

# **Managing the transitions from adolescent psychiatric in-patient care**

## **Toolkit**

Sheree Kane

NCB's mission is to advance the well-being of all children and young people across every aspect of their lives.

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# Introduction

## The Managing Transitions from Psychiatric Settings Project

The Managing Transitions from Psychiatric Settings Project was a year-long project funded by the Department for Children, Schools and Families (DCSF). It ran from April 2007 to March 2008.

The project looked at the transitional planning for young people leaving adolescent psychiatric in-patient settings. The aim of the project was to highlight the issues and needs of young people in those settings and identify ways to improve transitional planning. This toolkit was designed as a result of the project. The toolkit does not attempt to cover the very specific needs of young people in psychiatric care who have learning difficulties or disabilities. Nonetheless, some of the messages and materials may be relevant for these young people too.

The legislation and policy framework covered by the briefings was up to date at the time of writing, but may have been amended or superseded subsequently.

**Part 1** gives a synopsis of the project: the methodology; a summary of the findings; the key messages and recommendations for policy-makers, researchers, commissioners, Tier 4 in-patient services for adolescents, adult services and children's services.

**Part 2** looks at the ingredients for effective transitions and is aimed at professionals from in-patient establishments, community mental health services and children's services. These include staff development activities.

**Part 3** provides two briefings: mental health legislation and policy; and the Care Programme Approach (CPA). Both briefings have been written by Dr Cathy Street, formerly a research consultant at YoungMinds and now an independent mental health consultant.

The Mental Health Act 2007 has introduced significant amendments to mental health legislation, including a range of specific requirements for the treatment and care of children and young people. These briefings, aimed primarily at non-mental health professionals, may also be of use to mental health professionals as they adapt their practice to take account of these new requirements.

**Part 4** provides three briefings entitled 'Looked after children – understanding care status'; 'Care planning for looked after children'; and 'Care leavers and leaving care'. These are aimed at mental health professionals working with young people who are, or have been, looked after in the care system.

**Part 5** provides a briefing on young asylum-seekers and refugees leaving adolescent psychiatric care, written by Dr Charles Watters and Rosa Hossain of the European Centre for the Study of Migration and Social Care at the University of Kent.

**Part 6** provides a literature review on managing transitions from in-patient psychiatric settings for young people, written by Steve Howell of the National Children's Bureau.

**Part 7** provides a resource section, which includes a glossary of terms for mental health professionals and non-mental health professionals, and a list of useful organisations and websites.

# Part 1 The Managing Transitions from Psychiatric Settings Project

This synopsis contains key messages from the five case studies (which include the views of the young people concerned, the professionals involved in their care planning, and family members), and from the views expressed by 25 young people who are currently patients and 35 in-patient staff.

Their identities have been kept confidential. All the names of the young people and staff involved in the project have been kept anonymous and, where there are direct quotes, a pseudonym has been used.

Given that this was a small-scale project, we do not claim that these findings reflect a comprehensive national picture of what is happening to all young people as they prepare to leave adolescent psychiatric care. However, they do provide a snapshot of pertinent key issues that are common within the literature and which national policies have sought to address.

This synopsis starts with the project methodology, followed by a summary of the findings, with key messages and recommendations for policy-makers, researchers, commissioners, Tier 4 in-patient services for adolescents, adult services and children's services.

## Project methodology

The project worked with two adolescent psychiatric in-patient settings and identified themes and issues through case studies, focus groups and questionnaires.

## Case studies

The transition experiences of five young people – identified by the establishments involved in the project as being ready for discharge – were examined in detail.

Case A	young man, aged 19
Case B	young woman, aged 22
Case C	young woman, aged 19
Case D	young man, aged 19
Case E	young woman, aged 19

Of the five, there were three white young women and two young men who were black, of African-Caribbean origin. One young woman was placed in a unit specifically for young people with learning difficulties and mental health issues. The two young men had come into hospital via the criminal justice system and had insecure immigration status.



The young people were interviewed during their time in psychiatric care and details of their discharge plans were noted. The project also followed their progress as they prepared to leave hospital and once they were discharged. At the time of writing, four out of the five young people had been discharged.

A sample of professionals were also interviewed. These included in-patient staff, community mental health workers, leaving care workers and family members.

### **Focus groups**

In addition to the detailed case studies, semi-structured focus groups were organised to capture views on the issues of preparation for leaving hospital and life post-discharge from a wider range of young people in adolescent psychiatric care. The groups ranged from young people who had recently been admitted to those preparing to be discharged, and covered both young men and women, from a range of different backgrounds, with different ethnicities, class backgrounds, ages, medical conditions and legal statuses. In total, 25 young people agreed to take part.

### **Questionnaires**

Questionnaires were given out to all the staff across the two hospital settings, in order to ascertain a range of views and suggestions on transitional planning. In total, 35 in-patient staff responded to the questionnaire. Discussions were also held with a range of staff from different disciplines across the hospitals.

## **Summary of the findings**

The decision to admit a young person into psychiatric care is not taken lightly and often comes at the end of a long and difficult road of failed interventions in the community. For many young people, psychiatric care provides stability, boundaries and security that have not always been achieved in their lives prior to admission.

Given the length of stay in hospital and the intensity of issues being dealt with, it is not surprising that many young people form strong relationships with their peers, the in-patient staff and the hospital itself. How these relationships are managed, both during their stay in hospital and after their discharge, is extremely important in the process of helping young people to let go and move on.

A common theme expressed by the young people is the need to feel wanted by their families and not forgotten. Even in cases where it was clear that there was no possibility of a return to the family home, the young person's desire to return was still prominent. The family is seen as the biggest source of support post-discharge but they, too, need support from professionals. Family work, in particular in relation to how young people manage the realities of their relationships and family dynamics, is crucial – especially given the level of importance that many young people place on these relationships.

In order to be able to hand over the baton of care – whether to the family, the community or an adult placement – young people need to have a consistent professional to whom they can turn for support and guidance. To facilitate this,

young people need to have formed relationships *whilst they are still in psychiatric care* with the practitioners who will take over the lead role once they are discharged. The earlier this happens, the better. There are major obstacles to this occurring: high caseloads, a lack of engagement and understanding of the importance of contact, problems with funding, and gaps between child and adolescent mental health services (CAMHS) and adult services. Where young people have regular contact with an identified professional from community agencies during their stay in hospital, there was a better understanding of their needs and what the plan should comprise.

A multi-agency approach that takes account of all the significant adults in the young person's life, including family and other external services such as leaving care services if applicable, ensures that post-discharge support is maximised. This approach works best where there is mutual understanding and respect and everyone has a clear role to play.

Planning for young people leaving in-patient psychiatric care is made more difficult by the lack of appropriate resources and placements to meet their needs as they move on. The key issue for all young people is knowing where they are to be discharged to. However, delays and disappointments are a common experience due to a lack of appropriate placements and available bed spaces in those placements that could meet young people's needs. Added to this, placement providers may carry out assessments and thereby raise expectations, only to find that they cannot meet the assessed needs, resulting in disappointment and frustration. A successful transition is underpinned by a comprehensive assessment of need, clear goals and defined outcomes. The views and wishes of young people are key to a successful transition. This works best when they are given the opportunity to be heard and contribute to the assessment of their need and their future plans.

Although all young people want to know when and where they will be moving to, equally important is how they will spend their time. Young people want help and support so that they can integrate back into society. They want education and training, opportunities to get employment, and they need help in addressing the skills gaps and accessing mainstream provision. There needs to be clear and specific plans so such wishes and aspirations do not drift post-discharge.

Developing a positive social life and support network can contribute to long-term recovery, resilience and well-being. However, it was interesting that very few of the young people who gave their views to the project identified this as important post-discharge. Young people need help and support to develop relationships outside the hospital and opportunities to reintegrate back into the community.

One group of young people within the psychiatric system requires particular attention. Young people with immigration issues are increasingly entering the psychiatric system, and their plans have to take account of immigration issues as these have a major impact on what happens to them post-discharge. Without proper verification and action on immigration cases, some young people may be at risk of having no status and being detained or deported on discharge. In the longer term, they may find themselves without access to services and resources, which may result in relapse or deterioration in mental

health conditions. All professionals from both in-patient and external community agencies have struggled because of the lack of advice, guidance and literature regarding the interface between mental health and immigration legislation. This needs to be rectified, as a matter of urgency, to enable staff to effectively plan for those young people with immigration needs.

To conclude, we rarely hear the voices of young people with mental health difficulties, let alone those within Tier 4 specialist services. There was initial trepidation in the planning of this project as to how the young people might be able to contribute, but this quickly dissipated on meeting the young people themselves. The views and opinions given by the young people were moving, honest – and show the way forward, cutting through the bureaucracy and complications that have existed in providing mental health services. Young people who have been in psychiatric care want the same as their peers, but are particularly vulnerable in a society that may not be tolerant or understanding of their needs. They need to be heard, they need to be recognised and they need support. The future well-being of young people coming out of psychiatric care should be of concern to us all.

**Interviewer:** *What is the most important thing you want, when you leave hospital?*

**Young person:** *I just want to be happy*

## Key messages

The messages that emerged from the project clustered around the following themes:

- ◆ **attachment**
- ◆ **involvement of, and relationship with, family**
- ◆ **the link between the young person, in-patient team and external organisations**
- ◆ **care planning**
- ◆ **immigration.**

### Attachment

- ◆ The impact of the young person's history of attachment and current attachments to staff, place (psychiatric establishment) and their family is a recurring theme in how young people perceive and manage the transition process.
- ◆ The potential impact of the loss of major attachment figures, change of workers, placement and support can, if not managed carefully, place huge risks on the young person's recovery and treatment.
- ◆ Young people need time and to learn the skills to be able to 'let go' and move on.
- ◆ Staff also need help and guidance in letting go.

- ◆ Although attachment theory and the impact of attachment are common concepts within children's services, they are not concepts that are part of the thinking and vocabulary of adult services and provision.
- ◆ Young people want contact with professionals from the community agencies involved in their care, to know that they are not forgotten and that someone cares.
- ◆ Young people need continuity as they leave hospital to enable them to cope with an important period of change.
- ◆ The stability and security of hospital is important, especially if there has been a long history of instability and insecurity or young people have been in long-term care prior to admission.
- ◆ If the only period of stability and opportunity in a young person's life to develop long-term relationships has been within psychiatric in-patient care, there are risks that these young people might struggle in a more open and freer environment. How to create the same sense of security and boundaries beyond the secure setting is extremely challenging and there appear to be no easy answers.

### **Involvement of, and relationship with, family**

- ◆ Contact with family was seen by many as being extremely important. Young people needed to feel wanted by their families and not forgotten. Many young people, regardless of the quality of relationships, saw their family as an important source of support, post-discharge.
- ◆ Where young people had strong feelings of connection with their family, they appeared to move on from hospital more easily.
- ◆ Although there was clear evidence of families being invited to CPA reviews, how they were going to be involved in the care planning was not always apparent. Integrated family participation appears to work best when families have clearly identified tasks to carry out within the care planning process and where their contribution is valued and makes a difference.
- ◆ To move forward, young people need to be able to make sense of initial attachments, the dynamics within the family that might persist and how they manage their health amidst this.
- ◆ In some cases, preparation for the young person's return to their home authority and move on to less restrictive placements meant the families were back at the forefront of providing support.
- ◆ The level of support and guidance available to families when their adult child moves on from hospital is variable. It appears to be dependent on the professionals involved post-discharge and their views on how families fit within the care, treatment and recovery of young people. Some were more proactive in taking a whole-family approach to the long-term stability of their clients.

## The link between the young person, in-patient team and external organisations

- ◆ The links, contact and involvement of young people and the in-patient team with external agencies varied widely.
- ◆ One of the biggest problems for those providing national beds was getting home authorities to take responsibility for the young people placed outside their area.
- ◆ Where adult services had not been involved at the point of admission, engaging those services later on in the process could be problematic – particularly if young people were admitted from across the UK.
- ◆ The transition between CAMHS and adult services was neither smooth nor straightforward.
- ◆ To facilitate effective transitions, community professionals need to be identified and actively involved in the care and treatment plans as early as possible.
- ◆ The CPA review is the key event that external professionals attend. However, contact in-between, particularly with the young people, is variable.
- ◆ For most young people, external professionals didn't feature as being involved in their care plans, apart from finding the next placement – despite the fact that young people wanted more contact.
- ◆ It was evident that those external professionals who made regular contact during the young person's stay in hospital appeared to have a fuller understanding of the young person's needs and what might be appropriate in terms of services post-discharge.
- ◆ The natural and most obvious link relationships for in-patient staff are with their community mental health counterparts. However, a lack of understanding about the roles and responsibilities of other professionals in a young person's life, such as leaving care workers, can result in missed opportunities to involve others and maximise support and services post-discharge.

## Care planning

- ◆ Transition and discharge planning should be likened to a relay race when the in-patient team hands over the baton to the community team.
- ◆ Care planning works best when there is a clear identification of holistic needs, clarity and agreement over who will be meeting those needs and how. Fully involving family members and other external non-mental health professionals helps to maximise the package of support available.
- ◆ Although recording and care planning might not always have clearly identified what the outcomes might be, in practice many young people were clear about what steps had to be taken and what the end goal needed to be to enable them to move on.
- ◆ Young people knew what their care plan was, but for some the content didn't really matter – it was getting out of hospital that was the most important thing.

- ◆ Young people's views should be more actively sought and explicitly incorporated into the care plan.
- ◆ CPA reviews were seen as extremely important both by young people and all the professionals involved. This was the one part of the care planning process that is guaranteed to see all the professionals present.
- ◆ Overall, young people felt involved in their care planning but ultimately recognised that it was others who made the most important decisions. The Mental Health Tribunal and in-patient doctors decided when they could leave hospital or 'come off section'; and the community agencies were seen as the ones who decided where they went next.

### *Care coordinator*

- ◆ Care coordinators play a crucial role in care planning, which the young people themselves recognise.
- ◆ Care coordination is often a function performed alongside other duties, which can make carrying out tasks associated with care planning challenging.
- ◆ The handover from in-patient care coordinator to community care coordinator is extremely important to ensure a smooth transition, particularly at the point of discharge.
- ◆ Equally important is the need for a relationship to be built between the new community care coordinator and the young person prior to discharge.

### *The transition: placements and preparation for moving on*

- ◆ Having been in an environment that recognises and understands the needs of young people, many will progress to adult provisions, often becoming the youngest in placement.
- ◆ Concerns were raised by in-patient staff over the lack of appropriate resources in the community and within adult services to meet the needs of young people leaving adolescent psychiatric in-patient care.
- ◆ Funding is a recurring theme in planning, which risks a service-led rather than a needs-led approach.
- ◆ In-patient staff and young people should be fully involved in helping to identify the next placement.
- ◆ Planning generally looked at one placement at a time. When a placement fell through there was then a risk of major delays and having to restart the process of referrals, assessment by placement providers, and then plans for discharge.
- ◆ Young people find it difficult to invest in a process where assessment carried out by potential placement providers does not result in a placement being offered. Young people say that potential placement providers should have a clear idea of their needs and know that they can offer a placement before meeting the young person.
- ◆ Most young people want a graduated move to their next placement so that they can become acclimatised to the new surroundings and get to know the staff. The best examples of transitional planning included numerous visits to the next placement prior to discharge.

- ◆ Once a placement has been identified, some young people find it difficult to engage, particularly if the timescale for moving on is unclear, and many young people go through a period of regression prior to discharge.
- ◆ Young people's perceptions and understanding of the skills they will need to move on from the hospital were variable. Many had high expectations of post-discharge support, often based on their experience in hospital.

### *Education, training, work and future opportunities*

- ◆ Young people want the opportunity to get qualifications, to be able to get a job and feel a valued member of the community.
- ◆ Young people, in-patient staff and community agency professionals all agreed that access to constructive activities such as education, training or work is important for long-term recovery and well-being.
- ◆ As well as identifying the next placement, education and work were other important issues for the majority of the young people. The best plans incorporated clear ways of helping young people to access constructive educational and training activities.
- ◆ Many young people have had a disrupted education and are concerned about how they are going to get the necessary skills and qualifications to be able to move forward – rather than end up re-offending or back in a psychiatric hospital.
- ◆ Those young people who were achieving academically prior to admission and had learnt the skills to study within a mainstream education environment, appeared to find it easier to reintegrate back into mainstream education provision if properly supported by in-patient staff and the education establishment.
- ◆ Although education staff within the adolescent psychiatric establishment work hard to address gaps in education, post-discharge access to education, training and to employment opportunities was variable.

### *Social networks and leisure*

- ◆ For most of the young people interviewed, fellow patients are their social network. Very few spoke about other friends. The challenge is how to help these young people develop social networks outside the hospital.
- ◆ Of those young people discharged during the project, their social networks comprised either older patients or residents in their placement. At the end of the project there was little sign of young people making friends with their own age group or with those outside the mental health system.

### *The interactions between different care planning processes*

- ◆ The input of looked after children's services and leaving care services into the care planning process of their clients was variable. Although there was always representation at CPA reviews, how these services contributed to the planning for discharge and support post-discharge was unclear.
- ◆ It was also not clear to both in-patient staff and leaving care workers how leaving care workers should or could engage in providing support and services to young people with severe mental health problems.

- ◆ The contribution that leaving care services could make and the range of entitlements that care leavers could access was either not known or not recognised by in-patient staff.
- ◆ There were inconsistencies over how the two review processes played out for a looked after young person; and it was unclear how one informed the other. Where an independent reviewing officer and social worker attended the CPA review, there was the potential to reduce the amount of duplication.
- ◆ Although local authority LAC (looked after child) care planning and pathway planning should have been taking place, these appeared to be totally separate planning processes from the CPA and discharge planning. No paperwork pertaining to the looked after care planning processes appeared to register on in-patient records nor was there any reference to the fact that they should have existed.
- ◆ It was often not clear for in-patient staff who the point of contact was for children's services or leaving care services. The points of contact between in-patient and community mental health were more clearly established.
- ◆ Professionals used to working within a particular setting, even within a multidisciplinary team, develop a common understanding and a common language that is not always understood by other professionals. There is a question mark over whether the different sets of professionals understand the terminology used separately by mental health staff and children's services staff.

## Immigration

- ◆ There are young people with a range of immigration needs within both adolescent psychiatric establishments: from asylum seekers, refugees, over-stayers to EU migrants to those whose immigration status is unclear.
- ◆ Advice and guidance is required by staff planning for young people with immigration needs, that is, clarification on the asylum process, roles and responsibilities of staff, the impact of immigration on transitional planning and the resources available.
- ◆ An awareness of immigration issues is central to care planning for young people with immigration needs. However, the triggers for action to clarify and resolve these issues were not systematic.
- ◆ The process of ascertaining the immigration status of young people was not straightforward, putting them at risk of having either no access to services or being deported post-discharge.
- ◆ The Border and Immigration Agency (BIA) have set up a system whereby a designated person within a local authority liaises with them directly on questions of status and progress of immigration matters. However, this system does not recognise that adolescent psychiatric in-patient settings need to know the status of their patients in order to plan accordingly.
- ◆ There is a lack of available information and guidance on the interface between mental health legislation and immigration; and how immigration impacts on the care planning process for professionals.
- ◆ There is a lack of information for young people on the immigration process and how this might impact on their entitlements.



## Recommendations: translating the key messages into practice

### Policy-makers

- ◆ A clear national policy on the transition between CAMHS and adult services would help to ensure that young people are no longer without due support and care to enable their transition from hospital to run smoothly – that they do not fall down the ‘cracks between services’. All young people in in-patient care who are 16 and over should be able to access adult services in a seamless fashion.
- ◆ The Home Office Border and Immigration Agency (BIA) need to consider how adolescent psychiatric hospitals access the appropriate information to inform care planning, so that immigration status and any consequent action is clear.
- ◆ Those working with young people within psychiatric settings and within community mental health teams need clear guidance and information on the immigration process, the needs of this group and the impact of these on care planning.
- ◆ Young people need information on the immigration process and its impact on their entitlements and where to get sources of support, particularly those who may not have recourse to public funds.

