

TRANSITIONS AUDIT REPORT
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This report provides an overview of 92 individuals' journey from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). This report was drafted using data collected in an audit evaluation of Carenotes, in order to further understand how young people in Sussex transition between services, and to inform the development of the new 16-25 pathway. It should be noted that this information does become out of date and should be used as a guide only.

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CONTENTS

1. Introduction	3
2. Purpose of the audit	3
3. Summary	4
4. Methodology – Data and sample information.....	4
Ethics.....	4
Final sample.....	4
Data collection	5
5. Demographic Information	5
6. Results.....	6
6.1 - Symptoms	6
6.2 - Diagnoses	7
6.3 - Trauma.....	8
6.4 - Interventions	10
6.5 - Multi-Agency involvement.....	11
6.6 - Time spent in between CAMHS and AMHS	12
6.7 - Length and strength of engagement.....	13
7 Group related findings.....	15
7.1 Gender	15
7.2 Looked after children (LAC).....	16
7.3 Neurodivergence.....	18
8. Discussion.....	19
9. Limitations	22
10. Procedural improvements or recommendations.....	24
11. Dissemination and Next Steps	25
12. Supplementary materials.....	26
13. Academic References.....	28

1. INTRODUCTION

Child and Adolescent Mental Health Services (CAMHS) were developed out of the Family Guidance Clinics of the 1950s. The service specifications had an upper age limit of 18 years to mirror the education system and reflect what was then considered to be the end of adolescence and the beginning of adulthood. In more recent times, it has been argued that young people are reaching full adulthood at a later age e.g., 25 years. Therefore, previous service models for CAMHS and AMHS (Adult Mental Health Services) may no longer be fit for purpose. The gap between CAMHS and AMHS may represent a cliff edge for some young people who frequently report negative experience of traversing the gap (Singh et al, 2008). Research has consistently highlighted that young people aged between 16-25 are in a particularly pivotal period, in which the onset of mental health issues and an increase in severity is often seen (Kessler et al, 2005). There are number of possible explanations for this. Neurological and physiological changes occur at the time of late adolescence. Young people also regularly experience several life changes and transitions during this period (moving out of home, living independently etc.) (Remschmidt, 2013). Further, young people often transition out of mental health services (e.g., CAMHS) at the age of 18. This reduction in support that may have been fundamental to their psychological wellbeing up until transition, may increase the risk of many young people developing additional or more severe mental health issues.

2. PURPOSE OF THE AUDIT

Many young people who are referred to CAMHS and reach threshold receive an intervention and are then discharged and stepped back down to Primary Care prior to their 18th birthday. This means they do not make transition between CAMHS and AMHS services. Some young people are referred from CAMHS to AMHS and are said to 'graduate' between services, where their care transfers and they continue to receive mental health support. This audit focuses on a cohort of young people between January 2018 and January 2019 who were discharged from CAMHS and were not referred directly to AHMS but were referred to AMHS within a 3-year period after their CAMHS discharge. We looked at demographics, diagnoses, engagement, and follow-up post-discharge from CAMHS to determine after what time period they were re-referred to services (AMHS), and why. It is envisaged that the audit output will help us better understand where the current system is working and where it may need developing in order to ensure those young people who are discharged from CAMHS at 18 years are managed effectively, safely, and have a positive experience. The purpose of this audit was to build a picture of the service users who were referred into AMHS after being discharged from CAMHS within a period of three years.

3. SUMMARY

Patterns were identified in the sample across various variables, including symptoms, diagnoses, traumatic life experiences, in-patient admissions, psychological & medical interventions, and multi-agency involvement. The majority of the service users were White-British, 21 years of age, and had more than one mental health diagnosis. Anxiety and depression were the most common conditions. Sixty-four percent of the sample also had neurodevelopmental conditions, and 23% of the sample were care leavers, henceforth referred to as the Looked After Children (LAC) group. The average number of mental health symptoms was lowest at CAMHS discharge. While much of the sample presented to AMHS with no new symptoms, they each met the threshold for AMHS involvement, which is typically more stringent than the threshold for CAMHS (Birchwood & Singh, 2013).

Additionally, data was captured regarding accounts of trauma, in-patient admissions and interventions offered. This was explored in detail for different groups of service users: LAC young people, neurodivergent young people, individuals with diagnostic comorbidity, and gender. Patterns emerged within the groups regarding symptomology at different time points (at CAMHS referral, discharge, and AMHS referral), diagnoses, traumas, interventions, and multi-agency involvement. We report trends observed across the cohort alongside case studies, which provide examples of some common journeys within this sample of young people.

This audit aligns with research indicating that the age of transition is a changeable and volatile period for young peoples' mental health. The purpose of the audit was to inform and provide justification for the development of further community support for young people aged 16-25. Additional mental health support at this stage will help to bridge the gap in support young people experience when they reach the end of formal education.

4. METHODOLOGY – DATA AND SAMPLE INFORMATION

ETHICS

This exercise was conducted as a clinical audit of services within CAMHS focusing on the time of transition, consequently, ethical approval was not required. Two researchers reviewed Sussex Partnership NHS Foundation Trust (SPFT) Carenotes to extract data relevant to the audit.

FINAL SAMPLE

The participants for this audit were selected from a larger data set of 322 anonymised participants who were discharged from CAMHS between January 2018 and January 2019 and were referred to AHMS within a period of up to three years without mental health support. The

full sample was not analysed due to time constraints, resulting in a final sample of 92 service-users. The sample was ordered chronologically, in order of unique identifying numbers (CIS numbers), with individuals who had received support from CAMHS at a younger age placed first. The first 58 individuals we audited were the young people with the longest CAMHS involvement. To diversify the length of CAMHS involvement within the sample, the other 35 young people were selected in groups of 10, at intervals of 50. The demographic details of the sample are provided below.

DATA COLLECTION

Our intention throughout this audit was to capture meaningful and rich data; data that told a story about each person's journey throughout mental health services and their transitions between them. We, the research assistants collecting data, were bound by Trust research and audit convention around ensuring all patient data was kept securely, confidentially and that data presented was anonymous and not identifiable.

A combination of quantitative and qualitative data collection methods were employed. Some of the key variables included: *presenting issues/symptoms at CAMHS referral, CAMHS discharge and AMHS referral; accounts of traumatic life events; in-patient admissions; mental health diagnoses and physical health conditions; length and strength of engagement with mental health services; interventions offered; referral and discharge dates and other service involvement*. Data was collected by examining referral letters, correspondences, notes, and appointments on Carenotes (Sussex Partnership NHS Foundation Trust's (SPFT) electronic health record system). The variables were then coded and quantitatively analysed.

In addition, qualitative case studies are embedded throughout this report. This includes the thoughts and comments of both clinicians and the young service users. helping to individualise and contextualise the data. This addition also aimed to mitigate some of the difficulties with drawing out consistent, usable quantitative data from Carenotes, which is reliant on open methods of reporting and can vary dependent on the practitioner.

5. DEMOGRAPHIC INFORMATION

Table 1. presents demographic information for the 92 service-users that make up the audit sample. The majority were White-British and were aged 21. Within the sample, there were similar numbers of males and females.

		Number	Percentage
Gender	Male	43	47%
	Female	47	51%
	Not Specified	2	2%
Age	20	13	14%
	21	67	73%
	22	11	12%
	25	1	1%
Religion	No Information	66	72%
	Christian	13	14%
	Atheist	10	11%
	Prefer Not To Say	3	3%
Ethnicity	White - British	74	81%
	Mixed Ethnicity	5	5%
	Black - Any	1	1%
	White - Any	4	4%
	Not Stated	8	9%
LAC	Yes	21	23%
	No	71	77%
Physical disability	Yes	21	23%
	No	71	77%

Table 1. Frequency and Percentages for Gender, Age, Religion, Ethnicity, LAC, and Physical Disability

6. RESULTS

The following section will present key findings for the following variables: presentation of symptoms at each stage of the individuals' involvement with mental health services; diagnoses prevalence and comorbidity; the number and type of traumatic life experiences recorded; the psychological and medical interventions offered during CAMHS treatment; multi-agency involvement (including in-patient admissions during CAMHS and AMHS) and the length and strength of CAMHS engagement.

