Richmond and Wandsworth Safeguarding Adults Board

Minding the Gap
Mental Health Transitions Framework 2020-2023

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CONTENTS

Acknowledgements

This protocol was developed with the help of:

Achieving for Children

Justin Walesby	Head of Referral & Assessment West Cluster
Shaira Makorie	Head of Leaving Care/UASC

Richmond and Wandsworth Councils Adult Social Services

Amy Shardlow	Service Manager, Mental Health and Substance Misuse Social Care Teams
Becca Walker	Senior Commissioning Manager, Prevention and Wellbeing Targeted Services
Caroline McDonald	Service Manager Mental Health, AMHP, Reviews & Accommodation Projects
Kenneth Philips	Commissioning Officer, Mental Health and Wellbeing
Lynn Wild	Head of Safeguarding Adults and Professional Standards
Virindar Basi	Safeguarding Adults Service Manager

Roehampton University

Aleata Alstad-Calkins	Director of Student Support Services

SLaM NHS Foundation Trust (for Wandsworth Community Drug and Alcohol Service)

Jane Eastaway	Borough Lead

South West London Clinical Commissioning Group

Marino Latour	Wandsworth Designated Safeguarding Adults Lead
Sarah Loades	Richmond Designated Safeguarding Adults Lead
Nigel Evason	Head of Children's Services and Mental Health & Learning Disabilities
Arlene Thomas-Dickson	Senior Transformation Manager Mental Health & Personalisation

South West London St. George's Mental Health NHS Trust

Simon Wylie	Deputy Head of Service Delivery

Wandsworth Council Children's Services

Eric Richardson	Service Manager, 0-25 Disability Social Work Service
Ruth Lacey	Head of Safeguarding Standards, Wandsworth Children's Services

Executive Summary

1) The mental health transitions framework focusses on supporting young people with mental health needs to transition between Children's to Adult services support in Richmond and Wandsworth and aims to complement each agency's own transitions working agreements. It was developed in partnership with members of the Richmond and Wandsworth Safeguarding Adult Board in response to recommendations from a Safeguarding Adults Review.

2) The aim of the transitions framework is to secure best possible outcomes for young people and their parents/carers by providing a clear pathway. It will support practitioners, and young people and their parents/carers to understand what they can expect and who will deliver each aspect of the services which they receive. The framework clarifies the role of each agency to simplify and clarify the process involved in accessing support leading up to and during transition from Children to Adult Mental Health Services.

3) There is evidence that young people struggle with the move between Children to Adult services. This is frequently amplified due to poor communication between involved professionals and a lack of clarity on the roles and expectations of the stakeholders involved in both Adult and Children's Mental Health Services.

1. Introduction

1.1. The mental health transitions framework focusses on supporting young people with mental health needs to transition between Children and Adult Services Support in Richmond and Wandsworth (including dual diagnosis and to complement each agency's own transitions working agreements). It was developed by a multi-agency task and finish group of the Performance and Workforce Sub-group to the Richmond and Wandsworth Safeguarding Adults Board. It was developed in response to recommendations from a Safeguarding Adults Review concerning a young person with significant mental health needs who moved successfully from a Children's residential placement into an adult mental health residential placement. As a result of changes within the residential care facility, her needs were no longer being effectively met. There was a number of agencies involved in supporting her and it was evident that there was little discussion or co-ordination between professionals. This guidance seeks to highlight good practice to ensure that there is an improved experience for other young people undertaking similar transitions.

1.2. The guidance does not replace single agency transition protocols or any wider agreements between agencies in terms of transition arrangements.

1.3. This document is aimed to clarify the roles of each agency involved in supporting young people with mental health needs to transition from Children to Adult Services Support in Richmond and Wandsworth.

2. Aim of guidance

2.1. The aim of the transitions framework is to secure best possible outcomes for young people and their parents/carers by providing a clear pathway to support practitioners and young people and their parents/carers, to understand what they can expect and who will deliver each aspect of the services which they receive.

