Humber Teaching
NHS Foundation Trust

TRANSITION GUIDELINES

SUPPORTING YOUNG PEOPLE MOVING FROM CHILD TO ADULT SERVICES (MENTAL HEALTH AND LEARNING DISABILITY)

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VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.

CHANGE RECORD

Version	Date	Change details
1.0	*20/09/17*	*New guidance*
1.1	*Nov 2019*	*Review – Minor amends made. Approved at Quality and Patient Safety Group (13-Nov-2019). Missing author information.*
2.0	*June 2022*	*Full review – Approved by Mental Health Practice Network (04/05/2022) and CAMHS Clinical Network (27/06/2022).*
2.1	*August 2022*	*Minor amends - Changes related to use of the Leaving CAMHS passport, minor changes to wording to improve clarity, and correction of old acronyms for services to current ones. Approved by MH division practice network (03/08/22) and CAMHS/LD Clinical Network (19/08/22).*
2.2	*December 2022*	*Minor amends – Paragraph added to Additional Considerations section. Approved at CAMHS Clinical Network (07/12/22).*

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1. Introduction

This guidance will ensure that transfer of care from child and adolescent mental health services (CAMHS) and Neuro Development Services (collectively referred to throughout as 'CYP services' for child and young person services) to adult services is carried out consistently and safely. It enables professionals to consider the most appropriate service for the young person, whilst fully involving them in the process and establishes joint working between all services.

The guidance is underpinned by the principles of NICE Guidance NG43 and is aimed at all professionals in CYP services and clinicians in services that ordinarily work with adults, including mental health services and learning disability services. It refers to young people requiring continuation of care to adult services, as identified by the professionals co-ordinating their package of care and support.

2. Principles

Transitions between CYP services and adult services should be a person-centred process which promotes the needs of the individual and positive joint working. Practitioners and managers in both CYP services and adult services are responsible for applying a degree of flexibility and for joint transition planning as part of a collaborative care planning process.

Quality Standards

- Young people should be at the centre of all care planning and delivery.
- The focus should be on promoting and developing independence.
- The young person should have an identified named worker. This would be the team leader if no key worker is allocated.
- Transfer needs to consider clinical presentation, services required and prognosis in order to ensure liaison with the appropriate team.
- Responsibility for the care provided must be explicit at all times.
- Transition/care plans should be consistent with the principles of the care programme approach and include person-centred planning.
- Young people in transition between services should be able to voice their needs and preferences.
- Access to services should be as simple as possible.
- Young people and their families should receive the service that is most appropriate to their clinical and developmental needs.
- Services should prevent any delays in assessment or treatment that is detrimental to a young person's mental health and future engagement with services.

3. Process and Responsibility

3.1 Who is Responsible?

When a young person makes a transition from CYP services to adult services, responsibilities are placed on practitioners and managers in both teams – those in the service from which the young person must transition, and on those in the incoming team.

3.2 Age of Transition

Transition from CYP services to adult services should not be based on a rigid age threshold but be individual to the presenting clinical need. When receiving support from CYP services

for mental health needs, consideration should always be given when the young person reaches 17 years old (and for young people within Neuro Development Services, when they reach 16 years old)as to whether they are likely to require continuation of mental health support from adult services.

The planning for transition should be started at least 6 months prior to the young person's 18th birthday (earlier if possible and relevant) and consider the following:

1. Options for future care needs, e.g. does the young person need to transfer to adult services?

2. What risks are associated with the young person?

3. Can the needs be met by another agency or support system?

4. What are the client's and their family's views on transition?

5. Does the young person have capacity to make decisions in respect of support required as a young adult?

For those young people accessing child services fewer than 6 months before their 18th birthday, a plan must be commenced at the assessment stage.

