Lincolnshire Partnership
NHS Foundation Trust

Lincolnshire Partnership NHS Foundation Trust (LPFT)

Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services

Document Type and Title:	**Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services**
Authorised Document Folder:	**Service Operational Protocols**
New or Replacing:	**Replacing v1**
Document Reference:	
Version No:	**V2**
Date Policy First Written:	**May 2017**
Date Policy First Implemented:	**July 2017**
Date Policy Last Reviewed and Updated:	**December 2019**
Implementation Date:	**January 2020**
Author:	**Quality Improvement & Assurance Lead Specialist Services**
Approving Body:	**Patient Safety and Experience Committee**
Approval Date:	**V2: 29 January 2020**
Committee, Group or Individual Monitoring the Document	**Patient Safety and Experience Committee**
Review Date:	**December 2021**

Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services

Valid from: May 2017 **Review date: December 2021**

'Transition' in the context of young people's mental health, means the transfer of young people out of CAMHS to other services (Adult Mental Health Services or otherwise), or being discharged, as a consequence of reaching a certain age.

NICE Guidelines 2016:

"Ensure the transition planning is developmentally appropriate and takes into account each young person's capabilities, needs and hopes for the future. The point of transfer should not be based on a rigid age threshold take place at a time of relative stability for the young person"

Transition from children's to adults' services for young people using health or social care services NICE guideline. Published: 24 February 2016 nice.org.uk/guidance/ng43

Overarching Principles

1. Involve young people and their carer's in service design, delivery and evaluation related to transition by:
    - Co-producing transition policies and strategies with them
    - Planning, co-producing and piloting materials and tools
    - Asking them if the services helped them achieve agreed outcomes
    - Feeding back to them about the effect their involvement has had

2. Ensure transition support is developmentally appropriate, taking into account the person's: maturity
    - Cognitive abilities
    - Psychological status
    - Needs in respect of long-term conditions
    - Social and personal circumstances
    - Caring responsibilities
    - Communication needs

3. Ensure transition support is strengths-based and focuses on what is positive and possible for the young person rather than on a pre-determined set of transition options and identifies the support available to the young person, which includes but is not limited to their family or carers.

4. Use person-centred approaches to ensure that transition support:
    - Treats the young person as an equal partner in the process and takes full account of their views and needs
    - Involves the young person and their family or carers, primary care practitioners and colleagues in education, as appropriate
    - Supports the young person to make decisions and builds their confidence to direct their own care and support over time
    - Fully involves the young person in terms of the way it is planned, implemented and reviewed
    - Involves agreeing goals with the young person
    - Includes a review of the transition plan with the young person at least annually or

more often if their needs change

- Addresses all relevant outcomes, including those related to:
  - Education and employment
  - Community inclusion
  - Health and wellbeing, including emotional health
  - Independent living and housing options

5. Health and social care service managers in children's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people. This work could involve, for example, developing a joint mission statement or vision for transition jointly agreed and shared transition protocols, information-sharing protocols and approaches to practice.

6. Service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs.

7. Every service involved in supporting a young person should take responsibility for sharing safeguarding information with other organisations, in line with local information sharing and confidentiality policies.

8. Check that the young person is registered with a GP.

The object of these guidelines is to ensure that a consistent approach is applied across the Trust in all departments including the inpatient settings in relation to young people between the ages of 16 and 18 (Looked After Children up to the age of 25, with collaborative working between CAMHS and AMHS).

For guidance relating to young people in inpatient settings refer to Clinical Care Policy Section 8.5 Admission to Inpatient Care for Children and Young People Aged 16–17 years and Appendix 8.1 Protocol for Admission of 16 or 17 year olds to an Adult Acute Inpatient Unit.

New Referrals

If the young person is **under the age of 16**, the referral will always be directed to the **Child and Adolescent Mental Health Service.**

For young people presenting with mild-moderate anxiety, depression or singular trauma (e.g. bereavement or other life event) and aged **16 and over,** they may be eligible to receive service from Steps2Change, otherwise should be referred to CAMHS.

