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Transition from CAMHS to Adult services policy

An easy read version to support professionals working with young people during the transition period. This does not replace the policy document.

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Purpose and scope of the transitions policy

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The policy provides guidance and principles of good practice in relation to the transition of services users from CAMHS to other services after their 18th birthday such as primary care, secondary care, IAPT and the VCS

The policy helps to ensure the transition process is well planned, efficient and takes care of how young people and parents/ carers experience the process.

All professionals working with young people during the transition period need to ensure this policy is adhered to.

The transition process should commence six months before a service user's 18th birthday with a formal referral to both the appropriate Adult Mental Health Team and Consultant Psychiatrist and continue for up to a further six months beyond transfer.

The policy applies to adolescent service users who are receiving services from CAMHS for symptoms, which include the following:

- A psychosis or major mental illness
- Mental health/ psychological needs, which are likely to continue into adulthood
- An enduring mental health problem
- Mental health/ psychological needs that would benefit from an intervention from the Wellbeing team

The above includes service users who are eligible for transfer to AMHS within a care planning framework (formally the Care Programme Approach or CPA).

Open case transition process

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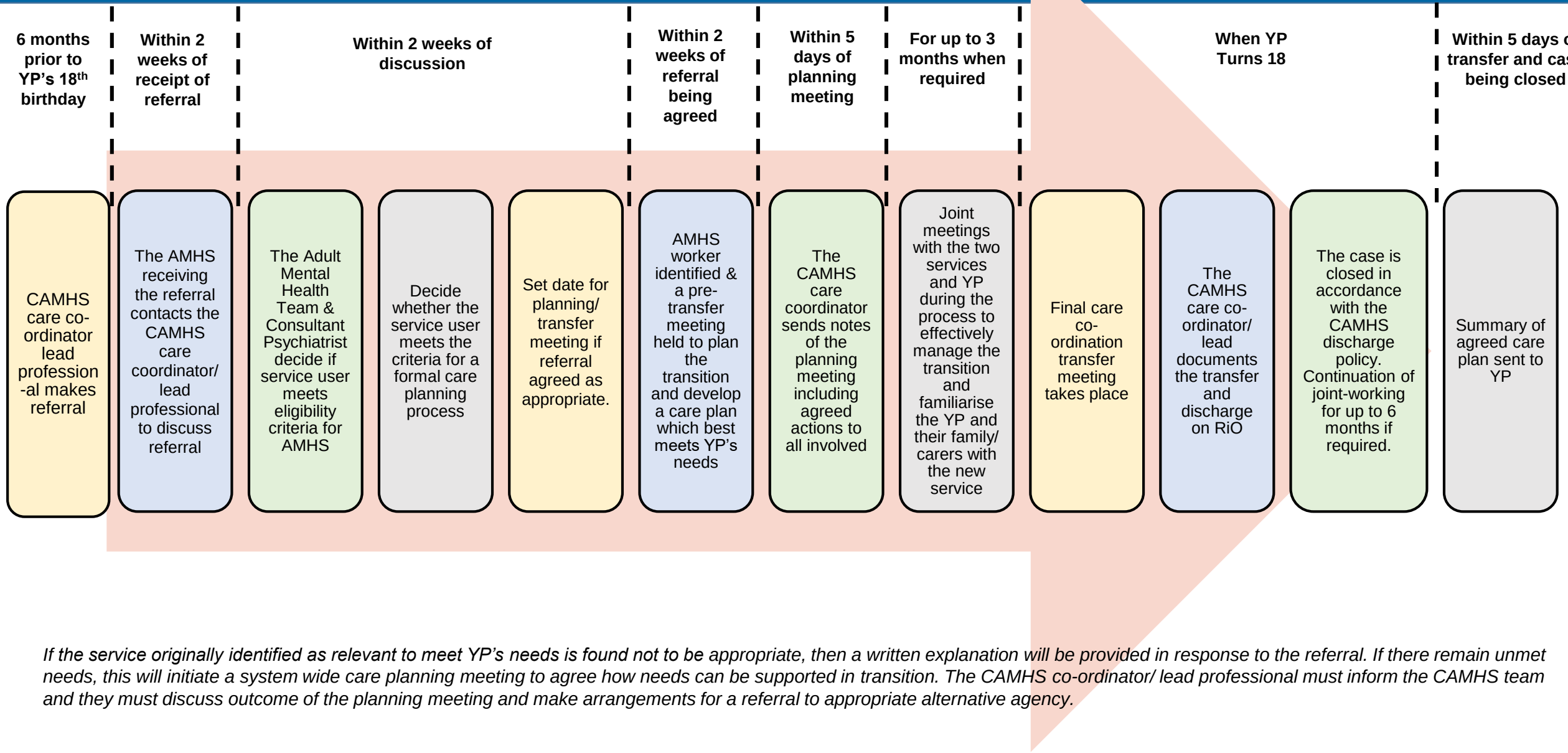

