

# Transition Guidance

**Covering the care arrangements of Young People Moving from  
Child and Adolescent Mental Health Services  
to  
Adult Mental Health services and Adult Learning Disability Services  
Within NHS Greater Glasgow and Clyde**

**Important Note:**

**The Intranet version of this document is the only version that is maintained.**

Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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## **1. Introduction**

- 1.1** This guidance outlines the processes that would ensure a smooth transition for young people moving between Child and Adolescent mental health services (CAMHS) and Adult mental health services (AMHS)
- 1.2** This guidance has been developed with the involvement of the following services/individuals:-
- Representatives from Child and Adolescent mental health services
  - Representatives from Adult mental health services
  - Liaison with representatives from Adult eating disorder service, Glasgow Psychological Trauma Team and Perinatal mental health services
  - Liaison with representatives from specialist learning disability service
  - Liaison with representative from forensic mental health service
- 1.3** It incorporates existing guidance within NICE (NG43 February 2016), NHSGG&C local guidance (MHS 46 Transition Guidance) and Action 21 from the Mental Health Strategy for Scotland 2017-2027 and is in accordance with existing operational guidance for services where applicable.
- 1.4** This guidance has been developed to ensure that the transition is planned and implemented consistently and safely. This should ideally be done with as little disruption possible to a young person's journey of care.
- 1.5** It is important to recognise transition is an ongoing process rather than a discrete event. Transition should start well before the actual transfer and involve the young person and carer, where appropriate, from the outset.

## **2. Scope of the guidance**

- 2.1** This guidance applies specifically to clinicians working within Child and Adolescent mental health services and Adult mental health services within NHS Greater Glasgow and Clyde
- 2.2** For the purposes of this guidance, Child and Adolescent mental health services (CAMHS) will refer to any Tier 3 locality (generic) CAMHS team which would provide access to any of the following services if required: Connect-ED (Eating disorders), Intensive CAMHS team, paediatric liaison, Tier 4 community CAMHS (including forensic CAMHS, complex trauma team and learning disability CAMHS) and will also include inpatient services. CAMHS services are currently commissioned to work with young people under the age of 18 years and 0 months.
- 2.3** Similarly, Adult Mental health services (AMHS) will refer to Adult community mental health teams (CMHT's) and acute adult inpatient services. This guidance also includes transition to adult specialist learning disability services (SLDS) including community learning disability teams (CLDT) and adult learning disability inpatient services. Adult services are commissioned to work with young people aged 18 years 0 months and above.
- 2.4** The guidance does not cover the transition to specialist services to Forensic Adult service as numbers are so small that they require case by case discussion. However, it will apply in circumstances where a referral from a specialist CAMHS team to a general adult mental health service or an adult SLDS is felt to be clinically appropriate.

- 2.5** The guidance considers specific circumstances involving specialist teams such as Perinatal mental health and Adult eating disorder services where it is usual practice for CMHTs to be involved jointly. It also covers the transition of young people with a learning disability from CAMHS to adult SLDS. Any minor differences in guidance for this group are specified in the text. Otherwise, for adults with learning disability, the general principles of this document should be followed.
- 2.6** For the purposes of this guidance, transition will be defined as a **co-ordinated, flexible and planned transfer of care of a Young Person from CAMHS to an adult mental health service.**
- 2.7** The eligibility criteria for referral to an adult CMHT by a CAMHS team within Glasgow is **any Young Person aged between 17 years and 9 months – 18 years 0 months**, deemed as requiring on-going psychiatric care within secondary care services.
- 2.8** The transition period would be expected to take at least 6 months, ideally 3 months before and 3 months after the young person's 18<sup>th</sup> birthday (i.e. to start from 17 years 9 months and to be completed by 18 years and 3 months). For more complex cases the period may to be reasonable extend the transition to a total of 12 months (6 months before and after the 18<sup>th</sup> birthday).
- 2.9** In the majority of cases it is not reasonable to commence the transition period before the age of 17 years and 6 months or beyond 18 years and 6 months.
- 2.10** Exceptions would be young people presenting with symptoms suggestive of a first episode psychosis and young women requiring input from Perinatal mental health services where age criteria for access to these services are different.
- 2.11** A young person presenting with symptoms suggestive of a first episode psychosis can be referred to ESTEEM, if appropriate after initial CAMHS assessment, from the age of 16 years 0 months in keeping with existing ESTEEM operational policy.
- 2.12** Young women presenting with significant mental health problems associated with pregnancy and in the first 6 months after child birth can be referred to the Perinatal mental health team, if clinically indicated, after initial CAMHS assessment irrespective of their age.
- 2.13** When considering transitions to SLDS this will only be for those with significant mental health needs or challenging behaviour. Adult SLDS will accept transitions and new referrals in relation to physical health for young people over the age of 16 who have left secondary education. If a young person under 18 years of age has complex health needs it may be in their best interests to refer early to adult SLDS. This should be discussed and agreed on a case by case basis.

