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. **Editor:** Lamb C.

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AIMS:

This paper is prepared by psychiatrists representing the General and Community and Child and Adolescent faculties of the Royal College of Psychiatrists, including individuals with experience of working at the interface between CAMHS and Adult Mental Health Services. It aims to set out a number of points of consensus regarding good practice with respect to both the mental health care offered to young people and the transition of their care from child to adult services. It is recognised that financial and workforce capacity issues will have an influence on local developments and arrangements with respect to 16 and 17 year olds. However whatever the resources available and whatever precise arrangements are in place, a number of good practice points should be applied.

BACKGROUND:

The transition from adolescence to adulthood is a crucial stage of social, personal and emotional development. It coincides with the emergence of personality disorders and a steep rise in the rates of mental disorder, particularly the severe end of the spectrum of affective disorders, anxiety disorders, eating disorders, obsessive compulsive disorder and psychosis.

Primary or co-morbid substance misuse is common in young people, adding to the complexity of presentation and treatment need. Teenage mothers have an increased risk of mental disorder compared with mothers over 20 years of age.

A mental health service for older adolescents should aim to provide interventions to prevent the majority of young people from developing long-term mental health problems, while engaging and treating those who have early onset of specific severe mental illness and facilitating their transition to ongoing treatment in adult services. In addition, there is agreement among authors that service transitions during adolescence should be smooth processes that offer uninterrupted

continuity of care and take into consideration a young person's physical, social and psychological growth and development (Forbes et al. 2001).

There has been longstanding concern in all four jurisdictions of the UK about young people with mental health problems who fall between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services. The issue was highlighted by a House of Commons Health Select Committee report (Select Committee on Health. 2000), which noted that the provision of mental health services for adolescents was patchy and that the 'cut off' points were variable and arbitrary. It also referred to the fact that cultural differences between CAMHS and Adult services act as a barrier to transition. The different professional cultures of CAMHS and adult mental health have contributed to differences in theory and practice, including differences in eligibility thresholds for referral and in the level and style of intervention (Reder et al., 2000). There are a number of neuro-developmental disorders e.g. Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder that persist into young adulthood but have not previously met the criteria for referral to adult mental health services. Particular groups of young people at high risk of developing mental health problems in adult life may not be accessing mental health services, including those looked after by the local authority, young people from Black and Minority Ethnic communities, 'Traveller' families, the homeless or those seeking refugee or asylum status (Richards & Vostanis, 2004).

Continuity of adolescent mental health problems into adult life must be taken into account when defining service need. In an overview of the evidence, Maughan (2005) shows that the majority of young adults with a psychiatric disorder had diagnosable problems much earlier in life and that of those with mental health problems at the age of 26 years, 50% had first met the criteria for the disorder at age 15 years. In England and Wales approximately 600 (10 per 100 000) 15-24 year olds take their own life each year and around 20 000 teenagers present to hospital each year as a consequence of self-harm (Social Exclusion Unit, 2000).

A number of documents and studies have identified service gaps and outlined the issues for young people with mental health problems (Kay H, 1999.), (Pugh K & Meier R, 2006). (The Children's Commissioner for England, 2007.) (Richards M & Vostanis P, 2004). (Smith K. & Leon L, 2001). (White PJ ed, 2003).

There is agreement among authors about a lack of clarity in the UK regarding where CAMHS ends and adult services begin. In a survey of services in one region of England, over 90% of contributors perceived the transition from CAMHS to adult mental health service as difficult (Gillam et al., 2005). Different areas of the UK vary in terms of the precise arrangements in place. In some areas CAMHS routinely treats all young people up to 18 years, in many others CAMHS are only

commissioned to provide a service up to a young person's 16th birthday and those over 16 years are treated by adult services. Phimester (2004) assessed service provision for young people in two health communities in England and found that young people over 16 years had access to CAMHS only if in full time education, yet many adult mental health services had an implicit minimum age of 18 years. These factors resulted in service gaps and significant unmet need.

Learning Disability Services:

In the case of young people with a severe learning disability, Children's Learning Disability Services frequently have good links and effective transfer of care to adult learning disability services. Problems are more likely to arise in the case of an adolescent with moderate or mild learning disability and a low level of general functioning. This group of young people 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 situation can arise in young people with higher functioning Autistic Spectrum Disorder or Asperger's Syndrome, especially in the absence of clear cut co-morbid psychiatric disorder.

Forensic Services:

The issues for the treatment and transfer of care of young people with a mental disorder who pose a risk to others or have a forensic history are complex. In these cases also, differences in eligibility criteria can result in a gap in service or treatment settings that do not meet the developmental needs of the young people concerned.

Inpatient Services:

The Royal College of Psychiatrists report (NICAPS. 2001. O'Herlihy et al) identified a national problem with a general shortage of Child and Adolescent inpatient beds, the lack of emergency facilities available, the inadequate inpatient provision for young people with severe and high risk needs and the use of adult psychiatric beds for children and young people. Similar findings were reported in the recent Regional Review of Tier 4 CAMHS in England (Kurtz Z, 2007). The Young Minds' study 'Who's Crisis?' (Street, 2000) identified particular problems with inpatient provision for young people aged 16-19, for young people with a co-morbid learning disability and for those with problems arising from drug and alcohol misuse.

In 2004 the Royal College of Psychiatrists Research Unit surveyed nine health authorities to gather information on admissions to adult psychiatric wards and paediatric wards. The findings indicated that in England and Wales, between 955 and 1266 young people are admitted to adult psychiatric wards each year. The average number of young people admitted to specialist CAMHS units in England and Wales each year is approximately 2000.