If the service originally identified as relevant to meet YP's needs is found not to be appropriate, then a written explanation will be provided in response to the referral. If there remain unmet needs, this will initiate a system wide care planning meeting to agree how needs can be supported in transition. The CAMHS co-ordinator/ lead professional must inform the CAMHS team and they must discuss outcome of the planning meeting and make arrangements for a referral to appropriate alternative agency.

Roles and responsibilities

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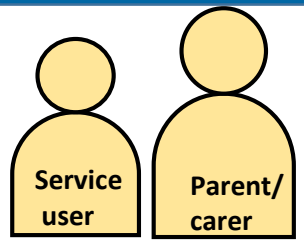
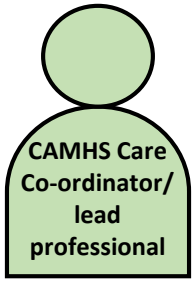
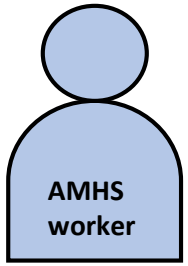


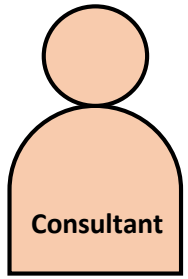
- Should be involved at each stage in the transfer process.
- Where applicable, this includes creation of transition plans and being provided with the appropriate information regarding the new service and the implications of the change in legal status post 18.
- Must be assisted to prepare for the transition



- Makes referral and discusses proposed transfer with YP and family/carers
- Responsible for informing the CAMHS consultant of any impending transfers, and to discuss referral to AMHS
- Makes a record of planning meetings detailing actions agreed and distributes to all involved
- Arranges final care co-ordination transfer meeting after YP's 18th birthday
- Sends a CAMHS discharge letter to YP, their GP and all those involved in YP's care
- When a YP is transitioned to AMHS within ELFT, Adults will automatically have access to the electronic records held on RiO at the time of transition. CAMHS will arrange for any historical paper files to be transferred to the adult service at transition, unless the client has previously dissented
- Responsible for ensuring that the transition between services goes smoothly



- Responsible for completing the documentation at the transfer meeting
- AMHS team manager's and CAMHS worker are responsible for ensuring admin staff are made aware of transfers in and out of teams and that records are updated



- When a service user's care is formally transferred from CAMHS to AMHS, consultant responsibility must also be transferred
- This should occur at the transfer meeting. Until this meeting consultant responsibility lies with the CAMHS consultant.
- In a situation where YP turns 18 prior to formal transfer but requires urgent admission, the admission will be to an adult bed and consultant responsibility transferred to the adult consultant upon admission. A transfer care planning meeting should then happen at the earliest available opportunity and the AMHS team should be involved in the care planning process.
- In unlikely situation where urgent admission is required for YP yet to turn 18 but formal transfer of care has already taken place, the admission must be to an adolescent facility and consultant responsibility transferred to the adolescent inpatient consultant upon admission. A transfer care planning meeting should then happen at earliest available time and original referring CAMHS community team should be involved in the care planning process.

All professionals working with young people during the transition period need to ensure the transition policy is adhered to.

