Evaluation of a Pilot Community Forensic Child and Adolescent Mental Health Service (FCAMHS) for Hampshire and the Isle of Wight (HIoW)

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Executive Summary

Background

The Hampshire & Isle of Wight (HIOW) Forensic Child and Adolescent Mental Health Service (FCAMHS) was established in April 2010 with pilot funding from the Department of Health (DH) running to the end of March 2012. The funding for this project was secured following a previous successful evaluation and establishment of regional specialist commissioning funding for the Thames Valley Regional Forensic CAMHS service.

In order to inform decision making about the future funding of the Hampshire & Isle of Wight FCAMH service at the end of the DH pilot funding period, the South Central Specialised Services Commissioning Group commissioned Solutions for Public Health (SPH) to undertake an independent evaluation of the service.

The aim of the evaluation is to inform the SCSCG as to the extent to which the Hampshire & Isle of Wight FCAMHS service has achieved the core functions as set out in the application to the DH in 2009/10.

The objectives were to assess:

- the extent to which the FCAMHS has provided tertiary forensic mental health advice, consultation, assessment, advice and interventions for agencies involved in the care of young people who are either in contact with the criminal justice system or who present with high risk behaviours elsewhere across Hampshire & the Isle of Wight
- the extent to which the FCAMHS has liaised and facilitated liaison between mental health organisations and organisations within the criminal justice system
- the contribution of the FCAMHS to strategic developments within the region
- the contribution of the FCAMHS in providing training for front line practitioners in the criminal justice system, CAMHS and other areas

Findings

The HIOW FCAMH service received a total of 137 referrals for children and young people between April 2010 and September 2011. The number of referrals received by the service covering the North of NHS South Central over this period was very similar at 141 referrals.

The age of children and young people referred to the HIOW service ranged from 7 years to 19 years old. The age profile for referrals to the FCAMH service in the North of NHS South Central was similar.

Both FCAMHS services drew a higher proportion of referrals from organisations based close to where the FCAMH services are located. Some 29% of the HIOW FCAMH referrals came from organisations based in and around Southampton and over half of the referrals to the FCAMH service in the North of NHS South Central came from organisations based in Oxfordshire.

Of the 137 HIOW referrals, 89 (65%) received an initial consultation, assessment and subsequent input. This was a much higher figure than for the FCAMH service in the North of NHS South Central where only 21% of cases received an initial consultation, assessment and subsequent input. Around half of the cases referred to the HOIW FCAMHS team that were closed by the FCAMHS team by the end of September 2011, required only 1 or 2 contacts with the team. However, four cases required more than 20 separate contacts with the team, one of which required 41 contacts. Of the cases still

in contact with the FCAMHS team at the end of September, a further 7 cases had already generated more than 20 contacts with the team.

In interviews with ten stakeholders from referring organisations and eight stakeholders with a more strategic perspective on the work of the FCAMHS team, the FCAMH service was generally highly valued.

Nine of the ten individuals we interviewed who had direct experience of making referrals to the service indicated that they were very satisfied with the service they had received. The service was valued as a source of expertise and advice for the management of complex presentations that could be considered as high risk by the locality CAMHS and YOT teams. The additional insight that the FCAMHS team could provide around risk assessments and around the management of children and young people with sexually harmful behaviours was particularly valued.

The FCAMH team's ability to signpost to other services and arrange for other types of specialist assessments was also valued by a number of interviewees. One respondent in particular highlighted the value of the service in assisting in liaison with the courts and in producing reports for court cases.

Those interviewees that had received formal training provided by the FCAMHS team have found it very beneficial, but there were one or two interviewees who had tried to secure places on this training but had been told it was over-subscribed and/or their team had not been prioritised to receive this training.

The interviews that were undertaken with CAMHS and children's services commissioners and others with more strategic input into the service were complimentary of the role the service had played in shaping service developments and strategic initiatives, although one respondent had concerns about the potential for "mission" creep and the service straying into areas beyond its original remit.

One commissioner noted a reduction in referrals for out of area forensic assessments since the establishment of the service, meaning that children and young people could be assessed more locally and at less cost to their PCT. The FCAMHS team have identified a number of cases where they believe that intervention by the team has impacted on the treatment of children and young people in a way that is likely to have reduced costs to NHS commissioners.

Interviewees also cited a number of ways I which the service might be improved in the future:

- By expanding the size of the team so that the team was able to visit and asses children in secure settings out of area more easily.
- By providing further training sessions (AIM and SAVRY training were both mentioned) particularly for those who had been unable to attend previous events.
- An interviewee at Bluebird House felt that there could be more active engagement from the FCAMHS team in patients from Hampshire and the Isle of Wight admitted to the unit. They perceived a relative lack of active involvement in comparison with the equivalent community FCAMH service in the North of NHS South Central.
- By increasing awareness of the service particularly amongst social services, GPs and GP commissioners

Interviewees had a number of concerns at the prospect of the service being discontinued after the end of the pilot funding period. Interviewees felt that over time, there would be an erosion in the confidence of the local CAMHS and YOT teams to manage these more complex cases. Some interviewees expressed concerns about the assessment of risk and implications on safeguarding that might ensure if the support of the FCAMHS team was no longer available. Some interviewees also thought that over time there would be increasing pressure on locality CAMHS teams and health

workers in the YOTs to manage these cases and/or and increase in referrals to more specialist out of area services.

Background

The Hampshire & Isle of Wight Forensic Child and Adolescent Mental Health Service (FCAMHS) was established in April 2010 with pilot funding from the Department of Health running to the end of March 2012. The funding for this project was secured following a previous successful evaluation and establishment of regional specialist commissioning funding for the Thames Valley Regional Forensic CAMHS service.

The Hampshire & Isle of Wight FCAMHS operates to a similar service model to that of the Oxford-based FCAMH service that has operated in the north of NHS South Central since 2004, provided by Oxford Healthcare. This service was also initially set up with pilot funding from the DH and following a positive independent evaluation in 2006, has since been funded by the South Central Specialised Services Commissioning Group (SCSCG).

In order to inform decision making about the future funding of the Hampshire & Isle of Wight FCAMH service at the end of the DH pilot funding period, the SCSCG has commissioned Solutions for Public Health (SPH) to undertake an evaluation of the service.

The core functions of the Hampshire & Isle of Wight FCAMH service, as specified in the application to the DH for the pilot funding to set up the service were described as follows:

- provision of a tertiary forensic mental health advice, consultation, assessment and intervention service for young people who are either in contact with the criminal justice system or who present with high risk behaviours elsewhere
- liaison with institutions such as Secure Children's Homes, Secure Training Centres and Young Offender Institutions (YOI)
- liaison with other agencies such as Youth Offending Teams (YOT) and courts
- liaison with national forensic adolescent inpatient services
- liaison with locality CAMHS teams and with adult forensic services
- informing strategic development of mental health services for young people at the mental health/criminal justice interface within the region
- provision of teaching to frontline practitioners in the criminal justice system (eg, YOT workers, prison officers), CAMHS and other agencies
- provision of specialist training opportunities within the team for mental health practitioners wishing to specialise in the area of child and adolescent forensic mental health

It is hoped that the findings of this evaluation will be helpful to others considering establishing community based forensic CAMH services in other parts of the UK.

Aims and Objectives

The aim of the evaluation is to inform the SCSCG as to the extent to which the Hampshire & Isle of Wight FCAMHS service has achieved the core functions as set out in the application to the DH in 2009/10.

The objectives are to assess:

- the extent to which the FCAMHS has provided tertiary forensic mental health advice, consultation, assessment, advice and interventions for agencies involved in the care of young people in contact with the criminal justice system across Hampshire & the Isle of Wight
- the extent to which the FCAMHS has liaised and facilitated liaison between mental health organisations and organisations within the criminal justice system
- the contribution of the FCAMHS to strategic developments within the region
- the contribution of the FCAMHS in providing training for front line practitioners in the criminal justice system, CAMHS and other areas

Methodology

The nature of the service provided by the Hampshire & Isle of Wight FCAMH team makes a direct evaluation based on patient outcomes difficult. Not only is the client group one presenting with highly complex needs and circumstances but also much of the work undertaken by the FCAMHS team is concerned with providing support, advice and specialist formal consultation to members of locality CAMHS, YOT and teams from and agencies and institutions. It is these teams that take forward the advice they are given from the FCAMHS team and are most likely to see the impact on the child or young person. Even in cases where the FCAMHS team undertake assessments and direct intervention in the most complex cases, individual direct outcomes are difficult to establish.

In light of this complexity of provision and client group we have used a number of different data sources to assess the impact that the FCAMHS has had over the last 18 months. These data sources include:

- Analysis of referral data for the 18 month period from April 2010 to September 2011 to quantify and profile the referrals made to the service and to describe the input provided by the FCAMH team
- Interviews with agencies that are likely to have made referrals to the FCAMHS team, such as locality CAMHS and YOTs to assess levels of satisfaction with the FCAMH service and to highlight possible areas of improvement
- Interviews with agencies with whom the FCAMHS team liaises around strategic developments within mental health services for children and young people
- Obtaining information from the FCAMHS team on the provision of formal training to front line professionals

About the HIOW FCAMH Service

The service functions as a regional tier 4 tertiary referral service for Hampshire, (including Portsmouth and Southampton) and the Isle of Wight. The area covered is of similar population to that of the area covered by the Thames Valley FCAMHS team (circa 2-2.5 million). The team is principally a tertiary referral service for CAMHS teams (including YOT Health workers) although contact from other agencies is not excluded. The service model (Appendix 1) places the service at a 'regional' level of function between existing local services for young people and specialist, nationally commissioned adolescent forensic mental health and learning disability inpatient provision.

The FCAMHS team is based in Southampton and is co-located with Swanwick Lodge a secure children's home. The staffing of the service during the pilot period has consisted of:

- Dr Jonathan Bigg, 0.6 WTE, Consultant child and adolescent psychiatrist

- Dr Suyog Dhakras, 0.2 WTE, Consultant child and adolescent psychiatrist
- Dr Alison Wallis, 0.2 WTE, Consultant clinical psychologist
- Mrs Nicky Cooper, 0.5 WTE, Team administrator

The team also had the benefit of Michael Crutchley, a senior but supernumerary trainee Consultant (nurse) practitioner (0.6 WTE) for much of the pilot.

The funding awarded by the DH for the 2 year funding period was £182k per annum.

The team wishes to be accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education etc) which may have contact with risky young people or young people in the criminal justice system who have mental health difficulties. For this reason initial contacts about possible referrals are welcomed from all agencies; however, referrals for assessments are usually only accepted with the knowledge and active support from local CAMHS tier 3 services.

