Joyce AS, Wild TC, Adair CE, McDougall GM, Gordon A, Costigan N, *et al.* 2004. Continuity of care in mental health services: toward clarifying the construct. *The Canadian Journal of Psychiatry* 49: 539-550.

Kendell R, Jablensky A. 2003. Distinguishing between the validity and utility of psychiatric diagnoses. *American Journal of Psychiatry* 160: 4-12.

Kennedy A, Sloman F, Douglass JA, Sawyer SM. 2007. Young people with chronic illness: the approach to transition. *Internal Medicine Journal* 37: 555 - 560.

Kent RM, Chamberlain MA. 2004. Transition from paediatric to adult neurological services: comment. *Journal of Neurology, Neurosurgery & Psychiatry* 75: 1208.

Kessler RC, Chiu WT, Demler O, Walters EE. 2005. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* 62: 617-627.

Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, Poulton PJ. 2003. Prior juvenile diagnoses in adults: developmental follow back of a prospective longitudinal cohort. *Archives of General Psychiatry* 60: 709-717.

Kipps S, Bahu T, Ong K, Ackland FM, Brown RS, Fox CT, *et al.* 2002. Current methods of transfer of young people with Type 1 diabetes to adult services. *Diabetic Medicine* 19: 649-654.

Knapp M, Perkins M, Beecham J, Dhanasiri S, Rustin C. 2008. Transition pathways for young people with complex disabilities: exploring the economic consequences. *Child: Care, Health & Development* 34: 512-520.

Ko B, McEnery G. 2004. The needs of physically disabled young people during transition to adult services. *Child: Care, Health and Development* 30: 317-323.

Kurtz Z, Street C. 2006. Mental health services for young people from black and minority ethnic backgrounds: the current challenge. *Journal of Children's Services* 1: 40-49.

Lamb C, Hall D, Kelvin R, Van Beinum M. 2008. *Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults. A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists, May 2008.*

Laugharne R, Priebe S. 2006. Trust, choice and power in mental health: a literature review. *Social Psychiatry and Psychiatric Epidemiology* 41: 843-852.

Laws S. 1998. *Hear me! Consulting with young people on mental health issues.* London: Mental Health Foundation.

Layard R. 2005. *Mental health: Britain's biggest social problem?* No. 10 Strategy Unit Seminar on Mental Health, London: Prime Minister's Strategy Unit.

Lee N. 2001. *Childhood and society: growing up in age of uncertainty.* Buckingham: Open University Press.

Lotstein DS, McPherson M, Strickland B. 2005. Transition planning for youth with special health care needs: results from a national survey of children with special health needs. *Pediatrics* 115: 1562-1568.

Ma K. 2005. Personality and attachment in adolescence. *The British Journal of Psychiatry* 186: 541-542.

Maitra B, Jolley A. 2000. Liaison between child and adult psychiatric services. In: Reder P, McClure M, Jolley A (ed.), *Family Matters: Interface Between Child and Adult Mental Health*. London: Routledge.

Malek M, Joughin C, Eds. 2004. *Mental health services for minority ethnic children and adolescents*. London: Jessica Kingsley Publishers.

Margo J, Dixon M, Pearce N, Reed H. 2006. *Freedom's orphans: raising youth in a changing world*. London: Institute for Public Policy Research.

McDonagh JE. 2006. *Growing up ready for emerging adulthood: an evidence base for professionals involved in transitional care for young people with chronic illness and/or disabilities*. Cambridge: Eastern Region Public Health Observatory.

McDonagh JE, Kelly DA. 2003. Transiting care of the pediatric recipient to adult care givers. *Pediatric Clinic of North America* 50: 1561-1583.

McDonagh JE, Viner R. 2006. Lost in transition? Between paediatric and adult services. *British Medical Journal* 332: 435-436.

McGorry P. 2007. The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Medical Journal of Australia (supplement)* 187: s53-s56.

Medical Journal of Australia. 2007. *Supplement 7: Early intervention in youth mental health*. www.mja.com.au/public/issues/187_07_011007/contents_011007_suppl.html.

Mental Health Foundation. 1999. *Bright futures: promoting children and young people's mental health*. London: Mental Health Foundation.

Miles K, Edwards S, Clapson M. 2004. Transition from paediatric to adult services: experiences of HIV-positive adolescents. *AIDS Care* 16: 305-314.

Mottaghipour Y, Woodland L, Bickerton A, Sara G. 2006. Working with families of patients within an adult mental health service: development of a programme model. *Australasian Psychiatry* 14: 267-271.

Muuss RE. 1996. *Theories of adolescence.* 6th ed. New York: McGraw-Hill.

Myers F, McCollam A, Woodhouse A. 2005. *National programme for improving mental health and well-being: addressing mental health inequalities in Scotland - equal minds*. Edinburgh: Scottish Development Centre for Mental Health.

National CAMHS Review. 2008. *Children and young people in mind: the final report of the National CAMHS Review*. Department for Children, Schools and Families and Department of Health.

National CAMHS Support Service, YoungMinds. 2005. *Exploring participation in CAMHS: improving the Involvement of Children, Young People and their Carers in CAMHS*. CAMHS National Conference, Stratford: Leicester, Northampton & Rutland Strategic Health Authority.

NHS Centre for Reviews and Dissemination. 1999. Getting evidence into practice. *Effective Health Care* 5: 1-16.

Nutt DJ, Fone K, Asherson P, Bramble D, Hill P, Matthews K, *et al.* 2006. Evidence-based guidelines for management of attention-deficit/hyperactivity disorder in adolescents in transition to adult services and in adults: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology* 21: 10-41.

O'Herlihy A, Worrall A, Banerjee S, Jaffa T, Hill P, Mears A, *et al.* 2001. *National inpatient child and adolescent psychiatry study (NICAPS): final report to the Department of Health*. London: Royal College of Psychiatrists' Research Unit.

Office for National Statistics. 2002. *Census 2001: first results on population for England and Wales*. London: Office for National Statistics.

Office for National Statistics. 2004. *Labour force survey*. London: Office for National Statistics.

Onyett S. 2003. *Team working in mental health*. London: Palgrave.

Patel V, Flisher AJ, Hetrick S, McGorry P. 2007. Mental health of young people: a global public-health challenge. *The Lancet* 369: 1302-1313.

Paul M, Berriman JA, Evans J. 2008. Would I attend child and adolescent mental health services (CAMHS)? Fourteen to sixteen year olds decide. *Child and Adolescent Mental Health* 13: 19-25.

Perkins R. 2001. What constitutes success? The relative priority of service users' and clinicians' views of mental health services. *British Journal of Psychiatry* 179: 9-10.

Petersen AC, Leffert N. 1995. Developmental issues influencing guidelines for adolescent health research: a review. *Journal of Adolescent Health* 17: 298-305.

Petersen L, Jeppesen P, Thorup A, Abel M-B, Øhlenschlæger J, Christensen TØ, *et al.* 2005. A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *British Medical Journal* 331: 602-608.

Phimister D. 2004. *CAMHS/Adult transition pilots evaluation report stage 1*. NIMHE West Midlands Mental Health Development Centre.

Por J, Golberg B, Lennox V, Burr P, Barrow J, Dennard L. 2004. Transition of care: health care professionals' view. *Journal of Nursing Management* 12: 354-361.

Pugh K, McHugh A, McKinstrie F. 2006. *Two steps forward, one step back? 16-25 year-olds on their journey to adulthood (SOS: stressed out and struggling)*. London: YoungMinds.

Reder P, McClure M, Jolley A, Eds. 2000. *Family matters: interfaces between child and adult mental health*. New York, NY, US: Routledge.

Reid GJ, Irvine MJ, McCrindle BW, Sananes R, Ritvo PG, Siu SC, *et al.* 2004. Prevalence and correlates of successful transfer from pediatric to adult health care among a cohort of young adults with complex congenital heart defects. *Pediatrics* 113: e197-e205.

Reiss J, Gibson R. 2002. Health care transition: destinations unknown. *Pediatrics* 110: 1307-1314.

Reyna V, Farley F. 2006. Risk and rationality in adolescent decision making. *Psychological Science in the Public Interest* 7: 1-44.

Richards M, Vostanis P. 2004. Interprofessional perspectives on transitional mental health services for young people aged 16-19 years. *Journal of Interprofessional Care* 18: 115-128.

Ritchie J, Spencer L. 1994. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R (ed.), *Analysing Qualitative Data*. London: Routledge.

Roberts RE, Attkisson CC, Rosenblatt A. 1998. Prevalence of psychopathology among children and adolescents. *American Journal of Psychiatry* 155: 715-725.

Rolison MR, Scherman A. 2002. Factors influencing adolescents' decisions to engage in risk-taking behavior. *Adolescence* 37: 585-597.

Rosen DS. 2004. Transition of young people with respiratory diseases to adult health care. *Paediatric Respiratory Reviews* 5: 124-131.

Rossi A, Amaddeo F, Bisoffi G, Ruggeri M, Thornicroft G, Tansella M. 2002. Dropping out of care: inappropriate terminations of contact with community-based psychiatric services. *British Journal of Psychiatry* 181: 331-338.

Royal College of General Practitioners. 2002. *Getting it right for teenagers in your practice*. London: Royal College of General Practitioners/Royal College of Nursing.

Royal College of Nursing. 2003. *Adolescent transition care*. London: RCN Publications.

Royal College of Nursing. 2004. *Adolescent transition care*. London: RCN Publications.

Royal College of Paediatrics and Child Health. 2003. *Bridging the gaps: healthcare for adolescents*. www.rcpsych.ac.uk.

Royal College of Physicians of Edinburgh Transition Steering Group. 2008. *Think transition: developing the essential link between paediatric and adult care*. Edinburgh: Royal College of Physicians of Edinburgh.

Royal College of Psychiatrists. 2002. *Acute inpatient psychiatric care for young people with severe mental illness: recommendations for commissioners, child and adolescent psychiatrists and general psychiatrists*. London: Royal College of Psychiatrists.

Royal College of Psychiatrists. 2008. *Factsheet 16: Parental mental illness: the problems for children: for parents and teachers*. www.rcpsych.ac.uk.

Rutter M. 1989. Isle of Wight revisited: twenty-five years of child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry* 28: 633-653.

Sawyer SM, Drew S, Yeo MS, Britto MT. 2007. Adolescents with a chronic condition: challenges living, challenges treating. *The Lancet* 369: 1481-1489.

Scottish Executive. 2003. *The mental health (care and treatment) (Scotland) Act 2003*. Edinburgh: Scottish Executive.

Scottish Executive. 2005. *Children's and young people's mental health: a framework for promotion, prevention and care*. Edinburgh: Scottish Executive.

Scottish Executive. 2006. *Delivery for mental health*. Edinburgh: Scottish Executive.

Select Committee on Health. 2000. *Fourth report: provision of NHS mental health services*. London: The Stationery Office.

Silva PA. 1990. The Dunedin multidisciplinary health and development study: a 15 year longitudinal study. *Paediatric & Perinatal Epidemiology* 4: 96-127.

Simmonds S, Coid J, Joseph P, Marriott S, Tyrer P. 2001. Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry* 178: 497-502.

Singh SP. 2000. Running an effective community mental health team. *Advances in Psychiatric Treatment* 6: 414-422.

Singh SP, Evans N, Sireling L, Stuart H. 2005. Mind the gap: the interface between child and adult mental health services. *Psychiatric Bulletin* 29: 292-294.

Singh SP, Grange T. 2006. Measuring pathways to care in first-episode psychosis: a systematic review. *Schizophrenia Research* 81: 75-82.

Singh SP, Greenwood N, White S, Churchill R. 2007. Ethnicity and the Mental Health Act 1983. *The British Journal of Psychiatry* 191: 99-105.

Singh SP, Paul M, Ford T, Kramer T, Weaver T. 2008. Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. *BMC Health Services Research* 8: 1-7.

Smith K, Leon L. 2001. *Turned Upside Down: Developing Community-based crisis services for 16-25 year olds experiencing a mental health crisis*. London: Mental Health Foundation.

Social Exclusion Unit. 2004. *Breaking the cycle*. London: Office of the Deputy Prime Minister.

Social Exclusion Unit. 2005. *Transitions: young adults with complex needs*. London: Office of the Deputy Prime Minister.

Sroufe LA. 1990. Considering normal and abnormal together: the essence of developmental psychopathology. *Development and Psychopathology* 2: 335-347.

Street C, Hertz B. 2005. *Putting participation into practice - a good practice guide for practitioners working in services to promote mental health and wellbeing of children and young people*. London: YoungMinds.

Tantam D. 2005. Pathways into adult care. *Psychiatry* 4: 141-144.

The Children's Commissioner for England. 2007. *Pushed into the shadows: young people's experience of adult mental health facilities*. London: The Office of the Children's Commissioner.

The National Assembly for Wales. 2001. *Child and adolescent mental health services: everybody's business*. Cardiff: The National Assembly for Wales.

Treasure J, Schmidt U, Hugo P. 2005. Mind the gap: service transition and interface problems for patients with eating disorders. *The British Journal of Psychiatry* 187: 398-400.

Tyrer P, Coombs N, Ibrahimi F, Mathilakath A, Bajaj P, Ranger M, *et al.* 2007. Critical developments in the assessment of personality disorder. *The British Journal of Psychiatry* 190: s51-s59.

UKCRC Advisory Group for Connecting for Health. 2007. *UKCRC Advisory Group for Connecting for Health: The Report of the Research Simulations*. London: UK Clinical Research Collaboration.

United Nations. 1989. *Convention of the Rights of the Child*. Geneva: Office of the United Nations High Commissioner for Human Rights.

Viner RM, Barker M. 2005. Young people's health: the need for action. *British Medical Journal* 330: 901-903.

Vostanis P. 2005. Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? *Current Opinion in Psychiatry* 18: 449-454.

Vostanis S, Richards V. 2002. *Transition services for 16-19 year olds*. Leicester: Leicester University.

Webster C, Simpson D, MacDonald R, Abbas A, Cieslik M, Shildrick T, *et al*. 2004. *Poor transitions: social exclusion and young adults*. Bristol: The Policy Press.

Westen D, Dutra L, Shedler J. 2005. Assessing adolescent personality pathology. *The British Journal of Psychiatry* 186: 227-238.

While A, Forbes A, Ullman R, Lewis S, Mathes L, Griffiths P. 2004. Good practices that address continuity during transition from child to adult care: synthesis of the evidence. *Child: Care, Health and Development* 30: 439-452.

World Health Organisation. 1992. *The ICD-10 classification of mental and behavioural disorders*. Geneva: World Health Organisation.

Young Person's Advisory Service. 2007. *Time to talk...time to listen: a consultation with Liverpool mental health service users aged 14-25.* Liverpool: Young Person's Advisory Service.

Young S, Toone B. 2000. Attention deficit hyperactivity disorder in adults: clinical issues: a report from the first NHS clinic in the UK. *Counselling Psychology Quarterly* 13: 313-319.

YoungMinds. 2006a. *A call to action: commissioning mental health services for 16-25 year-olds (SOS: stressed out and struggling)*. London: YoungMinds.

YoungMinds. 2006b. *Emerging practice: examples of mental health services for 16-25 year-olds*. London: YoungMinds.

Appendix 1: Mapping Tool

TRACK Study: Service Evaluation Questionnaire

The TRACK study aims to explore the process of transition from Child & Adolescent Mental Health Services (CAMHS) to adult mental health services in London, Coventry and North and South Warwickshire. We specifically want to identify the organisational factors that facilitate or impede effective transition of patients from CAMHS to adult mental health services. We want to understand how services plan transition, how the process is implemented and what problems, if any, are perceived by those undergoing transition.

The study is funded by NHS Service Development and Organisation Research and development programme (SDO). No group or individual will be making any commercial or financial gain from it. The Wandsworth Research Ethics Committee (MREC) has reviewed the study and has given it their approval.

As an initial step, we are mapping current service provision. We would be very grateful if you could spend a few moments to fill the enclosed questionnaire.

All data will be treated in the strictest confidence. Your team will not be identified in any database and the data will not be used for any purpose other than the mapping exercise.

For the purpose of this study, *a service is defined as provider agency that provides CAMHS tier 2/3/4 services with shared transition protocols and procedures.* If within your service, some teams use different protocols or procedures for transition, please count each group of teams using a shared transition procedure/policy/protocol as a distinct service.

If you have any queries, comments or suggestions, please contact :

Dr Zoebia Islam Tel: 024 7657 5882, E-mail: z.islam@warwick.ac.uk

or

Prof. Swaran P Singh :Tel: 024 76150190, E-mail: s.p.singh@warwick.ac.uk

Many thanks for your help

Date _____ **Team ID Number** ____

(for office use only)

1. ***Team name*** _____

2. **Respondent**

Name: _____

Profession: _____

Job Title: _____

3. **Catchment population** .....,000

4. **Service type:**

☐ CAMHS ☐ Assertive Community Team ☐ Adolesc... Service ☐

Other specialist service (please specify) _____

5. **Staffing levels**: Total FTE equivalent (Full Time =1.0; for part time, each half day= 0.1)

Total mental health care staff (excluding trainees)		
	Total FTE per discipline	Total FTE at Consultant grade
Nursing		
Psychology		
Psychiatry		
Social work		
Systemic Psychotherapy/		

Family Therapy		
Psychodynamic Psychotherapy		
Experiential Psychotherapy, e.g. Art Therapy		
Child Primary Mental Health Practitioner		
Occupational Therapy		
Other (please specify)		
Other (please specify)		
Other (please specify)		

6. **Case load**: What is your team's caseload?

A case is defined as 'a young person with whom your service has been actively working. Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion. The length of time spent with a case is not important.

Numbers referred in the last calendar year _____

Number of currently open cases _____

(The last calendar year will be taken as January 1st - December 31st 2006)

7. **Adult teams**: How many adult teams does your service relate to and/or transfer cases to?

CMHTs _____ Eating Disorders _____

Learning Disability _____ Psychotherapy _____

Forensic Services _____

Others (please specify)

_____

8. **Transition boundary**: How do you define the boundary between your service and adult services (that is, the criteria for referral on to the adult service)?

Age limit _____ Educational status _____

Other _____

Please give details: .....

.....

.....

.....

.....

.....

9. **Transition numbers**: How many patients stay within the service after crossing the transition boundary?

Please state the average number per year over the last three years _____

10. **Closure policy**: Do you have a written closure policy? ☐ ☐
Yes No

If yes, please attach a copy.

11. **Transition protocol**: Do you have a written policy/guidelines for transition of patients under your care to adult services? Yes ☐ No ☐

If yes, please attach a copy.

12. **Transition management**: Do you have a written policy/guideline for managing the interface (i.e. the point at which interaction occurs) between your service and adult services?

Yes ☐ No ☐

If yes, please attach a copy.

13. **Potential referrals**: How many cases on average do you consider to be suitable for transfer to adult services?

Please state the average number per year over the last three years _____

14. **Referrals accepted**: How many cases on average make a transition from your service to adult services?

Please state the average number per year over the last three years _____

15. **Transition Process**: for patients making a transition, do you aim for?

(a) Documented hand-over planning

Always	
Sometimes	
Never	

(b) Joint meeting with adult service

Always	
Sometimes	
Never	

(c) Involvement of the parents/carer in care plan and decision making

Always	
Sometimes	
Never	

(d) Involvement of the service users in care plan and decision making

Always	
Sometimes	
Never	

(e) Preparing the young person for ending one therapeutic relationship and starting another

Always	
Sometimes	
Never	

(f) Accountability for the process (e.g. a single clinician may be identified from one of the services to co- ordinate the transition).

Always	
Sometimes	
Never	

Please elaborate on how you carry out the above, and on how you carry out any other aspects of the transition process:

.....
.....
.....
.....
.....
.....
.....

.....
.....
.....
.....
.....
.....

(Please continue on a separate sheet if necessary)

On the next page, please provide us with details of all patients who crossed your transition boundary in 2006 and were or could have been transferred by your service to adult services. The information obtained in this study will be entirely confidential. It will be stored on a computer with each service identified only by a number code. Only the researchers involved in the study will be able to view the information. The mapping report will not identify services and not be circulated. However, it will appear in print at some stage.

Many thanks for your help.

Patient list for January 1st 2006- December 31st 2006

Young people referred (name of the adult service in question)
Young people you might have referred but did not (name of the adult service in question)
Young people you referred (name of the adult service in question) but who were not accepted by adult mental health services

Please continue on a separate sheet if necessary.

Appendix 2: Case note tracking questionnaire for actual referrals

TRACK Stage 2

Case Note Review – Transition from CAMHS to Adult MHS

Actual Referrals

Case no:

Patient name:

Case note reviewer: _____

Date of data collection:_____

This questionnaire should be completed *only if* the young person was successfully transferred to adult services.

When completing:

- **in general, tick boxes**
- **NR=not recorded**

SDO Project 08/1613/117)

SECTION 1: SERVICE / TRANSITION DETAILS

(must be completed prior to completing rest of the form)

CAMHS Team name and locality: _____

CAMHS Tier: 2 / 2-3 / 4

Team Borough or National/Specialist: _____

Trust: _____

Transitional hierarchy for completion of case note review:

Young person referred to AMHS (whether referral accepted or not): Yes ☐ No ☐

- if **yes**, data in Section 2 relates to time that referral was made
- if **no**, data in section 2 relates to time of crossing CAMHS/AMHS boundary (whether young person still being seen by CAMHS or not). In this case, **for this CAMHS**, please specify criteria for crossing **CAMHS/AMHS boundary:**

  ☐ age (specify:_____),

  ☐ leaving full-time education (specify: secondary school/ 6th form/college), OR

  ☐ other boundary (specify:_____)

Information collected from:

CAMHS notes ☐ CAMHS electronic records ☐ AMHS notes ☐

AMHS electronic records ☐ Other ☐ (specify)_____

SECTION 2: DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

YOUNG PERSON:

Date of birth: _____ (date) _____(month)_____(year)

Gender: Male / Female

Address: _____

_____

_____

UR/PID (NHS Patient Identification Number): _____

Ethnic Group [Insert no., see appendix 1]: ____ NR ☐

First Language: English ☐ Other ☐ (please state _____) NR ☐

Second language: English ☐ Other ☐ (please state _____) NR ☐

Age: _____

- **If the young person is under 18**:
  - name of identified person with parental responsibility:

    address: _____

    _____

    tel. no.: _____
  - A Looked After Child? Yes ☐ No ☐
- **If the young person is over 18 years:**
  - Does he/she have an identified carer? Yes ☐ No ☐
  - Relationship to young person: Parent ☐ Sibling ☐ Extended family member ☐

    Partner (or girlfriend/boyfriend) ☐ Friend ☐ Other ☐ (please state _____)

Young person's living arrangements:

On own ☐ parental home ☐ mother's home ☐ father's home ☐ foster carer's home ☐ shared accommodation (not with family) ☐ in another's home (describe relationship) ☐

Are other agencies involved with the young person?

