Transitions from adolescent secure to adult secure inpatient services: Practice guidance for all secure services

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NHS England and NHS Improvement

Contents

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:
• given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
• given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Summary

Effective transition from adolescent secure to adult secure inpatient units should comprise of the following elements:

- Early identification of the future care pathway:
    - Joint assessments by adolescent and adult secure services of young people aged between 17.5 and 18 years referred for secure inpatient admission.
    - Access assessment by adult secure service by 17.5 years
    - Parallel pathway planning
- Practical aspects:
    - Familiarisation to the adult secure service via:
        - Involvement of families and carers
        - Provision of information packs
        - Visits in advance
        - Meeting the new Multi-Disciplinary Team (MDT)
    - Consideration of individual needs
    - Consideration of any health inequalities
    - Graded transition
    - Input at Care Programme Approach (CPA) and Care, Education and Treatment Reviews (CETR) meetings
    - Involvement of Case Managers, this includes throughout the document those who are employed by NHS England and Improvement (NHS E/I) and those employed by NHS-led Provider Collaboratives[1].

[1] NHS-led Provider Collaboratives are several providers taking collective responsibility for services, through a Lead Provider for their originating population. They manage the pathway and budget for their population and have responsibilities around quality assurance and service improvement. They are accountable to NHS England and Improvement for decisions made and the quality of care.

Introduction

This guidance relates to all adolescent secure and adult secure services, including those for patients with mental illness, personality disorder, learning disability and autism. Adolescent and adult secure inpatient units differ in many ways in their provision of care and treatment. The point of transition between the two services is therefore frequently a stressful experience for young people. Supporting the relatively small number of young people and their families and carers during this transition is often a challenge to commissioners and providers, particularly as it is often experienced as being abrupt and fragmented in nature for all parties.

Coordinated, planned and supportive effective transition from secure adolescent inpatient units to adult inpatient units has clear benefits to young people. It supports them to maintain and further understand their mental health, increases confidence in their care and treatment, and encourages them to become more independent in the management of their mental health. It enables services to be provided in an integrated way that supports the promotion of equality and early identification and reduction of any health inequalities. Effective transition is also beneficial for commissioners and providers via increased stability of young peoples' mental health, enhanced progress along individual care pathways, and ultimately reducing length of stay.

The National Adult Secure and CAMHS Secure Transitions Task and Finish Group was established by NHS England to consider and improve the transition of young people from secure adolescent inpatient units to adult inpatient units (secure and non-secure).

Two groups of patients transitioning from secure adolescent to adult mental health inpatient services can be identified:

(1) Those patients who clearly fall within the adult secure pathway (i.e. meet criteria for admission to adult secure services; i.e. adult high, medium or low secure inpatient units).
(2) Those patients who do not meet the adult secure pathway criteria, i.e. have been admitted to an adolescent secure inpatient unit primarily due to their risk of harm to self rather than their risk of harm to others; this is especially common for young people admitted to adolescent low secure units.

This guidance relates to the first of these two patient groups. It aims to outline good practice standards and give clear guidance for the positive transition of young people from adolescent secure inpatient units to adult secure inpatient units.

This guidance has been developed in the context of services currently commissioned and provided but acknowledges and supports the commitment within

the Long Term Plan www.longtermplan.nhs.uk/publication/nhs-long-term-plan to create a comprehensive offer to 0-25 year olds that reaches across all MH services for children, young people and adults. There will be increasing focus on providing services which are needs based rather than age based with increasing flexibility around service boundaries and thus enabling a reduction in the number of transitions.