2.2. The framework aims to support all professionals involved in supporting young people in the move from Children to Adult services. It clarifies the role of each agency involved in the support of young people with mental health issues, during the process leading up to and during transition from children to adult mental health services.

3. Transition and focus of the framework

3.1. In general, Children Social Care offer support to young people up to the age of 18. There are, however, circumstances in which these Children Social Care Services are legally required to support young people who have previously experienced being looked after. This includes all young people who have been in care for 13 weeks or more. The post-18 support is to age 21 but can be extended to the age of 25. Services to care experienced young people includes support by a Personal Advisor (PA) who will assist the young person to achieve independence. Additional targeted support can include mental health, substance use and parenting support. Care leaving services are also a statutory function. There are a number of eligibility criteria to be in receipt of care leaving support:

- aged 16 or 17 and still in care (an eligible child);
- aged 16 or 17 and left care (a relevant child);
- aged 18 to 25 and left care (a former relevant child);
- aged 16 to 21 years (a qualifying care leaver).

3.2. Young people with mental health needs experience a number of important transitions as they move towards adulthood and the change in service delivery from Children Social Care to Adult Social Care can be difficult and complex.

3.3. This framework focuses on young people who have mental health needs i.e. a formal diagnosis and who are in receipt of support from secondary mental health services (Children and Adolescents Mental Health Services) and specialist mental health services and/or education support. It also focuses on young people with dual diagnosis. All young people making transition to secondary mental health adult care from CAMHS should follow the guidance in the SWLSTG CAMHS protocol which clearly sets out options, decision making process, criteria, legislation, expectations and key people involved, such as autism and mental health, or substance misuse and a mental health diagnosis.

3.4. All agencies should commit to the framework to ensure that there is active engagement in the process of identifying and managing risk. The agency with the key relationship with the young person should take responsibility for co-ordinating activities of all involved professionals. All professionals should mutually agree when this transfers to a different professional,

4. Principles

4.1. The framework reflects the principle that there must be a person-centred approach to supporting young people and their parents/carers and that they must be involved in all aspects of the planning for transitions. The following principles should be adhered to:

- Effective ***early planning*** should begin at least 6 months before the young person's 18th birthday and all service provisions and should continue until the new arrangements are stabilised, which may be up to the age of 25.
- Adopting a ***collaborative approach*** between agencies, professionals, the young person and their family.
- Comprehensive ***multi-agency engagement*** and clarifying who the involved professionals are supporting the young person.
- Sharing of high quality and relevant ***information*** between agencies.
- Full ***participation*** of the young person and their parents/carers.

5. Roles of each agency

5.1. Mental health services

5.1.1. Young people below the age of 18 receiving support from Child and Adolescent Mental Health Services who may transition to Adult Mental Health Services. These young people should be managed under the SWLSTG CAMHS Transition protocol.

- Young people experiencing a First Episode Psychosis (FEP) who are 17 years and 6 months or older will be referred to Early Intervention Services (EIS) and be treated, looked after and managed under the Care Programme Approach (CPA) framework.
- Specialist services such as Eating Disorder, Personality Disorder services – young people who require ongoing secondary mental health services will need to follow the SWLSTG CAMHS Transition protocol. This will include recording of decisions made pertaining to the care plan, next steps, who will be involved and expected care package design.

- Adolescent Assertive Outreach services provides intensive community treatment to young people in South West London presenting with a mental health crisis, and in many cases provides an effective alternative to hospital admission.
- In some instances, young people may not be eligible for Adult Mental Health Services and consideration should be given to offering them support from primary health care, including GP and the Well-being service and Voluntary sector provision.
- If the young person has been under CAMHS, support will be given about the best option for on-going care.
- Preparation to step down into primary care services must also be considered. The person must be equipped with relevant information on how to access adult services. Referral to IAPT and Primary Care Liaison (PCL) Team must also be considered to bridge the support gap