There are a number of concerns about the adequacy and effectiveness of treatment and care for young people offered by adult psychiatric wards. A study for the Children's Commissioners for England and Wales. (Pushed into the Shadows, 2007) highlights the issues for young people treated on adult psychiatric wards in England and Wales and makes a number of recommendations aimed both to prevent the inappropriate admission of young people to adult wards, and to safeguard young people who are admitted to adult wards. It also outlines the Human Rights issues regarding the treatment of children, under the United Nations Convention on the Rights of the Child (UNCRC1989).

The Mental Health Act 2007 for England and Wales (DoH, 2007) includes amendments and additions to the 1983 Mental Health Act. It places a duty on hospital managers to ensure that from April 2010, any young person under the age of 18 years, whether a voluntary or detained inpatient, is admitted to an environment suitable for their age subject to their need. In Scotland the Mental Health Delivery Plan has set the halving of admissions of under-18 year olds to adult beds as one of its performance targets, while the Scottish Mental Health Act stipulates that age-appropriate facilities, including access to education, must be provided to any young person under the age of 18 admitted under the Act.

NATIONAL POLICY:

The issue of the CAMHS/Adult interface is addressed in a number of key national policy documents.

The National Service Framework (NSF) for Mental Health in England (DoH, 1999) and that for Wales (National Assembly for Wales, 2002) refers to adults of working age from 16 years. Both identify the need for services that bridge the interface between child and adult provision and for the use of the Care Programme Approach (CPA) at the point of transfer between child and adult services.

In England, the needs of young people experiencing a first episode of psychosis are addressed specifically in the Mental Health policy Implementation Guide (DoH, 2001) which states that CAMHS and adult mental health services should work together with commissioners to ensure that all young people aged 14 to 35 years with a first episode of psychosis receive early intervention by a designated early psychosis service.

The Children's NSF in both England (DfES & DoH, 2004) and Wales (National Assembly for Wales, 2006) stipulates that young people up to 18 years with mental health problems should have access to age appropriate services. They also state that CAMHS should be working towards providing a service for all young people up to 18th birthday. In Wales this is expected to occur by 2010 in line with increased

resources over time (All Wales CAMHS Strategy: Everybody's Business. National Assembly for Wales, 2001). Resources have not yet been allocated for this purpose in Wales. In England one of the three key elements of comprehensive CAMHS is services for 16 and 17 year olds with the target for provision by December 2006. (DoH/DfES 2006). Some increase in central resource has been made available for this purpose in some areas of England, however in others no resource allocation has been made.

In Scotland the new Mental Health Act has made it a statutory requirement for a child and adolescent psychiatrist to be involved in relation to designated medical practitioner work (either the Responsible Medical Officer or the Designated Medical Practitioner need to be trained in child and adolescent psychiatry) when the Act is applied to young people under the age of 18 years. This has resulted in pressure from adult mental health services that, in order to be compliant with the Act, CAMHS should extend their age range to 18 years. No new funding has been provided in Scotland to allow existing CAMHS to take on the additional workload that emanates from the Act. The new Act in Scotland makes specific reference to the need to provide age appropriate inpatient facilities for young people under the age of 18 admitted under the Act.

The Scottish strategy document for the development of CAMHS (Children & Young People's Mental Health: a Framework for Promotion, Prevention and Care, 2005) advocates that CAMHS should aim to provide a comprehensive service to all children up to age 18 by 2014, but in the absence of appropriate funding this remains aspirational. Responsibility for CAMHS development now lies with the Mental Health Division in the Scottish Government, which published a Mental Health Delivery Plan in 2006. This includes specific performance targets in relation to CAMHS, including a reduction in admissions of young people under the age of 18 to adult beds. To support this, new adolescent inpatient beds have been commissioned, increasing the available adolescent beds from a low of 35 beds to a planned 56 beds in Scotland by 2010.

The NSF for Mental Health (DoH, 1999) which sets out standards for adult mental health services in England, states that children and young people should only be admitted to adult psychiatric wards in exceptional circumstances, and requires measures to be in place to safeguard the interests of any young person admitted. It states:

> 'If a bed in an adolescent unit cannot be located for a young person, but admission is essential for the safety and welfare of the user or others, then care may be provided on a ward for a short period. As a contingency measure, NHS Trusts should identify wards or settings that would be better suited to meet the needs of young people. A protocol must be agreed between the CAMHS and adult services. Protocols should set out procedures that safeguard the patient's safety and dignity'.

It is vital that both CAMHS and Adult Mental Health Services work with local commissioning bodies to ensure adequate provision of CAMHS inpatient beds. In the meantime clinicians will need to work together to meet the recommendations made by national policy and clinical practice guidance (Royal College Psychiatrists, 2002).

GENERAL PRINCIPLES:

There is a need for improved provision of developmentally appropriate mental health services to those over 16 years and planned arrangements and programmes for transition of care from child to adult services for young people with a range of mental health problems.

A number of risk factors have been identified for adolescents in transition, including becoming lost in the system and having nobody to ensure attendance. A number of protective factors that promote an effective transition have been identified. One of which is having a trusted adult who takes on the key role of transition or link worker and is the sole point of contact for the young person experiencing CAMHS to adult mental health service transition. (Lifeline 2003, Every Child Matters, DfES 2004. Social Exclusion Unit. 2004).