The DH pilot FCAMH service covering Hampshire and the Isle of Wight is currently managed by Oxford Healthcare, but the clinical staffing for the service is sub-contracted both to the Sussex Partnership NHS Trust and to NHS Solent. The Sussex Partnership NHS Foundation Trust has taken responsibility for the provision of Tier 2 and Tier 3 specialist community CAMH services across Hampshire since April 2011 following a tendering exercise.

Results

Analysis of Referral Data

Both the Hampshire and Isle of Wight FCAMH service and the Oxford-based FCAMH service covering the North of NHS South Central collected prospective data on referrals using an identical data specification. Both services supplied data to SPH on the referrals they had received for the period from April 2010 to the end of September 2011.

The tables below compare the referral data for the two services against a number of different data items. The inclusion of the data for the FCAMH service covering the North of NHS South Central enables the pilot service in Hampshire and the Isle of Wight to be compared to a more established service.

Children & Young People Referred to FCAMHS

1) Age of young people referred to the service

Table 1 shows the age and gender profile of the children and young people referred to the Hampshire and Isle of Wight Forensic CAMHS service between April 2010 and September 2011. Table 1 shows that 80% of children and young people referred to the FCAMHS service were male. All but one of the referrals aged 12 and under were for boys. The age of children and young people referred ranged from 7 to 19 years of age, but 82% of the male referrals and 97% of the female referrals were for children aged 13 to 18.

Table 1: Referrals to South FCAMHS by age and gender, April to September 2011 (actual number)

Age on Referral	Female	Male	Not Stated	Total
≤12	1 (4%)	19 (17%)	0 (0%)	20 (15%)
13 to ≤15	15 (58%)	49 (45%)	0 (0%)	64 (47%)
16 to ≤18	10 (39%)	40 (37%)	0 (0%)	50 (36%)
>18	0 (0%)	1 (9%)	0 (0%)	1 (1%)
Not stated	0 (0%)	1 (9%)	1 (100%)	2 (1%)
Total	**26 (100%)**	**109 (100%)**	**1 (100%)**	**137 (100%)**

Table 2 shows the age and gender profile of the children and young people referred to the Forensic CAMH service in the North of NHS South Central between April 2010 and September 2011. Table2 shows that 83% of children and young people referred to the FCAMH service were male. The age of children and young people referred to the FCAMH service in the North ranged from 4 to 19 years of age, but 86% of the male referrals and 78% of the female referrals were for children aged 13 or 18.

Table 2: Referrals to North FCAMHS by age and gender, April to September 2011 (actual number)

Age on Referral	Female	Male	Not Stated	Total
≤12	3 (13%)	17 (15%)	0 (0%)	20 (14%)
13 to ≤15	8 (35%)	49 (42%)	0 (0%)	57 (40%)
16 to ≤18	10 (43%)	51 (44%)	0 (0%)	61 (43%)
Not stated	2 (9%)	0 (0%)	1 (100%)	3 (2%)
Total	**23 (100%)**	**117 (100%)**	**1 (100%)**	**141 (100%)**

2) Ethnicity of young people referred to the service

Table 3 shows the ethnicity of the children and young people referred to the FCAMHS teams in the North and South of NHS South Central.

Table 3: Ethnicity of referrals to FCAMHS (North and South)

Reason for referral	Total South	Total North
White British	88 (64%)	94 (67%)
Other White background	2 (1%)	1 (1%)
Asian or Asian British	1 (1%)	5 (4%)
Black or Black British: African	1 (1%)	2 (1%)
Mixed heritage	4 (3%)	4 (3%)
Other Ethnic Groups: Any other ethnic group	0 (0%)	5 (4%)
Not Specified	41 (30%)	30 (21%)
Total	**137 (100%)**	**141 (100%)**

There were very few children from non-white ethnic backgrounds referred to either FCAMH service, but this reflects the relatively low proportion of ethnic minority populations in the areas served by the two services.

3) Young people's living arrangements at the time of referral

Figure 1 shows that children and young people were referred to the Hampshire & Isle of Wight FCAMHS service from a range of different places of residence. Most commonly, children were referred from the family home (43%), from foster care (18%) or from a children's home (10%). The majority were in community settings but a significant minority were in open and secure in-patient

settings, in custody (Young Offender's Institution (YOI), Secure Training Centre or Local Authority Children's Homes (LASCH)) or in Secure Care on welfare grounds

Figure 1: Living arrangements at time of referral South FCAMHS (actual number)

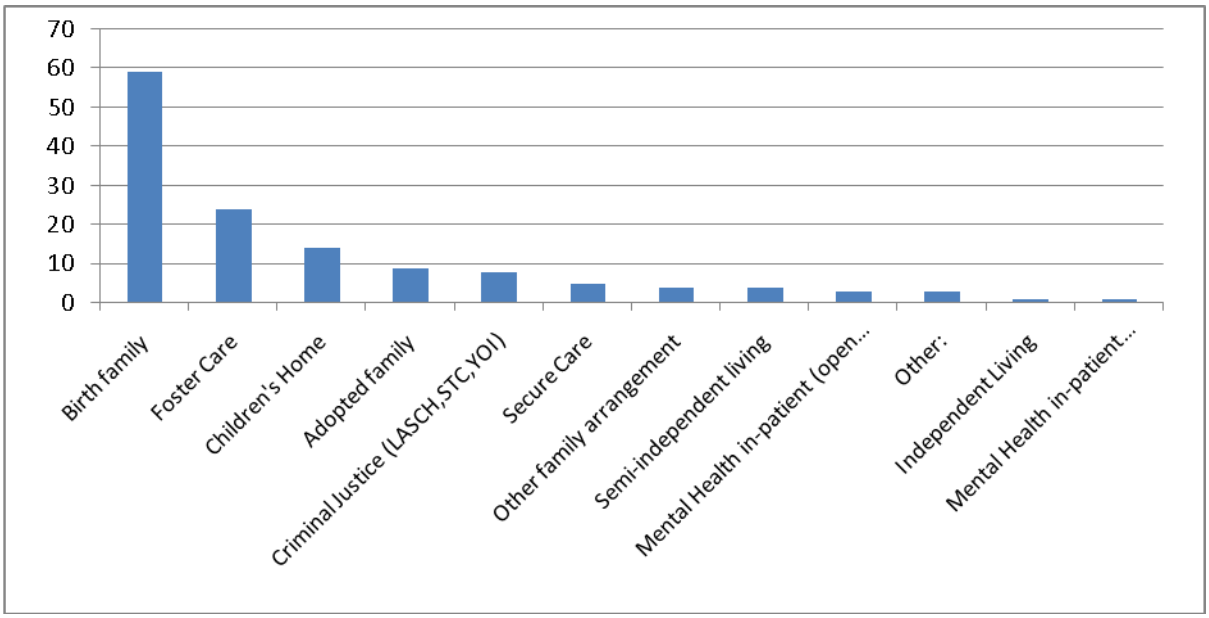
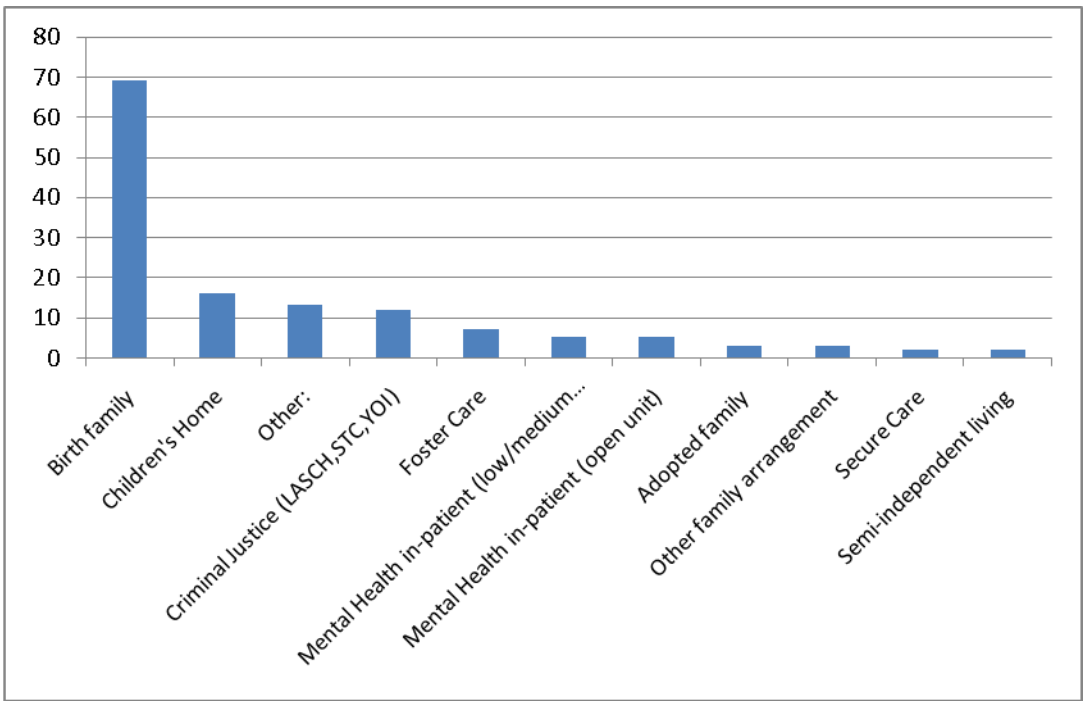


Figure 2 shows that children and young people in the North of South Central were most commonly living with their birth family (49%), in a children's home (12%) or in Other Settings (10%; principally in specialist educational placements). In Thames Valley, fewer children were referred whilst living in foster care than was the case in the HIOW service (seven versus 24 referrals respectively). However, as with HIoW service, whilst the majority of young people were in community settings a significant minority were in open and secure in-patient settings, in custody (Young Offender's Institution (YOI), Secure Training Centre or Local Authority Children's Homes (LASCH)) or in Secure Care on welfare grounds.

Figure 2: Living arrangements at time of referral North FCAMHS (actual number)



4) Reasons for referral

Table 4 presents a summary of the key reasons for referral to the FCAMH services. Of the presenting problems, sexually harmful behaviour and violence/ aggression either separately or in conjunction were the most common reasons for referral to FCAMH services.