5.2. Social Care

5.2.1. Children Social Care:

- Future First – this team supports young people who have been previously looked after. These include care experienced young people who may have an Education, Health & Care Plan (EHCP). This team offers support up to the age of 21 or 25 if the young person continues in further education or employment. The Future First team may, where needed, arrange placements in specialist residential care or in special education services as part of the care and support. All young people are allocated a Personal Advisor at age 16.5 up to age 21 or to 25. The statutory responsibility for care experienced young people goes beyond the operational team and includes the Council as a whole.
- The AfC Kingston and Richmond Leaving Care Team works with Children Looked After and care leavers between the ages of 16-25 or beyond if in education. Young people under the age of 18 are allocated a social worker and the young people aged over 18 (or if under 18 but no longer a Child Looked After) are allocated to a Personal Advisor. The role of the team is to support young people with the transition into adulthood to achieve their life potential, including safe and suitable accommodation, good emotional and physical wellbeing, identity, education training and employment and budgeting. When a care leaver is accepted by Adult Social Care, joint working takes place until age 25, with Adults as the lead agency, including identifying suitable accommodation.
- For Children Looked After in the Disabled Children's Team, the Leaving Care Team starts joint working at age 17.5 (or attends the final Looked After Children Review) and a personal advisor is allocated in preparation for their 18th birthday as part of the transition and will then joint work with Adult Social Care.
- During the transition period there is a 6-weekly transitions meeting that is attended by all relevant stakeholders to discuss and plan effectively. As far as possible joint working between Children and Adult Services is recommended to avoid unnecessary placement moves after the responsibility for care transfers to Adult Services. In addition, there needs to be co-ordination between the Children Services Pathway Plan and the Adult Services Support Plan to avoid confusion to young people and their families.

5.2.2. Adult social services

- The Adult Social Services teams are responsible for offering care and support to young people from the age of 18. This will include undertaking a Care Act assessment, securing adult accommodation (if appropriate) and ensuring that the young person has support in place to achieve recovery and increasing independence.

- In Wandsworth, this function is carried out by the 0 to 25 Disability Team up to age 25. After the age of 25 the responsibility will transfer to the relevant Adult Social Services team e.g. Mental Health or Substance Misuse Team.
- In Richmond, this function is carried out by the Richmond Mental Health Social Care Team or Richmond Learning Disability Team dependent on whether the primary presenting needs are Mental Health or Learning Disability. There is a Transitions co-ordinator who is the main point of contact between Children and Adult Services.
- Whether the transition is at the age of 18 or 25, the expectation is that the referring team will refer to Adult Services at least 6 months in advance of this, to enable sufficient time for planning for the transition with the involvement of all parties.

5.3. Clinical Commissioning Group

5.3.1. The CCG is responsible for the commissioning and quality assurance of the provision of secondary mental health services and this is undertaken through a robust quality assurance programme. When the young person has been detained for treatment under the Mental Health Act and is eligible for (section 117) aftercare, provision this is jointly funded between the CCG and Local Authority. Aftercare provision includes accommodation, care and support, and access to community facilities such as day care. The duty to arrange aftercare support lies with the Local Authority.

5.3.2. The agency arranging the placement and care (Local Authority or CCG) is responsible for ensuring that the accommodation and care and support remain appropriate to support the young person. This is undertaken through regular reviews of the young person as well as the Local Authority quality assurance programme when the services are within the Borough. When joint funding – the responsibility to carry out reviews should be undertaken with relevant agencies and professionals involved in the young person's life.

5.4. Accommodation and care providers

5.4.1. When a young person is in a young person's residential placement or a specialist school which is registered with OFSTED, they may (need to) move into an adult provision registered with the Care Quality Commission (CQC) or into a supported living accommodation provider. In many instances this may involve a move out of borough, and this may impact on which Mental Health Trust is responsible for the provision of the services to the young person.

5.4.2. The costs for the placement will usually be the responsibility of the Local Authority unless joint funding has been agreed or when the person is eligible for fully funded NHS care (Continuing Health Care).

5.5. Education

5.5.1. When a young person is pursuing further education or higher education, proactive contact should be made with the education provider's support department to ensure that their transition is supported. The education provider's support services can complement the existing support structure, and also ensure that adjustments are made prior to the young person's arrival.

