Preparing for Adulthood – supporting children to transition

People Directorate Protocol

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1. Context

This protocol is based on what young people, their parents and carers say is important in terms of their preparation for adulthood:

1.1. Independence and somewhere to live;
1.2. Work and doing things that are interesting and satisfying;
1.3. Good health and well-being;
1.4. Having friends and being part of a community.

The guidance details key and relevant requirements that support children to move on into adulthood and is designed to support professionals to collaborate and cooperate to meet individual need. The legislative requirements are set out in 3 defined areas of practice 1) Children's Services, 2) Special Educational Needs and 3) Adult Social Care and these are supported by NICE Guidance:

- SEND Code of Practice 2014;
- The Children and Families Act 2014;
- The Care and Support (Children's Carers) Regulations 2014;
- The Children (Leaving Care) Act 2000;
- The Care Act 2014 – specifically Sections 58 to 66.

The above outline the key principles of transition to adulthood for the 3 groups of young people defined below (see definitions), and to take certain additional steps. These reflect best practice in relation to preparation for adulthood and joint working arrangements between Adults and Children's Services teams. Whilst the legal responsibility for these sits with the Local Authority, it is essential partner agencies and providers are engaged to ensure these working arrangements are successfully implemented and regularly monitored.

In short, the regulations:

- Establish a duty for local authorities to assess a child, young carer or *child's carer* before they turn 18, in order to help them plan if they are likely to have needs once they (or the child they care for) turn 18 and if it will be of "significant benefit"

- Give local authorities a duty to assess the needs of an adult caring for a child who has a disability and allows regulations to be made in relation to the exercise of this duty

- Include a duty on local authorities to offer an assessment to young carers where it appears that a child is providing care and also provides that an assessment can be carried out jointly with another assessment.

- Provide continuity so that where a Young Person is receiving Children's Services, those services will not stop abruptly when the person turns 18, but must continue until Adult Services have a plan in place.

2. What do we mean by Preparing for Adulthood?

Preparing for adulthood is an experience common to all children and can apply at different ages dependent on individual need and ability. For some children some additional thought and consideration may be required to assist parents to prepare their children for adult life and essentially legislation requires officers of the Local Authority to consider this specifically between the ages of 14 and 25 years. In Coventry when young people move from childhood to adulthood this is has been known as a 'Transition'. Whilst this applies to all young people, this guidance specifically relates to those that have or have the appearance of need and where service provision already exists.

Preparing for adulthood starts at an early age enabling children and young people to take charge of their own lives, build self-care skills and to do increasingly more for themselves. It is individual specific but the Children and Families Act 2014 places specific requirements that this starts at 14 years.

It is recognised that developing independence and preparing for adult life can be a worrying time for young people and their families. The way that young people access support and services, if required, will change and they will start to make decisions for themselves. It is important to be prepared for these changes. This can include getting a job, moving on and enjoying activities as a young adult in the community.

Our intention is to ensure that all those involved have the information they need to assist in making the right decisions at the right time.

3. Our Aim

We aim:

1. To provide a positive experience of transition into adulthood for all young people with special educational needs and disabilities, through a 'person centred' approach that prepares young people effectively for adulthood.

2. To promote independence in a way that supports young adults from 14 years to lead a fulfilling life and to achieve their hopes and aspirations. Young people are central to this process and will be considered in their own right. To do this we will include partners from Education, Health and Social Care.

3. That young people with additional needs would have the same opportunity as their peers to achieve employment, independent living, to be part of a community and achieve and maintain good health and wellbeing.

