/patient ratio, the more intensive Tier 4 units have the highest ratio (e.g. The Phoenix Centre 1:2), whereas the multidisciplinary teams have higher ratios (e.g. Brookside 1:7). The ADHD team in Peterborough have the highest ratio of 1:14.

### Looked After Children

Cambridgeshire and Peterborough both have significant populations of looked after children (LAC). Peterborough has the greater proportion of LAC (81 per 10,000), compared with Cambridgeshire (36 per 10,000 children) and England as a whole (55 per 10,000). Most children enter out-of-home care for reasons of abuse and neglect, although the data presented in this report show a significant minority in Cambridgeshire (but not Peterborough) are taken into care due to either child or parental disability or illness (more than double the national percentages). This may explain the larger proportion of children in Cambridgeshire who were found to be voluntarily accommodated when compared with both the national average and the Peterborough area (additionally, the larger number of unaccompanied asylum seekers in Cambridgeshire compared with Peterborough may also influence the higher number of voluntary placements). However in both areas most children were accommodated as the result of a court order, generally a full or interim care order. The most common type of placement in Cambridgeshire and Peterborough was foster care, and only small numbers of children experienced more than three placements over the course of a year.

Historically, LAC in England have tended to fare worse than children able to live in their family home, in areas such as education, employment and health and have shown higher rates of criminal activity. Broadly consistent with this overall picture, the data presented in this report also show that the academic performance of LAC in Cambridgeshire and Peterborough is poorer than their non-looked-after peers, from Key Stage 1 through to GCSEs. For example, less than 70% of LAC in Cambridgeshire and just over 40% in Peterborough (who are old enough to take GCSEs) achieved at least 1 GCSE pass; compared with 98.8% and 97.4% of all children in Cambridgeshire and Peterborough respectively who achieved the same benchmark. This may also influence a young person’s choice to leave education earlier and might be reflected in the higher levels of unemployed LAC when compared with their age cohort. In Peterborough, 36.4% of young looked after children at year 11 age (15/16) on 30th September 2008 were not in education and were unemployed, which was more than double the national average for LAC. However in Cambridgeshire, higher than average proportions of LAC remained in fulltime education at Year 11. In Cambridgeshire, rates of youth offending for LAC were low, similar to the figure for all young people in the local area. The percentage of LAC in Peterborough who received a conviction or caution was somewhat higher, but similar to the national average for rates of youth offending in looked after children.
Contrary to national statistics for LAC, in both Cambridgeshire and Peterborough there were higher proportions of looked after children who had educational needs recognised by a Special Educational Needs (SEN) statement. There also were no recorded permanent exclusions for LAC in Cambridgeshire and Peterborough, and school attendance was good, particularly in Peterborough. The health needs of looked after children in both Cambridgeshire and Peterborough were well attended to, with 90% and above having received appropriate checks in the past 12 months. Substance misuse in both areas was low with approximately half as many LAC, or better, identified as having substance misuse issues.

The mental health problems of LAC are known to be complex and LAC are consistently over-represented in mental health prevalence estimates. In terms of accessing CPFT services, 101 LAC were service users in 2008/09 which translates to approximately 13% of all LAC in the area.

In terms of leaving care, almost two fifths of looked after children chose to leave care between ages 16 and 18, with a further three fifths choosing to leave at age 18 and very few remaining beyond that age. Most tended to leave from either a foster placement, a children’s home or other community placements, and tended to transition directly to living independently. After leaving care, approximately one third of LAC in Cambridgeshire and Peterborough were not in employment, education or training (NEET) at age 19, highlighting an area in which formerly looked after young people may need ongoing support with after leaving care.

In several areas of functioning looked after children in Cambridgeshire and Peterborough do better than LAC in other parts of England. However in general, LAC are often disadvantaged when compared with their age-group peers who are not in care. Primary problem areas include educational attainment, employment, and mental health. These fundamental areas will be measured in subsequent studies that monitor transition trajectories and outcomes.

**Policy**

The care and services available for young people within a given area are influenced by a number of important policies at national, local and sometimes service-specific levels. One of the most important national directives with regards to children and young people was the 2003 green paper ‘Every Child Matters’. The main goals of Every Child Matters are that all children should be supported to be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being. These five points are employed as outcome criteria for how well local authorities are performing with regard to caring for children and young people.

National Service Frameworks (NSFs) help set the standards for healthcare nationwide. There are two particular NSFs that are relevant to the mental health of children and young people, firstly the National Service Framework for Children, Young People and Maternity Services and secondly the National Service Framework for Mental Health. One of the areas requiring attention is the transition between CAMHS and AMHS in which both NSFs highlight factors relating to transition such as age appropriate service provision and access to services for all young people. The Health and Social Care Advisory Service (HASCAS) recently completed a study focusing on the issue of transition and published a literature review for informed practice and also a self assessment checklist to assist local authorities.
Although there is no national policy addressing specifically how transitions for child and adult mental health services should happen, there are some documents, such as the NSFs which make explicit recommendations and many local authorities have developed policies regarding service transition.

The CPFT have implemented a transition protocol from CAMHS to AMHS, in May 2008. The protocol states that plans should be consistent with the Care Programme Approach, which is the nationally adopted approach for working with people with mental health needs with four main points: Assessment, a care plan, an appointed key worker, and a regular review. CAMHS have a responsibility to identify all young people at or near age 17 who meet the criteria for the transition to AMHS and begin planning the transfer 3-6 months before the transfer date. An AMHS assessor will be appointed and a meeting between the CAMHS case worker, the young person and the AMHS assessor is held in which a transfer date will be discussed, a care-coordinator identified and responsibilities agreed upon.

For looked after children, or children in care, the Department of Health ‘Framework for the Assessment of Children in Need and their families’ discusses in general how children known to social services should be assessed. The Children (Leaving Care) Act 2000 sets out that for young people who are eligible under the Act, the local authority must conduct a needs assessment within 3 months of the young person turning 16, which then forms the basis of their own personal pathway plan, which sets out how their needs will be assessed at least until they turn 21 years old. The Pathway plan should address for example, the needs for personal support, accommodation, education and training, employment and financial support. The Act also stipulates that each young person be allocated a Personal Advisor, who is responsible for helping the young person implement the Pathway Plan.

For young people leaving care, Cambridgeshire policy states that 6 weeks before the young person turns 16, their social worker will request assistance from the 16+ advisory service in completing a needs assessment which must be completed within 3 months of the young person’s 16th birthday. Next is a creation of the Pathway plan which when completed the 16+ Advisor assumes case responsibility for the young person and becomes their Personal Advisor. The Cambridgeshire County Council policy encourages young people to stay in care until at least age 16 although it is also required to provide appropriate accommodation for those under 18 who wish to leave care early. The exception to this is when the young person has a disability that prevents them from living as an independent adult. Peterborough works within the same broad framework as Cambridgeshire and all other local authorities nationwide, and has a lot of information online aimed at explaining the transition process to young people in the care system.

In conclusion, this report provides a foundation for the CLAHRC theme transitions work by describing the existing services in the area and highlighting the next directions for the research. It is anticipated that a subsequent qualitative study will complement this more quantitative report, giving a picture of the experiences and perceptions of key stakeholders in local services. Under the project banner of ‘transfer of care at 17’ or TC17, cross-sectional research is currently underway looking at the service use and mental health of young people engaged in local mental health services. This work will in turn inform the next planned research step that involves longitudinally designed studies that will help to determine the midterm trajectories of young people transitioning away from child and adolescent services.
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1. Child and Adolescent Mental Health Services (CAMHS)

Mental health care in the United Kingdom is covered under the National Health Service (NHS). Child and adolescent mental health services (usually known as CAMHS), operate under a four-tier model of service, summarised in Figure 1. The CAMH tiers of intervention are not necessarily progressive and a child may enter this system at any stage relevant to their assessed needs.

In Cambridge and Peterborough, NHS mental health services are provided by the Cambridge and Peterborough NHS foundation Trust (CPFT).

Foundation Trusts are new trusts that are part of the Government’s plan for decentralisation. As of March 2010 there are 129 NHS Foundation Trusts in operation across England. The Department of Health give a full description of Foundation Trusts:

“NHS foundation trusts (often referred to as foundation hospitals) are at the cutting edge of the Government’s commitment to the decentralisation of public services and the creation of a patient-led NHS. NHS foundation trusts are a new type of NHS trust in England. They have been created to devolve decision-making from central government control to local organisations and communities, so they are more responsive to the needs and wishes of their local people. The introduction of NHS foundation trusts represents a profound change in the history of the NHS and the way in which hospital services are managed and provided.”

The CPFT is comprised of three locality teams that cover the South (Cambridge), Central (Huntingdon and Fenland) and the North (Peterborough) areas. In 2007, a programme of transformation of services was begun. Four main reasons were given for the necessity of a transformation of services:

1. Some services no longer reflected ‘best practice’
2. There were unacceptable levels of service provision across the Trust
3. A more strategic approach to delivering annual cost improvement programmes was required
4. Trust transformation was to be the ‘driving force’ behind a bid for Foundation Trust status

The documented objectives of the development of the transformation include:

- Developing a vision for future services embedding recovery principles into all aspects of services.
- Delivery consistent services with equitable access to service
- Providing an integrated service reducing boundaries and bottlenecks between teams
- Delivery of services which are safe, effective and based on best practice
- Focussing on the whole client pathway not just the service
- Delivering at least 2.5% cash –releasing efficient saving per annum
- Developing service models that help manage the risk relating to out of area placements
Figure 1. The 4-Tier Structure of CAMHS

**Tier 1**
- All children

**Tier 2**
- Children at risk of disorder
- Professionals working independently, but often as a network & in community

**Tier 3**
- Children with illness & disorder
- Professionals working together as a close multi-disciplinary team in a clinic setting

**Tier 4**
- Highly specialist services, often residential, for children with very severe illness, disorders or problems of all kinds

Roles and professionals:
- Social workers
- Therapists
- Paediatricians
- Community Nurse Specialists
- Primary health care professionals
- Primary mental health workers
- Education Welfare officers
- Youth workers
- Clinical & Educational Psychologists
- Youth workers
The Care Pathways

Following the CPFT service transformation, 27 new care pathways have been developed across the Trust:

“A care pathway is the planned route that a service user will take from their first contact with a member of the NHS (usually their GP), through referral, to the completion of their treatment. It is best described as a timeline, on which every event relating to treatment can be entered. Events such as consultations, diagnosis, treatment, medication, assessment, teaching and preparing for discharge can all be mapped on this timeline.” ¹⁴

The 27 CPFT care pathways (outlined in Figure 2) aim to:

- Ensure people are treated at the most appropriate part of the service
- Improve access to services
- Reduce waiting time for treatment
- Reduce variations in care
- Avoid multiple assessments
- Provide a range of evidence based treatments
- Meet all national standards
- Deliver commissioners value for money within a stepped mental health model
- Allow the trust to take forward key service developments at no additional cost to commissioners
- Deliver the Trust cost improvement programme over the lifetime of the integrated business plan (IBP)
- Form the basis of a new contract currency (unit of activity) with our commissioners