### Research and development

- ◆ Consideration needs to be given to the use that can be made of attachment theory and concepts within adult health and social services, in particular those around issues of transition and discharge planning.
- ◆ Longitudinal studies looking into the impact of relationships between young people, in-patient staff and their environment would be beneficial in informing the work of in-patient care and discharge planning.
- ◆ Further studies need to be done to look at the issue of delays in discharge to see if there are practical and strategic solutions to this problem.
- ◆ Further project work and studies are required to look at how to assist young people to move on more effectively from secure settings and cope with life outside the adolescent psychiatric in-patient establishment.
- ◆ Further studies are necessary to look at the pathways of young people in terms of education, training and employment; to inform the work and development of in-patient care and community mental health services; and to develop community-based services to reach those groups of young people who are at risk of exclusion.
- ◆ Further studies should be done to look at the social networks of young people leaving adolescent psychiatric care – the trends and patterns – with the aim of providing practical advice on how to help young people in the future.
- ◆ There needs to be further development work, which is evaluated, on how the LAC care planning and the CPA system can be made more complementary or dovetailed more efficiently.

- ◆ There is a need for further study of young people with immigration issues leaving psychiatric in-patient care in relation to care pathways, outcomes and the interface between mental health services and immigration authorities.

## Commissioners

- ◆ Clear protocols and agreements need to be in place from the outset as to the role and expectations of commissioners.
- ◆ There has to be a needs-led rather a service-led approach to planning.
- ◆ Placement providers should be given an up-to-date assessment of the young person's needs by the hospital or unit. A young person should only be seen by a prospective placement provider once they have an understanding of the young person's needs and have identified that they have a placement to meet those needs.
- ◆ In-patient staff and the young people should be involved in helping to identify what might be a suitable placement.
- ◆ There needs to be a proper handover period, including post-discharge support from the hospital, that accords with the needs of young people leaving long-stay psychiatric care. A needs-based transition package can help to minimise the potential impact of the loss of major attachment figures, a change of workers, placement and support.

## Tier 4 in-patient services for adolescents

- ◆ The impact of the relationship between young people, the in-patient staff and the hospital or unit has to be recognised within the care planning process so that this can be managed effectively pre- and post-discharge.
- ◆ Staff need support and guidance in how to 'let go' so as not to adversely affect the transition and discharge process.
- ◆ The key to linking in-patient, commissioning bodies and community-based services is to agree a protocol between them that establishes their roles and responsibilities.
- ◆ It is in the interest of the patient's long-term recovery and treatment, successful transition and outcomes, that care coordinators have adequate time allocated for care planning. It is economical in the long run and might actual pre-empt problems such as regression.
- ◆ Care planning works best when there is a clear identification of holistic needs, clarity and agreement over who would be meeting those needs and how. Fully involving family members and other external non-mental health professionals helps to maximise the package of support available.
- ◆ Outcomes in care planning need to be SMART: specific, measurable, achievable, realistic and time-limited.

## Adult services

- ◆ Community agencies need to be involved as soon as possible after a young person's admission so that they are able to form and maintain relationships

with young people. This would provide continuity for young people as they leave hospital and cope with a period of change.

- ◆ Consideration needs to be given as to how to replicate the stability and security provided by in-patient care once young people are discharged into less restrictive placements or into the community.
- ◆ To facilitate effective transitions, community professionals need to be identified and actively involved in care and treatment plans at the earliest possible stage.
- ◆ There should be regular contact with young people in-between CPA reviews.
- ◆ Adult services need to ensure that all key agencies that could contribute to the care plan are actively involved and kept informed.
- ◆ The community care coordinator should be having regular contact with the young person prior to discharge to enable a smooth transition.

## Children's services

- ◆ Children's services need to be proactive in keeping in touch with young people and staff, explaining their role and responsibilities, contributing to the care plan, and providing support and services post-discharge.

## For all three services: Tier 4 in-patient services for adolescents, adult services and children's services

Given the importance placed on families and the impact of relationships, both the in-patient and community mental health professionals have to consider how to involve families in the care plans of young people.

Family work, in particular that relates to how the young person manages the realities of their relationships and family dynamics, is crucial.

Family participation appears to work best when the families have clear tasks to do, and can see how their input makes a difference and is valued.

For young people who are looked after or are care leavers, children's services' leaving care services could also play a role in working with them and their families. This could be factored into care planning.

Young people want to have access to education and training that gives them opportunities to get employment when they are discharged. These need to be given a high priority in care planning and the details sorted out prior to discharge.

How young people develop social networks and support outside hospital has to be a continuing part of their care plan for when they are discharged. Part of the work on transitions has to look at the young person's skills in making new relationships, the components of this and building confidence in doing so.

In-patient staff, community mental health and children services' staff, social workers and leaving care workers all need to gain an understanding of their respective roles, responsibilities and how they can contribute fully to the different care planning systems.

Triggers should be in place – from within in-patient care, community mental health and children’s services including leaving care – to ensure that points of contact are identified and that young people get what they are entitled to.

## Part 2 Transitions

### Ingredients for an effective transition

The five key ingredients are: young people’s participation; cross-agency working; working with other support systems; care planning and discharge planning; and outreach support/handover.

#### Young people’s participation

This is central to young people’s successful transition and means they are:

- ◆ fully involved, listened to and have their views taken into account
- ◆ helped to develop skills to contribute (invaluable as they get older as they may need to negotiate support and services more independently)
- ◆ helped to develop a sense of responsibility, value and self-worth
- ◆ given opportunities to feel that they are a part of the community and can contribute
- ◆ given clear information about, and are prepared for, each stage of transition
- ◆ helped to take ownership of their lives and futures
- ◆ helped to comply with interventions
- ◆ sure to have their developmental needs identified and met
- ◆ given frequent contact with community agencies during in-patient care, so they are familiar with those agencies when they are discharged.

#### Cross-agency working

This comprises:

- ◆ frequent contact between professionals
- ◆ the integration of planning processes
- ◆ the support of an overarching strategy between agencies
- ◆ the support of clear operational procedures
- ◆ having funding in place
- ◆ maintaining and developing links with community agencies from the point of admission.

#### Working with other support systems

This involves:

- ◆ recognising the importance of relationships with family and friends
- ◆ enabling the young person to have regular contact with them
- ◆ encouraging positive links between young people and the community

- ◆ providing a clear idea of how family and friends can help as well as what to do when things go wrong
- ◆ helping parents and carers to 'let go' so as to empower the young person as they move through the transition phase to become more autonomous and independent.

## Care planning and discharge planning

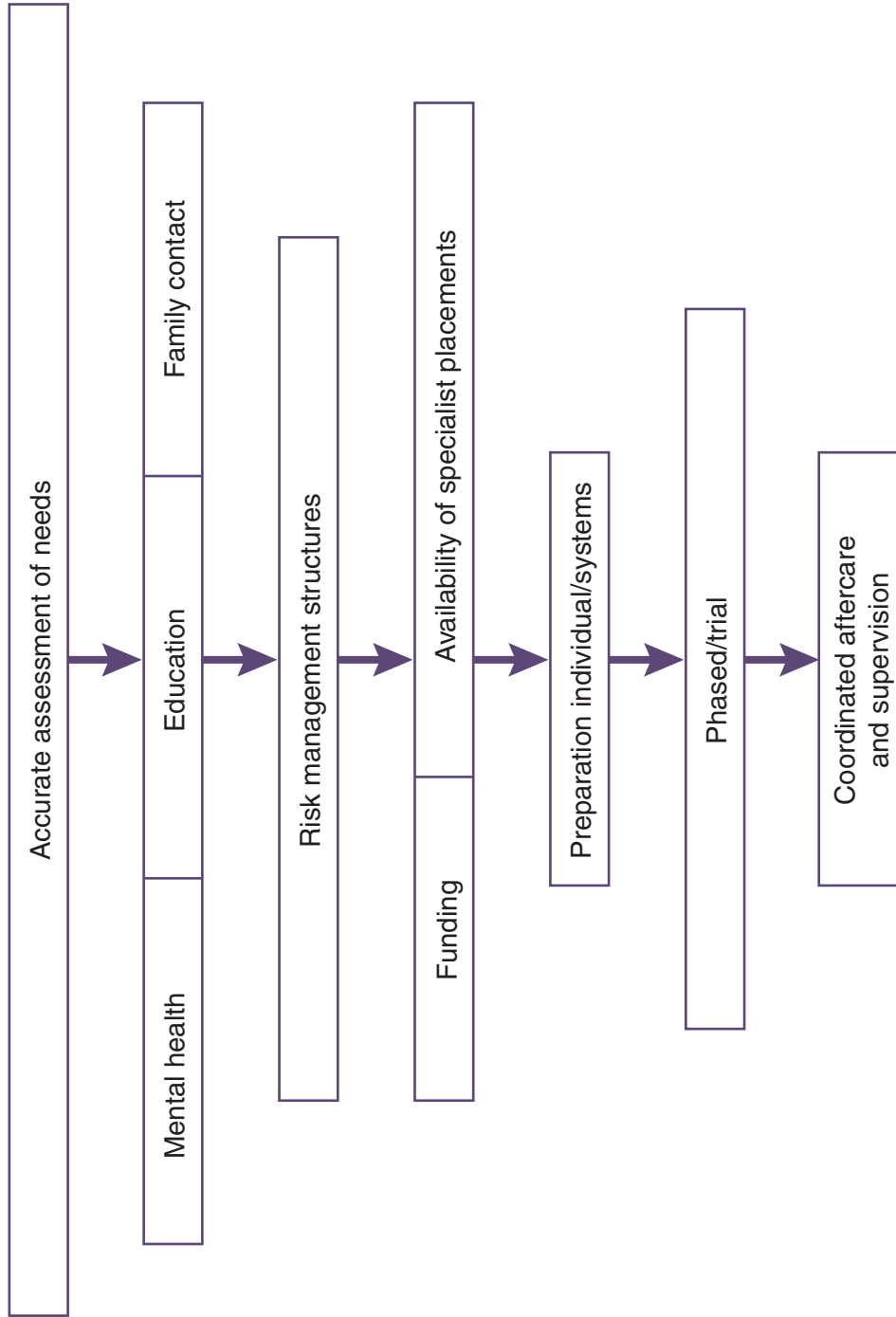
This entails:

- ◆ focusing on short- and long-term goals and targets, and identifying clear and specific outcomes
- ◆ anticipating and resolving problems such as funding issues
- ◆ involving the young person, family and all the agencies
- ◆ making a holistic assessment of needs – looking at the young person's future placement; economic well-being; structured daytime activities, education, training and employment; social life and relationships; support from family and friends; quality of life as they move through transition; and identifying contingency arrangements if setbacks occur
- ◆ recognising the relationships that young people form whilst in hospital and helping young people to manage the loss of those relationships when they move on
- ◆ recognising the impact of change for young people as they leave hospital and building in strategies to help young people cope and manage this period
- ◆ identifying likely problems and risks ahead of time and putting in place support to overcome, or at least cope with, difficulties they will encounter
- ◆ identifying the risks and triggers for relapse and readmission
- ◆ identifying the services and support required to address the young person's needs as they move from the structured environment of their current placement
- ◆ addressing how interventions started in hospital will be continued, monitored and reassessed in the community
- ◆ having adequate funding in place
- ◆ having contingency arrangements for setbacks.

## Outreach support/handover

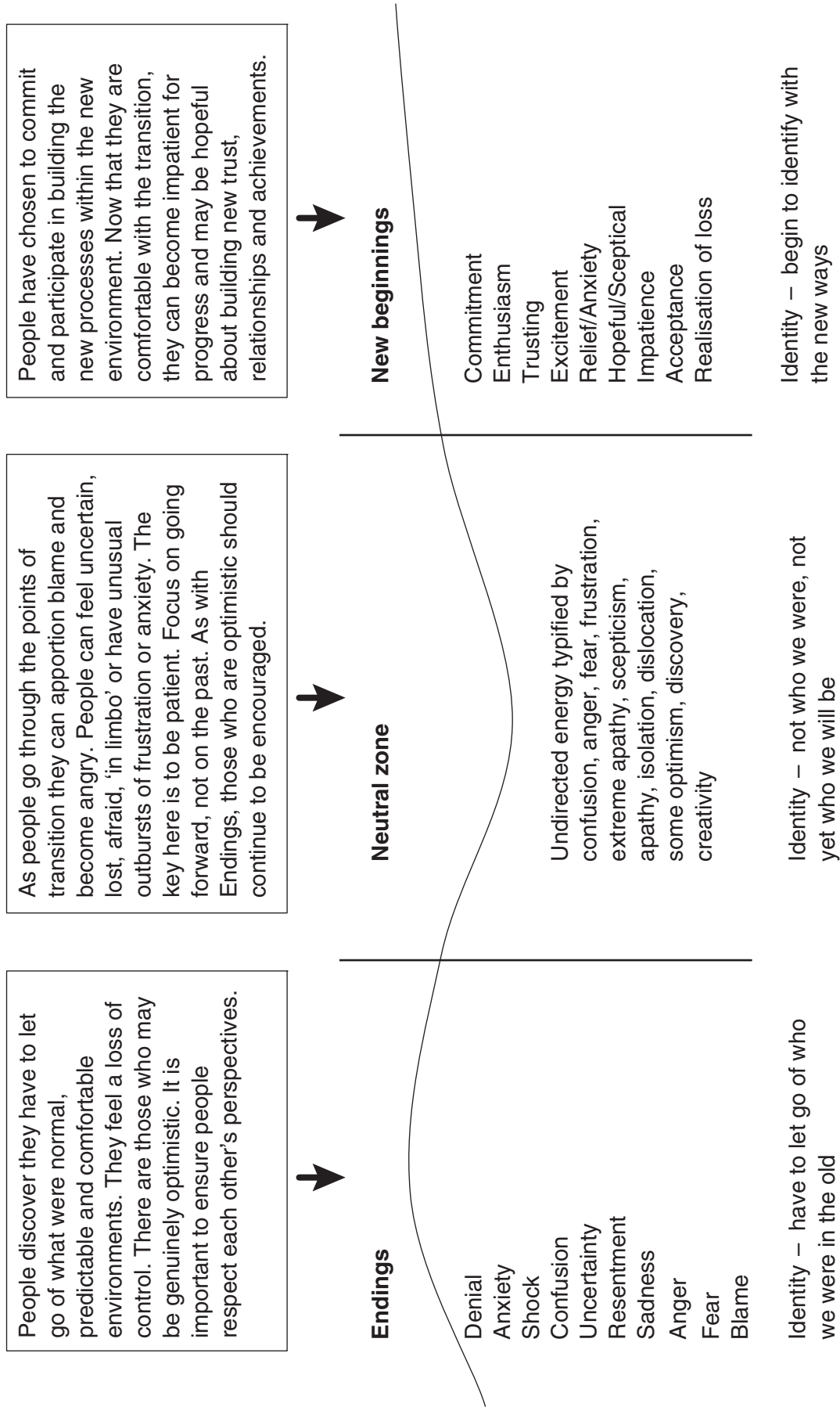
This comprises:

- ◆ funding to be agreed at the point of admission
- ◆ the terms of the outreach support from in-patient staff to evolve as the needs of the young person change, so that there is a tailored outreach package that meets the young person's individual needs and circumstances
- ◆ a process that helps young people to move on and let go, and settle post-discharge.



*By Dr Anupama Iyer, consultant psychiatrist, St. Andrew's Health Care, with permission*

**Figure 1: The 'ideal' transition trajectory**



Taken from JISC infoNet – The transition curve at [www.jiscinfonet.ac.uk/infokits/change-management/transition-management/transition-curve](http://www.jiscinfonet.ac.uk/infokits/change-management/transition-management/transition-curve)

**Figure 2: The three phases of transition**

## Briefing 1 Conceptual model: needs, outcomes, services and review

A key to effective transition is a thorough assessment of the young person's needs with clearly definable outcomes, which can be matched with the appropriate services and support to meet those needs.

This briefing is aimed at practitioners involved in the assessment, planning and review process for young people in psychiatric settings. It provides a conceptual model for looking at the cycle of needs, outcomes, services and review. It will also be of interest to managers and supervisors looking for a tool to use in supervision and case management, to help staff focus on breaking down the tasks of assessment and planning.

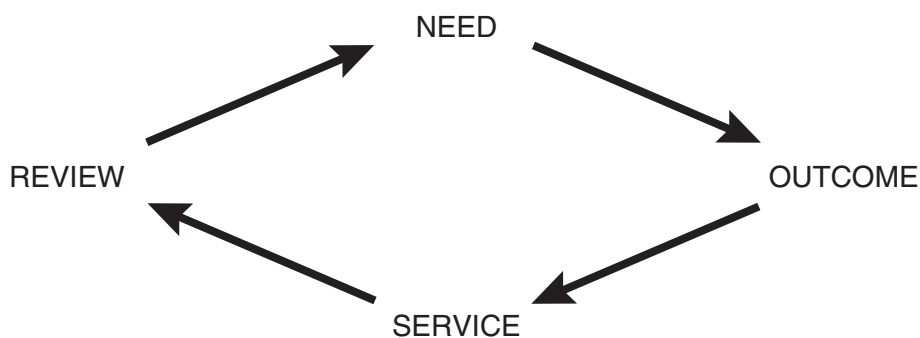
To have effective plans that meet the needs of a young person, it is paramount that all the needs of young people are properly identified to the best of the professionals' knowledge at any particular time. If a need is identified that may not be met by the setting currently or even in the longer term, this need should still be identified. It may be that alternative options need to be explored and planned for in advance.

By helping to break down the task, this model makes the job of assessing and meeting needs manageable.

The aim is to provide you with a tool to help you to feel more confident in identifying needs and plan more effectively. This conceptual model can be used to aid the range of planning systems used in different secure settings, including the CPA (Care Programme Approach) and integrated children's system.

### The model

The following model can be applied to the assessment process of any young person.



Adapted from the work of the NCB Care Planning for Looked After Children Project 2004 [www.ncb.org.uk/careplanning](http://www.ncb.org.uk/careplanning)

**Figure 3: Needs–outcome–service model**



<b>NEED</b>	What children and young people require to thrive, for their health and development, in order to maximise their opportunities to reach their full potential as they move towards adulthood and beyond.
<b>OUTCOME</b>	Think about what you want to achieve. In order to know whether you met the need, you have to establish exactly what outcome you are looking for. If the outcome states that the young person be happy, this would be too vague. How would you know if you achieved this? Is this actually a realistic outcome as no human being is happy all the time? Outcomes need to be SMART: S – Specific M – Measurable A – Achievable R – Realistic T – Time-limited You should also be able to provide evidence that the outcome has been met.
<b>SERVICE</b>	Think about the task that needs to be done to meet the need and who will do this. A service can be a person, such as a specific professional doing a particular task.
<b>REVIEW</b>	This is when you look at whether the service you put in place, or the task undertaken to address the need, has achieved the outcome you were looking for. If the need has not been met, then you may have to look at another service to meet the need.
<b>UNMET NEED</b>	It is extremely important to record needs that have been identified and have not been met or cannot be met and the reasons for this. This information is important in terms of strategic planning and for indicating issues that affect the ability to meet identified needs to the relevant bodies.

The model places the young person’s needs at the centre. It will assist you to avoid jumping ahead and thinking about what services you have available rather than identifying the actual need.

## The practitioner's role in assessment and planning



When you look at this picture, what do you see? Is it a picture of a man drowning; or of a man wearing a hat, pulling himself up from the water? Could it be a man playing a piano? We all have different ways of looking at things. The same applies to our work with young people.

Important aspects of the assessment and planning process are the practitioner who undertakes these activities and the organisational context in which they take place.

It is important to recognise how the practitioner's own identity, values and attitude, professional knowledge and skills might impact on the assessment and planning process. Equally important is recognising the environments in which the particular setting operates. This includes an awareness of the national policies and priorities, local commissioning strategies and plans for individual patients as well as how the particular establishment in which the practitioner is located operates: its history, purpose and methodology for meeting the needs of its client group.

Both personal and environmental factors influence how work is carried out, and the way in which the information is gathered, analysed and interpreted to formulate the care plan.