Consideration should be given to the information provided by the referrer (wherever possible with the young person's opinion sought too) to determine whether it is most appropriate for the referral to be accepted by the CAMH services or Steps2Change.

Where Steps2Change receive a self-referral for someone under the age of 16 this will be forwarded to CAMHS or Healthy Minds, dependent on the nature of the referral. Should the self-referral appear urgent Steps2Change will contact the CAMHS PAL to discuss as a potential crisis referral.

If the young person is **aged 17 and 9 months or older*** then they should be referred into the appropriate **Adult Mental Health Service, unless it is an emergency or recent (discharged within the past 6 months)**, in which case **CAMHS should undertake assessment** and provide intervention prior to transition if clinically appropriate to remain with CAMHS. If it is felt transition will be required, the CAMHS to Adult Service transition process should be initiated immediately.

If there are difficulties establishing which LPFT service is best placed to offer input to a young person aged 16 – 18th Birthday, discussions should take place between the relevant LPFT services and further information requested from the referrer as necessary. The locality interface meetings would be appropriate for these discussions. The LPFT service who received the initial referral will be responsible for gathering further information from the referrer as appropriate, for liaising with other LPFT services and for communicating with the service user and the referrer about which LPFT service has been identified as being best able to meet the service user's described mental health needs.

Open CAMHS cases needing transfer to Adult Mental Health Services

CAMH service users who require ongoing mental health service involvement must be helped to make a smooth transition to Adult Mental Health Services. The following local principles will apply:

1. There is no single age limit for transition and any transition should be age appropriate for each individual and assessed against their presenting need. The age at which this transition process to Adult Mental Health Services should start will be discussed by the CAMHS Lead Professional / Care Coordinator with the young person and with relevant Adult Mental Health Service/s.

2. Although some young people will require a much longer period, the transition process should be offered as being a minimum of a 6 month period unless the Young Person requests a shorter transition period. When a young person involved in CAMHS service becomes approximately 17 ¼ years, the CAMHS worker should consider whether there is likely to be a future need for transition to adult services. If there is a likely need for transition then this should be discussed with the young person, and where appropriate the parents, with a view to establishing when this will be clinically appropriate. CAMHS input should not be withdrawn until transition Adult Mental Health Service has taken place and the transition plan has been completed. Reasonable adjustments should be considered to take into account individual variations.

3. Where it is thought transition is required, the identified CAMHS Care Coordinator/Lead Professional (could be a Child Psychiatrist) will take responsibility for attending an Interface meeting (or agreeing a meeting outside of the interface meeting) to discuss with Adult Mental Health colleagues the presentation of the young person. This should be done in a timely way to

allow a minimum of 6 months transition period. Young Person will be placed in the relevant cluster at the interface meeting with support from AMH colleagues.

4. Where a Young Person is receiving a social care funded package of care this should be highlighted when brought to the interface meeting, to ensure that LPFT section 75 Social Work are aware of the potential transfer of responsibility for the care package at the point of transition. Even though the CAMHS lead professional is unlikely to have the full details of the package of social care, any detail that is held by the CAMHS service should be provided to the LPFT Social Worker to ensure that Transition arrangements can be put in place between LPFT and Lincolnshire County Council.

5. If the transfer is between Child Psychiatrist and Adult Psychiatrist, it is the responsibility of the involved CAMHS Child Psychiatrist to ensure that a three way meeting is planned with Adult Psychiatry the young person and where appropriate the parents.

6. Where young people do not meet the criteria for an adult service, but there is identified ongoing needs, then the young person must be transitioned back to the primary care GP. The same transition process and planning must take place for those transitioning back to the GP; transition plans should be agreed with the young person and the GP sent a copy of the plan. Consideration should be given to utilising the Managed Care Network for these young persons with continuing needs that fall outside of the services provided by LPFT. If there is a disagreement about which Managed Care Network service/s should be involved this should be escalated to the relevant service managers for decision. It is essential service users do not feel 'passed around' and that GPs are not made to do referral following discharge from LPFT.