These new care pathways have been built on two concepts; stepped care and the principles of recovery. Stepped care refers to the method of treating service users at the lowest appropriate service tier in the first instance and then stepping up care if and when appropriate. The stepped care approach is illustrated in Figure 3.
### Child and adolescent mental health

1. Early intervention - tier 2
2. Choice and partnership approach - care pathway (core pathway) - tier 3
3. Neurodevelopment pathway
   - Neuro-ADHD sub-pathway - tier 3
   - Neuro-ASD sub-pathway - tier 3
4. Children with learning disabilities - tier 3
5. Tier 4 pathway
   - Complex eating disorders (Phoenix)
   - Complex adolescent eating disorders (Darwin)
   - Complex child development problems (Croft)

### Adult mental health

6. Primary care pathway
7. Adult rehabilitation and recovery care pathway
8. Intake and treatment care pathway
9. Acute care pathway
10. Acute care sub pathway Psychiatric Intensive Care Unit (PICU)
11. Low-secure care pathway
12. Early intervention care pathway
13. Eating disorders care pathway
14. Personality disorders care pathway
15. Substance misuse care pathway
16. Prison in-reach care pathway

### Older people’s mental health

17. Community pathway
   - Community functional care - sub-pathway
   - Community dementia - moderate and severe care sub-pathway
   - Community dementia - diagnosis and stabilisation care sub-pathway
18. Intermediate care pathway
19. In-patient treatment care pathway
20. Young onset dementia care pathway
21. Day therapies care pathway

### Learning disabilities

22. Acute care pathway (6-12 week)
23. Rehabilitation care pathway

### Supported living

24. Complex care packages

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*Figure 2. The 27 care pathways within the CPFT*
Figure 3. The stepped care approach
The CPFT is a system of care that uses the following principles of recovery:

- Focusing on people rather than services
- Monitoring outcomes rather than performance
- Emphasising strengths rather than deficits or dysfunction
- Educating people who provide services, schools, employers, the media and the public to combat stigma
- Fostering collaboration between those who need support and those who support them as an alternative to coercion
- Through enabling and supporting self management, promotes autonomy and, as a result, decrease the need for people to rely on formal service and professional support

The point of entry into CAMH services will depend on the severity and complexity of the individual case. An overview of the likely pathway for most people is given in Figure 4.

**Referral Criteria**

CAMH services within the CPFT accept referrals for children and young people up to their 17th birthday. In all cases the impairment of the child or young person must be at or below 60 on the Children’s Global Assessment of impairment (CGAS). A copy of the CGAS can be found in the Appendix. An impairment level between 60 -51 indicates:

“some noticeable problems in more than one area. Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.”

Referrals are generally made by any professional that is working with the child or young person. There are a range of difficulties that can be referred including: depression or mood disorder, self-harm, anxiety including post traumatic stress disorder, obsessive compulsive disorder, psychosis, eating disorders, complex neurodevelopmental disorders (e.g. ADHD), Tourette’s and complex tic disorders, somatisation disorders, severe behavioural disorders, substance misuse, learning disability with enduring/challenging behaviour or mental health problems, attachment disorders. Difficulties that would not warrant a referral in the first instance include: problems that are primarily school or college based, family difficulties, normal responses to bereavement, school refusal or complex enuresis/soiling. A more detailed account of referral types can be found in the Appendix.
<p>Figure 4. CPFT Pathway overview</p>
CPFT CAMH services

The specific CPFT services that are available to young people in Cambridge and Peterborough are illustrated in Figure 5. Services are divided into child and adolescent (up to 17 years) and adult services (18+), although there is some overlap within and between some services. For example, the Young Adult Service caters for people aged between 17-25 years old. Some services are area specific and some are trust-wide. A brief definition of each service is given below. In Figure 5 ‘Gateway workers’ refer to primary care mental health workers trained in brief therapy techniques of proven effectiveness who have been employed to help GPs to manage and treat common mental health problems in all ages including children.

Child & Adolescent Mental Health Services

Butterfly is a Learning disabilities team that is part of CAMH central, providing services for children and young people (0-19).

Cambridge Area Behaviour Support (CABS) is a service for children with behaviour problems.

CAMH Learning Disabilities (CAMH LD) is a service that works with young people (0-19) with learning disabilities and/pr complex needs.

CAMHS Central provides assessment and treatment for children and adolescents (0-17 years) with emotional, behavioural and neurodevelopmental problems along with support for their families. Advice also given to professionals.

CAMHS Fenland is a multidisciplinary team providing out-patient assessment and treatment of children and adolescents (0-17 years) presenting with the severe or persistent mental health problems or disorders. Advice given to other professionals and training given to primary care staff.

CAMHS North is a multi-disciplinary team including psychiatrists, occupational therapists, mental health nurses, specialist teachers, child and family worker, psychologists, family therapists, clinical nurse specialists, administration staff, and learning disability nurses. The service caters for the needs of children, adolescents and their families who are experiencing serious mental health difficulties in the Greater Peterborough area.

CAMHS South is a multidisciplinary team providing assessment of young people under the age of 17 presenting with emotional, behavioural, eating disorders and neurodevelopmental disorders.

Child & Family Court Assessment service offers expert psychiatric and psychological opinion and treatment to children and families. Services include: consultation, reports for court, medico-legal reports and family therapy.

www.courtteam.cpft.nhs.uk
Neurodevelopmental service (NDS). This service is divided into integrated multiagency teams (i-MATs) providing for: Attention deficit hyperactivity disorder (ADHD), autistic spectrum disorders (ASD) and children’s learning disability team.

Primary Mental Health Worker Team. Primary mental health workers (PMHW) have backgrounds such as in nursing and social work and have experience of working with children and young people up to 17 years old. This service offers support and advice to other professionals who may have concerns about children or young people. Service users may include GPs, Connexions personnel and social workers.

The Cedars is a specialist out-patient service for children and adolescents (0-17 years). The service provides assessment, consultation, treatment and training. A range of presentations including emotional including self-harm, anxiety, obsessive compulsive disorder.

Young Users service (YOUS). Trust wide service for substance misuse (drugs & alcohol). Tier 3 & up to 18 years in Peterborough and tier 2 & up to 19 in the rest of the county. Provides support & information for young people including looked after children and young people excluded from mainstream education.

The Darwin Centre is a 16-bed centre providing in-patient, day-patient and outreach care for young people (12-18 years) suffering from severe mental illness.

The Phoenix Centre is an 11-bed centre providing both in-patient and out-patient care for adolescents with eating disorders (12-17 years).

The Croft is a 10-bed unit providing psychiatric services for children (0-12) and their families. Assessment and treatment for children with complex developmental or psychiatric problems or children presenting with severe emotional and behavioural problems.

Psychological Health is a trust-wide service providing psychological assessment and treatment. The service also provides staff training and supervision and is involved in research and evaluation.

Connexions: Although not a CPFT service per se, connexions can be used as a resource for 13-19 year-olds in the area and has links with CAMH and social services. (Cambridgeshire) www.youthoria.org

Educational Psychology.: Not a CPFT service but is often involved in helping children with emotional and behavioural difficulties in the area.
Figure 5. CPFT Child and Adolescent & Adult Services
Adult Mental Health Services

**Assertive Outreach - Trustwide.** Also known as the Intensive Support Team (IST), this service works with people with mental health problems that find it hard to engage with traditional services. The service sees people in a variety of places wherever the person feels most comfortable and stresses social and practical help including vocational rehabilitation. The intervention continues until transition can be made to another mental health service.

**Acute Care.** Part of this service is based at Acer Ward in Hinchingbrooke Hospital provides in-patient and home-based care. Acer Ward has 16 acute admission beds and an Electro Convulsive Therapy (ECT) suite. The second team in Peterborough is comprised of two in-patient wards along with a crisis resolution home treatment team (CRHTT). Services are available for 17 to 65 year olds experiencing mental health problems.

**Adrian House** is a 24-bed acute ward in Fulbourn Hospital, Cambridge providing assessment and treatment for patients aged 18-65. The philosophy of care reflects a patient-centred approach, with a strong emphasis on a robust, ward-based programme of therapeutic activities. Patient care is organised through the primary nursing model. There are two beds used for the treatment of drugs and alcohol problems.

**Adult Eating Disorders inpatient.** Based at Addenbrooke’s Hospital, this 12-bed in-patient ward caters for people (17-65) with eating disorders.

**Adult Eating Disorders TW.** This trust-wide service for adults with eating disorders consists of a community team and an in-patient unit. Most users receive treatment as out-patients.

**Cambridge Forensic Psychiatry.** This service provides treatment for mentally disordered offenders and patients, aged 18-65 years, who require specialist forensic care in community and inpatient settings.

**Cambridge Rehabilitation Team.** This service is comprised of two teams (north and south) providing intensive support and interventions for adults with a severe and enduring mental illness and who may also have severe social problems and lack of motivation and self-confidence.

**CAMEO** is a service for people experiencing symptoms of psychosis for the first time.

**Cedars Recovery Unit** is an 18-bed assessment and treatment ward based in Fulbourn Hospital, Cambridge. The service is for 18-65 year-olds.

**Cobwebs** is an intensive rehabilitation service (18-65 year-olds) located at a 12-bedroom house in Cambridge.

**Community Mental Health** is based in Huntingdon and comprised of two teams; the intake and treatment tam and the rehabilitation and recovery team. Both teams are multidisciplinary supporting people within the 17-65 age range.
Complex Cases. This is a specialist trust-wide service for people with severe personality disorder.

Court Diversion and Liaison Team. Based in Peterborough, this service offers assessment of offenders who have mental health problems within the Criminal Justice System.

Crisis Resolution. This service, based in Cambridge, offers multidisciplinary assessment and home treatment as appropriate for people who would be otherwise admitted to hospital.

Designated Health Team looked after children. Among other staff, this team includes two consultant psychiatrists.

Ely Social Inclusion is a service that provides recovery-focused treatments for adults with mental health problems. The interventions help social reintegration, providing a space for people to develop social networks and relationships.

The Friends ward is a 25 bed acute admission ward at Fulbourn Hospital, Cambridge that provides assessment and treatment for people between 18-65.

George Mackenzie House is a 20-bed low-secure psychiatric unit for mentally ill patients (18-65 years) presenting with challenging or disturbed behaviour who cannot be managed on an open psychiatric ward. It can also take referrals from the Forensic Psychiatry Service.

Huntingdon Forensic Services provides treatment for mentally disordered offenders and patients (18 -65) who require specialist forensic care. The team works with adult mental health services, probation service, courts and prison services.

IAPT. Improving access to psychological therapy is a service set up primarily to improve access to therapy for people suffering from anxiety and depression. Offering a range of treatments including guided self-help, computerised cognitive-behavioural therapy, individual and group treatments.

Intake and treatment teams TW. A trust-wide service providing assessment and treatment for adults with moderate to severe mental illness. The teams make recommendations for treatment within the appropriate service.

Liaison Psychiatry. A specialist team of psychiatrists, nurses, psychologists and social workers based at Addenbrooke’s Hospital, Cambridge. This service provides assessment, treatment and diagnosis for anyone referred by a medical or surgical team. An out-patient service is also offered.