“You need something in-between rather than just jumping from child to adult services….you need one specific person who will stick with you and not lots of different people who will just pass you on the whole time.” (Quote from young person - Pushed into the Shadows. 2007. Office of Children’s Commissioner).

Qualitative research carried out across the UK has identified a number of process components important for successful transition of care including, preparation for transition, case management, strong therapeutic relationships, joint management of care and flexibility regarding point of transfer (Forbes et al., 2001). All the key policies and guidance relating to adolescent mental health specify the need for full participation of the young person in these processes. (NSF DoH, 2000) (Every Child Matters. DfES, 2004), (UNCR 1989).

A number of specific clinical conditions may have especially problematical transitions from CAMHS to adult mental health services: for example young people who are suffering from Psychosis, Anorexia Nervosa or severe substance misuse. Such young people can suffer a catastrophic deterioration in their condition when transferring from CAMHS to adult services and can be lost to follow-up. When considering such clinical conditions it is important to have transition arrangements in place that allow flexible utilisation of services that prioritise the clinical needs of the patient.

MODELS OF SERVICE:

In recent years there has been considerable impetus in the development of innovative services across the UK that promote greater working between Child and Adult Mental Health Services (Maitra & Jolley, 2000).

In order to combat the gaps in service and inequity of provision, an increasing number of mental health services have developed clinical liaison or link posts to facilitate joint working by CAMHS and adult mental health teams. Others have set up specific teams for older adolescents/young adults - some of these teams are generic, others are disorder specific e.g. Early Intervention Services for psychosis. Many of these teams work across the traditional age range of transition.

Research on service structure recommends any or a combination of the following types of transition service:

- Designated transition service
- Designated transition team within a service
- Designated staff trained in adolescent work seconded to adult teams

(Richards & Vostanis. 2004).

Fully funded Community based Multi-disciplinary team.

In some areas there are fully funded multidisciplinary teams designed to bridge and work jointly with CAMHS and Adult Mental Health to meet the generic mental health needs of older adolescents. In England many of these teams link with or are part of the Early Intervention Service for Psychosis and in addition have good working relationships with the local Home Treatment and Crisis Resolution Teams as well as Social Services, Education, the local Youth Offending Team and Substance Misuse Service.

National surveys of community mental health services for older adolescents / young adults carried out in England between 1999 and 2005 (Lamb C, 2001, 2005) explored the skills, capabilities and main characteristics of identified teams. There were variations in resource and different models of service delivery among the teams surveyed. However there were key similarities. Common aspects included a multidisciplinary team with a mix of expertise from both CAMHS and Adult Mental Health, providing individual and family psychosocial and psychological interventions alongside medication. The teams promoted a youth centred and flexible approach with an emphasis on effective engagement of young people through outreach and joint working with other agencies. They provided expertise to treat the range of mental disorder presenting in this age group. Many of the community services lacked age appropriate day provision and psychiatric inpatient services.

Disorder Specific Service:

A number of disorder specific services have been set up to span the traditional age range across CAMHS and Adult services. In England the Adult Mental Health NSF outlines the policy requirement for Early Intervention Services for first episode psychosis in 14 to 35 year olds. This policy has been widely implemented across England and in some areas has acted as a catalyst to the further development of generic mental health services that bridge the transition age. In Scotland, Early Intervention Service for Psychosis in Glasgow and Edinburgh treat young people from 14 to around 21 years and have created new links between CAMHS and Adult Services in that area.

Designated Liaison/Link Posts:

A number of NHS Trusts have funded 'transition' or 'liaison' posts, which comprise one or two clinicians, often community psychiatric nurses with expertise in working with adolescents. These individuals carry out assessments and some face to face work, in addition to working jointly across both the adult mental health and CAMHS teams to facilitate work with older adolescents.

Transition Mental Health Team for 'Looked After Children':

Other NHS Trusts have joined with other agencies and implemented multi-agency commissioning to provide transition (16 to 18 year old) mental health teams for the sole use of Looked After Children (i.e. those young people in care or in the process of leaving social services care).

'**Virtual Team':**

Another example of a model linking both CAMHS and adult teams is that of a 'virtual team' where designated members from the respective multidisciplinary teams work together to provide a range of skills and expertise to help meet the developmental and mental health needs of older adolescents presenting to either service.

Most of the models cited above have improved the mental health service offered by forging strong working links or formal partnership agreements with other agencies involved with young people. Successful partnerships have been formed with non statutory and voluntary organisations as well as those from the statutory sector.

WORKFORCE CAPACITY:

There is an urgent need to quantify and design services appropriate for 16 and 17 year olds. Workforce and capacity requirements for specialist CAMHS working with up to 16 years old have been published (Kelvin. 2005) (York & Lamb 2006). The needs of the 16 and 17 year

old cohorts are widely held to be much greater than comparative year cohorts in the age periods up to 16th birthday, but it was not known how much greater.

The evidence based information for workforce capacity for this age group had not been available.

Raphael Kelvin (Kelvin, 2007) has now calculated the evidenced based tariff of staffing required to deliver comprehensive CAMHS to this 16 and 17 year old age cohort. It is based on the model of "specialist" or Tier 2/3 CAMHS (NHS Health Advisory Service, 1995) - a community based multi-disciplinary team offering specialised mental health services to young people with complex and severe mental health problems. In general, more than one professional is required in the management of these young people, for example medical input for medication and complexity or risk management, a therapist to provide individual work and a family therapist to address family issues. Co-morbidities are common in young people referred to specialist services and it is common to require the input of more than one clinician. Work will necessarily involve re-integration into education, training or work. This model of a mental health team for older adolescents differs from the typical "adult community mental health team" in that it includes interventions for neuro-developmental disorders such as ADHD and Asperger's Syndrome, in addition to other disorders which might not usually meet the eligibility criteria for adult specialist care.