3.3 Flexibility of Age of Transition

In some cases it is necessary to be more flexible regarding the transition stage where there are important clinical reasons, including:

- Is it possible to complete a piece of therapeutic work beyond 18 years of age in CYP services so that no transition will be required?
- Is the young person going away for higher education and a transition would be rapidly followed by a further transition?
- For those new referrals of young people aged 17 years 6 months and over, consideration should be given to whether mental health support should be offered by adult services in the first instance. This should include taking into account the preference of the young person, expected duration of intervention proposed, and presenting needs. If a young person has initial contact with CYP services including the CAMHS Home intensive support team, CAMHS crisis team or Contact Points at 17 years and 6 months or later, those teams are able to follow the process described below to transition a young person into adult services, which may in some cases avoid the requirement to refer them into Core CAMHS to do so.
- The above questions should also be considered when young people currently in receipt of CYP services in another locality from a different provider relocate to the Trust's locality after the age of 17 and six months. In such cases it may be that the out-of-area CYP service directly transitions the young person into the relevant adult service locally without referral to local CYP services, if it is considered that appropriate intervention cannot be provided in the time available by local CYP services. In such cases, the Trust's CPA guidance on receiving out-of-area transitions should be followed and the young person and relevant family/agencies made aware of available CYP crisis services in the local area.

- When CYP services and adult services are simultaneously involved in providing care to a young person, a risk assessment will clearly identify who is the lead professional and agency involved with the young person. This risk assessment will be uploaded onto the clinical record.

- Where needs related to learning Disability are particularly complex, transition planning and meetings at an earlier age is likely to be appropriate

The provision of inpatient and crisis services would be expected to remain with CYP services until the young person is 18 years old. Any proposed deviations from this should be agreed with the service managers for adult inpatient/crisis services, and an agreed method of highlighting the deviation on the clinical record should be actioned so that adult service practitioners are able to identify young people under 18 years old for whom it has been agreed adult services will provide crisis or inpatient support.

3.4 Transition Planning

All young people aged 17+ years will be monitored by the CYP services' team leaders using the Humber Teaching NHS Foundation Trust electronic dashboard to ensure that all young people have a transition or discharge plan by at least aged 17 years and 6 months. The Modern Matron will complete an audit every 6 months and will feedback outcomes to teams through Team Leaders and Clinical Network.

- For YP with a diagnosis of a learning disability and or autism who display, or are at risk of developing, behaviour that challenges or mental health conditions who were most likely to be at risk of admission there is a Dynamic Risk Register (DSR) which is held by the Humber Transforming Care Partnership. Additionally to being placed on Level 1,2 or 3 of the Dynamic Support Register, Young People over the age of 16 will be placed onto Level 6 'Transition' on the CYP DSR, they will then also be placed onto Level 6 'Transition' of the Adult DSR which duplicates the information stored on the CYP DSR and ensures that the Adult DSR Network are aware of Young People who will soon be requiring Adult services, thereby supporting the transition process and ensuring information about complex cases is shared early to achieve the best outcomes.
  Young People or their families can opt-out of having their information recorded on the Adult DSR if they choose, and this is done when consent is first obtained to be added to the CYP DSR.
  For any queries, please email eryccg.admissionavoidancehub@nhs.net

- The young person should be offered the opportunity by their CAMHS keyworker or other nominated CAMHS clinician to complete the 'Leaving CAMHS Passport' which is available on the Trust intranet. Ideally this will be completed (or at least offered) prior to the optional consultation referenced below.

- The professionals involved with a young person in any CYP service within the Trust can request an optional consultation with potentially appropriate adult services (invited dependent on apparent needs of the young person) to support transition planning. Ideally this will be accessed when the young person is between 17 years and three months and 17 years and six months old though this may occur earlier or later dependent on individual circumstance. The consultations are organised and co-ordinated by the Complex Emotional Needs Service (CENS) and can be requested by emailing hnf-tr.cens@nhs.net.

- Any adult service receiving a referral where there are apparent mental health needs from a CYP service may also request a consultation by following the same process. This includes in circumstances where a referral is received by an adult service for the direct transition of a young person currently receiving support from a CYP service in another locality.