☐ health (please state _____)

☐ social care (please state _____)

☐ education (please state _____)

☐ voluntary (please state _____)

Is the young person in education?

Full time ☐ Part time ☐ No ☐ NR ☐

If so: School ☐ college ☐ other ☐ (specify:_____)

What is the highest level of education reached to date?

Some School ☐ GCSE ☐ Some college ☐ A-level ☐

Other ☐ (specify:_____) NR ☐

Is the young person currently in employment?

Full time ☐ Part time ☐ No ☐ NR ☐

If so, specify type: _____

FAMILY DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

Parents' details:

Married & cohabiting ☐ Cohabiting ☐ Separated ☐ Divorced ☐ NR ☐

If parents separated or divorced or looked after child (specify which or both): _____

Current contact with mother: regular ☐ irregular ☐ none ☐

Current contact with father: regular ☐ irregular ☐ none ☐

Parental Occupation: Father _____ / NR ☐

Mother _____ / NR ☐

Family history of mental health difficulties:

Overall: Yes ☐ No ☐ NR ☐

Mum Yes ☐ No ☐ NR ☐

Dad Yes ☐ No ☐ NR ☐

Siblings Yes ☐ No ☐ NR ☐

Uncles/aunts Yes ☐ No ☐ NR ☐

Grandparents Yes ☐ No ☐ NR ☐

Other family Yes ☐ No ☐ NR ☐

Family members who attend CAMHS

Mother: regularly ☐ sometimes ☐ never ☐

Father: regularly ☐ sometimes ☐ never ☐

One or more siblings: regularly ☐ sometimes ☐ never ☐

Other family member(s):

please specify _____: regularly ☐ sometimes ☐ never ☐

please specify _____: regularly ☐ sometimes ☐ never ☐

please specify _____: regularly ☐ sometimes ☐ never ☐

Has a carer's assessment been offered at any stage?

If so, by whom? CAMHS ☐ Adult MHS ☐ Other ☐ (specify _____)

If so, when? Before transition ☐ at time of transition ☐ after transition ☐

Was it accepted? Yes ☐ No ☐ NR ☐

Was it carried out? Yes ☐ No ☐ NR ☐

SECTION 3: DETAILS OF REFERRAL TO CAMHS FOR THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

Referral: Routine ☐ Urgent ☐

Referred by: General Practitioner ☐ Paediatrician ☐ Health Visitor ☐

School Nurse or School Health Advisor ☐ Other Education-based professional ☐ Social Worker ☐ Self or family referral ☐ Another CAMHS ☐ Other ☐ (specify _____)

Reasons for referral? (tick as many as are relevant)

Emotional (e.g. anxiety, depression, OCD) ☐ Behavioural ☐

Developmental (e.g. autism spectrum disorder, ADHD) ☐ Eating Disorder ☐ Psychosis ☐

Family relationship issues ☐ Crisis or complex psychosocial (e.g. deliberate self harm) ☐

Learning difficulties ☐ Poor academic progress ☐ peer problems ☐

Other ☐ (specify _____)

SECTION 4: DETAILS OF ASSESSMENT AT CAMHS DURING THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

How many weeks between referral and assessment? _____

Assessed by (specify number of each profession in brackets):

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )

Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Initial Diagnoses (from correspondence to referrer/case notes):

Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____

DSM 4 code diagnoses: _____ code: _____

Other: _____

Previous contact with this CAMHS / another CAMHS

specify number _____ nil ☐ NR ☐

Age at first referral to any CAMHS _____

Number of other CAMHS attended _____

Age at first referral to this CAMHS _____

Number of previous (not including this referral) referrals to this CAMHS _____

Number of previous referrals to this CAMHS not accepted by service _____

Cumulative length of episodes of care, prior to this episode, at this CAMHS _____

List all known diagnoses / key problems for all previous contact with any CAMHS:

SECTION 5: DETAILS OF SUBSEQUENT CONTACT WITH THIS CAMHS

Interventions delivered (tick as many as relevant)

Medication ☐ Family Therapy ☐ General support or follow up ☐

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) ☐

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) ☐

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) ☐

Consultation / liaison with other agencies ☐

If so: SchoolEducation ☐ Social Services ☐ YOT (Youth Offending Service) ☐
Multi-agency ☐ Other (specify _____) ☐

Other (specify: _____) ☐

CAMHS professionals who delivered face-to-face work or consultation:

Total number: _____

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )
Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s): _____

Status: While attending CAMHS, was the young person, at any time:

- A Looked After Child (in Care) / attending Leaving Care services
  Yes ☐ No ☐ NR ☐
- Given a Statement of Special Educational Needs: Yes ☐ No ☐ NR ☐
- On the Child Protection Register: Yes ☐ No ☐ NR ☐
  - If yes, specify categories:

    physical abuse ☐ emotional abuse ☐ sexual abuse ☐ neglect ☐
- Admitted to hospital for mental health problems: Yes ☐ No ☐ NR ☐

  ☐ mental health unit

  ☐ paediatric unit
- Detained under a section of the Mental Health Act 1983
  - Yes ☐ No ☐ NR ☐

- If yes; Section 2 ☐ Section 3 ☐ other ☐ (specify_____)
- Involved with YOT Yes ☐ No ☐ NR ☐
- Refugee or asylum seeker Yes ☐ No ☐ NR ☐

SECTION 6: DETAILS AT TIME OF REFERRAL TO AMHS / CROSSING TRANSITIONAL BOUNDARY

Number of weeks between assessment at CAMHS and referral to AMHS/ crossing transitional boundary: _____

CLINICAL DETAILS

Clinicians involved (specify number of each profession in brackets**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )
Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s):_____

Diagnoses / Impression (from correspondence/case notes):
Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____

DSM 4 code diagnoses: _____ code: _____

Other: _____

Interventions being delivered (tick as many as relevant)

Medication ☐ Family Therapy ☐ General support or follow up ☐

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) ☐

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) ☐

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) ☐

Consultation / liaison with other agencies ☐

If so: Early Intervention in Psychosis Team (EIT) ☐ other AMHS ☐ School/Education ☐
Social Services ☐ Multi-agency ☐ other ☐ (specify _____)

Other (specify: _____)

Status:

- A Looked After Child (in Care) / attending Leaving Care services
  Yes ☐ No ☐ NR ☐
- Has a Statement of Special Educational Needs: Yes ☐ No ☐ NR ☐
- On the Child Protection Register: Yes ☐ No ☐ NR ☐
  - If yes, specify categories:

    physical abuse ☐ emotional abuse ☐ sexual abuse ☐ neglect ☐
- In a hospital for mental health problems: Yes ☐ No ☐ NR ☐

  ☐ mental health unit

  ☐ paediatric unit
- Detained under a section of the Mental Health Act 1983
  - Yes ☐ No ☐ NR ☐
  - If yes; Section 2 ☐ Section 3 ☐ other ☐ (specify_____)
- Care Programme Approach (CPA)
  - Yes ☐ No ☐ NR ☐
  - Standard ☐ Enhanced ☐
- Involved with YOT Yes ☐ No ☐ NR ☐
- Refugee or asylum seeker Yes ☐ No ☐ NR ☐

REFERRAL DETAILS

Method of *successful* referral: (tick as many as are relevant; this refers to the ultimately successful referral to adult services. Any initial unsuccessful referrals will be recorded later)

Letter ☐ telephone ☐ electronic ☐ other ☐ (specify _____)

If letter, copied to: GP ☐ young person ☐ Parent(s)/carer(s) ☐ Other ☐ (specify _____)

Clinicians involved in *successful* referral:

SDO Project 08/1613/117)

Discipline of clinician making any referral to AMHS: _____

To whom the referral was sent: Discipline of clinician, if specified _____

Specific AMHS:

_____

Reason for referral: Presentation (tick as many as indicated)

☐ on going mental health problems/disorders requiring specialist treatment: specify medication and/or psychological treatment and/ or monitoring

_____

☐ new episode of the mental health problem(s)/disorder(s) for which the young person was already seen by CAMHS

☐ new episode of a different mental health problem(s)/disorder(s) in a young person who was already seen by CAMHS for a different problem/disorder

☐ new episode of mental health problem(s)/disorder(s) in a young person newly referred to and assessed by CAMHS

☐ new episode of mental health problem(s)/disorder(s) in a young person newly referred to but not assessed by CAMHS

☐ Management of risk (specify: self-harm or suicide ☐ harm to others ☐

self-neglect ☐ vulnerability to abuse ☐)

☐ other (specify: _____)

Detail in referral: (circle as many as indicated)

o Diagnoses or presentation: included ☐ not included ☐

o current treatment: included ☐ not included ☐

o past mental health history: included ☐ not included ☐

o past medical history: included ☐ not included ☐

o family history: included ☐ not included ☐

o family mental health history: included ☐ not included ☐

o current household: included ☐ not included ☐

o current status: included ☐ not included ☐

Successful Referral to:

Type of AMHS: CMHT ☐ consultant psychiatrist ☐ Psychology Team ☐

adult inpatient unit ☐ Early Intervention I Psychosis Team ☐

Eating Disorders Service ☐ Learning Disability Service ☐ Forensic Service ☐

Adult psychotherapy Service ☐ Other ☐ (specify_____)

Reason for choice of service: (tick as many as appropriate):

local service ☐ type of assessment required ☐ type of intervention required ☐

type of disorder or condition ☐ severity of disorder or condition ☐ patient preference ☐

parent or carer preference ☐ other ☐ (specify_____)

Other unavailable services that would have been referred to: _____

Number of weeks between referral being made and any response from AMHS: ____

Number of weeks between referral being made and decision from AMHS: ____

Decision about referral made by AMHS:

- accepted and allocated ☐ accepted to waiting list ☐
- following discussion with CAMHS ☐ without discussion ☐

If not ultimately accepted by any CAMHS, fill in potential referral questionnaire instead of this one.

Details of any unsuccessful referrals:

Were any unsuccessful attempts at referring to AMHS made prior / concurrently to this referral?

Yes ☐ No ☐

If yes:

- What was method of unsuccessful referral (tick as many as are relevant)?

  Letter ☐ telephone ☐ electronic ☐ other ☐ (specify _____)

  If letter, copied to: GP ☐ young person ☐ Parent(s)/carer(s) ☐ Other ☐ (_____)
- What discipline was the clinician who made the unsuccessful referral to AMHS?

  _____

- To whom the unsuccessful referral was sent:

  Discipline of clinician, if specified _____

  Specific AMHS: _____
- Type of AMHS: CMHT ☐ consultant psychiatrist ☐ Psychology Team ☐

  adult inpatient unit ☐ Early Intervention I Psychosis Team ☐

  Eating Disorders Service ☐ Learning Disability Service ☐ Forensic Service ☐

  Adult psychotherapy Service ☐ Other ☐ (specify_____)
- Reason for choice of service: (tick as many as appropriate):

  Local service ☐ type of assessment required ☐ type of intervention required ☐

  type of disorder or condition ☐ severity of disorder or condition ☐

  patient preference ☐ parent or carer preference ☐ other ☐ (specify_____)
- Non-acceptance of referral communicated: to CAMHS referrer ☐ to young person ☐

  to parent(s)/carer(s) ☐ to General Practitioner ☐
- Reason: does not meet referral criteria ☐

  no relevant service available (specify what service: _____) ☐

  no relevant expertise (specify in what: _____) ☐

  No reason ☐ other reason (specify _____) ☐
- Alternative sources of help suggested: no ☐ yes ☐ (specify_____)

TRANSITION PROCESS

Preparation of family:

Transfer of care mentioned to young person: Yes (date: _____) ☐ No ☐ NR ☐

Transfer of care mentioned to parent(s)/carer(s): Yes (date: _____) ☐ No ☐ NR ☐

Young person's consent for referral to AMHS sought:

documented clearly ☐ inferred ☐ not recorded ☐

Reason for transfer to AMHS communicated to young person:

documented clearly ☐ inferred ☐ not recorded ☐

Discussion about the ending of the therapeutic relationship(s):

documented clearly ☐ inferred ☐ not recorded ☐

Preparation for professionals

Transition planning meeting between CAMHS and AMHS (number):

(__) offered by CAMHS but not taken up by AMHS

(__) offered but not arranged

(__) offered and arranged

(__) discussion between professionals alongside joint appointment with young person

(__) discussion between professionals alongside joint appointment with parent(s)/carer(s)

(__) discussion between professionals alongside joint appointment with young person and parent(s)/carer(s)

AMHS staff involved in transition planning meeting (identify* professionals the young person will see, if they are involved):

_____ Involved? Yes ☐ No ☐

_____ Involved? Yes ☐ No ☐

CAMHS staff involved in transition planning meeting (identify* professionals the young person has been seeing, if they are involved):

_____ Involved? Yes ☐ No ☐

_____ Involved? Yes ☐ No ☐

Contents (tick as many as necessary): timeframe ☐ transition boundary ☐

reasons for suggested referral to AMHS ☐ information about AMHS ☐

what will be initially offered by AMHS ☐ who will initially see the young person ☐

change from family-oriented service to individual-oriented service ☐ Issues of consent ☐

concerns of young person ☐ concerns of parent/carer(s) ☐ preferences of young person ☐

preferences of parent(s)/carer(s) ☐ Other points/concerns raised (specify): _____

Additional telephone contact: Yes ☐ No ☐ NR ☐

Reason: _____

Between: _____

Additional Email contact: Yes ☐ No ☐ NR ☐

Reason: _____

Between: _____

Additional letter contact: Yes ☐ No ☐ NR ☐

Reason: _____

Between: _____

Other (details): _____

Between: _____

Duration of joint transition planning (up to transfer of care): Number of weeks: _____

Handover of care

- Successive appointments with CAMHS then AMHS: yes ☐ no ☐
- Joint appointment(s) with CAMHS/AMHS: offered by CAMHS but not taken up by AMHS ☐ offered but not arranged ☐ offered and arranged ☐
- If not offered, any reason documented? _____
- If arranged:
  - attended by (list):
    - ☐ Young person and other family or friends: _____

      _____
    - ☐ Professionals from AMHS _____

      _____
    - ☐ Professionals from CAMHS _____

      _____
  - Took place at: CAMHS ☐ AMHS ☐ other ☐ (specify: _____)
  - Took place at: last CAMHS appointment ☐ first AMHS appointment ☐ neither ☐

Any other steps taken to prepare the family for the process of transition?

SDO Project 08/1613/117)

Young person: _____

_____

parent(s)/carer(s): _____

Period of parallel care between CAMHS and AMHS?

Duration (weeks): _____ Number of sessions: _____

Reason: _____

Documentation transferred to AMHS (tick as many as necessary)

Referral letter ☐ summary of CAMHS contact ☐ some CAMHS notes ☐ all CAMHS notes ☐ contemporary risk assessment ☐ Care Programme Approach documents (if on CPA) ☐

Other ☐ (specify _____)

SECTION 7: AMHS CONTACT DETAILS

CLINICAL DETAILS

First seen by: (specify number of each profession in brackets)**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( ) Family/Systemic Therapist ( ) Psychotherapist (e.g. Psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify: _____) ( )

Occupational Therapist ( ) other (specify_____) ( )

Subsequently seen by: (specify number of each profession in brackets)**:**

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( ) Family/Systemic Therapist ( ) Psychotherapist (e.g. Psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify: _____) ( )

Occupational Therapist ( ) other (specify_____) ( )

Discipline of case manager(s)/key-worker(s): _____

First appointment offered by AMHS

Number of weeks between referral by CAMHS and first appointment ***offered*** by AMHS: _____

Joint meeting with CAMHS: yes ☐ no ☐

Appointment withdrawn and young person discharged because of:

disengagement with CAMHS ☐ non-response to AMHS attempts to arrange appointment ☐

Attended: by young person ☐ young person and parent(s)/carer(s) ☐

parent(s)/carer(s) only ☐ DNA ☐

If DNA, what was the outcome? Discharged ☐ further appointment ☐

Diagnoses / Impression following initial assessment

Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____

DSM 4 code diagnoses: _____ code: _____

Outcome of initial assessment:

discharged ☐ on-going clinical management ☐ DNA: Further appointment ☐

Second appointment

- Number of weeks after first _____ No second appointment ☐
- Type: General follow-up ☐ specific intervention ☐ (specify _____)
- Attended: by young person ☐ young person and parent(s)/carer(s) ☐ parent(s)/carer(s) only ☐ DNA ☐
- If DNA, outcome: Discharged ☐ further appointment ☐

Interventions offered overall (tick as many as relevant, and whether refused or accepted by young person)

Inpatient admission: Number ____

For each: refused / accepted _____

duration

_____

status (voluntary / under MHA [specify section]) _____

Day facility attendance: specify _____refused ☐ accepted ☐

Medication: specify _____ refused ☐ accepted ☐

Family Therapy: Behavioural ☐ Systemic ☐ other ☐ refused ☐ accepted ☐

General support or follow up refused ☐ accepted ☐

Individual therapy: Type if noted _____ refused ☐ accepted ☐

Carer support: refused ☐ accepted ☐

Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for young person) _____

Experiential Therapy: Type: _____ refused ☐ accepted ☐

Consultation with other agencies: specify _____ refused ☐ accepted ☐

Referral

To other AMHS: specify _____refused ☐ accepted ☐

To other voluntary or statutory agencies: specify _____ refused ☐ accepted ☐

Other: specify: _____refused ☐ accepted ☐

Status (at any time in contact with AMHS):

- A Looked After Child (in Care) / attending Leaving Care services
  Yes ☐ No ☐ NR ☐
- Has a Statement of Special Educational Needs: Yes ☐ No ☐ NR ☐
- On the Child Protection Register: Yes ☐ No ☐ NR ☐
  - If yes, specify categories:

    physical abuse ☐ emotional abuse ☐ sexual abuse ☐ neglect ☐
- In a hospital for mental health pro s : Yes ☐ No ☐ NR ☐

  ☐ mental health unit

  ☐ paediatric unit
- Detained under a section of the Mental Health Act 1983
  - Yes ☐ No ☐ NR ☐
  - If yes; Section 2 ☐ Section 3 ☐ other ☐ (specify_____)

- Care Programme Approach (CPA)
  - Yes ☐ No ☐ NR ☐
  - Standard ☐ Enhanced ☐
- Involved with YOT Yes ☐ No ☐ NR ☐
- Refugee or asylum seeker Yes ☐ No ☐ NR ☐

Attendance at AMHS

Discharged ☐ open but lost to follow up ☐ open but infrequent attendance ☐

open and regular attendance ☐

If discharged at any point by AMHS

- reason: presenting problem resolved altogether ☐

  presenting problem resolved somewhat ☐ does not meet referral criteria ☐

  no relevant service available (specify what service: _____) ☐

  no relevant expertise (specify in what: _____) ☐ No reason ☐ DNA ☐

  other reason ☐ (specify_____)
- Alternative sources of help suggested: no ☐ yes ☐ (specify _____)
- Discharge communicated: to CAMHS referrer ☐ to General Practitioner ☐

  to young person ☐ to parent(s)/carer(s) ☐

If discharged and CAMHS informed, what was CAMHS response? (tick as many as relevant)

☐ continued efforts to refer to AMHS:
  ☐ re-referral to another AMHS
  ☐ telephone consultation with AMHS (n=)
  ☐ face to face consultation with AMHS (n=)

☐ discharged to primary care / other health service (specify:)

☐ further appointment considering options then discharged to primary care

☐ referral to other agencies (voluntary and statutory): list _____

☐ On-going input from CAMHS

If ongoing input: Number of sessions ____ Duration of contact (weeks) _____

Subsequently closed? Yes ☐ No ☐

In any case:

How many appointments offered in the first three months? _____

How many appointments attended (%)? _____

How long has there been between the first appointment and now / discharge in weeks? _____

If poor attendance (two successive appointments missed at any time), what efforts were made to engage the young person?

- Letters: Yes (n=) ☐ No ☐ NR ☐
- Phonecalls: Yes (n=) ☐ No ☐ NR ☐
- Other: specify _____

If poor attendance, what efforts were made to contact the parent(s)/carer(s)?

