**Transition from Child and Adolescent   
Mental Health Services to Adult Mental Health   
Services Policy**

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| 2.0 | 2012 | Dr Barnaby Major/ Dr Ruma Bose/ Dr Nick Bass/ Dr Gary Jenkins | Final | This policy is designed to provide guidance for the procedure and practice in the transition of service users from Child & Adolescent Mental Health Services to Adult Mental Health Services. |
| 2.1 | 2014 | Dr. Graeme Lamb | Final | The revised version provides additional guidance around referral for transfer and the transfer of historical clinical records between CAMHS and Adult Services. |
| 2.2 | 2016 | Dr Helen Bruce  Dr Dudley Manns  Dr Viktor Kulik  Dr Graeme Lamb | Final | Revised version broadens scope of the policy to include range of presentations in adolescents |
| 2.3 | 2019 | Dr Helen Bruce  Dr Dudley Manns  Dr Viktor Kulik  Dr Graeme Lamb | Final | Extension agreed for 1 year |
| 2.4 | 2022 | Dr Cathy Lavelle  Tim Bull  Dr Sarah Dracass  Dr Liz Dawson  Claire McKenna | Final |  |

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**1 Introduction**

1.1 Adolescence is the period of developmental transition from childhood to adulthood. It is a period of profound emotional, physiological and social change for young people and their families. It is a period associated with increased rates of psychiatric morbidity, substance misuse and risk-taking behaviours.

1.2 Adolescence is not strictly defined by age; however, the point at which service users with ongoing mental health problems are transferred from adolescent to adult services typically occurs at 18 years.

1.3 It is recognised that healthcare transition is often inadequately planned, inefficiently executed and poorly experienced. There is a risk of disengagement at this crucial time as a result.

1.4 The purpose of this policy is to provide guidance and principles of good practice in relation to the transition of service users from Child and Adolescent Mental Health Services (CAMHS) to other services after their 18th birthday such as Primary Care, Secondary Care, IAPT and Voluntary Sector

1.5 For the purposes of this policy, transition should be conceived of as a process. Transfer of care from CAMHS to Adult Mental Health Services (AMHS) takes place at a point during this process (normally around the time of the service user’s 18th birthday).

1.6 When planning any transition every effort should be made to put the service user and their family/carers at the centre of this process. Particular consideration should be given to the service user’s developmental needs around this time.

**2 Scope of the Policy**

2.1 This policy is aimed at all professionals working in Child and Adolescent Mental Health Services, Primary Care Services, IAPT services and Adult Mental Health Services (AMHS).

2.2 This policy is applicable to adolescent service users who are receiving services from CAMHS for symptoms which indicate: -

* 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

2.3 Some service users identified as eligible for transfer to AMHS will be transferred within a care planning framework (formally the Care Programme Approach - CPA), outlined in the Trust-wide Care Programme Approach Policy (January 2009). However, the principles of good practice such as timely referral, informing and preparing young people and their family/carers for transfer of care, and good communication between services should also apply to all young people for whom transfer is occurring.

2.4 Not all young people receiving care in CAMHS will require transfer to AMHS. With regard to transfers to Primary Care and IAPT services from CAMHS, the process will be that of discharge supported when required by a “warm handover” which is a conversation between services about the young person’s situation at discharge. For a transfer from CAMHS to a Voluntary Sector offer, clear signposting via the discharge letter sent to the Young Person possible future support is required.

2.5 It is the responsibility of all clinicians working with young people during the transition period to ensure that this policy is adhered to.

2.6 In order to facilitate effective transition and joint working a bi-annual interface meeting will be established between CAMHS and AMHS in each of the boroughs.

**Standards for Transition from CAMHS to Mental Health Services as an Adult**

* The needs of the young person, not of the service, should come first and foremost
* The young person (and where appropriate their family) will be at the centre of the process, and involved at all stages
* There should be effective information sharing between services that is clearly communicated within the transfer process
* Where possible there should be a joint discussion 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
* The transition of YP to GP for ongoing medication reviews should follow the same process as a closure to CAMHS
* For transfers 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.
* A care planning process is integral to transferring to adult services if the young person has been subject to CPA when transferring to Adult Mental Health Services.
* Community transfer of care should not be undertaken when the young person is acutely unwell. Transition plans created in conjunction with the YP, parent carer where applicable and agreement from the AMHS for any transition goals set.
* A period of joint care may be beneficial to the young person if they are transferring to Adult Mental Health secondary care services
* 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
* There will be regular meetings between CAMHS and Adult MH services to discuss changes in the Adult offer, how this impacts the transition of young people from CAMHS, any escalated cases for a review of lessons learned etc
* Audited experience surveys for a sample of completed transitions every 6 months (suggested % YP per service to be agreed) to be reviewed in the Quality Committee.