### **3. Principles**

- **The process should have the young person's interests at the centre and should serve to meet the needs of the individual involved**
- **The young person and carer, where appropriate, should be involved in the planning and decisions about the transition process**
- **Transition arrangements should minimise the number of referrals and where possible should be managed directly within mental health services.**

- **Decision-making around referrals of young people very close to their 18<sup>th</sup> birthday should be patient centred, pragmatic and flexible.**

#### **4. Process for individuals already known and open to CAMHS**

- 4.1 The process of transition should be a co-ordinated, gradual and flexible process.
- 4.2 The need for transfer from CAMHS to Community Mental Health Team (CMHT) should be reviewed by the involved clinicians in discussion with the young person and carer, where appropriate. If deemed clinically appropriate, the transition process should commence at least 3 months before the young person's 18<sup>th</sup> birthday. It should be a priority for the CAMHS team to consider the young person's ongoing needs.
- 4.3 When a referral to CMHT is being considered the young person and carer, where appropriate, should be informed and assisted to prepare for the transition (this should be on-going throughout the process). **The young person's needs and wishes should be at the centre of any care proposed.**
- 4.4 A written referral should be sent to the appropriate CMHT prior to the Young Person's 18<sup>th</sup> birthday with the view to identifying an appropriate and named clinician in the CMHT.
- 4.5 While planning for the transition the process should and could begin from age 17 years and 9 months, it is expected that adult services would assume lead role for any care provided after the individuals 18<sup>th</sup> birthday including unscheduled care via mental health assessment units (MHAU) and admissions. It is therefore key that adult services are made aware of any young people who are likely to require care beyond their 18<sup>th</sup> birthday.
- 4.6 Once the referral is accepted as appropriate by the CMHT then the young person should have access to adult services unscheduled care team (crisis teams or MHAUs) from the age of 18 years 0 months even if the initial appointment has not been attended. A young person should not have to wait for their first CMHT appointment to access adult crisis supports.
- 4.7 Adult services can generally not assume full responsibility for a young person's care under the age of 18 in the event that admission and/or detention are required. If admission or crisis intervention is required before the young person has reached the age of 18 years and 0 months then this would, where possible, be provided by CAMHS teams and Skye House Adolescent In Patient Unit.
- 4.8 It is not always possible to "complete an episode of care" within the suggested transition timescale particularly for complex cases. A diagnosis of a chronic, severe and enduring illness or complex, risky presentation (e.g. personality disorder or complex neurodevelopmental disorder with significant emotional dysregulation) should not delay or halt the process of transition but would be a reason for earlier discussions to take place to agree a care plan which includes outpatient and inpatient care.
- 4.9 The intensive CAMHS team (I-CAMHS) will not accept new referrals of patients who are over 18 years of age.
- 4.10 In the event that a young person reaches their 18<sup>th</sup> birthday, is open to CAMHS and has NOT been referred to the local CMHT but requires unscheduled care within usual working hours the CAMHS team should manage\_this.