- Letters: Yes (n=) ☐ No ☐ NR ☐
- Phonecalls: Yes (n=) ☐ No ☐ NR ☐
- Other: specify _____

If poor attendance, any contact with:

☐ CAMHS? Specify _____

☐ General Practitioner? Specify _____

SECTION 8: DETAILS USEFUL FOR PARTICIPATION IN STAGE 4

Last known address: _____

_____

_____

Phone number: _____

Last known GP and contact details: _____

Details of any current case manager/key worker:

Name: _____ Role: _____

Service contact details: _____

_____

_____

Any general comments on the nature of the transition (positive / negative etc):

Appendix 1: Ethnicity Classification (from Census 2001 Ethnicity Classification System)

1. White British 2. White Irish 3. Other White Background 4. Mixed White and Black Caribbean 5. Mixed White and Black African 6. Mixed White and Asian	7. Other Mixed Background 8. Indian 9. Pakistani 10. Bangladeshi 11. Other Asian Background 12. Caribbean	13. African 14. Other Black Background 15. Chinese 16. Other ethnic group (please state)

SDO Project 08/1613/117)

Appendix 3: Case note tracking questionnaire for potential referrals

TRACK Stage 2

Case Note Review – Transition from CAMHS to Adult MHS

Potential Referrals

Case no:_____

Patient name: _____

Case note reviewer: _____

Date of data collection:_____

This questionnaire should be completed if AMHS did not accept the referral, or if the young person crossed the transition boundary but was not subsequently referred to AMHS

When completing:

- **in general, tick boxes**
- **NR=not recorded**

SDO Project 08/1613/117)

Potential Referral Questionnaire completed because:

a) AMHS did not accept referral ☐

b) young person crossed transition boundary but was not referred to AMHS ☐

c) A referral has been made but AMHS have not yet made their final decision ☐

If c) how many weeks between referral to adult services and now? _____

SECTION 1: SERVICE / TRANSITION DETAILS

CAMHS Team name and locality: _____

CAMHS Tier: 2 / 2-3 / 4

Team Borough or National/Specialist: _____

Trust: _____

Transitional hierarchy for completion of case note review:

Young person referred to AMHS (whether referral accepted or not): Yes ☐ No ☐

- if **yes**, data in Section 2 relates to time that referral was made
- if **no**, data in section 2 relates to time of crossing CAMHS/AMHS boundary (whether young person still being seen by CAMHS or not). In this case, **for this CAMHS**, please specify criteria for crossing **CAMHS/AMHS boundary:**

  ☐ age (specify:_____),

  ☐ leaving full-time education (specify: secondary school/ 6th form/college), OR

  ☐ other boundary (specify:_____)

Information collected from:

CAMHS notes ☐ CAMHS electronic records ☐ AMHS notes ☐

AMHS electronic records ☐ Other ☐ (specify)_____

SECTION 2: DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

YOUNG PERSON:

Date of birth: _____ (date) _____(month)_____(year)

Gender: Male / Female

Address: _____

_____

_____

UR/PID (NHS Patient Identification Number): _____

Ethnic Group [Insert no., see appendix 1]: ____ NR ☐

First Language: English ☐ Other ☐ (please state _____) NR ☐

Second language: English ☐ Other ☐ (please state _____) NR ☐

Age: _____

- **If the young person is under 18**:
  - name of identified person with parental responsibility:

    address: _____

    _____

    tel. no.: _____
  - A Looked After Child? Yes ☐ No ☐
- **If the young person is over 18 years:**
  - Does he/she have an identified carer? Yes ☐ No ☐
  - Relationship to young person: Parent ☐ Sibling ☐ Extended family member ☐

    Partner (or girlfriend/boyfriend) ☐ Friend ☐ Other ☐ (please state _____)

Young person's living arrangements:

On own ☐ parental home ☐ mother's home ☐ father's home ☐ foster carer's home ☐ shared accommodation (not with family) ☐ in another's home (describe relationship) ☐

Are other agencies involved with the young person?

☐ health (please state _____)

☐ social care (please state _____)

☐ education (please state _____)

☐ voluntary (please state _____)

Is the young person in education?

Full time ☐ Part time ☐ No ☐ NR ☐

If so: School ☐ college ☐ other ☐ (specify:_____)

What is the highest level of education reached to date?

Some School ☐ GCSE ☐ Some college ☐ A-level ☐

Other ☐ (specify:_____) NR ☐

Is the young person currently in employment?

Full time ☐ Part time ☐ No ☐ NR ☐

If so, specify type: _____

FAMILY DETAILS AT TIME OF REFERRAL TO AMHS/CROSSING TRANSITIONAL BOUNDARY

Parents' details:

Married & cohabiting ☐ Cohabiting ☐ Separated ☐ Divorced ☐ NR ☐

If parents separated or divorced or looked after child (specify which or both): _____

Current contact with mother: regular ☐ irregular ☐ none ☐

Current contact with father: regular ☐ irregular ☐ none ☐

Parental Occupation: Father _____ / NR ☐

Mother _____ / NR ☐

Family history of mental health difficulties:

Overall: Yes ☐ No ☐ NR ☐

Mum Yes ☐ No ☐ NR ☐

Dad Yes ☐ No ☐ NR ☐

Siblings Yes ☐ No ☐ NR ☐

Uncles/aunts Yes ☐ No ☐ NR ☐

Grandparents Yes ☐ No ☐ NR ☐

Other family Yes ☐ No ☐ NR ☐

Family members who attend CAMHS

Mother: regularly ☐ sometimes ☐ never ☐

Father: regularly ☐ sometimes ☐ never ☐

One or more siblings: regularly ☐ sometimes ☐ never ☐

Other family member(s):

please specify _____: regularly ☐ sometimes ☐ never ☐

please specify _____: regularly ☐ sometimes ☐ never ☐

please specify _____: regularly ☐ sometimes ☐ never ☐

Has a carer's assessment been offered at any stage?

If so, by whom? CAMHS ☐ Adult MHS ☐ Other ☐ (specify _____)

If so, when? Before transition ☐ at time of transition ☐ after transition ☐

Was it accepted? Yes ☐ No ☐ NR ☐

Was it carried out? Yes ☐ No ☐ NR ☐

SECTION 3: DETAILS OF REFERRAL TO CAMHS FOR THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

Referral: Routine ☐ Urgent ☐

Referred by: General Practitioner ☐ Paediatrician ☐ Health Visitor ☐

School Nurse or School Health Advisor ☐ Other Education-based professional ☐ Social Worker ☐ Self or family referral ☐ Another CAMHS ☐ Other ☐ (specify _____)

Reasons for referral? (tick as many as are relevant)

Emotional (e.g. anxiety, depression, OCD) ☐ Behavioural ☐

Developmental (e.g. autism spectrum disorder, ADHD) ☐ Eating Disorder ☐ Psychosis ☐
Family relationship issues ☐ Crisis or complex psychosocial (e.g. deliberate self harm) ☐

Learning difficulties ☐ Poor academic progress ☐ peer problems ☐
Other ☐ (specify _____)

SECTION 4: DETAILS OF ASSESSMENT AT CAMHS DURING THE EPISODE OF CARE RESULTING IN REFERRAL TO AMHS OR CROSSING OF TRANSITIONAL BOUNDARY

How many weeks between referral and assessment? _____

Assessed by (specify number of each profession in brackets):

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )
Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Initial Diagnoses (from correspondence to referrer/case notes):

Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____

DSM 4 code diagnoses: _____ code: _____

Other: _____

Previous contact with this CAMHS / another CAMHS

specify number _____ nil ☐ NR ☐

Age at first referral to any CAMHS _____

Number of other CAMHS attended _____

Age at first referral to this CAMHS _____

Number of previous (not including this referral) referrals to this CAMHS _____

Number of previous referrals to this CAMHS not accepted by service _____

Cumulative length of episodes of care, prior to this episode, at this CAMHS _____

List all known diagnoses / key problems for all previous contact with any CAMHS:

SECTION 5: DETAILS OF SUBSEQUENT CONTACT WITH THIS CAMHS

Interventions delivered (tick as many as relevant)

Medication ☐ Family Therapy ☐ General support or follow up ☐

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) ☐

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) ☐

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) ☐

Consultation / liaison with other agencies ☐

If so: SchoolEducation ☐ Social Services ☐ YOT (Youth Offending Service) ☐
Multi-agency ☐ Other (specify _____) ☐

Other (specify: _____) ☐

CAMHS professionals who delivered face-to-face work or consultation:

Total number: _____

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )
Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s): _____

Status: While attending CAMHS, was the young person, at any time:

- A Looked After Child (in Care) / attending Leaving Care services
  Yes ☐ No ☐ NR ☐
- Given a Statement of Special Educational Needs: Yes ☐ No ☐ NR ☐
- On the Child Protection Register: Yes ☐ No ☐ NR ☐
  - If yes, specify categories:

    physical abuse ☐ emotional abuse ☐ sexual abuse ☐ neglect ☐
- Admitted to hospital for mental health problems: Yes ☐ No ☐ NR ☐

  ☐ mental health unit

  ☐ paediatric unit
- Detained under a section of the Mental Health Act 1983
  - Yes ☐ No ☐ NR ☐
  - If yes; Section 2 ☐ Section 3 ☐ other ☐ (specify_____)
- Involved with YOT Yes ☐ No ☐ NR ☐
- Refugee or asylum seeker Yes ☐ No ☐ NR ☐

SECTION 6: DETAILS AT TIME OF REFERRAL TO AMHS / CROSSING TRANSITIONAL BOUNDARY

Number of weeks between assessment at CAMHS and referral to AMHS/ crossing transitional boundary: _____

CLINICAL DETAILS

Clinicians involved (specify number of each profession in brackets):

Mental Health Nurse ( ) Clinical Psychologist ( ) Psychiatrist ( )

Social Worker ( ) Primary Mental Health Worker ( )

Family/Systemic Therapist ( ) Psychotherapist (e.g. psychodynamic) ( )

Experiential Therapist (e.g. Art, Drama. Specify:_____) ( )

Paediatrician ( ) Paediatric Nurse ( ) Other (specify _____) ( )

Discipline of CAMHS case manager(s)/key-worker(s):_____

Diagnoses / Impression (from correspondence/case notes):

Clinical diagnoses / key problems: _____

ICD 10 diagnoses: _____ code: _____

DSM 4 code diagnoses: _____ code: _____

Other: _____

Interventions being delivered (tick as many as relevant)

Medication ☐ Family Therapy ☐ General support or follow up ☐

Individual therapy (Type if noted, e.g. CBT, psychodynamic._____) ☐

Parenting support (Type if noted, e.g. groups/ parallel or separate sessions with/from individual sessions for child_____) ☐

Experiential Therapy (Type if noted, e.g. Art Therapy: _____) ☐

Consultation / liaison with other agencies ☐

If so: Early Intervention in Psychosis Team (EIT) ☐ other AMHS ☐ SchoolEducation ☐
Social Services ☐ Multi-agency ☐ other ☐ (specify _____)

Other (specify: _____)

Status:

- A Looked After Child (in Care) / attending Leaving Care services
  Yes ☐ No ☐ NR ☐
- Has a Statement of Special Educational Needs: Yes ☐ No ☐ NR ☐
- On the Child Protection Register: Yes ☐ No ☐ NR ☐
  - If yes, specify categories:

    physical abuse ☐ emotional abuse ☐ sexual abuse ☐ neglect ☐
- In a hospital for mental health problems: Yes ☐ No ☐ NR ☐

  ☐ mental health unit

  ☐ paediatric unit
- Detained under a section of the Mental Health Act 1983
  - Yes ☐ No ☐ NR ☐
  - If yes; Section 2 ☐ Section 3 ☐ other ☐ (specify_____)
- Care Programme Approach (CPA)
  - Yes ☐ No ☐ NR ☐
  - Standard ☐ Enhanced ☐

- Involved with YOT Yes ☐ No ☐ NR ☐
- Refugee or asylum seeker Yes ☐ No ☐ NR ☐

REFERRAL DETAILS.

NB when entering this information in database, put in unsuccessful referrals section

Method: (tick as many as are relevant)

Letter ☐ telephone ☐ electronic ☐ other ☐ (specify _____)

If letter, copied to: GP ☐ young person ☐ Parent(s)/carer(s) ☐ Other ☐ (specify _____)

Clinicians:

Discipline of clinician making any referral to AMHS: _____

To whom the referral was sent:

Discipline of clinician, if specified _____

Specific AMHS: _____

Reason for referral: Presentation (tick as many as indicated)

☐ on going mental health problems/disorders requiring specialist treatment: specify medication and/or psychological treatment and/ or monitoring_____

☐ new episode of the mental health problem(s)/disorder(s) for which the young person was already seen by CAMHS

☐ new episode of a different mental health problem(s)/disorder(s) in a young person who was already seen by CAMHS for a different problem/disorder

☐ new episode of mental health problem(s)/disorder(s) in a young person newly referred to and assessed by CAMHS

☐ new episode of mental health problem(s)/disorder(s) in a young person newly referred to but not assessed by CAMHS

☐ Management of risk (specify: self-harm or suicide ☐ harm to others ☐ self-neglect ☐ vulnerability to abuse ☐)

☐ other (specify: _____)

Detail in referral: (circle as many as indicated)

- Diagnoses or presentation: included ☐ not included ☐
- current treatment: included ☐ not included ☐
- past mental health history: included ☐ not included ☐
- past medical history: included ☐ not included ☐
- family history: included ☐ not included ☐
- family mental health history: included ☐ not included ☐
- current household: included ☐ not included ☐
- current status: included ☐ not included ☐

Referral to:

Type of AMHS: CMHT ☐ consultant psychiatrist ☐ Psychology Team ☐

adult inpatient unit ☐ Early Intervention I Psychosis Team ☐

Eating Disorders Service ☐ Learning Disability Service ☐ Forensic Service ☐

Adult psychotherapy Service ☐ Other ☐ (specify_____)

Reason for choice of service: (tick as many as appropriate):

local service ☐ type of assessment required ☐ type of intervention required ☐

type of disorder or condition ☐ severity of disorder or condition ☐ patient preference ☐
parent or carer preference ☐ other ☐ (specify_____)

Other unavailable services that would have been referred to: _____

Number of weeks between referral being made and any AMHS response: _____

Number of weeks between referral being made and decision from AMHS: _____

Decision about referral made by AMHS: not accepted ☐ not referred ☐ pending ☐

If pending: please record all details of contact with adult services to date. E.g. how long since referral, nature of all contact between CAMHS and AMHS (method, date, subject), the reason for the delay, any joint working between CAMHS and AMHS to date etc.

If not accepted by AMHS:

AMHS response (tick as many as relevant):

- Non-acceptance of referral communicated: to CAMHS referrer ☐ to young person ☐

  to parent(s)/carer(s) ☐ to General Practitioner ☐
- Reason: does not meet referral criteria ☐

  no relevant service available (specify what service: _____) ☐

  no relevant expertise (specify in what: _____) ☐

  No reason ☐ other reason (specify _____) ☐
- Alternative sources of help suggested: no ☐ yes ☐ (specify_____)

CAMHS response: (tick as many as relevant)

☐ continued efforts to refer to AMHS:

- ☐ re-referral to another AMHS
- ☐ telephone consultation with AMHS (n=)
- ☐ face to face consultation with AMHS (n=)
- ☐ other (specify _____)
- ☐ Additional comments: _____

☐ discharged to primary care / other health service (specify:)

if yes, failure of transfer to AMH communicated? yes ☐ no ☐

☐ further appointment considering options then discharged to primary care

☐ referral to other agencies (voluntary and statutory): list _____

☐ On-going input from CAMHS

If ongoing input:

Number of sessions ____

Duration of contact (weeks) _____

Subsequently closed? Yes ☐ No ☐

Alternative sources of help suggested by AMHS: no ☐ yes ☐ (specify_____)

Section 7: CAMHS contact details subsequent to *AMHS not accepting referral of young person or young person crossing transition boundary in absence of a referral to AMHS

Number of weeks between now and *:_____

If no referral made to AMHS (tick as many as necessary)

Reason:

- ☐ continuing presentation that meets CAMHS referral criteria but known not to meet AMHS referral criteria
- ☐ need for ongoing specialist mental health care but clinician's perception is that AMHS do not accept referrals for this reason
  Specify care required: _____
- ☐ need for ongoing specialist mental health care but clinician's attempts to refer for similar reasons have met with AMHS refusing referral
  Specify care required:
  _____
- ☐ need for ongoing specialist mental health care but clinician's perception is that AMHS do not have the relevant service / expertise / interventions (e.g. family based interventions)
  Specify service/expertise/interventions required:
  _____
- ☐ referral refused by young person
- ☐ referral refused by parent(s)/carer(s)
- ☐ Plan to refer to adult services in the future
- ☐ other:
  specify_____

Current age of young person: _____

Outcome:

☐ Ongoing care with CAMHS

Number of sessions ____ Duration of contact (weeks) _____

Subsequently closed? Yes ☐ No ☐

If still open, pending referral decision from AMHS? Yes ☐ No ☐

☐ Discharged to GP

☐ Discharged to Other Service: specify type _____

☐ Disengaged

☐ Lost to follow up

☐ Other: specify

_____

SECTION 8: DETAILS USEFUL FOR PARTICIPATION IN STAGE 4

Last known address: _____

_____

_____

Phone number: _____

Last known GP and contact details: _____

_____

_____

_____

Details of any current case manager/key worker:

Name: _____ Role: _____

Service contact details: _____

_____

_____

Any general comments on the nature of the transition (positive / negative etc):

_____

_____

_____

Appendix 1: Ethnicity Classification (from Census 2001 Ethnicity Classification System)

1. White British	7. Other Mixed Background	13. African
2. White Irish	8. Indian	14. Other Black Background
3. Other White Background	9. Pakistani	15. Chinese
4. Mixed White and Black Caribbean	10. Bangladeshi	16. Other ethnic group (please state)
5. Mixed White and Black African	11. Other Asian Background	
6. Mixed White and Asian	12. Caribbean	

Appendix 4: Stage 3 interview schedule

TRACK

Telephone interview topic guide for staff and managers involved in providing Child and Adolescent Mental Health Services and Adult Mental Health Services

Introduction to TRACK and interview

Thanks for taking part and returning consent form.

Permission to record the interview.

Arrangements for respondent validation of transcripts.

Arrangements for contacting researchers. (Information sheet)

Section 1: Achieving Successful Transition from CAMHS to Adult Mental Health Services

What is the current process for ensuring successful transition from CAMHS to Adult Mental Health Services?

- What is your role in the process? Beginning and ending of role boundary?
- What is the cut-off age or criteria for end of CAMHS and starting age or criteria for take up of adult mental health services in the Trust?
- What services are available to service users/carers during transition? Range of services (including dual diagnosis). Geographical boundaries? Links to voluntary organisations?
- How do the range and availability of services meet user/carer needs?
- Availability of policies and guidelines to staff to inform the process of transition?

How is the service currently organised to achieve successful transition?

- Organisational structures? Management systems?
- Team meetings between CAMHS and Adult Services? Collaborative decision making? Communication of decisions to support transition?
- Arrangements and mechanisms for following up with service users/carers or teams where transition has not occurred or there are problems? How effective are these?
- Resources to support transition? Human resources in teams? Shortages? Use of temporary staff? Access to information and computer equipment?
- What are the greatest challenges to achieving successful transition in the way services are currently organised?

Section 2: Preparing and engaging service users for and in transitional arrangements

How are individual users/carers prepared for and engaged in transitional arrangements?

- How are they involved in decisions about meeting their needs?

- Are there any areas where this might be improved?
- Examples where transition has worked well and why.
- Examples where transition has worked less well and why.

Section 3: Barriers and facilitators to achieving successful transition?

What are the barriers to achieving successful transition?

- Most common three?
- How to reduce/overcome these?
- Why do you think these barriers exist?
- What would help you to overcome them?

What are the facilitators (success factors) in achieving successful transition?

- Most common?
- How to promote/sustain these?
- Availability to you?

Section 4: Inter-agency Working

How do you manage/promote interagency working during transition?

- Priorities in achieving this?
- Approaches to decision making?

- **How does this impact on achieving transition?**
- Please give examples based on your experience.

Thank you for taking part in this interview.

Appendix 5: Stage 4 interview schedule for service users

Topic List: Interview Schedules for Service Users

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I am a researcher based at _____. We are doing a study looking at what happens when a person who is attending a child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As you have moved from one service to another in the past two years we would like to talk to you today about your experiences of mental health services and the time when you stopped going to Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

Schedule for service users

- I would like to remind you that all that you tell me will remain confidential. The only situation where this would not apply is if you told me something that made me concerned that there was a risk of serious harm to either yourself or to another person.

- All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.

- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet

- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.

1. Child and Adolescent services – entry, illness course and overall experience

Could you tell me the story about how you first came to see someone at the Child and Adolescent Mental Health Services?

(Prompts: Who asked you to be seen there and why?

How old were you?)

Could you tell me about your experiences of using Child and Adolescent Mental Health Services?

(Prompts: What happened at CAMHS?

Was there anything helpful?

Was there anything unhelpful?

Is there anything you would change?)

2. Transition Planning

How did you realise that you would have to move from the Child and Adolescent Mental Health Services to the Adult service?

Was there anything that helped or was unhelpful in preparing you for this move?

Thinking back, is there anything that would have been more helpful in preparing you for the move, or anything that you would change?

3. Transition issues

What do you think were the main reasons why you were referred to adult services?

Was the reason something that makes sense to you?

Thinking about you and your family, what would be good reasons for you to move from the Child and Adolescent Mental Health Services to the Adult services?

4. Adult services – entry, engagement and defaulting, and overall experience

Have you been to the adult service you were referred to?

(Prompts: If so 'in what ways?'

If no, 'why not?')

What has it been like going there?

5. Comparison of Adult to Child and Adolescent services

Are there any ways in which it has been better/easier/more helpful going to the adult service than CAMHS?

Are there any ways in which CAMHS was better/easier/more helpful than going to than the Adult service?

6. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on you?

(Prompts:

Independence from parent

Engagement with services

Understanding of problems

Effects on severity of mental health problems-Better?, Worse?,

Any new problems?

What are you doing now? (college/working/hobbies, etc)

Is there anything else you would like to say about the transition from CAMHS to adult services that we haven't talked about yet?

Appendix 6: Stage 4 interview schedule for parents

Topic List: Interview Schedules for Carers

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I'm a researcher based at _____. We are doing a study looking at what happens when a person who is attending a child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As your child has moved from one service to another in the past two years we would like to talk to you today about your and [name of service user] experiences of mental health services and the time when he stopped going to Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

Schedule for carer

- I would like to remind you that everything that you tell me will remain anonymous. All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.

1. Child and Adolescent Mental Health services – entry, illness course and overall experience

Could you tell me the story about how X first came to see someone at the Child and Adolescent Mental Health Services?

(Prompts: What was the problem?

Who asked him/her to be seen there and why?

How old was s/he?)

Could you tell me about your and X's experiences of using Child and Adolescent Mental Health Services?

(Prompts: What happened at CAMHS?

Can you think of anything particularly helpful?

Anything you found unhelpful?

Is there anything you would change?)

2. Transition Planning

How did you realise that X would have to move from the Child and Adolescent Mental Health Services to the Adult service?

Was there anything that helped or was unhelpful in preparing X and you for this move?

Thinking back, is there anything that would have been more helpful in preparing you and X for the move?

3. Transition issues

What do you think were the main reasons why X was referred to adult services?

Was the reason something that makes sense to you?

Thinking about X and your family, what would be good reasons for X moving from the Child and Adolescent Mental Health Services to the Adult services?

4. Adult services – entry, engagement and defaulting, and overall experience

Have you or X been to the adult service X was referred to?

Prompts: If so 'in what ways?',

If no, 'why not?'

What has it been like going there?

5. Comparison of Adult to Child and Adolescent services

What have you found to be the main differences in adult services as compared to the child and adolescent services?

Are there any ways in which it has been better/easier/more helpful going to the adult service than CAMHS?

Are there any ways in which CAMHS was better/easier/more helpful than going to than the Adult service?

6. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on you or X?

Prompts:

Independence from parent

Engagement with services

Understanding of problems

Effects on severity of mental health problems-Better?, Worse?,

Any new problems?