- This consultation is not a decision-making forum; its function is to provide information and support to CYP service clinicians in planning a transition for young people with mental health needs who they work with into adult services. The information from such consultations should be discussed with the young person and their family, before a final decision is made by the CYP clinician about whether a referral to adult services is appropriate, and if so, which service the young person would be most appropriately referred to.

- A consultation is not required by these guidelines, though individual receiving adult services may wish to request one prior to accepting a referral. It is perhaps most appropriate where:

    - The needs of the young person are particularly complex or involve high levels of risk
    - There is a lack of clarity or disagreement about what mental health support might be appropriate to offer a young person in adult services
    - The young person may have support needs that involve multiple adult services (e.g. input from both adult learning disability services and an adult mental health service, or from adult eating disorder services and a community mental health team).

- Where it is not considered that there is a need for a consultation meeting, or there are no mental health needs considered appropriate for such a forum (e.g. direct referral from CYP services for a young person with a diagnosis of LD being directly transitioned to adult LD services) it is acceptable for CYP and adult services to liaise directly with each other to plan and complete a young person's transition into adult services.

- If a young person does not meet the criteria for specialist adult health services, involving the GP in transition planning is recommended by NICE guidelines.

Regardless of whether a consultation is held, if it is determined that the young person requires further ongoing input from adult services the following actions will be considered (see Appendix A for a summary of this process):

- The CYP services key worker will co-ordinate transition with the identified adult clinician with support from both managers if required.
- Ordinarily, transition from CYP services to Adult LD services for individuals with a Learning Disability is undertaken from one team directly to another using the service referral form. If the young person is receiving psychiatry input and requires continuation of this into adult LD services, a direct referral from the CYP psychiatrist to adult service psychiatrist should be completed alongside the team referral.
- The adult team manager or clinical lead will allocate in a timely manner the appropriate named practitioner to pick up the continuation of care for the young person.

- For young people requiring continuation of input from a consultant psychiatrist in adult services (for example related to ongoing prescribing of ADHD medication), the referral should be directed to the relevant locality community mental health team (CMHT). If there are no additional CMHT needs, the young person will be allocated to the team's consultant psychiatrist. A psychiatry handover is required.
- The name of the adult worker should be shared and an introduction made with the young person and other relevant family, professionals or agencies as soon as possible to assist them in their preparation for transfer into adult services.
- It is the responsibility of the CYP services named clinician and the adult services clinician to transfer safely the management of care under the care programme approach (CPA).
- CYP services should ensure that the Trust risk assessment documentation is reviewed and updated prior to the transfer into adult services. It is the responsibility of both services to ensure appropriate risk management plans are in place at transition.
- Consideration should be given to MAPPA implications for young people transferring from secure packages of care including children's residential secure services or inpatient services.
- The CYP services clinician will be the lead professional in a young person's care until the age of 18 and take the lead in overseeing and co-ordinating the appropriate level of support needed within adult services. This may require a multi-agency approach to ensuring all aspects of care are recognised and supported. This remains the case even when an adult service is providing an intervention prior to the age of 18 if the young person remains open to CYP services. A CPA review or other planning meeting, involving the young person, should take place as soon as possible, and this should document clearly the transition plan and the date upon which the adult services clinician becomes the lead professional instead of the CYP services clinician.
- If the young person, their family, CYP services and the receiving adult service agree that the young person will be closed to CYP services before their 18th birthday and provided planned treatment solely by an adult service, the nominated adult worker is the lead professional and responsible for co-ordinating and overseeing the young person's care from that point. Agreement should be indicated in the Transition plan and should demonstrate agreement from the young person, (carers if appropriate) and Both CAMHS and AMH named workers. This should then be communicated via a letter including the plan to the GP and referrer if different.
- If a young person is transitioning from CYP services to adult services after their 18th birthday, the CYP services clinician remains the lead professional until the date agreed in a CPA review or other planning meeting, involving the young person, which should take place as soon as possible, and should document clearly the transition plan and the date upon which the adult services clinician becomes the lead professional instead of the CYP services clinician.
- As standard, all clinicians should be aware of potential safeguarding issues in relation to the young person and others during transition, and ensure appropriate liaison and information sharing between CYP and adult services. The clinician identifying a relevant issue should take the lead in ensuring other services are aware. CYP and adult clinicians should be particularly alert to potential safeguarding issues arising from a young person under the age of 18 receiving mental health support from adult services, for example where they are engaged in a group treatment with adults.
- The CYP and adult clinicians will ensure where appropriate the young person's family are fully involved in the transfer of care and support. It will be the responsibility of the CYP services named clinician to oversee, co-ordinate and support transition and be the link between the young person and other professionals involved.