6.1 - SYMPTOMS

The number and type of presenting mental health issues were recorded at CAMHS referral, CAMHS discharge, and AMHS referral. These included: *low mood, anxiety, mood instability, OCD, disordered eating, low self-esteem, impulsivity, ADHD, ASC, developmental issues, learning disabilities, hearing voices, substance misuse, suicidal ideation, suicide attempt, self-harm, relational difficulties, social isolation, aggression, anger, inappropriate sexual behaviour, flashbacks, sleeping difficulties and 'other' symptoms.*

Overall, service users had the highest number of symptoms at CAMHS referral ($M = 5.55$), followed by AMHS referral ($M = 4.23$), with CAMHS discharge having the fewest symptoms ($M = 3.13$). This indicates service users experienced an improvement in their mental health after receiving support from CAMHS but experienced more symptoms after a period without formal mental health support.

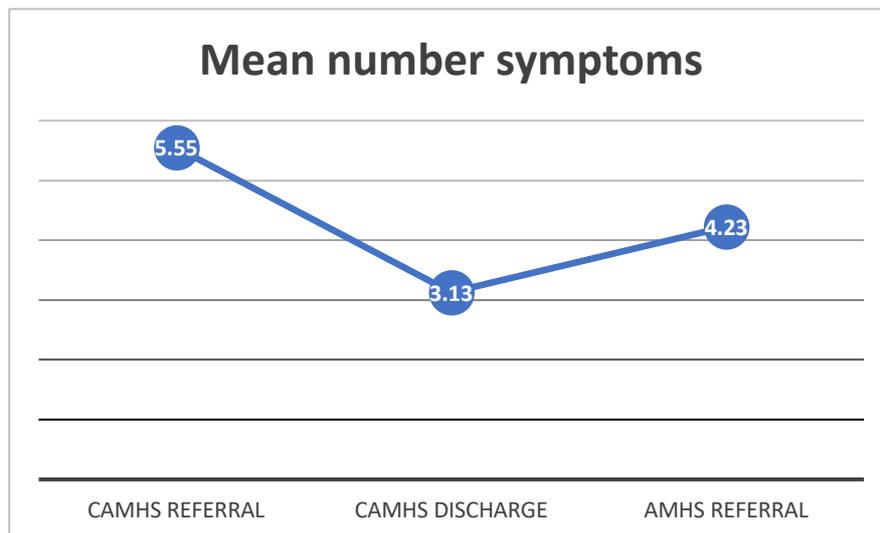


Figure 1. Mean Number Symptoms at CAMHS-r, CAMHS-d, AMHS-r

We examined the number of individuals whose mental health presentation appeared to change between CAMHS discharge and AMHS referral. Change in this context was assessed by the presence of two or more new symptoms at AMHS referral. Overall, 43.5% of the sample presented to AMHS with symptoms which had previously been treated by CAMHS. 56.5% of the sample had a change in presentation (two or more new symptoms) at AMHS referral.

Compared to the rest of the sample, the 56.5% of service users who had a change in presentation were significantly more likely than the rest of the sample to have a greater number of symptoms at a) AMHS referral ($M_{\text{symptom change}} = 5.57$; $M_{\text{rest of the sample}} = 2.61$; $t(82) = 4.67$; $p = .001$) and, b) CAMHS referral ($M_{\text{symptom change}} = 6.22$; $M_{\text{rest of the sample}} = 4.66$; $t(87) = 2.45$; $p = .02$). However there was no significant difference in number of symptoms between the two groups at CAMHS discharge ($M_{\text{symptom change}} = 3.57$; $M_{\text{rest of the sample}} = 2.55$; $t(87) = 1.91$; $p = .054$). This appears to highlight a subset of the sample with highly complex, enduring and varied mental health issues upon referral to mental health services, but who do well with on-going support.

6.2 - DIAGNOSES

The number and type of diagnoses of service users within the sample was explored. Seventy-eight percent had two or more conditions, anxiety and depression were the most

prevalent diagnoses and 64% of the sample were neurodivergent. Of the neurodivergent sample, 59% also had a diagnosis of either depression or anxiety (see *figure 2*). Different groups within the sample (including the neurodivergent group) and their specific needs are explored later in this report (see page 18).

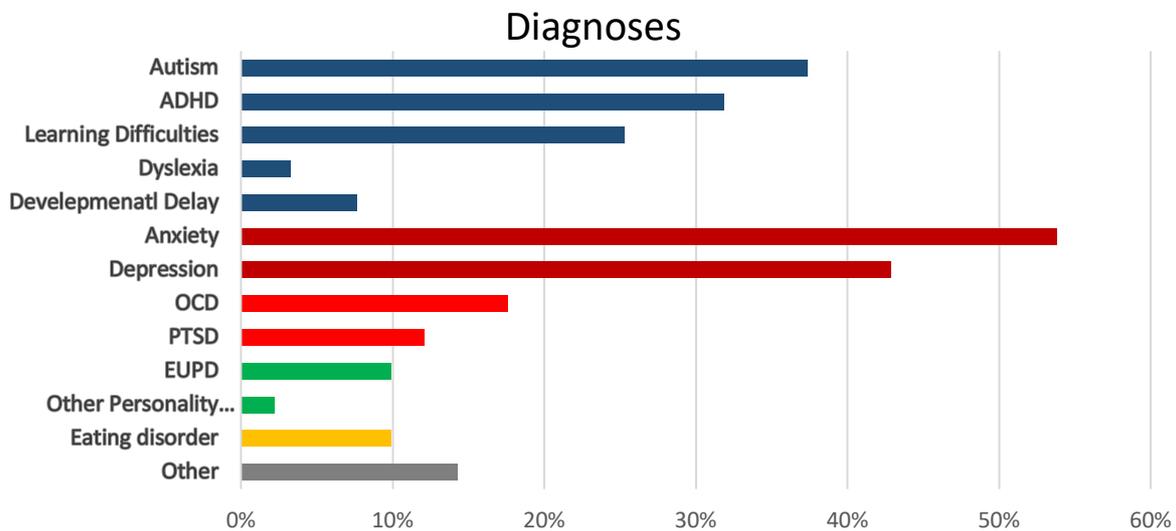


Figure 2. Percentage of the sample with different diagnoses

6.3 - TRAUMA

Accounts of trauma were recorded in this audit, including physical, psychological, and sexual abuse, neglect, bullying, bereavements, and other traumas. 'Other traumas' referred to any life event the service user or clinician described as 'traumatic', including, parental divorce and witnessing domestic abuse. When there was no evidence of any traumatic experiences in the Carenotes entries, individuals were marked as having 'no information' (*figure 3*). All trauma figures are approximations and are likely to be underestimated; service users are unlikely to disclose all accounts of trauma, and some accounts of trauma may not have been recorded on Carenotes.