5.5.2. It is vital that there is a good plan on how young people will move into and out of any specialist further or higher education facilities. These must be planned with engagement of all relevant stakeholders and with sufficient time to ensure that there is good transition with involvement of the young person, their support network and all involved professionals.

5.6. GPs

5.6.1. GPs are at the centre of primary care mental health, detecting mental health problems and related needs, intervening where possible and appropriate, and signposting to appropriate services. As GPs hold comprehensive information about a patient's history and circumstances, they can ensure that services are personalised. GPs are the key service provider responsible for ensuring that the transition between primary and specialist services is consistent and addresses a holistic approach to physical, psychological and mental health care.

5.7. Joint working

5.7.1. There will need to be periods of joint working between and within the stakeholders named above.

6. Involving young people and their parents/carers

6.1. The young person must be actively involved in all decisions around transition and this should be as early as possible with recognition that the young person may need time and support to consider the impact of the change.

6.2. Family members should be involved, unless there is a reason not to, or an expressed wish by the young person not to involve their family. Even where a young person does not give consent for information or plans to be shared with family members, it is important to consider how parents, carers and other family members who have anxieties about service transition can be supported. For example, they could be given information about what would be offered to a young person in those circumstances.

6.3. 'Corporate Parent' is the collective responsibility of the Council, elected members and employees, for providing the best possible care and safeguarding for the children who are looked after by the council. This responsibility cuts across all departments of the council for children and adult services, alongside partner agencies. However, it has been highlighted that complexities arise in regard to information sharing as Children's and Adult's services use different Information Technology systems, therefore the access to records is not readily available. As such, clear communication and information sharing is essential across the different services involved with the young person transitioning into adult services.

6.4. All services involved with a young person leaving care who is in transition to adult services, should ensure they are familiar with the 7 principles to which they must adhere, which became a statutory responsibility under Children & Social Work Act 2017.

6.5. The Local Authority must alert Adult Mental Health providers if a person jointly supported is in fact leaving care where they have not 'transitioned' from Childrens and Adolescent Mental Health Services (CAMHS). Adult Mental Health services must ensure to include the 'corporate parent' in the same manner as any other parent, as described in this policy.

6.6. Advocates and peer support groups need to be considered as a supplement to the support which the young person and their parent/carers receive from professionals. They need to ensure a social model is considered to support the person to engage with the wider society

7. Multi-agency Involvement and engagement

7.1. The complexity of the mental health transition arena makes it **vital for there to be a clearly defined lead professional/co-ordinator who keeps in touch with all other involved professionals**. This is exacerbated when the person also has to change location to move from a young people's facility into an adult facility. It is important for all agencies involved with the young person in their current location as well as those who will be involved in the new geographic location, to engage in the planning process.

7.2. Following on from regular Education and Health Care Plan reviews of young people's needs, there would be a **Multi-agency Transition Planning discussion** at least 6 months before they turn 18. In most instances this would be led by the Local Authority. All Children's services involved with the young person, all potential adult services taking over care, and the young person/parents/carers should be involved in this meeting. It should explore and share information regarding substance misuse, etc.

- The young person's diagnosis and how their mental health condition impacts on their lives.
- The recovery / support plan for the young person.
- Risk assessment regarding any changes or current concerns and how these are managed.
- Discussion on issues such as accommodation and care and support and how these are best delivered.
- Who will be the lead professional during the transition, changes which will take place, and how communication will be undertaken between agencies.
- How the young person will engage with the planning and actions, and what support they will be given at this time.
- The extent of joint working required for a smooth handover between various services and the timing of this to minimise disruption for the young person.
- Sharing any relevant Children's and Adult social services assessments which will increase understanding of the young person's needs

7.3. The multi-agency planning group should **meet at least twice** to support the changes, however more meetings may be needed in some instances. It is recommended that the multi-agency group meet at least 6-monthly during the transfer. The most appropriate lead professional may change over time and this should be reviewed at each meeting of the multi-agency group.