4. Our Values

We want to enable and empower young people to be informed so that they can make good choices and achieve an independent life but feel supported when necessary. Our approach will be based on values that are:

- Outcome focused
- Partnership based

- Respectful
- Honest
- Aspirational
- Open to challenge
- To work collaboratively
- Consistent approach

5. Principles of well managed support

We believe the following aspects should be in place in all circumstances to enable transfer to Adults Services effectively:

- Children and young people will have received relevant support and guidance from 14 years in preparation for adulthood
- Identification of likely future adult needs as early as possible. Whilst in some cases this should be from the age of 14 onwards (see guidance below; 'When a Transition Assessment must be carried out') it should be undertaken in any event at the most appropriate time for the Young Person where this is of 'significant benefit'
- Young people (and their parents/carers) should not be left suddenly without support or services on their 18th birthday and then required to wait for reassessment for eligible Adult Services
- Children, young people and families should have access to good quality Information, Advice and Guidance (IAG) before point of transfer in a variety of formats as required to meet their needs
- Any assessments or reassessments and changes to care arising from these, should take into account the development and mental capacity of the young person and/or their parents & carers
- Safeguarding considerations must be paramount at all times
- Where possible, named 'lead practitioners' for transition should support 'pre-transition' activity (including visits & meetings) throughout the transition phase
- A whole-family approach to assessment of need should be taken that considers not just the needs of the child/Young Person but also their parents/carers as they approach transition
- (Where possible) greater independence should be empowered and self-reliance encouraged, to reduce lifelong service dependency
- Transition arrangements should reflect the areas young people and families have told us are important to them .They should help them to maintain a healthy body and mind, allow them to pursue education, employment or training if they wish to, stay safe, and have enough money to access the support they require

- Cooperation between providers of Children's/Young People's and Adult's Services with a focus on joint working before, during and after the point of transition to ensure any changes to care and support are implemented smoothly, and concerns and worries are addressed

6. When a Transition Assessment must be carried out

- Local authorities must carry out a transition assessment of anyone in the three groups when there is significant benefit to the young person or carer in doing so, and if they are likely to have needs for care or support after turning 18.
- That a young person or carer is 'likely to have needs' means they have any likely appearance of any need for care and support as an adult – not just those needs that will be deemed eligible under the adult statute. It is highly likely that young people and carers who are in receipt of children's services would be 'likely to have needs' in this context, and local authorities should therefore carry out a transition assessment for those who are receiving children's services as they approach adulthood, so that they have information about what to expect when they become an adult.
- For young people with special educational needs (SEN) who have an Education, Health and Care (EHC) plan under the Children and Families Act, preparation for adulthood must begin from year 9.
- Where it is judged by the local authority that the young person or carer is likely to have needs for care and support after turning 18, but that it is not yet of significant benefit to carry out a transition assessment, the local authority should consider indicating (when providing its written reasons for refusing the assessment) when it believes the assessment will be of significant benefit.

7. Young People with Special Educational Needs and Disability

A disability as defined by the Equality Act 2010; a physical or mental impairment, which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. Should Examples covered by the protocol include: learning difficulties, learning disabilities, mental health needs, long-term neurological conditions, autistic spectrum disorders, sensory, and physical impairments.

A Special Educational Need is defined in the SEND Code of Practice 0-25 years – January 2015; A child or young person has SEN if they have a learning difficulty or disability which calls for special educational provision to be made for him or her. A child of compulsory school age or a young person has a learning difficulty or disability if he or she:

- has a significantly greater difficulty in learning than the majority of others of the same age, or
- has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions.

Coventry will use the Education, Health and Care Plan as primary plan to support the different stages of Transition whilst and young person remains in education or training.

8. Features of a transition assessment

- The transition assessment should support the young person and their family to plan for the future, by providing them with information about what they can expect. All transition assessments must include an assessment of:
    - current needs for care and support and how these impact on wellbeing;
    - whether the child or carer is likely to have needs for care and support after the child in question becomes 18;
    - if so, what those needs are likely to be, and which are likely to be eligible needs;
    - the outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them.

- Transition assessments for young carers or adult carers must also specifically consider whether the carer:
    - is able to care now and after the child in question turns 18;
    - is willing to care now and will continue to after 18;
    - works or wishes to do so;
    - is or wishes to participate in education, training or recreation.