Bullying was the most frequently recorded trauma (22.8%), followed by other traumatic experiences (16.3%), and accounts of sexual abuse (13%). There was no significant correlation between trauma experiences and the number of symptoms at CAMHS referral, CAMHS discharge and AMHS referral. Specific traumas and number of trauma experiences by group are explored later in the report (see page 9)

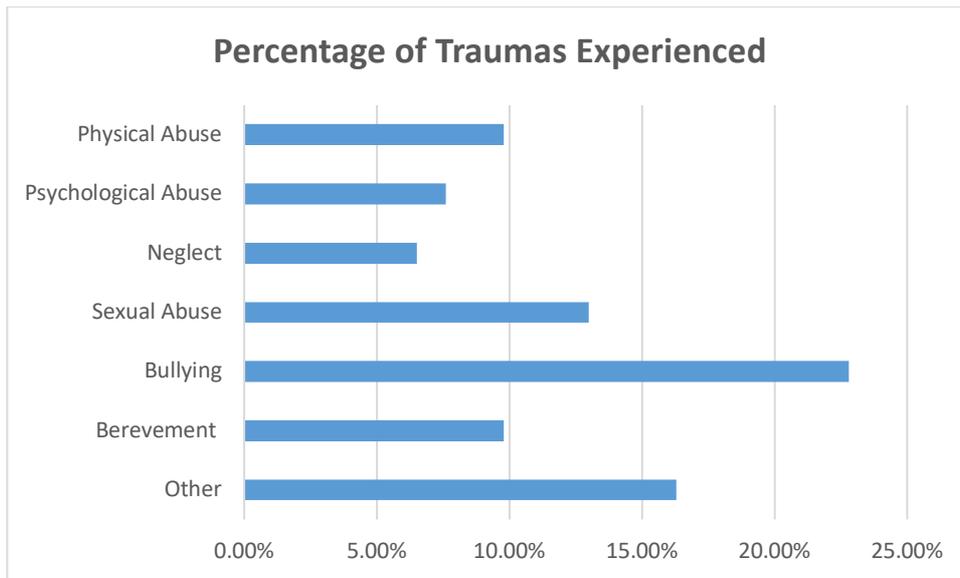


Figure 3. Percentage of Recorded Traumatic Life Experiences

Comorbidity and trauma

Seventy-eight percent of the sample had more than one diagnosis; this high proportion of comorbidity warranted further group level analyses. Within this group, 26% had two diagnoses, 24% had three, 15% had 4, and 13% had 5-8 diagnoses (see figure 4 for percentage of each diagnoses). Considering the impact of trauma on the mental health of young people, we examined comorbidity in the service users who reported experiencing trauma. Within the comorbidity group, 58.9% had one or more traumas. An independent samples t-test found that individuals with diagnostic comorbidity had significantly more recorded traumatic life events than the non-comorbid group ($M_{\text{comorbid}} = .99$; $M_{\text{one condition}} = .37$; $t(90) = -2.46, p = .02$).

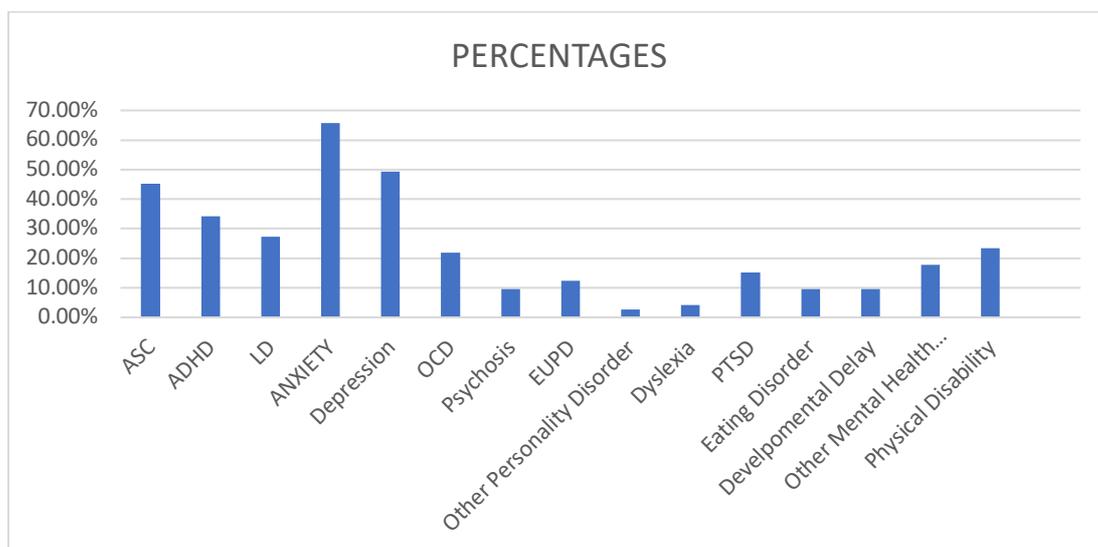


Figure 4. Percentages of Diagnoses for Comorbidity Group

6.4 - INTERVENTIONS

Data was collected detailing the therapeutic interventions individuals were offered (see *figure 5*). Medication was the most frequently prescribed intervention (70.7%). 14.1% of the sample received only medication and did not receive any other form of intervention (e.g., psychological therapies). Of the psychological interventions offered, other talking therapies were most common (38%), which refers to interventions such as counselling and psychotherapy, followed by family therapy (23.9%).

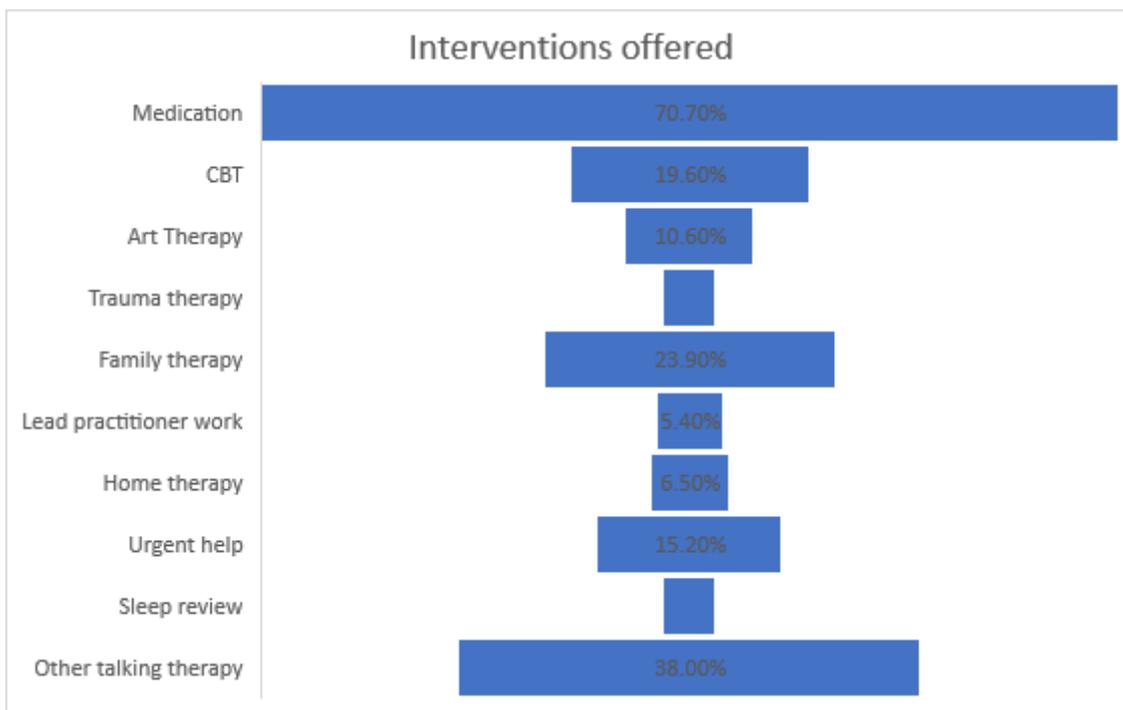


Figure 5. Percentage of Interventions Offered

Medication-only

Using the data regarding therapeutic interventions offered during CAMHS, we found 14.1% of the sample received only medication-based interventions, without being offered psychological therapies. This subsection of the sample was identified as the 'medication only' group. A chi-square analysis revealed that individuals who received only medication were significantly more likely to have comorbid mental health diagnoses. Further, individuals with ADHD or anxiety were significantly more likely to only be offered medication over any other diagnosis (See [table 4](#) in the supplementary materials section for these figures).

CASE STUDY

'Maya' was referred to CAMHS aged eight and later received a diagnosis of ADHD, for which she received medication only as an intervention. During her time in CAMHS, she was admitted into an in-patient unit, having struggled with anxiety, low mood, mood instability, hearing voices, anger, aggression, flashbacks and, ultimately, attempting suicide. She reported various accounts of trauma as a child, including psychological abuse, sexual abuse and bereavement. At the age of 17, she was discharged from CAMHS, after deciding to stop taking her ADHD medication. At discharge, she was dealing with the same mental health issues, with the addition of relational difficulties. Maya's mother expressed written concerns over her daughter's upcoming discharge from CAMHS and what service would be available to support Maya as a young adult. After 53 months, aged 21, Maya was referred to AMHS. Here she presented with similar symptoms of low mood, mood instability, impulsivity, substance misuse and suicidal ideation.