Early Identification of Pathway

Access Assessments

It is crucial to identify which adult mental health pathway young people in secure adolescent inpatient care will follow when they turn 18; i.e. whether they meet criteria for treatment via the adult secure pathway (i.e. provided by adult secure mental health services in low, medium and high secure hospitals and/or by community forensic mental health teams). All young people who are likely to meet the adult secure pathway criteria (i.e. they present a significant, serious or grave and immediate risk of harm to others in the context of their mental health difficulties) should be referred for an access assessment before and no later than the age to 17.5 years. This will require discussion with and formal referral to the relevant adult secure access assessment service, facilitated by the adult secure Case Manager for the patients originating area. The access assessment should be consistent with the standards as outlined in **Appendix 2 of the Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b** and, as outlined in section 2.2 of the appendix, focus on four key questions:

I. *How clinically urgent is the admission*
II. *Is there a need for admission to secure inpatient services?*
III. *Level of security the patient requires?*
IV. *What is the patient's initial assessment/treatment needs?*

Access assessments for young people transitioning from adolescent secure inpatient units are likely to be considered **non-urgent** in nature, and therefore section 3.2.2 of Appendix 2 of the Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b should apply; i.e.:

- *These timescales are dictated on the basis that all information has been sent by the referrer to the access assessment service*
- *A written response regarding appropriateness of referral must be provided within a maximum of 7 days of receipt of the referral or sooner if nature of the referral dictates*
- *A proposed time frame in which the assessment will be conducted must be discussed and agreed between the access assessing service and the referrer*
- *The access assessing service must confirm the time and date of the assessment*
- *The assessment must take place within a maximum of 21 days*
- *The final written report must be shared with the referrer within 7 days of the assessment.*

In determining what level of security is required for a young person transitioning from adolescent to adult secure inpatient care, consideration should be given to their **physical, procedural and relational security needs**.

Input into the access assessment from the young person, their family and/or carers, the referring unit, and the young person's wider professional network (e.g. Social Care Children's Services) should be promoted where appropriate and in adherence to the adult secure services specifications and Secure Carers' Toolkit - #Gettingthrough - information for Parents and Carers, and the secure CAMHS carers toolkit (in development).

As per section 4.3 of the appendix, assessments undertaken outside of the specific access assessment process (e.g. a report prepared for court) is not an access assessment but could, as with other available information, form a useful part of the referral information considered in carrying out the access assessment.
If the referring clinical team do not agree with the outcome of and recommendations made by the access assessment service, the dispute resolution and arbitration process should be followed as outlined in sections 5.2 and 5.3 of Appendix 2 of the Medium and Low Secure (Adults) specifications C02/S/a and C02/S/b.

Parallel Pathway Planning

Adolescents, due to their emotional development, tend to have greater fluctuation in mental state and recovery compared to adults; this should be reflected in their psychiatric formulation. This presents increased challenges in identification of their pathway, including whether discharge to the community is achievable or what level of security is required should ongoing hospital admission post 18 be required. Therefore, **parallel pathway planning** is required in the months prior to transition from adolescent secure inpatient care. This will require adult secure services to have a flexible and inclusive approach to the identification of the specific pathway for each young person.

Transition is a stressful event for any patient and **flexibility is therefore required**. This is particularly pronounced for young people transitioning from adolescent to adult secure units, due to the different environments and therapeutic approaches often found in adult compared to adolescent units, the different ages of other patients, and because the young person may be undertaking **multiple other transitions** at the age of 18 years.

This is especially evident for those young people who are Looked After Children, either through being subject to a Care Order or through parental agreement. All such young people will have a Pathway Plan, which sets out how they are to be supported as they become adults. This plan will be in place from the time that they are 16. It is reviewed formally at least every six months and it is important that it is

consistent with the relevant health planning processes. After they become 18, they will continue to be provided with support as Care Leavers, although the structure of social care services is such that young people often have changes in personnel at this point (e.g. their Children's Services social worker is likely to pass their case to a Personal Advisor. Their support as Care Leavers continues to be provided through Children's Social Care. If an assessment is required for their ongoing support through Adult Social Care, this will require a separate referral and should be discussed with their Personal Adviser.

Some children may have an allocated social worker without being Looked After, for example, if they have an identified disability or Special Educational Need. If the child has an Education, Health and Care (EHC) plan, this can continue until they are 25 years old. The transitional arrangements to Adult Social Care should be clarified in these cases.