Is there anything else you would like to say about the transition from CAMHS to adult services that we haven't talked about yet?

Appendix 7: Stage 4 interview schedule for CAMHS clinicians

Topic List: Interview Schedule for CAMHS Key-workers

Introduction

Thank you for agreeing to be interviewed today. My name is _____ and I am a researcher based at _____. We are doing a study looking at what happens when a person, who is attending a child and adolescent mental health clinic, has their care transferred to an adult mental health service.

As your client has moved from one service to another in the past couple of years we would like to talk to you today about your and your client's experiences of mental health services and the time when your client stopped going to Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

- I would like to remind you that all the information obtained in this study will be entirely confidential. It will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the university the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who was interviewed are combined anonymously when the results are reported so no one can be identified.

1. Transition Planning

Could you tell me what your service did once it was decided [name of service user] needed to transfer to another service?

(Prompts:
- *How did you go about making the referral?*
- *Which service were they transferred to? Why?*
- *What is your ideal of a good transfer of care? Which aspects did X receive/not receive?*
- *Any difficulties in accessing this service?*
- *What did CAMHS do to help client with transition?*

2. Transition issues

What were the main reasons why X was referred to you?

(Prompt: Appropriateness?)

3. Comparison of Adult to Child and Adolescent services

To your knowledge are there any differences in the service [name of service user] receives in adult services when compared with CAMHS?

(Prompts in terms of:
- Accessibility (out of hours/emergency contact)
- Continuity of care (seeing the same individuals, keyworker contact, being able to form a therapeutic relationship with the client)
- Quality of care (the benefits of any interventions offered, the quality of information and care given)
- Their diagnosis
- The types of staff they see
- Types of intervention)

What services do you expect X to receive in adult service?

4. Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on [name of service users]?

(Prompts:

Independence from parents, engagement with services, understanding of problems and effects on severity of mental health problems-Better?, Worse?, Any new problems?)

Is there anything else you would like to mention that we haven't talked about yet?

SDO Project 08/1613/117)

Appendix 8: Stage 4 interview schedule for AMHS clinicians

Topic List: Interview Schedules for AMHS Care-coordinator

Introduction
Thank you for agreeing to be interviewed today. My name is _____ and I am a researcher based at _____. We are doing a study looking at what happens when a person who is attending a child and adolescent mental health clinic has their care transferred to an adult mental health service.

As your client has moved from one service to another in the past two years we would like to talk to you today about yours and your client's experiences of mental health services and the time when your client stopped going to Child and Adolescent Mental Health Services. This will help us to develop ideas on how to improve services, especially for people who may have to move from one service to another in the future and their carers.

- I would like to remind you that all the information obtained in this study will be entirely confidential. It will be stored on a computer with each person identified only by a number code. Only the researchers involved in the study will be able to view the information and when this information is used in future reports and publications no one will be able to recognise you from the information.
- Are you willing for me to record our conversation so that I don't have to write while we are talking? Nobody outside the research team will hear the tapes, and back at the University the tapes will be kept in a locked filing cabinet
- To make the research most useful, I need to know both positive and negative things so please don't hesitate to tell me if you have any problems to report. The comments from everyone who is interviewed are combined anonymously when the results are reported so no one can be identified.

1 Transition Planning

Could you tell me what happened once it was decided [name of service-user] would come to your service?

(Prompts:
- *Any discussion between you and your client's key-worker/staff at CAMHS?*

- *Was anything else done (e.g. Discussion with client? giving written information to the client?, or arranging a visit/a period of joint-working?*
- *Could anything else have been done?).*

2 Transition issues

What were the main reasons why X was referred to you?

(Prompt: Appropriateness?)

3 Comparison of Adult to Child and Adolescent services

To your knowledge are there any differences in the service [name of service user] receives in Adult services when compared with CAMHS?

(Prompts in terms of:

- *Accessibility (out of hours/emergency contact)*
- *Continuity of care (seeing the same individuals, key-worker contact, being able to form a therapeutic relationship with the client)*
- *Quality of care (the benefits of any interventions offered, the quality of information and care given)*
- *Their diagnosis*
- *The types of staff they see*
- *Types of interventions)*

4 Potential impact of transition

In your opinion, has the process of changing from CAMHS to AMHS had any effect on [name of service user]?

(Prompts:

Independence from parents,

engagement with services,

understanding of problems

effects on severity of mental health problems-Better?, Worse?

Any new problems?)

Is there anything else you would like to mention that we haven't talked about yet?

Disclaimer:

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed by authors in this publication are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health. The views and opinions expressed by the interviewees in this publication are those of the interviewees and do not necessarily reflect those of the authors, those of the NHS, the NIHR, the NIHR SDO programme or the Department of Health"

Addendum:

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme, and managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO), based at the London School of Hygiene & Tropical Medicine.

The management of the SDO programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Although NETSCC, SDO has conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.

BJPsych | The British Journal of Psychiatry (2010) 197, 305–312. doi: 10.1192/bjp.bp.109.075135

Process, outcome and experience of transition from child to adult mental healthcare: multiperspective study

Swaran P. Singh, Moli Paul, Tamsin Ford, Tami Kramer, Tim Weaver, Susan McLaren, Kimberly Hovish, Zoebia Islam, Ruth Belling and Sarah White

Background
Many adolescents with mental health problems experience transition of care from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS).

Aims
As part of the TRACK study we evaluated the process, outcomes and user and carer experience of transition from CAMHS to AMHS.

Method
We identified a cohort of service users crossing the CAMHS/AMHS boundary over 1 year across six mental health trusts in England. We tracked their journey to determine predictors of optimal transition and conducted qualitative interviews with a subsample of users, their carers and clinicians on how transition was experienced.

Results
Of 154 individuals who crossed the transition boundary in 1 year, 90 were actual referrals (i.e. they made a transition to AMHS), and 64 were potential referrals (i.e. were either not referred to AMHS or not accepted by AMHS). Individuals with a history of severe mental illness, being on medication or having been admitted were more likely to make a transition than those with neurodevelopmental disorders, emotional/neurotic disorders and emerging personality disorder. Optimal transition, defined as adequate transition planning, good information transfer across teams, joint working between teams and continuity of care following transition, was experienced by less than 5% of those who made a transition. Following transition, most service users stayed engaged with AMHS and reported improvement in their mental health.

Conclusions
For the vast majority of service users, transition from CAMHS to AMHS is poorly planned, poorly executed and poorly experienced. The transition process accentuates pre-existing barriers between CAMHS and AMHS.

Declaration of interest
None.

Young people with mental health problems can get 'lost' during transition of care from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS).[1–3] Disruption of care during transition adversely affects the health, well-being and potential of this vulnerable group.[2–9] Ideally, transition should be a planned, orderly and purposeful process of change from child-oriented to adult models of care, taking into account both developmental and illness-specific needs.[1,10–12] If the process is seen simply as an administrative event between CAMHS and AMHS, many health and social care needs may remain unmet.[13]

Transition is often discussed but rarely studied. The national policy in the UK emphasises the need for smooth transition from CAMHS to AMHS[2,14–17] but there is no published evidence on the process, models and outcomes of transition. A systematic review of 126 papers on transition found only one on a mental health population and only within the US context.[5] Transition is a critical aspect of continuity of care, yet we know little about who makes such transitions, what are the predictors and outcomes of the process, and how it affects service users and their carers. Without such evidence, mental health services cannot develop and evaluate efficient models that promote successful transition or plan the future development and training programmes to improve transitional care. The TRACK study was designed to answer some of these questions in the UK context.

The overall aims of the TRACK study were to:

1 conduct an audit of the policies and procedures relating to transition within six mental health trusts in London and the West Midlands (three trusts in each region) (Stage 1);

2 evaluate the process of transition by a case-note survey identifying all actual and potential referrals (see below for definitions) from CAMHS to AMHS in the preceding year, 'track' their journey and outcomes in terms of referral and engagement with adult services, and determine the predictors of successful transition (Stage 2);

3 conduct qualitative interviews across organisational boundaries and services within health and social care agencies to identify specific organisational factors that constitute barriers and facilitators to transition and continuity of care (Stage 3);

4 explore the views of service users, carers and mental health professionals on the process of transition experience from a subsample of service users (Stage 4).

In this paper we present findings from Stages 2 and 4. A paper from Stage 1 has already been published.[18] The TRACK report including Stage 3 findings is available in full at www.sdo.nihr.ac.uk/projdetails.php?ref=08-1613-117. The study received ethical approval from Wandsworth Local Research Ethics Committee.

Method

We used the following definitions: actual referrals were all individuals that crossed the transition boundary and were accepted by AMHS; and potential referrals included individuals that crossed the transition boundary but did not complete transition to AMHS, regardless of the reasons for non-transition.

Transition pathways were categorised as optimal or sub-optimal. The optimal transition criteria were developed from an audit of CAMHS transition protocols[18] and literature on good practice in relation to continuity of care.[19] These criteria included:

(a) information transfer (information continuity): evidence that a referral letter, summary of CAMHS care, or CAMHS case notes were transferred to AMHS along with a contemporaneous risk assessment;

(b) period of parallel care (relational continuity): a period of joint working between CAMHS and AMHS during transition;

(c) transition planning (cross-boundary and team continuity): at least one meeting involving the service user and/or carer and a key professional from both CAMHS and AMHS prior to transfer of care;

(d) continuity of care (long-term continuity) – either engaged with AMHS 3 months post-transition or appropriately discharged by AMHS following transition.

Sub-optimal transitions were those that failed to meet one or more of the above criteria.

Design

The study was undertaken in six mental health trusts (service provider organisations within the National Health Service), three in Greater London and three in the West Midlands, covering a population of 8.1 million with wide socioeconomic, ethnic and urban–rural heterogeneity. All CAMHS teams that managed young people until the age of transition were included. Highly specialised and tertiary services (e.g. a national eating disorder service) were excluded because of the atypical population served and the logistical problems of tracking individuals from services that accept referrals from across the country.

Case ascertainment

Case ascertainment was a two-stage process. First, central databases of all included CAMHS were searched for open cases of individuals who had reached age x or above (where x is the age boundary for transition to AMHS). Since the age boundary for different services (x) varied, for each service x was specifically defined as per that service's transition protocol.[18] In the next stage, all CAMHS clinicians within included services were contacted by letter and email explaining the study and requesting details of actual and potential referrals during the study period. Initial contacts were followed up by further emails and telephone calls during the study period until all clinicians had submitted cases or provided a nil response. For the qualitative study, the young people identified for inclusion were contacted through their care coordinators to explain the study and seek informed consent.

Tracking tool

Two data extraction tools, one each for actual and potential referrals were devised and piloted for reliability. Data were collected on sociodemographic and clinical variables, transition pathways and transition outcomes (for actual referrals) and reasons for non-transition in potential referrals. Interrater reliability was checked by two researchers independently extracting data from the tools from five actual referrals from a site unrelated to the project. Comparing 491 non-text variables for each of the five cases, an error rate of less than 2% was found. Study tools are available in the full study report.

Ascertaining diagnoses

Since CAMHS case notes vary in recorded diagnoses, we categorised presenting problems into seven diagnostic groups: serious and enduring mental disorders, including schizophrenia, psychotic disorders, bipolar affective disorder, depression with psychosis; emotional/neurotic disorders, including anxiety, depression (without psychosis), post-traumatic stress disorder, obsessive–compulsive disorder; eating disorders, including anorexia nervosa, bulimia nervosa, atypical eating disorder; conduct disorders, including behavioural disorders; neuro-developmental disorders, including autism-spectrum disorders, intellectual disabilities; substance use disorders, including alcohol and/or drug misuse; and emerging personality disorder. Data on presenting problems were discussed with three CAMHS clinicians (M.P., T.F. and T.K.) to assign a diagnostic group. Comorbidity was defined as the presence of more than one diagnostic category from the seven above.

Predictors of transition

In the absence of previous evidence, we could not develop a prediction model for transition. Instead a two-stage analysis was conducted with initial identification of independent variables with an association ($P<0.05$) with the dependent variable using Pearson χ^2-tests (Fishers exact tests where necessary) for categorical variables and unpaired t-tests for continuous variables. Prior to logistic regression, significant independent variables that were highly associated with each other were recoded into a composite variable to reduce co-linearity. Two logistic regression analyses were planned: first, to determine predictors of achieving transition (being an actual rather than a potential referral); and second, to determine predictors of optimal transition. However, the small numbers of individuals identified in the study who experienced optimal transition precluded the second regression analysis (see Results). It was felt inappropriate to conduct a multilevel analysis as the study did not aim to determine the impact of trust-level variables on transition outcomes. With only six trusts in the sample, there would be insufficient variation in trust-level data for such an analysis. However, to account for possible clustering within trusts, i.e. to account for individuals within trusts being less variable than individuals between trusts, the logistic regression was repeated and standard errors (and therefore 95% confidence intervals and P-values) adjusted for cluster effects (see Results). This analysis was conducted using Stata version 9 for Windows.

Qualitative case studies

Semi-structured qualitative interviews were conducted with a subsample of service users who had completed transition, and where possible their carers and CAMHS and AMHS care coordinators. A purposive sample of service users ($n=20$) was initially identified comprising 10 service users, each in two groups: those who did or did not remain engaged with AMHS 3 months post-transition. Within each group we sampled individuals with or without evidence of joint working between CAMHS and AMHS. Within this primary sampling frame we sought to achieve range and diversity in terms of study site, diagnosis, gender, ethnicity and whether or not the service user was an age outlier at time of transition. Service users who declined to participate or who were deemed clinically unsuitable for inclusion were substituted with a matched case. Interviews were conducted by two researchers (K.H. and Z.L.) using topic guides developed by the project team and amended to incorporate emergent themes from all study components. The main focus was on preparation for transition, transition experiences, transition outcomes and

factors identifiable as related to positive or negative transition outcomes.

Qualitative analysis

Interviews were recorded, transcribed and entered onto NVivo software (www.qsrinternational.com). K.H. led the development and application of a coding frame with input from Z.I. and the qualitative study lead (T.W.). Use of NVivo facilitated investigator checking of coding. Qualitative analysis was undertaken using the constant comparative method within the framework approach described by Ritchie & Spencer.[29] This approach was particularly appropriate for integrating a thematic analysis built upon multiperspective data.

Results

Quantitative study results

We encountered major difficulties when searching the central CAMHS databases and these could not be interrogated using the study criteria (see full report for details). We therefore relied primarily on clinician recall to identify cases. A total of 154 individuals were thus identified (London 112; West Midlands 42). The rate of actual and potential referrals per 100 000 population in the London sites were 2.68 and 1.49 respectively and in the West Midlands sites 2.23 and 2.97 respectively. The service boundary for transition from CAMHS to AMHS (x) ranged from 16 to 21 years (mode 18).

Transition pathways

Of the 154 participants, 90 (58%) were accepted by AMHS (i.e. actual referrals). Sixty-four (42%) were potential referrals (i.e. those who crossed the transition boundary during the study period but did not make a transition to AMHS). Transition pathways for the entire cohort are shown in Fig. 1.

Sample description

The total sample consisted of 78 (51%) males and 76 females with a mean age of 18.12 years (s.d. = 0.82). A third (31%) were White and 23% Black and minority ethnic, but ethnicity was not recorded in a large proportion (27%). The majority (71%) lived with their parents and nearly two-thirds were either in employment or education (60%). Diagnostically, half ($n = 78$) had emotional/neurotic disorders, a quarter ($n = 38$) had neurodevelopmental disorders and 22% ($n = 34$) had serious and enduring mental disorders. Other disorders included substance misuse ($n = 14$, 9%), conduct disorders ($n = 6$, 4%), eating disorders ($n = 6$, 4%) and emerging personality disorder ($n = 4$, 3%). For five individuals (3%) the presenting problem was not recorded. Almost a fifth ($n = 29$, 19%) had comorbid mental health disorders.

Sociodemographic and clinical variables

Table 1 shows sociodemographic and clinical details of the participants in the actual and potential referrals groups. Those

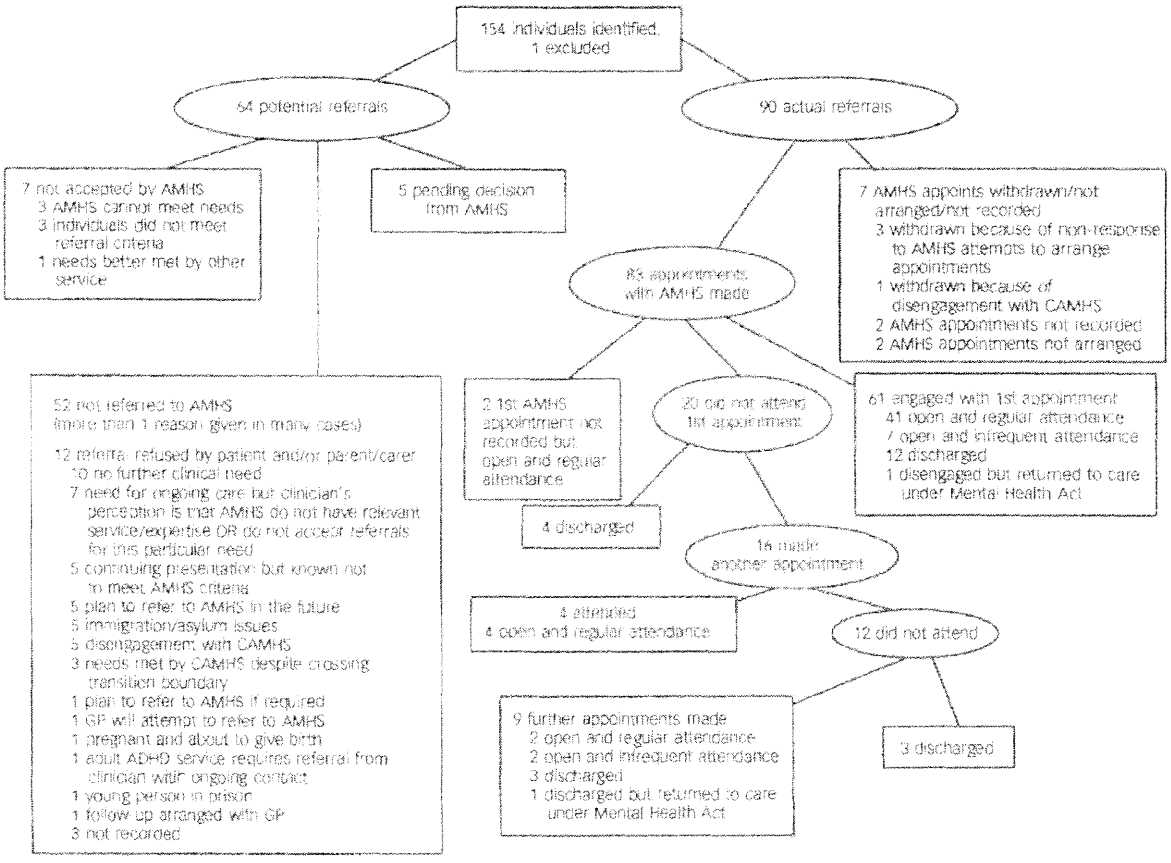

Fig. 1 Outcomes of all referrals from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS).

GP, general practitioner; ADHD, attention-deficit hyperactivity disorder.

Table 1 Demographic variables comparing actual and potential referrals

Variable	Actual referrals group ($n = 90$)	Potential referrals group ($n = 54$)	χ^2	P
Male, *n* (%)	49 (54.4)	29 (45.3)	1.24	0.26
Age at first referral to any CAMHS, years: mean (s.d.)	13.34 (3.9)	14.29 (2.9)	1.69	0.09
English as first language, *n* (%)	82 (91.1)	54 (84.4)	1.64	0.200
Living with parent, *n* (%)	58 (64.4)	52 (81.3)	6.99	0.03
Educational attainment GCSEs and below, *n* (%)	43 (47.8)	27 (42.2)	1.35	0.51
Parent attended CAMHS, *n* (%)	34 (37.8)	20 (31.3)	11.64	0.003
Positive family history of mental health problems, *n* (%)	51 (56.7)	22 (34.4)	3.64	0.06
'Looked after child' while attending CAMHS, *n* (%)	24 (26.7)	8 (12.5)	4.56	0.03
Evidence of special educational needs, *n* (%)	19 (21.1)	10 (15.6)	0.74	0.39
Evidence of child protection involvement, *n* (%)	12 (13.3)	1 (1.6)	6.70	0.01
Evidence of youth offending team involvement	7 (7.8)	7 (10.9)	0.45	0.5
Refugee or asylum seeker status, *n* (%)	10 (11.1)	9 (14.1)	0.02	0.96
Serious and enduring mental illness, *n* (%)	32 (35.6)	2 (3.1)	22.87	<0.0001
Emotional/neurotic disorder, *n* (%)	43 (47.8)	35 (54.7)	0.71	0.4
Eating disorder, *n* (%)	1 (1.1)	5 (7.8)	4.49	0.03
Conduct disorder, *n* (%)	3 (3.3)	3 (4.7)	0.81	0.67
Substance misuse, *n* (%)	12 (13.3)	2 (3.1)	4.76	0.03
Emerging personality disorder, *n* (%)	4 (4.4)	0	2.92	0.09
Comorbidity (2 or more disorders), *n* (%)	23 (25.6)	6 (9.4)	6.41	0.01
Admitted to hospital while attending CAMHS, *n* (%)	31 (34.4)	3 (4.7)	19.25	<0.0001
Detained under Mental Health Act, *n* (%)	15 (16.7)	1 (1.6)	9.16	0.002
Risk of self-harm at transition, *n* (%)	5 (5.6)	6 (9.4)	1.50	0.22
On medication at time of transition, *n* (%)	69 (76)	29 (45)	15.89	<0.0001

CAMHS, child and adolescent mental health services.

in the actual referrals group were more likely to have been living with parents, having attended CAMHS with their parents, to be involved with a child protection agency or be a 'looked after child', been admitted to a psychiatric hospital, to have been detained under the Mental Health Act, to have a serious and enduring mental disorder, substance misuse, an emerging personality disorder or more than one category of presenting problem (comorbidity), but less likely to have an eating disorder. To reduce the number of variables to enter into the logistic regression, a known broader social risk score variable was created that equalled the sum of the following: 'looked after child', child protection involvement, youth offending team involvement, special educational needs or refugee/asylum seeker.