- 4.11** If the young person requires unscheduled care outwith usual working hours then they should be seen by the adult unscheduled care team (MHAU or ciris team) who would then liaise with the CAMHS team to direct care on the next working day.
- 4.12** If the young person requires to be admitted to hospital an adult psychiatry bed should be used but the CAMHS consultant should retain RMO responsibility until a transfer of care is agreed with adult services.
- 4.13** There are limitations in accessing CAMHS emergency/urgent tier 4 care for young people who reach their 18<sup>th</sup> birthday and are still open cases to a Tier 3 CAMHS team. This should be kept in mind by Tier 3 CAMHS clinicians when considering the need for a referral to the local adult CMHT.
- 4.14** The written referral from the CAMHS case manager, following discussion with the relevant child and adolescent consultant psychiatrist, should contain:
1. Patient demographics including carer details where appropriate
  2. Psychiatric history
  3. Current problems and diagnosis
  4. Legal status
  5. Current mental state
  6. Predicted future level of involvement including other agencies involved
  7. Medication history (where applicable)
  8. History of significant side effects (where applicable)
  9. Physical health problems (where applicable)
  10. Relapse indicators
  11. FACE/CARAS Risk Assessment
  12. Transition Care plan (<https://www.nhsinform.scot/media/2252/tcp-document-july-2018.pdf>)
- 4.15** It is the CAMHS care manager's and CMHT 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.
- 4.16** In exceptional circumstances CAMHS may deem it appropriate to request the transfer of care prior to a service users 18<sup>th</sup> birthday, due to their needs being better met by CMHT. These cases should be discussed on a case-by-case basis by the CAMHS and CMHT clinical teams and the reasons for this decision made explicit.
- 4.17** Similarly, 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 their 18<sup>th</sup> birthday. These cases should be discussed on a case by case basis by the CAMHS and CMHT clinical teams and the reasons for this decision made explicit.
- 4.18** Individuals with eating disorder symptoms should transition directly to the appropriate adult CMHT as per the process outlined above unless the primary diagnosis is an eating disorder and this remains the main focus of intervention in which case a direct referral to the AEDS can be made. If required, the Adult CMHT will consider a referral to the community Adult eating disorder service (AEDS) after initial assessment. Concurrent referrals to the AEDS may be considered after initial discussion with the adult CMHT if clinically indicated and the transfer of care would involve both adult services.
- 4.19** Consideration should be given to the use of the care programming approach for transitions that involve multiple agencies and services reflecting the complexity of the process but CPA is not essential for transition and should not be a reason for delaying the process.

- 4.20** The transition process should be flexible enough to allow for a period of joint working between involved services where this is deemed to be in the young person's best interests.
- 4.21** Any concerns about transfer of care between CAMHS and CMHT should be referred to the Head of Service and Clinical Director for each service.

## **5. Process for new referrals**

- 5.1** All routine and urgent referrals of individuals referred to CAMHS up to 17 years and 9 months will automatically be processed and seen by CAMHS if appropriate. There is an expectation that if at this stage it seems likely that the person will need care beyond their 18<sup>th</sup> birthday that a transition discussion still takes place.
- 5.2** All referrals of individuals referred to CAMHS between ages 17 years and 9 months and 18 years 0 months will be processed by CAMHS initially. For routine referrals, CAMHS will liaise with the local CMHT to discuss an initial joint appointment, if felt to be appropriate, within 4 weeks. CAMHS will remain involved until the young person's 18<sup>th</sup> birthday even if it is agreed that adult services will commence work with the patient before this time.
- 5.3** For urgent referrals for individuals referred to CAMHS between 17 years 9 months and 18 years 0 months requiring assessment within 5 working days, consideration should be given to organising a joint assessment by CAMHS and general adult services (CMHT staff). Following discussion between CAMHS and CMHT staff it would be expected that a joint appointment would be offered within 5 working days if appropriate. Subsequent decisions about future care provision will be agreed based on the individual's clinical need.
- 5.4** Urgent referrals for individuals between 17 years 9 months and 18 years 0 months requiring a same day assessment will be assessed by CAMHS in the first instance during normal working hours and at an A&E or MHAU for unscheduled care. After this initial assessment of risk there is an expectation that prompt discussion would take place with the local CMHT about future provision and transition of care. If clinically indicated a joint appointment would take place within a maximum timescale of 4 weeks.
- 5.5** The rationale for this guidance is that it provides a single entry point to mental health services for referrers. This ensures equity of access for young people and clarity of the entry point to mental health services for referrers. Referrers should not be in a position of having to refer to both CAMHS and adult services, particularly in an emergency.
- 5.6** Liaison between CAMHS and CMHT/ CLDT regarding urgent referrals would be through each team's duty system.

## **6. Process for in patients**

- 6.1** Where clinically appropriate and possible the most suitable option would be to plan for discharge of the young person from CAMHS inpatient services to Tier 3 CAMHS and for transition to occur through the community team as outlined above. Transitions involving inpatients should be planned on a case-by-case basis and retain a degree of flexibility in decisions about the most appropriate option.