Kelvin's calculations produce a staff tariff for a team serving a general population of 100,000 (approximately 2,222 16 and 17 year olds) based on the known prevalence of psychiatric disorders, attendance fractions and the number of clinicians required to provide evidence based interventions for a broad range of psychiatric presentations including: neuro-developmental disorders, eating disorders, depressive disorders, adjustment disorders and emerging personality disorders in addition to severe and enduring mental disorders such as Bipolar Disorder and the psychoses.

According to Kelvin's calculations (Appendix 1), the staffing required for specialist/tier 3 CAMHS at ages 16 and 17 only, based on a catchment general population of 100,000 is 12 whole time equivalents (wte) for a non-teaching centre and 15.3 whole time equivalents (wte) for a teaching centre. This includes Youth Offending and Substance misuse work. The staffing required to provide comprehensive specialist/tier3 CAMHS for 0 to 17th birthday for a general population of 100,000 is 16 wte for a non teaching centre and 20 wte for a teaching centre (Kelvin, 2005), (York & Lamb, 2006) but does not include youth offending or substance misuse work. In order to compare the new 16./17 year olds data with the data for 0 to 16 year olds (Kelvin 2005), the year 16 cohort staff tariff of 3.3 was subtracted as was the tariff for youth offending and substance misuse work. Based on this information, Kelvin calculated that comprehensive CAMHS for 16 and 17 yr olds (for a general population of 100,000) not including youth offending and

substance misuse work, requires 6.6 wte clinicians (1.45 wte consultant psychiatrists) for a non teaching centre and 8.4 wte clinicians (1.8 wte consultant psychiatrists) for a teaching centre. This equates to 3.3 wte and 4.2 wte clinicians per year (age cohort 16 yrs or 17 yrs) per 100,000 general population for a non teaching centre and a teaching centre respectively.

This information enabled Kelvin to estimate a ratio of the staff tariff for specialist/Tier 3 CAMHS for year 16 or 17 compared to the staff tariff for any one single year group 0 to 15 years inclusive. For a non teaching centre the ratio is 3.9. For a teaching centre the ratio is 3.8. He concludes that if we want to deliver equitable levels of service to 16 and/or 17 year olds compared to the younger age cohorts then 3.9 more staff for each year at 16 or 17 are required than for each year in the existing CAMHS providing for 0 to 16th birthday (0-15 years inclusive). This information can be used to calculate the extra staff required for a given Tier 3 CAMHS team in order to extend their service up to 18th birthday.

Recommendations for the staffing tariff for a comprehensive Tier 3 CAMHS service from 0 to 18th birthday (not including YOT and Substance misuse work) based on Kelvin's calculations are (16 + 3.3) = 19.3 wte for a non teaching centre and (20 + 4.2) = 24.2 wte for a teaching centre.

RECOMMENDATIONS:

In each Primary Care Trust (England) or Local Health Board (Scotland and Wales) area, commissioners for CAMHS and Adult Mental Health services must work together to ensure provision of appropriate mental health services for 16 and 17 year olds. They should For ensure that in each NHS Trust, agreement is reached between CAMHS and Adult Mental Health Services on the process of transition and the age at which it will occur. Further agreement will be required on which groups of young people will be referred on to Adult Mental Health teams and which will require alternative arrangements for ongoing treatment of a mental health problem. Alternative arrangements might include primary care counsellors, GP, clinical psychology, student counselling services, youth service counsellors or other non statutory or voluntary sector provision. The key consideration is that the young people concerned can access appropriate mental health expertise for their particular difficulties and that their views are taken into account during the planning process.

1. This paper recommends that specific agreement is reached by local CAMHS and Adult Services with respect to the arrangements for the transfer of care to adult mental health of young people with severe mental disorder.

The following diagnoses would generally fulfil the criteria for referral to adult mental health services:

- Schizophrenia and related psychoses
- Bipolar Disorder
- Severe Obsessive Compulsive Disorder
- Severe Depressive Disorder
- Severe or chronic Eating Disorder

The principles of integrated planning offer a useful model in ensuring that individuals at the transition between CAMHS and Adult Services obtain seamless care. For those presenting with severe mental disorder needing ongoing care with adult psychiatric services, discussion should take place between services at an early stage (at least 6 months prior to the age of transition). The young person must be consulted and involved in discussions. Where possible prior to transfer of care, a period of joint working should be introduced, with the key worker from each service linking to facilitate meaningful engagement of the young person. Formal handover of care should be marked by a specific multidisciplinary case conference. In England and Wales this should be by the Care Programme Approach (CPA). Services should aim to have a degree of flexibility around time of transition in line with the developmental needs of the young person concerned.

2. It is recommended that specific agreement is reached and protocols written regarding the transfer of care for young people who are in treatment with children's mental health services and are within the diagnostic groups listed below.

- Attention Deficit Hyperactivity Disorder (ADHD)
- Autistic Spectrum Disorder (e.g. Asperger's Syndrome).
- Emerging Borderline Personality Disorder.
- Mild to moderate Learning Disability.
- Psychological sequelae of chronic physical illness (e.g. Cystic Fybrosis, Diabetes)
- Psychological sequelae of abusive experiences.