Lucille Van Geest Centre. This is a neurodevelopmental service divided into integrated multiagency teams (i-MATs) providing for: Attention deficit hyperactivity disorder (ADHD), autistic spectrum disorders (ASD) and children’s learning disability team.

Mental Health Chaplaincy. The aim of this service is to give high quality pastoral care to individuals with mental health problems. Offering one to one support, befriending and a listening ear.

Mental Health Resource Centre. Working with individuals recovering from mental health problems to identify changes that they want to happen and offering support to make these changes happen.
**MOSAIC.** The Mosaic centre offers therapeutic group work and individual sessions. Services include: ethnic minority services, complementary therapy, art therapy, hearing voices group, employment services, anxiety and depression groups and activities of daily living.

**Pathways Social Inclusion Team.** The service provides recovery focused interventions for adults with mental health problems. Using a Whole Life approach, the service aims to overcome some of the effects of social exclusion.

**PDS.** Peterborough Drugs Service is an integrated service for adults dealing with all substance related issues.

**Peterborough Recovery Team.** Longer term and intensive service for individuals with severe and enduring mental illness – mainly psychosis.

**Peterborough Rehabilitation Team.** The team provides longer term intensive support and interventions in a variety of settings for people with a severe and enduring mental illness and who may also have severe social problems or lack of motivation and self confidence.

**Primary Care Psychological Health Service** is a trust-wide service offering help, advice, signposting and a range of psychological therapies for people with mild to moderate mental health problems. Services offered include: computerised & individual CBT, workshops, group therapy, employment support assessment and onward referral to other mental health services and signposting to other sources of help.

**Prison in reach** teams are in the area at HMP Whitemoor, HMP Peterborough and HMP Littlehey. The teams include psychiatrists, psychologists, psychiatric nurses, counsellors and psychotherapists.

**Psychological Health Adults** is a trust-wide service, integrated with other teams working across all pathways. The team provides psychological assessment and treatment, training for staff and are involved in research and evaluation. Psychology graduates are also employed as graduate mental health workers.

**South Rural Social Inclusion** is a Recovery-focused service helping people with mental health problems overcome some of the effects of social exclusion.
2. CPFT Children’s Services Mapping 2008/09

The following data were collected by the Children’s Services Mapping\textsuperscript{15}. What follows is a summary of the main findings that have specific relevance for CPFT.

**CAMHS Service Users**

**Primary Presentation**

The majority of cases (32\%) presenting to services within CPFT are those children/adolescents with emotional disorders (e.g. depressive and anxiety disorders). Sixty one percent of the total number of service users (SU) present with emotional, hyperkinetic (ADHD, ADD) conduct (Conduct Disorder, Oppositional Defiant Disorder) disorders/problems. A very small percentage (1\%) present with psychotic disorders or substance abuse, however were this narrowed to only include 15-18 year olds this figure is likely to increase as the risk of developing these disorders/problems increases during this period of adolescence.

![Primary Presentation of CAMHS Caseloads Within the CPFT](image-url)

*Figure 6. Primary Presentation of CAMHS Caseloads Within the CPFT*
Age and Gender

The explanation of low prevalence rates of children/adolescents presenting with either psychotic disorders or substance abuse problems is borne out by the demographic spread of cases across all services within the CPFT, with particular reference to age. The most prevalent age range of those presenting to CAMHS was 10-14, where the risk of psychotic disorders such as schizophrenia and substance abuse is low. The dominant gender changed with age, with a larger proportion of males in the lower age ranges (0-14) and a higher proportion of females in the higher age ranges (15-18). Of particular interest to the CLAHRC theme research is the number of CAMHS adolescents at the age of eligibility for transition to adult mental health services (16-18). A reasonably sized population exists of nearly 300, every year, from which to draw research samples from.

![Age and Gender across CPFT CAMHS Services](image)

**Figure 7. Age and gender across CPFT CAMHS Services**

Ethnicity

The most prevalent ethnic group within the CPFT CAMHS is White, comprising 95% of the SU population (See Table 1).

**Table 1. Ethnicity of SUs across CAMH Services with CPFT**

<table>
<thead>
<tr>
<th>White</th>
<th>Mixed (White + Other)</th>
<th>Asian</th>
<th>Black</th>
<th>Other</th>
<th>Not Stated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1650</td>
<td>49</td>
<td>26</td>
<td>5</td>
<td>3</td>
<td>11</td>
</tr>
</tbody>
</table>
CAMHS Services

Current Caseloads

CPFT provided the child service mapping group with data on all their CAMHS services including current caseloads. The data were collected in 2008/09 and therefore caseloads are likely to have changed. However the data do give a general picture of where the majority of cases can be found. As shown in Figure 8, the two teams with the largest caseloads are Brookside Clinic in Cambridge and the CAMHS Team in Huntington.

Table 2 summarises the type of services provided across CAMHS teams within CPFT and reports of the staff-patient ratio of these services. As can be expected due to the nature of the service, the tier 4 services providing intensive inpatient treatment have the highest staff-patient ratio. The ADHD (Peterborough) and integrated ADHD teams have the lowest staff-patient ratios and these teams provide assessment and treatment across Cambridgeshire and Peterborough for children with ADHD and their families.

![Figure 8. Current case loads of CPFT CAMHS Services](image-url)
Table 2. Summary of type, tier, caseload, clinical staffing levels and staff/patient ratios for CAMHS teams within CPFT

<table>
<thead>
<tr>
<th>Team</th>
<th>Type of CAMH Service</th>
<th>Tier</th>
<th>Total Caseload</th>
<th>Clinical Staffing Levels (wte)</th>
<th>Staff/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD Team (Peterborough)</td>
<td>Target Team</td>
<td>3</td>
<td>99</td>
<td>1.92</td>
<td>1:52</td>
</tr>
<tr>
<td>Brookside</td>
<td>Multidisciplinary generic Team</td>
<td>3</td>
<td>358</td>
<td>22.58</td>
<td>1:16</td>
</tr>
<tr>
<td>Butterfly (LD Team, Huntingdon)</td>
<td>Targeted Team</td>
<td>3</td>
<td>50</td>
<td>4.09</td>
<td>1:13</td>
</tr>
<tr>
<td>CAMH-LD Team</td>
<td>Targeted Team</td>
<td>3</td>
<td>80</td>
<td>6.23</td>
<td>1:13</td>
</tr>
<tr>
<td>CAMH-LD Service (Huntingdon)</td>
<td>Targeted Team</td>
<td>3</td>
<td>54</td>
<td>3.2</td>
<td>1:17</td>
</tr>
<tr>
<td>CAMHS Team (Huntingdon)</td>
<td>Multidisciplinary generic Team</td>
<td>3</td>
<td>374</td>
<td>17.9</td>
<td>1:21</td>
</tr>
<tr>
<td>Children with LD (Peterborough)</td>
<td>Targeted Team</td>
<td>3</td>
<td>30</td>
<td>2.2</td>
<td>1:14</td>
</tr>
<tr>
<td>Community CAMHS (Peterborough)</td>
<td>Multidisciplinary generic Team</td>
<td>3</td>
<td>40</td>
<td>3.8</td>
<td>1:11</td>
</tr>
<tr>
<td>Darwin Centre for Young People</td>
<td>Tier 4 Unit/Team</td>
<td>4</td>
<td>39</td>
<td>26.4</td>
<td>1:1.5</td>
</tr>
<tr>
<td>Fenland</td>
<td>Multidisciplinary generic Team</td>
<td>3</td>
<td>198</td>
<td>8.15</td>
<td>1:25</td>
</tr>
<tr>
<td>Integrated ADHD Team</td>
<td>Targeted Team</td>
<td>3</td>
<td>107</td>
<td>2.15</td>
<td>1:50</td>
</tr>
<tr>
<td>Neurodevelopmental Teams (Peterborough)</td>
<td>Targeted Team</td>
<td>3</td>
<td>34</td>
<td>2</td>
<td>1:17</td>
</tr>
<tr>
<td>Specialist CAMHS (Peterborough)</td>
<td>Multidisciplinary generic Team</td>
<td>3</td>
<td>195</td>
<td>12.1</td>
<td>1:16</td>
</tr>
<tr>
<td>The Croft Child and Family Unit</td>
<td>Tier 4 CAMHS Unit/Team</td>
<td>4</td>
<td>34</td>
<td>17.55</td>
<td>1:2</td>
</tr>
<tr>
<td>The Phoenix Centre</td>
<td>Tier 4 CAMHS Unit/Team</td>
<td>4</td>
<td>67</td>
<td>21.58</td>
<td>1:3</td>
</tr>
</tbody>
</table>

Table 3 shows that a small percentage of CAMHS SU s come from particularly vulnerable groups including those with learning disability (LD; 14%), Looked After Children (LAC; 6%) and young offenders (YO; 1%).

Table 3. Proportions of vulnerable young people in CPFT

<table>
<thead>
<tr>
<th>Total CAMHS Cases</th>
<th>Total LD cases (%)</th>
<th>Total LAC Cases</th>
<th>Total YO Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1759</td>
<td>249 (14)</td>
<td>101 (6)</td>
<td>24 (1)</td>
</tr>
</tbody>
</table>
Source of Referral

As shown in Figure 4 the majority of cases are referred to CAMHS services through primary health care e.g. GP surgeries (42%). Child health and social services are another substantial referral source and together these services refer 72% of the cases to CAMHS within CPFT.

Figure 9. Spread of referral sources for CAMH Services within the CPFT
3. Looked After Children in Cambridgeshire and Peterborough

Demographic characteristics of Looked After Children

As at 31st of March 2009, there were 2,700 children in Cambridgeshire defined as ‘Children in Need’ (216 per 10,000 children), and 1,300 Children in Need in Peterborough (329 per 10,000)\(^\text{16}\). Cambridgeshire was below the national average of 276 per 10,000 children being classified as Children in Need, while Peterborough was above the national average\(^\text{17}\).

Of these children, 450 in Cambridgeshire were ‘Looked After Children’ (LAC) (36 per 10,000 children), and there were 315 LAC in Peterborough (81 per 10,000). Nationally, 55 of every 10,000 children are looked after, so again Cambridgeshire has less children looked after than the national average, while Peterborough is above the national average. However, numbers of LAC have (in general) increased in Cambridgeshire over the past five years, and decreased in Peterborough.

![Graph showing percentage of looked after children in each age group, by local authority and nationally.](image)

**Figure 10.** Percentage of looked after children in each age group, by local authority and nationally

In Cambridgeshire, 55% of LAC were male and 45% were female; in Peterborough 53% were male and 47% female. Figure 10 shows the age distribution of LAC. In both local authorities, the percentage of looked after children under one year of age is quite small, and there are more LAC in the 10-15 year old age group than any other age group (about double that of the 1-4 age group or the 5-9 age group). This pattern of age distribution is similar nationally. In all cases, the percentage of LAC in the 16 and over age category decreases, however in Peterborough there were fewer 16+ LAC relative to Cambridge and the national picture. Although this could be an artefact of the cohort at that time, it may also suggest that more looked after children in Peterborough are leaving care sooner after they turn 16.