Table 4: Reason for referral to FCAMHS

Reason for referral	Total South	Total North
Aggression	42 (31%)	49 (35%)
Sexually harmful behaviour	34 (25%)	27 (19%)
Legal/ YOS/ custody	14 (10%)	19 (13%)
Second opinion in complex case	13 (9%)	25 (18%)
Aggression and sexual harm	12 (9%)	9 (6%)
Fire setting	4 (3%)	6 (4%)
Other	16 (12%)	5 (4%)
Not stated	2 (1%)	1 (1%)
Total	**137 (100%)**	**141 (100%)**

The 16 Hampshire & Isle of Wight cases where the reason for referral was listed as 'other' involved advice being sought about worrying behaviour or about an appropriate placement and a few cases where the young person was judged to be at risk of harming themselves.

5) Diagnoses for young people referred or evaluated by FCAMHS

The diversity and complexity of the conditions referred to the FCAMH teams is summarised in this section. The diagnostic information provided was been provided either by the FCAMHS team following direct clinical assessment or by the referrer in the event of consultation having been undertaken by the FCAMHS team without direct clinical assessment. Diagnostic information was only included if there was clear evidence of appropriate clinical evaluation having taken place. Young people referred without clear diagnostic information or in whom no clear condition suggestive of a specific diagnosis was identified were grouped together (no diagnosis evident/available). This latter group represents a significant proportion (about a third of all referrals) to FCAMHS because frequently young people with high risk behaviours may be referred primarily because of risk issues rather than mental health issues; professionals frequently seek reassurance that no mental disorder is present in such cases.

Table 5 shows the first-cited, but not necessarily the only significant, diagnosis for each young person referred to the FCAMH services from April 2010 to the end of September 2011. (A significant number of the children and young people referred to the FCAMH service had more than one presenting problem (see table 7))

Table 5: First-cited diagnosis of children and young people referred to FCAMHS (South and North) April 2010 to September 2011

Primary Diagnosis	Total South	Total North
Autistic spectrum disorder	16 (12%)	18 (13%)
ADHD	14 (10%)	8 (6%)
Conduct disorder/emerging personality disorder	14 (11%)	25 (18%)
Attachment disorder/PTSD	13 (9%)	9 (6%)
Depression/anxiety/mood disorder	3 (2%)	5 (4%)

Psychosis	7 (5%)	8 (6%)
Learning disability/difficulties	12 (9%)	11 (8%)
Other (Tourette's syndrome, OCD etc)	8 (6%)	4 (3%)
No diagnosis evident/available	52 (37%)	53 (38%)
Total	**137 (100%)**	**141 (100%)**

Numerous young people referred to the FCAMH services had more than one presenting diagnosis. Table 6 shows all diagnoses recorded for the 137 referrals to the Hampshire and Isle of Wight FCAMH service and the 141 referrals to the FCAMH service in the North of NHS South Central.

Table 6: All diagnoses for children and young people referred to FCAMHS (South and North) April 2010 to September 2011

All Diagnoses	Total South	Total North
Autistic spectrum disorder	19 (10%)	23 (13%)
ADHD	22 (11%)	13 (8%)
Conduct disorder/emerging personality disorder	29 (15%)	29 (17%)
Attachment disorder/PTSD	24 (12%)	9 (6%)
Depression/anxiety/mood disorder	6 (3%)	6 (4%)
Psychosis	6 (3%)	8 (5%)
Learning disability/difficulties	20 (10%)	23 (13%)
Other	15 (8%)	9 (6%)
No diagnosis evident/available	52 (27%)	53 (31%)
Total	**193 (100%)**	**173 (100%)**

Table 6 shows that there were slightly more total diagnoses recorded for the children and young people referred to the Hampshire and Isle of Wight FCAMHs service than to the service in the North of NHS South Central. It also shows that both services were referred cases with a similar range of diagnoses. There were high levels of autistic spectrum disorder, conduct disorder, psychosis and learning disability in comparison with routine community clinical samples; this is in line with the academic literature.

Table 7: Number of referrals with multiple diagnoses (South and North) April 2010 to September 2011

All Diagnoses	Total South	Total North
No diagnosis evident/available	52 (38%)	53 (38%)
One diagnosis	47 (34%)	64 (45%)
Two diagnoses	24 (18%)	17 (12%)
Three diagnoses	10 (7%)	5 (4%)
Four diagnoses	4 (3%)	2 (1%)
Total	**137**	**141**

Table 7 shows that nearly 30% of all referrals to the Hampshire & Isle of Wight FCAMH service had more than one diagnosis. Excluding those with no known diagnosis, the proportion with multiple diagnoses was 45%. These are slightly higher proportions than are recorded for the FCAMH service covering the North of NHS South Central, though this may reflect differences in the recording of diagnostic information. These results demonstrate a high level of complexity in this clinical population. Some case history examples provided by the FCAMH service are included in Appendix 3.

6) Referrers to FCAMHS

Table 8 shows the number of referrals made by different categories of referring organisations to the FCAMH services. It indicates that over 80% of children and young people were referred to the Hampshire & Isle of Wight FCAMH service by either the local CAMHS (45%), YOT services (24%) or social services (15%). Compared to the referrals made to the FCAMH service in the North of NHS South Central, a greater proportion of referrals in the South came from Social Services and a smaller proportion from CAMHS teams.

Table 8: Number of referrals to FCAMHS by type of referring organisation (North and South)

Referring Organisation	Total South	Total North
CAMHS	67 (49%)	78 (55%)
YOT and criminal justice	36 (26%)	35 (25%)
Social services	26 (19%)	12 (9%)
Education	4 (3%)	9 (6%)
Children's services/ PCT/ Commissioning Directorate	2 (1%)	3 (2%)
Other	1 (1%)	3 (2%)
Blank	1 (1%)	1 (1%)
Total	**137 (100%)**	**141 (100%)**

Table 9 shows the geographical areas covered by the agencies that have made referrals to the South FCAMH service and shows that Southampton (29%), North Hampshire (28%) and the Isle of Wight (16%) were the main sources of referrals. The data in the table below is based on the postcode of the referring organisation rather than the postcode of the child or young person. Consequently it may slightly over estimate the number of Southampton referrals because the YOT based in Southampton also covers parts of South Hampshire.

Table 9: Number of referrals to South FCAMHS by geographical area covered by Referrer

Referrer Area	Total South	Percentage
Southampton	40	29%
North Hampshire	38	28%
Isle of Wight	22	16%
South East Hampshire	15	11%
Portsmouth (inc Cosham/Drayton)	15	11%
Mid and West Hampshire	7	5%
Total	**137**	**100%**

Table 10 shows the geographical areas covered by the agencies that have made referrals to the North FCAMHS service and shows half of the referrals were made by organisations based in Oxfordshire. A similar number of referrals were made from organisations in Berkshire and Buckinghamshire, but there were relatively few referrals from Milton Keynes.

Table 10: Number of referrals to North FCAMHS by geographical area covered by Referrer

Referrer Area	Total North	Percentage
Berkshire	27	19%
Buckinghamshire	31	22%
Milton Keynes	4	3%
Oxfordshire	79	56%
Total	**141**	**100%**

Table 7 showed that the main referrers to FCAMHS were CAMHS, YOT and social services. Table 11 shows the individual teams who have made more than five referrals to FCAMHS. This shows that the Southampton and Isle of Wight CAMHS teams have made the most referrals, followed by the Basingstoke CAMHS and YOT teams. For the FCAMH service in the North of NHS South Central the agencies making the most referrals were the Aylesbury and Oxford City CAMHS teams, followed by Mulberry Bush School (a national resource providing a therapeutic educational environment for young who experienced severe maltreatment) (Table 12).

Table 11: Number of referrals by agencies making multiple referrals to South FCAMHS

Referring Agency	Number of referrals	Percentage
Southampton CAMHS	14	15%
Isle of Wight CAMHS	14	15%
Basingstoke YOT	12	13%
Basingstoke CAMHS	11	12%
Southampton YOT	10	11%
Aldershot CAMHS	9	10%
Southampton social services	8	9%
Cosham YOT	7	8%
Havant CAMHS	6	7%
Total	**91**	**100%**

Table 12: Number of referrals by agencies making multiple referrals to North FCAMHS

Referring Agency	Number of referrals	Percentage
Aylesbury CAMHS	12	29%
Oxford City CAMHS	11	26%
Mulberry Bush School	8	19%
Abingdon CAMHS	6	14%
Bracknell CAMHs	5	12%
Total	**42**	**100%**

7) Frequency of referrals to FCAMHS

Figure 3 shows the number of referrals to the Hampshire and Isle of Wight FCAMHS each month from April 2010 to September 2011. The highest number of monthly referrals was received in June in both 2010 and 2011. The lowest number of referrals received was in January 2011.

Figure 3: Number of referrals by month of referral to South FCAMHS

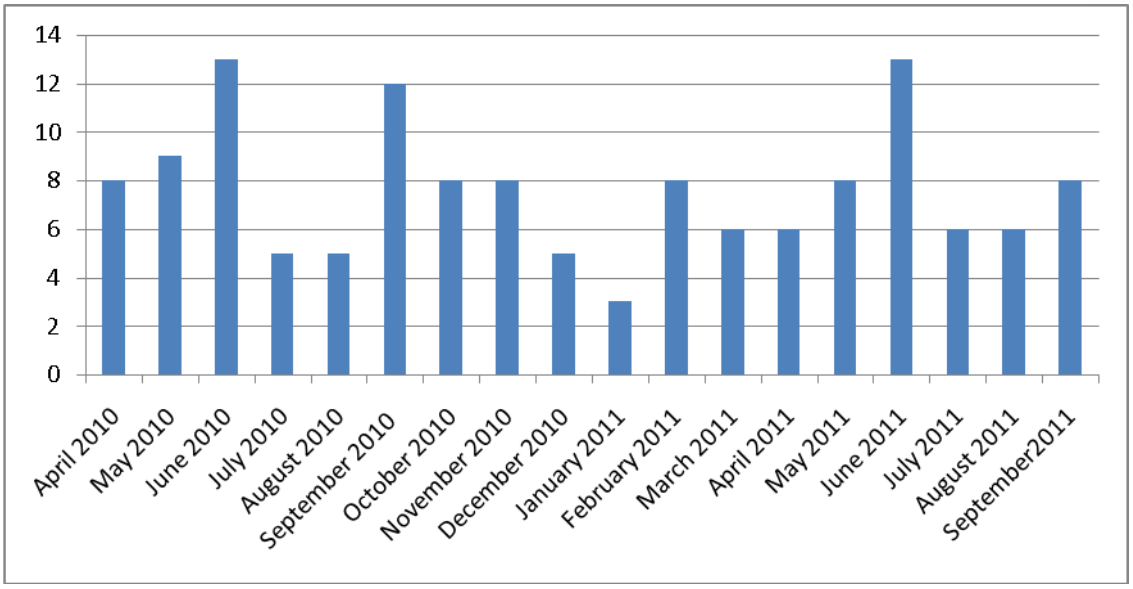
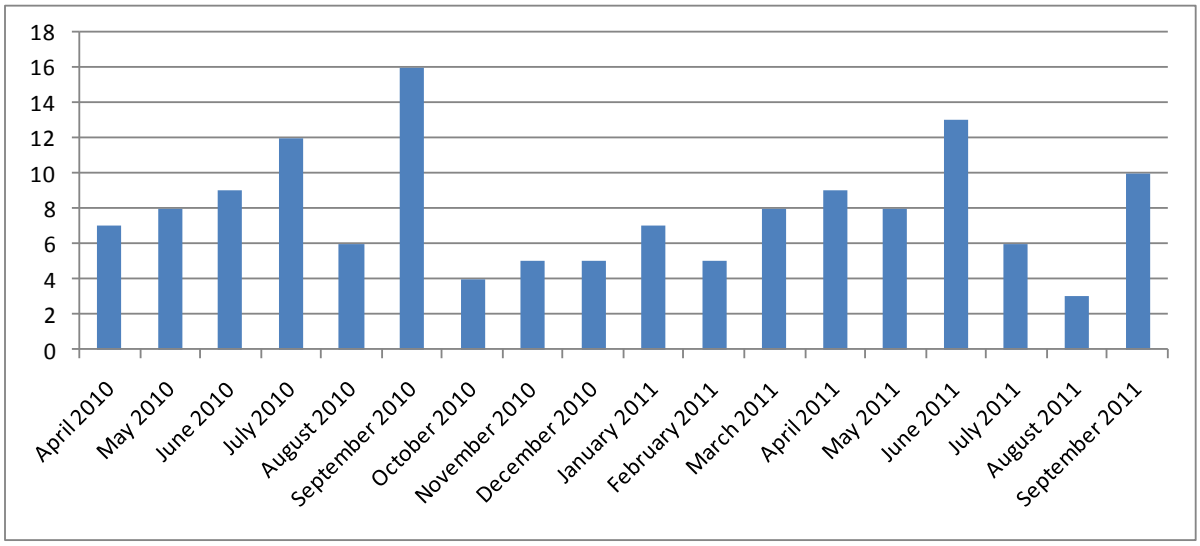