- 6.2 If it appears likely that the individual's episode of inpatient care is likely to continue past their 18<sup>th</sup> birthday, the CAMHS inpatient team will initiate discussion with the identified locality adult CMHT/ CLDT from 17 yrs 9 months onwards.
- 6.3 If the clinical consensus appears to be that the on-going episode of inpatient care can be completed within the subsequent 6 month period (i.e. before 18yrs 3 months) it may be appropriate for the young person to transition directly to adult community services on discharge. This should be discussed and agreed between CAMHS and CMHT.
- 6.4 If it appears likely that a longer admission (beyond 18 years and 3 months) is clinically indicated, the transition would take place directly from inpatient CAMHS to the appropriate locality adult inpatient service after the 18<sup>th</sup> birthday.
- 6.5 If the primary reason for admission is an Eating disorder and on-going inpatient care is deemed clinically appropriate, consideration should be given to a transfer to specialist Eating disorder inpatient beds.
- 6.6 This decision should be made after appropriate discussion with the relevant locality adult CMHT and the Adult Eating disorder service. There is an expectation that the relevant adult CMHT will continue to remain involved in the individuals care.
- 6.7 Unless deemed clinically inappropriate, transition from CAMHS inpatient care to adult services (either to a community team or to an adult inpatient ward) should be undertaken through the CPA framework reflecting the complexity of the process involved.

## **7. Roles and responsibilities**

- 7.1 The adult CMHT/ CLDT will provide a timely written acknowledgement of the outcome of the referral following discussion within the CMHT/ CLDT and will identify relevant individuals within adult CMHT who would be involved in the young person's care as per local operating procedures. This link person/ these links persons will be named in the written acknowledgement to facilitate conversations between services.
- 7.2 Transition is an extension of care and not a "new to service" process. A young persons care should be processed as other transfers of care and they should not be placed on team waiting lists alongside other new referrals.
- 7.3 There is an expectation within the principles of transition that adult services would commence some involvement before the young person reaches their 18<sup>th</sup> birthday and CAMHS will continue with some involvement after the young person reaches their 18<sup>th</sup> birthday.
- 7.4 CAMHS is the lead agency before 18y 0 months. CMHT is the lead agency after 18y 0 months.
- 7.5 Clinical responsibility for the young person's care will remain with CAMHS until the young person reaches their 18<sup>th</sup> birthday. This would include access to all aspects of CAMHS services including crisis and inpatient services prior to their 18<sup>th</sup> birthday. CAMHS staff will remain involved in the young person's care until an agreed end point is reached following discussion with the CMHT.
- 7.6 Where a young person is subject to CPA, this would serve as the appropriate framework for managing the transition and the expectation would be that this would continue as part of the

transition process. It should not be a requirement for a young person to be subject to CPA simply to facilitate transition.

- 7.7** The duration of the transition should be flexible and determined by the young person and their family/carer's own needs. Whilst there can be no absolute time frame set for the transition process, it is envisaged that it usually should not take longer than 6 months in total. This should allow for effective planning to begin 3 months prior to the service user's 18<sup>th</sup> birthday and for the continuation of joint working for up to three months afterwards.
- 7.8** When a young person is being seen by CAMHS, the EMIS case record should be accessible to the appropriate adult service at the time of transition. This facilitates the sharing of all information for both services.