<b>Influences</b>		
<b>Internal professional</b>	<b>External professional</b>	<b>Personal</b>
training	commissioning	life experience
legislation	resources	identity
policies/procedures	finances	family, peers
motivation	position/status	education
values/belief	values/belief	health
organisation	organisation	view of the world
position/status	motivation	community
	policies/procedures	beliefs, values

How an organisation or individual views young people or a particular group of young people may influence the extent to which young people are involved in the assessment and the decision-making process.

*Experience tells us that plans have a better chance of succeeding where the children themselves have been involved in their preparation.*  
(Timms, JE and Thoburn, J (2003) *Children in Secure Accommodation: A gendered exploration of locked institutional care for children in trouble*. London: Jessica Kingsley. p.18)

Research suggests that listening and really involving children and young people is the key to effective care planning. How to involve children and young people in the care planning process provokes much debate and difference of opinion, but it has to be given serious consideration if we are to overcome the barriers to meaningful participation.

The **cultural review** is a tool that could help practitioners look at issues that impact upon the care planning process. It can be used to develop a more analytical approach to care planning and, as Dalzell and Sawyer (2007) suggest, it provides an opportunity to explore the unconscious processes and hidden influences on a practitioner's ability to engage with young people and their families. This tool can be used individually or in supervision sessions. It can be used in preparation for an admission as well as in care planning.

### Cultural review

- 1 What do I know about young people and families with this particular background or life experience?
- 2 Where does my knowledge come from?
- 3 What prejudices may I hold (positive or negative)?
- 4 What do I know/expect about young people of this age, their lives and needs?
- 5 What might surprise me about this young person/family and why would it be a surprise?
- 6 How might the young person/family perceive me?
- 7 How might the assessment and/or plan and my agency/organisation/unit be perceived?
- 8 What impact might the assessment and care plan have on the young person and their family's life?
- 9 What agency norms and practices do I take with me on an assessment and during care planning (e.g. awareness of risk, resource restrictions, theories used within the work)?

Adapted from Holland, S (2004) *Child and Family Assessment in Social Work Practice*. London: Sage Publications. p130. Use of questions for social work assessments based on 'The Cultural Review: A tool for social researchers' in McCracken, DG (1998) *The Long Interview*. Beverley Hills, CA: Sage Publications.

## Effective working together

The transition process for young people involves a range of different professionals from a variety of different disciplines and services. It is important to make sure that all the key people and organisations are involved. The coordination of the transition process requires:

- ◆ effective communication
- ◆ an understanding of service criteria and boundaries between services
- ◆ an understanding of the respective roles and responsibilities of professionals involved
- ◆ an understanding of the expectations between, and of, services
- ◆ a clear plan of the tasks – who does what, timescales and intended outcomes
- ◆ the written agreement of all those involved, with responsibility taken for agreed action.

Protocols, procedures and service level agreements are all important tools in creating the framework for improving interagency and interdisciplinary working. The following checklist is designed to help care coordinators or other professionals to consider the detail of working together with other professionals, the family and young person.

### Effective working together transitions checklist

	Working well	Needs more work	Action to be taken
Effective communication			
An understanding of service criteria and boundaries between services			
An understanding of the respective roles and responsibilities of professionals involved			
An understanding of expectations between and of services or individuals			
A clear plan of the tasks – who does what, timescales and intended outcomes			
The written agreement of all involved and responsibility taken for agreed action			

### Sharing information

Information sharing between professionals is vital to ensure that young people’s needs are properly assessed and risks identified. Protocols and procedures need to be in place to ensure this happens and to address important issues such as confidentiality.

The admissions record that follows is a tool for use by children’s services staff to provide psychiatric in-patient staff with full background information on young people known to them. It should be completed as soon as possible after admission.

It can also be adapted for use by other professional groups, or as a template for additional information to complement mental health assessments, reports and referrals.

## Admission Information Record

An Admission Information Record should be completed for all looked after young people and care leavers who are admitted into psychiatric in-patient care by the local authority social worker or leaving care worker.

This form contains confidential information that should only be shared in accordance with the Data Protection Act 1998.

### Young person's details

Family name: \_\_\_\_\_ First name: \_\_\_\_\_

Other names that the young person is also known by (including nicknames):

Date of birth: \_\_\_\_\_ Gender Male  Female

Young person's first language or preferred means of communication:

Is an interpreter/signer required? Yes  No

Placement address prior to admission:

Postcode \_\_\_\_\_ Tel \_\_\_\_\_

### Placement type

1.	Placement with parents	<input type="checkbox"/>	7.	Specialist residential placement (therapeutic)	<input type="checkbox"/>
2.	Placement with relatives/friends	<input type="checkbox"/>	8.	Specialist residential placement (residential school)	<input type="checkbox"/>
3.	Foster placement with relatives/friends	<input type="checkbox"/>	9.	Health placement (including CAMHS)	<input type="checkbox"/>
4.	Foster placement	<input type="checkbox"/>	10.	Secure accommodation	<input type="checkbox"/>
5.	Placement with adopters	<input type="checkbox"/>	11.	Supported lodgings	<input type="checkbox"/>
6.	Residential placement (children's home)	<input type="checkbox"/>	12.	Other, please specify	<input type="checkbox"/>

Is this placement still open? Yes  No

**Young person's identity**

Young person's ethnicity: \_\_\_\_\_

Young person's religion: \_\_\_\_\_

Young person's nationality: \_\_\_\_\_

**Young person's care status  
(This refers to care status immediately prior to admission)**

Care Order (Note: still a 'looked after child' whilst in in-patient care)

Accommodated (Note: not a 'looked after child' whilst in in-patient care)

**Young person's care leaving status**

Currently entitled to services as a care leaver Yes  No

Entitled to services as a care leaver on discharge Yes  No

**Young person's immigration status**

(if not British or holding British citizenship)

Current immigration status (tick relevant box)

1.	Refugee status	<input type="checkbox"/>	5.	On a visa (student, holiday) (note expiry date)	<input type="checkbox"/>
2.	Discretionary leave (note expiry date)	<input type="checkbox"/>	6.	Has a claim under human rights legislation	<input type="checkbox"/>
3.	Humanitarian protection (HP) (note expiry date)	<input type="checkbox"/>	7.	No further appeals in process, end of the line	<input type="checkbox"/>
4.	Seeking appeal (note when appeal date was made)	<input type="checkbox"/>	8.	Undocumented	<input type="checkbox"/>

Their Home Office reference number: \_\_\_\_\_

If an asylum seeker, are they in possession of their ARC (asylum registration card)?

Yes  No

If not, where is it?

\_\_\_\_\_  
\_\_\_\_\_

Does the young person have a current immigration legal advisor? Yes  No

If **yes**, give details:

Name \_\_\_\_\_

Address \_\_\_\_\_

Tel no/email address \_\_\_\_\_

What further action needs to be taken in regard to the young person's immigration status?

What action	Who is responsible	Timescales

**Safety**

Is there essential information required immediately by the establishment, in order to:

keep the young person safe? Yes  No

safeguard others? Yes  No

Specify or indicate where additional information can be obtained:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anyone to whom the young person's address and details should not be given?

Yes  No

If **yes**, please provide details:

Name \_\_\_\_\_

Address (if known) \_\_\_\_\_

Relationship to young person (if known) \_\_\_\_\_



**People with parental responsibility**

	Name	Relationship to young person	Contact details
Parents			
Others			

**Responsible children's services authority**

Case no.: \_\_\_\_\_

Team/Service: \_\_\_\_\_

Name and address of social worker: \_\_\_\_\_  
 \_\_\_\_\_

Tel no/email address: \_\_\_\_\_

Name of team manager: \_\_\_\_\_

Tel no/email address: \_\_\_\_\_

When will the first visit take place? \_\_\_\_\_

Frequency of subsequent visits: \_\_\_\_\_

Dates of planned LAC/Pathway review meetings:  
 (If not arranged, what is the timescale for arranging this?)  
 \_\_\_\_\_  
 \_\_\_\_\_

Out-of-hours contact:

Name \_\_\_\_\_

Tel \_\_\_\_\_

**Key agencies**

Agency	Position	Name	Address	Tel no/email address

## Essential information about the young person

### Emotional and behavioural development

Does the young person display any behavioural patterns, including abusive incidents to self or others, that have been of concern to current or previous carers?

Yes  No

If **yes**, please explain why:

*This could include aggression, anxiety, withdrawal, self-harm, inappropriate sexual behaviour, offending, substances misuse, lack of awareness of personal safety, etc.*

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How is this behaviour managed?

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Has/is the young person receiving support to deal with these issues?

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Are there additional resources required or available to assist the establishment in meeting the needs of the young person?

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Is there further information about the young person's behaviour that the establishment needs to know at this time? (It is important that establishments are provided with information about positive aspects of the young person's behaviour and development, including what has worked in the past.)

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<b>Health</b>	
Has the young person had a health assessment within the last year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the young person have a Health Care Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, has a copy been made available to the establishment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Will the establishment be responsible for keeping the record up to date?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the young person have disabilities or learning difficulties?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If <b>yes</b> , please give details: _____	
Is the young person using any medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If <b>yes</b> , please give details of medication/purpose/form, e.g. cream or tablet, dose; how it is administered and when: _____ _____	
Is the young person known to suffer from any allergies?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, how has this been managed? _____ _____	
Does the young person use any special equipment? For example, hearing aid or special footwear? Please specify: _____ _____	
If necessary, have arrangements been made for the establishment to receive any essential equipment required by the young person?	
	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the young person have specific dietary needs or restrictions for health, religious or cultural reasons or by choice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If so, please specify: _____ _____	
Does the young person have any outstanding medical or dental appointments?	
	Yes <input type="checkbox"/> No <input type="checkbox"/>
Please give details and identify how these will be addressed: _____	
Are there any other health concerns that are outstanding and not yet been addressed? Please specify: _____ _____	

**Education**

Details of school/college or other educational provision attended by the young person prior to admission:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

Key contact, i.e. designated teacher, form tutor, headteacher

If the young person is not in education or training, what are the plans to meet their educational, training or employment needs?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the young person have a Personal Education Plan? Yes  No

Tick box if completed and attached

If not, when will the information be provided? (Provide date)

\_\_\_\_\_

Please list the young person's achievements and interests (include qualifications, non-academic achievements, clubs attended, interests):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who will liaise with the education staff within the establishment regarding the young person's educational needs and future plans post-discharge?

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Tel: \_\_\_\_\_

Email: \_\_\_\_\_

### Family and social relationships

Draw the family tree (also include significant relationships not related by blood)

<b>Key</b>		
□	Male	
○	Female	
—	Strong/close relationship	
.....	Weak/hot close relationship	
+	Deceased	
/	Divorced/separated	

What are the arrangements for contact between the young person and their family/friends?  
List each person and include those where contact arrangements have yet to be made.

Person: \_\_\_\_\_

Frequency: \_\_\_\_\_

Type, i.e. face to face, telephone, letterbox: \_\_\_\_\_

Arrangements: \_\_\_\_\_

Is there anyone with whom contact with the young person is restricted or forbidden?

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Tel no: \_\_\_\_\_

Has a court made any order or recommendation restricting contact?    Yes     No

If **yes**, please give details:

\_\_\_\_\_

\_\_\_\_\_

Has the young person and their family been involved in any form of family work prior to admission? Please specify: type, aim of work, progress, and plans for ongoing family work now the young person has been admitted. Also address any family issues that might impact on care and treatment (*e.g. relationships, contact, life events, support post discharge*).

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**Identity**

Is there any information in relation to the young person's religious, spiritual, cultural or linguistic needs that it would be helpful for the establishment to know?

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Are there any other issues pertaining to the young person's identity (such as sexuality, gender, age) that would be helpful for the establishment to know?

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## Staff and team development activities

The following activities can be used by managers, supervisors, internal or external facilitators, during staff meetings or practice development sessions, to assist in the development of effective care planning and management of the transitions for young people leaving psychiatric in-patient care. The activities can be used singularly by staff for self-development or adapted for use with groups.

### Activity 1: Peer review of planning activity

The following activity was adapted, with permission, from the exercise 'Peer review of assessments' in Dalzell, R and Sawyer, E (2007) *Putting Analysis into Assessment*. London: NCB.

#### *Aim*

To encourage peer mentoring and practice-sharing in relation to planning.

#### *Objectives*

By the end of the activity, participants will have:

- ◆ given constructive feedback to each other about the quality of care planning
- ◆ shared their experience and expertise across the team, group or organisation
- ◆ reflected on the peer review of planning.

#### *Target group*

This activity can be used by either in-patient or community mental health practitioners, for example by multidisciplinary teams, single disciplines or in a session with ward or unit staff.

#### *Time*

One and a half hours plus preparation time.

This is a suggested time which can be adapted according to the participant's need and time available.

#### *Ideal numbers*

6–12 (or any number as long as it is even).

#### *Activity*

- ◆ In advance of the session, invite each participant to identify and provide a care plan that has been completed recently. This ensures a random selection.
- ◆ Devise a code to mark which plan belongs to which participant (this will prove useful later on) and mark them.
- ◆ Attach a feedback sheet (p. 44) to the back of each care plan.
- ◆ Invite participants to form pairs.
- ◆ Distribute two care plans to each pair, using the codes to make sure that no one is looking at their own.

- ◆ Invite participants to read through each care plan and note the strengths and areas for improvements on the attached feedback sheet, using the trigger questions as prompts.
- ◆ Inform the participants that they will have 20–30 minutes to discuss and comment on the care plans.
- ◆ After 20–30 minutes, collect the care plans with their accompanying feedback sheets, then use the codes to help you distribute them to their authors.
- ◆ Allow participants 15 minutes to read through the comments about their care plans written on the feedback sheet.
- ◆ After 15 minutes, encourage participants, still in pairs, to discuss their responses to the comments.
- ◆ Reconvene the group and invite feedback from everyone, as individuals. Prompt them with questions such as: Was it helpful to have this feedback? Did it ring true or were you surprised by the comments? Is there anything you would like to ask, for clarification? How has it left you feeling? Are there any actions you will take as a result?

## Facilitator's notes

Before participants embark on the activity, it's worth mentioning that the author of the care plan will get to read the comments at the end of the activity and therefore feedback should be sensitive and cautious. Comments should be backed up with helpful suggestions. Importantly, the aim of the activity is to be a critical friend.

In the feedback discussion, there is a risk that participants may be feeling exposed or become defensive. You will need to use your judgement to decide how far to take the discussion and whether it is likely to be helpful and productive for the individual participants and the team as a whole.

The more regularly this activity is done, the more comfortable and less defensive participants will tend to be towards receiving feedback and giving constructive advice.

## Feedback sheet

<b>Strengths</b> (Identify the strengths and state why)	<b>Areas for development</b> (Identify the areas for development and state why)

## Activity 2: Decision-making

### *Aim*

To think and reflect on how you make decisions in assessment and care planning.

### *Activity*

Refer to the care plans from Activity 1. Think about the decisions you have made in the process of making the care plan. Look at each section of the care plan and consider the following questions:

1. What decision did you reach and why?
2. What are the pros and cons of that decision?
3. What other decisions could have been made?
4. What are the pros and cons of those decisions?
5. Have you still made the right decision?

## Activity 3: Deciding what will help young people to be okay when they leave adolescent psychiatric care

### *Introduction*

Young people are central to transitional planning. An effective transition incorporates the views, opinions and feelings of young people.

During the course of the project, young people and the professionals working with them in the psychiatric establishments and community agencies wrote down what three things they thought would help young people to be okay when they left hospital. Of the case studies looked at during the project it was noticeable that, for those for whom the transition was successful, the three things that the young people identified as important were met. These needs also accorded with the plans made for them by the professionals involved.

This activity can be used as a staff developmental tool within or between in-patient care or community agencies. It can also be used as a tool for planning with young people and can include family members and other significant adults.

### *Aim*

To help professionals involved in transitional planning to identify the similarities and differences in perceptions of what young people and professionals think.

### *Objectives*

By the end of the activity, participants will have:

- ◆ considered patients' needs as they prepare for discharge
- ◆ developed awareness of similarities and differences of opinion in what might contribute to a successful transition from hospital
- ◆ considered potential gaps in support and services, and how to address those gaps.

### *Activity*

- ◆ Begin by asking participants the following question:

*What would help to make sure that (name of young person) will be okay when they are discharged from the unit/hospital?*

- ◆ Use part 1 of the attached template to record their answers. (You can ask the young person concerned to come up with his or her own list of responses to the question, which can also be recorded on the template. Family members and other professionals involved in the care planning process could also be asked.)
- ◆ Compare the similarities and differences between your answers and record these in parts 2 and 3.
- ◆ Explain to the participants that the end result will provide a picture of the perceptions and reality of what support will be needed and what is available for when the young person is discharged. Differences can be sorted out prior to discharge and any unmet needs can be addressed.
- ◆ Complete part 4.

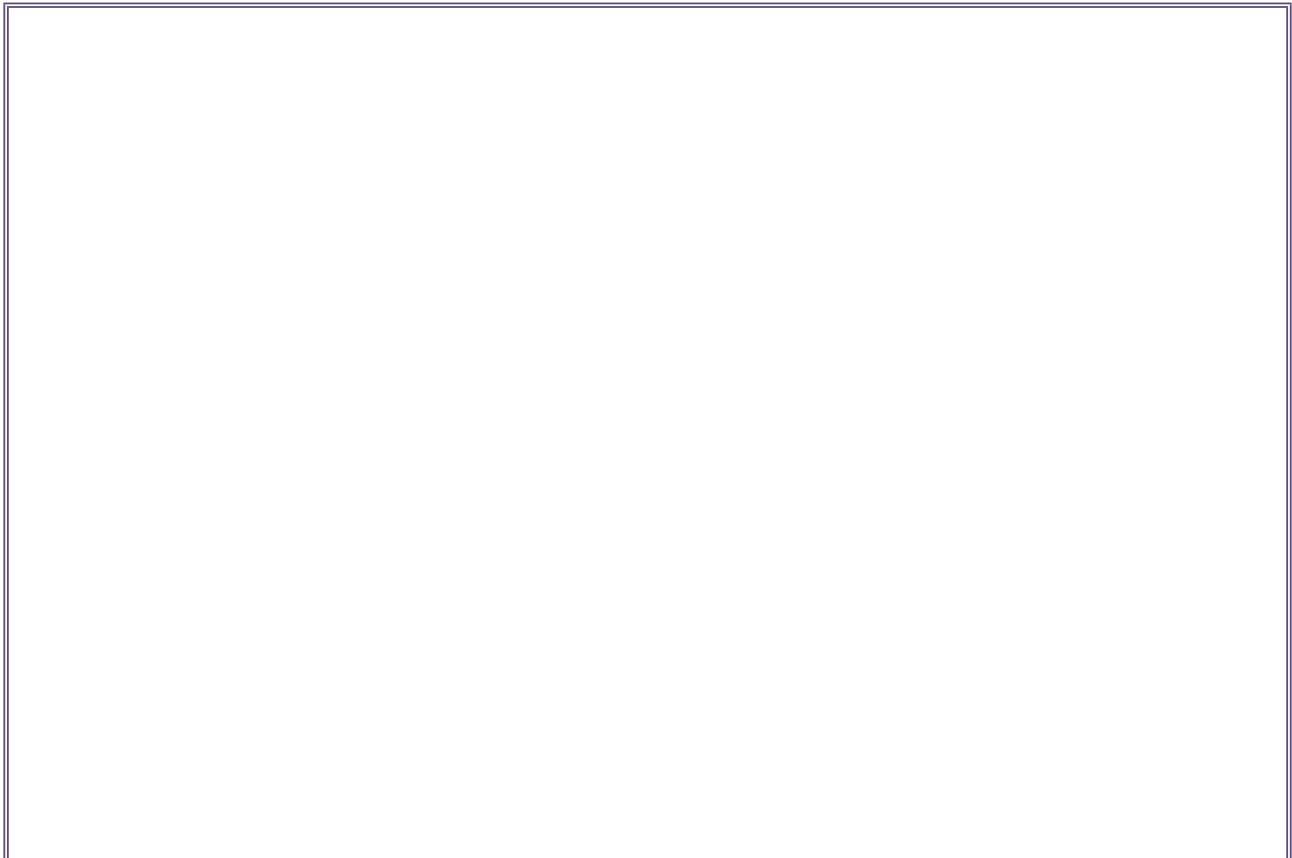
**1 What will help to keep you okay when you leave**

Young person	Name	Name	Name	Name

**2 What are the similarities between viewpoints and have they been addressed in the planning?**



**3 Are there differences in the viewpoints of those involved? If so, what are they?**





#### **4 How are the differences going to be addressed?**



## Part 3 Young people and the Mental Health Act 2007 and the Care Programme Approach

### Briefing 2 The Mental Health Act 2007 and young people

by Dr Cathy Street, independent mental health consultant

#### Introduction

When a person requires compulsory admission and detention in a hospital for the treatment of a mental health disorder, the main piece of legislation that comes into play is the Mental Health Act 1983 (the 1983 Act). This has recently been updated and amended by the Mental Health Act 2007, alongside a revised Code of Practice which provides more detail about practice that cannot be covered in statute. The Code is due to come into effect in November 2008.