- Consideration should be given to the possibility of the young person themselves having a caring role within their family structure. They may require additional assessments to be undertaken that acknowledge and recognise a need for additional support.
- Transition plans need to be holistic, seamless and inclusive, and developmentally appropriate taking into account the young person's identified needs, strengths and hopes /aspirations for the future.
- If a child or young person has a presentation considered consistent with psychosis, it is ordinarily the case that they will be referred to PSYPHER, who provide early intervention psychosis services in Hull and East Riding. A comprehensive transition of medical responsibility will take place at age eighteen from CAMHS psychiatry to PSYPHER's psychiatry input.
- Children and Young People with a Hull GP receiving support from the CAMHS eating disorder service can be transitioned directly to Evolve.. During the transition, a consultation to support this transition planning (including adult mental health services) may be requested, following the process described above. Transition to Evolve for these children and young people should be in line with these guidelines; assessment and transition planning with Evolve can be undertaken from 17 years 4 months, intervention may commence before the age of 18 provided the young person also remains supported by the CAMHS eating disorder service.
- For children and young people with an East Riding GP receiving support from the CAMHS eating disorder service, transition will be to the the appropriate adult mental health service within the Trust, as Evolve are not currently commissioned to provide a service for individuals with an East Riding GP.

3.5 Transition from Inpatient Care

If a young person requires transition from a CYP inpatient setting to an adult inpatient unit the principles of this transition protocol should be followed using the CPA process (guidance linked above under 2.3). It is essential that the needs of the individual are prioritised and if in exceptional circumstances the young person is transferred prior to their 18th birthday this needs to be in line with the Emergency and Atypical Admission to Adult Inpatient Unit Procedure and with appropriate safeguards in place.

Any young person aged 17 years and six months or greater currently in a CYP inpatient setting, where mental health needs are present, can be referred for a consultation with adult services which will be co-ordinated by CENS, by emailing hnf-tr.cens@nhs.net.

3.6 Care Programme Approach (CPA)

The CPA meeting will promote communication between teams and allow collaborative care planning and shared decision making for all those involved in the young person's care including the young person themselves and their family/carers.

This should include ensuring the young person's wishes regarding how they would like their parents/carers involved in the transition of care and on an ongoing basis within adult services.

The CPA meetings will also help formulate the care plan that may reflect the changing needs of the young person and their family. The CPA documentation will be used to document the agreed plan of care which clearly articulates the wishes of the young person in relation to parents/carers involvement with future assessment, planning and support.

A period of joint working may be appropriate for a set period of time to avoid an abrupt ending and promote smooth transition. The young person's Consultant Psychiatrist, if

involved, will retain medical responsibility until clear medical handover has taken place with the accepting Consultant Psychiatrist and completion of the transition process.

The named CYP services worker should continue to assume responsibility for the co-ordination of the young person's care plan until the handover has been completed at or subsequent to the appropriate care planning meeting.

If the young person experiences a crisis or relapse in this period, the CYP service's worker should assume responsibility until the situation is assessed as being stable. This does not exclude joint working but hopefully gives a clear sense of clinical responsibility and stability for the young person.

Where transfer occurs from a CYP inpatient unit to an adult inpatient unit, then the above process needs to include the adult inpatient consultant as well as a representative from the receiving unit to enable a planned, safe transfer.