The fact that any pathway planning should aim to **reduce the number of transitions** and promote **parallel pathway planning** for each young person, is why the adolescent medium and low secure service specifications allow, where clinically appropriate, for transition of young people during their 18th year (i.e. between their 18th and 19th birthday). This ability for some young people to remain in adolescent secure inpatient units for a short period (maximum one year) is often helpful in the overall identification of the correct pathway (e.g. to enable completion of a specific therapeutic goal). Conversely, it may be appropriate for some young people to transfer to an adult secure unit prior to their 18th birthday; individual patient factors and the dynamics within the relevant secure units should be the determining factor rather than solely based on date of their 18th birthday.

Such flexibility should be extended to young people referred to but not yet admitted to adolescent inpatient secure units. For example, it may be more appropriate for some almost 18 year olds whose emotional development is advanced to be admitted to a secure adult unit rather than a secure adolescent unit, to avoid multiple transitions; i.e. they are "atypical cases" as outlined in the Age-appropriate services paragraphs of the Mental Health Act Code of Practice (2015) (see appendix 1). Therefore, **joint access assessments** of these young people by adolescent and adult secure services should be undertaken for all young people aged between 17.5 and 18 years who are referred for secure inpatient admission. Input should also be sought from adult secure mental health services **at the time of any mental health sentencing recommendations** to courts for young people aged 17 years and older.

Practical Arrangements to Promote Positive Transition

Once it has been identified that a young person will transition from an adolescent secure inpatient unit to an adult secure inpatient unit, there are a number of practical arrangements that should be undertaken.

Pre-admission Familiarisation

The young person should be **familiarised to the adult secure unit** that they will transition to in advance of any final move. For their family and carers this should be consistent with the existing secure carers toolkit and section 3.5 re Pre-admission of appendix 1 of the adult medium and low secure specifications:

> *The pre-admission phase is crucial to orientate the patient, their family and carers (where appropriate) to secure care and includes:*
>
> - *Introduction to key service staff and other patients*
> - *Visits to the admitting service as appropriate and may include use of digital technology where direct visits are not possible /appropriate*
> - *Provision of information about the admitting service in the form of a Welcome Pack*

The expectation should be that such a visit or visits should occur unless a clear justification can be otherwise provided. If the young person's risk/illness is such that they cannot complete visits to the adult secure service, members of the multidisciplinary team, particularly nursing team, should complete regular visits to the adolescent secure service in advance of transition to promote the establishment of relationships between the young person their new care team.

Where available, the young person should be offered support from Lived Experience Peers and or Peer Support Workers, particularly those who have experienced transition from adolescent to adult secure services.
In addition to the young person, where appropriate their **family and/or carers** should be also be familiarised to the adult secure inpatient unit.

Graded Transitions

Graded transitions, i.e. transitions from an adolescent secure inpatient unit to an adult secure inpatient unit that are phased over a number of weeks, should be promoted where practically possible; this will require clear safeguarding processes and clarity regarding clinical and risk management responsibilities. This may include multiple visits, meeting key members (e.g. primary nurse) of the adult secure service multidisciplinary team on a number of occasions, and a phased transition of therapy e.g. via attendance in individual and/or group psychological therapy sessions, occupational therapy activities, etc.

Participation at CPA and CETR meetings

Central to planning and facilitating good transition should be **attendance at Care Programme Approach (CPA) meetings and (where applicable) Care, Education Treatment Review (CETR) meetings** by both adolescent and adult secure services during the phase of transition; i.e. a minimum of six months prior to and a minimum of six month following a move from an adolescent secure unit to an adult secure unit. This will ensure input from both services in the joint setting and review of treatment goals and provide clear structures and forums for monitoring and optimising the young person's transition according to the agreed timescales. Adolescent secure and adult secure **Case Managers** should also be actively involved in the CPA and CETR processes.

Consideration of Individual Needs

As with all admissions to inpatient services, specific consideration should be given to the individual patient's needs and requirements. This may include reasonable adjustments for needs arising from a diagnosis of Autism(see relevant service specifications).

Young people may have specific individual needs arising from educational goals; it is important to consider how their educational progression can best be maintained at the point of their transition to adult secure services.