According to the Department of Health (*Mental Health Act 2007 – overview*, 2007 available from [www.dh.gov.uk/nationalserviceframeworks/mentalhealth](http://www.dh.gov.uk/nationalserviceframeworks/mentalhealth)), the legislation:

*sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained or treated without their consent. The main purpose of the legislation is to ensure that people with serious mental disorders which threaten their health or safety or the safety of the public can be treated irrespective of their consent where it is necessary to prevent them from harming themselves or others.*

The Act covers all ages including under 18 year olds and there is no minimum age limit. However, in the 2007 legislation there are important new amendments which introduce new safeguards that apply specifically to children and young people. It should be noted that in the revised Code, 'children' means people under the age of 16 and 'young people' means people aged 16 or 17.

## What the Mental Health Act 2007 covers

The areas covered by the Act (and the revised Code of Practice) are wide-ranging. Some of the areas covered are summarised in the table below:

Provision of information for patients and nearest relatives	Provision of separate facilities for men and women
Involvement of carers	Visiting arrangements
Definition of mental disorder	Review tribunals
Capacity (or lack of) to consent to admission or treatment	Independent mental health advocates
Applications, including emergency applications, for detention in hospital	Medical treatment and treatments subject to special rules and procedures
Police powers and places of safety	Guardianship
Privacy and safety, personal searches	The use of restraint
Information sharing	Aftercare provision
	The function and powers of hospital managers

Paragraphs 4.6 and 4.7 of the new Code set out a range of factors to consider in deciding whether a patient should be compulsorily detained. These relate to the health or safety of the patient or the protection of others, and include:

- ◆ consideration of the evidence that a patient may be at risk of suicide, self-harm or self-neglect, or be unable to look after their own health or safety
- ◆ that they may be jeopardising their own health or safety ‘*accidentally, recklessly or unintentionally*’
- ◆ that their mental health will deteriorate if they do not receive treatment.

The potential benefits of treatment should be weighted against any adverse effects that being detained may have on a patient’s well-being; and there should be consideration of whether other methods of managing the risk, and of providing treatment and care, are available. Underpinning the legislation is the stance that:

*When a patient needs to be in hospital, informal admission is usually appropriate when a patient who has capacity to do so consents to admission.*

(Paragraph 4.9, Code of Practice).

It is, however, highlighted that this should not be viewed as an absolute rule – that just because a patient cannot consent does not mean that the Act must be used. A further important point is noted in paragraph 3.4:

*The fact that someone has a mental disorder is never sufficient grounds for any compulsory measure to be taken under the Act. Compulsory measures are permitted only when specific criteria about the potential consequences of a person’s mental disorder are met.*

*There are many forms of mental disorder which are unlikely to ever call for compulsory measures.*

The different sections that apply, and the assessment and consultation processes required when detention in hospital is thought to be necessary (and who should be involved) are explained. These include:

- ◆ **Section 2** – to be used when the full extent of the nature and degree of a patient's condition is unclear and an initial in-patient assessment is needed; or a judgement needs to be reached as to whether a patient will accept treatment on a voluntary basis following admission; or there is a need to carry out a new in-patient assessment or reach a judgement about whether treatment on a voluntary basis is possible. A Section 2 can last for up to 28 days; it cannot be renewed or extended.
- ◆ **Section 3** – to be used if a patient is already detained under Section 2 and where further treatment and care is needed, or where the nature of the patient's mental disorder and the likelihood of them accepting treatment on a voluntary basis have already been established. The initial duration is for up to six months; a Section 3 can be renewed for a further six months and then for 12-month periods.
- ◆ **Section 4** – relates to emergency applications which can be made on the basis of a single medical recommendation '*but only in very limited circumstances*' and where the criteria under Section 2 are met, there is an urgent necessity for detention, and obtaining a second medical recommendation would cause undesirable delay. A Section 4 can last for up to 72 hours and cannot be extended; if, during that time, a second medical recommendation for detention is made, the section is converted to a Section 2.
- ◆ **Section 5** – covers the holding powers of doctors, approved clinicians and nurses in certain circumstances when it is thought an application for detention under the Mental Health Act should be made, or it is thought necessary to immediately prevent a patient from leaving a hospital for their own health or safety, or for the protection of other people.
- ◆ **Other sections** in the Act include: **Section 135** which covers warrants for police officers to enter premises and to remove a person when it is believed they have a mental disorder and are not receiving proper medical care; **Section 136** which allows for any person found in a public place who appears to a police officer to be suffering from a mental disorder and to be in immediate need of care or control to be removed to a place of safety.

## Changes in the new legislation

In the overview of this Act, produced by the Department of Health in 2007 ([www.dh.gov.uk](http://www.dh.gov.uk)), some of the key changes to the 1983 Act are noted.

There is now:

- ◆ a single definition of mental disorder and there are no longer references to categories of disorder
- ◆ an 'appropriate medical treatment' test that applies to all the longer term powers of detention

- ◆ a broadening of professional roles to allow for a wider group of practitioners to take on the functions currently performed by approved social workers (ASWs) and responsible medical officers (RMOs)
- ◆ differences in the definition of the 'nearest relative' and also information about how nearest relative functions can be delegated
- ◆ supervised community treatment (SCT) for patients following a period of detention in hospital
- ◆ an order that can reduce the time before a case has to be referred to a Mental Health Review Tribunal (MHRT) by hospital managers
- ◆ a requirement that hospital managers ensure patients under 18 are accommodated in an age-appropriate environment, subject to their needs
- ◆ a duty on the appropriate national authority to make arrangements for the provision of independent mental health advocates
- ◆ safeguards for patients requiring electroconvulsive therapy (ECT).

Not all of the amendments in the new Act will come into force immediately. For some, the agreed commencement dates – recognising the changes to service provision that will be needed – fall in the next one to two years.

## Provisions within the Act specific to children and young people

Chapter 36 of the Mental Health Act Code of Practice (DH, 2008) provides guidance on a range of issues specific to children and young people. This includes the role of those with parental responsibility for giving consent to treatment or hospital admission – who will usually be, but are not always, the parents of the child or young person. The Chapter covers arrangements for children who are looked after by the local authority and explains the issue of Gillick competency with regard to children under 16. There are various recommendations concerning patient confidentiality and the use and disclosure of information.

Paragraph 36.9 describes the concept of the zone of parental control, where it is noted that two questions must be asked:

- ◆ Is the decision one that a parent would be expected to make within what is considered 'normal' practice in society and relevant to any human rights decisions made by the courts?
- ◆ Are there any indications that the parent might not act in the best interests of the child?

When a decision falls within the zone of parental control, people with parental responsibility can consent, on behalf of a child under 16, to the child being given medical treatment or to be informally admitted to hospital for such treatment. However, this Code also notes that if a Gillick-competent child refuses treatment then practitioners should not rely on parental consent.

In addition to the above questions, the Code of Practice notes that the parameters of the zone will vary from one case to the next and are determined not only by social norms but also by '*the circumstances and dynamics of a specific parent and child or young person*' (paragraph 36.12). It suggests that mental health professionals might consider the nature and invasiveness of

what is to be done to the patient (and the extent to which this may entail curtailment of liberty) and that the greater the age, maturity and understanding of the child or young person '*the more likely it will be that it should be the child or young person who takes the decision*' (paragraph 36.12). Where a child who is Gillick competent refuses treatment, then the Code also advises that practitioners should not rely on parental consent.

For capable young people aged 16 and 17, an important provision of the amended Act is that when they either give consent to or refuse admission to hospital or a registered establishment (an independent hospital registered to take patients detained under the Act), for the treatment of a mental health disorder, they cannot have their consent or refusal overridden by those with parental authority. These provisions are covered in Section 131, which also sets out the circumstances when authorisation from a court may be needed.

In the case of informal admissions of a 16 or 17 year old who lacks capacity to consent to admission and/or treatment in hospital, different considerations apply, including whether to use provisions under the Mental Capacity Act 2005 (MCA) or to use common law principles. Paragraphs 36.25 and 36.26 of the Code provide further detail on these points.

### Which legislation to use?

This is a crucial consideration covered by the Mental Health Act Code of Practice. The Code stresses that the legal framework governing the admission to hospital and treatment of children and young people is complex and that it is important that practitioners should be familiar with other legislation, associated codes of practice and case law relevant to those under 18. These include:

- ◆ The Children Acts 1989 and 2004
- ◆ Mental Capacity Act 2005 (MCA)
- ◆ The Family Law Reform Act 1969
- ◆ The Human Rights Act 1998
- ◆ The United Nations Convention on the Rights of the Child 1989.

The Code states that the best interests of the child or young person must always be a significant consideration: that children and young people should be kept as fully informed as possible and their views, wishes and feelings be considered. Any intervention, consistent with effective care and treatment, should also be the option that is the least restrictive, is least likely to expose them to the risk of stigmatisation, and minimises separation from family and friends, and disruption to their education.

Paragraph 36.17 notes that:

*where the child or young person with a mental disorder needs to be detained, but the primary purpose is not to provide medical treatment for mental disorder, consideration should be given to using Section 25 of the Children Act 1989.*

It is further explained that if a child or young person is seriously mentally ill, they may require admission for treatment under the Mental Health Act.

However, if they are behaviourally disturbed and there is no need for them to go into hospital, their needs might be more appropriately met within secure accommodation under the Children Act.

## **Who should assess young people under 18 for admission?**

Under the Act, approved mental health professionals (AMPHs) have specific responsibilities regarding the assessment of people being considered for compulsory admission.

Paragraph 36.20 of the Code of Practice notes that, in the assessment of a person who is under 18 years of age, at least one of the two medical practitioners or the AMHP should be a clinician specialising in CAMHS (child and adolescent mental health services). If this is not possible, a CAMHS clinician should be consulted as soon as possible. Where a child or young person has complex or multiple needs, other specialist clinicians may need to be involved – for example, a learning disability CAMHS consultant.

## **Requirements for certain treatments**

Various regulations apply to treatments when a person who is detained, on supervised community treatment (SCT) or for certain other treatments, is an informal patient. Some important provisions for children and young people relate to treatment covered by Section 57 of the Act (primarily neurosurgery); and the use of electroconvulsive therapy (ECT), which is covered in Section 58.

Treatments falling within Section 57 cannot be given if a child or young person does not personally consent. Even where the child or young person is not capable of consenting and a person with parental responsibility consents, these treatments cannot be given. With regard to ECT, unless it is an emergency, the approval of a second-opinion appointed doctor (SOAD) is stipulated.

## **The provision of age-appropriate services**

A key amendment in the 2007 Act is the requirement for under 18 year olds to be admitted to in-patient facilities that are age-appropriate, subject to their needs. This requirement is covered by Section 131A of the Act, with the Code of Practice explaining that this encompasses appropriate physical facilities; staff with the appropriate training, knowledge and skills; access to education and age-appropriate leisure activities; and a hospital routine that will allow for their personal, social and educational development to continue as normally as possible. Facilities for visits from family and carers are also required.

This duty is aimed particularly at ending the inappropriate admission of children and young people to adult in-patient wards (although the key word here is inappropriate – some more mature young people, who may be living independently and in work, may prefer to be on an adult ward). It is expected to be in force from April 2010. This delayed commencement date has been agreed on the basis that the Secretary of State recognises that some hospitals will not be able to comply with the requirements of Section 131 immediately – although the Code of Practice notes that hospital managers are expected to take all reasonable steps to comply with this duty even before it comes into force.

## Mental health review tribunals (MHRTs)

The main purpose of MHRTs is to review the cases of patients who are detained under the Act, those who are conditionally discharged and those on supervised community treatment.

Children and young people who are detained have the same rights as adult patients to apply for a review – however, an important difference is that whilst adults who do not request a tribunal hearing must be referred for a tribunal hearing after a three-year period, those under 18 must be referred after 12 months. It has also been agreed that at least one member of the tribunal panel for a person under 18 years of age must have experience of children and young people.

This provision is expected to commence in October 2008.

## Advocacy

Independent mental health advocates (IMHAs) are intended to provide an important safeguard for patients who are subject to the Mental Health Act. IMHAs are expected to help patients understand their rights, and those of the nearest relative, under this legislation; to understand which parts of the Act apply to them; and to assist patients in obtaining information and understanding about their treatment. IMHAs can also help patients to exercise their rights, can represent them and speak on their behalf.

A commencement date of October 2009 has been given for the introduction of independent mental health advocacy services; and children and young people who are likely to be, or who are, detained under the Act, receiving supervised community treatment (SCT) or for whom ECT is being considered, will be eligible for support from these services. It is expected that the IMHAs who work with children will be given special training.

## Local authority duties

The Code of Practice explains the circumstances in which it is expected that local authorities will visit children and young people when they are in hospital. These include:

- ◆ children and young people being looked after by them, irrespective of whether they are under a care order
- ◆ where a child is in hospital (or likely to be in hospital) for a period of three months or more.

The Code also refers to their duties, placed on local authorities by the Children Act 1989, to promote contact between children and young people who are in need and their families.



## Briefing 3 Young people in psychiatric in-patient services and the Care Programme Approach (CPA)

By Dr Cathy Street, independent mental health consultant

### Background overview

The Care Programme Approach (CPA) was first introduced in 1990 and was intended to provide a care management process – a framework to support and coordinate provision – for all people in contact with specialist or secondary mental health services and social care services.

CPA was originally developed for adult services. However, it was also required for all young people aged 16 and over – an important requirement given that many of the young people who need in-patient care and treatment fall into this adolescent age band.

It is underpinned by a set of principles of good practice, which include clear care plans; active service-user participation in care; structured systems for reviewing care and treatment; and crisis planning. A key role in delivering CPA is that of the *care coordinator* – a named worker appointed to keep in close touch with the person receiving care and treatment and to be responsible for monitoring, coordinating and reviewing their care.

CPA was first reviewed in 1999 following the publication of the *National Service Framework for Mental Health* (1999). A second review, prompted by a number of important developments in the mental health field (not least the review of the 1983 Mental Health Act), concluded in early 2008. Whilst these reviews have resulted in some key changes, the underpinning principles set out in the original CPA still hold true.

The relevance of the CPA planning process has been recognised for some time with regard to children and young people, and has particular significance for young people who may require in-patient child and adolescent mental health services (CAMHS). This is stated in Standard 9 of the *National Service Framework for Children, Young People and Maternity Services* (DH 2006), as follows:

*When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by the use of the care programme approach. (p.5)*

### CPA – its new focus

When the Care Programme Approach was first introduced, there were two levels.

- ◆ *Standard CPA* was typically for people requiring the support of one agency or discipline, or low-key support from more than one agency

- ◆ *Enhanced CPA* was for people likely to require multi-agency involvement and coordination of services, usually those with a diagnosis of a severe and persistent major mental illness.

As a result of the recent review these two categories no longer apply. Whilst recognising the need to ensure that all individuals in contact with secondary mental health services receive high-quality, person-centred care, the recent Department of Health policy and practice guidance (*Refocusing the Care Programme Approach*, DH 2008) explains that:

*Individuals with a wide range of needs from a number of services, or who are at most risk, should receive a higher level of care coordination support. From October 2008, the system of coordination and support for this group **only** will be called the Care Programme Approach. (p. 2)*

The guidance goes on to note that, from October 2008, the term Care Programme Approach will be used to describe the process used in secondary mental health services to assess, plan, review and coordinate the range of treatment, care and support a person in contact with these services, and with complex needs, might require. It explains that:

*it is called an 'approach', rather than just a system, because **the way** that these elements are carried out is as important as the actual tasks themselves. Active service user involvement and engagement will continue to be at the heart of the approach, as will a focus on reducing distress and promoting social inclusion and recovery. (p. 11–2)*

It also highlights that, in the main, those people who will receive CPA in the future will not be significantly different from those who currently receive enhanced CPA. These are people who are at higher risk, who need multi-agency support, active engagement, more intense intervention and support with dual diagnoses.

The guidance also lists the characteristics to be considered when deciding whether a person, who has already been accepted as needing secondary mental health services, requires the support of CPA in the future. These characteristics include:

- ◆ severe mental disorder with a high degree of clinical complexity
- ◆ current or potential risk, including suicide, self-harm and harm to others (including a history of offending)
- ◆ whether a person has relapsed, is self-neglecting or not following their treatment plan
- ◆ other problems or difficulties such as substance, drug or alcohol misuse, and whether the person has a learning disability
- ◆ multiple service provision from different agencies
- ◆ current or recent detention under the Mental Health Act
- ◆ difficulties being experienced as a result of physical health problems, housing or accommodation problems, or ethnicity (which could include immigration status, race/cultural issues and/or language difficulties).

## What does CPA involve?

The following components are set out in the recent Department of Health guidance:

1. Support from a CPA care coordinator – a person who has been trained and where coordination of support is an identified part of their job description.
2. A comprehensive multidisciplinary, multi-agency assessment of an individual's needs and the associated risks (including consideration of drug and alcohol misuse, current and past substance misuse, and physical health needs).
3. An assessment of social care needs.
4. A comprehensive formal written care plan which includes risk and safety issues, contingency arrangements and a crisis plan.
5. Ongoing review and a formal multi-agency and multidisciplinary review at least once a year – in practice, such reviews are likely to be needed at more regular intervals and should consider the need for ongoing CPA support.

The guidance notes that individuals on CPA may have an increased need for advocacy support; and that carers should be identified and informed of their rights to an assessment of their needs.

With regard to contingency and crisis plans, it also notes that care plans should:

- ◆ include arrangements so that the service user or their carer can, at any time, contact the right person if they need to
- ◆ provide clear details of who is responsible for addressing the different elements of care and support.
- ◆ be offered to the service user, given to the GP for the individual and, if appropriate, given to any other significant care provider.

In terms of managing and assessing risk, it refers to the useful tools contained in the Department of Health guidance *Best Practice in Managing Risk* (DH, 2007, [www.nimhe.csip.org.uk/risk](http://www.nimhe.csip.org.uk/risk)). The underlying philosophy is also seen as one of positive risk management based on a collaboration with the service users and others involved in their care: one focused on recognising and building on the service user's strengths; and which emphasises the importance of assessing the dynamic or changing risk factors, as well as the more well-understood and static factors.

## What does this mean for children and young people in contact with mental health services?

The value of the CPA for children and young people with complex needs (that is, those who meet the criteria or present with some of the characteristics described earlier) is recognised in the Department of Health guidance. Though just as not all people using secondary mental health services will in future receive CPA, it is acknowledged that CPA is not the only planning method for children and young people. The overarching principles with regard to its use are as follows:

- ◆ Use of CPA needs to be coordinated with other systems such as the children's Common Assessment Framework (CAF), special educational needs reviews and any local systems for looked after children.
- ◆ It is important to minimise the use of different approaches; to avoid duplication; and to work towards agreeing clear links between the different frameworks. In particular, it will be crucial to ensure that young people are not overloaded with assessment and review meetings.
- ◆ CPA should be modified for children and young people at a local level, with decisions about which framework to use being decided across agencies on a case-by-case basis.
- ◆ The interplay between the CPA care coordinator role and that of the lead professional needs to be considered. Using locally agreed protocols, it must be made clear which system and which person takes the lead in which area, in order to avoid confusion and risk.