**3 Open Case Transition**

3.1 The process of transition from CAMHS to AMHS should commence six months before a service user’s 18th birthday and continue for up to a further six months beyond transfer.

3.2 When a referral to AMHS is being considered the CAMHS care coordinator/lead professional will discuss a proposed transfer with the young person and their family/carers.

The young person and their family/carers should continue to be involved at each stage in the transfer process and assisted to prepare for the transition. This includes being provided with the appropriate information regarding the new service and the implications of the change in legal status post 18.

3.3 A formal written referral should be sent to both the appropriate Adult Mental Health Team and Consultant Psychiatrist six months prior to the service user’s 18th birthday.

3.4 The referral should contain:

* A case summary (including medication history, physical health problems and Relapse indicators
* reasons for transfer
* The young person and their families’ views.
* Legal frameworks in place- MH Act, Children’s Act, MC Act, Care Order
* Details of the young person’s GP
* A request to arrange a planning/transfer meeting and allocation of a Care Coordinator within the receiving adult team.

It should also include the following attachments:

* An updated CAMHS needs assessment
* Updated documentation re the care planning process if relevant
* An updated risk assessment
* Carers assessment if relevant

3.5 The Adult Mental Health Service receiving the referral will contact the CAMHS care coordinator/lead professional within two weeks of receipt of referral to discuss the referral.

3.6 The Adult Mental Health Team & Consultant Psychiatrist will then decide whether the service user meets eligibility criteria for AMHS.

A further decision should also be made as to whether the service user meets the criteria for a formal care planning process, and hence whether they are appropriate for follow up by the Mental Health Team or by the Consultant Psychiatrist alone.

3.7 The Adult team will inform the CAMHS team the decision within 2 weeks.

If the referral is agreed to be appropriate, a planning/transfer meeting date within 2 weeks will be set at this time.

If the referral is deemed not 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.

3.8 For service users identified by the adult team as appropriate for handover and appropriate for allocation of a care coordinator, an AMHS worker should be identified and a pre-transfer meeting held to plan the transition and develop a care plan which best meets the needs of the young person. This may involve interventions by CAMHS, adult services or a mixture of both during the transition period. In order to effectively manage the transition and familiarize the young person and their family/carers with the new service, the young person should be seen jointly by the two services during the process of transition for up to 3 months when required**.**

**Care Planning/transfer meeting**

The planning meeting should be attended by:

* The young person
* Their parent/s/carers
* Representatives of the CAMHS and other services that are currently involved
* Representatives of the adult services that it is considered most appropriate to meet the needs of the young person who is approaching transition. This may be the local Community Mental Health Service, but may involve other services such Community Eating Disorders Service, Wellbeing Team, Community Learning Disability Team, Vocational, Employment and Education Services, Children’s Services, Housing and any other voluntary and statutory agencies involved with the young person

In all cases where people attending the meeting have additional communication needs, such as physical, sensory or learning disabilities, and people who do not speak or read English, their range of communication needs must be met via the Trust wide interpretation service.

The Care Planning meeting should discuss and agree a Care Plan which should include:

* An agreed timetable for the transfer
* The 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 the young person will be introduced to their new care coordinator in adult services.
  + Ensuring that the young person, their family/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 the transfer
  + Review of the care plan and current clinical risk assessment.
  + An agreed date for the final Care-coordination/care planning process transfer meeting

In considering transfer of care the needs of the carer should also be considered and a carer’s assessment offered if appropriate.

The CAMHS care coordinator/lead professional will make a record of this meeting which will detail the actions agreed and distribute the notes to all involved within 5 days.

If the planning meeting decides that the service originally identified as relevant to meet the young person’s needs, is not the appropriate service, the CAMHS care coordinator/lead professional will inform the CAMHS team. They will discuss the outcome of the planning meeting and make arrangements for a referral to the appropriate alternative agency.

The CAMHS care coordinator/lead professional will have the responsibility to ensure that the transition between services goes smoothly.

If it is not possible to follow any of the above procedure for any reason, the CAMHS care coordinator/lead professional should make a record of this in RiO and detail the actions that have taken place to ensure an effective handover.

The CAMHS care coordinator/lead professional will then arrange a final Care coordination transfer meeting after the service user’s 18th birthday at which responsibility for the young person’s care and treatment will be formally transferred to adult mental health services. This official transfer will include any Responsible Clinician responsibility.