3.7 Shared Decision Making

To support the shared decision making process and to ensure the young person and their family/carers have an informed understanding of the transition it is essential that:

- The young person and their parents are given realistic information about the services that would be likely to be delivered in the services to which they may be moving. If the young person has received multi-modal treatment but this is unlikely to be delivered in the adult service, this information should be provided early enough to allow the young person time to reflect and discuss with parents/carers and their current practitioners if they wish to.

- The young person and their parent/s are given some written information (or relevant website addresses) about their condition (if this has not been done earlier in treatment) and about the proposed service/s.

- Any choices that can be made by the young person, should be made by the young person themselves, with the help of their parent/s, other professionals and current care co-ordinator.

- The transition should be viewed as a process rather than a one-off event. The young person should therefore have the opportunity to return having thought about and discussed the transition with parent/s or significant others. Therefore, the transition should be discussed by the CYP services care co-ordinator during the course of *more than one* appointment.

- Ahead of any planned consultation meetings or transition meetings with adult services, CYP clinicians should discuss with young people and their families what specific needs they think they have that may require support after the age of 18. This may be preferable to focusing on the type of intervention that is being requested. This information can then be incorporated into transition conversations between professionals, alongside the professional view.

- There should be a discussion about who the young person would like to be present when they meet the new adult services practitioner, and how the young person wants their parents/carers to be involved when transition is made to the new service. Some young people want a copy of their appointment letter to be sent to their parents who may be

able to help them to get organised to attend the appointment, whereas others may see this as intrusive. Such decisions should be made based on the individual's needs and preferences rather than a 'one size fits all' approach to adult support.

- Vulnerable groups of young people include those who are working with a number of agencies because they are 'looked after', have offended, or are the subject of a child protection plan. For particularly vulnerable groups, the transition care planning should involve professionals from the relevant agencies and where possible an advocate for the young person.

3.8. Looked After Children and Care Leavers

Children and young people who are receiving a service from the Looked After Children (LAC) CAMHS service within Humber Teaching NHS Foundation Trust can be transferred to adult services following the process outlined above. An assessment of need and FACE risk assessment should have been completed as part of the LAC CAMHS input.

- Young people over the age of 18 who are supported by the Leaving Care Team in the East Riding, who are not already receiving a service directly from CYP services, should access adult mental health services by contacting Mental Health Advice and Support Team (MHAST) for a routine assessment or adult learning disability services by contacting the Intensive Support Team.

- Young people over the age of 18 who are supported by the Leaving Care Team in Hull, can access routine mental health assessment via CENS, which can be arranged by their leaving care assistant requesting this directly. They may also directly self-refer to MHAST who will undertake a routine assessment if they wish. If the need was clearly in relation a learning disability, then this service could be referred to by contacting the Intensive Support Team.

4. Escalation/Arbitration

All transfers of care between services should be agreed locally by the appropriate teams and the young person placed in the centre of all decision making to avoid unnecessary delays in care.

In exceptional circumstances where there is a disagreement regarding the point at which care is transferred or who is best placed to provide that care, team managers and clinical leads should escalate to service managers and senior clinical leads at the earliest opportunity. If no resolution can be found in a timely manner then escalation of concerns needs to be escalated to the relevant Clinical Divisional Manager(s).

5. Additional Considerations

All workers should at all times be aware of the child and adult safeguarding thresholds and needs of the young person, ensuring links with safeguarding teams as appropriate.

All workers should ensure full understanding for the individual and their family regarding the Mental Capacity Act.

If a CAMHS Consultant Psychiatrist is not available due to annual leave or sickness and will not be returning within the week when letters are due to be sent out, the Consultant Psychiatrist's secretary will notify the appropriate Clinical Team Leader. The Clinical Team Leader will ensure that the letters are checked by either another Consultant Psychiatrist, the Clinical Team Leader, or the Clinical Lead(Duty and Assessment) for the Team. If there is a clinical rational for delay than this must be documented by the clinician checking the letter. Likewise, if there is need to expediate the sending out of the letter this must also be documented and the letter sent.

This is to ensure the letters are not delayed and any advice or changes required, vital to care are not missed.

Appendix A- Typical Procedure for Transitions from CAMHS & LD to Adult Mental Health Services