The process of transfer and provision of ongoing care to these groups can be complex as they may not fulfil the referral criteria for an adult mental health team that prioritises severe mental illness. Local arrangements should reflect good practice guidance regarding each of the diagnostic groups. Commissioners must be informed of gaps in service and of their responsibility to commission new services where resources are lacking.

It is recommended that within each NHS Trust (in conjunction with local commissioners, senior practitioners and managers) CAMHS, adult mental health and other key agencies such as clinical psychology, social services, primary care and relevant non-statutory

services should work together to draw up standard agreements with respect to care pathways and the programmes of transition for each of the disorders listed above. It is recommended that young people and their families/carers are involved in this process.

As outlined above transition protocols should ensure that a planning meeting between agencies involved in the transfer of care takes place at an early stage. In areas where there is a long waiting list for example in clinical psychology, this should be taken into account when planning the timing of referral. Formal transfer of care should be marked by a specific meeting or case conference.

3. We recommend that pathways of care and treatment protocols are agreed between the local CAMHS and Adult Mental Health Service with respect to self harm and emergency presentations to Accident and Emergency departments. This should reflect good practice guidance (NICE guidelines) and the recommendations in the Royal College of Psychiatrists report. (Kaplan, 2007).

4. The Royal College Psychiatrists (Royal College Psychiatrists, 2002) English (DoH/DfES, 2004) and Welsh policy documents (National Assembly for Wales 2006; National Assembly for Wales. 2001) as well as Scottish policy documents (The Framework for Promotion, Prevention and Care, 2005; Mental Health Delivery Plan, 2006; Mental Health Act (Scotland) 2003), suggest that ideally no young person under 18 years should be admitted to an adult psychiatric unit, and that inpatient care should be in specialist, age appropriate facilities.

Until resources for appropriate adolescent services become available across the UK, it is vital that specific agreement should exist between CAMHS and Adult Mental Health Services on protocols for the safe admission and management of 16 and 17 year olds on adult psychiatric wards as outlined in the Royal College of Psychiatrists' council report (Royal College Psychiatrists, 2002). the 'Pushed into the Shadows' document (Children's Commissioner for England, 2007) and in the NSF for Mental Health in England and that for Wales. It is recommended that admissions to adult wards should be for brief periods only. In most circumstances an age appropriate inpatient setting that provides access to education, and expertise in child & adolescent mental health should be identified, and transfer of care arranged as soon as possible.

5. It is recommended that in cases where a 16 or 17 year old is receiving treatment in an 'Independent Sector' adolescent psychiatric inpatient unit, that the professionals involved ensure that transition arrangements are addressed as outlined above for the NHS sector.

PSYCHIATRIC EXPERTISE AND TRAINING:

The developmental needs of adolescents with severe mental disorder must be balanced with the needs for appropriate expertise in the professionals caring for them. Hence individuals presenting with early onset of a psychotic illness should have access to the local specialist service for that diagnostic group (e.g. Early Intervention Service for Psychosis) alongside access to CAMHS. Expertise in working with children and adolescents must be present in any mental health team treating adolescents under 18 years. It is recommended that no consultant psychiatrist should have sole clinical responsibility for a patient aged under 16 years unless that psychiatrist has specialist training in child and adolescent psychiatry. Similarly no psychiatrist should have sole clinical responsibility for a patient aged 18 years or over unless they have specialist training in adult psychiatry.

The changes introduced by the Postgraduate Medical Education Training Board (PMETB) with respect to the postgraduate training of psychiatrists are likely to have an impact on the training experiences available across the age range and on the relative expertise obtained in developmental issues. It is recommended that all psychiatrists have a training in developmental psychiatry in order that they may understand and manage the clinical issues arising out of transitions from child to adult services.

It is currently the case that in many circumstances, agreement is reached by which Child and Adolescent and Adult Psychiatrists work together to combine their expertise and that of members of CAMHS and adult multi-disciplinary teams, and other key agencies, in order to meet the mental health needs of the transitional age group of adolescents and young adults.

CONCLUSION:

Significant work has been undertaken across the UK to establish guidelines for effective interventions, team skills and models of service delivery at the CAMHS/Adult Interface. The developments are underpinned by efforts to improve communication and co-operation between Child and Adolescent and Adult Mental Health Services. As psychiatrists, we have an important role in combining our specialist skills and experience with those of our multidisciplinary colleagues to provide developmentally appropriate mental health services to the young people at the interface between child and adult services. In addition through collaboration between child and adult services we can facilitate successful transition planning and programmes that result in effective engagement of young people either with adult psychiatric services or alternative appropriate services such as clinical psychology or young people's counselling services.

Further collaboration between providers and commissioning of new services will be necessary in order to meet the gaps in provision for young adults with enduring neuropsychiatric disorders such as Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder and to fund appropriate transition arrangements. In addition significant investment is needed across all 4 jurisdictions of the UK in order to manage the deficits in age appropriate crisis intervention and psychiatric inpatient services for young people with mental disorders including those with Learning Disability.

Kelvin provides some preliminary estimates of the workforce capacity, including consultant psychiatrist time, that is required to provide a comprehensive community mental health service to 16 and 17 year olds.

In the absence of significant new resources there are a number of practical ways that CAMHS and Adult Mental Health can improve access to appropriate services for young people.