6.5 - MULTI-AGENCY INVOLVEMENT

A record was taken as to whether individuals had either in-patient admissions during CAMHS, AMHS, or during both CAMHS and AMHS (*figure 6.*). Sixty-seven percent of the sample didn't have an in-patient admission. Of the 33% who had an in-patient admission, they had significantly higher levels of EUPD, Psychosis, and PTSD diagnoses compared with those who had not had an in-patient admission (*See [table 5](#) in the supplementary materials section for these statistical figures*).

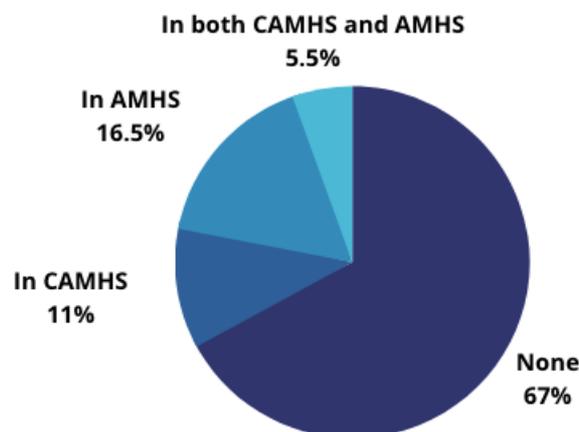


Figure 6. Percentage of In-patient Admissions

Data was also collected regarding non-NHS statutory and non-statutory services that were involved in the care of the service users. Sixty-nine percent of individuals had one or more other services involved in their care (*see figure 7*). Other services included Health in

Mind¹, Social Care (Local Authority), SWIFT (Family therapy), Police, Education support, voluntary and community support, Time to Talk². Services in the 'voluntary sector' included OK³, Mind the gap⁴, Allsorts⁵, GIDS⁶, YMCA⁷, Coastal Care⁸, Find it out⁹, Venture People¹⁰ and STAR¹¹.

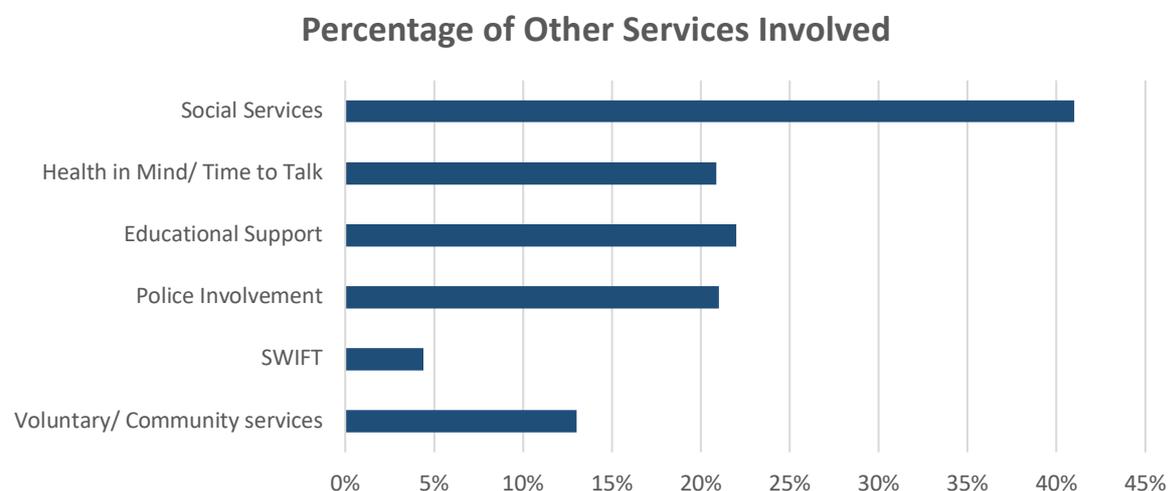


Figure 7. Percentage of Multi-Agency Involvement

6.6 - TIME SPENT IN BETWEEN CAMHS AND AMHS

The time service users spent between CAMHS and AMHS without any mental health support was calculated using referral and discharge dates. *Figure 8.* shows most of the sample (58%) were referred to AMHS between 7 and 36 months after CAMHS discharge, which can perhaps be viewed as a 'critical period' for transitions. After the 36-month mark, the probability of a service user being referred to AMHS reduced. Only 9% of the sample were referred in

¹ Health in Mind is a free NHS IAPT service available to adults living in the East Sussex area, experiencing emotional or psychological difficulties such as stress, anxiety and depression.

² Time to Talk provide NHS talking therapies in West Sussex.

³ RUOK offers support and information to young people under 18, about drugs, alcohol and sexual health.

⁴ Mind The Gap offers community wellbeing support to children and young people who are struggling to find or engage with the right services to support them.

⁵ Allsorts youth project supports children and young people under the age of 26 in the LGBTQ+ community.

⁶ The Gender Identity Development Service (GIDS) is for children and young people, and their families, who experience difficulties in the development of their gender identity.

⁷ Sussex Central YMCA is a register charity offering a range of services for children, young people and families in Sussex, including housing, youth and family support, sport, counselling and advice.

⁸ Coastal Homecare provides Home Care, Social Care and Personal Care services throughout West Sussex, Mid Sussex, East Sussex & Brighton and Hove.

⁹ Find It Out is a service that helps young people in West Sussex find local services, make referrals and talk about their mental health needs.

¹⁰ Venture People support adults experiencing and recovering from mental health issues.

¹¹ STAR is a drug and alcohol service in East Sussex.

AMHS after the 36-month mark. Twenty-one percent of the sample had an overlap between CAMHS and AMHS services.

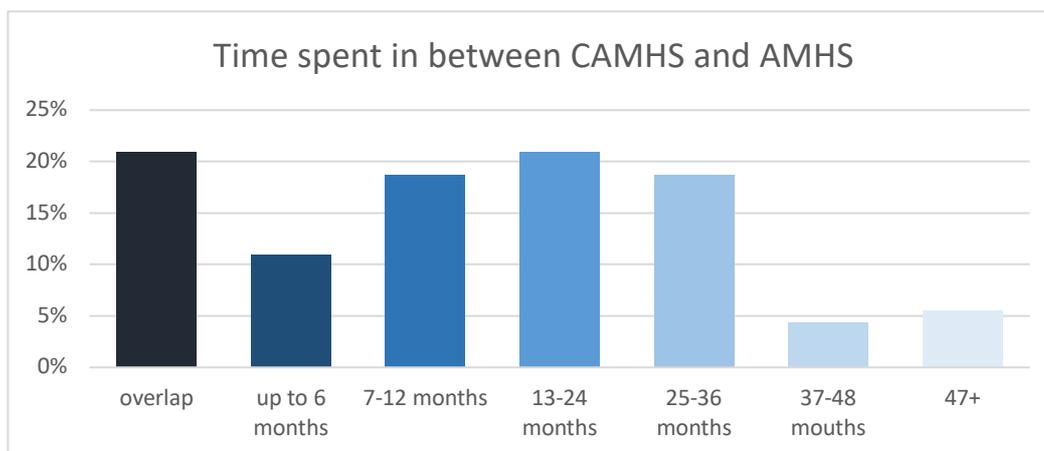


Figure 8. Time in Months Spent in Between CAMHS and AMHS

6.7 - LENGTH AND STRENGTH OF ENGAGEMENT

The length of service user's engagement was measured in two ways. First, by recording the number of therapeutic sessions a service user had during CAMHS, where length of engagement was categorized as 'short' (less than 8 sessions), 'medium' (8-15 sessions), 'long' (more than 15 sessions), or 'no information'. Second, by calculating the number of months service users spent under the care of CAMHS.