Figure 4 shows the number of referrals to the North FCAMHS each month from April 2010 to September 2011. The highest number of monthly referrals was received in September 2010. The lowest number of referrals received was in August 2011.

Figure 4: Number of referrals by month of referral to North FCAMHS



8) Input from the FCAMHS team

Table 13 shows the outcome of the contact with the FCAMHS teams. The majority of cases (65%) in the Hampshire & Isle of Wight FCAMHs team went on to have an assessment and subsequent input. This contrasts with the North FCAMH service where only 30 referrals received an assessment compared to 89 in Hampshire and the Isle of Wight. This may be in part due to the Hampshire & Isle of Wight FCAMHs team having a trainee consultant psychiatric nurse available thus providing additional capacity to undertake assessments. It may also represent a greater willingness on the part of the new service to undertake direct assessments where the more established Thames Valley service may not have done so.

Table 13: Outcome of contact with FCAMHS team

Outcome of contact with FCAMS team	Total South	Total North
Initial consultation, assessment and subsequent input	89 (65%)	30 (21%)
Initial consultation only, case closed immediately	24 (18%)	20 (14%)
Initial consultation, case closed after 3 months	13 (9%)	44 (31%)
Initial consultation, plus further input (no assessment)	9 (7%)	44 (31%)
Blank	2 (2%)	3 (2%)
Total	**137 (100%)**	**141 (100%)**

Subsequent input in both services comprised extensive multi-professional and family liaison and in some cases direct therapeutic input.

Figures 5 and 6 show the varied quantity of input from the FCAMHS teams into the cases referred to them. Figure 5 shows that around half of the children and young people referred to the Hampshire and Isle of Wight FCAMHS team required only 1 or 2 contacts with the team. However, a number required a significantly greater level of input, with nine cases requiring more than 20 contacts with the FCAMHS team and one case required 41 contacts (36 of which were attended contacts).

Figure 5: Total number of contacts including DNA & cancellations for South FCAMHS (open and closed cases)

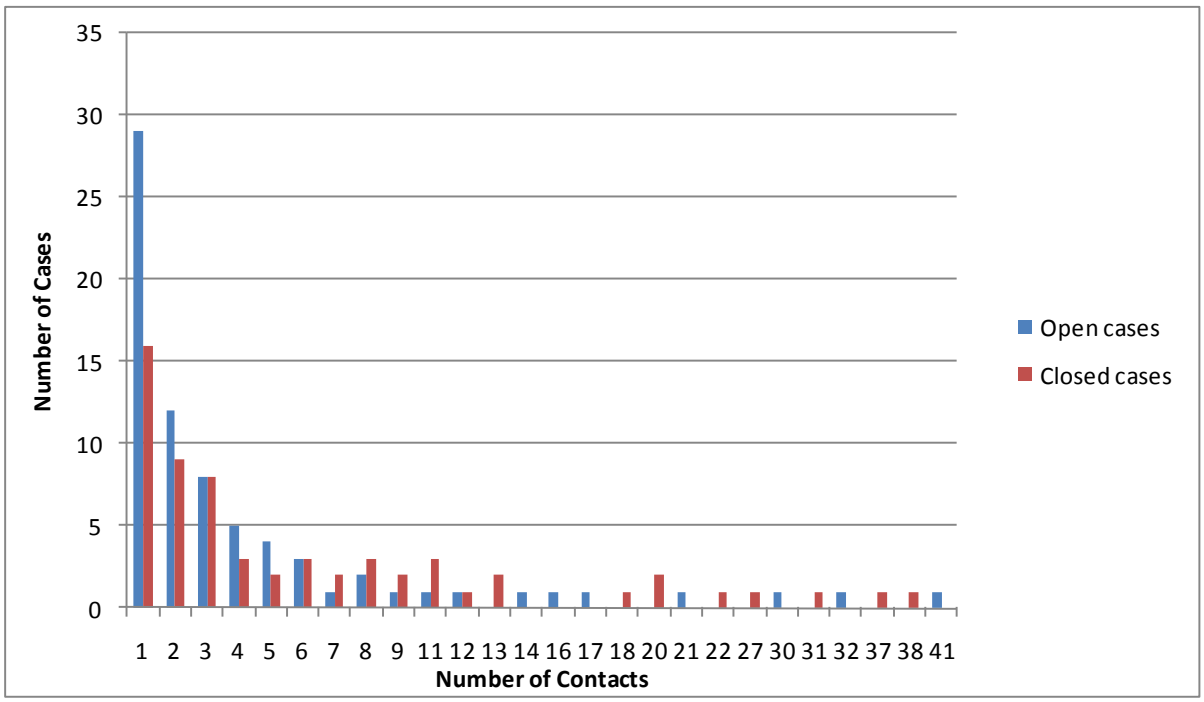
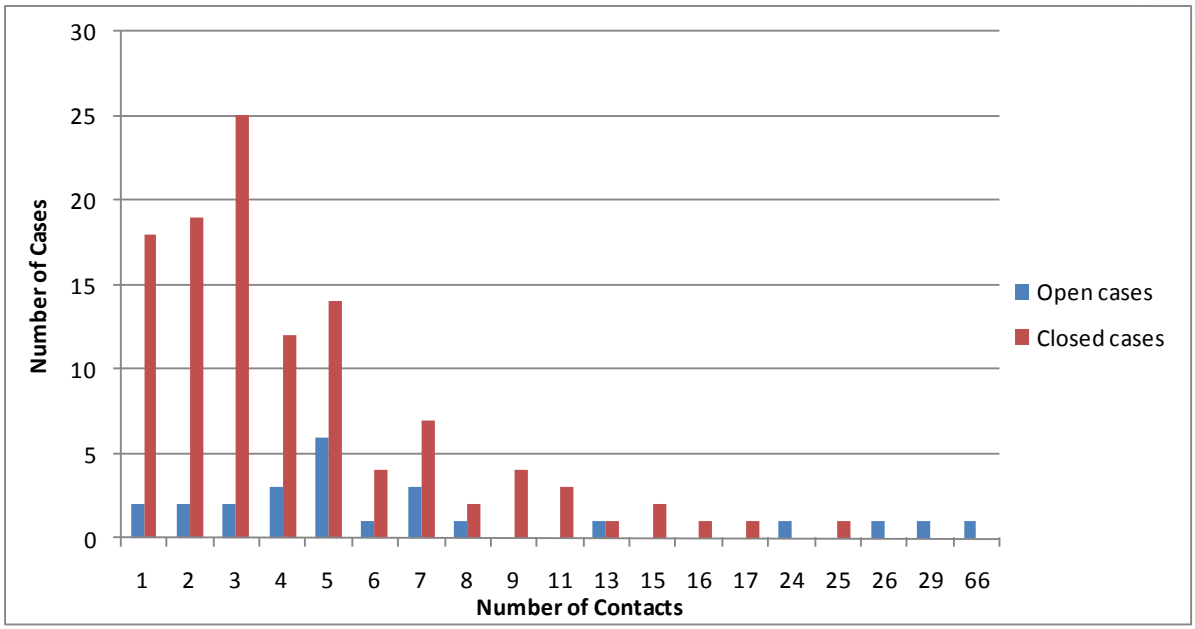


Figure 6 shows that around half of the children and young people referred to the FCAMHS team in the North of South Central required between 1 and 3 contacts with the team. However four cases required more than 20 contacts with the FCAMHS team with one case requiring 66 contacts.

Figure 6: Total number of contacts including DNA & cancellations for North FCAMHS (open and closed cases)



9) Status at discharge from FCAMHS

Table 14 shows the status at discharge from the FCAMH service. Where this is recorded and applicable, the two most frequent recorded responses in both the South and North of NHS South Central are 'Care Order' and 'Sentenced'.

Table 14: Status at Discharge from FCAMHS (North and South)

Subsequent outcome	Total South	Total North
Care Order	16 (12%)	25 (18%)
Sentenced (community or custody)/ on bail/ remand	9 (7%)	25 (18%)
Child in Need/ leaving care/ subject to CP Plan	6 (4%)	22 (14%)
Mental Health Act	2 (1%)	4 (3%)
Other	4 (3%)	7 (6%)
Status Not Known/ Not applicable	100 (73%)	58 (41%)
Total	**137**	**141**

Interviews with Referrers

Profile of Interviewees

A list of potential named organizations and individuals likely to make referrals to the FCAMH service was provided to SPH. These organizations and individuals were contacted by SPH and invited to arrange a date and time for a short telephone interview about their experience of the FCAMH service. A number of individuals approached by SPH in this way recommended additional or alternative people that they thought should be consulted in the evaluation. These individuals were also invited to arrange a date/time for a telephone interview.