- View the service and access to it from the perspective of the young person
- Identify a local forum to take thing forward
- Accept neither CAMHS nor Adult Mental Health have all the answers
- Establish partnerships with a range of statutory and non-statutory agencies
- Identify interested clinicians in CAMHS and adult community mental health teams willing to take on link role.
- Develop joint CAMHS/Adult Mental health training opportunities and possibilities for joint working

On a local and national basis ongoing dialogue and joint training events are key. This will encourage clinicians to share ideas and initiatives that can contribute to the further development of effective interventions and models of service. In addition to this, both adult and child and adolescent psychiatrists must work closely together and with their respective commissioners to ensure that resources are made available to meet the particular mental health needs of this vulnerable and high risk group of young people.

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Table 1.
Analysis of Clinical Need & Raw Data Set For Staff Hours: Per 100,000 Gen.Pop.

	Prevalence **Column 2**	**Number Per 2,222 16-17 yr olds Column 3**	**Attendance Fraction Per Annum** **Column 4**	**Treatment Guideline** **Column 5**	**Ave Input Per Case Per Annum** **Column 6**	**Staff Needed wte** **Column 7**
Depression	4 % 16-17 Yrs	89	@30 % 27 10% needing extra intensive support in transition	RC/CBT/IPT/PPT (100%) +/- medication (70%) Family Therapy (40%) Intensive transition support to adult services for 3 cases per annum	1-2 assessment attend 9 sessions DNA 10% + 1 2-4 Family mtgs 10 hours per case, for Liaison, CPA meetings, handover process	Medical assessments in 50% MDT assessments in 50% 1.5 hours per assessment meeting average 2.5 hours per assessment 14 cases x 2.5 hours = **35 hrs Medics** 13 cases x 2.5 hours **= 32.5 hours MDT** Treatments 10 individual sessions 10 x 1 hour x 27 = **270 hours MDT** medication sessions say 6 additional sessions for say 70% 19 cases x 6 x 0.45 hours = **51 hrs Medic** Family therapy 11 cases at 3 sessions each of 1.5 hours = **49.5 hrs Fam therapy** **3 x 10 = 30 hrs divided into** **15 hrs MDT** **15 hrs Medic**
Self Harm	7%	156	@ 35 % 55	Urgent assessment & Follow up 1-3 x	Assess 1 session 2 follow ups	Self harm assessor on call 55 cases x 3.5 hrs = 192 hrs 70 % assessed in normal hours = 134 hrs mixed medic/MDT time, depends on organisation say 50% each **67 hrs medics** **67 hrs MDT** daytime on call rota only Out of hours 58 hrs need per annum Divided **29 hrs Medics** **29 hours MDT**
Repeated self Harm Evolving Personality Disorder/ Borderline Personality Disorder	1% Allow for MDD & PTSD, crises, adjustment reactions	22	@95% 21	May need Fam Tx, Individ Tx DBT, PPT, CBT	25-40 sessions per year sessions for say 10 Family	10 cases x 30 hrs = 300 hrs Mixed Medic/MDT divided **50 hrs Medic** **250 hrs MDT**

? Complex Post Traumatic Stress Disorders					sessions say 5 per year for 10	10 cases x 5 x 1.5hrs = **75 Hrs Fam Tx**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendence Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
Obsessive Compulsive Disorder	1.5%	33	@50% = 17 10% needing extra intensive support in transition	CBT (100%) Medication (50%) Fam Therapy/mtgs say 30 % Intensive transition support to adult services for 2 cases per annum	1-2 assess 6-18 Tx Ave 12 Medication process say 8 sessions per year per case Fam Tx say 3-5 sessions 10 hours per case, for Liaison, CPA meetings, handover process	CBT 12 x 17 x 1 = **204 hrs MDT** Medication process 9 cases x 8 x 1 hr = **72 hrs medics** Fam therapy 5 cases x 4 sessions x 1.5hrs = **30 hrs fam therapy** **2 x 10 = 20 hrs divided into 10 hrs MDT 10 hrs Medic**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendence Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
ADHD Attention Deficit Hyperactivity Disorder	1 %	22	@ 70% 15 10% needing extra intensive support in transition	Medication (100 %), Reviews including time for, diet, behaviour, systemic consultation education links Family mtgs say 20% Newly referred cases either transferred from elsewhere or newly detected Say 2 per year Intensive transition support to adult services for 2 cases per annum	Medication reviews 3 per year Family work 3-5 meetings for 3 cases per year Assessment 2 x 1.5 hours Medication starting up Further 5 sessions in first year 10 hours per case, for Liaison, CPA meetings, handover process	15 cases x 1 hr x 3 **= 45 hrs medics** 3 cases x 1.5 hrs x 4 **= 18 hrs fam therapist** 2 cases x 1.5 hrs x 2 **= 6 hrs medics** additional start up medication sessions 2 cases x 2 x 1 hr = **4 hrs medics** **2 x 10 = 20 hrs divided into 10 hrs MDT 10 hrs Medic**
Anxiety disorders; Separation Anxiety, Phobias, Panic, Agoraphobia, Post Traumatic Stress Disorder,	8 % but allowing for multiple co-morbidities as anxiety so often co-occurs with depression and also ADHD and will be treated together we best work	111	@ 30% = 33	Psychotherapy (CBT/IPT/PPT/ group work) say 100% Fam Therapy say 50%	1 assess session 10 sessions individual or group tx for 33 cases Fam Tx say 3-4 mtgs for 16 cases	33 cases x 1.5 hrs = **49.5 hrs MDT** **33 cases x 1 hr x 10 sessions = 330 hrs MDT** 16 cases x 1.5 hrs x 4 = **96 hrs fam therapy**