Annex B of the guidance, which gives specific detail about the use of CPA with children and young people, notes that:

*Teams and individuals working in a given locality will need to be clear about where the threshold lies for the use of CPA. If a criterion of complexity of need is applied, there should arguably be no lower age limit for the use of CPA. (p. 47)*

Certain amendments may also be required to take account of the changing needs of children and young people over time (to a possibly greater extent than adults) and thus the need for more frequent reviews. There may be more complex multi-agency issues to negotiate, including for young people placed out of area or with long-term needs, and consideration of the age and developmental level of the child or young person and who are the relevant family members to be included.

Finally, there are also important practical considerations to take into account when involving children and young people. These include: the design of paperwork; communication that is tailored to their level of cognitive development; meetings that are 'young person friendly' with staff who have the skills and competencies to ensure that young people's views are heard and taken into account; and the provision of support to young people, their parents and carers, including where necessary, the use of advocates.

## Part 4 Care status, care planning and leaving care

### Briefing 4 Looked after children and young people – understanding care status

The term 'looked after child' was introduced in the Children Act 1989 and replaced the description of children being 'in care'. It means that children and young people are looked after by the local authority away from their parents but it is an umbrella term covering different types of legal status.

What can be confusing is that local authority practitioners sometimes use different terminology to describe what is essentially a looked after child. For example, LAC is an acronym used that derives from the term 'looked after child'. Practitioners might also describe a child by their legal status, such as 'accommodated' (Section 20, Section 31, on a Care Order).

It is important that, when a young person is admitted into hospital, their care status is established as there are different legal statuses. These differences have implications for the respective responsibilities of parents, the local authority and the young person's entitlement to services, including ongoing support after leaving care.

Keeping the young person's record up to date will ensure that care coordinators will know who or what team they need to keep informed of progress, who to involve in the young person's CPA review and the plans for discharge.

Practitioners need to establish which category the young person's care relates to, for example whether the young person is:

- ◆ subject to a care order (s31 Children Act 1989)
- ◆ 'accommodated' – by voluntary agreement with parents
- ◆ remanded to local authority accommodation (s23, para 1, Children and Young Persons Act 1969)
- ◆ entitled to leaving care services (Children (Leaving Care) Act 2000)
- ◆ a 'former relevant' young person (Children (Leaving Care) Act 2000)
- ◆ a 'qualifying' young person.

#### 1. Subject to a care order (s31 Children Act 1989)

Children or young people are made subject to a care order when the Family Proceedings or High Court have ruled that a child or young person has, or is likely to, suffer significant harm and placed the child or young person in the care of the local authority. This enables the local authority to share parental responsibility for the child or young person with the parents, and the authority then has the responsibility of deciding where the child or young person must

live. This will usually be a foster home, children's home or other residential establishment but some children on care orders may live with parents or family members.

Every child or young person in public care must have a care plan setting out how the local authority will meet the child or young person's care, education and health needs. This plan will be drawn up in consultation with the relevant agencies (for example, schools) and usually with the parents. The plan should take account of the child or young person's wishes and feelings. The local authority must formally review this care plan at least every six months. Care orders last until the young person's eighteenth birthday unless formally revoked by the court.

## **2. Accommodated – by voluntary agreement with parents (s20 Children Act 1989)**

This is where a child or young person is being cared for by the local authority with the agreement of the parents or the person with parental responsibility.

An accommodated child or young person might be placed in a foster home, children's home or other residential establishment.

Once a child or young person is 'accommodated' the local authority will be responsible for planning for their care in the same way as if he or she was the subject of a care order. The local authority must assess the child or young person's needs and draw up a care plan, which must be reviewed at least every six months and whenever the child or young person moves placement.

The local authority does not have parental responsibility for the child or young person; and if the parent requests that the child or young person be returned to their care then the child or young person will be discharged from accommodation and no longer be 'looked after'.

Where a child or young person enters the country as an unaccompanied asylum-seeker, the local authority is responsible for assessing their needs. If they are under 18 then there is a presumption that, as an unaccompanied asylum-seeker, they will need to be provided with accommodation under Section 20 as above; unless the assessment deems that there is an alternative to looking after the child or young person, such as when a relative living in the UK is assessed as being able to look after the child or young person.

## **3. Remanded to local authority accommodation (s23 para 1 Children and Young Persons Act 1969)**

Where a criminal court decides to remand a child or young person, pending trial, to local authority accommodation (with or without a secure requirement), the local authority has a duty to find a suitable placement for them. The child or young person is 'accommodated' and entitled to the same planning and review processes as children or young people in category 2 above.

#### **4. Entitled to leaving care services (Children (Leaving Care) Act 2000)**

Whatever route they have followed, all looked after children and young people may be entitled to leaving care services under the Children (Leaving Care) Act 2000. This applies to young people of 16 and above who have been 'looked after' for 13 weeks or more following their fourteenth birthday and are either:

- a) still 'looked after' (*'eligible children'*) or
- b) were 'looked after' but left care aged 16 or 17 (*'relevant children'*).

Such young people are entitled to a pathway plan detailing the ongoing support they will receive from the local authority on leaving care, including the provision of accommodation, financial and personal support.

#### **5. A 'former relevant' young person**

When the above young people (4a, 4b) reach the age of 18 they become *'former relevant children'*. Their pathway plan will continue until the age of 21, or 24 if the young person is still in education or training.

#### **6. A 'qualifying' young person**

Where a child or young person has a history of being looked after but do not meet the above timescales they become one of the *'qualifying children'*; and the local authority still has the power to offer them advice and assistance until the age of 21.

## Briefing 5 Care planning for looked after children

The following briefing is aimed at those who work outside local authority children services and is specifically relevant to in-patient staff who may be working with someone who was looked after by a local authority prior to admission.

For the purpose of simplicity, the following briefing will use the word child to denote anyone under the age of 18 years. This briefing describes the planning process for the generic looked after population, but does not cover the additional processes for children with disabilities.

When a child becomes a looked after child by the local authority, there are a number of processes and procedures that have to take place. This is to ensure that all the needs are identified and that plans are in place to meet those needs.

For every looked after child the following plans should be in place:

- ◆ care plan
- ◆ personal education plan (PEP)
- ◆ health plan.

When the child turns 16 years old, the care plan is called a pathway plan. Further details on pathway planning can be found in the briefing on young people leaving care (page 71).

These plans will now be explained in further detail.

### What is a care plan?

Each looked after child will have a care plan, the overarching plan for a child or young person. The care plan is the responsibility of the local authority social worker. All other plans mentioned above stem from it.

The following is a definition of the LAC care plan:

*This determines why it is in the child's best interest to become looked after or whether other support services would be able to meet their needs; it identifies their assessed needs and the services to meet those needs, and sets out the framework for the services provided to the child and family to enable the desired goals and outcomes to be achieved.*

The care plan as defined in the glossary of Williams, A and McCann, J (2006) *Care Planning for Looked After Children: A toolkit for practitioners*. (London: NCB)

The care plan contains within it the long-term plan for the child and how permanence is going to be achieved.

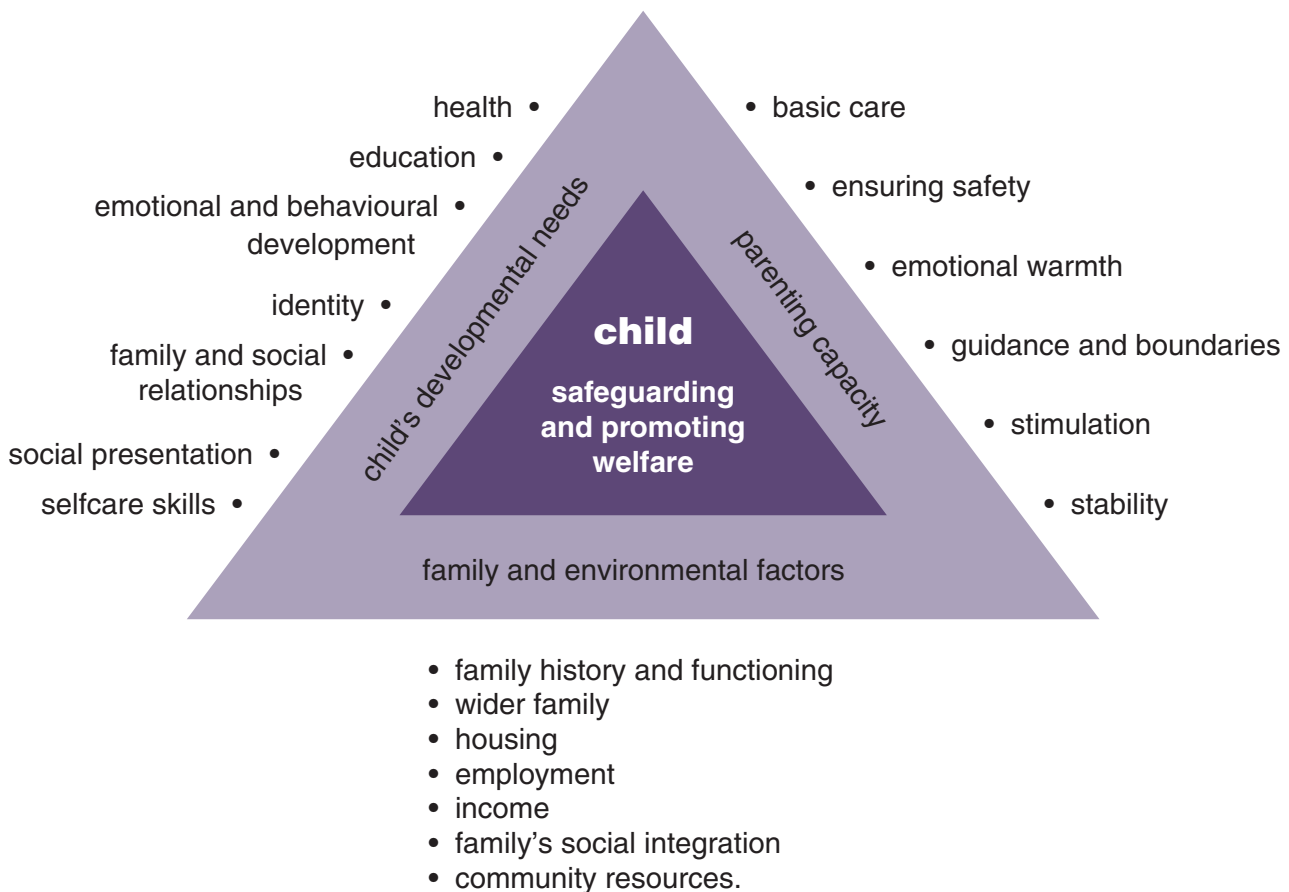


### Definition of permanence

This is a framework providing children with a sense of security, continuity, commitment and identity – a sense of belonging for each child. The objective is to ensure children have a secure, stable and loving family to support them through childhood and beyond. However, where the birth family might not be able to provide this, it can also be achieved through placement with a substitute family through adoption or long-term fostering.

Williams and McCann (2006) state that:

*the care plan is built upon a holistic specialist assessment which identifies developmental need, the capacity to meet need (parenting capacity and family and environmental factors) and an evaluation of what has happened to the child (history and chronology). The assessment must be continually updated and feed into revisions of the care plan and into the review process.*



**Figure 4: Assessment Framework Triangle**

Figure 4 shows the Assessment Framework Triangle (DH 2000), which details what areas should be covered when local authorities carry out an assessment of a child in need and what constitutes a holistic assessment of a child.

*The Framework for the Assessment of Children in Need and their Families* was published in 2000, providing a:

*systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live.*

(DH 2000 p. viii)

Howarth (2001) described the Framework as providing a:

*conceptual map for undertaking assessments of children in need and their families, which ensures that practitioners, managers and policymakers maintain a child focus, irrespective of how the world of the child changes and develops over time.*

Howarth, J (ed)(2001), *The child's world-assessing children in need*. London: Jessica Kingsley, p.26

For those children who become looked after, the assessment is followed by a care plan.

The local authority care plan should include:

- ◆ the child's needs and how the child's needs might be met
- ◆ what services are to be provided
- ◆ the type and detail of the proposed placement
- ◆ support in the placement
- ◆ arrangements for contact and/or reunification with the family
- ◆ arrangements for healthcare and education
- ◆ the aims, desired outcomes and timescales
- ◆ a list of actions to be taken and by whom
- ◆ contingency plans.

The views of the child, their parents or guardians, and other professionals working with the child should all be integral to the creation of the care plan. This aspect is particularly important. The local authority care plan should take into consideration any plans made within the psychiatric setting and those made for once they are discharged. The aim of this is to maximise the support and services available to children and, importantly, to ensure that different planning systems do not conflict with each other.

The local authority care plan should record all the needs of the child – even those that the local authority or any other agency cannot meet immediately, so that these are not missed at a later stage.

The local authority care plan is subject to review by an independent reviewing officer.

### **Definition of an independent reviewing officer**

Independent reviewing officers are registered social workers who chair all looked after children's statutory review meetings, from which position they can identify any problems in the child's care and any lack of clarity in the care plan. They ensure that everyone involved in the child's case can make a meaningful contribution, which includes listening to the views and wishes of child. They monitor the local authority's performance, working with the local authority to ensure children's needs are being met and to resolve difficulties.

All those involved in the care planning, including the child and the professionals, should be given a copy of the care plan.

### **Personal education plan (PEP)**

All looked after children should have a personal education plan.

The social worker is responsible for drawing up the PEP in partnership with the child, education professionals within the hospital or unit, parents and care coordinator.

There will be particular times in a child's life when the plans concerning education and training and future employment are more critical, such as when planning for discharge.

For children with special educational needs, Williams and McCann (2006) clearly state that 'care planning, the review of their statement and their transitional plan should come together and all should be clear about their individual and collective responsibilities'.

### **Health plan**

All looked after children should have health assessments carried out by a qualified medical practitioner in order to formulate their Health Plan. For a child in psychiatric care, their mental health needs will be a primary focus. However, all aspects of health would have to be considered and addressed, for example dental and optical health, immunisations and sexual health.

Health assessments/plans are extremely important to ensure continuity of healthcare if a child has a medical condition or an ongoing health problem. Some children's experience prior to coming into care may have meant that their health needs were overlooked or neglected. Treatment for health issues other than those pertaining to mental health may have been disrupted or health issues may remain undiagnosed.

Details about a child and their family's health history – that is, immunisations, conditions, illnesses – might be incomplete, misplaced or have not followed the child.

It is important that the local authority health plan dovetails and complements the care plan made within the hospital setting so as to avoid duplication and unnecessary health assessments.

Health assessments for looked after children are not compulsory but are seen as part of ensuring children's health needs are addressed and that they are and stay healthy. Children do, however, have the right to refuse the health assessment for looked after children. It is important that children understand the importance of preventive health and have all the information they need to make informed decisions about their own health.

## Statutory child care reviews

### The purpose of review meetings

It is a legal requirement that the plans for looked after children and young people are reviewed. This is done in a meeting called a statutory child care review meeting or LAC (looked after child) review.

LAC reviews or statutory child care review meetings take place as long as the child or young person is looked after by the local authority.

Before the age of 16, the care plan will be the main focus of the review meeting. Once a young person turns 16, the pathway plan becomes the care plan and is looked at at review meetings. Once the young person turns 18, if they have continued to qualify for services under the Children (Leaving Care) Act 2000, then their pathway plan should be reviewed at least every six months until they reach 21; or beyond if they continue to receive support and services from the local authority.

The aim of the review meeting is to look at what has happened since the last review meeting, how the child or young person is progressing in all aspects of their development and to decide what action needs to be taken, if any, to continue to best meet the needs of that child or young person. By the time a child reaches 16, the focus of any plan is about preparation for adulthood.

### Before the review meeting

The children's services social worker should meet with the young person before the review meeting takes place to discuss:

- ◆ the purpose of the review meeting
- ◆ who will be at the meeting and who the young person would like to invite
- ◆ what will be discussed, including any additional issues the young person would like brought up
- ◆ how the young person would like to contribute their views and whether they need help in doing so
- ◆ whether the young person would like to have an advocate present and, if so, to arrange for the advocate to meet with the young person beforehand
- ◆ the social worker's report, by going through it and addressing any questions or concerns.

The independent reviewing officer (IRO) should also meet with the young person as part of the preparation for the review meeting, to address any concerns or questions and to ensure that the young person's views and wishes are heard.

To ensure that the care plan is coordinated effectively and the needs identified are being met, regular contact between the children's services social worker, the young person and the in-patient staff is extremely important.

## Who chairs the meeting?

Statutory child care review meetings are chaired by an independent reviewing officer more commonly referred to as an IRO.

The role of the independent reviewing officer is to:

- ◆ review the care plan and make recommendations as required
- ◆ facilitate young people’s participation in review meetings and ensure their views and wishes are taken into account
- ◆ ensure that young people know their rights and help them access the complaints procedure if required
- ◆ identify the individuals responsible for implementing each review recommendation
- ◆ ensure that any failure to review cases in accordance with the regulations or to make arrangements to implement any aspect of the care plan is brought to the attention of the accountable service managers.

## Who else should be at the meeting?

Those involved in the LAC care plan, including the young person, the care coordinator and the social worker from children’s services, should attend the meeting. Parents should also be invited unless it is not in the best interest of the young person. The young person may also wish to invite an advocate.

## Timetable for review meetings

There is a clear timetable for when these meetings should take place.

First review	this should take place within four weeks of the young person first being looked after or when they have changed placements
Second review	this should take place within three months of the first review meeting
Reviews thereafter	these should take place every five months or earlier if changes need to be made to the care plan – for example, a young person can ask for the meeting to be brought forward or an IRO may set an earlier date to check on progress

## Following the review meeting

The young person, the in-patient unit and any other representative present at the meeting should be provided with a written record of the decisions that were made during the meeting and the minutes of what was discussed during the meeting.

## Briefing 6 Care leavers and leaving care

### Legislation

The legislation that covers the duties and responsibilities towards care leavers is the Children (Leaving Care) Act 2000. It is based on the consultation document, *Me Survive Out There: New arrangements for young people living in and leaving care* (DH 1999). It enacts commitments made within the White Paper *Modernising Social Services* (1998) and the government response to the *Children's Safeguards Review* (1998).

The does not replace the Children Act 1989. It builds on and extends the duties and powers included in the leaving care and after care provisions of that Act.

The purpose of the Children (Leaving Care) Act 2000 is to improve the life chances of young people looked after and leaving care. The main aims are to:

- ◆ delay young people's discharge from care until they are ready and prepared to leave
- ◆ improve assessment, preparation and planning for leaving care
- ◆ provide better personal support for young people after they leave care
- ◆ improve the financial arrangements for care leavers.

### Who is a care leaver?

#### Categories under the Children (Leaving Care) Act 2000

**Eligible children:** children aged 16–17 who have been looked after for at least 13 weeks since the age of 14 and who are still looked after.

**Relevant children:** children aged 16–17 who have been looked after for at least 13 weeks since the age of 14 and who have left care.

**Former relevant:** young people aged 18–21 who have either been eligible, relevant or both. A young person continues to remain 'former relevant' after the age of 21 if they are still being helped by the local authority with education or training. Support would continue until the end of the agreed programme of education or training. (The cut-off point is 24.)

**Qualifying children:** children aged 16–18 who leave care but have been looked after for less than 13 weeks since the age of 14.

If a young person is on a care order they remain eligible until the care order is discharged (either by order of the court or by attaining the age of 18 at which time the care order expires).

## Needs assessment and pathway planning

For young people over 16, the Pathway Plan builds on the existing LAC care plan and other relevant plans and becomes the care plan for the child when they attain care leaver status as defined under the Children (Leaving Care) Act 2000. All eligible young people should have a pathway plan. A needs assessment forms the basis of the pathway plan.

### *Needs assessment*

A needs assessment should be completed within three months of a young person becoming eligible. Young people should be actively involved in their assessment and pathway plan.

In accordance with the Children (Leaving Care) Act 2000 (Regulation 7 (4)) the needs assessment should look at:

- ◆ the young person's health and development
- ◆ the young person's need for education, training or employment
- ◆ the support available to the young person from members of his or her family and other persons
- ◆ the young person's financial needs
- ◆ the extent to which the young person possesses the practical and other skills necessary for independent living
- ◆ the young person's needs for care, support and accommodation.

### *Pathway plan*

The pathway plan should detail how the needs identified in the needs assessment are going to be met, the timescales for meeting the needs and who is responsible for carrying out the actions required to implement the plan.