7. CAMHS practitioners are responsible for ensuring compliance with the Clinical Care Policy during transition.

Principles of LPFT Assessment and Care Planning

i. Upon referral to the services of LPFT, everyone should receive an assessment of their mental health, appropriate to their level of need, to determine their requirement for clinical care and treatment.
ii. When accepted, all service users will have a lead professional identified who has clinical responsibility for co-ordinating care.
iii. All service users accepted by secondary mental health services should have a single plan or statement of care or treatment which is current, and relevant to their situation and setting.
iv. Services users will have a planned review to determine the effectiveness and outcome of the service user's care or treatment to meet their individually assessed needs.

8. 1st Transition meeting to include the young person (and their family where appropriate), the CAMHS professionals involved, and the proposed adult worker. This is an opportunity for information sharing and relationship building. This meeting should establish a transition plan to support the transition period. The transition plan should set the individual requirements for transition offering the young person a minimum of a 6 month period for the transition. Should the young person have only recently engaged with CAMHS or decided that they wish for a shorter period of transition then this will be agreed and written into the plan.

9. A named Transition worker will be identified and a period of joint working between CAMHS/adult workers will be undertaken in line with the transition plan, prior to discharge from CAMHS. This will strengthen relationship building and make the services more seamless to the service user. A named Transition worker will be identified (see Transition Pathway page 5).

10. As close as possible to the end of the agreed transition period, a final three way appointment between the young person, CAMHS clinician and the Adult clinician will take place. This is the formal point where CAMHS discharge and Adult services pick up the case.

Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services

Transition Process for CAMHS to AMHS

Following 17th Birthday

Where clinically indicated start discussions with the young person
And, where appropriate, the family over the potential need to
transition to Adult Services to continue their ongoing care beyond CAMHS

9 Months Prior to Transition

- Core cases to be taken to the Interface meeting and receiving Adult Service identified
- Eating Disorder and Learning Disability cases taken to the relevant team meeting
- Transition process initiated
- Clustering completed

Following Interface Meeting

The AMH worker is identified within two weeks of the interface meeting. AMH worker arranges a date for the first Transition meeting with CAMHS clinician

6 Months Prior to Transition

- First Transition Meeting takes place, involving CAMHS and AMHS, the young person and (where appropriate) their parent/carer with young person's consent
- The Transition Plan is agreed and signed. (The templates can be found HERE). The Plan should set out the process for transition e.g. how often there will be joint meetings or familiarisation with new places they will be seen etc.
- Named transition worker identified (CAMHS worker who regularly works with the young person)

Implementation of Transitional Plan

This will include a joint session and may include further transitional meetings

Pre-Transition, 6 months after writing the Transition Plan

The CAMHS worker must undertake the pre-transition survey with the young person on either the last or penultimate appointment, to ascertain if they feel prepared for transition at the point of discharge from CAMHS. (The surveys can be found HERE).