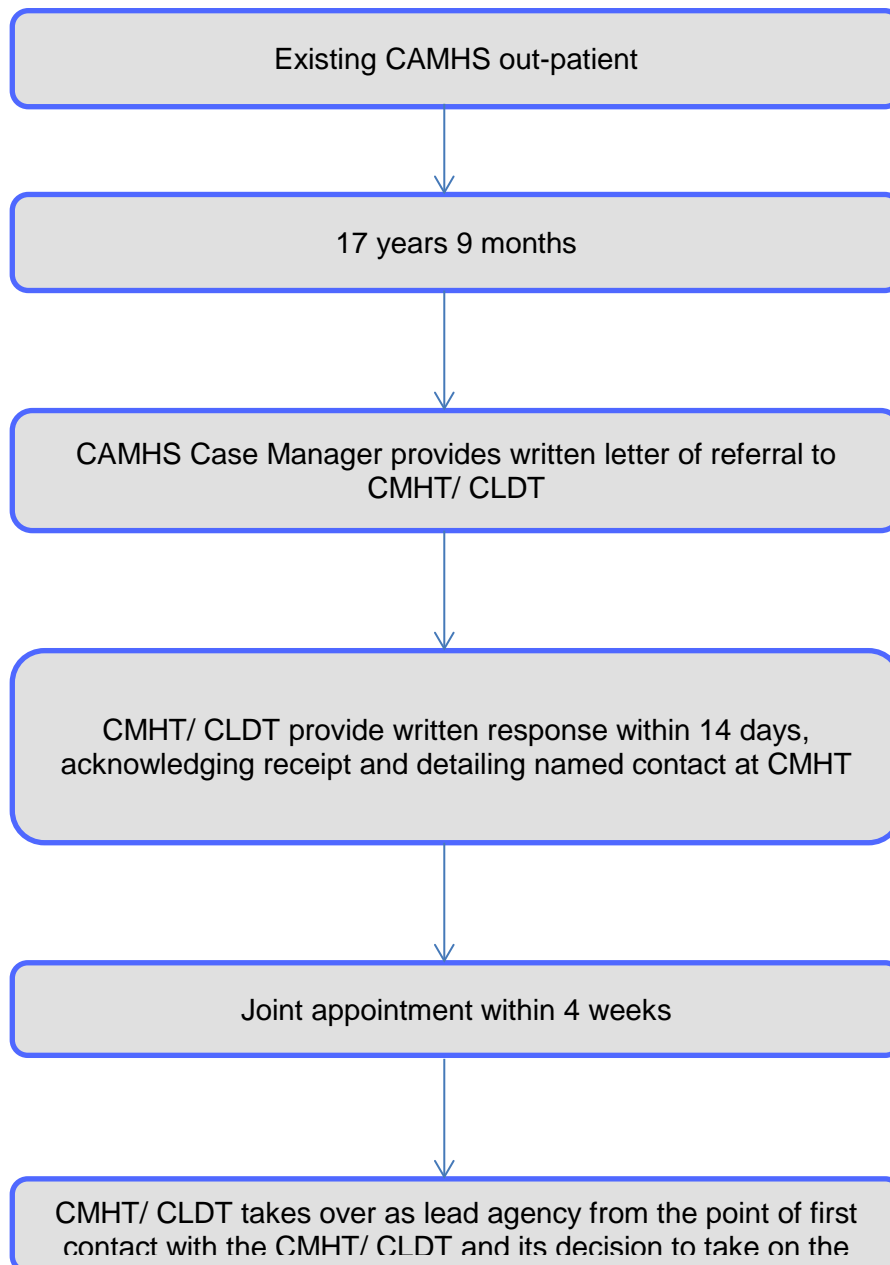
## **8. The transition care pathway**

**8.1** The flowcharts summarise the care pathway for young people, including those already known to services and new referrals and outlines the transition planning requirements.