Generalised Anxiety Disorder, Other	on the basis of say 5% (SAD 0.5-1.0% GAD 1-2% PD 1% SP 1% Specific P 2.0% PTSD 3%)		10% needing extra intensive support in transition	Occasionally medication Say 10-15% Intensive transition support to adult services for 3 cases per annum	Medication process 7-8 sessions per year for 4 cases 10 hours per case, for Liaison, CPA meetings, handover process	4 cases x 8 x 1 hr = **32 hrs medic** **3 x 10 = 30 hrs divided into** **15 hrs MDT** **15 hrs Medic**
Disorder ICD 10 or Problems/Symptoms/Risks **Column 1**	**Prevalence** **Column 2**	**Number In Catchment Area** **Column 3**	**Attendance Fraction Per Annum** **Column 4**	**Treatment Guideline** **Column 5**	**Ave Input Per Case Per Annum** **Column 6**	**Staff Needed wte** **Column 7**
Pervasive Developmental Disorders	1% all forms 0.3 % for core autism 0.7% for Aspergers/atypical autism This data will track the Aspergers/atypical autism cases as the core autistic cases will be part of a children's learning disability service requiring separate data	Based on 0.7% 16	@80%= 13	10 already known to service so needing follow up not assessment 3 new cases presenting per annum ADOS/ADI and feedback 2 cases in severe impairment category plus severe comorbidity Social Skills Behaviour (60%) Tx Occassional Meds Extra Transition work to adult services for 20% most severe cases 3 cases per year Family Mtgs say 20%	10 cases known review meetings and consultation 2-3 times per year 10 hours per assessment plus 2-3 reviews 10 treatment sessions per annum 2 new cases 6-8 sessions each 10 hrs liaison work per case	10 x 1hr x 2 = **20 hrs mdt** staff per annum 3 new cases ADI/ADOS 3 x 10 = **30 hrs ADI/ADOS** **(15 hrs Medic/15 hrs Psychol)** 3 reviews x 1 x 3 = **9 hrs (4.5 hrs MDT/4.5 hrs Medic staff)** 10 x 1hr = **10 hrs Medic** time 2 x 7 x 1.5 hrs = **21 hrs MD**T 10 x 3 = 30 hours divided into **20 hours MDT** **10 hours Medic**
Substance Misuse Disorders*	circa 7% Best Estimate, very weak database	155	@ 10% = 15	MST	3-6 months 3x12-24 = 36 – 72 sessions at 3 sessions per week per case taking mid point of 54 sessions per case	Based on the Cambridgeshire MST project each case requires around 0.2 wte (**MDT staff** per annum Therefore @10% presentation rates = 15 cases x 0.2 = **3.0 wte** **MDT = 2025 hrs**

						plus **Medic time** to address detoxifications and related issues at say 10% of MDT time = **0.3 wte medic** for the 10% presentation = **168 hrs**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendance Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
Conduct Disorders; Oppositional Defiant Disorder, Conduct Disorder	16-17 yrs ODD 6-10% CD 3-5%	 178 89	 @15% = 27 @15% = 13	Parent Training/ functional family therapy plus Indiv. problem solving & emotion regul	1-2 assess + 12 Parent Training/ functional family therapy 4-6 individual	Assess 15% = 40 cases 40 x 3hrs = **120 hrs MDT** + 50% take up of Tx = 20 x 12 x 1.5 = **360 hrs functional Family Therapy** 50% take up individual = 20 x 5 sessions = **100 hrs MDT**
Very Severe Conduct Disorders**	16-17 yrs 1 %	22	@70% = 15	MST	3-6 months 3x12-24 = 36 – 72 sessions at 3 sessions per week per case taking mid point of 54 sessions per case = 648 sessions per year	Based on the Cambridgeshire MST project each case requires around 0.2 wte **MDT staff** per annum Therefore @10% presentation rates = 15 cases x 0.2 = **3.0 wte MDT = 2025 hrs**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendence Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
Adjustment Disorders. Hard to specify Emotional and Behavioural Disturbance	? around 4%	89	? @5%= 4	Assess and advise brief treatment	Assess 1 + say 3-4 sessions therapy plus interagency consults say 1	4 x 1.5 hrs assessing = 6 hrs MDT 4 x 1hr x 3 sessions advise and treat = **12 hrs MDT**
Specific Learning Difficulties & Developmental Difficulties	Around 8-10%	200	? referred with emotional disorders secondary to SLD	Assessment usually in another category	2-3 psychometry sessions in selected cases	20 cases from the different categories x 3 x 1.5 hrs = **90 hrs Psychologist**
Somatoform Disorders; Chronic Fatigue Syndromes/ Neurasthenia, Conversion Disorder, Abnormal Illness Behaviours	8 %	178	@ 10% = 18 10% needing extra intensive support in	Assess 1-3, Joint work paeds, ind & family rehab 20-30 sessions per year CBT/IPP/FT Intensive transition support to adult	Assess 1-3 sessions 20-40 treatment sessions per year 10 hours per	Medic assess = 15 x 2 x 1.5 hrs = **45 hrs medic** Treatment 12 x 25 sessions x 1 hr = 300 hrs MDT divided **60 hrs Family Therapy** **240 hrs MDT Ind Therapy** **2 x 10 = 20 hrs divided into** **10 hrs MDT**