Predictors of transition

Table 2 shows the results of the logistic regression conducted twice, with the second analysis controlling for clustering within trusts. Having a severe and enduring mental illness and being on medication at the time of transition predicted transition in both analyses. The effect of clustering among trusts was evident in two predictor variables: having 'known broader social risk' and having been admitted for in-patient care.

Optimal transitions

Based on our four criteria, only 4 of the 90 individuals in the actual referrals group experienced optimal transition. They were 2 males and 2 females, all from Black and minority ethnic backgrounds. Three had a serious and enduring mental disorder and had been admitted to hospital, two under the Mental Health Act. All four were on medication and were from London. Three were referred from an adolescent service.

We were unable to explore predictors of optimal transition given how few individuals had experienced it. We therefore determined predictors of one of the key criterion of optimal transition – continuity of care. This was defined as 'still engaged with AMHS or appropriately discharged 3 months post-transition'. Logistic regression revealed that individuals with emotional/neurotic disorder were a third less likely to experience optimal continuity of care (odds ratio (OR) = 0.34, 95% CI 0.12–0.96, $P = 0.041$). There was no association of continuity of care with any clinical, demographic or process variables.

Qualitative study results

Of the planned 20 service user participants, we could only interview 11. The most common reason for failing to recruit was no response from the service users to our requests for participation (25%). The second most common reason was that a clinician felt that the service user was too ill to participate (18%). A total of 27 interviews were conducted with 11 service users, 6 parents, 3 CAMHS clinicians and 6 AMHS clinicians.

Emergent themes

Emergent themes are reviewed briefly below, with some illustrative quotes set out in the online supplement to this paper.

Preparation for transition. Participants described three preparatory mechanisms for transition: transfer planning meetings, joint working and good information transfer. About half (54%) of young people interviewed reported attending at least one transition planning meeting, usually in the weeks preceding transition, with care coordinators from both CAMHS and AMHS and at least one parent. Service users and carers who did not have

Table 2 Results of logistic regression: factors predicting actual transition with clustered results accounting for trust-level data

Independent variable	Odds ratio	95% CI	*P*	95% CI, clustered	*P*, clustered
Known broader social risk (score)	1.38	0.9–2.1	0.14	1.1–1.8	0.02
English as first language	0.76	0.3–2.3	0.62	0.4–1.3	0.30
Parents attend CAMHS	0.56	0.2–1.3	0.19	0.2–1.3	0.16
Admitted as psychiatric in-patient	5.05	1.0–26.8	0.05	0.2–147.3	0.34
Admitted under the Mental Health Act	3.0	0.5–48.3	0.165	1.6–15.5	0.01
Eating disorder	0.24	0.0–2.4	0.22	0.0–3.4	0.29
Substance misuse	1.66	0.3–11.0	0.59	0.3–8.7	0.55
Comorbidity	2.82	0.9–9.4	0.09	0.8–9.6	0.01
Serious and enduring illness	7.85	1.6–37.8	0.01	1.5–40.9	0.01
On medication at the time of transition	2.36	1.1–5.3	0.04	1.7–3.4	<0.01

CAMHS, child and adolescent mental health services.

transition planning meetings thought that these would have been helpful. Both CAMHS and AMHS clinicians attributed lack of time as a barrier to such meetings. Two service users were told only at their last CAMHS appointment that they were going to be moved to AMHS.

Joint working. Child and adolescent mental health services were generally seen by AMHS colleagues as being in favour of joint working. The AMHS care coordinators appreciated the benefits of joint working (getting to know the service user, being 'in the best interest of the client') but expressed concern about 'responsibility for someone on your case-load, should something go wrong'.

Parental involvement. Parents tended to be less involved with AMHS than with CAMHS. Although young people preferred not having their parents involved in their care any more, parents wanted to be more involved with adult services, in order to be able to express concerns or because they felt 'left in the dark'. One parent stated: 'I know he is now 18 but he is still my son and I worry about him'.

Outcomes of transition. Eight of the eleven young people were still engaged with AMHS at the time of the interview. In most cases ($n = 7$), young people felt that their mental health had improved since the transition to AMHS but did not necessarily attribute this improvement to transition to adult services. Care coordinator flexibility and persistence in the face of missed appointments helped with engagement, although this was more likely to happen when there was evidence of deteriorating mental health or emerging crises. Of the three young people no longer engaged with AMHS, one was discharged as his symptoms had resolved, one did not want to be seen and one was discharged because of non-attendance.

Other transitions. A number of young people experienced other transitions such as change of accommodation or educational status, becoming pregnant or becoming involved with other agencies. Only two young people were still living with their parents after transition. One young person was living with her partner and their child and another was homeless and living in his car. Of the five young women interviewed, three had unplanned pregnancies during the transition period. Four young people had physical health problems closely linked to their mental health and of these, two experienced parallel health service transitions from paediatric to adult care. Five young people had involvement with other services, including Social Services, health visitors, a homeless persons unit, the probation service, school/education support services, counselling services and an autism support service.

Discussion

It is a paradox that although treatment for mental disorders in young people have improved substantially in the past two decades, health system responses to young people with mental disorders have been inadequate.[21] Despite adolescence being a risk period for the emergence of serious mental disorders, substance misuse, other risk-taking behaviours and poor engagement with health services, mental health provision is often patchy during this period.[21,22] By following a paediatric–adult split, mental health services introduce discontinuities in care provision where the system should be most robust.

To the best of our knowledge, TRACK is the first study in the international literature of the transition process, outcome and experience in a systematically identified cohort of young people who cross the boundary from CAMHS to AMHS. Our biggest methodological challenge was case ascertainment and we were hampered by the poor quality of CAMHS databases. Recall bias among clinicians is likely and our transition rates are certainly underestimates. Additionally, case notes may not accurately reflect the quality and content of services delivered. However, our qualitative results appear to complement the quantitative findings of inadequate transitional care. The requirement of the ethics committee that we seek service user consent through care coordinators meant that we could not interview individuals from the non-referred population (potential referrals) who were invariably out of contact with services. Our catchment was large and diverse, making our findings generalisable to other services in the UK. Internationally, there has been concern about adolescent mental health services in general[21,22] and about transition in particular.[3,23,24] Our findings are likely to reflect similar problems internationally.

The findings from TRACK can be summarised as follows: although most service users who crossed the CAMHS transition boundary needed transfer to AMHS, a significant proportion (a third in this study) were not referred to AMHS. Those with neurodevelopmental disorders, emotional/neurotic disorders or emerging personality disorder were most likely to fall through the CAMHS–AMHS gap. Those with a severe and enduring mental illness, a hospital admission and on medication were more likely to make a transition to AMHS but many (a fifth of all actual referrals in this study) were discharged from AMHS care without being seen. Having social risks also predicted transition of care

when clustering at trust level was taken into account. This might reflect a greater likelihood of the London sample experiencing such risks. Less than 4% of those accepted by AMHS experienced optimal transition. Although we cannot conclude that optimal transition equates with good clinical outcomes, it certainly equates with good patient experience, a key marker of service quality. In the TRACK cohort, basic principles of good practice identified in transition protocols[18] were not implemented. For the majority of service users, transition from CAMHS to AMHS was therefore poorly planned, poorly executed and poorly experienced. Transition processes appeared to accentuate all the pre-existing barriers between CAMHS and AMHS.[3,25]

Aligning referral thresholds

We cannot say why young people with emotional/neurotic, neurodevelopmental or emerging personality disorders are not being referred to AMHS. It is possible that CAMHS may be adjusting their referral thresholds on knowledge and prior experience of local AMHS. If so, this obscures inadequacies in current provision. Where services exist, all young people with ongoing needs should be referred. Where services do not exist, notably those for young people with neurodevelopmental disorders, unmet service user needs should be systematically documented and made clear to AMHS providers and commissioners. Currently, neither CAMHS nor AMHS appear to accept responsibility for the health and welfare of this group. Their outcomes are not known and should be a serious cause for concern.

Transition boundary

Transition policies in the trusts recommend flexibility regarding transition boundaries based on service user need.[18] Our study found little evidence of such flexibility. Perhaps services should use 'age windows' to decide the optimal time for transition rather than a strict age cut-off. A crisis should be a relative contra-indication to transition; transitions should only be planned and proceed at times of relative stability. There may be situations where transition can only occur during or immediately following a crisis, or where the transition process itself precipitates a crisis, but these occurrences should be relatively rare.

Transition preparation

Since most transitions can be long anticipated, there should be an adequate period of planning and preparing the service user and their carer for transition. Information about adult services, what to expect, differences in service provision, issues of confidentiality and parental involvement should all form a package of information that CAMHS share with service users and carers prior to transition. The completion of a 'transition logbook' would be a cheap and simple intervention to help structure the transition process. It would be jointly completed by the service user and their care coordinator and contain relevant details such as contact names and numbers, the dates and number of appointments with each agency, the final transition date and service user views on the experience. Such a tool can be easily evaluated on its impact on the process, outcomes and service user experience.

Improving information transfer

We found that current information technology systems, particularly in CAMHS, did not allow clinicians and managers to access high-quality information on case-loads. Information transfer was also hampered by a lack of understanding of each other's services, inconsistent documentation, different systems used for transfer of electronic information and transfer of referrals to lengthy waiting lists during which professional dialogue was reduced. Inadequate information technology systems in mental health services clearly hinder informational continuity.[26] The recent National CAMHS Review[27] notes the frustrations that arise as a result of separate, incompatible information technology systems across different agencies and the need for systems reform and resource support. We recommend that protocols for transition should explicitly specify information that should be transferred between agencies. Where possible, case notes should follow the young person and detailed referral letters, including risk assessments, should be sent to AMHS to facilitate planning. Introduction of electronic records offers an opportunity to facilitate standardisation across services and trusts.

Managing multiple transitions

Many young people had multiple transitions between AMHS teams, among care coordinators and in their personal circumstances, the cumulative effect of which was complex and unsettling for service users. From our data we cannot tell whether services were unaware of these multiple transitions or unequipped to deal with them. Mental health services, however, must pay attention to these multiple transitions through multi-agency involvement, in order to address the complex needs of this vulnerable group.[2,7,28]

Improving liaison between CAMHS and AMHS

Maitra & Jolley[29] have described a model where child and adult psychiatrists regularly attend each other's clinical meetings at which they jointly address the mental health needs of parents and children within families. Another approach is the development of designated transition workers with posts split between AMHS and CAMHS.[5,30,31] Such innovations have several benefits, including a higher profile for children and young people within adult services, shaping of the process of referrals across services, improved scope for preventive work, possibilities of joint working and the availability of a forum for formal and informal discussions.

These strategies require closer collaboration between services and agencies, which is demanding of both time and personnel. In periods of fiscal austerity, it is difficult to make a case for enhancing existing services, creating new transition worker posts or developing specialist clinics such as for adults with attention-deficit hyperactivity disorder. The CAMHS–AMHS divide is also mirrored in the differing commissioning arrangements in the UK, where CAMHS are often commissioned by acute care or children's services, whereas AMHS is firmly within mental health commissioning. Research evidence such as TRACK therefore is the best way for academics and clinicians to influence policy and shape service provision. We believe that joint commissioning between mental health services for children and adults and shared commissioning approaches at a regional level are the best ways to improve transitional care. The Appendix outlines the overall recommendations of the TRACK project. Further recommendations can be found in the full report.

Bridging the divide

There are two contrasting approaches for improving care for young people undergoing transition from CAMHS to AMHS. We can improve the interface between services as these currently exist, or we can develop a completely new and innovative service

model of integrated youth mental health services. Each has its advantages, limitations and resource implications. Common to both approaches is the need for services to pay attention to the developmental needs of this age group in areas beyond healthcare transition such as changes in educational and vocational domains, independent living and social and legal status. Although we call for further research into ways of improving transitional care, TRACK findings by themselves demand early and substantial service improvement, some of which can occur without new resources and by simply improving liaison, planning and joint working between CAMHS and AMHS.

In their review of youth mental heath services across the world, Patel *et al*[31] concluded: 'our single most important recommendation is the need to integrate youth mental health programmes, including those in the health sector (such as reproductive and sexual health) and outside this sector (such as education)'. The findings of TRACK highlight how far away we are from such integration, given the problems of transition revealed at the interface of CAMHS and AMHS. Even though we do not as yet know how to achieve best transitional care, the status quo of existing service barriers should not be acceptable. We certainly need evidence for any models of transitional care that we test in the future. The search for that evidence should be a goal, rather than a prerequisite for service change. We need to ensure that the vital need for improving youth mental health is not ignored for fear of dismantling long-standing and yet unhelpful service barriers.

Swaran P. Singh, MBBS, MD, FRCPsych, DM, Health Services Research Institute, University of Warwick, Coventry; **Moli Paul**, MRCPsych, PhD, University of Warwick, Coventry; **Tamsin Ford**, MRCPsych, PhD, Peninsula College of Medicine and Dentistry, Plymouth; **Tami Kramer**, MRCPsych, **Tim Weaver**, PhD, Imperial College London, London; **Susan McLaren**, BSc, PhD, London Southbank University, London; **Kimberly Hovish**, BA, MSc, Institute of Education, London; **Zoebia Islam**, MSc, PhD, Birmingham & Solihull Mental Health Foundation Trust, Birmingham; **Ruth Belling**, BUD, Joint Heads, PhD, London Southbank University, London; **Sarah White**, MSc, St George's University of London, London, UK

Correspondence: Swaran P. Singh, Health Services Research Institute, Medical School Building, Gibbet Hill Campus, University of Warwick, Coventry CV4 7AL, UK. Email: S.P.Singh@warwick.ac.uk

First received 4 Nov 2009, final revision 21 Jun 2010, accepted 24 Jun 2010

Funding

The TRACK study is funded by the National Institute of Health Research (NIHR) Service Delivery and Organisation (SDO) programme (www.sdo.nihr.ac.uk). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

Acknowledgements

The TRACK study team included Professor Swaran Singh, Dr Ruth Belling, Dr Jenny Dale, Dr Nawina Evans, Dr Tamsin Ford, Dr Nicole Fung, Ms Katherine Harley, Dr Daniel Hayes, Ms Kimberly Hovish, Dr Zoebia Islam, Dr Bob Jezzard, Dr Tami Kramer, Professor Susan McLaren, Dr Moli Paul, Dr Annie Rourke, Dr Tim Weaver and Dr Sarah White.

Appendix

Overall recommendations from the TRACK study

(a) The needs of the service user should be central to protocol and service development regarding transition.

(b) Trusts should have regular updated mapping of local CAMHS, AMHS and voluntary services, identifying scope of operation, communication networks and key contacts.

(c) Protocols should be developed and implemented in collaboration with all relevant agencies and young people and their carers.

(d) Multidisciplinary training should be planned and delivered for transition, including local service structures, protocols and working with young people. This training should be linked to the appraisal process and skills and competency frameworks.

(e) Protocols should specify the time frame, lines of responsibility and who should be involved, how the young person should be prepared and what should happen if AMHS are unable to accept the referral.

(f) Protocols should stress flexibility in the age range to accommodate a range of needs and developmental stages, and have explicit referral criteria and service provision.

(g) Transition should occur at times of stability where possible; young people should not have to relapse in order to access a service.

(h) Agencies should try to avoid multiple simultaneous transitions.

(i) Improved information transfer between CAMHS/AMHS with the standardisation of record keeping or, where this is impossible, clear indication of what information should be made available. A referral letter summarising past contact, current state and risks is a bare minimum. If all records cannot be transferred, copies of all correspondence and contact summaries should be.

(j) Transition process should include collaborative working between CAMHS and AMHS, with cross-agency working or periods of parallel care.

(k) Carers' needs and wishes should be respected in the transition process and carer involvement in adult services should be sensitively negotiated between clinicians, service users and their carers.

(l) Services need to develop for young people with emotional/neurotic, emerging personality and neurodevelopmental disorders wherever there is gap in such provision.

(m) Active involvement by AMHS is required before CAMHS can discharge a case; transfer onto a long waiting list is unacceptable.

(n) Changes should be evidence based. Prospective research is required on the clinical course, service needs, health and social cost implications for the young people receiving little service provision after leaving CAMHS.

References

1 Royal College of Paediatrics and Child Health. *Bridging the Gaps: Health Care for Adolescents*. Royal College of Paediatrics and Child Health, 2003 (http://www.rcpch.ac.uk/).

2 Lamb C, Hill D, Kelvin R, Van Beinum M. *Working at the CAMHS/Adult Interface: Good Practice Guidance for the Provision of Psychiatric Services to Adolescents/Young Adults. A Joint Paper from the Interfaculty Working Group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists, May 2008*. Royal College of Psychiatrists, 2008.

3 Singh SP. Transition of care from child to adult mental health services: the great divide. *Curr Opin Psychiatry* 2009; 22: 386–90.

4 Forbes A, While A, Ullman R, Lewis S, Mathes L, Griffiths P, et al. *A Multi-Method Review to Identify Components of Practice which may Promote Continuity in the Transition from Child to Adult Care for Young People with Chronic Illness or Disability. Report for the National Coordinating Centre for NHS Service Delivery and Organisation R & D*. NCCSDO, 2002 (http://www.sdo.lshtm.ac.uk).

5 While A, Forbes A, Ullman R, Lewis S, Mathes L, Griffiths P. Good practices that address continuity during transition from child to adult care: synthesis of the evidence. *Child Care Health Dev* 2004; 30: 439–52.

6 Kennedy A, Douglass S. Young people with chronic illness: the approach to transition. *Intern Med J* 2007; 37: 555–60.

7 Department for Children Schools and Families and Department of Health. *Transition: Moving on Well. A Good Practice Guide for Health Professionals and their Partners on Transition Planning for Young People with Complex Health Needs or a Disability*. Department of Health, 2008.

8 Department of Health. *Good Transitions for Good People*. Department of Health, 2006.

9 American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians-American Society of Internal Medicine. A consensus statement on health care transitions for young adults with special health care needs. *Pediatrics* 2002; 110: 1304–6.

10 Blum RW, Garell D, Hodgman CH, Jorissen TW, Okinow NA, Orr DP, et al. Transition from child-centered to adult health-care systems for adolescents with chronic conditions: a position paper for the Society of Adolescent Medicine. *J Adolesc Health* 1993; **14**: 570–6.

11 McDonagh JE, Kelly DA. Transiting care of the pediatric recipient to adult care givers. *Pediatr Clin North Am* 2003; **50**: 1561–83.

12 Royal College of Nursing. *Adolescent Transition Care*. RCN Publications, 2004.

13 Vostanis P. Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? *Curr Opin Psychiatry* 2005; **18**: 449–54.

14 Commission for Health Improvement. *Transition of Care between CAMHS and Adult Services*. Commission for Health Improvement, 2003 (http://www.chi.nhs.uk/Ratings/Trust/Indicator/IndicatorDescriptionShort.asp?indica(orId=3555).

15 Department of Health. *Getting the Right Start: National Service Framework for Children: Emerging Findings*. Department of Health, 2003.

16 Department for Education and Skills. *Every Child Matters: Change for Children*. Department for Education and Skills, 2004.

17 Department of Health and Department for Education and Skills. *National Service Framework for Children, Young People and Maternity Services*. Department of Health, 2004.

18 Singh SP, Paul M, Ford T, Kramer T, Weaver T, Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. *BMC Health Serv Res* 2008; **8**: 1–7.

19 Freeman G, Crawford M, Weaver T, Low J, de Jonge F. *Promoting Continuity of Care for People with Severe Mental Illness whose needs span Primary, Secondary and Social Care: A Multi-Method Investigation of Relevant Mechanisms and Contexts*. NCCSDO, 2002.

20 Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In *Analysing Qualitative Data* (eds A Bryman, R Burgess): 172–94. Routledge, 1994.

21 Patel V, Flisher AJ, Hetrick S, McGorry P. Mental health of young people: a global public-health challenge. *Lancet* 2007; **369**: 1302–13.

22 McGorry P. The specialist youth mental health model: strengthening the weakest link in the public mental health system. *Med J Aust (suppl)* 2007; **187**: S53–6.

23 Cosgrave EM, Yung AR, Killackey E, Buckby JA, Godfrey, KA, Standford CA, et al. Met and unmet need in youth mental health. *J Ment Health* 2008; **17**: 618–28.

24 Davis M, Geller JL, Hunt B. Within state availability of transition-to-adulthood services for youths with serious mental health conditions. *Psychiatr Serv* 2006; **57**: 1594–9.

25 Singh SP, Evans N, Sireling, L, Stuart H. Mind the gap: the interface between child and adult mental health services. *Psychiatr Bull* 2005; **29**: 292–4.

26 Burns T, Clement S, Cathy J, McLaren S, Rees-Jones, I, Wykes T, et al. *Experiences of Continuity of Care and Health and Social Outcomes: The ECHO Study*. National Coordinating Centre for Service Delivery and Organisation, 2007.

27 National CAMHS Review. *Children and Young People in Mind: the Final Report of the National CAMHS Review*. Department for Children, Schools and Families and Department of Health, 2008.

28 Department for Education and Skills and Department of Health. *Report on the implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services*. Department of Health, 2006.

29 Maitra B, Jolley A. Liaison between child and adult psychiatric services. In *Family Matters: Interface Between Child and Adult Mental Health* (eds P Reder, M McClure, A Jolley): 285–302. Routledge, 2000.

30 Health and Social Care Advisory Service. *CAMHS to Adult Transition: A Literature Review for Informed Practice. Health and Social Care Advisory Service (HASCAS) Tools for Transition*. Department of Health and HASCAS, 2006 (http://www.hascas.org.uk/pdf_files/HASCAS%20tools%20for%20transition%20Lit%20Review.pdf).

31 Social Exclusion Unit. *Transitions: Young Adults withComplex Needs*. Office of the Deputy Prime Minister, 2005.

EXTRA CONTENT ONLINE

100 words

Edvard Munch (1863–1944)

Alexandra Pitman

The Norwegian Expressionist Edvard Munch caused outrage when his paintings were first shown in Berlin but became one of the most prolific artists of his time. Often described as having had bipolar affective disorder, his low moods and sense of isolation are evident in works such as *The Scream*, *Separation*, and *Evening on Karl Johan*. Yet the evidence of his diaries and his many biographies suggest more plausible diagnoses of depressive disorder and comorbid alcohol dependence. Art historians acknowledge his ability to represent extreme emotional states, while debating the extent to which Munch exploited the market for his 'flawed personality'.