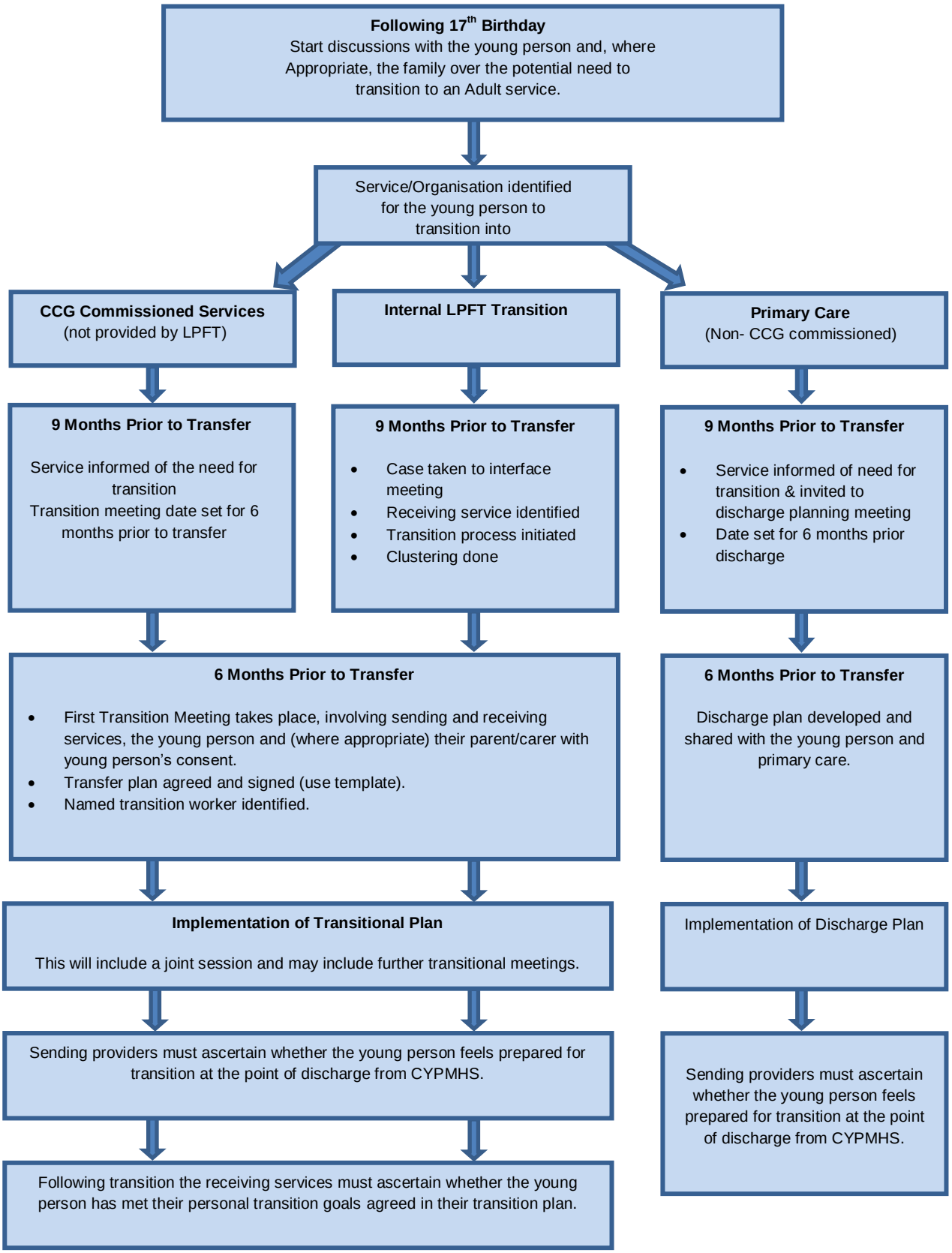
Post-Transition

Following transition the AMH worker must undertake the post-discharge survey within 3 months to ascertain whether the young person has met their personal transition goals agreed in their Transition Plan. (The surveys can be found HERE).