Practice Case Examples

Case 2

- Female adolescent with emotionally unstable personality disorder in the context of significant childhood maltreatment (neglect and sexual abuse) and attachment difficulties. Admitted to an adolescent medium secure unit at the age of 14 years due to risk of harm to others including fire-setting and interpersonal violence.
- Made good progress during the four years in the adolescent medium secure unit, to the extent that a supported accommodation placement was identified. This was trialled via Section 17 leave, but risks (mainly to self but also to others) increased significantly.
- An alternative care pathway to an adult secure service was considered necessary. A rapid access assessment confirmed the need for transfer to an adult medium secure service. There was close liaison between the adolescent and adult medium secure services by all members of the multidisciplinary team, and three pre-admission visits for the patient were arranged. The patient's family were involved in some of these visits and meeting the new multidisciplinary team. Transfer occurred in a timely but contained manner; this was aided by the sharing of care plans and detailed knowledge and understanding of the patient by the adolescent medium secure unit.
- Following transfer, and at the patient's request, key members of the adolescent medium secure unit's multidisciplinary team attended the patient's first CPA meeting at her new adult medium secure unit. Feedback form the patient was that this supported a positive ending and a sense of closure from her lengthy adolescent medium secure admission.

Case 3

- A young man with first episode of psychosis (schizophrenia) who was convicted of an attempted armed robbery which occurred in the context of his mental illness. Clear evidence of psychosis on remand; was transferred to an adolescent medium secure unit. Sentenced to a section 37 Hospital Order following psychiatric recommendations to Court. Made excellent progress in adolescent medium secure unit due to combination of response to medication, positive engagement in psychological interventions, and family therapy. Completed A level exams during admission.
- Progress enabled post 18 community discharge planning to his family home. Discussion with local adult community forensic team resulted in allocation of community care coordinator and gradual testing of section 17 leave with

local support and monitoring by a community team with expertise in forensic risk management. Successful discharge completed prior to the patient's 19th birthday.

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This guidance has also had input from Patient and Public Voice members of the Adult Secure Clinical Reference Group.

Appendix 1: Age-appropriate services – paragraphs 19.90 to 19.106 of the Mental Health Act 1983: Code of Practice (2015)

19.90 Section 131A of the Act says that children and young people admitted to hospital for the treatment of mental disorder should be accommodated in an environment that is suitable for their age (subject to their needs). This duty applies to the admission of all under 18s, whether or not they are detained under the Act and includes children and young people who are subject to a CTO, who are recalled to hospital, or who agree to informal admission.

19.91 This means that children and young people should have:

- appropriate physical facilities
- staff with the right training, skills and knowledge to understand and address their specific needs
- a hospital routine that will allow their personal, social and educational development to continue as normally as possible, and
- equal access to educational opportunities as their peers, in so far as that is consistent with their ability to make use of them, considering their mental state.

19.92 The duty requires hospital managers to ensure that the environment in the hospital is suitable. When determining the suitability of the environment, they must consult a person whom they consider having knowledge or experience in working with children and young people receiving in-patient mental healthcare and who are able to make this assessment (this will usually be a CAMHS professional). The duty applies to all in-patient mental health services, including highly specialised services such as eating disorder units, and learning disability services.

19.93 The Care Quality Commission (CQC) must be notified without delay if an under 18- year old is placed on an adult psychiatric ward for longer than a continuous period of 48 hours. Section 140 of the Act requires clinical commissioning groups
to notify local authorities in their area of the hospitals that are designed to be specifically suitable for patients under the age of 18.

19.94 Section 131A does not prohibit all admissions of individuals aged under 18 to adult wards. Such admissions are permissible only in exceptional circumstances, where this is considered to be the most suitable place for an under 18-year-old. These exceptional circumstances generally fall into two distinct categories, referred to in this guidance as ‘emergency situations’ and ‘atypical cases’ (see paragraphs 19.98 – 19.101).

19.95 In all cases, to be lawful, the admission of a person aged under 18 to an adult ward must be suitable for that particular individual at the time that the admission is being considered.

19.96 In all cases where an under 18-year-old is admitted to an adult ward, the reasons for the admission should be recorded, including an explanation as to why this is considered to be suitable having regard to their age and why other options were not available and/or suitable. Details of whether action will be necessary to rectify the situation, and what action taken by whom, and when, should also be recorded.