The pathway plan also has to identify what the outcome should be and the progress to be achieved by the next review or other specified date. Within the pathway plan, there should be a contingency plan in case any of the arrangements made in the pathway plan fall through or cannot be financed.

The pathway plan is not static. It should change over time as the young person moves towards adulthood.

For further details on pathway planning and young people's entitlements when they becomes care leavers, go to [www.leavingcare.org](http://www.leavingcare.org)



## Part 5 Young asylum-seekers and refugees leaving adolescent psychiatric care

by Dr Charles Watters and Rosa Hossain, European Centre for the Study of Migration and Social Care, University of Kent

### Introduction

The following guide outlines some of the laws and entitlements affecting refugee and asylum-seeking adolescents in the UK. It should be noted that the policy and legislative framework surrounding the rights and entitlements of this diverse group are complex and tend to change rapidly; indeed, many of the areas covered below are under judicial or policy review at the time of writing.

At present, the local authority where the client is ordinarily resident would normally have some degree of responsibility for the community care needs of vulnerable clients. Young people with families or other carers may have to actively seek out a needs assessment rather than being automatically assigned help from their local authority.

Social workers, NAM (New Asylum Model) case workers (UK Border and Immigration Agency staff), solicitors, independent legal advisors and/or relevant medical experts should always be consulted in the process of interpreting policies and applying for support or appealing against unfavourable decisions.

Trusted family members and friends are also an important source of social support for many asylum-seekers and refugees and may be involved in decision-making. Community and refugee organisations are a further source of support to be considered, and can often provide useful cultural expertise, help with interpreters, legal advice and advocacy services on behalf of the client (see contact list below).

In many cases, a holistic approach that takes into account an individual's practical and social needs as well as those related to mental health from a clinical point of view, is the most efficient approach when it comes to helping refugee and asylum-seeking clients with mental health problems.

### UK laws and policies

#### Immigration

##### *New Asylum Model (NAM)*

The New Asylum Model (NAM) was announced by the government in 2005, as an attempt to speed up the asylum process. As of March 2007, all asylum applications are processed under NAM. Under the NAM framework, both children and adult applicants are assigned their own case owner, known as the NAM case worker, who oversees the entire application process.

## Social care

### *Children Acts 1989 and 2004*

Under these acts, social services have a duty to assess the needs of unaccompanied asylum-seeking children and any other children 'in need' (including accompanied asylum-seeking children and non-asylum seeking children). In practice, accompanied children are much less likely to receive a formal assessment.

Local authorities vary considerably in the quality and depth of formal needs assessments and identification of child protection issues, for example in relation to concerns about child trafficking, sexual abuse, forced marriage and prostitution, as well as in the services they provide.

Support for unaccompanied children is the responsibility of local authority children's services departments rather than the BIA (UK Border and Immigration Agency; incorporating the former BIA/NASS). Most are accommodated in supported housing, lodgings, hostels or residential homes, while some are placed in foster care. The quality of housing arrangements varies across the country.

According to the most recent (2003) Department of Health guidelines, unaccompanied children should be cared for under Section 20 (rather than Section 17, applicable to children 'in need') throughout the assessment process, which guarantees a more comprehensive support package and grants eligibility for leaving care support after the age of 18 (see below).

### *Children (Leaving Care) Act 2000*

Asylum-seeking children who have been looked after for 13 weeks or more (on a care order or accommodated under Section 20) are entitled to leaving care support up to the age of 21, or 24 for those in an agreed programme of education. This involves an individual 'pathway plan', accommodation arrangements, advice on training and education opportunities, and financial support. If in receipt of asylum support from the BIA, he or she will not be dispersed.

**Dispersal** The *Immigration and Asylum Act 1999* introduced new measures to reduce pressure on services in London and the South East by dispersing asylum-seekers to other parts of the country. Since April 2000, unless there are exceptional circumstances, asylum-seekers who qualify for asylum support and who need both subsistence and accommodation are offered accommodation outside London and the South East.

### *NHS and Community Care Act 1990*

Section 47 of the NHS and Community Care Act (NHSCCA) imposes a duty on the local authority to make an assessment of an 'ordinarily resident' person's community care needs, irrespective of whether he or she requests one, based on the 'appearance of need'.

Where the need for care and attention is *urgent*, the local authority have the power under Section 47 para 5 to provide emergency accommodation and assistance without completing a full assessment.

A refusal by the social services to carry out an assessment can be challenged by formal complaint, complaint to the ombudsman or by judicial review.

### *Mental Health Act 1983*

People who have been sectioned under Section 3 of this Act and are discharged under Section 117 are entitled to aftercare in the community. This joint responsibility of the local and health authority can terminate only following a formal reassessment.

## **Healthcare**

Refugees, persons with humanitarian protection or discretionary leave and asylum-seekers (including those with ongoing appeals) are entitled to free primary and secondary healthcare.

Following a recent judicial review, failed asylum-seekers may also be considered 'ordinarily resident' subject to particular circumstances and, as before, GPs have the discretion to register them as such. Any treatment that is already underway while awaiting a decision is to be completed free of charge.

Evidence of (mental) health needs may constitute an important part of an asylum application, either as evidence of torture, rape or other human rights violations in the past, or as presenting exceptional circumstances under which it would be inhumane to return an individual to their country of origin. New evidence can be submitted as part of a fresh claim for asylum (from temporary leave to full refugee status). Medical evidence can also assist with gaining financial support (see below).

The requirement to provide appropriate mental health treatment may be used as grounds to defer dispersal by the BIA.

Healthcare provision for immigration detainees (including children and young people) is contracted to private providers and is often rudimentary.

## **Financial support**

### *Young adults 'leaving care'*

Those individuals supported under Section 20 will receive considerable financial support from their local authority. They should also submit an application for BIA asylum support, so that the local authority may be reimbursed for certain expenses. The young person should complete this application with his or her social worker.

### *Adult asylum support*

Young people who were supported under Section 17 will be treated as adults when they turn 18, and have to apply to the UK BIA for asylum support. However, in some cases they may instead be eligible for mainstream Department for Work and Pensions benefits (as assessed by the UK BIA).

### ***Immigration and Asylum Act 1999***

Section 96 para 1(c) of this Act states that support may be provided to enable the asylum-seeker (the main applicant only) to meet what appear to the Secretary of State to be expenses (other than legal expenses or other expenses of a prescribed description) incurred in connection with his or her claim for asylum, for example expenses towards a medical report by the Medical Foundation for the Care of Victims of Torture.

Under this act, failed asylum-seekers (children and adults) who can prove themselves to be *destitute* can apply for Section 4 support from the BIA. On top of this, they have to prove they fall into one or more of five designated categories. One of these is that the person is unable to leave the UK due to a physical impediment or other medical reason, in which case medical evidence is required. While medical reasons include mental health problems, terms such as 'unfit', 'unfair' or 'unreasonable' have been deemed irrelevant by a recent judicial review.

### ***National Assistance Act 1948***

Section 21 of this Act allows for the provision of residential accommodation and support. To qualify, a person should be 'in need of care and attention which is not otherwise available to them and is: a) over 18 years old and in need of care and attention due to age, illness, disability or any other circumstances; or b) an expectant or nursing mother'.

In order to be eligible for support, the need for care must arise from reasons *beyond destitution* (e.g. mental health needs). Under Schedule 3, Section 54 of the Nationality, Immigration and Asylum Act 2002, failed asylum-seekers who have refused to comply with removal directions are not eligible, unless it can be shown that the withholding of support is in breach of their European Convention Rights or their rights under the European Community Treaties. For there to be a breach of a person's rights under Article 3 of the ECHR (European Convention on Human Rights), a person would need to show that they had no other means of support and that if support were not provided severe illness or suffering would follow imminently.

## **International and European law**

Refugee and asylum-seekers' rights are based on international and European law, and their incorporation into national legislation (for example, through the Human Rights Act). The most relevant pieces of legislation are the:

- ◆ Universal Declaration of Human Rights (UDHR) 1948
- ◆ Geneva Convention 1951
- ◆ European Convention on Human Rights (ECHR) 1950
- ◆ Treaties of the European Union
- ◆ Convention on the Rights of the Child (CRC) 1989.

The UK has entered a reservation on article 22 of the Convention on the Rights of the Child (CRC) and retains the right to apply national immigration legislation towards children who are subject to immigration control.

## References and useful links

### Information on the web

#### *Asylum-seeker and refugee health care (web portal)*

[www.networks.nhs.uk/networks.php?pid=256](http://www.networks.nhs.uk/networks.php?pid=256)

An informal network of primary care professionals working with refugees and asylum-seekers.

#### *Department of Health: asylum-seekers and refugees (web portal)*

[www.dh.gov.uk/en/Healthcare/International/asylumseekersandrefugees/index.htm](http://www.dh.gov.uk/en/Healthcare/International/asylumseekersandrefugees/index.htm)

Webpage of the DH's asylum-seeker coordination team. Includes latest information on entitlement to NHS services.

#### *Health for asylum-seekers and refugees portal*

[www.harpweb.org](http://www.harpweb.org)

[www.mentalhealth.harpweb.org](http://www.mentalhealth.harpweb.org)

Contains information for healthcare professionals and asylum-seeking/refugee clients, including information on rights, advocacy and self-help, and a separate section on unaccompanied children.

#### *Medact Refugee Health Network*

[www.medact.org/ref\\_about\\_network.php](http://www.medact.org/ref_about_network.php)

Maintains an email group for sharing resources and information among health workers working with refugees and asylum-seekers. Also organises discussion events.

#### *Multikulti*

[www.multikulti.org.uk](http://www.multikulti.org.uk)

Contains information, in an accessible format and in several languages, on a range of relevant topics (including mental health) and links to a vast array of organisations and charities servicing refugees and asylum-seekers across the country.

#### *NRPF Destitution Network*

[www.islington.gov.uk/Health/ServicesForAdults/nrpf\\_network/policy\\_guidance.asp](http://www.islington.gov.uk/Health/ServicesForAdults/nrpf_network/policy_guidance.asp)

Provides guidance for local authorities and detailed guidelines on the entitlements of people with no recourse to public funds (NRPF), including people with mental health needs.

### Agencies and organisations

#### *Asylum Support Appeals Project*

[www.asaproject.org.uk](http://www.asaproject.org.uk)

Acts against destitution by providing free legal support for vulnerable asylum-seekers, including failed asylum-seekers, through refugee community organisations.

### *Connexions*

[www.connexions.gov.uk](http://www.connexions.gov.uk)

Offers practical advice, support and information for 13–19 year olds.

### *Medical Foundation for the Care of Victims of Torture*

[www.torturecare.org.uk](http://www.torturecare.org.uk)

### *Migrant Helpline*

[www.migranthehelpline.org.uk/](http://www.migranthehelpline.org.uk/)

Provides advice and support for refugees and asylum-seekers (especially in Kent and East Sussex).

### *Migrant and Refugee Communities Forum (MRCF)*

[www.mrcf.org.uk](http://www.mrcf.org.uk)

The Face 2 Face mentoring scheme offers support for migrants with mental health needs by mentors recruited through the MRCF Refugee Healthcare Professionals Programme. The mentors are qualified refugee doctors and adopt a holistic treatment approach.

### *Migrants Resource Centre*

[www.migrantsresourcecentre.org.uk/](http://www.migrantsresourcecentre.org.uk/)

Offers advice, training and education to refugees and asylum-seekers.

### *Refugee Action*

[www.refugee-action.org.uk](http://www.refugee-action.org.uk)

Runs a wide range of programmes and offers advice, including independent and confidential advice on voluntary return programmes run by IOM (International Organisation for Migration).

### *Refugee Council*

[www.refugeecouncil.org](http://www.refugeecouncil.org)

Offers legal and practical advice and information on a range of issues.

### *Refugee Legal Centre*

[www.refugee-legal-centre.org.uk/](http://www.refugee-legal-centre.org.uk/)

Offers legal advice and representation to asylum-seekers and refugees.

### *Solace*

Tel. 0113 249 1437

A charity offering counselling, psychotherapy and advocacy services to asylum-seekers and refugees in Yorkshire.

## **Further references**

Commission for Social Care Inspection (2005) 'Children seeking asylum' in *Safeguarding Children: The second joint chief inspector's report on arrangements to safeguard children*. Newcastle: CSCI.

[www.safeguardingchildren.org.uk/Safeguarding-Children/2005-report](http://www.safeguardingchildren.org.uk/Safeguarding-Children/2005-report)

Fellas and Wells (2006) 'Workshop – People without access to funds: Social care: Destitution and immigration' in *Meeting the Mental Health Needs of Refugees, Asylum Seekers and Immigration Detainees*. London: Development Centre/Social Perspectives Network. [www.spn.org.uk/fileadmin/SPN\\_uploads/Documents/Papers/SPN\\_Papers/spnpaper10.pdf](http://www.spn.org.uk/fileadmin/SPN_uploads/Documents/Papers/SPN_Papers/spnpaper10.pdf)

Home Office (2004) 'Asylum Support Policy Bulletin 29: Transition at age 18'. [www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumsupportbulletins/medical/pb85.pdf?view=Binary](http://www.bia.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumsupportbulletins/medical/pb85.pdf?view=Binary)

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## Part 6 Literature review: managing transitions from in-patient psychiatric settings for young people

by Steve Howell, NCB

*Re-entering society involves overcoming a series of obstacles, some of which are related to the need for basic daily-life routines, while others arise from problems in the aftercare plan. Preventive planning when the patient is still hospitalized may anticipate some, but not all, of the common transition pitfalls.*

(Ruben and Stout 1993, p.42)

As Ruben and Stout point out in *Transitions: Handbook of managed care for inpatient and outpatient treatment*, cited above, moving on from an in-patient hospital placement necessarily involves the individual in safely navigating or managing, with professional help, an essentially predictable set of practical and personal obstacles or pitfalls. The role of discharge planning is therefore to identify likely problems and pitfalls ahead of time and to set in place supports and strategies to enable the young person to overcome, or at least cope with, the difficulties they will encounter.

Outcomes for many care leavers as a group remain poor in relation to their peers, in spite of considerable improvement over recent years. *Care Matters* (DfES 2007) recognises that they require additional support during and after their time in care and to make the transition to adult life in a gradual, phased and prepared way. It is also now widely recognised that unfortunately a high number of looked after children have, or will develop, mental health problems, which may result in some young people having to be admitted into a psychiatric facility.

The legislative framework for leaving care may be in place, but evidence suggests there are continuing deficits in the quality of needs assessment and pathway planning, particularly for marginalised groups within the care population. In addition, other young people may not have formal care-leaving status but will be facing similar challenges of transition, including young people leaving custodial or psychiatric settings. These challenges typically range from practical issues such as accommodation, education and employment, through to complex personal needs such as unresolved bereavement issues, poor attachments and managing ongoing health concerns.

Discharge planning to arrange for continued care by carers and/or community services after a period of in-patient treatment can be vital to maintaining patient welfare as well as 'providing cost-effective utilization of resources' by reducing the likelihood of relapse and readmissions (Armitage and Kavanagh 1998, p.69). Access to community-based services or facilitated transition to adult services may all need to be negotiated. Literature confirms that the



experiences of some young people leaving psychiatric settings can mirror those of other groups of young people leaving institutional care, and that a considerable gap often still exists between the ideal of 'seamless transitions' between services, and the reality experienced by young people and their carers.

The need for, and frequent lack of, integration and close cross-agency working between in-patient settings and community services is thus a recurring one in literature on resettlement and discharge planning. Interventions begun in hospital, for example medication regimes, must be continued, monitored or reassessed in the community. Ideally any education and programmes on substance misuse or social skills begun within the institutional setting need consolidating in the community for rehabilitation to be ongoing and effective.

*Discharge planning is an integral part of in-patient care and is the vehicle that ensures the period of in-patient care is as short as possible and is part of an integrated package of care. Community CAMHS as well as local education and social services must therefore give high priority to discharge planning meetings and Section 117 meetings held by the Tier 4 facilities.*

(Richardson and Partridge 2003, p.122)

Despite the clear desirability of the above prescription, a recent study of the in-patient care of young people with mental health problems found that, while a few local examples of successful interagency work and good practice could be identified, overall these were 'few and far between' and that, on the contrary, there was:

*a widespread lack of post-discharge provision for young people, including long-term specialist provision – also that young people leaving in-patient CAMHS are not seen as a priority by community-based professionals.*

(Svanberg and Street 2003a, p.4).

The report found that interagency working, supported by clear operational procedures and funding, needed to be 'more firmly on the agenda' of CAMHS and social services. An earlier study by YoungMinds also found that 'post-discharge services are widely lacking' and this could result in 'bed blocking', which in turn exacerbated the shortage of CAMHS in-patient places (Street 2000, p.9).

Another study of re-admissions to psychiatric placements found that poor discharge planning and 'the relatively high number of unmet needs in the patient' in their community setting were major factors in relapse. Principal among such unmet needs were lack of 'structured daytime activity' or social life; unemployment and financial problems; and anxiety and depression (Cooper and McLees 2001).

Another, more recent, study of homelessness amongst former psychiatric patients found that effective discharge planning can make a significant contribution to preventing homelessness. As part of a larger continuum of care, discharge planning can help people reach the goals of stable housing, recovery and increased quality of life in the community (Backer and others 2007). The absence of such a continuum of care can too often result in discharge 'from psychiatric ward to the streets' (Forchuk and others 2006).

The difficulties experienced by many care leavers in finding a secure, supported and purposeful place in society, with access to secure housing, education, training or employment, are writ large for those leaving secure settings or psychiatric establishments, many of whom will in fact also have been in care at some point (Svanberg and Street 2003a). These needs can be identified and anticipated, and effective discharge planning should do so and attempt to organise the services which a person with mental illness, substance abuse or other vulnerabilities will need when leaving an institutional or custodial setting and returning to the community (Backer and others 2007). In order to achieve this it is important that links with a young person's carers and the relevant community-based services in their home area be maintained or developed after admission and that such sources of post-discharge support are informed of, and involved in, care and discharge planning arrangements. For example, the Royal College of Psychiatrists recommends that:

*In-patient services should provide written documentation to the referring community CAMHS on the findings and agreements arising from the pre-admission assessment, a report on the initial assessment review and, after the initial period of in-patient care, regular (e.g. six weekly) reports, the notes of all discharge planning meetings and a discharge summary.*

(Richardson and Partridge 2003, p.123)

For many young people entering an in-patient unit can be a very confusing and frightening time, full of apprehension as to what to expect, whether they will be safe or be able to go home when they want. However, paradoxically, the subsequent transition back into the community can be equally – if not more – challenging. After their initial fears many young people, especially those who have led very chaotic lives, may well experience a period of in-patient care as a time of very intense, all-enveloping care and order. They may form valued relationships with staff and fellow patients, the loss of which can be quite distressing. For this reason the transition back into the community should be not only carefully planned in liaison with the family, relatives and community-based services and supports, but also be a gradual process – phased to the individual's needs and capacities:

*Moving on after staying in an in-patient unit should be a gradual change, and you should have the support from the staff who know you. This is to try getting you to put into practice what you have learnt at the unit about managing your difficulties.*

(YoungMinds 2003, p.13)

## Statistics

The recorded incidence of diagnosable mental health problems amongst children and young people has increased in the last 30 years (Collishaw and others 2004). In particular the incidence of mental health problems, and notably the more serious conditions, is higher for adolescents than for younger children.

This latter group are inherently likely at some point to need to transfer between children's and adult services, another transition which can be problematic. Despite the recorded increase in levels of need, placements in child and adolescent in-patient psychiatric units are in short supply and, according to some observers, vary widely in terms of their models of care:

*Little is known about these services and still less about young people's experience of them.*

(Worral and others 2007, p.195)

## CAMHS bed provision

Estimates of the number of children and young people passing through in-patient psychiatric settings, either as informal patients or those formally detained under the Mental Health Act 1983 (MHA) vary, but according to NACRO:

*The figures that are available do show that approximately seven thousand children and young people pass through NHS mental health in-patient care each year. An unknown minority will be formally detained.*

(NACRO 2004, p.2)

According to one recent study of the residents of CAMHS in-patient units, children under 13 have an especially wide range of diagnoses, whilst adolescents in the 14–18 age group could be categorised into three main diagnostic groups: eating disorders, schizophrenia, and delusional, psychotic or mood disorders (O'Herlihy and others 2004, p.579).