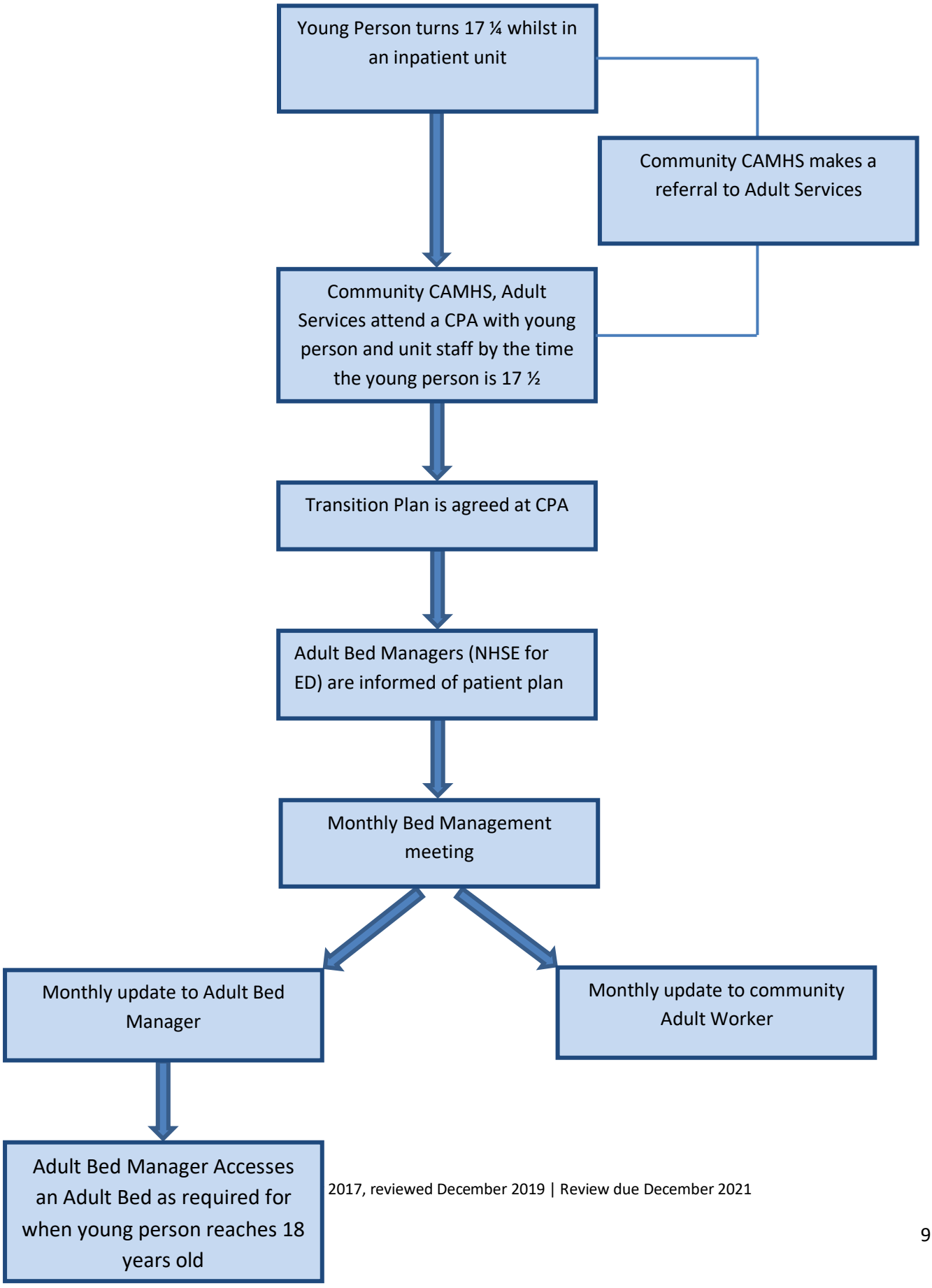
Local agreement is to complete the survey within the first month

Transitional Protocol between Child & Adolescent Mental Health Services (CAMHS) and Adult Services

Over Arching Full Transition Pathway



Transition Pathway for Young people in inpatient CAMHS



Accessing Crisis Services during Transition

Where a young person requires crisis interventions during transition, the young person's choice over which service to access should be at the centre of deciding the most appropriate service for delivering this intervention. There can be no hard and fast rule over decision making for whether this is delivered by the CAMHS or the AMHS/LD services. However, the following table should underpin the decision making process to ensure that the young person's needs are met in a timely and proactive manner.