19.97 In the case of children aged under 16, it is Government policy that they should not be admitted to an adult ward. If this occurs or if the child is treated in any other inappropriate setting due to lack of appropriate CAMHS beds, the commissioner of the CAMHS inpatient services should be notified. The commissioner should report it as a serious incident and investigate it in accordance with the NHS Serious Incident Framework.

19.98 In a small number of cases the child or young person's need to be accommodated in a safe environment could, in the short term, take precedence over the suitability of that environment for their age (referred to as an 'emergency situation'). Such situations will arise where the child or young person needs to be admitted urgently to hospital and accordingly waiting for a bed to become available on a CAMHS unit is not considered to be an acceptable option. An 'emergency situation' should be a rare and unusual case. It is not unusual for children or young people to require unplanned admissions and accordingly local policies should be in place to ensure that such admissions are to age appropriate environments.

19.99 There is a clear difference between what is a suitable environment for a child or young person in an emergency situation, and what is a suitable environment for a child or young person on a longer-term basis. In an emergency, such as when the patient is in crisis, the first imperative is to ensure that the child or young person is in a safe environment. Once the initial emergency situation is over, hospital managers must ensure that action is taken to transfer the child or young person to more appropriate accommodation unless they have determined that the adult ward is the most appropriate environment for the child or young person. In determining whether the environment is suitable beyond the initial crisis, in addition to the appropriateness of the mental healthcare that can be provided on the adult ward, the hospital managers would need to consider issues such as whether the child or young person can mix with individuals of their own age, can receive visitors of all ages, and has access to education.

19.100 An ‘atypical case’ describes a situation where those arranging a young person’s admission conclude that the best option for that young person is to be admitted to an adult ward even if a CAMHS bed were available. While likely to be rare, such cases may arise from time to time when the young person is very close to their 18th birthday and placing them on a CAMHS ward for a matter of weeks or days before transferring them to an adult ward would be counter-therapeutic and:

- the young person may express a preference to be on an adult ward, such as when they are under the care of the early intervention psychosis (EIP) team which has beds on an adult ward. The young person may prefer to have continuity of care from the EIP team rather than be admitted to a unit with different clinicians, or
- if a young mother requires admission for post-natal depression, admission to an adult mother and baby unit would allow the young mother to remain with her child, whereas admission to a CAMHS unit would not.

19.101 Where, whether owing to an emergency or because the admission is an ‘atypical’ case, it is considered appropriate for the child or young person to be admitted to an adult ward, it will still be necessary to ensure that appropriate steps have been taken to safeguard the young person. Discrete accommodation in an adult ward, with facilities, security and staffing appropriate to the needs of that young person, might provide the most satisfactory solution; for example, young female patients should be placed in single sex accommodation. Wherever possible all those involved in the care and treatment of children and young people should be CAMHS specialists. Anyone who looks after them must always have enhanced disclosure clearance from the disclosure and barring service (DBS), including a barred list check, and that clearance must be kept up-to-date.

19.102 Where the placement of a child or young person on a CAMHS unit might have a detrimental effect on the other children and young people, hospital managers need to ensure that the interests of other patients are protected. However, the needs of other children and young people should not override the need to provide accommodation in an environment that is suitable for the patient’s age (subject to their needs) for an individual patient aged under 18. This means that the detrimental impact on other young patients is not an acceptable reason for transferring a child or young person to an adult ward.

19.103 Children and young people aged under 18 should also have access to age-appropriate leisure activities and facilities for visits from parents, guardians, siblings, or carers.

19.104 Section 131A of the Act applies to under 18s who are detained in hospital, as a place of safety under sections 135 or 136 of the Act, but not to other places of safety. People under 18 may be admitted to adult hospital facilities in ‘emergency situations’. A child or young person may be detained in a place of safety that is not specifically designated for under 18s if this is assessed to be a suitable environment for the child or young person at that time, given the particular circumstances. If, subsequently, the child or young person is assessed as requiring admission to hospital, the admission must be to an age-appropriate (and otherwise suitable) environment and this should be arranged as soon as possible. Section 131A should never be relied upon as a reason for detaining a child or young person under the age of 18 in a police cell rather than a hospital. The safety of the child or young person should always be central to the decision-making process.