Data collected by the Department of Health show that in the years 2005/6:

- ◆ 141,661 bed days were spent by children and adolescents on specialist CAMHS wards
- ◆ 29,306 bed days were spent by 16–17 year olds on adult wards
- ◆ 353 bed days were spent by under-16s on adult wards.

Data collected by the Research Unit of the Royal College of Psychiatrists on CAMHS bed provision records the following:

- ◆ In 2006, there were 91 units with 1,128 beds, a 26 per cent increase compared with 1999, when there were 72 units with 844 beds.
- ◆ The number of NHS beds increased by 14 per cent from 632 to 721; independent sector beds increased by 92 per cent.

- ◆ The proportion of bed increases has been most significant in the forensic secure NHS units: from 16 in 1999 to 68 in 2006 (325 per cent) and the secure independent units from 56 in 1999 to 115 in 2006 (105 per cent) (Department of Health 2006a, p.30).

## Legal provision and guidance relating to aftercare

Standard 9 of the National Service Framework for Children, Young People and Maternity Services, which gives best practice guidance, addresses the mental health needs of children and young people. Standard 9.13 states that discharge planning should receive the same attention as admission planning, if any improvements achieved are to be maintained:

*Aftercare has a crucial role in the maintenance of treatment gains made during admission. In a minority of cases admission may be a stepping-stone towards longer-term alternative care or residential schooling. The team will need to liaise with a range of local education, social and mental health services.*

(Department of Health 2004, p.34)

Standard 9.14 points out that the in-patient unit needs to be able to hand over to 'an appropriately equipped community service'. This requires 'a shared understanding of the level of care required on discharge' and if the resources for this are not available in the community then 'there may be a continuing role for the in-patient team in the provision of outreach and after-care services'.

Aftercare for children and young people making the transition from in-patient settings is provided for by Section 117 of the Mental Health Act 1983 (and also, if they are or have been looked after for the necessary qualifying periods, the Children Act 1989 and the Children (Leaving Care) Act 2000). According to Section 117:

*It shall be the duty of the District Health Authority and of local social services to provide, in cooperation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the District Health Authority and the local social services authority are satisfied that the person concerned is no longer in need of such services.*

(Mental Health Act 1983, p.92)

Paragraph 27.6 of the Mental Health Code of Practice places a duty on the responsible medical officer 'to ensure that a discussion takes place to establish a care plan to organise the management of the patient's continuing health and social care need' (Department of Health and Welsh Office 1993, p. 106). Subsequent paragraphs (27.7 and 27.8) list who should be involved and stress the importance of those attending such planning meetings having the authority to take decisions committing their respective agencies' services. However, according to a report for the Research Unit of the Royal College of Psychiatrists:

*This guidance is rather weakly worded and a stronger and more enforceable duty should be considered.*

(Mears and others 2000, p.18)

The Quality Network for In-patient CAMHS (QNIC) at the Royal College of Psychiatrists has, since 2001, developed widely adopted standards against which in-patient services across the NHS and Independent sectors can be assessed. Within these, the need for children and young people to be prepared for discharge and to have a plan for subsequent care are explicit requirements of good practice. The 2005/2006 edition of the standards make explicit the need for discharge planning to begin as soon as possible and for it to involve all key stakeholders. For example, Standard 22.1 states that it is 'desirable' for the place of discharge to be known before admission 'where possible' and 'essential' for Section 117 meetings to be held prior to discharge, involving parents and young people and all relevant community-based services (Standard 23). Young people and their parents are to know the names of workers involved in follow-up after their discharge (23.7), and know the dates and times of their discharge and follow-up appointments (23.8). For looked after young people, arrangements are to be made with the relevant social services departments for ongoing care planning (23.9) and for 'plans for ongoing education' to be made (23.10) (Hartwell and others 2005, pp. 30–31).

## Care Programme Approach

In what are almost inevitably complex cases, the Royal College of Psychiatrists' *Seminars in Child and Adolescent Psychiatry* points out that there will almost inevitably be conflicts of interest and judgement. Clinicians may argue the need for further clinical work and that there has been insufficient provision for safe discharge of the patient, whilst budget holders may be more concerned to press for such discharge. The authors argue that prior agreement about the goals of an in-patient placement can minimise such tensions, which can be 'unsettling if not distressing' for young people and their families. The Care Programme Approach (CPA), introduced in 1990 to provide a framework for the effective mental healthcare of people with severe mental health problems, provides a framework for effective ongoing mental healthcare for in-patients after discharge:

*All patients, regardless of their length of stay, should have a discharge planning meeting under the rubric of the Care Programme Approach.*

(Gowers 2005, p.360)

The CPA is intended to achieve continuity of care. It prescribes a systematic assessment of the health and social care needs of in-patients; formation of a care plan identifying the health and social care required from different providers; the appointment of a key worker (care coordinator) to monitor and coordinate care and the regular review and modification of the care plan as deemed necessary:

*Continuity of care is essential when the care setting changes, and is often identified as having been lacking when untoward incidents have occurred. The care coordinator has a key role in keeping the 'story'*

*together ... and the care plan should be the key reference document irrespective of where care is being delivered.*

(Department of Health 2006b, p.15)

In theory, the process involves identifying and 'risk stratifying' high risk young people with complex long-term health needs and facilitating their transfer between services to achieve the much desired but often lacking 'seamless transition between agencies and services' (Hardacre 2006, p.36). The care plan should address not only narrow health needs but also wider needs such as housing, economic well-being, education and employment, family links and supports. Transition plans should ideally be flexible in execution with contingency arrangements for setbacks (Ruben and Stout 1993). However, it is clear that reality sometimes fails to mirror this ideal. There is still a shortage both of in-patient beds and community mental health services, and consequently a pressure to discharge into less than comprehensive community care and support. Adolescents may still find themselves placed in adult facilities due to the lack of an available adolescent placements or experience difficult transitions between child and adult facilities. A recent report from the Children's Commissioner for England, *Pushed into the Shadows* (2007), found that the sometimes chaotic circumstances under which the young people entered the mental health services was mirrored for some in the arrangements for their discharge from hospital, whether to community CAMHS or to adult services. Whilst some did acknowledge the helpfulness of discharges which were planned, discussed and phased, with options to return to the ward for help and support when necessary, others recalled their discharge as being abrupt and unsupported:

*Unprepared, and often unready, the young people reported having had little involvement in the planning of their discharge and varying levels of post-discharge support.*

(Children's Commissioner for England 2007, p.81)

The report noted a lack of appropriate placements for young people leaving secure provision and urged that mental health care trusts and PCTs work towards using the Care Programme Approach more consistently across the country to ensure continuity of care and better discharge planning. Young people consulted for the report spoke of the importance of providing them with clear information about discharge procedures and of their desire to be fully involved in all discharge planning and decisions as to their future – findings that exactly mirror those of Svanberg and Street's earlier research for YoungMinds:

*Young people described wanting to be involved as early as possible in their discharge planning. For some, it felt that this stage had been rushed through too quickly, and they had wanted more preparation.*

(Svanberg and Street 2003b, p.33)

The recent Department of Health *Good Practice Toolkit* for achieving quality in-patient mental healthcare (Care Services Improvement Partnership 2007a) also emphasises that services users and carers have a critical role to play in successful care planning, care management and arrangements for discharge.

It states that successful discharge arrangements are *conditional on* such an involvement. This participation and involvement should include the sharing of information with young people and their involvement in the processes of assessment and review, and in the safeguarding and development of key social supports regarding home, job, education and social networks.

## Parental and young people's involvement in the discharge planning process

It is an National Service Framework (NSF) marker of good practice that the views of service users are systematically sought and incorporated into the reviews of service. The 2006/2007 QNIC *Annual Report for In-patient CAMHS Provision* notes that:

*data from this cycle demonstrates that more in-patient CAMHS units have been successful in involving young people and their families in aspects of their care and treatment than in previous years.*

(Davies and Thompson 2008, p.27)

A research review of mental health services carried out for the National Children's Bureau confirmed that young people wanted to have their views listened to by staff who were 'available, approachable and skilled in engaging with young people' (Street 2004, p. 1). The UN Convention on the Rights of the Child 1989, the Children Act 1989, the Children Act 2004, the Mental Health Act 1983 and the National Service Framework for Children (2003) all recognise that children and young people have a right to participate in their care planning and to express their wishes and preferences. In the Department of Health's guidance, *Transition: Getting it right for young people* (2006c) by far the most important knowledge and skill required by young people of the professionals they encounter is the ability to communicate effectively with them and for them to be well informed as to generic teenage health issues.

Nonetheless, perhaps unsurprisingly, young people in several studies have expressed the view that their contribution to the planning process is encouraged only within parameters strictly defined by practitioners:

*They ask you for your opinion and stuff but they say I am giving inappropriate answers.*

(LeFrancois 2007, p.95)

Again, perhaps unsurprisingly, not all young people welcome every opportunity to participate and some suspect the purposes of the exercise:

*I think community meetings are a waste of time ... the same things everyday; for example who didn't flush the toilet? I think we should discuss people moving on.*

(Maher 2002, p.33).

Another study noted surprise among some mental healthcare staff at the apparent initial passivity of young people as recipients of services in in-patient

settings, surmising that they may need to establish a sense of dependency before being able to develop a more active role in their treatment. Despite such suspicions and doubts it would seem that most young people, once convinced that the invitation to participate as active agents in their own care is a genuine one, welcome the opportunity (Grossoehme and Gerbetz 2004). Once they understand that the opportunities to participate are real and open they can respond with some enthusiasm:

*What was striking was the progress children made towards developing their own agency, not only in relation to managing their previously out-of-control problems, but also in strategies to manage the social consequences.*

(Hepper and others 2005, p.571)

In *Making the CPA Work for You*, the theme of partnership between service users and services is emphasised in the subtitle:

*It is not about how you fit into services – it is about how services fit with you.*

(Department of Health 2007)

In the Healthcare Commission's *Criteria for Assessing Core Standards in 2007/2008: Mental health and learning disability trusts*, under 'Accessible and responsive care', Core Standard C17, is the requirement that the healthcare organisation demonstrate to service users, carers and the local community how it has taken their views into account when planning and delivering services. As already noted above, young people have expressed a need for more information and involvement in aftercare planning and it is obviously desirable that they feel ownership of, and commitment to, plans made for their future:

*I think people should know what they need to aim for because for months and months I had no clue where I was going. I'd just go by day to day and nothing happened and that is really frustrating because you want to go and you don't know what you've got to do to prove it.*

(Svanberg and Street 2003b, p.33)

The Royal College of Psychiatrists recommends that all specialist in-patient adolescent mental health services should have expertise in:

*working in partnership with family, educational and social welfare systems.*

(Royal College of Psychiatrists 2002, p.7)

The constructive participation of the family in treatment planning during hospitalisation has been identified as a key predictor of positive outcomes in several studies (Parmelee and others 1995, SCIE 2004, Nickerson and others 2007).



It is evident from the literature, and confirmed by the findings of the Managing Transitions Project that, however problematic, family relationships and links, and the possibility of some future reconnection with them, are seen as critical by most children and young people when thinking about their life beyond the in-patient unit. According to a National In-Patient Child and Adolescent Psychiatry (NICAPS) study, the majority of CAMHS patients (76.9 per cent) were discharged to the family home. On the other hand, difficulty in arranging community or family support was the reason for delay at discharge in over 60 per cent of such cases (O'Herlihy and others 2001). It follows that in-patient units and discharge planners must do everything they can to encourage any positive links, and engage families with treatment goals wherever possible:

*Parents are seen as an essential part of the 'solution' to the adolescent's difficulties.*

(Wilkinson 2001, p.158)

## **Interagency planning and collaboration between in-patient and community-based services**

*The planning process needs the involvement of an integrated multidisciplinary team of people (including the GP) who have the appropriate training, expertise and skills and who are able to cross-refer to provide coordinated care.*

(Department of Health 2008, p.11)

It is evident from all the literature on in-patient psychiatric care for children and young people that close collaboration with community-based, social and adult services is essential for transitions to be successful. Young people rarely have one discrete problem but rather a series of interrelated and interacting ones and, as such, they may very well require multi-agency, multidisciplinary input to support their needs effectively (YoungMinds 2006, Smith 1996). The arbitrary distinctions drawn between specialisms and between children's and adult services may not correspond with their developmental needs:

*The problems associated with youth transitions do not conclude at neat, age-specific points and therefore age-related policies ... do not fit harmoniously with the realities of the extended transitions that our sample members have undertaken.*

(Webster and others 2005, p.3)

This point echoes the findings of the House of Commons Health Committee, which expressed concern at the lack of consistency in terms of eligibility and entitlements between CAMHS and adult services and the very different cultures operating in these services. The result is that young people's needs may well be overlooked or 'fall between' very different models of care (House of Commons Health Committee 2000). Support after discharge, and in particular the lack of community support, can be a critical factor in determining success or failure in maintaining the improvements gained during a residential placement:

*There should be a strengthening of relationships between in-patient units and community CAMHS in order to ensure continuity of care. This might include outreach services from in-patient CAMHS and 'inreach' services from community CAMHS into in-patient units.*

(O'Herlihy and others 2002, p.83, see also Kurtz and others 2006)

## Conclusion

*Timely, safe and appropriate discharge is the result of good care planning from the decision to admit to providing post-discharge support.*

(Care Services Improvement Partnership 2007a, p.4)

For some of the children and young people with severe mental problems, a period of in-patient care may be necessary and the preferred option. However, it is crucial that such episodes are planned with a clear view as to supported transitions from the CAMHS in-patient setting to either independence or on to adult or community-based services.

*Transition is a process not task – and it should start early ... The process must be multi-agency – and the young person and their family should not be aware of the 'joins'.*

(Care Services Improvement Partnership 2007b, p.3)

According to Maskey (2005) it is by setting clear objectives for both admission and discharge, and reviewing these regularly, that in-patient child and adolescent psychiatric services can aim to minimise length of stay and thus deploy a very expensive resource most effectively. Key to this must be maintaining or developing the involvement of community-based services agencies:

*Admission to, and discharge from, in-patient services, necessitates active engagement with the local network of health, education and social services, if the benefits are to be maximised and time away from home minimised. For young people who have left school, the links should be with further education and employment services, and voluntary organisations working with adolescents in these fields.*

(Maskey 2005, p.347)

Despite this clarity as to what is necessary or desirable for effective transitions, Svanberg and Street's study of the discharge process for young people leaving in-patient mental health placements found evidence of both a severe lack of aftercare provision and few resources for supporting the transition back into the community:

*One of the greatest areas of concern from within our research was the lack of provision after young people were discharged from in-patient units.*

(Svanberg and Street 2003b, p.32).

In marked contrast, where planning and provision was good, and the young person was involved and felt supported, the result was a successful transition process where the supports could gradually be reduced as autonomy and confidence increased:

*During the first 6 months of my discharge I had regular appointments that were reduced when appropriate. I was supported and felt involved in my care plans. It was helpful to review my progress and make targets to achieve, concerning school or my health.*

(Svanberg and Street 2003b, p.33)

The NSF implementation report relating to CAMHS makes 'robust discharge planning', close interagency liaison and 'continuity of care', using the Care Programme Approach, 'markers of good practice' for in-patient care (Department of Health 2006b, pp. 32–33).

The dangers if such elements are lacking have long been recognised; for example in *Transitions: Handbook of managed care for inpatient to outpatient treatment* the authors pointed out the many pitfalls, which then and now can easily result in relapse and re-admission:

*Therapists are inaccessible, families reinforce old habits and patients themselves resume old behavioural and emotional habits, forgetting their recovery mission. Consequently the unstructured transition through which patients stumble after discharge leaves them at high risk for recidivism.*

(Ruben and Stout 1993, p.viii)

As already stated, in-patient care can be a very intense all-enveloping experience and consequently returning to the demands and pressures of the outside world can be a real shock, especially if family links or other social supports are weak, unhelpful or entirely lacking. Ruben and Stout called for effective transition planning which anticipates the practical, emotional and psychological problems that commonly await patients leaving a highly structured care environment. Several factors can affect relapse and re-admissions – the nature and intractability of the patient's condition; their ownership of, and compliance with, care regimes; and the social supports available to them. However, researchers generally agree that aftercare can play an important role in the short- and long-term rehabilitation of some former psychiatric in-patients (Thompson and others 2003). The NSF sets the quality benchmarks for a transition process, which address most of the concerns expressed by Ruben and Stout's 1993 handbook. However, Svanberg and Street's report, a decade later, clearly indicates that the problems, service gaps and pitfalls remain, and that the consequences can be costly, both in human and financial terms:

*Lack of support in the community in some areas meant that young people are exiting the 24-hour support of an in-patient unit and feeling abandoned if there is no after-care in place. This increases their chances of relapse, and some evidence of the revolving door syndrome of repeated access to inpatient CAMHS was apparent.*

(Svanberg and Street 2003b, p.32)

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## Part 7 Resources

This section includes:

- ◆ Glossary of terms (with subsections on mental health, and children's services)
- ◆ Further information, useful organisations and websites.

### Glossary of terms

#### **Mental health**

##### *Admission*

The point at which a person begins an episode of care, for example arriving at an in-patient ward.

##### *Aftercare under Section 117 of the Mental Health Act 1983*

Under Section 117, health authorities and local social services have a legal duty to provide aftercare for patients who have been on Section 3, 37, 47 or 48 but who have left hospital.

##### *AMHP (approved mental health professionals)*

The Mental Health Act 2007 sets out the responsibilities for AMHPs regarding the assessment of people when admission under the Act is being considered, as well as whether they themselves are, or consult with, a CAMHS clinician.

##### *Assertive outreach*

An approach to engaging with service users with a severe mental illness, who may be difficult to engage with: it involves services in the community that are accessible 24 hours a day and visits to service users in their own homes.

##### *ASW (approved social worker)*

Qualified social workers who have undergone additional specialised training on mental health and the law. They can apply to have a person formally detained in hospital under a section of the Mental Health Act 1983.

##### *Bipolar affective disorder*

This is also known as manic depression or bipolar disorder. It is a disorder characterised by swings in a person's mood from very, very high (mania) to very, very low (depression).

##### *Caldicott guardian*

A senior healthcare professional who, in each NHS organisation, is responsible for safeguarding the confidentiality of patient information. The name is derived from the Caldicott Report, which identified 16 recommendations for the use and storage of patient-identifiable information.

##### **CAMHS**

This stands for children and adolescent mental health services.



### *Care coordinator*

The professional with responsibility for coordinating assessment, care planning and service delivery of care services under the Care Programme Approach.

### *Care Programme Approach (CPA)*

A way of coordinating the multidisciplinary and interagency planning and provision of care for people with severe mental illness. It ensures that staff from different agencies regularly meet together to review progress with the service user and his or her carer, and also record unmet needs.

### *CPA reviews*

Reviews designed to monitor and evaluate the effectiveness of the care plan and focus on how the needs of the service user can continue to be met. These reviews also incorporate the statutory responsibilities to provide and review aftercare for mental health service users subject to Section 117. A CPA review should include:

- ◆ the service users for whom the care plan is designed
- ◆ all those involved in the care package, including carer(s)/advocate
- ◆ an evaluation of the care plan
- ◆ an opportunity to gather and share information
- ◆ a re-assessment of need for both service user and their carer
- ◆ a review of the CPA level
- ◆ an opportunity to identify unmet needs
- ◆ agreement by those present to any changes in the care plan.

### *Clinical psychologist*

This type of professional offers help via talking treatments such as cognitive behavioural therapy.

### *Clinical team*

A team of healthcare professionals from different disciplines (for example, nursing, psychiatry, occupational therapy).

### *Cognition*

Another word for 'thought'.

### *Community Mental Health Team (CMHT)*

A multidisciplinary team offering specialist assessment, treatment and care to people in their own homes and community.

### *Conditional discharge*

Where a restricted patient under the Mental Health Act is discharged subject to specific conditions and is liable to be recalled by the Home Office.

### *Conduct disorder*

A persistent pattern of behaviour that involves the violation of the rights of others. Verbal and physical aggression are central features of conduct orders.