In all, SPH approached 30 potential referrers and completed 10 telephone interviews. Telephone interviews lasted typically between 15 and 25 minutes and were carried out between 26th September and 10th October.

Interviewees were mostly employed by locality CAMHS and YOT teams as shown in table 14:

Table 15: Interviewees employing organisation

Type of Organisation	Number of Interviewees
Locality CAMHS Team	5
Youth Offending Team	3
Other	2
Total	**10**

The majority of the Interviewees were based in Hampshire as shown in table 15.

Table 16: Interviewees geographical location

Geographical Location of Interviewee	Number of Interviewees
Hampshire	7
Isle of Wight	1
Portsmouth	1
Southampton	2
Total	**11**

Satisfaction with the FCAMH service

Levels of satisfaction with the FCAMH service were very high in the referrers that we interviewed with 9 of the 10 interviewees stating that they were very satisfied with their contacts with the service. The remaining respondent said that they were more or less satisfied with the contact that had with the FCAMH service, although they had had comparatively little contact compared with some other referrers.

Nature and frequency of contact

The reported frequency of contact varied widely depending on the role of the individual in their organization and the number of cases they had come across where forensic input was considered.

Most contact was around specific cases/referrals although some interviewees were involved in regular meetings with the FCAMHS team and/or in supervision arrangements.

The role played by FCAMHS team

The role of the FCAMHS team that was most often highlighted by interviewees was around improving clinical governance and risk assessment.

"The FCAMHS team has improved clinical governance arrangements that were lacking previously. In the past, there were only limited and ad-hoc arrangements in place for forensic cases"

"The result is better risk assessment, which contains anxiety for practitioners and the network."

Interviewees also stated that the FCAMHS team had provided additional specialist expertise that complemented that available from locality CAMHS and YOT teams

"The team provides invaluable additional expertise around mental health presentations with forensic elements"

Knowledge and ability to sign post to other services was also seen to be a valuable contribution made by the team:

"It was helpful to have access to a team that could signpost the YOT to appropriate specialist services"

Liaison with courts and expertise in the criminal justice system was also valued by some interviewees:

"Court reports usually take 4 – 6 weeks and it is often difficult to find someone to do one as the courts do not pay particularly well. Now the FCAMHS team are able to support the YOT workers in getting psychiatric court reports completed more rapidly"

Interviewees who had attended training sessions run by the FCAMHS team, found them to be very valuable:

"The FCAMHS team has run AIM 1 and AIM 2 training sessions which have covered interventions to tackle sexually inappropriate behaviour which have been very valuable to the local CAMHs team. It has helped the local teams know what to try rather than running to the hills and helps at least contain behaviours rather than allowing behaviours to deteriorate."

However, some interviewees reported that places for some of this training had been limited and their staff had not been considered a high priority to attend.

Clinical benefits

Interviewees were asked about the following specific areas of clinical benefit that the FCAMHS team intend to offer to referrers:

- Identify and support learning disability

  Interviewees usually said that learning disability cases were made up only a small minority of the cases they would be involved with. A couple of interviewees were able to cite specific examples of cases of a young person with Learning Disabilities with forensic mental health needs where the FCAMHS team had been able to provide beneficial support by working with the CAMHS/YOT caseworker, school, parents, social services etc and by providing rapid access to specialist assessments for autism etc.

- Identify and treat psychosis early

  A number of respondents cited the existence of the Hampshire Early Intervention Psychosis service and said that they would be more likely to refer patients with symptoms of psychosis to this service rather than to FCAMHS.

- Manage complex presentations

  This was seen as a key contribution made by the FCAMHS team and interviewees appreciated the additional benefit that the FCAMHS team provided in the holistic view they take in assessing the needs of these young people. A number of interviewees cited cases presenting with sexually harmful behaviours as a key area where the FCMAHS team could provide support. One interviewee cited the benefits of having direct access to a forensic clinical psychologist in gaining advice on management of risky children and young people and in receiving specialist advice on medications and side effects. Other interviewees cited specific individual cases where FCAMHS involvement had helped them in the management of complex cases.

- Facilitate transition to adult provision

  A number of respondents had not been involved with forensic cases that had required transition to adult services. One respondent cited a specific example where they felt that transition had not worked as well as it might have, although this was due to the young person moving between police authorities and local authorities a couple of times in a short time period, rather than an deficiency in the input provided by the FCAMHS team. However, the respondent felt that the local mental health services were a bit slow to catch up with the young person and wondered if more could have been done during transition to facilitate this.

  Other respondents highlighted their co-location with the FCAMHS team (in the case of Swanwick Lodge) and shared sessional input from a member of the FCAMHS team (in the case of Brookvale) as factors that aided discussions around transition.

- Assessing and managing risk of harm to others

  Interviewees valued having the ability to be able to request specialist risk assessments be undertaken for cases about which they had concerns. The fact that the FCMAHs team have training in SAVRY was cited as an important benefit by one respondent. Another respondent considered that the FCAMHS team brought a different perspective to the assessment of risk that was helpful to the locality CAMHS teams.

Areas for improvement

Interviewees identified a number of potential areas where the service might be improved. The most commonly quoted of these was in expanding the size of the service. A number of respondents noted that the team was quite small and covered a large geographical area. There was a perception amongst some interviewees that the FCAMHS team often had to prioritise what they took on and were very aware that visiting a young person in custody outside of NHS South Central could take one of the team away for a whole day. One respondent said that the FCAMHS team were sometimes difficult to get hold of at short notice which they put down to the small size of the team.

One respondent working in children's services for a local authority had only recently become aware of the existence of the FCAMH service and was quite surprised, and a little disappointed not to have found out about it sooner. They were keen to see the service promote itself more widely so that everyone who could benefit from it was aware of what was available.

Another respondent thought that the team could be more involved in transitional arrangements for young people transferring from custody into community services.

A couple of respondents had been aware of training events being run by the FCAMHS team but had not been able to secure places at these events for themselves or their colleagues. One interviewee stated that their team had not been "prioritised" for a particular training event.

Consequences of service ceasing

Interviewees thought that if the FCAMH service were not to be continued beyond the end of the funding period, this would diminish the capacity of the mental health services to adequately manage this patient group. Interviewees cited the following potential consequences of discontinuing the service:

- Potentially would leave locality teams with unmet needs especially around sexually harmful behaviours
- If forensic cases are not adequately managed then there is a significant risk of their behaviour escalating with long term costs to society
- The ability and confidence of CAMHS and YOT teams to manage these complex cases would diminish over time
- As a consequence there would be more pressure on YOT health workers and Tier 3 CAMHS services
- More out of area placements – at cost to LA and NHS
- Slower reintegration programmes
- No expert risk assessments – potentially increased risk to local communities, leading to increased inpatient provision.
- Gap in services for high risk young people – criminal, offending and self harming behaviours.
- Access to the FCAMHS team has been crucial in undertaking thorough assessments of these risky and complex cases.

Examples of Case Histories cited by Referrers

A couple of referrers made reference to individual case study examples when describing how the FCAMHS team had supported them.

One interviewee cited a particular case of a young person who was exhibiting sexually harmful behaviour where the local CAMHs team lacked all the necessary expertise and capacity to support the child and family. The FCAMHS team undertook a clinical assessment of the young person and sent a nurse consultant to work with the family. This had a positive impact and in the interviewee's view probably prevented the living arrangements of the young person from breaking down.

Another interviewee cited the case of a young woman where there were complex issues with the whole family and police involvement. The FCAMHS team assisted the CAMHS worker to see the young person whilst in police custody and carry out a mental health assessment to inform the management of the young person. The FCAMHS team remained involved with the case, leading to the placement of young person and advising network with regard to reintegration and phasing of reintegration.

Interviews with Strategic Stakeholders

Profile of interviewees

A list of potential named strategic stakeholders to the FCAMH service was provided to SPH by Jonathan Bigg. These individuals were contacted by SPH and invited to arrange a convenient date and time for a short telephone interview about the FCAMH service.

In all, SPH approached 11 stakeholders and completed 8 telephone interviews between 26th September and 4th November which typically lasted between 15 and 25 minutes.

Interviewees had a variety of roles as shown in table 16:

Table 17: Interviewee role

Role	Number of Interviewees
CAMHS (commissioner/ manager)	4
Children's services (commissioner / manager)	2
Inpatient services	1
Public Health	1
Total	**8**

The geographical base of the interviewees is shown in table 13:

Table 18: Interviewees' geographical location

Geographical Location of Interviewee	Number of Interviewees
Southampton	4
Hampshire	2
Isle of Wight	1
Other	1
Total	**8**

Nature and frequency of contact

Two stakeholders had not had any direct contact with the FCAMHS team themselves but work with colleagues who have made referrals to the service. Others have had contact with FCAMHS in a variety of ways such as joint attendance at meetings relating to cases and involvement in discussions about the wider provision of CAMHS services and the development and evaluation of the FCAMHS model.

Ways in which FCAMHS team has enhanced service provision

Interviewees cited the specialist advice and expertise that FCAMHS can provide in managing difficult and complex cases.

> *The service has provided somewhere for children with specialist problems to get treatment at a relatively local level.*

> *The service is invaluable in helping to manage the really difficult, complex children that the local CAMHs find it difficult to cope with.*

> *The key contribution made by FCAMHS is around the containment of risk and in giving locality CAMHS teams confidence and support in managing these complex cases.*

Interviewees also stressed the value of FCAMHS in helping to find appropriate placements and in pre-planning work such as supporting young people prior to discharge from custody.

> *Without FCAMHS input, it's likely that (a young person) would have continued to move from placement to placement without having their needs appropriately assessed and met.*

Another interviewee spoke of the broader role of FCAMHS in assisting with the planning of services, for example in discussions to establish a specialist sexually harmful behaviours service across Hampshire.

Interviewees had also received feedback about the FCAMH service from colleagues within both the health and local government sectors which has generally been positive.

One interviewee who commissioned CAMH services highlighted the fact that before the FCAMH service was established they used to refer 3-4 cases a year to the Maudsley Hospital in London for a full forensic mental health assessment (costing around £5k each). Since the FCAMH service has been available, this has not been necessary to make these referrals as the FCAMHS team can now undertake these assessments.

Support to front line practitioners

Several interviewees mentioned the training provided by FCAMHS, for example around sexually harmful behaviours. One interviewee commented that training is delivered in a non-judgmental and easy to understand way.

Another interviewee raised the useful input the FCAMHS team have made to a joint Child Health Commissioning Board.