\(^\text{16}\) The data presented are taken from the statistical release on the Department for Children, Schools and Families website entitled ‘DCSF: Children Looked After in England (including adoption and care leavers) year ending 31 March 2009’ (unless otherwise referenced). This is the most recent information available on looked after children, however please bear in mind that the numbers will have changed. Also please note that due to rounding conventions designed to maintain the anonymity of individuals upon which the statistics are based, totals are rounded and small numbers suppressed entirely (please see document for further details on rounding conventions). As a result, some percentages quoted do not add up to 100.
The majority of LAC in Cambridgeshire and Peterborough are of white ethnic origin. Table 4 summarises ethnic origin of LAC in both local authorities. Cambridgeshire and Peterborough have slightly higher percentages of white ethnic origin LAC than the national average, which is a reflection of the demographic of the region.

Table 4. Ethnic origin of LAC in Cambridgeshire and Peterborough as at 31.03.09 (%)

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Mixed</th>
<th>Asian or Asian British</th>
<th>Black or Black British</th>
<th>Other ethnic groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire</td>
<td>81</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Peterborough</td>
<td>84</td>
<td>9</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

As at 31st March 2009, there were 45 unaccompanied asylum seeking young people being looked after in Cambridgeshire (10% of the overall figure), and less than five unaccompanied asylum seekers in Peterborough (therefore no further information was reported to protect the anonymity of this small group). About 50% of those recorded were of Asian ethnic origin, 16% were of Black ethnic origin and the remainder were of other ethnicity.

Reason for being ‘Looked After’

The category of need allocated by the local authority usually represents a general reason why the child or young person has been taken into care. The need categories of LAC in Cambridgeshire and Peterborough are represented in Figure 11 below. The most common reason for being taken into care in both local authorities is abuse or neglect. Nationally, approximately 61% of LAC are placed in care due to abuse or neglect. In Cambridgeshire, child or parental disability or illness accounted for a further 19% of children being taken into care, whereas in Peterborough there were only small numbers (less than 5) in these categories of need (therefore details were not reported in national figures to protect the anonymity of the individuals).

![Figure 11. Percentage of looked after children in each category of need](image-url)

More recently, Cambridgeshire LA have indicated to the authors of this report that approximately 50% of LAC are asylum seekers.
The legal status of LAC in Cambridgeshire and Peterborough is presented in Figure 12. The category for ‘accommodated under S20’ means that these children were placed in care voluntarily under Section 20 of the Children Act. Around 40% of children in Cambridgeshire were voluntarily accommodated, which is slightly higher than the national average of 32%. This may potentially have been influenced by the higher numbers of children placed in care due to child or parent illness or disability, or by the numbers of unaccompanied asylum seekers in Cambridgeshire. Around 26% of children in Peterborough were voluntarily accommodated. The remaining three categories show the percentage of children who were taken into care by court order. As at 31st March 2009, there were no recorded looked after children in Cambridgeshire or Peterborough with the legal status of ‘freed for adoption’, ‘youth justice legal statuses’ or ‘detained on child protection grounds in LA accommodation’, and these are not represented in the figure.

![Figure 12. Percentage of looked after children by legal status](image)

**Placement characteristics**

The vast majority of LAC in both Cambridgeshire and Peterborough were in foster care (72% and 79% respectively). Table 5 below summarises types of care placements in both areas.

**Table 5. Type of care placement of LAC in Cambridgeshire and Peterborough as at 31.03.09 (%).**

<table>
<thead>
<tr>
<th></th>
<th>Foster placements</th>
<th>Placed for adoption</th>
<th>Placement with parents</th>
<th>Other placement in community</th>
<th>Secure units, children's homes and hostels</th>
<th>Other residential settings</th>
<th>Residential schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridgeshire</td>
<td>72</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>11</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Peterborough</td>
<td>79</td>
<td>5</td>
<td>5</td>
<td>-</td>
<td>6</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>
Within the 12 months up until 31st March 2009, 6.5% of LAC in Cambridgeshire and 6.7% of LAC in Peterborough experienced three or more placements over the course of the year, which is below the national average of 10.7%. This statistic is one of the national indicators (NI62) for looked after children which aim to measure how well England as a nation is doing in terms of improving conditions for LAC. Another national indicator (NI63) is the percentage of LAC under age 16, who have been in care continuously for at least 2½ years and have spent at least two years in the same placement. Nationally, 67% of these LAC have spent at least two years in the same placement, while in Cambridgeshire and Peterborough the percentage of LAC in a stable placement for at least two years are 61% and 77.3% respectively. In Cambridgeshire, 47% of LAC were placed in accommodation less than 20 miles from their home, while in Peterborough, a higher proportion of LAC were placed within 20 miles of their home (71%). The figure for Peterborough is similar to the percentage of LAC throughout England who are placed within 20 miles of their home (72%), however the figure for Cambridgeshire is considerably lower. Of all placements, 54% and 46% in Cambridgeshire and Peterborough respectively were within the local authority boundary, both of which are lower than the national figure of 61% of children who are placed in accommodation within the boundaries of the responsible local authority.

**Caseloads for professionals working with Looked After Children**

Although no published data are available regarding caseloads for social workers and other professionals working with Looked After Children nationally, three localities in Cambridgeshire provided a general picture of the current caseloads of their teams. One team reported having 127 cases open (each ‘case’ representing an individual child) with 7.5 staff in the department; and caseloads varied from about 9 for part-time staff to 27 for a senior social worker. Another team had 101 open cases with 12 workers (2 senior social workers, 5 social workers and 5 senior child and family workers) in the department; and caseloads ranged from around 10-15 for a social worker to 5-8 for child and family workers, although a number of child and family workers also co-worked cases with qualified social workers. The third team reported having around 300 open cases and 25 staff (approximately 10 social workers and 15 personal advisors), and caseloads ranged from about 12 for a newly qualified social worker, 16 for a social worker, and 16-20 for a personal advisor.

Managers pointed out that when allocating cases, as well as just ‘the numbers’ factors such as the experience and qualifications of the worker are considered. Generally those in the roles of personal advisor and child and family worker are not qualified social workers, so there are restrictions in the types of cases they take and often they may co-work cases with a qualified worker, performing tasks such as supervising contact and life story work. Adoption and legal work can only be completed by a social worker who has been qualified for at least three years. Other considerations mentioned by managers included skills – for example, who could do life story work well if that was required for a case; and the driving distance – one team manager commented that some of the workers drove more than 1000 business miles per month to visit children in placements.
Outcomes for looked after children

Data about outcomes for looked after children (including education, employment, health and criminal activities) can be found in a further government statistical release, which covers a 12 month period ending 30th September 2008. During this period, there were 225 children in Cambridgeshire and 200 in Peterborough who were school-aged and had been looked after for at least 12 months. Of these children, 80 (35%) in Cambridgeshire and 85 (43%) in Peterborough had a statement of Special Educational Need (SEN) – both higher than the national average of 27.9%; however this can be seen as a positive outcome as it means that the extra needs of these children have been identified and addressed. There were no permanent exclusions in Cambridgeshire or Peterborough (compared to 0.5% nationally) and in Peterborough school attendance for looked after children was good, with only 5% of LAC missing more than 25 days of school. In Cambridgeshire 12% of LAC missed more than 25 days of school, which is very close to the national average of 11.9%.

Regarding educational achievement, data for Key Stages 1-3 are presented in Figures 13-15, and indicate that overall looked after children do not perform as well academically at school as the rest of their age cohort. For example, at Key Stage 1 the percentages of all children attaining the target levels for reading, writing and mathematics were 84%, 80% and 90% respectively, whereas for looked after children the percentages were considerably less at 57%, 50% and 62%. There are small differences in achievement depending on subject area (e.g. more children reached targets for mathematics than writing) or on geographical location (e.g. the percentages of all children in Peterborough reaching Key Stage 1 targets were slightly lower overall); but in general the graphs show that much lower percentages of LAC attain target educational levels from as early as Key Stage 1 (Year 2 at school) when compared with all children. This trend remains at Key Stage 2 (Year 6 at school) although the gap between all children and LAC appears to widen a little (the percentages of all children achieving targets remains mostly constant, but drops slightly for LAC). At Key Stage 3 (Year 9 at school) there were no data included in the above-mentioned statistical release regarding all children; however data published from another statistical release from the same year was used. The data shows that the achievement gap between looked after children and all children nationally widens again at Key Stage 3.

Similar trends were observed when looking at the data for GSCE grades achieved by looked after children compared with all children, shown in Figure 16. Again the percentages of LAC achieving GCSEs were much lower than the national average. In Peterborough GSCE achievement appeared particularly low, with just 41% of LAC achieving 1 A* to G grade GCSE or an NVQ. There are some categories with no data reported (i.e. 5 GCSEs at A* to C grade in both Cambridgeshire and Peterborough, and 5 GCSEs at A* to G grade in Peterborough), which indicates that there were less than 5 people in this category. Nationally, 68.8% of LAC in Year 11 sat for GCSE examinations. This figure was slightly higher in Cambridgeshire (70%) but in Peterborough only 45% of LAC in Year 11 sat for at least one GSCE examination.
Figure 13. Percentage of children at Key Stage 1 achieving target level for the age group

(NB: No figures were supplied for LAC in Peterborough at Key Stage 1 as there were only a small number of eligible children old enough to take Key Stage 2 tests and percentages would have been based on less than 5 children).

Figure 14. Percentage of children at Key Stage 2 achieving target level for the age group

(NB: Some data for Peterborough were not reported due to low numbers).
Figure 15. Percentage of children at Key Stage 3 achieving target level for the age group

Figure 16. Percentage of young people achieving GCSE grades

Looked after children were also more likely to not be in full-time education at Year 11 age (around age 16). Nationally, 69% of LAC are in full-time education at Year 11 (compared with 82% of all young people of that age), while 15% of LAC are in full-time or part-time training or employment (compared with 11% of all young people that age) and 16% of LAC are unemployed, which is four times the percentage of all young people who are unemployed at that age. In Cambridgeshire, higher percentages of all young people and of LAC specifically remain in fulltime education at Year
Only small numbers of LAC in Cambridge were in training or employment, or were unemployed, therefore no percentages were reported. However in Peterborough the percentages of all young people and of LAC specifically who remained in fulltime education were lower (76.9% and 63.6% respectively). There were no LAC in Peterborough known to be in fulltime employment or training, but 36.4% of LAC at this age were unemployed (compared with just 6.5% of all young people at Year 11).

There were higher rates of youth offending in looked after children aged 10 and above than in all children nationwide. In the 12 months ending 30th September 2008, 8.8% of looked after children nationally had been cautioned or convicted during the previous year, compared with 4.3% of all children between ages 10 and 17. In both Cambridgeshire and Peterborough, slightly less children than the national average (4%) had been cautioned or convicted during that 12 month period. This figure was exactly the same for looked after children in Cambridgeshire, indicating that LAC in this area do not exhibit higher than average youth offending. However in Peterborough 8% of LAC had been convicted or cautioned in the previous 12 months, which is double the local average for all children between 10 and 17 years of age.

Looked after children are required to attend health checks at least annually to ensure that their development is on track and there have been no over-looked health needs. In Cambridgeshire and Peterborough, 96% and 95% respectively of pre-school aged children (5 or younger) had up-to-date developmental assessments, which is higher than the national average of 87.5%. For all children who had been looked after for at least 12 months, both Cambridgeshire and Peterborough again performed above the national average in keeping health assessments, dental checks and immunisations up to date. These figures are presented in Table 6.