The CAMHS worker will also ensure that there is an updated clinical summary and risk assessment available for the meeting, detailing progress since the initial referral and any change in the clinical condition or risk assessment.

Following the final transfer meeting, the CAMHS care coordinator/lead professional will send a CAMHS discharge letter to the young person, their GP and all those involved in the young person’s care.

The AMHS worker will be responsible for completing the documentation at the transfer meeting.

It is the AMHS team manager’s and CAMHS worker’s responsibility to ensure that administration staff are made aware of transfers in and out of teams, and that records (both electronic and manual) are updated.

The CAMHS care coordinator/lead professional will document the transfer and discharge on the RiO. The discharge/transfer summary should include the following information:

* The reason for the transfer
* The child/young person’s condition at the time of transfer
* A written final evaluation summary of the child/young person’s progress towards identified treatment/care goals, including any on-going risks and possible management strategies
* A summary of the care plan agreed with adult mental health services
* The name of the new care coordinator

This summary will be sent within 5 working days of the child/young person’s transfer and the case subsequently closed on Rio.

**Examples of shared working during the transition period include:**

* Joint meetings with both care co-coordinators,
* Visits by the young person and their family to look around the new community base
* A practice journey or planning for a journey to the new site,
* Introduction to new clinicians before the transfer meeting
* Arrangements to allow a period of contact with the CAMHS care co-ordinator/named clinician if the young person is confused or anxious to support engagement with new team.

**Resolving Disputes**

On occasions, there will be disputes as to the appropriate service for the individual young person. It is essential that these disputes are resolved as quickly as possible.

When a dispute arises, the CAMHS care coordinator/lead professional should arrange a case discussion. This should be held as soon as possible from the time when the conflict/lack of agreement has arisen.

The relevant team managers from CAMHS and Adult services should attend the case discussion where it will be expected that an agreement will be reached on the most appropriate way forward to meet the health needs of the service user. Ideally the CAMHS consultant and AMHS consultant will both be present.

If an agreement cannot be reached at this meeting, the 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.

This should happen no longer than 5 days after the case discussion.

If a 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.

**Young People Who Do Not Attend (DNA)**

Where a child/young person who is or has been referred by CAMHS to Adult Mental Health services does not engage with the transition process, the CAMHS clinician should ensure that the ELFT Did Not Attend policy is followed.

If the young person 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.

The CAMHS clinician should also write to the young person 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.

**Transfer to other services**

For transfer to non-mental health services, such as primary care, IAPT and secondary care, and to OOA non-mental health services such as University medical teams, please refer to the process outlined in the ELFT discharge policy:

* All young people should have a written and agreed plan at discharge if no further interventions or treatment are planned. The plan should identify resources for advice, information, self-help and support, so that the young person and, where appropriate, parents/carer knows what to do if they become unwell.

**4 In Patient Transition**

4.1 For service users admitted to the Trust’s Adolescent inpatient service (the Coborn), who are approaching 18 years of age and are not previously known to community CAMHS, it will be the responsibility of the Coborn team to initiate the transition process.

* When a referral to AMHS is being considered, the young person, family or carers should be informed at the beginning of the admission to the CAMHS in-patient unit.

4.2 For service users admitted to an adolescent inpatient service within the Trust, in other NCEL Provider Collaborative beds, or elsewhere (e.g. the private sector), who are approaching 18 years of age and are already known to community CAMHS, it is the responsibility of community CAMHS from where the young person normally resides, to initiate the transfer process and follow this up as necessary. However, in some cases it may be more appropriate to refer from the in-patient service and this should be agreed between the in-patient service and the CAMHS community team as clinically appropriate. Such circumstances may include:

* If the young person has been an inpatient for a significant period of time, such that the in-patient team have more knowledge than the community team.
* If the young person was not known or only very briefly known to the community team prior to admission e.g. admitted following an emergency assessment.
  1. For service users 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 years, the Provider Collaborative Case Manager will ensure that the Provider Collaborative commissioning team are informed so that consideration as to the most appropriate clinical transfer plan, and agreement about which community CAMHS and AMH teams need to be involved, and any additional funding arrangements after the age of 18 years can be put in place.
  2. When a young person aged 17 ½ and above is ready to be discharged from Coborn before their 18th birthday, then they should be discharged to their community CAMHS team.

Transition from a CAMHS in-patient setting will be either:

* The young person will be discharged from hospital to the care of their AMH team shortly after their 18th birthday.
* The young person will require on-going inpatient treatment beyond their 18th birthday and will require transfer to adult inpatient service

When the clinical view is that an episode of care can be completed shortly after the 18th birthday, the young person will remain in the Coborn and will be discharged to the AMH service.