Referrals, planning meetings and closing cases

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Referrals should contain:

- A case summary including medication history, physical health problems and relapse indicators
- Reasons for transfer
- YP and their families' views
- Legal frameworks in place- MH Act, Children's Act, MC Act, Care Order
- Details of YP's GP
- A request to arrange a planning/transfer meeting and allocation of a Care Coordinator within the receiving adult team
- An updated CAMHS needs assessment
- Updated documentation re the care planning process if relevant
- An updated risk assessment and a carers assessment if relevant

The planning meeting should be attended by:

- The YP
- Their parents/carers
- CAMHS reps and other services involved
- reps of the adults service considered most appropriate to meet YP's needs
- Other services involved with YP
- Communication needs must be met via ELFT's interpretation service.

The care plan should include:

- An agreed timetable for transfer
- Details of the transition process with planned milestones
- An agreed plan and timetable for any joint working required ahead of the transfer including how and when YP will be introduced to their new care co-ordinator in Adults services.

The planning/ transfer meetings should cover:

- A care plan should be discussed and agreed
- Ensuring YP, families/ carers know who to contact and what to do if they feel things are not going according to plan
- Agreement on roles and responsibilities during and after transfer
- Review of care plan and current risk assessment
- An agreed date for the final care co-ordination/ planning process transfer meeting
- CAMHS worker needs to ensure there is an updated clinical summary and risk assessment for the final care co-ordination transfer meeting detailing progress since initial referral and any changes

The transfer and discharge of the YP from CAMHS must be completed in line with discharge policy and documented on RiO including:

- Reason for transfer
- YP's condition at time of transfer
- Final evaluation summary of YP's progress towards identified treatment/ care goals, including any ongoing risks and management strategies
- Summary of agreed care plan
- Name of new care co-ordinator
- Other family members concerned in original referral need their right to confidentiality respected

Standards for transitions

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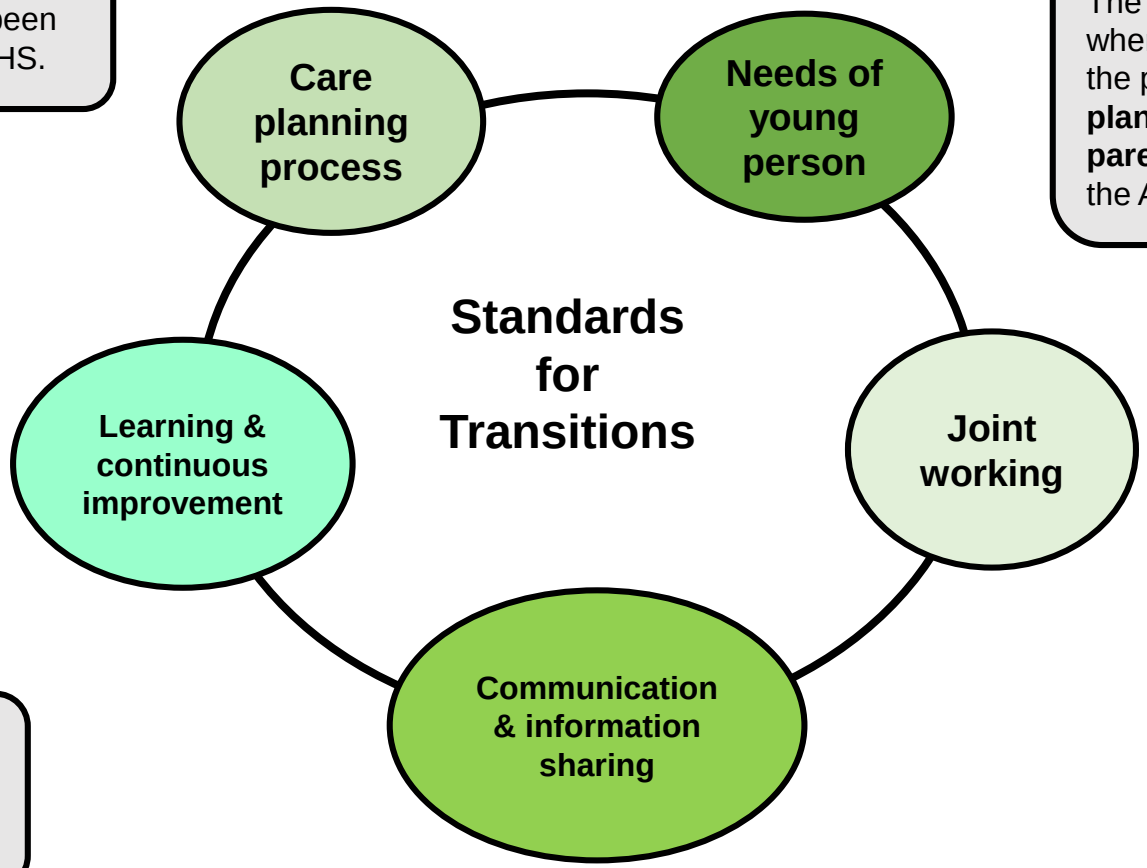
A **care planning process** is integral to transferring to adult services if YP has been subject to CPA when transferring to AMHS.

