

Protocol

Transition of Young People from CAMHS to Adult Mental Health Services

Reference: [CAEC IDENTIFIER]

Written by: Laura Abbot – Chillipep
Helen Crimlisk – Sheffield Health & Social Care NHS FT
Ann Murphy – Sheffield Children's NHS FT
Ovi Sandica – Sheffield Children's NHS FT

Peer reviewer Steve Jones, Joint Clinical Director, CWAMH

Approved: April 2015

Review Due: April 2017

Purpose

The Protocol outlines the principles and processes that underpin the transfer of care “transition” of young people from CAMHS (Child and Adolescent Mental Health Services) to AMHS (Secondary Adult Mental Health Services) in Sheffield.

Intended Audience

CAMHS practitioners

Table of Contents

1. Introduction
2. Intended Audience
3. Guideline Content
4. References

1. Introduction

This protocol describes the transition arrangements for young people from Child and Adolescent Mental Health Services to Adult Secondary Mental Health Services.

As of 12 Jan 2015, the age of transition will usually be 18 years (rather than 16 years which has previously been the case).

Young people who have been treated within CAMHS may also "transition" into other services for the care of their mental health problems e.g. IAPT, 3rd Sector provision etc. The principals behind transition apply regardless of where transition is to, but this protocol describes the transition arrangements between specialist CAMHS and AMHS Secondary Mental Health Services.

Transition processes are relevant to all young people in CAMHS receiving care as an inpatient or outpatient who need further treatment from Secondary Adult Mental Health services above the age of 18 and also those who because of service agreements (Ref 16/17 doc) may transition at an earlier age (e.g. severe eating disorders and psychosis)

The main principles which should inform the transition process include:

- Person-centered care to ensure that the young person and their carers, where appropriate, are kept informed and involved with the process.
- A whole systems approach used to ensure partner agencies and primary care are aware of transition arrangements and can contribute to continuity of care during the transition period.
- Transition processes set out in this policy will be initiated by CAMHS where AMHS is the appropriate provider of follow on care or treatment (**Standard 1**). If there is uncertainty about this, there should be discussion between CAMHS and AMHS and a decision clarified in writing. (**Standard 2**)
- All young people who are currently receiving a service in CAMHS should start preparation for transition well before the proposed transition date with discussion and clarification about ongoing treatment needs (**Standard 3**) and provision of written information to the young person (**Standard 4**)
- The intended transition should be logged with the CAMHS admin team (**Standard 5**)
- A comprehensive summary of care and brief referral letter should be sent to AMHS and the GP (**Standard 6**) and standard CAMHS discharge outcome measures undertaken (**Standard 7**)

Transition of Young People from CAMHS to Adult Mental Health Services

- An initial transition meeting should be set up, which should be supported by CAMHS and attended by relevant professionals from CAMHS and AMHS **(Standard 8)**
- A full assessment should be undertaken and documented by AMHS **(Standard 9)**
- A care plan should be developed collaboratively with the young person, written and copied to the young person, GP and CAMHS **(Standard 10)**
- Clustering /HONOS/ diagnosis and PROMs should be completed by AMHS **(Standard 11)**
- Follow up arrangements should be clarified in writing to the young person, the GP and CAMHS and other agencies as appropriate **(Standard 12)**
- Consideration should be given as to whether adjustments are needed to ensure age appropriate care (e.g. involvement of carer, reminders of appointments by text, transition group referral, arrangements for appointments etc. **(Standard 13)**

2. Intended Audience

CAMHS practitioners who are transitioning a young person's care from CAMHS to AMHS.

3. Guideline Content

This protocol should be followed and reasons for deviation from the protocol must be documented in the patient notes.