To measure the strength of engagement within the sample, individuals were given one of four ratings during the audit ('good', 'moderate', 'poor', or 'no information') for their engagement with CAMHS and other services at each CAMHS referral, CAMHS discharge, AMHS referral. These ratings were based on clinicians' written opinion in notes and correspondences, as well as gathered from the number of attended vs non attended appointments service-users made. Table 2. presents the frequencies and percentages of length and strength of engagement within the sample. The variables pertaining to length and strength of engagement during CAMHS were then used in subsequent statistical analyses to examine whether engagement predicted amount of time spent between CAMHS and AMHS or the number of symptoms at different time points.

		Number	Percentage
Length of Engagement			
	Short	17	18.50%
	Medium	16	17.40%
	Long	59	64.10%
Strength of Engagement at CAMHS referral			
	Poor	7	7.60%
	Moderate	21	22.80%
	Good	48	52.20%
Strength of Engagement at CAMHS discharge			
	Poor	19	20.70%
	Moderate	19	20.70%
	Good	34	37%
Strength of Engagement at AMHS referral			
	Poor	14	15.20%
	Moderate	11	12%
	Good	29	31.50%

Table 2. Frequency and Percentages for Length of Engagement and Strength of Engagement

A regression analysis was conducted to determine whether strength of engagement and length of engagement predicted the amount of time service users spent in-between CAMHS and AMHS without any mental health support. The regression model was significant ($R^2 = .14$, $F(2, 50) = 3.98$, $p = .03$). The results indicated that strength of engagement was a significant predictor of time spent in-between CAMHS and AMHS, where every unit change in strength of engagement, ten less months were spent in between CAMHS and AMHS ($\beta = -10.03$, $p = .01$). This means, service users who engaged better with services tended to spend less time in between services after CAMHS discharge. The length of engagement, however, was not a significant predictor of time in-between services ($\beta = .04$, $p = .47$).

We also examined whether length and strength of engagement during CAMHS would predict service users' number of symptoms at CAMHS referral, CAMHS discharge, and AMHS referral. The regression model for CAMHS referral was significant ($F(2, 48) = 3.58$, $p = .04$, $R^2 = .13$). However, individually, strength of engagement ($\beta = 1.03$, $p = .06$) and length of engagement ($\beta = .02$, $p = .06$) were not significant predictors of symptoms at CAMHS referral. The model suggests that service users who had a greater number of symptoms at CAMHS referral had stronger and longer engagement with CAMHS.

The regression model for CAMHS discharge was not significant ($F(2, 49) = 3.06, p = .06, R^2 = .11$). The results indicate that strength of engagement ($\beta = .58, p = .29$) was not a significant predictor but length of engagement was a significant predictor of symptoms at CAMHS discharge ($\beta = .02, p = .03$). This suggests that service users who engaged with CAMHS for a longer period had fewer symptoms at discharge.

The regression model for AMHS referral was not significant ($F(2, 45) = .72, p = .49, R^2 = .03$). The results indicate that strength of engagement ($\beta = .63, p = .41$) and length of engagement ($\beta = .01, p = .39$) were not significant predictors of number of symptoms at AMHS referral. Therefore, length and strength of engagement during CAMHS did not predict number of symptoms at AMHS referral.

7 GROUP RELATED FINDINGS

7.1 GENDER

The sample consisted of 43 males and 47 females. Compared to females, more males were Looked After Children (LAC) (30% male, 16% female) and received medication only, with no additional psychological therapies (19% male; 9% female). However, more females received in-patient admissions (40% female, 28% male).

Males and females did not significantly differ in the number of diagnoses they were given. However, males were significantly more likely to be diagnosed with a neurodevelopmental condition. A further exploration suggested that ADHD was the only neurodevelopmental condition where males were more likely to receive a diagnosis. Alternatively, female service users were significantly more likely to have PTSD than male service users (See [table 6](#) in the supplementary materials section for the chi-square test figures).

In addition, some gender differences relating to symptomology were found. At CAMHS referral, females were more likely to present with anxiety and/or self-harm. While male service users were more likely to present with school refusal and/or aggression. See [figure 9](#) for further information.

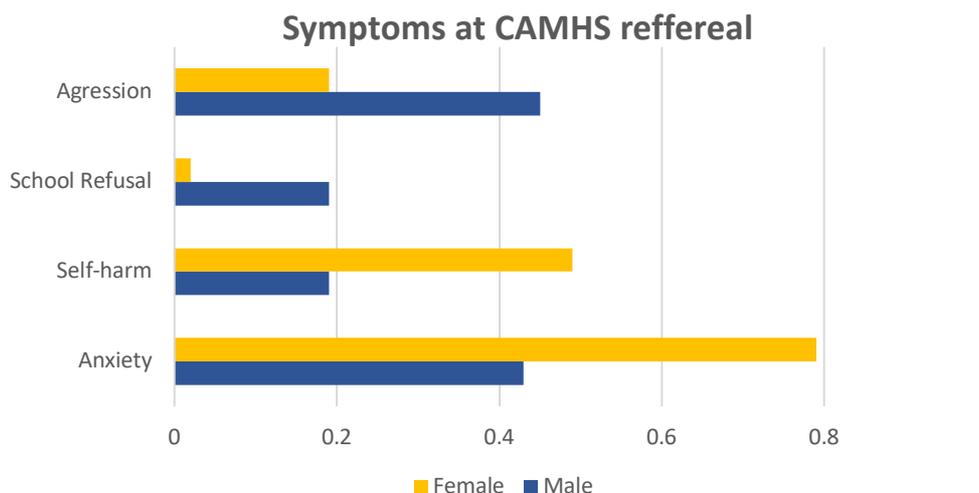


Figure 9. Percentage Symptoms at CAMHS Referral

At CAMHS discharge, female service users were significantly more likely to present with low mood (See [table 6](#) in the supplementary materials section for the chi-square test figures). No significant differences were found in the diagnoses of males and females at AMHS referral.

7.2 LOOKED AFTER CHILDREN (LAC)

Looked After Children (LAC) made up 23% of the sample. The high proportion of LAC individuals were identified as a key subgroup within the sample. Within this group, 76.2% had more than one mental health diagnosis, suggesting that comorbidity was high for LAC individuals. Certain diagnoses appeared to be more prevalent within this group than the rest of the sample. For example, findings indicated that both an emotionally unstable personality disorder (EUPD) and developmental delays were significantly higher in LAC individuals. However, OCD diagnoses were significantly lower in LAC individuals than in the rest of the sample.

Additionally, symptomology for LAC vs non-LAC individuals was explored at CAMHS referral, CAMHS discharge, and AMHS referral. At CAMHS referral, LAC individuals had a significantly higher percentage of inappropriate sexual behaviour recorded than the rest of the sample. At CAMHS discharge, LAC service users had a significantly higher percentage of mood instability, social isolation, anger and aggression compared with non-LAC service users. Finally, at AMHS referral, significantly more LAC individuals were hearing voices than the non-LAC group (See [table 7](#) in the supplementary materials section for the chi-square test figures). These findings illustrate changes in the mental health presentation of the LAC group over time, which can differ compared with young people who had not been in care. Of note was the

development of hearing voices after CAMHS discharge. Further, 61.9% of the LAC group had one or more trauma, which may explain some of the patterns in symptomology for this group and could emphasise the importance of taking a trauma-informed approach.

Multi-service involvement was common for the LAC group (see *figure 9*). Typically, the LAC group had increased service involvement in nearly all areas of service provision, most notably, an increase of police involvement, social workers, and the voluntary sector. An independent samples t-test indicated that overall multi-service involvement was significantly higher in the LAC group, in comparison to the non-LAC group ($M_{LAC} = 1.32$; $M_{Non-LAC} = 2$; $t(87) = -2.15$, $p = .04$).