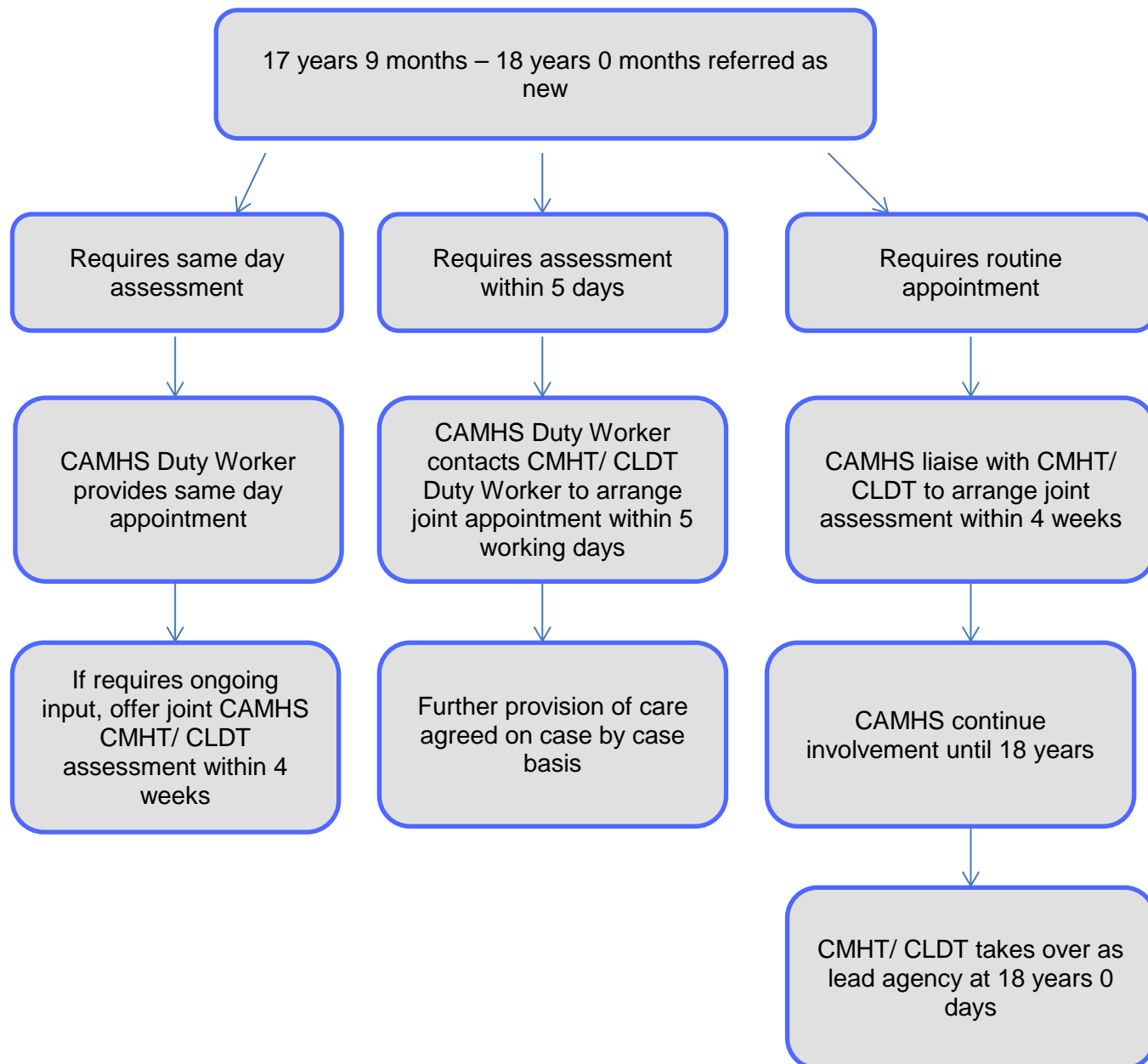
**8.2** The 4 main options in the care pathway are:-

1. Out patient CAMHS transition pathway
2. New Referral unknown to CAMHS transition pathway
3. Inpatient transition pathway
4. Unscheduled care pathway