- For example, assessments must include an assessment of the outcomes, views and wishes that matter to the child or carer in question, and an assessment of their strengths and capabilities. The power to join up assessments also applies, so for example if an adult is caring for a 17 year-old in transition and a 12 year-old, the local authority could combine:
    - the child's needs assessment of the 17 year old under the Care Act;
    - any assessment of the 17 year old's needs under section 17 of the Children Act;
    - any assessment of the 12 year old's needs under section 17 of the Children Act;
    - the child's carer's assessment of the adult under the Care Act; and
    - the parent carer assessment of the adult under the Children and Families Act.

- Transition assessments should be carried out in a reasonable timescale. Local authorities should inform the young person or carer of an indicative timescale over which the assessment will be conducted and keep them informed.

- Transition assessments should consider the immediate short-term outcomes that a child or carer wants to achieve as well as the medium and longer-term aspirations for their life. Progress towards achieving outcomes should be monitored.

- EHC plans must be person-centred and must focus on preparation for adulthood from Year 9.

- In all cases, the young person or carer in question must agree to the assessment where they have mental capacity and are competent to agree. Where a young person or carer lacks mental capacity or is not competent to agree, the local authority must be satisfied that an assessment is in their best interests.
- For young people below the age of 16, local authorities will need to establish a young person's competence using the test of 'Gillick competence'.
- The Care Act places a duty on local authorities to provide an independent advocate to facilitate the involvement in the transition assessment where the person in question would experience substantial difficulty in understanding the necessary information or in communicating their views, wishes and feelings – and if there is nobody else appropriate to act on their behalf. This duty applies for all young people or carers who meet the criteria, regardless of whether they lack mental capacity as defined under the Mental Capacity Act.

9. Transition Pathway

The 14-18 years and 18-25 years Pathway Flowchart gives an overview of how professionals from various agencies will work together to supportt. Aspirational conversations will have started in the year before year 9 to help support the formal planning in year 9. A multi-professional group has been set up from professionals across the service areas to support the transition process. This is called The Operational Transition Forum. Occasionally a young person may have highly complex needs and 2 or more pathways may overlap, these may require joint working and between Children's and Adults services. For example, a young person who is Looked After with complex needs may be supported through a Personal Advisor supporting the Pathway Plan.

The number of statutory assessments will be undertaken throughout the transition pathway. Refer to the High Level Pathway Flowchart for details.

Transition from childhood through to adulthood can be challenging for children who have disabilities and their families. The All Age Disability service provides support that supplements children or adult services support for 14 to 25-year olds with the aim of enabling seamless preparation for adulthood.

Together we will work through the following as age/stage appropriate focusing on the individual as a decision-maker:

  - Education and Employment, Independency, Community inclusion, Health and current and future eligibility for services including the need for a carer and consideration of the needs of the carer. There is a focus on developing resilience including through the short-term service offer.

- Transition principles that we work to (based on Preparing for Adulthood) are:
  - Early preparation and planning;
  - Holistic assessment;

  - Planning and Review;
  - Active involvement of young people and their families;
  - Raising aspirations and focusing on key life chances;
  - Provision of information and advocacy;
  - Flexibility in transfer arrangements i.e. Arrangement may need to continue over a period of years; Integrated streamline assessment and planning processes across agencies

- To do this Social Workers (Children's and Adults), Occupational Therapists and Special Education Needs Officers will work together in a seamless way as a 'virtual team'

Transition planning will start in school year 9 (14 years) with Adult Social Workers taking a more active role at year 13.