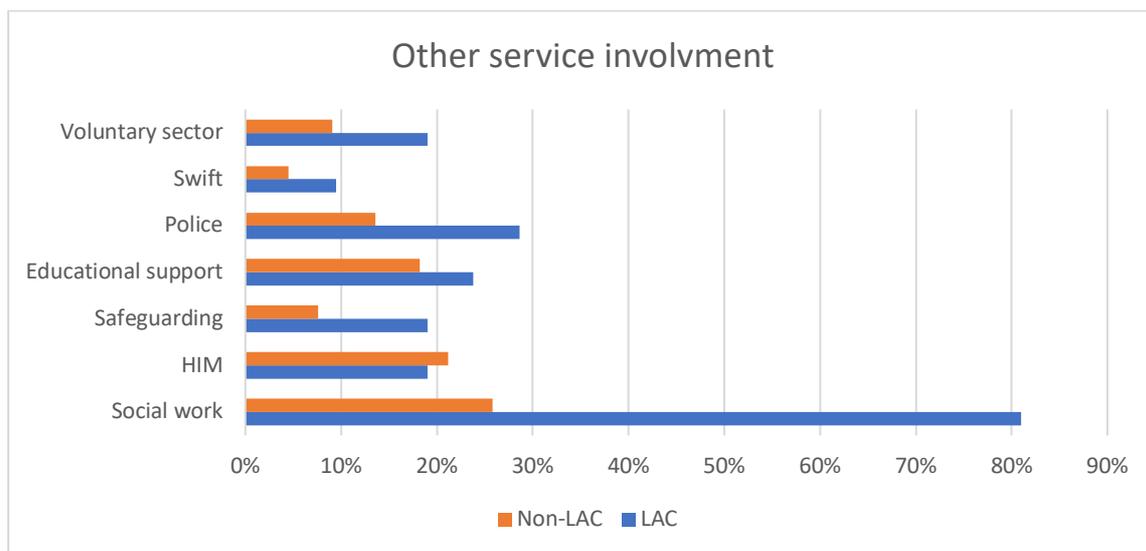


Figure 9. Percentage of Other Agency Involvement for Looked After Children (LAC) versus non-Looked After Children (non-LAC)

CASE STUDY

'Gemma' received support from CAMHS from the age of nine. She was a 'Looked After Child' and was known to children's services and CAMHS from an early age. In CAMHS, she reported multiple accounts of complex and enduring childhood traumas. She struggled with anxiety and mood instability, suicidal thoughts and self-harm. She was offered medication, CBT and counselling. At the beginning, she engaged well with support, but as she approached 18, her engagement deteriorated. Her anxiety improved, and she had stopped self-harming. However, she was still low in mood, had begun to misuse substances and experience hearing voices. After discharge from CAMHS, over the course of six months, her self-harming increased, and she attended A&E on multiple occasions. Her mental health continued to decline over the rest of the year, and she was referred to AMHS after a suicide attempt. Later, she was diagnosed with Emotionally Unstable Personality Disorder. Despite involvement with a range of services (adult social care, SWIFT, pastoral care) as well as having received varied and extensive therapeutic support in CAMHS, her mental health deteriorated while she did not have support of mental health services between the ages of 17 to 18.

7.3 NEURODIVERGENCE

More than half of the sample were diagnosed with a neurodevelopmental condition, with 64% diagnosed as having ASC, ADHD and/or Dyslexia. In order to understand young people's transitions out of CAMHS within the context of neurodivergence, the following findings explored the mental health journey of this group.

Within the neurodivergent group (ND), 17% were diagnosed with a neurodevelopmental condition and had no other mental health conditions; whereas 18.6% had two diagnoses, 23.7% had three, and 40.7% had four or more. This indicates a high prevalence of diagnostic comorbidity within the ND group. Additionally, ND individuals were significantly more likely to have spent a longer time in CAMHS compared to NT individuals, with referrals occurring at an earlier age ($M_{ND} = 106$ months; $M_{Rest\ of\ the\ sample} = 49$ months; $t(90) = -6.27, p = .001$). For an in-depth comparison of diagnoses, symptoms and multi-service involvement for the ND group and the rest of the sample (see Table 3 for the statistically significant findings).

Regarding multi-agency involvement, ND individuals had a high percentage of multi-service involvement, with 79.7% having 1 or more additional services involved in their care. Forty-seven percent of the ND group had no recorded traumas, 31% had one, and 22% had two or more. Twenty-nine percent of the ND group were also LAC children.

For an in-depth breakdown of diagnosis, symptoms and multi-service involvement comparing the neurodivergent and non-neurodivergent group see [Table 3](#) in the *supplementary materials section*. This presents all significant findings relating to the neurodivergent group.

CASE STUDY

'Josh' is a young man who was referred to CAMHS at the age of nine. He was diagnosed with dyslexia and asthma and was referred for his anxiety and OCD rituals. He also presented with low mood, self-esteem issues, impulsivity and suicidal ideation. He was identified as suitable for CBT and medication. However, he received only medication and care planning. He engaged moderately well with services and at 18 years old was transitioned to Health in Mind for CBT.

Twenty-six months after discharge he was referred to AMHS, aged 20, for both an ADHD and ASC assessment. He also presented with anxiety, OCD rituals, relational difficulties, aggression, and inappropriate sexual behaviour. Other services involved in his care were social services, Health in Mind, the Police, SENCO.

CASE STUDY

'Michael', a 21-year-old male, was referred into CAMHS aged 17 for his persistent low mood and suicidal thoughts. Until the age of 18, he received some family therapy and counselling sessions within CAMHS. This psychological support helped him manage his depression and he was discharged from CAMHS feeling more positive. Two years later, at the age of 20, he was referred into AMHS during a depressive period, and it was here where he was referred to the adult neuro-developmental service. Later, he received a diagnosis of ADHD.

8. DISCUSSION

This audit was carried out with the intention to better understand the transitional journey of service users after leaving CAMHS at age 18 but who are later referred to AMHS after a period without mental health support. Data was collected for 92 young people who were discharged from CAMHS between January 2018 and January 2019 and who were then referred to AMHS within a period of three years. This sample was described in relation to their demographics, symptoms, diagnosis, interventions, trauma background, multi-service involvement, engagement with services, and time spent in between services. Additionally, group related differences were investigated based on gender, neurodivergence and LAC status.

There were high levels of comorbidity where the most common mental health diagnoses were anxiety and depression. Large proportions of the sample were also diagnosed with neurodevelopmental (ND) conditions and had been Looked After Children (LAC). Significant differences were found in relation to prevalence of certain conditions and presentations in males and females, those diagnosed ND and non-diagnosed ND, and those who were LAC and non-LAC. The findings suggested that those with EUPD, PTSD, and psychosis are more likely to have in-patient admissions. Overall, these findings give us a better understanding of how different groups of service users may present on referral to CAMHS and AMHS, and what their needs may be at discharge.

The journey from CAMHS to AMHS

Service users presented with the highest mean number of symptom when they were first referred to CAMHS. This number decreased by the time they were discharged from CAMHS at age 18, indicating the importance and value of CAMHS input for this group of service users. However, in the absence of support from mental health services, compared to CAMHS discharge, service users presented with a higher number of symptoms at AMHS referral. The decrease in symptoms between CAMHS and AMHS may be explained by CAMHS interventions having a positive effect. While discharge at age 18, as opposed to a transition straight to AMHS, may have seemed appropriate for the service users in this sample

who presented with less symptoms, their mental health deteriorated in the absence of CAMHS support. While the number of symptoms at AMHS referral was not as high as CAMHS referral, the threshold for AMHS is more stringent (Birchwood & Singh, 2013). We may therefore assume the service users presented at AMHS with more severe symptoms. These findings highlight the need for appropriate measures of symptomatology to determine service user's needs.

Most of the sample were referred to AMHS between 7-36 months after discharge, after which referral rates reduced. Firstly, this suggests that there is a critical period at which young people discharged from CAMHS may need additional mental health care. It also evidences the need for extended mental health support for young people after the age of 18.

Treatments and support at CAMHS

A substantial proportion of this sample received medication only as a treatment or intervention during their engagement with CAMHS. While it appears that many of those who received medication only may have done so for conditions such as anxiety and ADHD, it does identify a need for more holistic support and treatment, particularly for young people with complex cases, such as those reported in the case studies.