7.4. As far as possible, **routine reviews** such as Mental Health NHS Trust Care Plan Approach, Children and Family assessment and Local Authority Care Act Assessment, etc., **should be co-ordinated** and if possible carried out in parallel with one another to reduce the number of times the young person and their parents have to discuss these issues and to ensure a joined up approach between agencies. Professional judgement will need to be used on how best to achieve this and it can be discussed at the multi-agency planning meeting.

7.5. Planning should focus on ensuring that there are clear multi-professional teams' plans in place for what will happen when the young person turns 18, and funding and provision comes under adult services. The needs of the young person should remain paramount and planned changes should take into account changing circumstances and plans may have to change to adapt to unexpected periods of mental health relapse. This may require services to work together to agree the most appropriate support for the young person – it

also may mean some shared funding by partner agencies to manage these unexpected situations.

8. Training

8.1. Effective transitions planning and implementation require agencies to work together collaboratively. In order for this to be effective it is vital for all staff to know how each other's services operate in order to provide a co-ordinated and joined up approach.

8.2. Inter-agency, multi-disciplinary training can assist in sharing practice knowledge, facilitate discussion, solve problems and promote networking and these should outline the requirements of this framework

9. Conclusion and review

9.1. This framework is designed to provide guidance on managing mental health transitions cases effectively to achieve the best outcomes for young people and their parents/carers. It does not replace single agency transition or working arrangements and instead seeks to build on and complement these by providing a multi-agency dimension.

9.2. The guidance will be reviewed and updated (if needed) annually by the Performance and Workforce Sub-group of the Richmond and Wandsworth Safeguarding Adults Board.

Glossary of Terms

Achieving for Children	Children's Social Services provider for Richmond and Kingston Boroughs.
Advocate	A person who puts a case on someone's behalf.
Care Act assessment	A statutory assessment undertaken by Adult Social Services to determine what a person's care and support needs are.
Care experienced	This refers to anyone who has been, or is currently in care, or from a looked-after background at any stage in their life, no matter how short, including adopted children who were previously looked-after.
Care Programme Approach (CPA)	CPA is a package of care that is used by Secondary Mental Health services. It includes development of a care plan, (including a crisis plan), and allocation of a Care Coordinator.
Children and Adolescents Mental Health Services (CAMHS)	CAMHS is the local specialist NHS service that works with children or young people who have difficulties with their mental health or wellbeing.
Dual diagnosis	If a person has problems with both their mental health and substance misuse, they may be given a 'dual diagnosis', when both problems are diagnosed.
Early Intervention Services	Services working with people from the age of 17 and above, as soon as possible after their first experience of psychosis, in order to minimise the impact on their life.
Education and Health Care Plan (EHCP)	For children and young people aged up to 25 who need more support than is available through special educational needs support. EHCPs identify educational, health and social needs and set out the additional support to meet those needs.
OFSTED	Office for Standards in Education, Children's Services and Skills. They inspect services providing education and skills for learners of all ages, inspect and regulate services that care for children and young people.
Practitioner	A person engaged in the practice of a profession or occupation; or someone involved in a skilled job or activity.
Safeguarding Adults Board (SAB)	Statutory multi-agency partnership whish is set up in every Borough to help safeguard adults with care and support needs.
Secondary Mental Health Services	Specialist services that usually need a referral from a GP. For example, community mental health, home treatment, assertive outreach and early intervention teams.
Section 117 aftercare	Some people who have been in hospital under the Mental Health Act 1983 ('sectioned') can get continued help (or aftercare) when they leave hospital. It aims to reduce the chance of a relapse and the need to go back to hospital.
Stakeholder	An individual or group that has an interest in any decision or activity of an organisation.
Support Plan	Also known as "care and support plan", a Support Plan is for anyone who needs care or cares for someone else. The plan details the type of support needed, how it will be given and how much money the Council will spend on the care.
Transition	Transition is the purposeful planned movement of young adults between ages 16 and 18 from child-centred to adult-orientated health and social care systems.