High Level Pathway Flowchart

All Age Disability – service and support offer for Preparing for Adulthood

Start to consciously look ahead to adulthood

Year 9 (14 year olds)

Key steps

- Child flagged as 14 years old
- Existing EHCP - extended to become primary support plan for the individual young person to include transition
- Social Workers included in EHCP review
- family conversation to identify strengths-relationship maps ,circles of support, to understand aspirations and establish common goals for the EHCP including transition
- Sign off the plan by Team Leaders and SEN
- Letter to family – followed by meeting focusing on readiness to transition, future and working together- moving on events

Early planning and action for a smooth transition to adulthood

Year 11-12 (14 – 16 year olds)

Key steps

- Transitions workers consistently go through the components set out above in partnership with young person and key professionals – linking to the Education, Health and Care Plan
- EHCP review includes MDT relevant to the young person
- Systematically work through following as age/stage appropriate: Education and Education and Employment, Independency, Community inclusion, Health and Current and future eligibility for services including the need for carer
- Year 12 review to include SEN, Children's Social Worker and Adult Social Worker for advice and guidance

Intensive transition support to enable smooth transition to adulthood and appropriate support

Year 13 (16year olds)

Key steps

- Adult worker provides advice and guidance at year 12 review
- Young person flagged as 17 years and Adult SW allocated to support transition
- Professional meeting to determine readiness and who should be involved
- Adulthood planning meeting
- Service-user led – promoting choice and control (planning future provision)
- Entry into intensive short-term service (as appropriate) & accelerate independent living
- Needs and Wellbeing Assessment completed by 17 ½ years
- Key focus on the shift from parents/carers to young adult

Embedding and supporting adulthood

18 – 25 year olds

Long term care

- EHCP remains the primary plan for all young adults in Education
- SEN and ASC work together to maximise transition opportunities
- For some, social care services will end. However, Adult Social Care will ensure that person offered further services that delay the need for care and support as appropriate

No longer eligible

- Provision of information and advice to alternative community resources.
- Consideration of the needs of the carer.

Maximising linkages with Education, Health and Care plan approach

Joined- up multi-disciplinary approach throughout

Children's Services | **Adult Services**

10. Assessment between Children's and Adults

For young people with an Education Health and Care Plan(EHCP) at year 9 their transition planning will be supported by the school SENCO, The EHC Plan Coordinator and the Children's Social worker.

This collaborative arrangement will continue until school year 11. If the young person has very complex needs and is likely to require support through Adult Social Care at aged 18 years planning and information will be undertaken as part of the year 11 annual review. This is the review where shadow working will start between Children's Social Care and Adults Social Care and advice and guidance would be provided to inform the planning for adulthood. Case Management will continue to be provided via the Children's Social Worker with a requirement that the Adult Social Care Practitioner would commence a Needs and Wellbeing Assessment in year 12. The EHC Plan will be updated with outcomes and provision to support preparation for adulthood after these annual reviews by the EHC Plan Coordinator.

This is a guide and earlier or later planning will be flexible to meet the needs of the individual and the family.

11. Adult Carers and Young Carers

Local authorities must assess the needs of an adult carer where there is a likely need for support after the child turns 18 and it is of significant benefit to the carer to do so. For instance, some carers of children who have disabilities are able to remain in employment with minimal support while the child has been in school. However, once the young person leaves education, it may be the case that the carer's needs for support increase, and additional support and planning is required from the local authority to allow the carer to stay in employment.

12. Mental Capacity

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged **16** and over. The MCA is built on the following 5 guiding principles:

1) The starting point is to assume that a person has capacity

2) All practicable steps must be taken to support someone to make their own decision

3) No one should be said to lack capacity just because they make an unwise decision

4) When someone does lack capacity for a specific decision this decision should be made in their best interests

5) Before anyone takes a decision or carries out an action for someone else they must see if it can be done in a way that is less restrictive of their rights.

Young people aged 16 and over have the right to make their own decisions in relation to the provision that is available for them, including being consulted about provision in their areas, although there is nothing to stop them asking their parents, or others to help them make the decision. However, some young people, and possibly some parents, will not have the mental capacity to make certain decisions. A person has capacity for a specific decision if they are able to do all of the following:

- Understand the key points of the information they are given
- Retain that information long enough to make a decision
- Use and weigh the information
- Communicate the decision

Where someone does not have capacity for a particular decision the MCA tells staff how to act in the persons best interests and the steps that must be followed. This will always include participation by the young person and consultation with them to determine their wishes, feelings, beliefs and values. Part of the best interests' process will also involve consultation with others and parents/carers will have a significant role in this consultation. They will be asked what they can share about the young person's wishes, feelings, beliefs and values. They will also be asked what they think is in the young person's best interests.