4.5 All discharges should be arranged under a care planning process framework and should include professionals from community CAMHS and professionals from Adult Mental Health Services in accordance with the ELFT Discharge policy.

When a Young person is approaching their 18th birthday and will require on-going inpatient care after they have turned 18, then a planned transfer to adult inpatient service should be arranged.

All such transfers of care should be carried out with the involvement of young person and their family/carers.

4.6 For Young People transferring to other ELFT in-patient services, the Coborn team will liaise with the local AMH in-patient team to arrange transfer. It is the role of adult inpatient services to consider any measures for gate keeping inpatient admission by utilising alternatives such as Adult Mental Health Home Treatment Team as appropriate.

For Young People 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.

In the event that there is likely to be an undue delay in the transfer of care to adult inpatient services then the matter should be escalated to clinical directors in an effort to keep delays to a minimum. For Young People transferring within ELFT escalation will be to ELFT CAMHS and Adult Directorate Clinical Directors. For young people transferring to services outside ELFT, escalation will be to the NCEL CAMHS provider collaborative Clinical Director.

Transitions to adult services for young people 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-coordinator/CAMHS general manager and the Tier 4 Inpatient team.

For young people remaining on the Coborn site after their 18th birthday, the ELFT Safeguarding policy and procedures will be followed to ensure that there are safeguards in place for the other young people on the unit.

**5 Consultant Responsibility**

5.1 The allocated CAMHS worker is responsible for informing the CAMHS consultant of any impending transfers, and to discuss referral to AMHS.

5.2 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.

5.3 In a situation where a young person turns 18 years of age prior to the formal transfer of care, but requires urgent admission, the admission will be to an adult bed. Consultant responsibility will be transferred to the adult consultant upon admission. A transfer care planning meeting should then happen at the earliest available opportunity to ensure effective transition and appropriate transfer of information. The AMHS community team should be involved in the care planning process.

5.4 In the unlikely situation where urgent admission is required for a service user who has yet to turn 18 years of age, but formal transfer of care has already taken place, the admission must be to an adolescent facility. Consultant responsibility will be transferred to the adolescent inpatient consultant upon admission. A transfer care planning meeting will then happen at the earliest available time to ensure appropriate transfer of information. The original referring CAMHS community team should be involved in the care planning process.

**6 Time Frame**

6.1 The optimal time frame for transition is a full year from six months prior to the service user’s 18th birthday however the duration needs to be modified according to the young person and their family/carer’s own needs. This time frame should allow for effective planning to begin six months prior to the service user’s 18th birthday and for the continuation of joint working for up to six months afterwards if required.

**7 Closed Cases**

7.1 Following transition, all cases must have a formal closure summary prepared by the allocated CAMHS worker uploaded to RiO prior to closure. The case will be closed in accordance with the CAMHS discharge policy.

7.2 Where a case has been closed in CAMHS and a service user presents to services at or after their 18th birthday, the service user will be the responsibility of AMHS and the associated locality inpatient ward.

**8 Out of Borough Transition**

8.1 When a service user moves to alternative independent accommodation outside of the borough at the age of 18 years, the open case transition procedure is to be followed with the relevant adult team in the new area, including the transfer of consultant responsibility.

**9 Exceptions to the above**

9.1 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. These cases should be discussed on a case by case basis by the CAMHS and AMHS clinical teams and the reasons for this decision made explicit.

9.2 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. These cases should be discussed on a case by case basis by the CAMHS and AMHS clinical teams and the reasons for this decision made explicit.

9.3 Any unresolved disagreements about transfer of care between CAMHS and AMHS should be referred to the Clinical Directors of the two services.

**10 Transfer of Case Notes**

10.1 When a young person is transitioned to AMHS within ELFT, adult services will automatically have access to the electronic records held on RiO at the time of transition.

10.2 CAMH Service will arrange for any historical paper files to be transferred to the adult service at transition, unless the client has previously dissented.

10.3 For YP referred to AMHS after closure in CAMHS, adult services will be able to access any electronic notes on RiO but will need to request any historical papers files from CAMHS if required.

10.4 The other family members concerned in the original referral need their right to confidentiality respected. These include the parents, siblings and that of third parties where possible consent should be sought for the disclosure of their information. When this is not possible potentially damaging information from or about family members and/or third parties should be removed.

**11 Implementation**

11.1 The updated policy will be published on the Trust Intranet and circulated to all clinical staff on CAMHS and AMHS.

11.2 Compliance with this policy will be audited in 2022.