Age of Young Person	**Current status with LPFT**	**Crisis team responsible for responding to the current crisis**	**Pathway following first contact**
18 years +	Still in Transition from CAMHS	Adult CHRT or LD CHAT	Liaison with the CAMHS core team but remain with Adult CHRT or LD CHAT
17 years 9 months	Not known to CAMHS or closed for over 6 months	Adult CHRT or LD CHAT	Continue with adult pathway and being seen by Adult Services
17 years 9 months	Open to CAMHS or closed with last 6 months	First contact CAMHS C&HT	If second contact required, this should be a joint appointment and transition should be started.
17 years 6 months to 9 months	Not known to CAMHS or closed for over 6 months	First contact CAMHS C&HT	Short term remain with CAMHS C&HT. Requiring ongoing intervention, this should be taken to an interface meeting to discuss the most appropriate service to meet the YP's need.
17 years 6 months to 9 months	Open to CAMHS	CAMHS C&HT	If transition plan in place, add crisis to the plan. If no planned transition, remain with CAMHS until discharge.
Under 17 years 6 months	And not open to Adult Services	CAMHS C&HT	As per standard pathway into CAMHS.
17 years +	Open to CAMHS with known LD or ASD	CAMHS C&HT	If known to require frequent crisis and home treatment input, transition and joint working should commence with Adult LD CHAT.
16 +	Open to Adult MH or LD or Psychological Therapies	Adult CHRT or LD CHAT	The young person should remain with adults service unless they are requesting CAMHS. CAMHS will provide advice if required. Should it be deemed that CAMHS is a more appropriate service this should be taken to an interface meeting.

Should the young person require inpatient admission as a result of the assessment during the crisis intervention, then the young person opinion should be sort over whether a CAMHS or AMHS/LD bed should be sort. Collaborative discussions should take place between the CAMHS and AMHS/LD to ensure the best outcome is achieved for the individual in the most timely way.

Transition from CAMHS to primary care and non-CCG commissioned services.

If a young person is being discharge from CAMHS because they have reached a certain age, and not because their needs are met, then this continues to be a transfer of care. A receiving service will need to be identified which will usually be the patient's GP (but occasionally could other health care providers or voluntary sector services). A discharge plan will need to be formulated 6 month prior to discharge and shared with the young person and primary care (the receiving service). On discharge, all relevant information, in the form of a discharge summary, is passed onto primary care and shared with the young person concerned.

This Transition Protocol will apply to all services which interface with LPFT CAMHS. These include:

1. Adult Mental Health Services
2. Eating Disorder Service
3. Early Interventions in Psychosis Service
4. Learning Disability Service
5. Children currently under the Umbrella of Neurodevelopmental Disorders.

Main LPFT Policies and Documents Relevant to this protocol

1. Interface Meeting Terms of Reference
2. Clinical Care Policy
3. CAMHS Referral Criteria
4. Step2Change Referral Criteria
5. Eating Disorders Service
6. Eating Disorders Service Referral Criteria and Referral Form
7. Early Interventions in Psychosis Pathway.

All relevant services need to ensure that their current operational model is in keeping with the CAMHS to AMHS/LD Protocols.

References:

February 2016
NICE
"Transition from children's to adults' services for young people using health or social care services"

February 2011
Governmental Mental Health Strategy
"Careful planning of the transfer of care between services will prevent arbitrary discontinuities in care as people reach key transitions"

"Planning for transition early, listening to young people and improving their self-efficacy"

2011
LPFT Transition Protocol Children's Services to Adult Services

March 2010
Policy and Protocol for the transition of young person's passing from CAMHS to AMHS and other provisions in the East Midlands

2006
National Service Framework for Children, Young People and Maternity Services
Standard 9 – The Mental health and Psychological Well Being of Children and Young People
"Services ensure that young people experience a smooth transition of care between child and adult services and protocols are in place to ensure a flexible and organised approach is taken"

2004
National Service Framework for Children, Young People and Maternity Services
Standard 4
"When the Mental health care of a young person is transferred to services for working age adults, a joint review of the Young Person's needs must be undertaken to ensure that effective handover of care takes place."