13. Key Agencies involved in the Preparing for Adulthood Pathway

Children's Social Care

Adult Social Care

Health – CWPT

Children's Learning Disability Team

Child & Adolescent Mental Health Service (CAMHS)

Statutory Assessment and Review Service

Schools

Colleges

Grapevine

Early Help

14. Roles and responsibilities

14.1 Children's Social Care

This will usually be the Children's Disability Team Social Worker but applies to all Children's Sevices Practitioners working with children or young people with disability.

Undertake annual Children & Families (Transition) assessments which contribute to the year 9 annual review.

The Social Worker will attend the Education Health Care Plan (EHCP) annual reviews for cases open to Children's Social Care (Through Care, Child Sexual Exploitation (CSE), Area Teams and Children's Disability Team (CDT)) from year 9 – until the young person turns 18 years.

School will request advice from Social Care 6 weeks before annual review. The Social Worker will provide advice prior to the annual review which will be circulated to all invited and will contribute to the EHCP. This will be linked to transition and the 4 PFA outcomes. It should include needs, provision and outcomes.

14.2 Child in Need (CIN) Review Meetings will continue to take place and be set up by Children's Social Care with the young person, their family, health, education and any other relevant professionals to maintain the focus on preparing for adulthood and planning what needs to happen. The young person's Plan will continue to be updated by the Children's Social Worker and reviewed at CIN Meetings until the young person turns 18 years to ensure planning is on track. The Adults Social Worker will attend CIN Reviews from 16 years onwards with the Children's Social Worker to inform preparation and planning.

14.3 Looked After Children

A young person looked after by the Local Authority may be preparing to leave care at the age of 16 years or 17 years of age. The Local Authority is responsible for these young people and must continue to promote their educational achievement, training, employment and support them to build skills for independence.

Local Authorities have a duty to ensure that:

- the child's Personal Education Plan is maintained
- the child has a Pathway Plan, which supports and helps them to prepare for living independently
- the child's education is promoted, exploring training, higher education, possible employment and having access to all the services they require to help them
- the child is aware of and receives the 16-19 Bursary Fund
- the child is allocated a Personal Advisor (PA) who will support them until they are 25yrs. A Personal Advisor ensures a care leaver is provided with the correct level of support they need

14.4 Looked After Children's (LAC) Review Meetings – where a young person is 'Looked After' by the Local Authority, the Looked After Reviews will continue to take place and be set up by Children's Social Care with the young person, family, carers, health, education, Personal Advisors (PA) and any other relevant professionals to maintain the focus on preparing for adulthood and planning what needs to happen. The young person's Care/ Pathway Plan will continue to be updated by the children's

Social Worker until the young person turns 18 years old. The Independent Reviewing Officer (IRO) will continue to have oversight of the Care/ Pathway Plan to ensure planning is on track. The Adults Social Worker will attend LAC Reviews from 16 years onwards with the Children's Social Worker to inform preparation and planning.

Some looked after children or young people have special educational needs and disabilities. The Local Authority has the same duties for these young people to provide the same support described above when they are preparing to leave care at 18 years old. For more information see the Through Care website.

Some young people with additional needs and disabilities may require social care support as an adult. In these circumstances the same transition process, protocol and guidance applies from 14 years old. The 14-18 years and 18-25 years Pathway Flowcharts gives an overview of how professionals from various agencies will work together to support transition.

14.5 Children's Social Care and Adults Social Care

Adults Social Care will act in an advice/guidance capacity to inform planning and preparation for adulthood, and attend CIN and LAC Reviews from 16 years onward where it is necessary.