The British Journal of Psychiatry (2010) 197: 312. doi: 10.1192/bjp.197.4.312

Transition of care from child to adult mental health services: the great divide

Swaran P. Singh

Health Sciences Research Institute, Warwick Medical School, University of Warwick, Coventry, UK

Correspondence to Professor Swaran P. Singh, MBBS, MD, FRCPsych, DM, Professor of Social & Community Psychiatry, Health Sciences Research Institute, Warwick Medical School, University of Warwick, Coventry CV 4 7AL, UK
Tel: +44 2476574885;
e-mail: S.P.Singh@warwick.ac.uk

Current Opinion in Psychiatry 2009, 22:386–390

Purpose of review

Adolescents with mental health problems often require transition of care from child and adolescent to adult mental health services. This review is a synthesis of current research and policy literature on transition to describe the barriers at the interface between child and adolescent mental health services and adult mental health services and outcomes of poor transition.

Recent findings

Adolescence is a risk period for emergence of serious mental disorders. Child and adolescent mental health services and adult mental health services use rigid age cut-offs to delineate service boundaries, creating discontinuities in provision of care. Adolescent mental health services are patchy across the world. Several recent studies have confirmed that problems occur during transition in diverse settings across several countries. In physical health, there are emerging models of practice to improve the process and outcomes of transition, but there is very little comparable literature in mental healthcare.

Summary

Poor transition leads to disruption in continuity of care, disengagement from services and is likely to lead to poorer clinical outcomes. Some young people, such as those with neurodevelopmental disorders and complex needs, are at a greater risk of falling through the care gap during transition. Services need robust and high-quality evidence on the process and outcomes of transition so that effective intervention strategies can be developed.

Keywords

adolescent mental health, child mental health services, continuity of care, transition

Curr Opin Psychiatry 22:386–390

0951-7367

Introduction

There has been long-standing concern about young people with mental health problems getting lost to care in their move (transition) from child and adolescent mental health service (CAMHS) to adult mental health service (AMHS). Despite the obvious importance of ensuring continuity of high-quality care during transition, there is very little evidence about the magnitude of the problem, outcomes of individuals who fall through such care gaps, interventions that might improve the process, and the experience of service users and carers about transition. This review summarizes recently published research evidence and policy documents (2006–2008) on transitions from CAMHS to AMHS, drawing parallels from selective transition literature in physical conditions.

Adolescence as a 'risk period'

The journey into adult life is a time of profound physiological, psychological and social change for young people and their families. Overall rates of mental health problems in young people increase during adolescence, problems become more complex, and serious disorders such as psychosis emerge. Apart from being a risk period for higher psychological morbidity, adolescents also have greater propensity for risk-taking behaviours, falling between child and adult services, and being at greater risk of disengagement from services [1].

Young people with mental health problems have very high rates of long-term morbidity and mortality [2]. A recent UK survey found that 10% of 5–16-year-olds have a mental health disorder [3]. Overall, at least one in four to five young people will have at least one mental disorder in any given year [4]. Comorbidity is also common in adolescence, in terms of both psychiatric disorder and additional problems; and comorbidity among those attending CAMHS is likely to be even higher [5,6•]. The Breaking the Cycle report [7] found that 98% of young adults (16–25-year-olds) accessing services in the UK had more than one problem or need. Common comorbid problems included homelessness, problems

associated with leaving care, lack of training/education opportunities, barriers to employment, crime, poor housing, drug and alcohol misuse and learning disability. Mental health problems in adolescence also predict problems in adulthood [1,8]. The National Comorbidity Survey Replication in the USA found that 75% of people with a mental disorder had an age of onset younger than 24 years [9]. Several recent studies provide additional support that there is phenomenological continuity in mental disorder from childhood to adult age including in bipolar disorders [10••], functional somatic symptoms [11] and personality disorders [12].

Defining transition

The concept of transition has two distinct meanings: developmental transition and healthcare transition. From a developmental perspective, adolescence is a crucial stage of emotional, psychosocial, personal and physiological developments as young people embark on adult roles through tasks such as separating from family, deciding on a career path and defining self in a social context. From a healthcare perspective, young people with ongoing health problems have to move from one service to another upon reaching certain age milestones. These two transitions usually occur simultaneously, but needs related to developmental transition may remain unmet if transition is seen simply as an administrative healthcare event [13]. Transition is often too focused on service transfer rather being part of a holistic process of moving to adulthood and independence [14].

Adolescence: stage or age?

Adolescence is a developmental stage, rather than something defined strictly by age [15]. However, services and policies are often demarcated by rigid age boundaries. There is a lack of consensus on when CAMHS ends and AMHS begins [1,16•]. In the UK, some services use age cut-offs between 16 and 18 years, whereas others consider CAMHS appropriate only for those in full-time education [16•]. In its surveys on mental health, the UK National Office for Statistics groups 16 and 17-year-olds with adults and those aged 15 and under as children, with no separate category for adolescents [17]. It has been argued that services should consider the health and developmental needs of two groups, children under 12 years and young people between 12 and 24 years [4]. An alternative view, often made explicit in transition policies, is that whereas all age-based boundaries are ultimately arbitrary, there should be flexibility around transition based upon developmental needs of the service user [16•]. Such a flexible approach may be intended in policy, but in practice busy teams struggling with complex loads often use rigid age boundaries as a way of managing capacity and restricted caseloads rather than providing what is in the best interest of the service user.

Magnitude of the problem

Child psychiatry has emerged relatively recently as a subspecialty, and adolescent focus is an even newer concern [4,18]. CAMHS and adult services differ in their theoretical and conceptual views of diagnosis, cause and treatment focus and have quite different service organization and professional training. These differences accentuate the problems at their interface, creating barriers in transition [19]. These barriers cut across local healthcare economies; transition problems occur in diverse healthcare systems across different continents [1,16•,18,20–22].

A recent large US study examined the patterns of mental health service use by persons of transition age (16–25 years) based on nationally representative 1997 Client/Patient Sample Survey and population data from the US Census Bureau [23]. The annual rate for inpatient, outpatient, and residential services was 34/1000 for 16 and 17-year-olds and 18/1000 for 18 and 19-year-olds. This confirms a precipitous decline in service utilization just at the time when serious mental health problems are beginning to emerge. The authors recommended that resources should be specifically targeted towards shared planning between CAMHS and AMHS to facilitate continuity of care for young adults who are 'ageing out' of CAMHS, as well as for those who experience their first episode of mental disorder in early adulthood.

In the US, a survey of transition provision within 41 states found that a quarter of child mental health services and half of adult services offered no transition support. Another US study [24] found that continuity of care was hampered by separate child and adult mental health systems, marked by separate policies for access, lack of clarity in access procedures and lack of shared planning. A recent study from Australia found that many young people referred by CAMHS were not accepted by AMHS, despite having substantial mental health needs and functional impairment [20]. Despite several policy initiatives [25••,26,27•], CAMHS in England and Wales continue to have problems in ensuring optimal transition of care [1,16•,19]. With few arrangements in place for young people negotiating transition boundaries, some slip through the care net only to present to adult services later on, by which time they may have developed severe and enduring mental health problems [28].

Transition in physical health

Advances in medical care have led to increased life expectancy for young people with chronic illness or physical disability [29,30,31•,32••]. This in turn has led to higher numbers crossing over from paediatric to adult care; yet transition-related research is sparse even in physical disorders [31•,33]. A recent review of transitions

in diabetes reported that published studies have major limitations imposed by small sample sizes and selection bias. The review confirmed that a significant proportion of young people were lost to follow-up during the transition process. There was some evidence that implementing an educational transition programme, having a transition care coordinator and having a transition clinic attended by both adult and paediatric physicians improved clinic attendance [34••].

A recent US survey highlighted the concerns of general physicians about transition for young adults with childhood-onset conditions. These concerns clustered into six distinct categories: patient maturity, patient psychosocial needs, family involvement, provider's medical competency, transition coordination and health system issues. Adult specialists felt that paediatricians were reluctant to let go of their cases; and considerable concerns were raised about patients' autonomy versus caregiver involvement [31•]. Transition problems seem to cut across specialties and diagnostic categories and embody common challenges for child and adult services across the healthcare spectrum [35].

McDonagh [15] has identified several barriers to optimal transition in physical disorders. These include changes in established, long-term therapeutic relationships between young people and health professionals; differences between adult and child models of care; young people's level of maturity and understanding; differing perceptions of the adult care system; adolescent resistance to transfer; family stressors; inadequate education and training for adult care providers on adolescent disorders; and lack of organizational support. This could easily be a list of transition problems in mental healthcare. McGorry [18] has argued that 'public mental health services have followed a paediatric–adult split in service delivery, mirroring general and acute healthcare. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest'.

Transition from child and adolescent mental health service to adult mental health service: UK findings

A recent national review of CAMHS provision in the UK found that transition from CAMHS to AMHS caused major concerns to service users, carers and clinicians [27•]. Many 16–18-year-olds did not get support and care during transition. Young people with ongoing mental health problems that did not amount to serious mental disorders were specifically excluded from adult services; this group included those with attention deficit hyperactivity disorder (ADHD) and behavioural problems. There were a few examples of good practice around the country, including specific transition workers, transition services and services such as early intervention in psychosis that operated astride the CAMHS–AMHS divide. The review concluded that services should flexibly focus on needs rather than chronological age but recognized that such changes had significant resources and training implications.

A more recent multisite multimethods study of transition policies, practice, procedures and outcomes in England (the TRACK study) has published its first paper [16•]. Using a questionnaire to determine transition policies and practice across Greater London, the study found that most CAMHS had existing transition protocols to guide the process. Protocols were largely similar in their stated aims and policies, but differed in several key procedural details, such as joint working between CAHMS and AMHS and whether protocols were shared at trust or locality level. An enduring mental health problem was considered a key criterion for individuals requiring transition. However, many disorders that fell outside of this criterion, such as neurodevelopmental disorders (ADHD, autism spectrum disorder, mild to moderate learning disability) and emotional/personality related problems, were likely to fall through the care net. All protocols emphasized that service users' involvement should be central in transition planning and implementation, yet no protocol specified how users should be prepared for transition. A major omission from protocols was procedures to ensure continuity of care for patients not accepted by AMHS. The TRACK study is due to publish its final report in April 2009.

Despite policy documents and initiatives, there are still unacceptable variations in service provision for young people with mental health problems, both between regions and within local areas in the UK, leading to inequalities of care provision [27•]. The challenges at the interface between CAMHS and AMHS are not all the responsibility of CAMHS. These require strategic collaboration between all agencies providing care for adults and children and range from specific local arrangements between CAMHS and AMHS for transition policies, the development of pathways to care and treatment protocols at the interface, to broader national initiatives to improve workforce capacity and training.

Neurodevelopmental disorders

For children with disabilities transition from childhood to adulthood is more problematic, and transition for young people with mild to moderate learning disability is particularly complex. They may not meet the eligibility criteria for either the Adult Learning Disability Service or the Adult Community Mental Health Team, yet require ongoing support and psychiatric intervention. This also occurs commonly with high-functioning young people

with an autism spectrum disorder or Asperger syndrome, especially in the absence of clear-cut comorbid psychiatric disorder [1,16•]. There is also growing recognition of inadequate services for young people with ADHD [36••]. Only about a fifth of community paediatricians in the UK have access to dedicated clinics for adults with ADHD [37].

Young people in special circumstances

Many young people in special circumstances (such as the Looked After or those leaving Local Authority care; the homeless) and from certain minority groups such as asylum seekers may be particularly vulnerable to mental health problems. Pathways and access to mental healthcare are particularly problematic for people from Black and minority ethnic backgrounds [38••,39]. Such groups may not access either CAMHS or AMHS [28] because of both the stigma of mental illness and the perception that services are not culturally appropriate [40]. Others such as those with a forensic history or with significant risk to others have complex needs and yet may not meet eligibility criteria of community services. These groups are particularly vulnerable to problems during transition [1].

The effect of poor transition

The most disruptive outcome of poor transition is that young people with ongoing needs disengage from services during the transition process. Disengagement from mental healthcare is in many cases a major problem [41•] with socially isolated adolescents at the greatest risk of dropping out of treatment [42]. The most vulnerable therefore are at greatest risk of dropping out of care. Young people are also less likely to collaborate with clinicians about their treatment, partly because many feel that they do not have an adequate 'say' in the care they receive [43]. Poor transition simply adds to the risk of such disengagement.

In mental healthcare, young service users and their carers often have very different perspectives on treatment goals and outcomes from those of clinicians. Additionally, when young people turn 18 mental health services are no longer obliged to involve their parents or carers in treatment due to the assumed autonomy of the 'adult' service user. Studies show that families feel left out of the treatment process following transition and involving families collaboratively reduces the risk of disengagement as well as carer distress (e.g. [44]).

Conclusion

Whereas everyone seems to agree that good-quality transition from CAMHS to AMHS is a crucial aspect of care provision, the phenomenon itself is rarely studied. There are significant gaps in our knowledge about the process, outcomes and experience of transition from CAMHS to AMHS. We do not convincingly know who makes such a transition, who falls through the care gap, what are the predictors and outcomes of successful transition, how the process of transition is experienced by users, carers and clinicians, and what organizational factors facilitate or impede successful transition. Without such evidence, we cannot develop and evaluate specific service models that promote successful transition or plan future service development and training programmes. Findings from the TRACK study should provide such evidence in the UK context.

Acknowledgements

The TRACK study is funded by the National Institute of Health Research (NIHR) Service Delivery and Organisation (SDO) programme (www.sdo.nihr.ac.uk).

The TRACK Study team includes Professor Swaran Singh, Dr Ruth Belling, Dr Jenny Dale, Dr Navina Evans, Dr Tamsin Ford, Dr Nicole Fung, Ms Katherine Harley, Dr Daniel Hayes, Ms Barbara Herts, Dr Zoebia Islam, Dr Bob Jezzard, Dr Tami Kramer, Professor Susan Mc Laren, Dr Moli Paul, Dr Anne Rourke, Dr Tim Weaver, and Dr Sarah White.

References and recommended reading

Papers of particular interest, published within the annual period of review, have been highlighted as:

- • of special interest
- •• of outstanding interest

Additional references related to this topic can also be found in the Current World Literature section in this issue (p. 422).

1 Lamb C, Hall D, Kelvin R, *et al.* Working at the CAMHS/adult interface: good practice guidance for the provision of psychiatric services to adolescents/young adults. A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists. Lamb C, editor; 2008.

2 Royal College of Paediatrics and Child Health. Bridging the gaps: healthcare for adolescents. 2003 (www.rcpch.ac.uk).

3 Green H, McGinnity A, Meltzer H, *et al.* Mental health of children and young people in Great Britain, 2004. A report for the Office of National Statistics. Hampshire: Palgrave Macmillan; 2005.

4 Patel V, Flisher AJ, Hetrick S, *et al.* Mental health of young people: a global public-health challenge. Lancet 2007; 369:1302–1313.

5 Ford T, Goodman R, Meltzer H. The British child and adolescent mental health survey 1999: the prevalence of DSM-IV disorders. J Am Acad Child Adolesc Psychiatry 2003; 42:1203–1211.

6 • Ford T, Hamilton H, Meltzer H, *et al.* Predictors of service use for mental health problems among British school children. Child Adolesc Mental Health 2008; 13:32–40.

A 3-year follow-up survey of over 2000 British children aged 5–15 for 3 years showing that predictors of services are the impact of psychopathology, contact with teachers or primary healthcare, and parents' and teachers' perceptions that the child had significant difficulties.

7 Social Exclusion Unit. Breaking the cycle. London: Office of the Deputy Prime Minister; 2004.

8 Silva PA. The Dunedin multidisciplinary health and developmental study: a 15 year longitudinal study. Paediatr Perinat Epidemiol 1990; 4:96–127.

9 Kessler RC, Chiu WT, Demler O, *et al.* Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005; 62:617–627.

10 •• Geller B, Tillman R, Bolhofner K, *et al.* Child bipolar I disorder: prospective continuity with adult bipolar I disorder; characteristics of second and third episodes; predictors of 8-year outcome. Arch Gen Psychiatry 2008; 65:1125–1133.

Longitudinal, prospective, 8-year outcome study showing continuity between childhood and adult bipolar I disorder. In adult patients with child BP-I, the 44.4% frequency of manic episodes was 13–44 times higher than population prevalences, strongly supporting continuity.

11 Steinhausen HC, Winkler Metzke C. Continuity of functional-somatic symptoms from late childhood to young adulthood in a community sample. J Child Psychol Psychiatry 2007; 48:508–513.

12 De Clercq B, De Fruyt F. Childhood antecedents of personality disorder. Curr Opin Psychiatry 2007; 20:57–61.

13 Vostanis P. Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? Curr Opin Psychiatry 2005; 18:449–454.

14 Kirk S. Transitions in the lives of young people with complex healthcare needs. Child Care Health Dev 2008; 34:567–575.

15 McDonagh JE. Growing up ready for emerging adulthood: an evidence base for professionals involved in transitional care for young people with chronic illness and/or disabilities. Cambridge: Eastern Region Public Health Observatory; 2006.

16 • Singh SP, Paul M, Ford T, *et al.* Transitions of care from child and adolescent mental health services to adult mental health services (TRACK study): a study of protocols in Greater London. BMC Health Services Res 2008; 8:1–7.
Survey of Greater London CAMHS transition protocols showing that, whereas most services have protocols with identical underlying principles, protocols vary in the process and user involvement in transition.

17 Cooper C, Bebbington P. Mental health. In: Bajekal M, *et al.*, editors. Focus on health. London: Office for National Statistics; 2006. pp. 109–122.

18 McGorry P. The specialist youth mental health model: strengthening the weakest link in the public mental health system. Med J Aust (Suppl) 2007; 187:s53–s56.

19 Singh SP, Evans N, Sireling L, Stuart H. Mind the gap: the interface between child and adult mental health services. Psychiatric Bull 2005; 29:292–294.

20 Cosgrave EM, Yung AR, Killackey EJ, *et al.* Met and unmet need in youth mental health. J Mental Health 2008; 17:618–628.

21 Davis M, Geller JL, Hunt B. Within-state availability of transition-to-adulthood services for youths with serious mental health conditions. Psychiatr Serv 2006; 57:1594–1599.

22 Cameron CL, Birnie K, Dharma-Wardene MW, *et al.* Hospital-to-community transitions. A bridge program for adolescent mental health patients. J Psychosoc Nurs Ment Health Serv 2007; 45:24–30.

23 Pottick KJ, Bilder S, Vander Stoep A, *et al.* US patterns of mental health service utilization for transition-age youth and young adults. J Behav Health Serv Res 2008; 35:373–389.

24 Davis M, Sondheimer DL. State child mental health efforts to support youth in transition to adulthood. J Behav Health Services Res 2005; 32:27–42.

25 •• Department for Children, Schools and Families and Department of Health. Transition: moving on well. A good practice guide for health professionals and their partners on transition planning for young people with complex health needs or a disability. London: Department of Health; 2008.
Detailed policy and good practice guide from a UK health service perspective.

26 Department of Health. Transition: getting it right for young people. London: Department of Health, Child Health and Maternity Services Branch; 2006.

27 • National CAMHS Review. Children and young people in mind: the final report of the National CAMHS Review. Department for Children, Schools and Families and Department of Health; 2008.
National review of the current state of child and adolescent mental health services in the UK with progress since 2004 policy guidance, revealing areas of both strength and weakness. Has a brief section on transition.

28 Richards M, Vostanis P. Interprofessional perspectives on transitional mental health services for young people aged 16–19 years. J Interprof Care 2004; 18:115–128.

29 Department for Children, Schools and Families and Department of Health. A transition guide for all services: key information for professionals about the transition process for disabled young people. 2007 (www.everychildmatters.gov.uk)

30 Sawyer SM, Drew S, Yeo MS, Britto MT. Adolescents with a chronic condition: challenges living, challenges treating. Lancet 2007; 369:1481–1489.

31 • Peter NG, Forke CM, Ginsburg KR, Schwartz DF. Transition from pediatric to adult care: internists' perspectives. Pediatrics 2009; 123:417–423.
Two-stage postal survey of over 100 adult physicians in the USA to establish their concerns about transition for adults with childhood-onset conditions. Main concerns were lack of training, lack of family involvement and families' expectations, patients' psychosocial needs, needing specialists, disability/end of life issues, and financial pressures.

32 •• Royal College of Physicians of Edinburgh Transition Steering Group. Think transition: developing the essential link between paediatric and adult care. Edinburgh: Royal College of Physicians of Edinburgh; 2008.
Excellent overview of generic issues in transition care for young people with chronic illnesses as well as four exemplar conditions (cystic fibrosis, chronic renal disease, type I diabetes and childhood cancer survivors) to highlight some of the diverse issues. Provides several lessons for mental health services.

33 Burke R, Speerin M, Price A, *et al.* Survey of primary care pediatricians on the transition and transfer of adolescents to adult healthcare. Clin Pediatrics 2008; 47:347–353.

34 •• Nakhla M, Daneman D, Frank M, Guttman A. Translating transition: a critical review of the diabetes literature. J Pediatric Endocrinol Metabol 2008; 21:507–516.
A substantial review of diabetes literature on transition with evidence for service models for improving transitional care such transition care coordinators, and joint working between paediatric and adult clinicians.

35 McDonagh JE, Viner R. Lost in transition? Between paediatric and adult services. Br Med J 2006; 332:435–436.

36 •• Nutt DJ, Fone K, Asherson P, *et al.* Evidence-based guidelines for management of attention-deficit/hyperactivity disorder in adolescents in transition to adult services and in adults: recommendations from the British Association for Psychopharmacology. J Psychopharmacol 2007; 21:10–41.
Much needed expert guidelines on managing adolescents with ADHD who make a transition to adult services and also adults newly presenting with ADHD symptoms.

37 Marcer H, Finlay F, Baverstock A. ADHD and transition to adult services: the experience of community paediatricians. Child Care Health Develop 2008; 34:564–566.

38 •• Singh SP, Greenwood N, White S, Churchill R. Ethnicity and the Mental Health Act 1983. Br J Psychiatry 2007; 191:99–105.
Systematic review and meta-analysis of ethnic differences in detention rates showing that, while detention rates are high in minority ethnic groups, explanations based on racism in mental health have no evidence base.

39 Singh SP, Grange T. Measuring pathways to care in first-episode psychosis: a systematic review. Schizophr Res 2006; 81:75–82.