Table 6. Health checks completed for LAC in the whole of England, and in Cambridgeshire and Peterborough localities as at 30.09.08 (%)

<table>
<thead>
<tr>
<th></th>
<th>Immunisations up to date</th>
<th>Teeth checked by a dentist</th>
<th>Annual health assessment completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>82.3</td>
<td>87.3</td>
<td>86.5</td>
</tr>
<tr>
<td>Cambridgeshire</td>
<td>90</td>
<td>98</td>
<td>93</td>
</tr>
<tr>
<td>Peterborough</td>
<td>93</td>
<td>93</td>
<td>96</td>
</tr>
</tbody>
</table>

Nationally, 4.9% of LAC had a substance misuse issue identified (and of these, 63% received an intervention for this issue). In Cambridgeshire only 5 LAC (2%) were identified as having a substance misuse issue, though it was not recorded how many of these received or refused intervention. In Peterborough, figures were omitted in the document which indicates that less than five individuals would have been identified as having a substance misuse issue.

**Mental health**

Nationally, the Strengths and Difficulties Questionnaire (SDQ) is used with LAC to highlight potential emotional and behavioural problems (with a higher score indicating more difficulties). The average score on the SDQ for all looked after children nationally is 13.9. This is higher than the general
population averages for Britain of 8.4 for parent report and 6.6 for teacher report which were published in 2000. Looked after children in Cambridgeshire appear to fare a bit better than LAC in other regions, scoring on average 7.4 on the SDQ; however this estimate should be interpreted with caution as the figure includes 10% or more children with a score of 0, possibly indicating a response bias. In Peterborough, the average score on the SDQ is 20.7, which suggests LAC in Peterborough are in general experiencing higher than average emotional and behavioural difficulties even for looked after children.

It was reported to Children’s Services Mapping that in 2008/2009, 6% of service users within the Cambridgeshire and Peterborough Foundation Trust were looked after children. This translated to 101 individuals, which indicates that approximately 13% of LAC in Cambridgeshire and Peterborough (based on the numbers as at 31.03.09) were accessing CAMH services.

**Mental health pathway for LAC involving CAMHS**

A pathway for LAC with emotional and behavioural problems is outlined in chapter 25 of the Cambridgeshire looked after children manual. The information is the most recent currently available, however, some aspects of the processes outlined here may be subject to revision (see Figure 17 for an accompanying graphical illustration of the pathway). The document is designed to explain the four tier CAMHS system to social care professionals and assist them in identifying problems and offering early intervention for looked after children, who are a population with higher than average mental health need. In Cambridgeshire, social care professionals can consult with FAST Mental Health (Fostering, Adoption and Sixteen plus Team Mental Health), who will give advice on the most appropriate service to refer to. It is stated within the 16+ Advisor Service policy document that mental health needs of looked after young people should be covered within their needs assessment and Pathway Plan (see chapter 4). There are also two consultant psychiatrists who work specifically with LAC.

**At TIER 1:** Discussion and clarification should be sought with the health professional that completed the Looked After Child health assessment, for example the GP, Paediatrician, LAC Nurse. Discussion should also take place with the Educational Service for Looked After Children as to their involvement and knowledge of the child. An informed decision will then be made as to an appropriate course of action such as continuing professional support or referral. Local advice and counselling services are available for children and young people to access such as, Centre 33 and Timestop. School Support Services, Educational Services for Looked After Children (ESLAC) and Connexions are also able to offer counselling, support, information and advice.

**At TIER 2:** The Educational psychology service will be involved in assessing children with regard to their educational needs. If a mental health concern is identified the concern will be discussed with other professionals and referrals made as necessary.

Advice and guidance can be sought from FAST Mental Health (Fostering, Adoption and Sixteen plus Team Mental Health) about the appropriate course of action for concerns that are not resolving or becoming more severe. Referrals may be directed to Accessible Independent Counselling Services (AICH) or the local multi-agency allocation group (MAAG) for allocation of an appropriate service. Referrals are made through the completion of a common referral form.
At TIER 3: The FAST Mental Health addresses as priority; Youth Care Challenge, children in residential care and youth care. They also offer consultation to foster carers, adoptive parents and social workers around placement breakdown. The service holds a remit for training and attending foster carers support meetings. Consultant psychiatry (psychotherapy) offers a mental health advice service to the countywide 16+ team and other professionals working with older adolescents leaving care. At Brookside Consultation Clinic, fostering and adoption social workers may discuss concerns regarding children living in the catchment area with the liaison team. The outcome of this discussion may include referral to MAAG, referral to the Fostering and Adoption Psychology Team or referral to CAMH services.

Specialist CAMH Services

Referrals can be discussed with the Primary Mental Health Workers in each team: Cambridge, Fenland and Huntingdon. The Child & Adolescent Mental Health Service prioritise referrals as falling within categories 1, 2 or 3. Category 1 referrals are seen within a week, category 2 referrals within six weeks and category 3 will wait on the routine list until a space is available (12 weeks). To keep waiting times to a minimum, it would be helpful for alternative referrals to be considered for those in category 3 as other agencies/interventions may be easier to access and more effective than a referral to CAMH.

At TIER 4: The mental health services available at this tier are inpatient services and are only accessible via a referral from Tier 3 services.

Referral categories for CAMH are shown in Table 7.

**Table 7. CAMH Referral categories identified by LAC team**

<table>
<thead>
<tr>
<th>1. Urgent (seen within 1 week).</th>
<th>2. Significant Mental Health Problems (generally seen within 6-8 weeks).</th>
<th>3. Clients to be seen within 12 weeks of allocation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severely depressed.</td>
<td>• School refusal (acute onset).</td>
<td>Everything else e.g.</td>
</tr>
<tr>
<td>• Psychosis – acute onset.</td>
<td>• Depressed.</td>
<td>• mild depression.</td>
</tr>
<tr>
<td>• Significant self harm.</td>
<td>• Self harm.</td>
<td>• acute onset behaviour disorders.</td>
</tr>
<tr>
<td>• Known suicidal intent.</td>
<td>• Obsessive Compulsive Disorder.</td>
<td>• bullying/peer relationship difficulties.</td>
</tr>
<tr>
<td>• Acute onset/rapid deterioration Anorexia Nervosa.</td>
<td>• Phobia - acute onset.</td>
<td>• acute family breakdown.</td>
</tr>
<tr>
<td>• Acute onset school refusal where there has been previously good functioning.</td>
<td>• Anorexia Nervosa.</td>
<td>• Phobias affecting current quality of life.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bipolar Disorder.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• abuse follow up work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• behaviour disorders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• long-standing family dysfunction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• non-disruptive phobias.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• adjustment reactions to fostering/adoption/family breakdown.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ADHD/ Asperger’s Syndrome.</td>
</tr>
</tbody>
</table>
**School Support Services/ESLAC**

Education Support for Looked After Children (ESLAC) is a team of qualified teachers. The team offers countywide support to Looked After Children in both primary and secondary schools offering direct help. The ESLAC teachers monitor and support the educational progress of all looked after children and assist designated teachers and social workers with the completion of personal education plans (PEPs) for every looked after child in school.

ESLAC teachers have a designated range of schools and responsibility for the looked after children in those schools. They provide specific support at key points in those children's education, such as transition from nursery to primary school and primary to secondary school, SATs and GCSEs. They can also give extra support when it is most needed, for example, when a child first comes into care, when they move foster placement or pending their adoption. Because of its specific focus, the team has developed expertise on all matters relating to the education of looked after children. It is therefore the key point of contact in this regard for the Office of Children and Young Peoples Services (OCYPS), the Education department and other agencies, both within and outside Cambridgeshire.

**Multi agency Allocation Group (MAAG)**

Any agency can make a referral to be considered at a MAAG panel by completing a referral form to the local OCYPS team.

Services that can be accessed through this group are:

- Behaviour difficulties - FABS (Fenland Team), HUBS (Huntingdon Team), CABS (Cambridge)
- Routines
- Family relationships
- Helping you find support in your local community
- Lifestyle issues
- Basic care
- Ensuring safety
- Bonding and attachment
- Guidance and boundaries
- Family security
- Assessing parenting capacity and identifying strengths and areas for development
- Stimulation and play
Figure 17. A care pathway map for Looked After Children with emotional and behavioural problems
Leaving care

Across England, in the year ending 31st March 2009 there were approximately 24,700 children and young people who ceased to be looked after for a variety of reasons. Of these, there were 8,700 young people who were ‘care leavers’ at 16 or above and making the transition to independent living. There were more male care leavers (61%) in this year than females. Their age upon leaving care is presented in Figure 18. Almost 40% of young people left care before they were 18, however the vast majority left at age 18. Only 1% remained in care after their 18th birthday.

Figure 18. Age on leaving care

For most care leavers, their final placement before leaving care was a foster placement, however the final placement for significant proportions of care leavers was in a children’s home or other community placement. Table 8 summarises the final placements of care leavers.

Table 8. Final placements of LAC in England who left care in the year ending 31.03.09 (%)
In the year ending 31st March 2009, there were 80 care leavers aged 16 and above in Cambridgeshire, and 45 in Peterborough. Most of the published data for care leavers were provided for the whole of England but have not been provided at locality level. However, the national data give an indication of what the characteristics of these young people might be.

**Adult life for former looked after children**

There is some information available on the current activities of young people who were 16 on 1st April 2006 and looked after at that time (they were 19 as at 31st March 2009). In Cambridge, 34% of these former looked after children were in full-time education, although nothing beyond A level. A further 25% were in full-time training or employment, and 30% were not in employment, education or training (NEET) for reasons other than illness or disability. In Peterborough, 27% were in fulltime education, 31% were in fulltime employment or training, and 31% were NEET. By comparison, of all LAC nationally 7% remained in higher education beyond A level, 26% remained in other further education below A level (23% full-time, 3% part-time), 30% were in training or employment (21% full-time, 9% part-time), and 31% were NEET (5% due to illness or disability, 26% for other reasons). At age 19, 14% of former looked after children in Cambridgeshire who were 16 in April 2006 were living in ordinary lodgings, and 61% were living independently. In Peterborough, 42% were reported to be living independently and 27% were living with family or relatives. Other options for which there were no recorded cases included community home, semi-independent transitional accommodation, supported lodgings, foyers, emergency accommodation, bed and breakfast, in custody, or other. Nationally, 43% of former LAC were living independently at this time while small percentages had made use of these other types of supported accommodation.

The statistics presented here should be interpreted with a degree of caution. There are generally small numbers of looked after children which often means that percentages are based on small sample sizes, particularly when broken down by various categories, and some data were withheld due to very low numbers in certain categories. However, these figures do provide a general snapshot of recent cohorts of looked after children in Cambridgeshire and Peterborough, giving an idea of some of the challenges they may be facing as a group.
4. Mental health and social care policies for children and young people in Cambridgeshire and Peterborough

National policy – the wider context

The care and services available for young people within a given area are influenced by a number of important policies at national, local and sometimes service-specific levels. At a national level there is legislation, as well as white and green papers released by the government, which set out the rights of service users and requirements for service providers for all people across the nation.