It is expected that the Children's and Adults practitioners will work together to support preparation for adulthood post 16 years. Case management responsibility with remain with Children's Services with Adults Services acting in an advice/guidance capacity to inform planning and preparation. The Children's Social Worker will remain the lead practitioner until the young person reaches 18 years at which point Adult Social Care will assume case management leadership.

At age 16 years the principles of the Mental Capacity Act will be followed and decision making documented in terms of best interests where it applies. The young person will be supported to make decisions and there will be a shift in emphasis away from parental decision making where it is appropriate to do so.

14.6 How Children's workers can support preparation for adulthood

Encouraging children and young people to:

- Try new things
- Travel independently and if support is needed secure this via the Travel Training Team
- Make their own decisions
- Use technology as a tool for support
- Develop positive habits, skills & routines
- Complete tasks (such as making a cup of tea) on their own
- Make friends and develop relationships
- Access community activities

14.7 Adult Social Care

An Adults Social worker will contribute to the year 11 EHCP annual review and subsequent reviews where appropriate to do so and it is likely that the young person will have an appearance of need and has already been referred to Adult Social Care. They will provide information and guidance about the types of support and services that may support a young person in adulthood if required and will further the plan to achieve optimum levels of independence. Information provided will include eligibility thresholds for access to adult social care provisions, personalised support options and direct payments and the referral process.

The Adult Social Care Practitioner will work in partnership with the young person, their parent/carer and the Children's Social Worker from year 11 onwards to complete the needs and wellbeing assessment (by 17 years) and will provide a draft support plan to inform future provision and potential cost implications by 17½ years. In the immediate months prior to the young person's 18th birthday, the Adults Practitioner will ensure all relevant provision is secured and where necessary amend the support plan to reflect changes that have taken place. The Adult Support Plan will be activated in readiness for the young person's 18th birthday and at this point Adult Social Care will assume case management responsibility and transfer from Children's Services will be considered complete.

14.8 Education

Special Educational Needs and Disability Co-ordinator (for young people still in education and training) will be responsible for:

- The school SENDCo (Special Educational Needs & Disability Co-ordinator) will organise the year 9 transition review which will form part of the year 9 statutory annual review meeting.
- The SENDCo will invite all professionals who have had recent involvement with the young person giving them at least 6 weeks' notice of the meeting date. This will include the link EHCP Co-ordinator, Children's Social Care and Health professionals where the young person receives support through these services.
- The SENDCo will ensure that the parents/carer and young person are invited to this transition/annual review. It is essential that the views and wishes of the young person and their parent/carer is central to this planning. The views and wishes should be gathered where possible prior to the Transition/Annual Review and circulated. If this is not possible they must be gathered and recorded as part of the Year 9 Transition/Annual Review meeting using the Annual Meeting Summary for year 9 and above which can be found on the Coventry SEND Local Offer.

The SENDCo will chair the Review Meeting and ensure that all actions, support and specific outcomes linked to the four Preparing for Adulthood Outcomes are agreed and recorded within the meeting summary. These include:

1) Higher education and/or employment – exploring different employment options, such as support for becoming self-employed and help from supported employment agencies.

2) Independent living - young people having choice, freedom and control over their lives, their support, and their accommodation and living arrangements, including supported living.

3) Participating in society - having friends and supportive relationships, and participating in and contributing to the local community.

4) Being as healthy as possible in adult life.

This information should be circulated to all those invited to the meeting within 15 days of the meeting taking place.