Transition Process

- The transition process overarches pre-transition preparation in CAMHS, transition handover meeting (s) and development of age-appropriate care plan post-transition in AMHS

CAMHS	Issues	AMHS
Pre-transition preparation		Post-transition issues
Education and provision of information to YP about their condition and proposed treatment plan (Discussion with AMHs if uncertainty about care pathway)	Provision and sharing of information and planning further care	Plan to address any outstanding information gaps Review psycho-educational needs and address appropriately Consider referral to transition group

Transition of Young People from CAMHS to Adult Mental Health Services

Recent review of treatment needs, risks and creation of summary of care and reasons for referral	Treatment / care needs and risks	Arrange review of care plan in line with need, review and revise as necessary and plan discharge
Plan and set up transition meeting and support young person to attend meeting with carer if appropriate	Transition meeting	Consider age specific issues required and make adjustments necessary – room, who should be present, time etc.
Discuss issue of young person's choice with regard to carer / family involvement	Relevant carers / family involved	Respect wishes of young person with regards to carer / family involvement
Clarify with young person what their needs / requests are with regard to future care or treatment	Collaborative discussion to agree care plan	Ensure understanding and appropriate communication to young person, carers, GP and CAMHS confirming completion of transition process and plan for future

Dealing with Disagreements

From time to time, a situation could arise where there is a disagreement regarding the need for or circumstances of future service provision. In such cases, workers from both teams should discuss concerns within MDTs and resolve disagreements via a face to face professionals meeting if necessary. Further disagreements should be referred to senior professionals within the teams and managed through clinical disagreements policies if necessary.

Specialist CAMHS Teams

Child and Adolescent Mental Health Services (CAMHS) provide a specialist comprehensive assessment, treatment and consultation service for families in which there is a child with a severe or longstanding mental health problem.

The service is for children and young people up to their 18th birthday.

Interventions available range in intensity from consultation to other professionals through to residential treatment and there is a 24 hour seven day a week psychiatric on-call service.

The service includes the following clinical teams: two area based specialist CAMHS teams, Vulnerable Children's Team comprising a Forensic and Youth Justice pathway and a Looked After Children's pathway, a Learning Disability and Mental Health team, and a regional day/inpatient unit providing intensive Tier 4 input.

The CAMHS Service is part of Sheffield Children's NHS Foundation Trust.

Transition of YP from CAMHS to AMHS Review date:[Apr/2017]

CAMHS Single Point of Access:

CAMHS SPA, Centenary House, Heritage Park, 55 Albert Terrace Road, Sheffield. S6 3BR
Tel: 305 3218

Area Teams:

Centenary Community CAMHS Team

Centenary House, Heritage Park, 55 Albert Terrace Road, Sheffield. S6 3BR

Tel: 226 2348

Beighton Community CAMHS Team

The Becton Centre, Sevenairs Road, Beighton, Sheffield, S20 6NZ

Tel: 271 6540

Specialist Pathway Teams:

Vulnerable Children's Team: MAPS for Looked After Children Pathway

Centenary House, Heritage Park, 55 Albert Terrace Road, Sheffield. S6 3BR

Tel: 226 0876

Vulnerable Children's Team: Forensic and Youth Justice Pathway

Star House, 43 Division Street, Sheffield S1 4GE

Tel: 226 0660

Learning Disabilities and Mental Health

Centenary House, Heritage Park, 55 Albert Terrace Road, Sheffield. S6 3BR

Tel: 226 2788

Tier 4:

The Becton Centre, Sevenairs Road, Beighton, Sheffield, S20 6NZ

Tel: 305 3106

SHEFFIELD HEALTH AND SOCIAL CARE FOUNDATION TRUST**Community Mental Health Teams**

Community Mental Health Teams are organised according to 4 geographic areas linked to GP practices. Each team has the same sub teams and functions.

Duty Teams

The Duty Team are available from 7.30 – 8pm Monday to Friday and are available for advice and discussion. They are made up of Access, Recovery and Administrative staff with input from an Approved Mental Health Professional (AMPH), a Section 12 approved Psychiatrist and an on call Manager. The duty team triage all unscheduled work (referrals, requests for advice, unexpected calls or visits from patients or the public), seek further information as required and arrange an appropriate response. The responses vary from an immediate Crisis response or Mental Health Act Assessment to advice/signposting or a timely appointment with an appropriate worker.