One of the most important national directives with regards to children and young people was the 2003 green paper ‘Every Child Matters’ (which informed the 2004 revision to the Children Act). The overarching goals of Every Child Matters are that all children should be supported to: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being. These five points are employed nationwide as outcome criteria for how well local authorities are performing with regards to caring for children and young people. The Children Act (2004) requires all local authorities to develop a Children and Young People’s Plan which sets out how the local authority plans to address these five criteria. The National Service Framework for Children, Young People and Maternity Services published by the Department of Health further elaborates on standards of good practice for the NHS and local authorities across a number of domains.

Every Child Matters and the follow-up publication ‘The Children’s Plan’ emphasise collaboration between organisations within a local authority and aim to address the overall well-being of children and young people. Other national legislature relevant to children and young people address particular aspects of well-being, as detailed below.

Child and Adolescent Mental Health Policy

National Service Frameworks (NSFs) help set the standards for healthcare nationwide. There are two particular NSFs that are relevant to the mental health of children and young people: the National Service Framework for Children, Young People and Maternity Services (particularly Standard 9 ‘The Mental Health and Psychological Well-being of Children and Young People’) and the National Service Framework for Mental Health, described in the 2009 ‘New Horizons’ report.

Transition between CAMHS and AMHS (adult mental health services) has been identified as an area requiring attention. Both NSFs referred to above highlight factors related to transition, such as the importance of age-appropriate service provision for children and young people; access to services for all young people (it was noted that 16-17 year olds sometimes ‘fell in the
A gap’ between child and adult services); and the need to support and improve the transition between CAMHS and AMHS1-2.

The Health and Social Care Advisory Service (HASCAS) recently conducted a study focusing on this issue of transition, and published a Literature Review for Informed Practice as well as an annotated bibliography and a self-assessment checklist to assist local authorities. Recommendations from this study include making the change more gradual over a longer period, involving young people in making choices about their services, improving continuity of care perhaps by implementing a case management approach, and creating a role for a transition worker to be a consistent point of contact during the process25-26.

While there is no national policy specifically addressing how transitions from child to adult mental health services should happen, some documents make explicit recommendations (such as the NSFs) and many local authorities have developed policies regarding service transition.

**Looked After Children**

The Department of Health ‘Framework for the Assessment of Children in Need and their Families’ discusses in general how children known to social services should be assessed. The framework states that children may be defined as ‘in need’ for a variety of reasons and the extent of that need will vary according to their circumstances27. The following diagram illustrated in Figure 19 (from page 3 of the Framework) illustrates some of these different levels of need within social care.

![Figure 19. Representation of Extent of Children in Need in England at any one time.](image)
The group within the dashed line represents all children who would be known to social services. Children Looked After are a sub-group defined by the need for temporary or permanent accommodation away from their family home. There are two main routes into care – through a care order, or through voluntary accommodation. Care orders are court orders usually obtained by a local authority when they believe a child to be suffering (or likely to suffer) significant harm due to the care currently given to them. Voluntary accommodation may occur for other reasons, such as if a parent is ill and temporarily unable to care for their child; however under a voluntary order a parent can cease accommodation whenever they choose. There are generally more children in care under court order than voluntarily.28

While the Children Act (2004) sets forth the provision about services for children and young people to be provided to their local authorities, a sub-section specifically addresses the needs of children who have been looked after by the local authority and are now leaving that care. The Children (Leaving Care) Act 2000 is based largely on responses to the consultation document ‘Me, Survive, Out There? – New Arrangements for Young People Living in and Leaving Care’, published in 1999, which stated that care leavers were forced to become independent much earlier than many young people and thus advocated greater support and better preparation for care leavers.29

The Children (Leaving Care) Act 2000 sets out that for young people eligible under the Act (i.e. they have been looked after for at least 13 weeks since age 14 and are now 16 or above), the local authority must conduct a needs assessment within 3 months of the young person turning 16, which forms the basis of their own personal Pathway Plan, which sets out how their needs will be addressed at least until their 21st birthday. The Pathway Plan should address the needs for personal support, accommodation, education and training, employment, family and social relationships, practical skills, financial support, health needs and contingency planning. The Act also stipulates that each young person be allocated a Personal Advisor, who is responsible for helping the young person implement the Pathway Plan.10

Transitions policies in Cambridgeshire and Peterborough

Cambridgeshire and Peterborough Foundation Trust (CPFT) – Mental health

The CPFT have implemented a transition protocol from CAMHS to AMHS, from May 2008. The protocol sets out its purpose as ensuring that young people with continuing health problems are supported in the transition from CAMHS to AMHS, and also to give guidance on providing age-appropriate inpatient care for young people.9 The protocol states that plans should be consistent with the Care Programme Approach, which is the nationally adopted approach for working with people with mental health needs, with four main aspects: assessment, a care plan, an appointed key worker, and regular review. Other principles of the protocol include that young people and their carers should be involved in the transition planning, that they should be
given a choice of services, and that throughout the transition it must be made explicit to all involved which service currently has lead clinical responsibility.

The protocol states that the criteria for a young person to transfer from CAMHS to AMHS are that “the young person has symptoms which indicate a psychosis or major mental illness, or the young person has mental health/psychological needs which are likely to continue into adulthood, or an enduring mental health problem”. It is the responsibility of CAMHS to identify all young people at or nearing age 17, who they feel meet the criteria, and to begin planning for transfer 3-6 months before the potential transfer date.

CAMHS will make a formal transfer request in writing to AMHS, who will appoint an assessor. The assessor will liaise with the current CAMHS case worker and a joint meeting will be arranged involving the CAMHS case worker, the AMHS assessor, the young person and their carer. After assessment a further joint meeting will be held, at which a transfer date and a care co-ordinator will be identified, and responsibilities will be agreed upon. The transfer plan should then be implemented and reviewed by the group within 6 months.

If the assessment has found that the young person does not meet AMHS criteria, alternative services should be discussed at the meeting. If the young person is to be referred to other services not provided by the Trust, the same procedures should be followed as much as possible.

**Cambridgeshire County Council – Leaving Care**

A policy document for the Young People’s 16+ Advisor Service is available to download on the Cambridgeshire County Council website. The content is heavily based on the Children (Leaving Care) Act 2000, but elaborates on timeframes and specific requirements in the transition ‘process’, including standards for the areas that the needs assessment should address.²²

The Cambridgeshire policy states that six weeks before an eligible looked after young person turns 16, their social worker will request assistance from the 16+ advisory service in completing a needs assessment. It is expected that a 16+ Advisor will be allocated to the young person at this point; and the 16+ Advisor, LAC social worker and the young person will meet to complete the needs assessment (and potentially other relevant people including carers, education, health, etc). The assessment must be completed within three months of the young person’s 16th birthday, but if it is already known that the young person will leave care at 16 the meeting should be brought forward.

The next step is the creation of the Pathway Plan, which will be based on the needs assessment and should look ahead at least as far as the young person’s 21st birthday. All looked after young people will already have a care plan in place which is reviewed regularly throughout their time in care; the Pathway Plan replaces this. When the Pathway Plan is completed, the 16+ Advisor assumes case responsibility for the young person and is known from then as their Personal
Advisor. The Personal Advisor will be responsible for preparing, implementing and reviewing (at least every 6 months) the Pathway Plan, but they are also there to provide support and advice, and to help the young person link up with appropriate services. It is recognised that the support role will vary depending on how much support the young person already has from their own network, but it is expected that the Personal Advisor will be in touch with the young person at least every six months until they are 21.

The Cambridgeshire County Council policy states that they wish to encourage young people to stay in care until at least age 18, however the local authority is required to provide care leavers with appropriate accommodation while under 18 if they do not wish to remain in their placement after 16, and to help them apply for council housing at 18. Eligible 16 and 17 year olds should also be financially supported by the local authority to a level at least equivalent with what they would receive on benefit. Care leavers are also eligible for a leaving care grant which is designed to help them purchase essential furniture and household items, and there are further financial incentives if they are in full-time education such as deductions from student loans and funding towards vacation accommodation.

The exception to the above is when the looked after young person has a disability that will prevent them from living as an independent adult. In this case, they will not be referred to a 16+ Advisor, but a Social Services Transition Worker. This is discussed in more detail within the document ‘Transitions Protocol from Children’s to Adult Services for young people requiring support in adult life’\textsuperscript{30}, available from the Cambridgeshire County Council website. Young people who are likely to need support as an adult due to disability are usually identified in school Year 8, at which point the Transitions Team would become involved (although the Children’s team would continue to hold the case). Over the next 6 years the transitions service will coordinate annual reviews involving social care, specialist workers from Connexions, relevant education representatives and other relevant organisations; taking into account the young person’s wishes as much as possible. After the young person turns 19 the Transitions Team will facilitate the case transfer to Adult Social Care, and participate in a review six weeks after transfer before ceasing involvement.

**Peterborough City Council**

Peterborough works within the same broad framework as Cambridgeshire and all other local authorities nationwide. Although there does not appear to be a downloadable policy regarding looked after children or leaving care currently, Peterborough City Council has a lot of information online aimed at explaining the process to young people in the care system\textsuperscript{11}, as well as a brochure for care leavers which explains what they are entitled to\textsuperscript{31}. This brochure goes through a number of points for children leaving Local Authority care, including:
- **What they are entitled to:** advice on living expenses, and financial help in further education
- **How the council can help:** all leaving care will be named a Leaving care Personal Advisor who gives advice and help with the pathway plan
- **The pathway plan:** advice on how to get a job, accommodation needs, and health issues
- **Entitlements for 16-17 year olds:** assessment of their needs and advice on Job seeker’s allowance if not working, and Local Housing allowance
- **Entitlements for 18-21 year olds:** financial help for employment and education
- **Advice on setting up home:** leaving care grant and other support such as Income maintenance allowance, special clothes and equipment for new job, support to maintain contact with their family, and Christmas allowance
- **Information on accommodation:** help finding suitable accommodation such as support lodgings with their own room
- **Connexions:** information about connexions and the contact details of a Connexions advisor
Conclusions and Future Directions

This mapping exercise was specifically designed to inform the CLAHRC Child and Adolescent theme research programme, which is primarily concerned with the transition from child to adult mental health services. The aim was to outline the current services for young people in Cambridge and Peterborough with a particular focus on the quantitative aspects of services and populations. We have concentrated on CAMH Services and Social Services who both provide for groups of children and young people that have or are particularly vulnerable to developing serious mental health problems. The report provides a comprehensive descriptive overview of the current complexion of local services and includes an initial sketching out of potential pathways that young people may take in receiving advice and treatment for mental health difficulties. In addition, as Looked After Children are over-represented in the mental health statistics, a full review the quantitative aspects of this local population was included here.

The report is, however, necessarily limited in several aspects. First, the experience of providing or receiving services in either CAMH or Social Care is not addressed. Future qualitative components of the research will be able to speak more directly to the phenomenological nature of being part of a service and the process of making a transition from care to independent living or from child to adult mental health services is like for service users and providers. Similarly, gaining insight to the managerial perception of the way transitions work in the area is thought to be an essential, instructive part of future work.