Areas for improvement

Interviewees suggested a number of ways in which the service could be improved, several of which involved expanding the capacity of the team and the reach of the service across the region. For example, one interviewee had tried to arrange some training for her staff but had been told that places were very limited. One interviewee felt that the FCAMHS team has a good skills mix at the moment but that expanding this, for example to include creative therapy type interventions would be useful.

Two interviewee's felt that the FCAMHS team could be better integrated with other services, one suggesting that the FCAMH service is used more as an expert source of advice at the moment and that they would like to see the FCAMHS team work in a fully integrated way with multi-disciplinary team leads across Tier 3/4 CAMHS and act as the lead professional and co-ordinator for appropriate cases. The other interviewee favoured integrating inpatient, in-reach and community FCAMH services into a single service.

> *This would provide a single and comprehensive forensic CAMHS service covering an entire area with less likelihood of anything falling between the gaps between different services.*

This interviewee also felt that the community based FCAMHS team should play a more active role in facilitating admission to and discharge from inpatient services and in supporting inpatients:

> *The level of engagement and active participation of the community FCAMHS team once inpatients are admitted to Bluebird House could be improved.*

This interviewee also felt that although members of the FCAMHS team do attend meetings about HIOW patients at Bluebird House their level of active engagement compares less favourably to the more established Oxford-based service. Although unsure of the reason for this, the fact that the HIOW FCAMHS is a more recently established service was suggested as a possible factor.

Other areas raised by individual stakeholders included uncertainty about whether there is sufficient awareness of the FCAMH service in all areas, for example amongst GPs and the GP commissioning community and agencies who were not directly involved in setting up the pilot. Another concern raised by one interviewee related to the possibility of FCAMHS attempting to fill gaps in other services or experiencing 'mission creep' into areas which the FCAMH service may not be commissioned for, for example around sexually harmful behaviours.

Strategic Influence

Four of the eight interviewees felt that the FCAMH service has influenced the strategic development of CAMHS and FCAMH services.

> *The FCAMHS team has played an active part in shaping service developments and strategic initiatives. They are well represented on appropriate groups looking at strategy for this patient group.*

One interviewee has not noticed any impact from the establishment of the HIOW CAMHS on a neighbouring FCAMHS team and another interviewee from an inpatient service has not noticed any affect on the number of referrals received from HIOW.

Avoiding Costs

One PCT commissioner indicated that since the establishment of the pilot FCAMHS service, their PCT has stopped referring forensic cases to the South London and Maudsley NHS Foundation Trust for clinical assessment. Previously, their PCT had referred 3-4 patients per annum, each costing around £5k.

Another interviewee considered that they were more confident that there were no cases currently in custody that should be placed in the nationally commissioned medium secure forensic child and adolescent inpatients services. Prior to the pilot FCAMH service being established, they would have been less convinced that this was the case.

In addition, the FCAMHS team has identified a number of specific cases where they believe that intervention by the team is likely to have resulted in savings for NHS commissioners. These savings are likely to have arisen from reduced hospital length of stays, avoidance or reduction in the duration of out of area placements, avoidance of custody and early returns to community living. The details of such cases, as reported by the FCAMHS team, are included in Appendix 2.

Consequences of service ceasing

Six of the interviewees were in favour of the FCAMH service being funded in a more permanent, sustainable way. The other interviewee felt that it would be more efficient in the long term to establish a single FCAMH service covering the whole of the South Central region.

Several interviewees identified potential consequences if the service were not to be funded beyond the end of the pilot period.

> *It's very likely that over time children would end up in wrong places with the attendant sequelae in adult life.*

The ability to retain as many of these children as close as possible to their homes is particularly important and would be reduced were the FCAMH service not available.

The most vulnerable children in Hampshire would be placed in a precarious position and there would be concerns about safeguarding.

Although, the FCAMHS caseload is relatively small, these are incredibly resource intensive cases and the Tier 3 services may struggle to cope.

There would be a risk that they (children's services) would not be able to get the information they need to understand the level of risk that a young person poses. This would limit their ability to manage the risk appropriately.

Training Provision

One of the stated core functions of the FCAMHS team is provision of teaching to frontline practitioners in the criminal justice system (eg, YOT workers, prison officers), CAMHS and other agencies.

Within the annual report for 2010/11 that the FCAMHS service provided to the South Central Specialised Services Commissioning Group the following teaching and training activities delivered by the team are recorded:

Teaching

(a) In November 2010, the team held a well-attended, well-received Launch Event in Southampton, with great support from our partners in OBMH (especially Yvonne Taylor who chaired the day), Caroline Twitchett from DH and the nationally renowned Adolescent Forensic Psychiatrist, Prof Sue Bailey. All FCAMHS members presented workshops in the afternoon. The results of the evaluation of this event are shown in Appendix 4 below.

(b) Jonathan Bigg has delivered two well-received 2-day training events for clinicians. Alone, he trained 7 people (including one FCAMHS colleague) on "AIM 0-12" in Portsmouth city in December 2010, and (with a non-FCAMHS colleague) on "AIM 2" for 8 professionals (three from FCAMHS) in Southampton in May.

(c) Suyog Dhakras, Michael Crutchley and Alison Wallis will deliver SAVRY violence risk assessment training to children's professionals later in February 2012. The agreed programme design will involve combined training on most aspects, followed by specific workshop time on writing Court reports on risk / "dangerousness" for more experienced staff (especially YOT officers) and evaluating specific risk scenarios for less experienced staff.

(d) Jonathan Bigg presented a workshop at a national training day about sexually harmful behaviour in Birmingham in April 2011. He has now repeated the presentation at a workshop in Leeds in November 2011.

(e) Several trainees have gained experiences with FCAMHS already and others have enquired about placements. Most notably we have been thrilled to provide the clinical placement for the last 2 years of Michael Crutchley's Trainee Consultant (Nurse) Practitioner 4-year programme. We have also had a final year (ST6) CAMHS psychiatry trainee with us for a special interest day per week for 6 months.

(f) With YOT Health workers, FCAMHS has run a monthly academic hour on Forensic topics. This has been consistently well received.

Supervision

a) Jonathan Bigg and Suyog Dhakras have supervised Specialist Trainee Psychiatrists with Forensic CAMHS learning needs.

b) AW has provided supervision for clinicians working with Forensic cases.

c) FCAMHS clinicians provide monthly supervision to YOT Health workers and have regular contact at other times according to need.

d) A good deal of FCAMHS work involves case-based clinical supervision to clinicians and whole professional networks.

Jonathan Bigg is also part of the South of England peer group. This brings together psychiatrists working in a variety of adolescent forensic services every three months to discuss cases of interest, seek advice and the experience of peers and share information relevant to work in the specialism.

Conclusions

The HIOW FCAMH service received a total of 137 referrals for children and young people between April 2010 and September 2011. The number of referrals received by the service covering the North of NHS South Central over this period was very similar at 141 referrals.

The age of children and young people referred to the HIOW service ranged from 7 years to 19 years old. Around 80% of children and young people referred to the FCAMH service were male. The age profile for referrals to the FCAMH service in the North of NHS South Central was similar, although there were more referrals of younger children under the age of 11.The majority of referrals were made by locality CAMHs and YOTs and social services.

Both FCAMHS services drew a higher proportion of referrals from organisations based close to where the FCAMHS services are located. Some 29% of the Hampshire & Isle of Wight FCAMH referrals came from organisations based in and around Southampton and over half of the referrals to the FCAMH service in the North of NHS South Central came from organisations based in Oxfordshire.

Of the 137 HIOW referrals, 89 (65%) received an initial consultation, assessment and subsequent input. This was a much higher figure than for the FCAMH service in the North of NHS South Central where only 21% of cases received an initial consultation, assessment and subsequent input. Around half of the cases referred to the FCAMHS team that were closed by the CAMHS team by the end of September 2011, required only 1 or 2 contacts with the team. However, four cases required more than 20 separate contacts with the team, one of which required 41 contacts. Of the cases still in contact with the FCAMHS team at the end of September, a further 7 cases had already generated more than 20 contacts with the team.

Both stakeholders from referring organisations and those with a more strategic perspective on the work of the FCAMHS team generally valued the FCAMHS service highly.

Nine of the ten individuals we interviewed who had direct experience of making referrals to the service indicated that they were very satisfied with the service they had received. The service was valued as a source of expertise and advice for the management of complex presentations that could

be considered as high risk by the locality CAMHS and YOT teams. The additional insight that the FCAMHS team could provide around risk assessments and around the management of children and young people with sexually harmful behaviours was particularly valued.

The FCAMH team's ability to signpost to other services and arrange for other types of specialist assessments was also valued by a number of interviewees. One respondent in particular highlighted the value of the service in assisting in liaison with the courts and in producing reports for court cases.

Those interviewees that had received formal training provided by the FCAMHS team have found it very beneficial, but there were one or two interviewees who had tried to secure places on this training but had been told it was over-subscribed and/or their team had not been prioritised to receive this training.

The interviews that were undertaken with CAMHS and children's services commissioners and others with more strategic input into the service were complimentary of the role the service had played in shaping service developments and strategic initiatives, although one respondent had concerns about the potential for "mission" creep and the service straying into areas beyond its original remit.

One commissioner noted a reduction in referrals for out of area forensic assessments since the establishment of the service, meaning that children and young people could be assessed more locally and at less cost to their PCT. The FCAMHS team have identified a number of cases where they believe that intervention by the team has impacted on the treatment of children and young people in a way that is likely to have reduced costs to NHS commissioners.

