Transfer of Care at 17 (TC-17)
Executive Summary

An investigation of factors which influence two groups of young people facing transitional care at 17:
1. young people in local authority care (YPiC);
2. CAMHS users (CAMHSu)

Valerie Dunn, Matthew Owens, Mischa Gwaspari, Kelly Harris, Megan Ryan, Sonya Tsancheva, Ian Goodyer

Developmental Psychiatry Section
Dept of Psychiatry,
Douglas House
18b Trumpington Road
Cambridge CB2 8AH
Tel 01223 746053
vjd20@cam.ac.uk; mo344@medschl.cam.ac.uk; ig104@cam.ac.uk

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Background

Young people in care (YPiC) and young people using Child and Adolescent Mental Health Services (CAMHSu) not only face the usual demanding transitions of adolescence, they face major transitions in their care arrangements. YPiC face the move out of the care system to independent living and CAMHSu face discharge, transfer to another service or transition to Adult Mental Health Services (AMHS). What little evidence there is suggests poor outcomes in both groups in terms of future mental health problems, educational achievement and employment prospects.

Objectives

The primary aim of this pilot study was to inform a planned longitudinal phase in which young people from each group will be followed through the transitional period for 12 months. The aims of the pilot study are both procedural, to pilot the methodology, and investigative in their own right, to examine and describe possible factors which may have an influence on successful transitions. We were specifically interested in mental health as both outcome and influence.

Design & Measures

A standard cross-sectional design was adopted in which participants were interviewed by trained researchers. Interviews established lifetime and current psychiatric diagnoses and service use. Computerised self-report questionnaires assessed current psychological distress, barriers to service use and personality. Standard IQ sub-tests estimated performance and verbal IQ. Participants were asked permission to be contacted in the future with a view to participating in the longitudinal phase of the study.

The Sample

YPiC were recruited via Cambridgeshire County Council and Peterborough City Council. Those eligible were approached by social workers at routine appointments. The CAMHSu group was recruited via Cambridge and Peterborough Foundation Trust (CPFT). Eligible participants were approached by treating clinicians at routine appointments and aged 16.5 – 17 years.

Results

A total of 27 YPiC and 26 CAMHSu participated. YPiC participants had done poorly in school, were more likely to have been arrested and to be classified as NEET at entry into the study. GCSE results in the CAMHSu group were in line with national and regional figures and half were engaged in academic study. Estimated verbal IQ was significantly lower in the YPiC group which may be associated with disruption in education.

All CAMHSu and approaching 75% of YPiC reached criteria for a lifetime psychiatric diagnosis. Most disorders were chronic and impairing. The groups presented distinct diagnostic profiles: CAMHSu depression (69%), anxiety disorders (50%) and eating disorders (35%); YPiC behaviour disorders (48%) and alcohol/substance use disorders (41%) although a third had also been depressed. YPiC reported very little anxiety and there were no cases of conduct disorder in the CAMHSu group. Comorbidity was high and comparable in both groups. All young males in the YPiC group met criteria for diagnosis at some time in their lives compared to 53% (8) of the YPiC

females. Psychotic-like symptoms were recorded in 42% of the CAMHSu and 46% of the YPiC group. Lifetime non-suicidal self injury was recorded in 46% of YPiC and 62% of CAMHSu and suicide attempts in 35% and 23% respectively. As they prepare to face the imminent care transition, over half (52%) the YPiC and three quarters (77%) of CAMHSu participants still met diagnostic criteria and reported high levels of psychological distress.

Lifetime service use was high in both groups but non-compliance (with at least one referral) was higher among YPiC participants than CAMHSu (84% vs 16%, p<.001). In the YPiC group 69% had been referred to mental health clinics. No CAMHSu participants had been referred to the Youth Offending Service compared to 41% in the YPiC group. More than one third of young people in each group reported receiving counselling at school or turning to a 'special' teacher for informal support. Barriers to service take-up include fear, lack of trust and poor insight.

In the YPiC group, over half (52%) entered care as adolescents (over 13). YPiC participants cited relationships with social workers, foster carers and other staff as being of central importance to life in care.

Transition decisions had been made for 20 YPiC and 16 CAMHSu. Fourteen YPiC were due to move to independent living, of whom 10 currently met clinical criteria for diagnosis. Five young people were remaining in current stable foster placements while continuing their education. In the CAMHSu group six participants were due to be discharged, four of whom reached current threshold for diagnosis. Two were being specifically referred to GP care, one to the adolescent and drug service, five to adult mental health services and five young people reported a gradual reduction in appointments over the coming months in preparation for discharge. All YPiC and 62% of CAMHSu participants were happy with the transition decision and felt they had been given ample opportunity to ask questions.

Conclusions

Our findings suggest that the transitions in both groups may be compromised by persisting poor mental health. This is further complicated in the YPiC group by a greater lack of insight into their mental health needs and, possibly as a consequence, a higher rate of non-compliance with service use. The high prevalence of psychotic like symptoms in both groups is unexpected and requires further evaluation as the bearing of these symptoms on future well-being is unknown. It is unclear whether these psychotic-like symptoms were detected by the services.

Improving the mental health and related impairments of young people before they face transition or putting in place a system which ensures continuity of care for persisting mental health difficulties, may enable more young people to make positive transitions. The managerial separation of CAMHS services into tiers whereby NHS services broadly take responsibility for tier 3 and 4 severe mental illness and local authorities broadly for tier 1 and 2 mild to moderate behavioural disorders is client insensitive. The current organization is itself a barrier to correct service provision for mentally ill adolescents with social care needs and for the social care adolescents with mental health needs.