			transition	services for 2 cases per annum	case, for Liaison, CPA meetings, handover process	**10 hrs Medic**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendence Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
Tourrettes Syndrome	0.5%	10	@ 2%= 2	Assess 1-2 x Tx medication and CBT 6-8 sessions	1-2 assess + 6 medication in first year, then 2-3 med reviews yearly 6- 8 CBT sessions	2 x 3.0 hrs assessing = **6 hrs Medic** medication 6 sessions x 0.45 hrs x 2 = **5.4 hrs Medic** 1 x 7 hrs therapy = **7 hrs MDT**
Disorder ICD 10 or Problems/Symptoms/Risks Column 1	**Prevalence Column 2**	**Number In Catchment Area Column 3**	**Attendance Fraction Per Annum Column 4**	**Treatment Guideline Column 5**	**Ave Input Per Case Per Annum Column 6**	**Staff Needed wte Column 7**
Eating Disorders	1.3 %	29 (for Anorexia Nervosa or Bulimia Nervosa)	Around 80% = 23 p.a	Assessment And intermittent review Individual CBT/Psychotherapy Family Therepy Transition support	1-2 6 x per year 12-20 5-8 7 hours Liaison per case	Assessment 3 hrs x 23 = **69 hrs Medic** Medic review 23 x 6 x 1 hrs = **138 hrs medic** Individual Treat 23 x 18x 1 hrs = 414 Hrs MDT/Dietician Divided **150 hrs dietician 264 hrs MDT** 16 x 6 sessions x 1.5 hrs = **144 hrs Family Therapy** 15 x 7 hrs Transition support = **105 hrs MDT**
Bipolar affective Disorders And Psychosis	0.3 %	7 pa	Around 90% = 7	Assessment Medication Management Individual Support/Psycho-education and Psychological Therapy in some case Family Psycho-education Therapy Support Transition support	2-3 sessions 8-12 per annum per case 20-30 sessions per case 8-10 per annum per case 7 hours Liaison per case	7 x 3 x 1 = **21 Hrs Medic** 7 x 13 x 0.45 hrs = **41 hrs Medic** 7 x 25 x 1hr = **175 hrs MDT** 7 x 9 x 1.5 hrs = **95 hrs Family Therapist** 6 x 7hrs = **42 hrs transition supp MDT**

Table 2.
Translating Raw Hours Data from Table 1 Into Balanced Service Development for 16 & 17 Year Olds

Per 100,000 all ages **16 & 17 year olds** **N = 2,222** **Staff Group Skills mix as detailed in Table1 by condition**	**Hrs Raw data from table 1**	**Hrs Raw data from table 1**	**Raw Whole Time Equivalents WTE Derived from raw hours totals**	**Whole Time Equivalents WTE Allowing for balanced staff mix of senior/ junior grades** **Non teaching centre**	**Whole Time Equivalents WTE Allowing for balanced staff mix of senior/ junior grades Add 25%** **Teaching centre**
Medic time (consultant)	32.5 15 67 29 (out of hours) 50 72 10 45 6 4 10 32 15 15 4.5 10 10 168 45 10 6 5.4 69 138 21 41	910.4 Hrs plus 29 on call DSH ? on call for all other crises eg psychosis etc	1.45 wte Plus on call services	1.45 wte Plus on call services	1.8 wte Plus on call services
MDT time (ind/fam skills)	35 270 15 67 29 (out of hours) 250 204 10 49.5 330 15 20 21 20 2025 120 100 2025 12 240 10 7 264 105 175 42	6431.5 plus 29 on call DSH ? on call for all other crises eg psychosis etc	7.6 wte all junior grades	1 wte consultant level Plus 7 wte junior level MDT	1.25 wte consultant level 8.75 wte junior level MDT

Family therapy specifically	49.5 75 30 18 96 360 60 144 95	927.5	1.1 wte	0.15 wte consultant level 1.0 wte junior level	0.2 wte consultant level 1.25 wte consultant level
Dietician	150	150	0.2 wte	0.2	0.25 wte
Psychologist	15 4.5 90	109.5	0.13 wte	0.02 consultant level 0.11 wte junior level	0.3 wte consultant level 0.14 wte junior level
Subtotals	8528.9 hrs per annum	8528.9 hrs per annum	10.48	10.93	13.9
PMHW at 10% of totals for all other clinicians	852.9 hrs per annum	852.9 hrs per annum	1 wte	1.1 wte	1.4 wte
Totals	**9381.8 hrs per annum**	**9381.8 hrs per annum**	**11.48 wte**	**12 wte**	**15.3 wte**
Admin staff				4.8	6.1
IT data support staff				0.8	0.8

Appendix To Tables

CBT cognitive Behavior therapy

IPT Interpersonal psychotherapy

PPT Psychodynamic Psychotherapy

ADI Autism Diagnostic interview

ADOS Autism Diagnostic observational schedule

MST Multisystemic Therapy

MDT Multidisciplinary Team (clinicians) MDT = all non medical staff with usual specialist CAMHS basic skills plus identified additional skills/specialisms eg Cognitive Behaviour Therapy/Pscyhodynamic Psychotherapy/Interpersonal Psychotherapy/Group therapy/Dialectical Behaviour Therapy/Parent training/Family Therapy

CAMHS Child and Adolescent Mental Health Service

PMHW Primary Mental Health worker

DBT Dialectical Behaviour therapy

RC Routine Specialist Clinical Care/integrative work