Interviewees also cited a number of ways I which the service might be improved in the future:

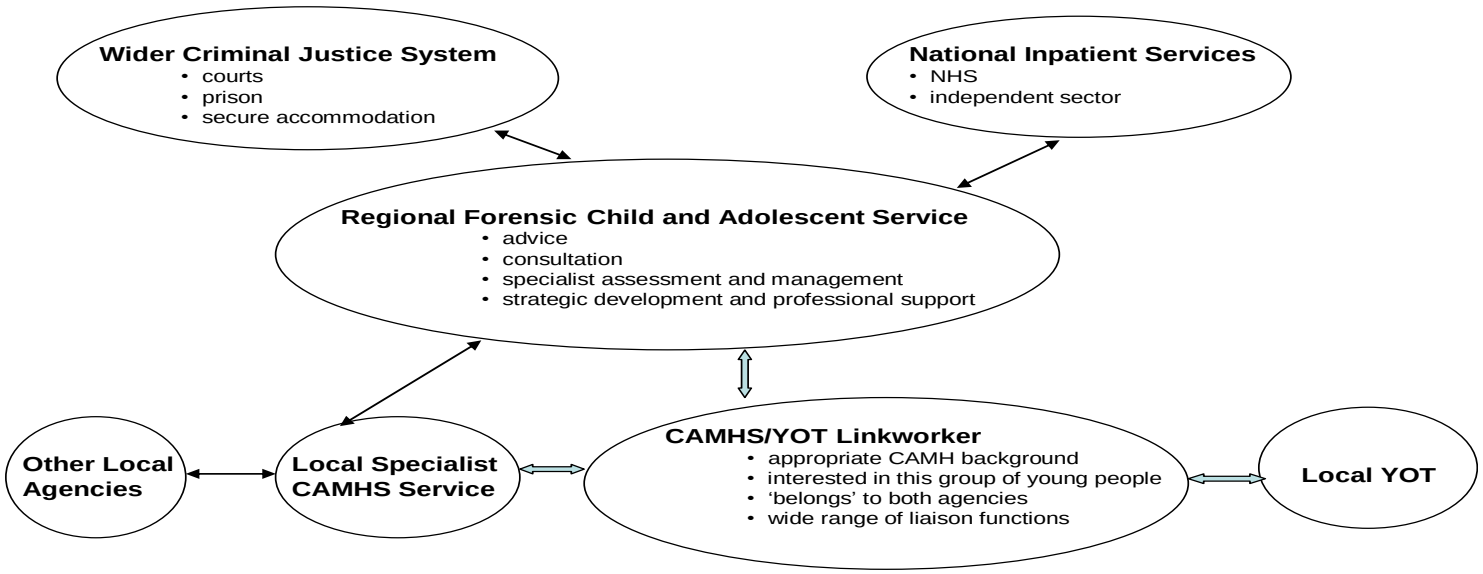
- By expanding the size of the team so that the team was able to visit and asses children in secure settings out of area more easily.
- By providing further training sessions (AIM and SAVRY training were both mentioned) particularly for those who had been unable to attend previous events.
- An interviewee at Bluebird House felt that there could be more active engagement from the FCAMHS team in patients from Hampshire and the Isle of Wight admitted to the unit. They perceived a relative lack of active involvement in comparison with the equivalent community FCAMH service in the North of NHS South Central.
- By increasing awareness of the service particularly amongst social services, GPs and GP commissioners

Interviewees had a number of concerns at the prospect of the service being discontinued after the end of the pilot funding period. Interviewees felt that over time, there would be an erosion in the confidence of the local CAMHS and YOT teams to manage these more complex cases. Some interviewees expressed concerns about the assessment of risk and implications on safeguarding that might ensure if the support of the FCAMHS team was no longer available. Some interviewees also thought that over time there would be increasing pressure on locality CAMHS teams and health workers in the YOTs to manage these cases and/or and increase in referrals to more specialist out of area services.

Appendices

Appendix 1: FCAMHS service model

Figure 2: Regional Community Forensic Child and Adolescent Service: Clinical Network



Oxfordshire and Buckinghamshire Mental Health NHS
NHS Foundation Trust

Appendix 2: Cases where costs to NHS Commissioners were potentially avoided

	Number of patients	Custody certainly avoided at least once	Hospital stay thought to have been reduced	Out of area residential stay thought to have been avoided or reduced	Returned home or to community living more quickly
Certainly needed expert violence risk assessment	16	7	4	3	4
Certainly needed expert sexual risk assessment	13	1	2	5 + 1 transfer to more appropriate unit	5 + 1 transfer to more appropriate unit
Total Certainly	**29**	**8**	**6**	**9**	**10**
Probably needed expert violence risk assessment	11	1	2	1	2
Probably needed expert sexual risk assessment	11			4	6
Total Probably	**22**	**1**	**2**	**5**	**8**

- Expert violence or sexual risk assessment for complex cases, from community-based out-of-area resources costs typically £4000 or more. We estimate that all “certainly needed” cases would have required that and at least a third of the “probably needed” cases also.
- Each stay in a hospital or residential unit caring for such challenging young people will typically cost £250,000 or more per year.

Appendix 3: Examples of FCAMH Case Histories

1. 17 year old Rob had raped two much younger women. His return to the community after custody had to be away from his home area. FCAMHS helped to assess how concerning his apparent lack of empathy was and helped the professional network to manage the risks he posed to the community. High anxieties were diminished with the measured collection of data about his behaviour in the locality. Over the six months he was in the new area, coherent communication and FCAMHS-facilitated information exchange helped containment of the risks. No new offences or concerning behaviours occurred. He engaged in education. He moved away from the area after his initial licence conditions expired and his case was successfully transitioned onto the local adult Probation Service.

2. 16 year old Phil was thought by many to be a paedophile in the making. He had been seen by an expert service in London, which (in the opinion of FCAMHS) produced a report of questionable value, based on little evidence. The family had made a significant number of complaints about that service and local services. FCAMHS assessed him, the family and his educational needs. FCAMHS opinion was that he was autistic and presented little risk of harm to the public with the measured ongoing management plan they helped put in place. The family and professionals were particularly relieved to know better how to view him and to manage him safely.

3. 17 year old James had a keen interest in committing mass murder and violent suicide. FCAMHS assessed and treated his depression, saw him successfully through early psychotic symptoms and then handed over to adult services. When discharged he was no longer homicidal and had the beginnings of a personally valuable future to look forward to.

4. 15 year old Alice was admitted to a private hospital because of depressive symptoms and homicidal plans against her family. The inpatient unit and community CAMHS team assessed that the hospital environment was counter-productive, but were very concerned about her being in the family home again. FCAMHS worked unexpectedly hard to get a well-planned and agreed discharge plan in place. Although delayed discharge had seemed likely, FCAMHS facilitated more speedy return to the community while also ensuring that a peculiarly precipitous, unsafe and unplanned discharge by the hospital consultant was aborted. She settled into independent living, building links with the family again via the Tier 3 CAMHS team.

5. Lara is 13 and had a brain tumour removed. She was extremely violent as a result. She needed placing in a national highly-specialist hospital for safety and for rehabilitation. FCAMHS advised the local Health Commissioner and the professional network on the appropriateness of this hospital placement and steered the hospital towards focused intervention. The inpatient team appeared to wander away from the initial brief with their lead consultant off on a prolonged period of absence; Lara became permanently based in the seclusion suite. FCAMHS took on the task of reasserting the need for the initially agreed focus, in order to promote quicker progress through instilling a greater level of hope. Exit planning resumed swiftly, with a trip to the cinema and the swimming pool the next week. Earlier discharge seems far more likely again.

6. Aaron was 15 when placed away from home in a private residential establishment. FCAMHS was contacted at the start of the 2-year pilot, just after he was placed in the new area. Previously thought of as risky and unmanageable, FCAMHS assessed that risks were being heightened by poor childcare from a poorly managed and largely bank-staffed care team. FCAMHS was very clear that Aaron needed to move and sadly observed him gain a criminal record because of how sub-standard management encouraged him to behave. The team helped local services to source a new placement. However, concerns about quality of care for residents led CQC to close the home suddenly. In the home area he was managed far better and settled well. FCAMHS believes that had

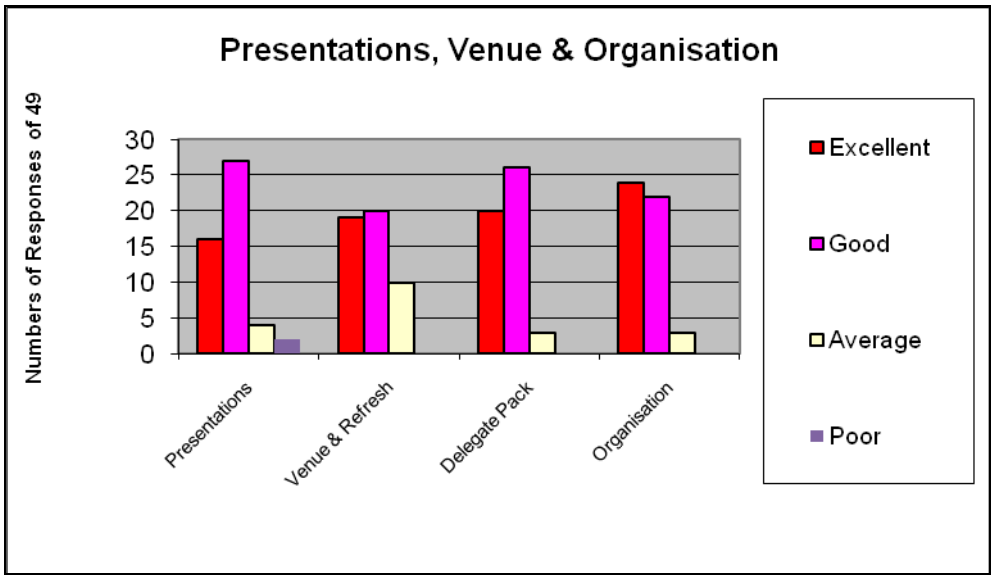
it been in existence earlier, it would have been able to help develop a sustainable plan from statutory resources, delivering far better outcomes for Aaron and saving a year's worth of placement costs.

Appendix 4: Evaluation of FCAMHS Conference

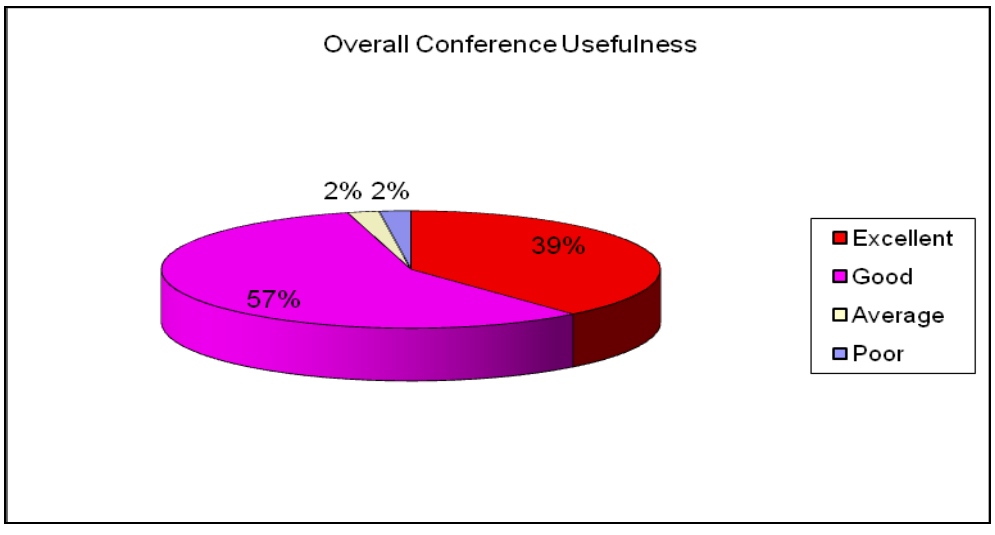
Summary of Evaluation Forms

One hundred and nineteen (119) delegates attended the conference (including speakers and facilitators) – 92% of those booked. Forty nine (49) delegates completed the evaluation form which represents 41% of those present. Please find below a summary of the forms including comments made.