Regular meetings between CAMHS and AMHS to discuss changes in the Adult offer, how this impacts transitions from CAMHS, any escalated cases for a review of lessons learned etc.

Audited **experience surveys** for a sample of completed transitions every 6 months to be reviewed in the Quality Committee.

A number of discussions should take place within 3-6 months prior to transfers involving Adult inpatient or Adult Mental Health Secondary care services.



The **needs of the YP** should come first. The YP (and where appropriate their family) will be at the centre of the process and involved at all stages. **Transition plans created in conjunction with the YP and parent/ carer** where applicable and agreement from the AMHS for any transition goals set.

Joint discussions to support the transfer, supported by a **clear case summary** within discharge letters for transfers to services other than Adults inpatient or secondary care from CAMHS.

A period of joint care may also be beneficial to YP if transferring to Adult Mental Health secondary care services.

Effective information sharing between services that is clearly communicated within the transfer process.

Information regarding any child protection/vulnerable adult concerns will be clearly communicated within the transfer/referral assessment and planning process, jointly involving social care colleagues where required. The Trusts **Safeguarding children/vulnerable Adults procedures will be adhered to at all times**.

Types of transitions

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Transfer involving Adult inpatient or Adult Mental Health Secondary care services

- A number of discussions should take place within 3-6 months prior to the transfer.
- More on inpatient transitions on next slide.

Out of borough transition to alternative independent accommodation at 18 years of age

- The open case transition procedure is to be followed with the relevant adult team in the new area, including the transfer of consultant responsibility.

Transfer to GP for ongoing medication review

- Should follow the same process as a closure to CAMHS

Transfer to Primary Care and IAPT services

- The process will be that of discharge in line with ELFT's discharge policy
- Supported when required by a "warm handover", which is a conversation between services about the YP's situation at discharge.

Transfer to voluntary sector offer

- Clear signposting via the discharge letter needs to be sent to YP outlining possible future support.

No further intervention or treatment planned

- All YP should have a written and agreed plan at discharge in line with ELFT's discharge policy even if no further intervention or treatment is planned
- The plan should identify resources for advice, information, self-help and support so that the YP and where appropriate parents/ carers know what to do if they become unwell.

Inpatient transitions

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Admitted to ELFT's Adolescent inpatient service (The Coborn), approaching 18 & NOT previously known to community CAMHS	• Responsibility of the Coborn team to initiate the transition process • When a referral to AMHS is being considered, the YP, family or carers should be informed at the beginning of the admission
Admitted to an adolescent inpatient service within ELFT, in other NCEL Provider Collaborative beds, or elsewhere (e.g. private sector) who are approaching 18 & already KNOWN to community CAMHS	• Responsibility of Community CAMHS from where YP normally resides to initiate the transfer process and follow up • In some cases it may be more appropriate to refer from the in-patient service; agreed between the inpatient service and CAMHS community team as clinically appropriate • E.g. if YP has been inpatient for a significant period of time or YP not known or only briefly known to community team prior to admission
Admitted to an adolescent facility outside of the NCEL Provider collaborative area who are likely to still be in hospital after the age of 18	• The Provider Collaborative Case Manager will ensure that the Provider Collaborative commissioning team are informed • This is so appropriate clinical transfer plan and agreement about which community CAMHS and AMH teams need to be involved and any additional funding arrangements after 18 can be put in place • Transitions to adult services for YP admitted to Tier 4 units other than the Coborn should be overseen by the CAMHS Provider Collaborative Patient Flow Team (Case Manager) community CAMHS care co-ordinator/ CAMHS general manager and the Tier 4 inpatient team