Second, although the report has outlined the key adult mental services, considerably less space has been devoted to mapping these services. It was thought that an initial focus on the child services was logical given that transitions originate from child services. Nevertheless, it is clearly important to describe and understand more about adult services as they are involved in the decision making process for each individual who may be considered suitable for adult services and ultimately are involved in setting the criteria for referral. In a similar vein, the report has excluded a systematic study of the voluntary organisations that provide services in the area. Although doubtless of the utmost importance, a review of the voluntary was beyond the scope of the current report.

This report has laid the foundations for the next phase in the CLAHRC theme programme by outlining services and beginning to describe the target populations. The next step will involve a fuller description of the mental health and service use of cohorts of young people attending CAMH services and young people in care. Both will be of the age where a transition from services will be imminent. Each individual studied will either be on the cusp of moving to independent living/transferring to adult mental health services or will be staying in care/being discharged from CAMH. In turn these cross-sectional studies will inform subsequent longitudinal work by highlighting the potentially important variables that may predict successful outcomes for young people.
Children's Global Assessment Scale (CGAS)

David Shaffer, M.D., Madelyn S. Gould, Ph.D. Hector Bird, M.D., Prudence Fisher, B.A. Adaptation of the Adult Global Assessment Scale (Robert L. Spitzer, M.D., Nathan Gibbon, M.S.W., Jean Endicott, Ph.D.)

PLEASE RECORD A CGAS SCORE EVEN IF THIS IS BASED ON YOUR MEMORY OF THE YOUNG PERSON'S FUNCTIONING AT THE TIME OF REFERRAL. THE DATE OF RATING IS REQUIRED ONLY IF THIS WAS RECORDED CLOSE TO THE TIME OF THE 'INDEX' REFERRAL.

<table>
<thead>
<tr>
<th>CGAS Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-91</td>
<td>DOING VERY WELL&lt;br&gt;Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and has many interests (e.g. has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc.). Likeable, confident, everyday worries never get out of hand. Doing well in school. No symptoms.</td>
</tr>
<tr>
<td>90 - 81</td>
<td>DOING WELL. Good functioning in all areas. Secure in family, school, and with peers. There may be transient difficulties and “everyday” worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally “blow-ups” with siblings, parents or peers).</td>
</tr>
<tr>
<td>80 – 71</td>
<td>DOING ALL RIGHT – minor impairment&lt;br&gt;No more than slight impairment in functioning at home, at school or with peers. Some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g. parental separations, deaths, birth of a sibling) but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them.</td>
</tr>
<tr>
<td>70 – 61</td>
<td>SOME PROBLEMS - in one area only&lt;br&gt;Some difficulty in a single area, but generally functioning pretty well, (e.g. sporadic or isolated antisocial acts such as occasionally playing hooky, petty theft; consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties which do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.</td>
</tr>
<tr>
<td>60 – 51</td>
<td>SOME NOTICEABLE PROBLEMS – in more than one area Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.</td>
</tr>
<tr>
<td>50 – 41</td>
<td>OBVIOUS PROBLEMS – moderate impairment in most areas or severe in one area&lt;br&gt;Moderate degree of interference in functioning in most social areas or severe impairment functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.</td>
</tr>
<tr>
<td>40 – 31</td>
<td>SERIOUS PROBLEMS – major impairment in several areas and unable to function in one area&lt;br&gt;Major impairment in functioning in several areas and unable to function in one of these areas, i.e. disturbed at home, at school, with peers or in the society at large, e.g. persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or through disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).</td>
</tr>
<tr>
<td>30 – 21</td>
<td>SEVERE PROBLEMS - unable to function in almost all situations&lt;br&gt;Unable to function in almost all areas, e.g. stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g. sometimes incoherent or inappropriate).</td>
</tr>
<tr>
<td>20 – 11</td>
<td>VERY SEVERELY IMPAIRED - considerable supervision is required for safety&lt;br&gt;Needs considerable supervision to prevent hurting others or self, e.g. frequently violent, repeated suicide attempts OR to maintain personal hygiene! OR gross impairment in all forms of communication, e.g. severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.</td>
</tr>
<tr>
<td>10 – 1</td>
<td>EXTREMELY IMPAIRED - constant supervision is required for safety&lt;br&gt;Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene.</td>
</tr>
</tbody>
</table>

Specified time period: 1 month

CGAS SCORE =
## Referral Problem Types

<table>
<thead>
<tr>
<th>Problem</th>
<th>Criteria for referral</th>
</tr>
</thead>
</table>
| **Depression or Mood Disorder** | - Where the difficulties are beyond age-appropriate mood variation.  
- Where there is an impact on daily living – e.g., sleeping, eating, etc.  
- Where there is positive family history of mental illness or suicidal ideation.  
- At least 2 weeks duration, unless an urgent or emergency presentation                                                                                     |
| **Self-harm**                   | - Where there is concern about self-harm, in context of other difficulties, consider discussing the case with a clinician at Child and Adolescent Mental Health Team to help determine the level of priority, before making a written referral. If deemed urgent the GP should be consulted first who can then advise on urgency and refer to CAMHS as necessary  
- Acute Overdose cases should be sent directly to the nearest Hospital with an Accident & Emergency Department for immediate medical care, NOT referred to the Child and Adolescent Mental Health Service.  
- If the overdose was historical then get advise from GP (or A and E) as soon as possible and GP to consider referral to CAMHS                                                                 |
| **Anxiety including Post Traumatic Stress Disorder** | One or more of the following:  
- Where it is affecting the child’s/young person’s development or level of functioning.  
- Where there is an impact on the parent/carer/child relationship.  
- Where there is a sudden change or deterioration.  
- At least 2 weeks duration, generally 4 or more weeks                                                                                                         |
| **Obsessive-Compulsive Disorder** | Please consider an early consultation and possible referral.                                                                                                                                                            |
| **Psychosis**                   | Request urgent/emergency GP assessment and ask GP to decide if necessary to refer immediately to the Child and Adolescent Mental Health Service, including those secondary to substance misuse                                         |
| **Eating Disorders**            | (anorexia, bulimia, food avoidant emotional disorder, fear of choking or vomiting and highly selective eating) Where there is concern in relation to eating disorders, please consider an early referral to the service.  
- If considered urgent please ask GP to review and refer as necessary  
- It is helpful to complete medical investigations (Bloods, weight/height etc) via the GP, prior to referral.  
- Note for less severe cases of selective eating and fears about food, ask for support from community Paediatrics or community nurse in first instance or health visitor for young children                                                                 |
| **Complex Neurodevelopmental problems eg** | Difficulties may include:  
- Significant delay in the acquisition of appropriate social skills.  
- Difficulties with the child’s peer group relationships.  
- Unusual or very fixed interests.                                                                                                                             |
| **Aspergers Syndrome, ADHD** | • Marked preference for routine and difficulties adapting to change.  
• Bizarre or unusual behaviours.  
• If query Aspergers please ask Paediatrician to assess first; CAMHS to be involved in cases where there is subsequent diagnostic uncertainty or co-occurring emotional or behavioural disorder requiring specialist CAMHS input  
• If query ADHD needs to show, Hyperactivity, impulsivity, inattention in children over five years of age that is unresponsive to behavioural intervention in the home and school and is persistent in two or more settings e.g. school and home  

**Locality variations**  
• In Hunts area must be seen by community Paediatrician before referral to CAMHS  
• In Fenland area may consider referral without school support services involvement or Paediatricians involvement  
• In Peterborough cases must be seen by the School Doctor/Paediatrician first  
• In Cambridge area if ? ADHD please ensure there has already been assessment by an education service related specialist; such as the SENCO or Ed Psychologist or in -school behaviour support, prior to referral to CAMHS |

| **Tourettes and Complex Tic Disorders** | In the first instance refer to Paediatric services for assessment and management. If they have co-occurring problems of sufficient severity to meet tier 3 CAMHS eligibility such as co-morbid OCD or ADHD or depression etc  
• In cases of severe Tourettes refer to CAMH |

| **Somatisation Disorders, Hypochondriacal, Dissociative, Conversion Disorders, Pain Syndromes & Chronic Fatigue Syndromes, Medical Conditions and Physical Disabilities with mental health complications** | Refer to Paediatricians first then to CAMHS if necessary. Paediatricians have access to some hospital based CAMHS services in each locality for in patients and some paediatric clinics. For ambulant out patients paediatricians can refer to locality CAMHS outpatient service, will need to meet CGAS criteria for impairment. |

| **Severe Behavioural Disorders: Consultation services** | **Locality variations** –  
• **Peterborough** locality CAMHS will only see cases which may have a co-occurring other major mental disorder in addition to the behaviour disorder  
• **Hunts CAMHS** will only see cases which may have a co occurring other major mental disorder in addition to the behaviour disorder  
• **Fenland CAMHS** : refer cases without co-occurring other mental health disorder to the locality MAAG Panel (Multi-Agency Allocation Group).  

**However – There is an expectation that –**  
• **Behaviour at home has been of concern for at least 6 months** – Note: education support services are better placed to provide support where problems are at school.  
• **An attempt should have been made to resolve the difficulties with the help of Tier 1 or Tier 2 service** such as: the Child & Family Nurse, community parenting support eg 123 Magic/Triple P/Webster Stratton, Youth Inclusion Support Project (YISP), education support services, the Youth Offending Service (YOS), Social Care, or
Cambridge/Huntingdon/Fenland/Peterborough Behaviour Services (CABS/HUBS/FABS). If this help has not moved the situation on adequately, it will then be appropriate to refer on to the Tier 3 service.

- For some children and young people, it is not reasonable to suggest referral to Tier 1 or 2 services e.g. because the problem has become too severe. In such cases, we will accept referrals where the behaviour problem is associated with a moderate degree of impairment. Please consider the CGAS scale in the appendix: we will accept referrals where there is interference in functioning in most social areas, or severe impairment in one area i.e. a CGAS score of 50 or below
- The referrer should demonstrate that parents/carers are willing to work with us to bring about change in their own management of the behaviour. For older children/young people, it is also helpful if he/she also wishes to work on his/her own behaviour.
- If there is not motivation to change, we will accept a referral in exceptional circumstances – for example where there is reason to believe that a mental health assessment could be helpful to the child/young person.