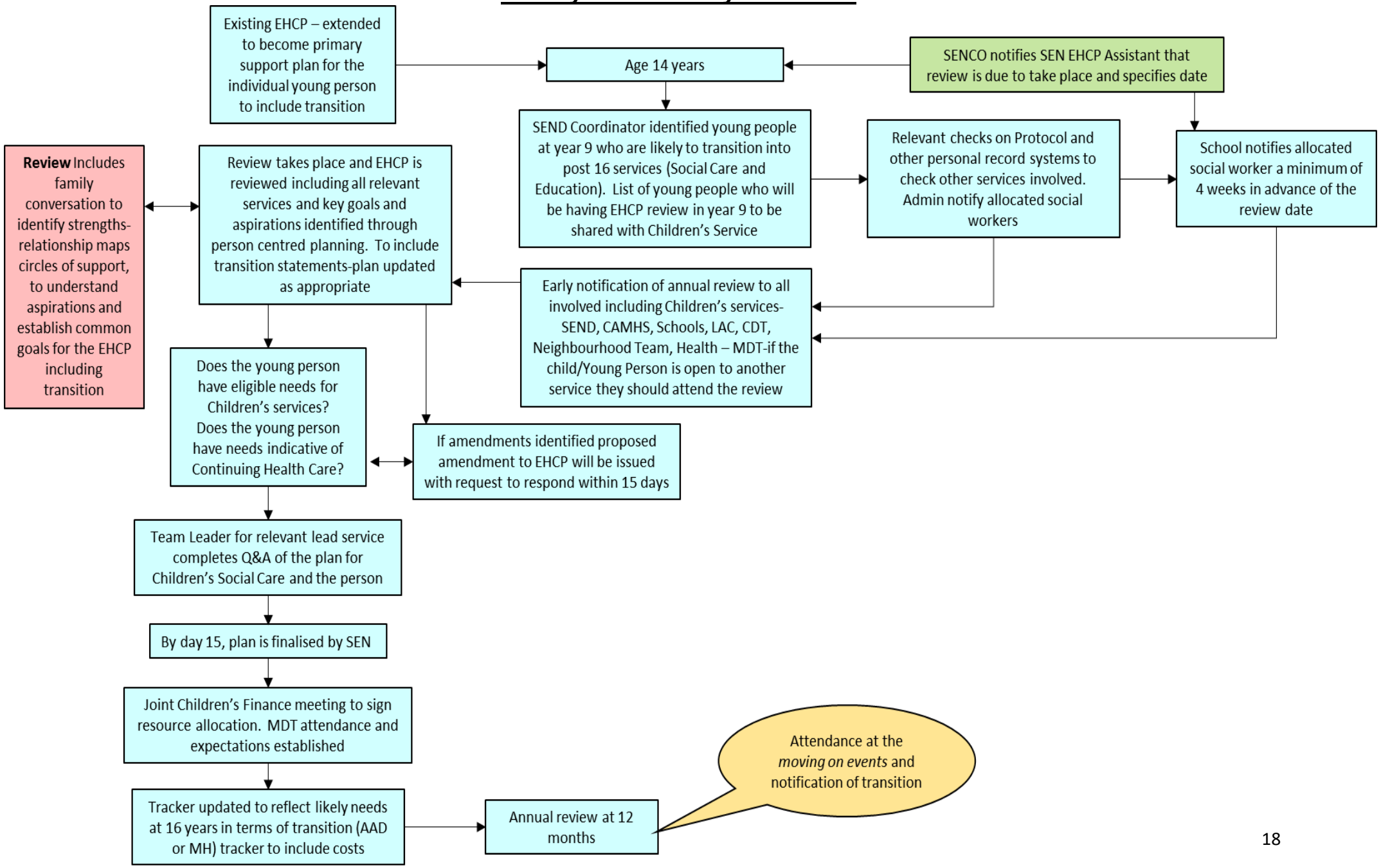
14.9 Other Professionals/Parents/Carer and Young Person

- Any agreed actions must be followed up by those nominated at the meeting within agreed timescales.
- There is likely to be actions for the young person and their parent carer too.