40 Bradby H, Varyani M, Oglesthorpe R, *et al.* British Asian families and the use of child and adolescent mental health services: a qualitative study of a hard to reach group. Soc Sci Med 2007; 65:2413–2424.

41 • O'Brien A, Fahmy R, Singh SP. Disengagement from mental health services: a literature review. Soc Psychiatry Psychiatr Epidemiol 2008.
Disengagement, like transition, is much discussed but rarely studied. A major review of magnitude and predictors of disengagement from mental healthcare.

42 Schimmelmann BG, Conus P, Schacht M, *et al.* Predictors of service disengagement in first-admitted adolescents with psychosis. J Am Acad Child Adolesc Psychiatry 2006; 45:990–998.

43 Laughame R, Priebe S. Trust, choice and power in mental health: a literature review. Soc Psychiatry Psychiatr Epidemiol 2006; 41:643–652.

44 Dixon L, Adams C, Lucksted A. Update on family psychoeducation for schizophrenia. Schizophr Bull 2000; 26:5–20.

opinion & debate

Psychiatric Bulletin (2005), 29, 292–294

SWARAN P. SINGH, NAVINA EVANS, LESTER SIRELING AND HELEN STUART

Mind the gap: the interface between child and adult mental health services

Adolescents with mental health problems are poorly served by mental health services, since responsibility for care often falls between child and adult services. Within the UK, there is no consensus on how service boundaries should be delineated. Some services use an age cut-off at some point between 16 and 18 years, whereas others consider child services to be appropriate only for those in full-time education. The Audit Commission (1999) reported that nationally 29% of health authorities commissioned child and adolescent mental health services for young people before their 16th birthday only, although adult services were not considered suitable for those under 17 years old. The report highlighted the poor development of adolescent services and their inadequate links with other agencies, including adult mental health services.

Even though adolescence is a risk period for the emergence of serious mental illnesses such as schizophrenia, it has generally received only patchy attention from services (Reder *et al*, 2000). The Mental Health Foundation report *Bright Futures* suggested that young people generally have a poor image of adult services (Mental Health Foundation, 1999). Admitting young people to acute adult wards is particularly problematic and is likely to set them on a lifelong path of aversion to mental health care. Communication between child and adult services is notoriously poor. Although many young people experience transition to adult services, just under a quarter of services in the UK have specific arrangements for such transfer of care (Audit Commission, 1999).

There is considerable variation across the country in how well this transition is managed. A Select Committee on Health report on National Health Service mental healthcare identified several problems in the transition from child to adult services (Select Committee on Health, 2000). These problems included the failure of services to work together, the need for care management and planning to be led by a single practitioner who can coordinate care across all relevant agencies, the shortage of in-patient services for adolescents, the need for early intervention and the poor liaison between various agencies. In addition, access to psychotherapy is generally more difficult in adult services. There is therefore a serious risk of disruption in care provision for adolescents who are transferred to adult mental health services. A review of continuity in transition from child to adult services highlighted the paucity of high-quality research in this area (While *et al*, 2004).

In this paper we explore the conceptual and practical barriers that exist between child and adult services and recommend strategies for effectively managing this interface, especially in light of the development of specialist services such as early intervention in psychosis, which bridge the child–adult divide.

Barriers at the interface

The interface between child and adult services is influenced by how the services have evolved in their structure and function and how they differ in their conceptualisation and management of mental illnesses (Reder *et al*, 2000).

Evolution of services

Adult psychiatry has evolved under the successive influences of neurology, phenomenology, psychology and sociology, and has developed treatment strategies which were once entirely asylum-based but are now increasingly provided in the community. The primary focus of adult psychiatry has been the individual's morbid mental state. Treatment strategies are aimed mainly at ameliorating such states by biological and psychological therapies. Child psychiatry, on the other hand, emerged later and primarily within a sociological context, with concerns about vagrant, traumatised or delinquent youth. It gradually broadened its horizons to include developmental concerns and the role of systems such as the family. The assessment focus is therefore on interactions between developmental and emotional processes, family relations and social experiences, with treatments geared primarily towards psychological and systems interventions.

Differing perspectives

These organisational and theoretical differences are most vivid at the interface, where different perspectives collide, such as when a young person with behavioural problems and an unstable family is referred to an adult service that regards an absence of diagnostic phenomenology as a barrier to offering help. The needs of a child envisioned within a family context allow child services to offer help to the family unit, respect for the autonomy of an adult prohibits adult services from intervening where an individual declines help. Young people negotiating the developmental tasks of adolescence, such as independence, sexuality, career and independent living, are therefore caught between two very different services, one that considers them and their problems as part of the family unit, and the other that considers them as adult and autonomous. Concerns about confidentiality also inhibit adult services from sharing findings and plans with family members, unless the young person gives explicit consent. Families who wish to stay involved in treatment plans are often left feeling isolated and removed from major

decisions made by adult services. All these heighten the risk of the young person withdrawing from care at the point of transition.

Diagnostic uncertainty

Many young people have difficulty negotiating adolescence and can experience a wide range of problems, which may persist into adult life if not addressed early. The disturbances of conduct disorders, for instance, can persist into adult life (Scott, 1998) and if such individuals get into trouble with the law or misuse substances, they are likely to fall through the care net. The distress of social problems such as domestic violence, homelessness, unemployment, parental separation or parental mental illness can masquerade as psychopathology, or be ignored as 'reactive' and hence perceived as less serious than a diagnosable mental illness. The diagnostic uncertainty caused by overlap between the 'normal' turmoil of adolescence and the non-specific prodrome of serious mental disorders, combined with frequent drug use in this age-group, is a further barrier to young people receiving appropriate help from adult services.

Rigidity of boundaries

The developmental stage at which someone becomes an 'adult' is impossible to define. Services that have clear age-related boundaries may have explicit processes in place for managing the transition, but the rigidity of the age cut-offs can hamper rather than facilitate the ability of services to meet the needs of individuals astride these age bands. Tight demarcations and referral criteria can be ploys to cope with budgetary restraints and managing case-loads, rather than explicit attempts to target services appropriately.

Availability of services

Child services generally have more in the way of individual and family psychotherapy provision, whereas access to local in-patient and day-patient facilities is often limited and is sometimes non-existent. The converse is true of adult services. This can lead to an abrupt disjunction when a young person who has been in psychotherapy, possibly for some years, is abruptly transferred to an adult service where the only readily available non-pharmacological treatment option may be admission to a local day service populated largely by older patients with very different needs.

Lack of a common language

The structural and functional differences between services have also introduced concepts that may be alien to all but those who are directly involved in providing a service. Adult services struggle to understand exactly what is meant, for example, by tiers 1, 2, 3 and 4, or the differences between primary child and adolescent mental health workers and primary care mental health workers. Workers in child services may struggle to understand the differences between case management, care programme approach and the differences between the standard and enhanced care programme approach.

opinion & debate

Managing the interface

How is the interface between child and adult services best managed? Given the barriers identified above, there can be no clear-cut and easy answer, which could be implemented overnight. Several strategies could be considered, dependent upon local needs and priorities, including the following.

Specialist services

Giving evidence to the Select Committee on Health, several organisations such as Young Minds, Sainsbury Centre, Rethink, the Royal College of Psychiatrists and the Royal College of Nursing recommended the setting up of specialist services for young people aged 16–25 years. Despite the obvious advantages of such specialised services, it is unlikely that these will appear nationally in the near future. One interesting area of opportunity is the emerging early intervention services, which are clearly astride child and adult services, and are meant to provide care for young people aged 14–35 years who are experiencing psychosis. Early intervention services that successfully manage the interface may provide a template for other youth and even adult services dealing with a broader range of mental disorders. One element, which could be adopted relatively rapidly, would be for a reciprocal arrangement whereby staff from child services are seconded for perhaps two sessions a week to work in the early intervention service, and vice versa.

Liaison models

Maitra & Jolley (2000) have described a liaison project in the London Borough of Hammersmith and Fulham in which child and adult psychiatrists routinely attend each other's meetings to discuss cases involving children: either child patients who have a carer with potential mental health problems or children of adult patients who are actually suffering or at potential risk of mental health problems. The authors note several benefits of such liaison, including a higher profile for children within adult services, shaping of the process of referrals across services, improved scope for prophylactic work, possibilities of joint working and the availability of a forum for formal and informal discussions. Given the resource implications of such models, an audit of the process and outcomes would be very useful in helping other services develop similar working patterns.

Joint working

The dilemmas and dichotomies of different perspectives – a child within a family system, as opposed to an adult with a distinct mental health problem – can be effectively dealt with by child and adult services working jointly in

opinion & debate

individual cases. Child services bring the important understanding of developmental processes in the assessment and management of young people; adult services are usually better equipped to provide diagnostic precision and appropriate pharmacological treatments. This approach also facilitates interdisciplinary learning and fosters therapeutic skills in both child and adult services. However, lines of responsibility and accountability must be clear, lest in the hope that the 'other side' is responsible, neither service delivers.

Specialised workers astride service

Specialised workers who are members of both child and adult services can potentially harvest the advantages of both liaison models and joint working. However, there is a paucity of such trained staff. There may also be concerns about clinical responsibilities, supervision, fragmentation of working practice and divided loyalties across teams.

Protocols and guidelines

At the very least, all child and adult services should have written protocols for managing the interface. These should include:

- protocols for transition from child to adult services
- guidelines for admitting young people to adult in-patient units
- emergency provision for young people in crisis
- management plans for young people with mental illness and comorbid drug use.

Training and research

The bodies responsible for training professionals to work in the mental health field should consider the development of a course for specialist workers to enable such staff to work with children from the age of 14 years or so up to young adulthood. This would require adult services to adopt a more family-based and systems approach, and child services to improve their phenomenological and diagnostic skills. Priority should also be given to research into interface issues, problems of transition and effectiveness of different models of joint working and managing the interface.

Conclusion

Desite a number of recent reports on this topic, there has been little progress in improving the interface between child and adult mental health services. Change will require both a 'top down' and a 'bottom up' approach. Regional offices responsible for delivery of both types of service in their area should become central in the development of better interfaces. National bodies should take the lead in developing training for joint workers. On the ground, clinical and managerial professionals from child and adult services need to begin working together to develop protocols to facilitate transition. This is also a fertile area for research, which should be pursued both at local and national level.

Declaration of interest

None.

References

AUDIT COMMISSION (1999) *Children in Mind*. London: Audit Commission.

MAITRA, B. & JOLLEY, A. (2000) Liaison between child and adult psychiatric services. In *Family Matters: Interface Between Child and Adult Mental Health* (eds P. Reder, M. McClure & A. Jolley), pp. 285–302. London: Routledge.

MENTAL HEALTH FOUNDATION (1999) *Bright Futures. Promoting Children and Young People's Mental Health*. London: Mental Health Foundation.

REDER, P., McCLURE, M. & JOLLEY, A. (2000) Interface between child and adult mental health. In *Family Matters. Interface Between Child and Adult Mental Health* (eds P. Reder, M. McClure & A. Jolley), pp. 3–20. London: Routledge.

SCOTT, S. (1998) Aggressive behaviour in childhood. *BMJ*, **316**, 202–206.

SELECT COMMITTEE ON HEALTH (2000) Transitions between child/adolescent and adult services. In *Fourth Report. Provision of NHS Mental Health Services*. London: Stationery Office (available at http://www.parliament.the-stationery-office.co.uk/pa/cm/99900/cmselect/cmhealth/373/37312.htm).

WHILE, A., FORBES, R., ULLMAN, S., *et al* (2004) Good practices that address continuity driving transition from child to adult care: synthesis of the evidence. *Child Care Health and Development*, **30**, 439–452.

***Swaran P. Singh** Senior Lecturer in Community Psychiatry and Clinical Lead ETHOS Early Intervention Service, Department of Mental Health, St George's Hospital Medical School, London, tel: 0208 725 3390, fax: 0208 725 3538, e-mail: s.singh@sghms.ac.uk, **Navina Evans** Consultant Child and Adolescent Psychiatrist, Newham Primary Care Trust, **Lester Strelling** Consultant Adult Psychiatrist, Barnet Early Intervention Service, Barnet Enfield and Haringey Mental Health Trust, **Helen Stuart** Consultant Child Psychiatrist, North East London Mental Health Trust, London

This page has been left intentionally blank

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Wednesday, 10 September 2014 3:28 PM
To: KOTZE, Beth; Kristi Geddes
Subject: Re: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Dear Beth and Kristi,
I can attend on Oct 13 and 14 and confirm that I believe the interviews are best done together.
Kind regards,
Tania

On 10 Sep 2014, at 12:47 pm, "KOTZE, Beth" [redacted]> wrote:

> Two days in October is probably more practical.
> I could do 13th and 14th
> Under the circumstances we think we should do the interviews together
> Will just need Tania's confirmation
> B.
>
> **Associate Professor Beth Kotze**
> **MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)**
> **Acting Associate Director, Health System Management**
> **Mental Health and Drug and Alcohol Office**
> **NSW Ministry of Health**
> **Direct Dial:** [redacted]
> **Address:** [redacted]
> **Email:** [redacted]
> **Website:** www.health.nsw.gov.au/mhdao
> <image001.png>
>
> **From:** Kristi Geddes [redacted]
> **Sent:** Wednesday, 10 September 2014 12:44 PM
> **To:** KOTZE, Beth
> **Cc:** SKIPPEN, Tania
> **Subject:** Re: Barrett Centre Investigation - interviews [ME-ME.FID2743997]
>
> Thanks Beth.
>
> I am not in the office today, but will look at starting to gather the additional requested information when I am back in tomorrow.
>
> In the meantime, as we had discussed, I have now contacted almost all of the relevant witnesses and split them according to patients over one day for Tania in September and one for you in October. I can re-issue the formal requests with new dates, but I'm not sure that all can be done in one day. Are you proposing to stay overnight and spread them across the Monday and Tuesday? I just want to be absolutely sure about dates before I re-issue the interview requests, so that they won't need to be changed again, particularly given that a number have involved insurers/ the union.
>
> In relation to the level of specificity, I have sought guidance from the department if they are expecting an individual review of the plans for each patient, or an overall review with specific consideration of the more complex patients. I will let you know when I get their response.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 10 Sep 2014, at 11:34 am, "KOTZE, Beth" < > wrote:

Dear Kristi
I have now touched base with Tania and this is what we've agreed:

1. Tania will use the 2 days when she comes up in September to finalise the review of the clinical files and to write up the clinical summaries that will be required for the report for all the patients in scope. These will be in the nature of brief over-view of each clinical scenario with particular comment on the documented transition plans.
2. In relation to the care coordinators can you please clarify:
    a. A number of the patients have 2 care coordinator names written beside them on the summary sheet – what does this mean? Was there a principal coordinator and a buddy? Or were there 2 care coordinators with clearly delineated roles? Some names have 'associate cc' written beside them – but in other cases there are 2 names and no difference noted.
    b. Is there a written statement of duties for the care coordinators?
    c. Vanessa Clayworth's name isn't against any of the patients as care coordinator – what was the nature of her role? Was it formalised? If so can we please have a copy of the statement of duties?
    d. What is 'business as usual' transition/discharge practice for the service as articulated in formal policies and procedures? If there is a service transition/discharge policy and procedure? Can we please have a copy?
    e. Were there any specific policies/procedures/statement of duties put in place for the transition coordination for these particular patients? If so can we please have a copy?
3. Re the BAC review (?2008) can we please have any excerpt relevant to the topic of transition/discharge planning? Given the very long length of stay of the service one would expect that this would be a major field of activity even during 'business as usual', let alone in preparation for the closure. Did BAC routinely conduct followup of former patients? If so is a summary report available?
4. We will conduct the interviews together – so Tania will come up with me on Monday 13th October. The priorities for the interviews that day are the 2 medical officers (Clinical Director and Acting CD) and the care coordinators for the patients Looking through the sheet, it looks like all the patients in question had at least 2 care coordinators and some 3 but the same care coordinators were involved with more than 1 of the patients – by my calculations it looks like there are care coordinators involved with these patients? That would be 10 witnesses. I think we should try for 1 hour each for the medical interviews and 45 minutes for the care coordinators.
5. In relation to the ToR and particularly noting 3.1.4 which refers to the information available to clinicians and is quite specific about the care planning for the , we definitely need to get information from the services to which they were referred. Can we obtain some general information about each one (what does the service provide etc) and if they have intake forms or assessments

785
TD 880

and initial care plans or equivalent? Tania and I can follow up with telephone calls to verify or clarify anything that we need to – so a key contact name and telephone number for each would be helpful.

In essence we are proposing that:

- the medical interviews and the file review and the information from the receiving services deal with the patient cohort overall (ToR 3.1.2;3.1.3,3.1.4)
- the medical interviews, the care coordinator interviews and the file reviews and the info from the receiving services deal with the specific cases identified as having poor outcome or complex transitions (ToR 3.1.4)

Can you clarify your interpretation of 3.1.2 – it could be read to mean that we would have to interview all the patients and their families to get the other side of the story – ie what did they think their needs were and how well were they met? It could also be limited to, based on the documented care planning and interviews, were the psychobiosocial needs of the patients and families identified comprehensively and comprehensively planned for?

Regards
Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
Direct Dial:
Address:
Email:
Website: www.health.nsw.gov.au/mhdao
<image002.png>

From: Kristi Geddes [
Sent: Tuesday, 9 September 2014 7:56 AM
To: KOTZE, Beth
Subject: Re: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Thanks Beth.

I will do my best to group the care coordinators according to patients, however there may be some overlap issues. Would you like to speak with RN Vanessa Clayworth or would you prefer leave that to Tania? Unfortunately, I do not have specific details of the extent of her involvement with any particular patients, I've just been advised that she played a key role in the transition planning and would therefore be someone we need to speak with.

In the interests of time, do you think it would be possible to obtain the information you require from the receiving agencies via information requests instead of interviews? If so, if you are able to provide me with a list of the specific information you require, I can attend to those requests and hopefully have the information for you upon your return from leave.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes
Senior Associate
Minter Ellison

On 8 Sep 2014, at 5:23 pm, "KOTZE, Beth" < wrote:

> Thanks Kristi
> If at all possible we need to have the clinicians grouped by patients so that I do all the interviews associated with patient x and Tania does all the interviews associated with patient y.
> If we start with the medical staff and the care coordinators for the patients whose files I reviewed that would be good – there were the and then
> I've had a look at the ToR again and I think it may be difficult to answer 3.1.2 and 3.1.3 in general and 3.1.4 in particular without talking to the agencies that received the referrals because appropriateness goes to the issue of the capacity and capability at the receiving end and the quality of the communication – I am wondering if some of these interviews could be done by telephone if the staff of these agencies are comfortable and willing to cooperate.
> What do you think?
> Beth

Associate Professor Beth Kotze
MBBS FRANZCP FRACMA Cert Child Psychiatry MMed (Psychotherapy) MHA (UNSW)
Acting Associate Director, Health System Management
Mental Health and Drug and Alcohol Office
NSW Ministry of Health
Direct Dial:
Address:
Email:
Website: www.health.nsw.gov.au/mhdao
<image003.png>

From: Kristi Geddes
Sent: Monday, 8 September 2014 11:40 AM
To: KOTZE, Beth
Subject: Barrett Centre Investigation - interviews [ME-ME.FID2743997]

Hi Beth,

I hope you had a lovely weekend after your trip up on Friday.

As discussed, I am currently arranging staff interviews for you on Monday, 13 October 2014. You had requested meeting with Dr

Brennan, Dr Sadler and then each of the care coordinators for the three deceased patients. In total, that would be 9 witnesses.

I'm allowing an hour for each interview and based on your flight times last Friday, unfortunately that would only leave time for 6. I just wanted to check how you would therefore prefer I prioritise interviews. I have currently prioritised Dr Brennan and Dr Sadler and then at least one care co-ordinator for each patient. That leaves us with one spot left over.

I've been advised by WMHHS that RN Vanessa Clayworth, although not a care coordinator, played an integral role in transition planning.

I just wanted to check if perhaps I fill the last spot for that day with RN Clayworth and/or if you would prefer stay on an extra day and speak with all care coordinators for those complex patients?

Obviously, I will endeavour to instead arrange for Tania to interview the other care coordinators for those patients if you are not able to.

I look forward to hearing from you.

Kind regards,
Kristi.

Kristi Geddes Senior Associate

Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000

www.minterellison.com

Please consider the environment before printing this email

This email has been scanned for the NSW Ministry of Health by the Websense Hosted Email Security System.
Emails and attachments are monitored to ensure compliance with the NSW Ministry of health's Electronic Messaging Policy.

Disclaimer: This message is intended for the addressee named and may contain confidential information.
If you are not the intended recipient, please delete it and notify the sender.
Views expressed in this message are those of the individual sender, and are not necessarily the views of the NSW Ministry of Health.

This email has been scanned for the NSW Ministry of Health by the Websense Hosted Email Security System.
Emails and attachments are monitored to ensure compliance with the NSW Ministry of Health's Electronic Messaging Policy.

SKIPPEN, Tania

From: Kristi Geddes <[redacted]>
Sent: Monday, 13 October 2014 11:59 AM
To: KOTZE, Beth; SKIPPEN, Tania
Subject: Barrett - Vanessa Clayworth [ME-ME.FID2743997]

Hi Beth and Tania,

I've just received an email from the Australian Workers Union, on behalf of Vanessa Clayworth, confirming that she will not be attending the interview tomorrow due to medical concerns [redacted].

Please let me know if you want me to see if I can reschedule Dr Sadler to earlier in the day.

Kind regards,
Kristi.

Kristi Geddes Senior Associate
[redacted]
Minter Ellison Lawyers Waterfront Place • 1 Eagle Street • Brisbane • QLD 4000
[redacted] www.minterellison.com

Please consider the environment before printing this email

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Friday, 17 October 2014 8:44 AM
To: SKIPPEN, Tania
Subject: Qld review
Attachments: Qld review client profiles and transition evidence summary_12 October 2014.docx; Report intro.docx

Follow Up Flag: Follow up
Flag Status: Completed

Add title

Table of Contents

Table of Contents

Introduction

This report has been completed by the health service investigators[1] under section 199 of the Hospital and Health Boards Act 2011 (HHBA) for the Director-General, Queensland Health in line with the Terms of Reference and appointment to investigate and report on matters relating to the management, administration or delivery of statewide public sector health services in Queensland Health (Appendix A).