We have noted several other services who were involved in the support of this cohort of young people. Over half were involved with other services. However, details regarding the support they received was minimal, and we were unable to determine whether they continued receiving support from these services in their time in between CAMHS and AMHS. This highlights the disparate working of services who come in to contact with young people experiencing or at risk of mental ill-health. Closer multi-agency working may enable young people who appear to be ready for discharge at 18, to be stepped down to community services. While this may take some of the burden away from the NHS, it is unclear whether the services listed have the training and capacity to provide low intensity mental health care to young people at risk of worsening mental health.

Does CAMHS engagement impact later mental health outcomes?

It was found that for every unit change in strength of engagement (i.e., where 'moderate' to 'good' is one unit of change), ten fewer months were spent in-between support from CAMHS and AMHS. This suggests that young people who engage well with services are more likely to seek future support than those with poor engagement, who may be less likely to engage. It is possible this highlights a group of young people who, due to factors we were unable to capture in this data, were unable to access the support offered by CAMHS and, as a result, were less active in seeking support from AMHS. This emphasises a need to shift the responsibility to seek help away from young people who are not able to engage with services. Reaching out and finding creative ways to engage these young people during CAMHS may support them with their mental health and prevent future referrals.

Neurodivergence

More than half of the sample were diagnosed with a neurodevelopmental condition, The ND group presented with lower level of self-harm, anxiety, and low mood compared with the rest of the sample. These findings are not consistent with population wide studies of autistic children and adults, which suggests these symptoms are more prevalent than in the neurotypical population (Licence et al. 2019). A possible explanation may be that, as 17% did not receive any further mental health diagnoses, the ND group were primarily referred into CAMHS for neurodevelopmental assessments (e.g., ASC, ADHD). However, whilst the ND group presented with lower perceived mental health needs at CAMHS referral (e.g., less anxiety, self-harm and low mood), ND individuals were significantly more likely to have spent a longer period engaged with CAMHS compared to the rest of the sample. This could indicate that ND individuals' needs are not appropriately addressed by existing services or assessment tools and as a result ND people spend more time in services. This implies that ND service users may need tailored support designed for this group.

These findings are consistent with existing research which suggests that young males are more likely to be diagnosed with a neurodevelopmental condition, particularly ADHD, and present with aggression (May et al., 2019). However, while there is a body of literature which indicates an increase in autism diagnoses in females, there is also recognition of the potential differences between male and female presentation of autism (May et al., 2019). It is of note, that there were no differences in number of autism diagnoses between males and females in the current sample. This suggests that CAMHS may be recognising differences between male and females' presentations of autism. However, the case studies from the audit indicate that there may be a proportion of young people who present to CAMHS who are later referred to AMHS for neurodevelopmental assessments. It appears that in some cases, there were indications that could have warranted earlier assessments, such as anxiety paired with OCD rituals. This finding highlights the potential value of routine screening for neurodevelopmental conditions such as ADHA and autism at CAMHS referral.

Looked After Children and Trauma

While there was a high percentage of reported trauma amongst the cohort of service users within the audit, due to auditing errors, lack of disclosure by service users and underreporting on Carenotes by clinicians, this figure may be underreported. As previously outlined, there were high levels of comorbidity in care leavers, which was significantly greater for those who had reported a traumatic life event. This indicates the severe impact traumatic life events can have on the mental health of young people. This is of particular importance when considering care leavers, who are known to have experienced high levels of trauma (Graham & Johnson, 2019). Emotionally Unstable Personality Disorder (EUPD) and

developmental delays were more common in the LAC group than the rest of the sample. Despite high multi-service involvement, the LAC subgroup tended to present to CAMHS and AMHS with symptoms of mood instability, inappropriate sexual behaviour and/or anger.

Diagnoses like EUPD and presentations of inappropriate sexual behaviour are widely considered to be linked with childhood trauma. It may be the case that the complex presentation of the LAC service users calls for different types of support, such as trauma informed care and attachment interventions, which cannot be centralised in one service.

9. LIMITATIONS

Recording of transition-related information

The data for the audit was collected from Carenotes, which presented several challenges when attempting to find transition-related information. This highlighted the need for a more comprehensive and standardised protocol for recording transitions. A specific difficulty came from the fact that 21% of the service users had an overlap of CAMHS and AMHS involvement. Considering that the original sample of service users was supposed to comprise people who were not transferred to adult services, having this overlap group could indicate a problem in the management of service users' records. In particular, despite not receiving input from CAMHS, some service users remained open to a number of services after turning 18. For example, at age 18, not all CAMHS service users had been appropriately discharged from CAMHS or other services they had previously been engaged with. This appeared to be a common problem in CAMHS and consequently, prevented appropriate transition. In addition, care notes records suggested that a group of service users were in receipt of support during the CAMHS to AMHS transition period. However, this record was misleading as rather than support for mental health, they were meeting professionals to discuss transition to AMHS.

A further challenge with using Carenotes as a means of data collection is in the identification of transition-relevant information. Carenotes lacks a location for clinicians to record information about transitions. Consequently, data for the current audit was gathered from a variety of sources. For example, transition information was found in 'Notes', 'Appointments' or 'Correspondence' sections of Carenotes. Due to this inconsistency, transition-related information was difficult to source, and some entries may have been missed.

Discrepancies in reporting also meant that information was not recorded for a proportion of service users after age 18. This meant that, for a significant percentage of the sample, it is unclear which factors contributed to an AMHS referral. Information about this 'critical period' is key, however, as previously outlined, relevant information was not easy to

locate via the Carenotes system. Consequently, certain variables may have been underrepresented in the report due to the following reasons:

- *Reporting of service users' symptoms/ mental health presentations at CAMHS discharge.*

Unlike referrals, where clinicians and referees clearly state symptomology and often the five P's (Presenting, Predisposing, Precipitating, Perpetuating and Protective Factors), there was a dearth of clear, consistent, and detailed reporting of symptoms at CAMHS discharge. Typically, entries regarding imminent discharges from CAMHS focused on clinician's or service users' attitudes, rather than recording persisting mental health symptoms or transition planning.

- *GP and parent involvement during transition period.*

GP and/or parent involvement during the time of transition was also inconsistently recorded and underreported. Forty-six percent of the sample had 'no information' recorded for parental involvement at the time of CAMHS discharge, and a further 58% had 'no information' regarding GP involvement. For the service users who did have GP or parental involvement during CAMHS transition, information was inconsistent, unclear, and typically consisted of email or text correspondence

- *Third-sector and non-CAMHS service involvement.*

Information regarding other services involved in service-user's care, particularly third-sector organisations, was difficult to obtain. For example, an attempt to assess individuals' strength of engagement with 'other services' resulted in 'no information' for 86% of cases. It is therefore difficult to ascertain what support service users were receiving (if any) in between discharge from CAMHS and referral to AMHS, and whether the lack of support contributed to their eventual referral to adult services.

Sampling limitations

It is important to note that the findings presented in this audit are limited. Data was collected for 92 service users. However, this small sample size means the findings of the audit cannot be generalised to the wider population. Further, the sample was ordered chronologically, in order of unique identifying numbers (CIS numbers), with individuals who had received support from CAMHS at a younger age placed first. The first 58 individuals audited had the longest CAMHS involvement. The remaining 35 service users were selected in groups of 10, 50 spaces apart. Consequently, the sample is disproportionately focused on individuals with earlier admissions into CAMHS. In addition, the data only relates to individuals that were referred into AMHS within, and up to, a period of three years after CAMHS discharge. This may have implications for the transitional 'critical period' that was identified: 58% of the sample were referred to AMHS between 7 and 36 months after CAMHS discharge.

Author's inexperience

The two primary authors completed this audit during a placement year with SPFT between their 2nd/3rd year of Psychology Undergraduate studies. We conducted the analyses at pace and were required to rapidly become acquainted with Carenotes and to develop our data analysis and presentation skills. Considering our level of training and given the difficulties with Carenotes and the resulting limitations of some variables, we report these results not as a robust analysis of CAMHS-AMHS transitions but as a window into the nature of transitions for this cohort of young people. Consequently, there are limitations with regards to the generalisability. Nevertheless, the results demonstrate some important patterns for the young people who 'graduate' from CAMHS but are later referred to AMHS.