Access Teams

Transition of Young People from CAMHS to Adult Mental Health Services

The Access team undertakes initial assessments of referrals including Crisis Work and re-assessments if a review /advice is necessary because of a worsening clinical picture. They are a multidisciplinary team comprising Community Mental Health Nurses, Approved Mental Health Practitioners, Occupational Therapists, Psychiatrists and Psychologists. In addition to undertaking assessment work they also offer short term work to clients whose level of complexity or risk requires this or whilst awaiting allocation from the Recovery team.

Recovery Teams

The Recovery Team provides treatment packages for individuals with mental health problems whose needs cannot be effectively met within a primary care setting or via short term work with the access team. The team consists of Community Mental Health Nurses, Social Workers, Support Workers, Occupational Therapists, Psychiatrists, Psychologists, SDS Support Planners and an Art and Music Therapist. **Early Intervention in Psychosis** teams are integrated within the Recovery teams of the CMHTs. They will provide joint working for YP with or suspected to have psychosis from the age of 14.

Home Treatment Teams

The Home Treatment Team provides short term intensive support to individuals who would otherwise require admission to hospital. The team works between the hours of 8am to 6pm, 7 days a week. At weekends the team is based at Netherthorpe House from where a city-wide service is provided. The Home Treatment team works closely with the inpatient wards to promote early discharge and with the RETHINK Crisis House (Thornsett Road). As the Home Treatment Team is an alternative to admission, 16 and 17 year olds would only have access to this team in exceptional circumstances after discussion with Clinical Directors at SHSC.

Young People can be transitioned directly into the Recovery team or the Access team depending on level of need.

Contact details

North: Northlands Southey Hill, Sheffield, S5 8BE
271 6217

South West: Argyll House 9 Williamson Rd, Sheffield, S11 9AR
27186 54

South East: Eastglade Centre 1 Eastglade Crescent, Sheffield, S12 4QN
271 6451

West: The Yews 1 Worrall Rd, Sheffield, S30 3AU
271 6100

Learning Disability Team

Transition should follow the above policy at 18.

Sheffield Autism and Neurodevelopmental Service (SAANS) - provides assessment and post diagnostic support for people suspected of having ASD aged 16+. The team will

Transition of Young People from CAMHS to Adult Mental Health Services

accept referrals for assessment from 16+. Treatment for co morbid problems should continue to be provided by CAMHS until the age of 18.

Sheffield Eating Disorders Service (SEDS) - provides and treatment for severe eating disorders aged 16+. The team will accept referrals and transitions form CAMHS from 16+.

Affix patient label or complete

SCH Hospital Number.....

Surname.....

Forename.....

D.O.B.....

NHS Number.....

Standards Proforma for Transition

to AMHS Review date:[Apr/2017]

Transition of Young People from CAMHS to Adult Mental Health Services

	Standards	Responsibility	Date	Evidence / person
1	CAMHS identify YP who needs ongoing treatment in AMHS	CAMHS		
2	If uncertainty about this discussion with AMHS and decision in writing	CAMHS/AMHS		
3	Discussion with YP about process, timescales and expectations	CAMHS		
4	Provision of written information about process and standards to YP	CAMHS		
5	Log of transition with admin staff at CAMHS	CAMHS		
6	Summary of care sent to AMHS along with referral (copy to GP)	CAMHS		
7	Discharge SDQ and other outcome measures (?) to be completed	CAMHS		
8	Initial meeting set up with CAMHS and AMHS – attendance of YP (and carer if appropriate) to be supported by CAMHS	CAMHS/AMHS		
9	Full assessment documentation to be completed by AMHS	AMHS		
10	Care plan to be written and shared with YP and GP	AMHS		
11	Clustering/ HONOS to be completed	AMHS		
12	Follow up arrangements clarified in writing to CAMHS and GP	AMHS		
13	Consideration given to age appropriate care as required after discussion with YP/carers	AMHS		

4. References

Transition of Young People from CAMHS to Adult Mental Health Services