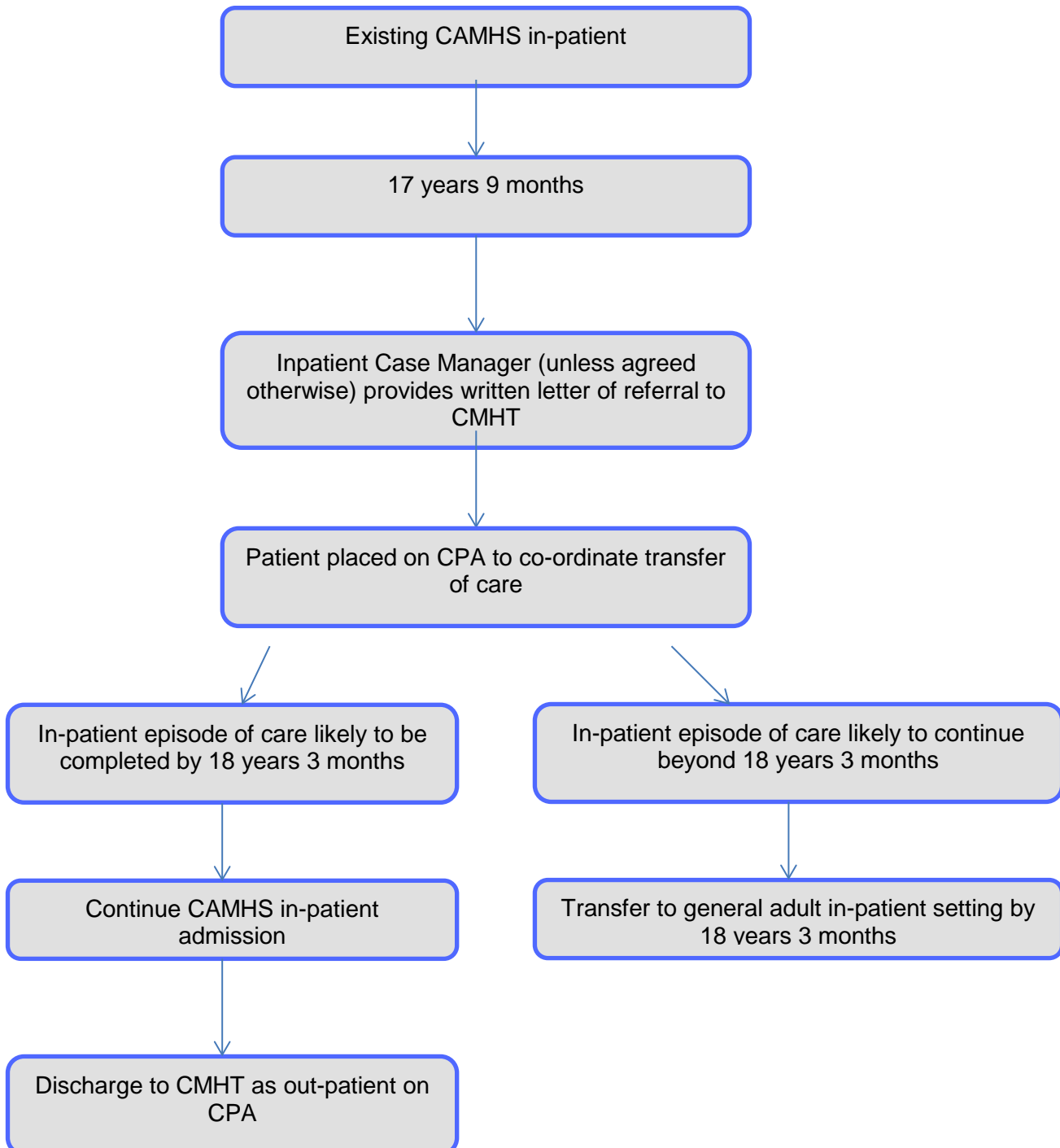
**Outpatient CAMHS transition pathway**



**New Referral unknown to CAMHS transition pathway**



**Inpatient transition pathway**



**Appendix 4**

**Unscheduled care pathway**

**Under 18y 0 months  
9am to 5pm**

CAMHS offer review

Under 18y 0 months

Seen by locality CAMHS team, ICAMHS or paediatric liaison team depending on where they present to/ who refers

May be redirected to out of hours team if cannot commence assessment before 4pm

\*see separate CAMHS protocol

**Under 18y 0 months  
5pm to 9am**

CAMHS offer review

<16y 0 months

attend RHC A&E for review by CAMHS OOH service

May be redirected to in hours team if cannot commence assessment before 8am

16y 0 months- 17y 11 months inclusive

Attend A&E or MHAU (depending on who refers and what need is) for review by CAMHS OOH service

May be redirected to in hours teams if cannot commence assessment before 8am

**Over 18y 0 months  
9am-5pm**

**Over 18y 0 months  
5pm-9am**

Adult unscheduled care services offer review via A&E or MHAU

Open to CAMHS; no transition request submitted

Open to CAMHS; transition request submitted

Open to CAMHS; no transition request submitted

Open to CAMHS; transition request submitted

CAMHS offer review

CAMHS and CMHT to agree who offers review as matter of urgency via duty workers

Adult unscheduled care team liaise with CAMHS team next working day to plan care & discuss transition needs

Adult unscheduled care team liaise with CMHT next working day ; CMHT and CAMHS to discuss to plan care



**CPA Coordinator Details**

West Glasgow and East Dunbartonshire- Lorna Hutchison  
East Glasgow and a part of the North- Cathy Craig  
South Glasgow, East Renfrewshire and a part of the North- Charles Harty

Contact the relevant coordinator at:

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