Purpose

The purpose of the health service investigation was to:

- Note that a policy decision was made by Queensland Health in 2013 (and communicated by the Minister on 6 August 2013) to close the Barrett Adolescent Centre (BAC), Wacol, West Moreton Hospital and Health Service in January 2014 and move the mental health care for its adolescent patients from being institutionally-based in a stand-alone mental health facility to being community-based.
- Investigate and report on the statewide transition and healthcare planning measure undertaken by the Department of Health and West Moreton, Metro South and Children's Health Queensland Hospital and Health Services and any other relevant Hospital and Health Service in Queensland, in relation to the then current inpatients and day patients of the BAC.
- Note that three previous patients of the BAC have died in 2014 and that their deaths are currently being investigated by the Queensland Coroner.

Scope of the investigation

The functions of the health service investigators were to:

1.1 Investigate the following matters relating to the management, administration and delivery of public sector health services:

1.1.1 Asses the governance model put in place within Queensland Health (including the Department of Health and West Moreton, Metro South and Children's Health Queensland Hospital and Health Services and any other relevant Hospital and Health Service) to manage and oversight the

[1] Associate Professor Beth Kotze, Acting Associated Director, Health System Management, Mental Health and Drug & Alcohol Office, NSW Ministry of Health; Ms Tania Skippen, Associate Director, MH-Children and Young People, Mental Health and Drug & Alcohol Office, NSW Ministry of Health; and Ms Kristi Geddes, Senior Associate, Minter Ellison Lawyers.

healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

a) Advise if the governance model was appropriate given the nature and scope of the work required for the successful transition of the then patients to a community based model;

1.1.2 Advise if the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;

1.1.3 Advise if the healthcare transition plans developed for individual patients by the transitions team were appropriate and took into consideration patients care, patient support, patient safety, service quality, and advise it these healthcare transition plans were appropriate to support the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

1.1.4 Based on the information available to clinicians and staff between 6 August 2013 and closure of BAC in January 2014, advise if the individual healthcare transition plans for the then current inpatients and day patients of the BAC were appropriate. A detailed review of the healthcare transition plans for patients should be undertaken.

2.1 Make findings and recommendations in a report under section 199 of the HHBA in relation to:

2.1.1 The ways in which the management, administration or delivery of public sector health services, with particular regards to the matters identified in paragraph 1 above, can be maintained and improved: and

2.1.2 Any other matter identified during the course of the investigation.

Conduct of the investigation

Kristi to add – records, interviews and process. Appendix B.

Interviews

Documents reviewed

The following documents related to the governance model put in place to manage and oversight the healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014 were reviewed:

•

The following policies and procedures were provided by West Moreton Health Service District as relevant to consumer transition planning during the transition period August 2013 to January 2014:

- *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts (Version No. 1.0)*, by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

Policy decision

Add details from WMHHHS CE notes on the policy decision.

Governance Model

What was the governance model?

Committees

Stakeholders

Implemented over what time period?

Similar best practice models??

QLD review

Client profiles and transition evidence summary

Guidance:

Reference: *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts* (Version No. 1.0), by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

- Consumer demographic information
- Consumer intake form
- Consumer assessment form with associated assessment modules attached
- Recovery plan including 3 parts (1. Recovery plan – consumer focused; 2. Individual care/treatment plan – service/duty of care focused; 3. Relapse prevention plan). An individual care/treatment plan generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode/Discharge Summary (Mandatory from inpatient and Community Service Providers)
- Clinical documentation should be forwarded to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.
- Transferring service must ensure the information has been received by the receiving service and must document in the consumer's record that this has occurred.
- The receiving service contact details and follow-up appointment details must be noted in the consumer's transferring service medical record prior to transfer.
- Unless consent is not given, prior to transfer, the transferring service Principal Service Provider or equivalent must notify (at the minimum) and preferably consult with the consumer's carers and family regarding the pending transfer of care.

797
TS 892

Patient	MH Act status	Referral forms including MHA2000 docs if relevant	Assessment including forensic Hx if relevant. Risk Ax	Outcome Measures	Recovery Plan	End of Episode/ Discharge Summary	Documents forwarded 3 days prior	Docum'td appt	Family/ carers notified and/or consulted	Receiving PSP face to face contact within 7 days	Transfer of ITO complete	Receiving District
Inpatients												
		N/A	X	X	X	X	X	X	X	X	N/A	
		X,	X	X,	X	X	X		X	X	X	
		X	X	X	X	X	X	X	X	X		
		N/A	X	X	X	X	X at time	X	Check	X	N/A	
		N/A	X	X	X	X	X at time	X	X			
		X	X	X	X	X	X	X	X	X	X	

Patient	Assessment of future service needs	Direct consumer Axs and consultation	Review Consumer medical charts	Contact w referring agency and local MHS	Conta ct w family	Clinical need and Risk taken into account	Length of stay of pt conside red	Age of patient conside red	Demographi cs considered	Family engagement considered/ Contact made with family	Funding sourced to provide additional Wrap around care	Additional supports sourced eg: housing and disability supports
Inpatients												
	X	X	X	X	X	X	X	X	X	X		
	X	X	X	X	X	X voiced distress at BAC closure	X	X	X	X		
	X inc education, employment , housing	X	X	X	X	X	X	X	X	X		
	X	Check	X	X	Check	X	X	X	X	Check		
	X	X	X	X	X	X headspace f/up	X	X	X	X		
	X	X	X	X	X	X	X	X	X	X		

** above criteria noted in response from CE WMHHS 24 Aug 2014

806
901

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Friday, 17 October 2014 3:15 PM
To: SKIPPEN, Tania
Subject: Qld report 20141017.docx
Attachments: Qld report 20141017.docx

Follow Up Flag: Follow up
Flag Status: Completed

814
TJ ~~909~~

QLD review

Client profiles and transition evidence summary

Guidance:

Reference: *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts* (Version No. 1.0), by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

- Consumer demographic information
- Consumer intake form
- Consumer assessment form with associated assessment modules attached
- Recovery plan including 3 parts (1. Recovery plan – consumer focused; 2. Individual care/treatment plan – service/duty of care focused; 3. Relapse prevention plan). An individual care/treatment plan generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode/Discharge Summary (Mandatory from inpatient and Community Service Providers)
- Clinical documentation should be forwarded to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.
- Transferring service must ensure the information has been received by the receiving service and must document in the consumer's record that this has occurred.
- The receiving service contact details and follow-up appointment details must be noted in the consumer's transferring service medical record prior to transfer.
- Unless consent is not given, prior to transfer, the transferring service Principal Service Provider or equivalent must notify (at the minimum) and preferably consult with the consumer's carers and family regarding the pending transfer of care.

815

Patient	MH Act status	Referral forms (including MHA2000 docs) completed	Assessment including forensic History and Risk Assessment and management plan	Outcome Measures completed	Recovery Plan	End of Episode/ Discharge Summary	Documents forwarded 3 days prior	Documented appointments	Family/ carers notified and/or consulted	Receiving PSP face to face contact within 7 days	Transfer of ITO complete	Receiving District
Inpatients												
		N/A	✓	✓	✓	✓	✓	✓	✓	✓	N/A	
		✓,	✓	✓,	✓	✓	✓		✓	✓	✓	
		✓	✓	✓	✓	✓	✓	✓	✓	✓		
		N/A	✓	✓	✓	✓	✓ at time	✓	Check	✓	N/A	
		N/A	✓	✓	✓	✓	✓ at time	✓	✓			
		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

818

Patient	Assessment of future service needs	Direct consumer A ✓s and consultation	Review Consumer medical charts	Contact w referring agency and local MHS	Contact w family	Clinical need and Risk taken into account	Length of stay of pt considered	Age of patient considered	Demographics considered	Family engagement considered/ Contact made with family	Funding sourced to provide additional Wrap around care	Additional supports sourced eg: housing and disability supports
Inpatients												
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓ voiced distress at BAC closure	✓	✓	✓	✓		
	✓ inc education, employment, housing	✓	✓	✓	✓	✓	✓	✓	✓	✓		
	✓	Check	✓	✓	Check	✓	✓	✓	✓	Check		
	✓	✓	✓	✓	✓	✓ f/up	✓	✓	✓	✓		
	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

817

** above criteria noted in response from CE WMHHS 24 Aug 2014

TB 8/8/13

822

826
TS-921

829
TL 824

831
TA-926

EXHIBIT 117

QLD review

Client profiles and transition evidence summary

Guidance:

Reference: *Inter-district Transfer of Mental Health Consumers within South Queensland Health Service Districts* (Version No. 1.0), by the Division of Mental Health, Darling Downs – West Moreton Health Service District.

- Consumer demographic information
- Consumer intake form
- Consumer assessment form with associated assessment modules attached
- Recovery plan including 3 parts (1. Recovery plan – consumer focused; 2. Individual care/treatment plan – service/duty of care focused; 3. Relapse prevention plan). An individual care/treatment plan generated from the care planning module in CIMHA is also acceptable.
- Consumer End of Episode/Discharge Summary (Mandatory from inpatient and Community Service Providers)
- Clinical documentation should be forwarded to the receiving service at least 3 days prior to the transfer of clinical care of the consumer.
- Transferring service must ensure the information has been received by the receiving service and must document in the consumer's record that this has occurred.
- The receiving service contact details and follow-up appointment details must be noted in the consumer's transferring service medical record prior to transfer.
- Unless consent is not given, prior to transfer, the transferring service Principal Service Provider or equivalent must notify (at the minimum) and preferably consult with the consumer's carers and family regarding the pending transfer of care.

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Friday, 17 October 2014 4:43 PM
To: SKIPPEN, Tania
Subject: RE: Qld report 20141017.docx
Attachments: Summary table.docx

Follow Up Flag: Follow up
Flag Status: Flagged

From: SKIPPEN, Tania
Sent: 17 October 2014 15:14
To: SKIPPEN, Tania
Subject: Qld report 20141017.docx

Transfer of Care Principles (Qld Health Procedure)*						
Completion and transfer of documentation including:						
MH Act status						
Referral forms (including MHA2000 docs) completed	N/A	✓	✓	N/A	N/A	✓
Transfer of ITO complete	✓	✓	✓	✓	✓	✓
Assessment including forensic History and Risk Assessment and management plan	✓	✓	✓	✓	✓	✓
Outcome Measures	✓	✓	✓	✓	✓	✓
Recovery Plan	✓	✓	✓	✓	✓	✓
End of episode/ Discharge summary	✓	✓	✓	✓	✓	✓
Documents forwarded 3 days prior	✓	✓	✓	✓ at time	✓ at time	✓
Documented appointments	✓	✓	✓	✓	✓	✓
Family/carers notified and/or consulted	✓	✓	✓	✓	✓	✓
Receiving PSP face to face contact within 7 days	N/A	✓	✓	N/A	N/A	✓
Receiving District/mental health service						
Transition planning reflects evidence of:						
Assessment of client future service needs	✓	✓	✓	✓	✓	✓
Direct consumer assessment and consultation	✓	✓	✓	✓	✓	✓
Review of consumer medical charts	✓	✓	✓	✓	✓	✓
Contact with referring agency and local mental health service	✓	✓	✓	✓	✓	✓
Clinical need and Risk taken into account	✓	✓	✓	✓	✓	✓
Length of stay of client was considered	✓	✓	✓	✓	✓	✓
Age of client was considered	✓	✓	✓	✓	✓	✓
Demographics were considered	✓	✓	✓	✓	✓	✓
Family engagement considered/ Contact was made with family	✓	✓	✓	✓	✓	✓
Additional considerations (unrelated to the Policy):						
Funding was sourced to provide comprehensive care						
Additional supports sourced eg: housing and disability supports						

SKIPPEN, Tania

From: SKIPPEN, Tania
Sent: Friday, 17 October 2014 5:06 PM
To: SKIPPEN, Tania; KOTZE, Beth
Subject: Report 20141017.docx
Attachments: Report 20141017.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Final for Friday version

Matter:

Queensland Health
Health Service Investigation –
Barrett Adolescent Psychiatric Centre
1084936

Authors: Associate Professor Beth Kotze and Tania Skippen

Date:

Table of Contents

Expert Clinical Review Report: Transitional Care for Adolescent Patients of the Barrett Adolescent Centre

Authorisation

This report has been prepared in accordance with the Instrument of Appointment and Terms of Reference, both dated 14th August 2014 and both authorised by Mr Ian Maynard, Director-General Queensland Health, and revised 28th August 2014.

Scope and Purpose

To provide expert clinical review and a report under section 199 of the Hospital and Health Boards Act 2011 (HHBA) for the Director-General, Queensland Health in line with the Terms of Reference.

The functions of the health service investigators were to:

1.1 Investigate the following matters relating to the management, administration and delivery of public sector health services:

1.1.1 Asses the governance model put in place within Queensland Health (including the Department of Health and West Moreton, Metro South and Children's Health Queensland Hospital and Health Services and any other relevant Hospital and Health Service) to manage and oversight the healthcare transition plans for the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

a) Advise if the governance model was appropriate given the nature and scope of the work required for the successful transition of the then patients to a community based model;

1.1.2 Advise if the healthcare transition plans developed for individual patients by the transition team were adequate to meet the needs of the patients and their families;

1.1.3 Advise if the healthcare transition plans developed for individual patients by the transitions team were appropriate and took into consideration patient care, patient support, patient safety, service quality, and advise if these healthcare transition plans were appropriate to support the then current inpatients and day patients of the BAC post 6 August 2013 until its closure in January 2014;

1.1.4 Based on the information available to clinicians and staff between 6 August 2013 and closure of BAC in January 2014, advise if the individual healthcare transition plans for the then current inpatients and day patients of the BAC were appropriate. A detailed review of the healthcare transition

plans for patients [redacted] should be undertaken.

2.1 Make findings and recommendations in a report under section 199 of the HHBA in relation to:

2.1.1 The ways in which the management, administration or delivery of public sector health services, with particular regards to the matters identified in paragraph 1 above, can be maintained and improved: and

2.1.2 Any other matter identified during the course of the investigation.

Process

1. Extensive documentation was made available to the reviewers; refer Index of Documentation (Appendix A), including patient files, policies and miscellaneous.
2. Written statement from Dr Anne Brennan, 13/10/14.
3. Interviews were conducted face to face over 2 days being 13th and 14th October 2014.

Context

- On 6th August 2013 Minister for Health, Mr Lawrence Springborg announced the closure of the Barrett Adolescent Centre (BAC), Wacol, West Moreton Hospital and Health Service (WMHHS)[1]. A planning process to develop new service options for the population of the State was announced under the governance of Children's Health Queensland (CHQ)[2]. A governance process to manage the transition of current individual patients of BAC was developed.
- The concentrated and focussed process of managing the transition of individual patients from the care of BAC to alternative options commenced in September 2013[3] with the expectation that the service would close in January 2014.
- The process of managing the transition of individual patients was centred on individualized and comprehensive needs assessment, including mental health, health, educational/vocational, housing/accommodation needs, and care planning, extensive investigation to identify available and suitable services to provide coordinated care in community settings, iterative planning and collaboration with consumers and families and carers.
- The clinically driven process was supported by a formal governance structure comprising:

[1] Refer: letter dated 24th August 2014 from Lesley Dwyer Health Service Chief Executive West Moreton Hospital and Health Service to Dr John Allan.

[2] This process was identified as out of scope by the reviewers because it concerned strategic forward planning at the population level rather than care planning for the individual patients of BAC.

[3] Refer interview with Dr Anne Brennan.

- Clinical Care Transitional Panel:
  - Chaired by Dr Anne Brennan
  - Key members: internal to BAC: multidisciplinary senior clinicians responsible for patient care and Acting Principal of the school.
  - Reported to the State-wide Adolescent Extended Treatment and Rehabilitation Implementation Steering Committee and the West Moreton Management Committee
  - Met twice-weekly and on an ad hoc basis to focus on day to day patient care and planning for transition. An issues log was maintained and provided to the reviewers by Dr Brennan.
  - Agendas provided to reviewers (Appendix A). No formal Terms of Reference available.
- The West Moreton Management Committee[4]:
  - Chaired by A/Director of Strategy
  - Key members: range of senior clinician and management representatives from the health service, representative from CHQ and MHAOD Branch.
  - Reported to the Chief Executive WMHHS and Chief Executive and Department of Health Oversight Committee.
  - Met weekly from September 2013 until January 2014.
  - Paperwork……
- Chief Executive and Department of Health Oversight Committee:
  - Chaired by…
  - Key members: Deputy Director General Department Health, Health Service Chief Executives from key hospital and health services; Executive Director MHAOD Branch and other key representatives from CHQ.

- The clinically driven process was supported by additional and specific resourcing:
  - Project Officer appointed to support the Clinical Care Transitional Panel and the Barrett Adolescent Update Meeting.
    - Appointed …..
    - Role to schedule agenda to ensure all patients reviewed in a timely way and record keeping.

---

[4] This meeting appears to have had an alternative meeting name: Barrett Adolescent Update Meeting.

- The closure of BAC was supported by a formal communication plan in effect from September 2013 to February 2014. This was managed by the Project Officer (above). The scope included families and carers, community, staff of BAC, hospital/health services, industrial organisations etc.
- Note that three previous patients of the BAC have died in 2014 and that their deaths are currently being investigated by the Queensland Coroner.
- The published literature (Appendix B) regarding transitional care for adolescents provides guidance and principles in relation to the planning and outcomes required for this group:
    - Optimal transition may be defined as adequate transition planning, good information transfer between teams and continuity of care following transition.
    - Predictors of positive transition include individual factors such as severe mental illness and treatment and care issues such as medication and inpatient care.
    - Neurodeveleopmental disorders, personality disorders, complex needs and emotional/neurotic disorders can be associated with less favourable outcomes.
    - Other factors associated with poor outcomes include if the process is seen simply as an administrative event.
    - It is better to undertake transitional care in the context of relative stability for the young person rather than crisis.
    - Transition preparation requires adequate period of planning and preparing the young person and carer for transition. The planning needs to broad account of health and developmental transitions recognising the young person's developing maturity and changing health-seeking behaviours.
    - Models for collaboration that support transition include: shared care/joint working across services and liaison models.
    - Barriers to transitional care include: lack of alignment between referral thresholds and criteria between CAMHS/CYMHS and Adult MHS.
- The Queensland Health Procedure Document 201000447, Inter-district Transfer of Mental Health Consumers within South Queensland Service Districts, effective 8/11/10 and active at the time of the closure of BAC, provides guidance in relation to transitional care, notably including: the roles and responsibilities of transferring and receiving services; and consideration of potential shared care arrangements.
- Noting that transition is a process in which the communication and negotiations between the referring and receiving services are critical, this review was limited to review of the available documentation and interviews with key clinicians formerly from BAC. Staff of receiving services were not interviewed and limited

documentation was available from these services. Education staff were also not interviewed.

Findings

- The process of transitional planning occurred in an atmosphere of crisis with escalation of distress in a number of the adolescents and staff of BAC. However whilst this contributed to the complexity of the situation, it does not appear to have detrimentally affected the process of transitional care planning for the patients.
- Transitional care planning was led by a small multidisciplinary team of clinicians led by the Acting Clinical Director. Their task was enormous as they were required to review and supervise current care plans, manage incidents and crises, seek out information about service options that many times was not readily available, negotiate referrals, coordinate with the education staff and manage communication with patients and their families/carers. The team was dedicated to these tasks with the day to day supervision of the young people undertaken by the Care Coordinators.
- In relation to the patient cohort, it is noted:
    - The young people were a very complex group with various combinations of developmental trauma, major psychiatric disorder and multiple comorbidities, high and fluctuating risk to self, major and pervasive functional disability, unstable accommodation options, learning disabilities, barriers to education and training, drug and alcohol misuse. In short, this was a cohort in the main characterized by high, complex and enduring clinical and support needs.
    - This would have been very significant challenge in general in organizing transitional care for such a complex group under ideal conditions. Each very complex young person required highly individualized care assessment and planning. These are not the kind of individuals who readily 'fit' with service systems because of the scope and intensity of their needs. The model of care in existence at BAC had promoted prolonged inpatient care and the closure required the rapid development of care pathways to community care.
    - The BAC team undertook an exhaustive and meticulous process of clinical review and care planning with each individual young person's best interests at the core of the process.
- The process of communication and negotiation between the clinical team and the young person and their family/carers was careful, respectful, timely and maintained. As would be expected during a time of heightened emotions and anxiety about the future, there appears to have been a level of misunderstandings

along the way but these appear to have been in each case dealt with promptly and appropriately. The misunderstandings arose, for example, in circumstances of unopened emails or unexpected emerging clinical need. There is evidence of parent information sessions, letters to parents, individual email responses to parents and phone calls to support timely communication. Fact Sheets, FAQ sheets and the Executive Review Committee recommendations which were provided to parents and made publicly available on the WMHHS website.

- The transition plans, without exception, were thorough and comprehensive. In some instances it was not possible to identify a variety of options for each care domain, but in each case at least 1 reasonable option was able to be identified matched to a particular care domain. At times there was considerable delay in settling on the final option – but this reflected the considerable work involved in identifying a range of suitable options and working through processes of negotiation with receiving agencies.
- In a number of instances the young people had disorders that did not cross the threshold to service in the community mental health system. It is noteworthy that there were examples of successful negotiations that led to services accepting the referrals by exception. For example, the reviewers did not find any example where it was not possible to organize a reasonable system of care for any individual.
- The inevitable challenges arose during this process, such as the changes in established long-term relationships between the clinicians of BAC and the young people; the differences between the culture and approach to care provided in services provided for adolescents and the culture and approach to care in adult services and the impact of the young person's developmental stage and maturity on their health-seeking attitudes and behaviors; and, adolescent's resistance to transfer from a service where they felt safe and 'connected' in a relatively closed environment to a community system of care and, in the case of transfer to an adult system, the different expectations of their maturity and health-seeking behaviour and the different expectations of involvement of their family.
- Whilst there was some drop-out rate from some aspects of the care organized, the reviewers did not identify any examples where a young person was completely lost to care, nor where a core component of care was completely missing. Where , for example, did drop out of ongoing care with it would appear that did remain under the care of a case manager from and there was also contact from with a from .
- There were numerous examples of the BAC staff working in a collaborative way with receiving agencies, as evidenced by the number of times young people were escorted to the other agencies, the detailed discussions in relation to risk management, maintaining contact post-transfer of care and joint working by staff across the agencies. These activities would be considered best-practice in transitional care and in the main appear to have been implemented. The reviewers