<table>
<thead>
<tr>
<th>YOUS (YOung USers) Substance Misuse Services</th>
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<tbody>
<tr>
<td>As funding is different from the rest of CAMHS YOUS team will take referrals up to the 19th birthday</td>
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<tr>
<td>Referral via the usual referral path for the rest of CAMHS</td>
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<tr>
<td>- Has significant mental health issues alongside evidence of dependence on substances</td>
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<tr>
<td>- Or substance use has led to loss of consciousness/overdose</td>
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<tr>
<td>- Self harm in conjunction with substance misuse</td>
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<tr>
<th>Learning disability with enduring challenging behaviour/mental health problems</th>
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<tr>
<td>Please contact the Child &amp; Adolescent Learning Disability (CALD) (for Fenland = Butterfly Team) directly</td>
</tr>
<tr>
<td>- For cases with both a learning disability and mental health problem</td>
</tr>
<tr>
<td>- Including Neurogenetic disorders and epilepsy and head injury with the above criteria met</td>
</tr>
<tr>
<td>- Preschool children where there is evidence of significant developmental delay: should see Paediatrician first to assess prior to CAMHS referral</td>
</tr>
<tr>
<td>- Age limit 19th birthday in Cambridge, Fenland, Huntingdon</td>
</tr>
<tr>
<td>- Age limit 18th birthday in Peterborough, with agreed transition to Adult Services at this time</td>
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<tr>
<th>Attachment Disorders and Under 5 yr olds</th>
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<tr>
<td>NOTE this is the countywide criteria but there needs to be further work with locality/trust/commissioners to implement in all localities of the trust eg Peterborough and Fenland locality CAMHS cannot at this time offer this eligibility</td>
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<tr>
<td>- Significant parent infant relationship concerns</td>
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<tr>
<td>Including difficulties with feeding for example (Cambridge: Feeding Matters/Huntingdon: Feeding To Thrive Group)</td>
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<tr>
<td>- Should involve the community nursing/health visitor first</td>
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<tr>
<th>It is not appropriate to refer:</th>
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<tbody>
<tr>
<td>- Children and young people whose problems are primarily school/college-based. Refer to school/college concerned.</td>
</tr>
<tr>
<td>- Children and young people where the behaviour, although challenging, is age-appropriate.</td>
</tr>
</tbody>
</table>
| **Family difficulties** | Children and young people may present with emotional and behavioural difficulties in response to family stress – e.g., parental discord, divorce or separation. If referrers are aware of these issues, please be aware that parents should be encouraged to make efforts to resolve problems prior to referring the child.  
  - The Child and Adolescent Mental Health Service should not be used to support children in situations where problems first need to be resolved, if possible by parents. Such support can be obtained from other agencies – e.g., Mediation Services and Relate.  
  - The service will not be involved in any legal issues in relation to the separation. Solicitors should commission reports for court from professionals who work on a private basis. |
| **Response to bereavement** | It is not appropriate to refer children/young people with ‘normal’ grief responses to this service. More appropriate support can be offered by other agencies - e.g., Cruse, and Winston’s Wish.  
  - You may want to consider referral when the child/young person is experiencing significant distress following a death that has occurred within traumatic circumstances (e.g. suicide). Or an abnormal grief reaction. In these cases we may choose to meet carers without the child to offer them advice and support |
| **School Refusal** | This is normally the responsibility of the school, college or EWS service therefore refer to education support services first; it would be appropriate to refer to this department when the following conditions apply:  
  - Where there is severe difficulty in the child/young person attending school/college, often amounting to a prolonged absence and where the child is experiencing severe emotional upset on being faced with the prospect of attending school. This may be demonstrated by excessive fearfulness, anxiety, temper, misery, and complaints of feeling unwell without obvious cause.  
  - Where there is an absence of significant antisocial disorders e.g. stealing, destructiveness. |
| **Complex enuresis or soiling** | - In the first instance the specialist community enuresis or constipation clinic or paediatrician should see these children.  
  - We recommend referrals to come from these specialist paediatrics/child health clinics. |
TRANSITION PROTOCOL: CHILD AND ADOLESCENT MENTAL HEALTH SERVICES TO ADULT MENTAL HEALTH SERVICES

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KEY DIRECTORS
Name: Tim Bryson
Job Title: Director of Children’s Services and Nursing

RATIFIED BY FORUM: Healthcare Governance Committee

IMPLEMENTATION DATE: May 2008

REVIEW DATE: May 2010

Signed on behalf of the Trust: .................................
Karen Bell, Chief Executive

Elizabeth House, Fulbourn Hospital, Fulbourn, Cambs CB21 5EF Phone: 01223 726789
Transition Protocol: Child and Adolescent Mental Health Services to Adult Mental Health Services

1. **Purpose**
The purpose of this protocol is to ensure that young people with continuing mental health problems, particularly 16 and 17 year olds, are effectively supported during the transition from child and adolescent mental health services (CAMHS) to adult mental health services or other adult services.

The protocol also gives guidance on inpatient care so that young people with mental health problems receive age appropriate services. The guidance reflects national policy as set out in 'Pushed into the Shadows: Young People's Experiences of Adult Mental Health Facilities' published by the Children's Commissioner, Dept of Health guidance letters and the Mental Health Act 2007.

2. **Principles**

- It must be made explicit by at all times for the young person, his or her parents/carers and for all staff involved which service has the lead clinical responsibility for the young person
- Inter-agency arrangements should be made in ways which are consistent with due regard to confidentiality and personal information sharing
- Young people and their carers should be offered choice over the type of service they are involved in
- Plans should be consistent with the Care Programme Approach
- Co-operation and flexibility should characterise our approach to care planning to ensure the young person is helped by the most age appropriate services
- Young people and their carers should be involved in the transition care planning
- All staff (including bank and agency) on wards admitting young people must have the appropriate and current Criminal Records Bureau (CRB) disclosure
- All staff working with young people have the appropriate training in the needs of young people with mental health problems
- There should be a designated private room for the parents/family of the young people to visit
- Young people should be placed on wards where:
  - there are other young people
  - there is access to education appropriate to their needs, especially those who are of compulsory school age
  - Adult wards have access to games, music and books appropriate for young people
  - Young people have access to computer equipment
The young persons care plan will include access to sports and physical exercise.

- All young people will have access to the Independent Advocacy service and information on how to access this service.

- The importance of the young persons safety is paramount throughout any involvement in Mental Health Services.

### 3.0 Protocol for the Transfer of Care from CAMHS to Adult Services

#### 3.1 Referral

- Young people 17 years old and over will be referred to Adult Mental Health Services. If the young person is under 18 years old CAMH may be asked to be involved in the assessment and planning of the needs of the young person.

- Young people 16 years old and under will be referred to CAMH services.

#### 3.2 Criteria for consideration of transfer of a young person from CAMHS to Adult Services

- The young person has symptoms which indicate a psychosis or major mental illness or

- The young person has mental health/psychological needs, which are likely to continue into adulthood; or an enduring mental health problem.

#### 3.3 Transfer Planning

- CAMH will identify all young people aged 17, or nearing age 17, appropriate for transfer to Adult services, meeting the above criteria. Planning should start 3 - 6 months before potential transfer date.

- There should be effective information sharing between services that is clearly communicated within the transfer process.
• The Care Programme Approach (CPA) process is integral to transferring to adult services
• The young person (and where appropriate their family) will be at the centre of the process, and involved at all stages

3.4 Local Safeguarding Children/Vulnerable Adults
• Information regarding any child protection/vulnerable adult concerns will be clearly communicated within the transfer/referral assessment and planning process.
• Safeguarding children/vulnerable adults procedures will be adhered to at all times.

3.4 Transfer procedure

• The formal transfer will be made by letter to the appropriate Adult Mental health team using CPA guidelines and with the knowledge of the patient/carer and with reference to the Adult Mental health care pathways criteria
• CAMH will maintain responsibility until the young person is transferred to the Adult Mental health team
• CAMH will identify any young people aged 14 - 17years old with a psychotic illness and liaise with CAMEO Early Intervention Service. During this period CAMH will continue to be medically responsible, but CAMEO will be available for advice, support, assessment and any specific interventions where appropriate i.e. groups for the young person or their families or individual work. Where appropriate and by agreement a transfer to the CAMEO service can be undertaken at any point.
3.5 Transfer Assessment

- Adult Mental Health Services will allocate an assessor, who will contact the CAMH case worker/co-ordinator. They will agree the most appropriate method of assessment, which should include a meeting with the CAMH care team, following CPA guidelines, and/or review of current assessments etc.
- A joint CAMH and AMHT meeting should be arranged with the client and carer, with the CAMH case worker/co-coordinator and Adult Mental Health Service assessor.

3.6 Care Planning

When the initial assessment has been completed a meeting will be held (which will involve the young person/family as appropriate) between the assessor, the CAMH care team, and other agencies where appropriate, to discuss the situation, to plan the potential transfer of care and to agree the young person's new care plan. This will include:

- Identification of Care Co-ordinator
- Including planned date for transfer
- Any joint working needed
- Agreement on roles and responsibilities

Where it is agreed that it is not appropriate for a service to be provided by adult Mental Health Services, the CAMH and Adult services will provide advice for the young person and his/her carers about any alternative services that can provide help and support.

A plan will be produced summarising the above.

The transfer care plan will then be implemented and reviewed as appropriate within 6 months. The review will be chaired by the care co-coordinator.
3.7 Discharge from CAMHS to Adult Services

- At the end of the transfer process a discharge letter will be produced by CAMHS and circulated to all involved, including the young person and parents/carers. This may be as a result of a final review, or simply the end of the transfer plan.

3.8 Transfer to other Adult Services
Should the young person be referred to services not provided by the Trust, then the above principles and practice should be followed. Clear transition arrangements should be negotiated with the relevant adult service prior to the actual hand-over of care to ensure the safe and effective transfer. This should always include a communication of the transfer plan arrangements with the young person, their family and the GP, as well as the recipient service and any other key staff involved.

4.0 Inpatient care
There is national guidance for the appropriate access to care for 16 and 17 year olds if they require admission to psychiatric inpatient services (see DoH appendix 1). ‘Pushed into the Shadows: Young People’s Experience of Adult Mental Health Facilities’ Action Plan recommendations will be central to the planning of the young person’s admission (see appendix 2).
This protocol is intended to guide this process. Clinical decision-making should always be made in the light of as full information as possible, and be based on the assessed need and choices of the young person and his/her parents/carers.

For issues concerning young people and consent, reference should be made to the Trust consent policy.

**Under 17’s admission**
A young person under 17 (i.e. before their 17th birthday) who needs to be admitted to an inpatient bed should not be admitted to an adult psychiatric ward.

If a young person under 17 is admitted in exceptional circumstances to an adult psychiatric ward this would require notification through the serious untoward incident (SUI) procedure to the Primary Care Trust, and the Strategic Health Authority.

In this event, the Child and Adolescent Mental Health (CAMH) medical on-call service would be involved and would jointly manage the admission of the young person, and ensure a transfer to an age appropriate facility at the earliest possible time. The Adult RMO would be the responsible doctor, the CAMH Consultant will be involved for consultation and planning for the needs of the young person.
Under 18's admission

Young people aged 17 years, but under 18 years old, requiring admission will have their needs assessed by a psychiatrist trained in the assessment of young peoples mental health problems. A decision as to the most appropriate inpatient admission facility will be jointly reached between the CAMH service RMO and the Adult Mental Health Service RMO. Emergency admission may be required, but the above joint assessment should always be undertaken and an appropriate plan of care discussed and agreed with the young person and his/her parents/carers.

As required by the SHA, all admissions of under 18 year olds will be notified using the SUI procedure, but will not require a SUI review.

5.0 Key References

The key policy guidance documents are:

- Children's NSF 2004
- Every Child Matters - September 2003
- Trust Care Programme approach policy and procedure 2007
- Trust consent policy 2008
- Mental Health Act 2007
- Trust Integrated Business Plan 2008
- DoH Gateway letter 8390 - 27 June 2007 and 3 Sept 2007
  Pushed into the Shadows: Young People's Experiences of Adult Mental Health Facilities - Action Plan - June 2007
References