10. PROCEDURAL IMPROVEMENTS OR RECOMMENDATIONS

Changes to variables

This audit furthered understanding regarding the factors relevant to transitions, as well as the types of variables which failed to generate meaningful data. For example, the recording of specific symptoms at different time points of (CAMHS referral, CAMHS discharge, and AMHS referral) was informative and a useful tool by which to understand the mental health needs of specific groups and how these may change over time. However, there was no measure for the severity of these symptoms. Each symptom was assigned a score of '1', so a higher severity score represented a greater number of symptoms. For instance, a young person who was referred to AMHS after a suicide attempt was coded in the same way as an individual presenting with social anxiety – both were given a score of '1'. Likewise, if someone was referred into AMHS for substance misuse issues and social isolation, they were coded identically to someone who was referred due to hearing voices and self-harming – both individuals were given a score of '2'. With additional quantitative information from the Carenotes system, a more accurate understanding of the severity of the service users' difficulties at the times of transition might have been attained. However, some reports included qualitative information regarding severity. For example, substance misuse issues were found to typically begin between the ages of 18 – 21. At AMHS referral, these substance misuse issues were debilitating and appeared to have a significant effect on an individuals' ability to access mental health support. However, this was not information that could be coded for the quantitative analysis. Further qualitative analyses of Carenotes would help inform pathways for young people's (18-25) transitions in mental health services.

The variable 'strength of engagement' was assessed by giving each individual four separate ratings ('good', 'moderate', 'poor', or 'no information') for engagement at CAMHS referral, CAMHS discharge, AMHS referral and with other services. Coding of these variables

were completed based on clinicians' written opinions found in 'Notes' and 'Correspondences' sections of Carenotes, as well as inferred from the number of attended versus non-attended appointments. However, no numeric data regarding the actual number of missed versus attended appointments was recorded. This addition would have been a useful objective marker of strength of engagement.

Finally, this audit did not record data regarding the source of the referral. Routes of referral differed amongst service users for both CAMHS and AMHS. Referral sources included GPs, community services, social workers, and the police. This information may have afforded a better understanding of how service users came to be referred into AMHS, the type of support they were receiving outside of statutory services, and a comparison of mental health between CAMHS referral and discharge. Additional information as to when a service user receives a diagnosis would assist with understanding differences in needs between service user groups. For example, a diagnosis of Autism, ADHD, or Dyslexia in the later stages of CAMHS involvement may relate to the types of symptoms individuals presented with at CAMHS referral. This could support earlier identification of neurodivergence, which could in turn shape support for the service user during involvement with CAMHS. Further, it was not recorded how long service users remained open to a service without receiving interventions; why an offer of psychology was refused; or how satisfied service users or their families felt about the interventions they received. Additional information in service users' records would help broaden the variable 'interventions offered' and provide a richer and more meaningful understanding of the efficacy of different interventions offered during CAMHS.

11. DISSEMINATION AND NEXT STEPS

The results of this audit have been presented at the 16-25 Sussex Integrated Care Systems (ICS) Steering Group as well as the Youth Mental Health Summit in June 2022. Going forwards, the findings will be used to support the 16-25 transformation work and pathway development in Sussex, including the proposed service model for Adolescent Teams within the ATSS. It is hoped that this data will be shared further with children and young people's mental health system leads across Sussex and Kent as joint working will be essential in improving transitions and the mental health outcomes of young people.

This audit demonstrates a need for further mental health support for young people after 18, as well as highlighting both LAC and neurodivergent individuals as key vulnerable groups at the time of transition. This highlights a need for specialised and tailored support during the time of transition, as well as closer working between Children' Social Care LAC Services and neurodevelopmental services within both CAMHS and AMHS.

Comparing the findings in this audit to regional and national transition data would also help to further our understanding of transitions, both in relation to Sussex and more widely across the United Kingdom.

12. SUPPLEMENTARY MATERIALS

Variable	Group	Percentage	χ^2	df	N	p	ϕ
Psychosis	Neurodivergent	18.20%	5.832	1	92	0.016	-0.252
	Rest of the sample	3.40%					
Eating disorder	Neurodivergent	21.20%	7.617	1	92	0.006	-0.288
	Rest of the sample	3.40%					
Impulsivity at CAMHS referral	Neurodivergent	23.70%	4.743	1	92	0.029	0.288
	Rest of the sample	6.10%					
Low mood at CAMHS referral	Neurodivergent	55.90%	9.299	1	92	0.002	-0.32
	Rest of the sample	87.90%					
Anxiety at CAMHS referral	Neurodivergent	57.60%	5.543	1	92	0.019	-0.245
	Rest of the sample	81.80%					
Suicidal ideations at CAMHS referral	Neurodivergent	25.40%	12.552	1	92	< 0.001	-0.371
	Rest of the sample	63.60%					
Self-harm at CAMHS referral	Neurodivergent	16.90%	20.156	1	92	< 0.001	-0.471
	Rest of the sample	63.60%					
Aggression at CAMHS referral	Neurodivergent	45.80%	15.454	1	92	< 0.001	0.41
	Rest of the sample	6.10%					
Low mood at CAMHS discharge	Neurodivergent	37.30%	4.351	1	92	0.037	-0.219
	Rest of the sample	60.60%					
Anger at CAMHS discharge	Neurodivergent	15.30%	5.789	1	92	0.016	0.254
	Rest of the sample	0%					
Disordered eating at AMHS referral	Neurodivergent	5.10%	10.115	1	92	0.001	-0.341
	Rest of the sample	27.30%					
Self-esteem at AMHS referral	Neurodivergent	3.40%	7.236	1	92	0.007	-0.29
	Rest of the sample	18.80%					
Safeguarding	Neurodivergent	18.60%	4.549	1	92	0.033	0.222
	Rest of the sample	6.10%					
Educational Support	Neurodivergent	30.50%	7.435	1	92	0.006	0.284
	Rest of the sample	1.30%					

Table 3. Comparison of neurodivergent group and the rest of the sample on the basis of diagnosis, symptoms and multi-service involvement

Variable	χ^2	df	N	p	ϕ
Comorbid mental health diagnosis	3.440	1	92	0.047	0.104
ADHD	6.319	1	92	0.012	0.262
Anxiety	5.979	1	92	0.014	0.255

Table 4. Significant findings for the medication-only group

Variable	χ^2	df	N	p	ϕ
EUPD	5.266	1	92	0.022	0.239
Psychosis	7.165	1	92	0.007	0.279
PTSD	5.473	1	92	0.019	0.244

Table 5. Significant findings relating to mental health diagnoses of the in-patient compared to non-inpatient group

Variable	χ^2	df	N	p	ϕ
Neurodevelopmental Condition	8.897	2	92	0.012	0.311
ADHD	8.715	2	92	0.013	0.308
PTSD	9.800	2	92	0.007	0.326
Anxiety at CAMHS referral	7.770	2	92	0.021	0.291
Self-harm at CAMHS referral	8.709	2	92	0.013	0.309
School refusal at CAMHS referral	7.005	2	92	0.03	0.277
Aggression at CAMHS referral	8.015	2	92	0.018	0.295
Low mood at CAMHS discharge	11.592	2	92	0.003	0.357

Table 6. Significant findings relating to gender

Variable	χ^2	df	N	p	ϕ
EUPD	6.066	1	92	0.014	0.257
Developmental delay	5.065	1	92	0.024	0.235
OCD	5.729	1	92	0.017	0.25
Inappropriate sexual behaviour at CAMHS referral	6.876	1	92	0.009	0.275
Mood instability at CAMHS discharge	3.858	1	92	0.05	0.206
Social isolation at CAMHS discharge	3.979	1	92	0.046	0.216
Anger at CAMHS discharge	5.804	1	92	0.016	0.254
Aggression at CAMHS discharge	14.534	1	92	< 0.001	0.402
Hearing voices at AMHS referral	6.260	1	92	0.012	0.267

Table 7. Significant findings relating to mental health diagnoses for the LAC cohort

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