Inpatient transitions

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Aged 17 ½ and above is ready to be discharged before their 18th birthday	• The service user should be discharged to their community CAMHS team
Transferring to other ELFT inpatient services	• The Coborn team will liaise with the local AMH inpatient team to arrange transfer; or • It is the role of adult inpatient services to consider any measures for gate keeping admission by utilizing alternatives such as home treatment as appropriate. • Undue delay in transfer of care must be escalated to ELFT CAMHS and Adult Clinical Directors
Transferring to services outside ELFT	• The Coborn will liaise with the Provider Collaborative Patient Flow Team and Case Manager to identify an appropriate adult mental health bed from the relevant mental health trust • Undue delay in transfer of care must be escalated to the NCEL CAMHS provider collaborative Clinical Director
Young people who remain in inpatient service after their 18th birthday	• YP will remain in Coborn when clinical view is that an episode of care can be completed shortly after 18th birthday and will be discharged to the AMH service • ELFT safeguarding policy and procedures need to be followed to ensure safeguards in place for other YP on the unit

DNAs, disputes and exceptions

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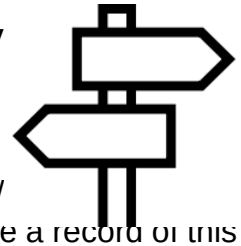
Young People Who Do Not Attend (DNA)

- Where YP does not engage with the transition process, the CAMHS clinician should ensure that the ELFT Did Not Attend policy is followed
- If YP continues to DNA and thus does not engage in the transition process, a summary of the attempts made to engage and involve the young adult in the process should be documented on RiO, including potential risks and the likelihood of future presentation to adult services
- A discharge summary should be written and sent within 5 working days to the GP, highlighting any potential risks and whether the young adult would benefit from future interventions if they present at a later date to the appropriate Adult Mental Health services
- CAMHS clinician should also write to YP informing them of the position and their discharge from service and providing them with the contact details of how to access services in the future if they should wish, including other support and services in the community that may be available to them.

Resolving disputes

- CAMHS care coordinator/lead professional should arrange a case discussion to be held as soon as possible from the time when the conflict/lack of agreement has arisen as to the appropriate service for YP and to be resolved as quickly as possible
- Relevant team managers from CAMHS and Adult services should attend and it's expected that an agreement will be reached on the most appropriate way forward to meet the health needs of YP. Ideally the CAMHS consultant and AMHS consultant will both be present.
- If agreement cannot be reached, CAMHS & relevant adult mental health and CAMHS managers should inform their respective Leads (Adult locality CD and mental health services and CAMHS ACD) who should discuss the situation and make a decision no longer than 5 days after the case discussion.
- If resolution can still not be made, then the appropriate Directors should be approached and must make a final decision.
- In all cases, the CAMHS care coordinator/lead professional has the responsibility to ensure that the young person involved receives the appropriate care and treatment whilst the conflict is resolved.

Exceptions to the policy



- If it's not possible to follow any of the care planning process for any reason, the CAMHS care co-ordinator/ Lead professional should make a record of this on RiO and detail the actions taken to ensure an effective handover
- Community transfer of care should not be undertaken when YP is acutely unwell.
- In exceptional circumstances CAMHS may deem it appropriate to request the transfer of care prior to a service user's 18th birthday, due to their needs being better met by AMHS.
- Cases may also arise where CAMHS may deem it appropriate that a transfer of care should be delayed; due to a service user's clinical needs being better met within CAMHS even after the 18th birthday.
- Above scenarios should be discussed on a case by case basis by the CAMHS and AMHS clinical teams and the reasons for these decisions made explicit.
- Any unresolved disagreements about transfer of care between CAMHS and AMHS should be referred to the Clinical Directors of the two services.