RATING OF PRESENTATIONS



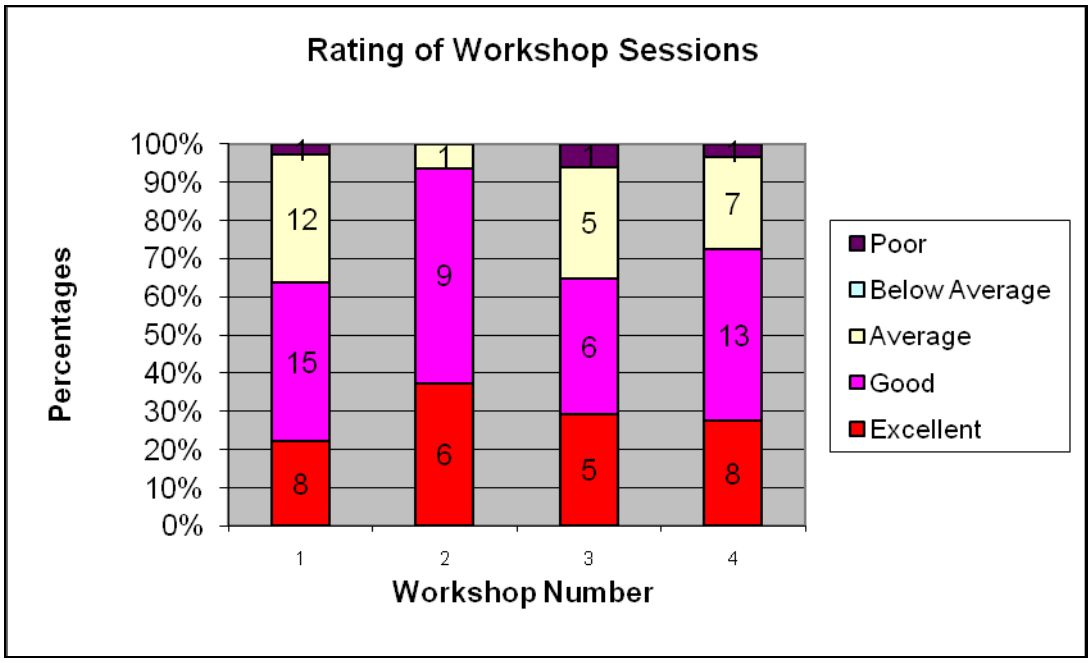
OVERALL CONFERENCE USEFULNESS



RATING OF WORKSHOPS

List of Workshops

- Workshop 1: Violent young people - understanding and working with them
- Workshop 2: Kids, crime, courts and custody - understanding young people's journey in the Criminal Justice System
- Workshop 3: Partnership: multiagency working and the implications for risk management
- Workshop 4: Young people displaying sexually harmful behaviour - understanding and working with them



COMMENTS:

- Excellent event, good speakers and very practical and relevant workshops. Thank you and good lunch.
- FCAMHS presentation slides do not match handouts. Please could these be sent electronically? Particularly valued Sue Bailey's presentation.
- Many thanks for funding this conference for all delegates, without that I would have not been able to attend. Workshop 1 - did not provide much info or food for thought, and didn't coordinate any useful dialogue with delegates. Workshop 2 - basic, but interesting. Good case discussion that provoked good / useful debate. Thanks.

- Well done a very comprehensive training day with multi-agency attendance. Excellent event for networking and for an update on FCAMHS. Will look forward to some more educational workshops where the opportunity to share and receive information is provided.
- A stimulating and useful day.
- Generally a good day. Useful and informative. Surprised at choice of venue in current economic climate and limited resources but an excellent venue.
- Violence workshop was practically helpful. Excellent networking with different disciplines and area of work.
- Enjoyable day, lots of useful information to help gain better understanding of needs of young people in YJS in how to support them.
- Great networking opportunities. Encouragement of further thought around this client group. Thank you.
- Really enjoyed the day!
- Useful day thank you. Food for thought. Useful insight into higher tier service and how the preventative work we do is worthwhile.
- Enjoyed Prof Bailey's presentation; workshops informative and useful.
- A very informative day. Quite exciting, look forward to hearing more as it progresses. Thank you.
- Excellent first speakers – Caroline and Sue Bailey.
- It was really useful to gain an understanding of CAMHS (forensic) referral and the process that follows this in particular workshop 4. I will be able to feed this information back to my team in social care.
- Useful introduction to new service. Most enjoyed lecture on clinical links to research. Relevant to current working environment.
- Glendalyn Children's Home have been fortunate enough to use this service which has been of tremendous help to our staff team in giving them confidence in their dealings with a young person with extreme challenging / violent behaviour. To have this advice at the end of a phone and such willingness to speak to the team very quickly face to face with support and professional advice is invaluable to us doing a very dangerous job.
- Innovative presenters, clear presentations. Jon Bigg and Sue Bailey very good.
- Enjoyable day, thank you.
- Sue Bailey's talk excellent.
- Workshops were particularly of use – very informative and good handouts, etc.
- I feel PowerPointed out. I would have welcomed an opportunity to get more involved. I would have also welcomed the chance to network in a more meaningful way. There needs to be more variety in the presentations styles, also some of it was a bit like teaching me to suck eggs. I have got something out of the day but feel that I would have got a whole heap more if it was presented differently. The message was good; the same old presentation style was painful. Sorry I am sure people put a lot of effort into their session but some people really are not suitable for public speaking.
- Really good to see so many representatives from different agencies / services supporting today. Very good speakers, I particularly liked the challenges Sue Bailey put into the room. They alone could have promoted constructive discussions and debates throughout the day.
- Good location (central) but then have to pay to park! Good mixture of interaction and good mixture of attendees. Helpful day, wonder about links with YOT and SRAP – YOT seemed quite anti the service .
- Very well organised event. I found the conference to be both informative and reassuring that this hard to recognise client group are being recognised as needing a robust service.
- The workshops seemed pointless, I assumed they would focus more on the role of forensic CAMHS. Other work could have been presented, such as evidence based interventions. These could have related to interventions that would be done by forensic CAMHS.

- Sue Bailey's presentation excellent. Content a little too basic for YOT. Could have included more on research and best current practice.
- Excellent venue, refreshments, etc. Sue's talk was good; however a lot of information to cover in a short space of time.
- Excellent day throughout – thank you.
- 12 out of 10 as usual – conferences organised by Louise Appleby are excellent.
- Sue Bailey's – interesting speaker. Some very busy slides not possible to take in and printout too small to be readable. Used word "evidence" as a verb!? Nitpicking I know. I found myself much more positive listening to what she said as it made a lot of sense. Worth coming for this alone. Jon Bigg / Suyog Dhakras – slides covered in abbreviations e.g. "close links with CMHS, LA, CJS, YOT, YOI's, STC's, LASCH." Inevitably, given the nature of the meeting, a lot of time talking about structure. More formal presentations of individual cases as illustrations would have been helpful. Case study in Workshop 4 was extremely helpful in understanding of issues and process. Workshop1 – good discussion of case history. Frustrating not to be able to hear all the contributions.

Appendix 5: Questions for Referrers to the FCAMHS Team

Interviewee:

Organisation and position:

Date of interview:

Name of interviewer:

1. What is the nature and extent of your involvement with the Hampshire & Isle of Wight FCAMHS service?

Have you ever had contact with the FCAMHS team?

IF YES:

2. How many times have you contacted the FCAMHS team in the last year?

3. For what reasons did you contact the FCAMHS team?

4. Which of the following has the FCAMHS team offered your team for your clients?

- Telephone advice Yes / No
- Client assessment Yes / No
- Ongoing treatment/supervision Yes / No
- Liaison and advice to courts Yes / No
- Other (please explain)

5. In terms of the following roles of the forensic CAMHS service, how has it helped you, and how could it improve its service?

Roles of the forensic CAMHS service	How has the forensic CAMHS service helped you in this area?	How could the forensic CAMHS service improve its service in this area?
Liaison with relevant agencies and institutions, to establish better links between mental health services and the criminal justice system		
A tertiary forensic mental health assessment service		
Training for frontline staff		

6. In terms of the clinical benefits anticipated from the forensic CAMHS service, how has it helped you, and how could it improve its service?

Clinical benefits anticipated from the forensic CAMHS service	How has the forensic CAMHS service helped you in this area?	How could the forensic CAMHS service improve its service in this area?
Identify and support learning disability		
Identify and treat psychosis early		
Manage complex presentations		
Facilitate transition to adult provision		
Assessing and managing risk of harm to others		
Any Others?		

7. Overall how satisfied have you been with the response(s) you received from the FCAMHS team?
   - Very Satisfied
   - Satisfied
   - Neither satisfied nor dissatisfied
   - Dissatisfied
   - Very dissatisfied

8. If the FCAMHS team no longer existed, what impact would this have on your ability to offer high quality care to your clients?

9. Are there any other comments you would like to make about this service?

Thank you and Close

IF NO:

10. Were you aware of the forensic CAMHS team's existence?

11. Why have you not contacted the FCAMHS team?

Thank you and Close

Appendix 6: Questions for Strategic Contacts for the FCAMHS Team

1. What is the nature and extent of your involvement with the Hampshire & Isle of Wight FCAMHS service?

2. Do you consider that the Hampshire & Isle of Wight FCAMHS service has enhanced the provision of services for children & young people with mental health needs who are in contact with the criminal justice system across Hampshire & the Isle of Wight?
    - If so, in what ways?
    - If not, why not?

3. Have you received any feedback either positive or negative from individuals or agencies who have accessed the service since it was set up in 2009/10?
    - If so, what has the feedback been?

4. Do you think the service has improved the ability of frontline practitioners in locality CAMHS/YOT teams to appropriately manage this client group?
    - For example, have you or any of your colleagues been involved in training courses etc

5. Are there any ways in which you feel that the service could be improved?
    - If so, how

6. Do you think the service has influenced the strategic development of CAMHS/FCAMHS services locally and/or nationally?

7. Would you favour this service being funded on a more permanent basis?

8. What do you think the consequences would be if the service was not funded beyond the end of the pilot period (end of March 2012)?

9. Are there any other comments you would like to make about this service?