NHS SCOTLAND

Principles of Transition

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Young person's views: What does the young person, and their family, want to happen next? Where and how will this be best delivered? The holistic wellbeing needs, experience and views of the young person should be explicit and central in all transitional assessment and planning. Use of the GIRFEC Wellbeing Indicators should be used in the transition planning process across services. The need for advocacy in ensuring supported representation of the young person's voice should be considered. The needs and views of the young person's family and those most closely involved in transitional care planning should be taken in to account; this can be done using the Transition Care Plan (link included in this document). Services should work to promote partnership between those who care about and those who have responsibilities towards the young person.

Recognition of the important relationships in a young person's life: Adult and children's services need to work together to transition the young person's treatment with an understanding of the important relationships (familial, friends etc) in that person's life. AMHS and CAMHS services have different ways of working in relation to information sharing. This needs to form an explicit part of the handover, as leaving the young person to inform their carers and friends that they will no longer be part of meetings can damage or fracture those relationships, which can then have a negative impact upon the young person. Consideration should also be given to other professionals that may play an important role in advocating for or supporting the young person, such as Teachers, GPs or School Nurses. GIRFEC principles should continue to guide planning and delivery of treatment.

Continuity: Services should aim to provide a continuous episode of treatment which may be delivered by different teams; rather than separate episodes of treatment that stop and start.

Agree priorities for care: In order to ensure a smooth transition at an individual level, there needs to be processes, and resources available, at a systems level.

Recognition of the impact of developmental stage: Remaining mindful of the other transitions that are occurring for the young person at the same time as the transition between CAMHS and AMHS, there should be a proactive and coordinated effort to facilitate a holistic approach to transitions. This includes consideration of housing, education, further training and employment, as well as their mental health and wellbeing needs. It may be appropriate to organise a young person's planning meeting using the GIRFEC framework.

Flexibility: A degree of flexibility which takes into account the personal, clinical and social stage the young person has reached, rather than age *per se*, should be given when transition is being considered. If an episode of treatment can be completed in one service by being flexible about age boundaries, then that should be considered preferable to a transition. However, if a decision is made to delay transition from CAMHS then there should be an explicit agreement about how these young people can access unscheduled care so that they are not disadvantaged by being open to CAMHS.
Early preparation/forward planning: Services should prepare young people and their families/carers for when it may be time to move on. Preparation should include guidance on advocacy, information sharing and involvement in care planning. This should be a collaborative process between CAMHS and the family, as well as CAMHS and AMHS.
Joint care planning: Adult and children's services should work together to ensure a smooth transition for the young person. This should include a planned period of overlap to avoid the abruptness of a sudden change in clinicians, culture, frequency of appointments and environment.
Recognition of and respect for different cultures: The different cultures of CAMHS and AMHS should be communicated to the young people and their family/carers/friends in a way that addresses the expectations of the young person and their families. This includes differences in theory and practice, as well as differences in the level and style of intervention. This should be communicated positively both verbally and in a written form.
Ensuring equity: Attention needs to be paid not just to the *process* of transition, but also to the *nature of the service to which young people are moving* to include differences in access to resources to support the person toward recovery.
Ensuring good communication: Robust communication pathways between mental health services and the wider Primary Care service (e.g. GP) need to be in place in order to support all young people and families to access the most appropriate service for their needs. This population includes those who require a transition from CAMHS to AMHS, and those who are transitioning out of mental health services. CAMHS and AMHS should provide Primary Care services with the details of the transition care pathway in place within the local area, and the role that they (primary care) have in supporting the child/young person or adult to access the most appropriate service to meet their needs.

Recognition of risk: Some young people, such as those with autism, are likely to experience transition as particularly challenging; transition planning should therefore be adapted to meet their needs. Such risks highlight the need for partnership in agreeing practical and sufficiently sustained support strategies between CAMHS, AMHS, those that care about, and those who have responsibilities towards, the young person.
Continuation of plan: Even if the young person is admitted to an adult ward during the process of transition, the transition within the community teams should continue as planned. There should not be a sudden or unplanned withdrawal of support from the CAMHS team.
Joint learning: The different cultures suggest scope for joint learning between adult and children's mental health services (including in-patient and community based services). This would enable both services to be able to understand and respond to the needs of young people, as well as enabling cross sector learning and the development of a shared values base. Consideration should be given to pre- and post-qualifying interagency training modules in relation to supporting young people to have a good transition.

Transition Care Plan Documents

The Transition Care Plan Guidance; Transition Care Plan and the Transition Care Plan Evaluation Form can all be found at:
https://www.nhsinform.scot/care-support-and-rights/health-rights/young-people/transition-care-plans-moving-from-camhs-to-adult-mental-health-services

Guidelines

- NICE Guidelines on Transitions: https://www.nice.org.uk/guidance/ng43
- Alliance/Scottish Government Transitions Report: http://www.alliance-scotland.org.uk/news-and-events/news/2017/05/experiences-of-transitions-to-adult-years-and-adult-services-new-report/#.WeCF_ThOWUl

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