### *Consultant psychiatrist*

A doctor who is a medical specialist in mental illness.

### *Commissioner*

In this instance the commissioners are primary care trusts, as they are responsible for buying (commissioning) specialist mental health services on behalf of the people living in their area.

### *CPN (Community Psychiatric Nurse)*

A registered mental nurse (RMN) who has had training to work in community settings, in addition to hospitals.

### *Delusion*

An abnormal belief held about one's self or the world.

### *Discharge*

The point at which a person formally leaves services. On discharge from hospital, the multidisciplinary team and the service user will develop a care plan.

### *Dispersal*

The Immigration and Asylum Act 1999 introduced new measures to reduce pressure on services in London and the South East by dispersing asylum-seekers to other parts of the country. Since April 2000, unless there are exceptional circumstances, asylum-seekers who qualify for asylum support and who need both subsistence and accommodation are offered accommodation outside London and the South East.

### *Dual diagnosis*

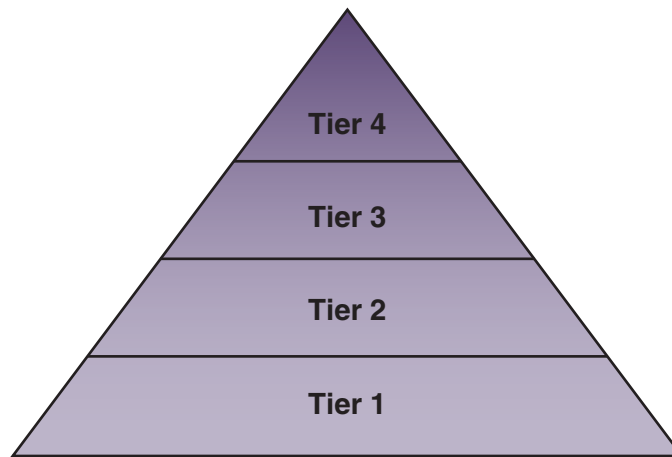
This is the combination of mental illness with other conditions, including:

- ◆ alcohol abuse
- ◆ drug abuse
- ◆ learning disability
- ◆ physical disability.

### *Forensic psychiatry*

Means pertaining to or connected with courts of law.

### *Four-tier strategic framework*



In 1995, the NHS Health Advisory Service published a thematic review of CAMHS, which described it as having a four-tier framework. This approach was later used as the baseline for future planning. Although there have been differences in the way the tiered strategic framework has been developed and applied across the UK, it has created a common language for describing and commissioning services.

*Tier 1* CAMHS at this level are provided by those who are non-mental health specialists working in universal services, such as GPs, health visitors, teachers, social workers.

*Tier 2* Practitioners at this level tend to be CAMHS specialists working in the community and primary care settings.

*Tier 3* This is usually a multidisciplinary team or service working in a community mental health clinic or child psychiatry out-patients service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

*Tier 4* This level comprises services for children and young people with the most serious problems, such as day units, highly specialised out-patient teams or in-patient units.

### *Mental Health Act Commission*

The organisation that reviews the way the Mental Health Act is applied to people detained in hospital.

### *MHRT (Mental Health Review Tribunal)*

An independent judicial body, which operates under the Mental Health Act and is charged with considering the need for a patient's continued detention in hospital.

### *National service framework for mental health*

The Department of Health's national service framework for mental health provides the national standards for promoting mental health and treating mental illness.

### *Nearest relative*

The definition of the 'nearest relative' can be found in the Mental Health Act 1983. Under Section 11 paragraph 4, they must be consulted with regard to a service user being assessed for compulsory treatment. The service user must be informed of this.

### *Occupational therapist*

Their role is to help people with mental health problems to build up the confidence and skills they need for personal, social, domestic, leisure or work activities. They focus on the learning of specific skills, using techniques such as arts, craft, drama, dance, writing, group work (such as anxiety management and assertiveness training), individual counselling and training activities about daily living.

### *Occupational therapy*

A means of assisting people to achieve their maximum level of independence.

### *Psychosis*

The word psychosis is used to describe a group of conditions that affect the mind and, to some extent, mean that the person loses contact with reality. A person may experience unusual or distressing perceptions, for example hallucinations and delusions, which may be accompanied by a reduced ability to cope with day-to-day activities and routine. Someone who has these unusual experiences is described as having a psychotic episode.

### *Relapse*

This is where symptoms start up again.

### *Restricted patients*

Patients restricted under Section 41 of the Mental Health Act 1983, whose discharge is subject to Home Office approval.

### *RMO (responsible medical officer)*

The doctor in charge of the formal patient's treatment.

### *SOAD (second opinion appointed doctor)*

A doctor charged with specific responsibilities under the Mental Health Act 2007 when certain treatments, including electroconvulsive therapy (ECT), are being considered for a child or young person.

## **Children's services**

### *Care order*

Given by the court to protect a child or young person if it is satisfied that the *child or young person is suffering or is likely to suffer significant harm* if he or she was not in the care of Social Services.

### *Care plan*

Determines why it is in the child or young person's best interests to become looked after or whether other support services would be able to meet their needs; it identifies their assessed needs and the services to meet those

needs; and sets the framework for the services provided to the child or young person and their family to enable the desired goals and outcomes to be achieved.

### *Care planning process*

The way in which decisions are made, and reviewed, about how looked after children and young people are cared for. This includes aspects of their lives such as where they live, contact with family, school, health, legal issues, money and activities. It comprises four stages:

- ◆ assessment
- ◆ planning
- ◆ intervention
- ◆ review.

It includes the court care planning process, where the court decides the final care plan for the child, which social services is then responsible for implementing.

### *Child in need*

A person under the age of 18 is defined as a 'child in need' under Section 17 of the Children Act 1989.

### *Children's guardian*

A person from the court who works to ensure the child or young person's views and best interests are represented to the court in care or other legal proceedings. May also be referred to as 'guardian' and previously known as a 'guardian ad litem'.

### *Corporate parents*

The whole council/elected members are 'corporate parents' to all the children and young people who are looked after by that authority/council. It not only refers to the councillors with responsibility for social/children's services but also to all the members and services that play a part by accepting responsibility for children and young people in their care, making their needs a priority and seeking the same outcomes any good parent would want for their own children.

### *Designated doctor and designated nurse*

Their roles are to assist primary care trusts to fulfil their responsibilities as commissioners of services to meet the needs of looked after children and young people. It is a strategic role, although the postholders may also provide direct services to individual children or young people.

### *Framework for the assessment of children in need and their families*

The holistic framework used by children's services to assess children, young people and their families.

### *Independent reviewing officers*

Registered social workers who chair all looked after children's statutory review meetings, from which position they can identify any problems in a child or

young person's care and any lack of clarity in the care plan. They ensure that everyone involved in the child or young person's case can make a meaningful contribution which includes listening to the views and wishes of the child or young person. They monitor the local authority's performance, working with the local authority to ensure children and young people's needs are being met and resolving difficulties.

### *Independent visitor*

If a young person does not have much contact with their family, they can have access to an independent visitor. The role of an independent visitor is to befriend, provide advice and to visit the young people so that they don't become isolated.

### *Looked after child*

An umbrella term for a child or young person provided with care and accommodation in the care system, sometimes referred to as LAC.

### *Pathway plan*

A care plan for young people defined as eligible for leaving care services under the Children (Leaving Care) Act 2000.

### *PEP*

All looked after children should have a PEP, also known as a personal education plan, which details the plans to help the young person achieve in education and training.

### *Permanence*

A framework providing children and young people with a sense of security, continuity, commitment and identity – a sense of belonging for each child and young person. The objective is to ensure children and young people have a secure, stable and loving family to support them through childhood and beyond. This can be achieved through: a return to birth parents; placement with extended family; placement with a substitute family through **adoption** or **long-term fostering** supported by a **residence order** or **guardianship**.

### *Personal adviser (PA)*

A person to support and plan for eligible young people from the age of 16 leaving care.

### *Review meeting*

A meeting or meetings where the care plan is considered, reconfirmed or changed and such decisions agreed and recorded in consultation with all those who have an interest in the child or young person's life, including the child or young person.

### *Review process*

A process of continuous assessment and monitoring of the care plan, ensuring that the right services are in place, at the right time, to meet the required needs and outcomes.

## Further information: useful organisations and websites

### Mental health

#### *CSIP*

The CSIP website provides regular update, news, information about the Mental Health Act 2007.

[www.mhact.csip.org.uk](http://www.mhact.csip.org.uk)

#### *Mind*

Mind also has a legal unit where advice can be sought on legal matters. The legal advice line is open Monday, Wednesday and Friday afternoons from 2pm to 4.30pm on 020 8519 2122 or email [legal@mind.org.uk](mailto:legal@mind.org.uk). Mind cannot take up individual cases.

[www.mind.org.uk](http://www.mind.org.uk)

#### *Royal College of Psychiatry*

The professional and educational body for psychiatrists in the UK. Its website contains a wealth of materials – factsheets, leaflets and publications – which are free to download.

[www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

#### *Young Minds*

A national charity committed to improving the mental health of all children and young people. It has a comprehensive website with a range of materials.

[www.youngminds.org.uk](http://www.youngminds.org.uk)

#### *SANEline*

A national charity concerned with improving the lives of everyone affected by mental illness.

[www.sane.org.uk](http://www.sane.org.uk)

#### *Mental Health Foundation*

Leading UK charity in mental health and disabilities. Provides information and advice about children and young people's mental health.

[www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)

### Specific topics

#### *Affective disorders*

##### **Bipolar World**

[www.bipolarworld.net](http://www.bipolarworld.net)

##### **Depression Alliance**

[www.depressionalliance.org](http://www.depressionalliance.org)

##### **MDF The Bipolar Organisation**

[www.mdf.org.uk](http://www.mdf.org.uk)

##### **Seasonal Affective Disorder Association**

[www.sada.org.uk](http://www.sada.org.uk)

## *Bereavement*

### **Cruse Bereavement Care**

[www.crusebereavementcare.org.uk](http://www.crusebereavementcare.org.uk)

### **Childhood Bereavement Network**

A national, multi-professional federation of organisations and individuals working with bereaved children and young people. It has a range of resources and guidance.

[www.childhoodbereavementnetwork.org.uk](http://www.childhoodbereavementnetwork.org.uk)

Based at NCB, 8 Wakley Street, London, EC1V 7QE

Tel 020 7843 6309 or email [chb@ncb.org.uk](mailto:chb@ncb.org.uk)

## *Bullying*

### **Anti-bullying Network**

[www.antibullying.net](http://www.antibullying.net)

## *Deaf people with mental health issues*

### **SignHealth**

A charity working with deaf people with mental health issues. It provides information, advocacy services, care homes, counselling and outreach support.

[www.signcharity.org.uk](http://www.signcharity.org.uk)

Email [info@signhealth.org.uk](mailto:info@signhealth.org.uk) or tel 01494 687600

## *Drug, alcohol and solvent abuse*

### **Alcohol Concern**

[www.alcoholconcern.org.uk](http://www.alcoholconcern.org.uk)

### **DrugScope**

[www.drugscope.org.uk](http://www.drugscope.org.uk)

### **National Treatment Agency for Substance Misuse**

[www.nta.nhs.uk](http://www.nta.nhs.uk)

### **Turning Point**

[www.turning-point.co.uk](http://www.turning-point.co.uk)

### **Re-Solv**

A telephone enquiry service for anyone concerned about solvent or volatile substance abuse problems. Also provides a written enquiry service for professionals and others concerned with solvent or volatile substance issues.

[www.re-solv.org](http://www.re-solv.org)

30a High Street, Stone, Staffordshire, ST15 8AW

Tel 0808 800 2345 (helpline)

## *Education, training and employment*

### **Connexions**

Offers advice education, training and employment for 13–19 year olds.

[www.connexions-direct.com](http://www.connexions-direct.com)

Helpline: 0808 001 3219



## *Eating disorders*

### **beat**

The leading UK charity for people with eating disorders and their families. Provides telephone helplines for people affected by eating disorders and runs a network of support groups, postal and telephone contact throughout the UK.  
[www.b-eat.co.uk](http://www.b-eat.co.uk)  
Tel 0870 770 3256

## *Looked after children and care leavers*

### **A National Voice**

An organisation run for and by young people who are or have been in care.  
[www.anationalvoice.org](http://www.anationalvoice.org)  
Email [info@anationalvoice.org](mailto:info@anationalvoice.org)

### **National Leaving Care Advisory Service (NLCAS)**

Provides advice, information and support on leaving care issues.  
<http://leavingcare.org>

### **Voice**

Provides advocacy and advice to children in care in England.  
[www.voiceyp.org](http://www.voiceyp.org)  
Email [info@voice.uk.org](mailto:info@voice.uk.org)

### **National Youth Advocacy Service**

Provides information, legal advice, representation and advocacy.  
[www.nyas.net](http://www.nyas.net)  
Helpline 0800 616 101  
Tel 01516 498 700  
Email [info@nyas.net](mailto:info@nyas.net)

## *Schizophrenia and psychosis*

### **Hearing Voices Network**

[www.hearing-voices.org](http://www.hearing-voices.org)

### **Rethink**

[www.rethink.org](http://www.rethink.org)

## *Self-harm*

### **National Self-Harm Network (NSHN)**

Provides support and advice to people who self-harm, their friends and families.  
[www.nshn.co.uk](http://www.nshn.co.uk)

### **Young People and Self-harm**

Information resource for young people who self-harm, their friends, families and for professionals working with them.  
[www.selfharm.org.uk/](http://www.selfharm.org.uk/)

## *Suicide*

### **Centre for Suicide Research, Oxford**

[www.cebmh.warne.ox.ac.uk:80/csr](http://www.cebmh.warne.ox.ac.uk:80/csr)

### **Centre for Suicide Prevention**

[www.medicine.manchester.ac.uk/suicideprevention/nci](http://www.medicine.manchester.ac.uk/suicideprevention/nci)

## **Papyrus**

A campaigning organisation concerned with the prevention of suicide by young people. Information for parents, teachers and healthcare professionals. Also provides contact with support groups for those who have been recently bereaved.

[www.papyrus-uk.org](http://www.papyrus-uk.org)

Tel 01706 214 449 (office)

Helpline 0870 170 4000

## *Youth organisations*

### **ArtsWork**

An independent national youth arts development agency committed to generating creative opportunities for young people aged 12–25.

[artswork.org.uk](http://artswork.org.uk)

### **English National Youth Arts Network (ENYAN)**

[www.enyan.co.uk](http://www.enyan.co.uk)

### **Prince's Trust**

[www.princes-trust.org.uk](http://www.princes-trust.org.uk)

### **UK Youth**

[www.ukyouth.org](http://www.ukyouth.org)

### **YMCA**

[www.ymca.org.uk](http://www.ymca.org.uk)

## **Specific groups**

### *Asylum-seekers and refugees*

Further details of useful resources can also be found in the Part 5 briefing: 'Young asylum-seekers and refugees leaving adolescent psychiatric care'.

### **Asylum-Seeking and Refugee Children: Developing Good Practice Project website ([www.ncb.org.uk/arc](http://www.ncb.org.uk/arc))**

This online resource provides essential information and resources for all those working with or for separated or unaccompanied refugee children and young people.

This website has been developed in response to the changing landscape and aims to support practitioners in their day-to-day work with asylum-seeking and refugee children. Packed with information, research findings and practical tools to help make day-to-day practice more effective, the website provides a single access point to the most comprehensive collection of resources and information on all aspects of assessment and planning relating to asylum-seeking and refugee children and young people.

The website has been produced in collaboration with local authorities, academic practitioners, voluntary agencies and community groups. It provides access to information, resources and support including: examples of good practice, project briefings, academic papers, a resources directory, training packs and current research.

### **British Red Cross Family Tracing Service**

Tel 020 7877 7000

[www.redcross.org.uk/TLC.asp?id=76239](http://www.redcross.org.uk/TLC.asp?id=76239)

### **The Children's Legal Centre – The Asylum Seeking and Refugee Children's Project**

The project's website is aimed at non-immigration specialist professionals working with asylum-seeking and refugee children. Provides up-to-date information on rights, entitlements and issues affecting asylum seeking and refugee children and young people.

Children's Legal Centre

University Of Essex

Wivenhoe Park

Colchester

Essex

CO4 3SQ

[www.childrenslegalcentre.com](http://www.childrenslegalcentre.com)

### **Refugee Access**

An informative website for asylum-seekers, refugees and agencies working in Yorkshire, Humberside and the Liverpool area. The website has wider appeal in that it has a range of resources helpful to asylum-seekers, refugees and professionals working in the field wherever they are in the UK.

Amongst its resources are translated materials on asylum, harassment, legal advice, health, volunteering, how to use information technology in the UK (email, internet, etc.), practical issues such as dealing with the TV licence, and women's rights. There is a directory of useful resources and examples of best practice.

[www.refugeeaccess.info](http://www.refugeeaccess.info)

### **Refugee Council Panel of Advisers**

A service offered by the Refugee Council that provides advice and information to unaccompanied refugee children.

Refugee Council

240/250 Ferndale Rd

London

SW9 8BB

Advice line 0207 346 1134 10am–5pm (Mon–Fri)

Drop-in service 9:30am–5pm (Mon–Fri)

[www.refugeecouncil.org](http://www.refugeecouncil.org)

### **Refugee Action – Choices Project**

Offers confidential, impartial information and advice to those considering a return to their country of origin, that is, voluntary returns.

For further information contact the nearest office or see the website.

Tel:

London 020 7654 7719/8

Manchester 0161 233 1216/9

Leeds 0113 244 5345

Leicester 0116 261 4841/4846

[www.refugee-action.org.uk/ourwork/choices/](http://www.refugee-action.org.uk/ourwork/choices/)

**IOM (International Organisation for Migration)**

Offers help and advice to asylum seekers who wish to return home and provides information and research on migration and immigration issues.  
[www.iomlondon.org](http://www.iomlondon.org)

*Forensic*

**The Forensic Science Society**

[www.forensic-science-society.org.uk](http://www.forensic-science-society.org.uk)

**Revolving Doors Agency**

[www.revolving-doors.co.uk](http://www.revolving-doors.co.uk)

*Learning disabilities and learning difficulties*

**Care and treatment of offenders with learning disabilities**

Provides information on people with learning disabilities who have or are at risk of committing offences.  
[www.ldoffenders.co.uk](http://www.ldoffenders.co.uk)

**Estia Centre – Mental Health in Learning Disabilities Network (MHiLD Network)**

An email network for anyone interested in the mental health needs of people with a learning disability. It is free to join.  
[www.estiacentre.org](http://www.estiacentre.org)

**The UK Learning Disability and Health Network**

An email network open to anyone with an interest in the health needs of people with a learning disability. It is free to join.  
[www.learningdisabilities.org.uk/ldhn](http://www.learningdisabilities.org.uk/ldhn)

**Foundation for People with Learning Disabilities**

A national organisation that promotes the rights, quality of life and opportunities for people with a learning disability through research, development and policy work.  
[www.learningdisabilities.org.uk](http://www.learningdisabilities.org.uk)

**Nora Fry Research Centre**

[www.bristol.ac.uk/norafry](http://www.bristol.ac.uk/norafry)

**Tizard Centre**

Provides research and development in community care particularly in the area of learning disabilities and challenging behaviour.  
[www.kent.ac.uk/tizard](http://www.kent.ac.uk/tizard)

**National Attention Deficit Disorder Information and Support Service (ADDISS)**

Provides information and resources about Attention Deficit Hyperactivity Disorder (ADHD) to anyone who needs assistance – parents, sufferers, teachers or health professionals.

The ADDISS Resource Centre  
10 Station Road  
London  
NW7 2JU

Tel 020 8906 9068

Fax 020 8959 0727

Email [info@addiss.co.uk](mailto:info@addiss.co.uk)

[www.addiss.co.uk](http://www.addiss.co.uk)

**The National Autistic Society**

[www.nas.org.uk](http://www.nas.org.uk)

**Valuing People Support Team**

An English government agency that supports the implementation of 'valuing people'. Provides resources and good practice ideas, including those for the mental health needs of people with a learning disability.

[www.valuingpeople.gov.uk](http://www.valuingpeople.gov.uk)