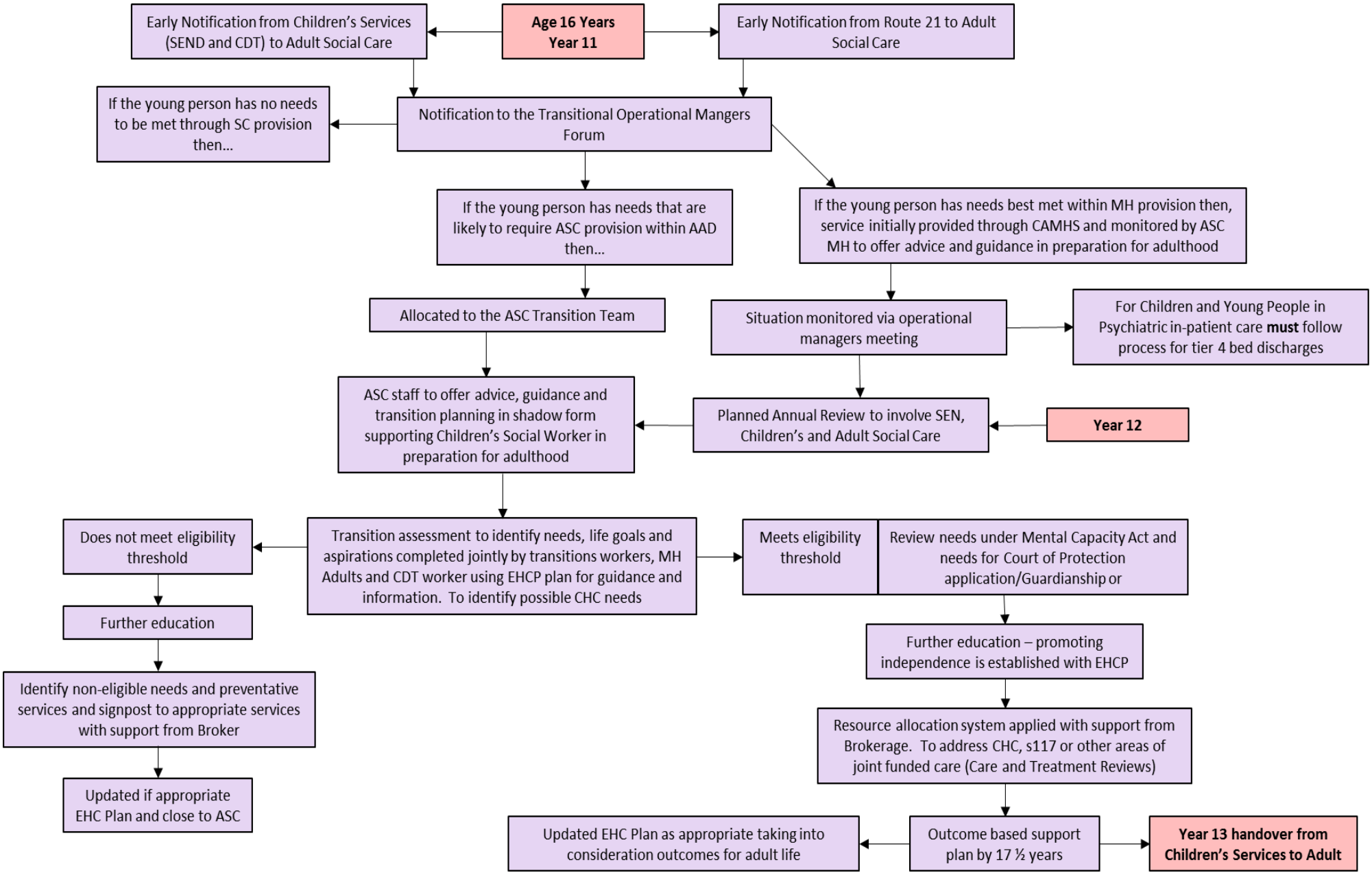
14.10 EHCP (Education, Health and Care Plan) Co-ordinator

Following receipt of the review summary which includes the transition action plan the EHCP Co-ordinator will be responsible for updating the Education, Health and Care plan which will then be distributed to all. This review will form the basis of transition planning in subsequent years until the young person has successfully transitioned out of education and training.

14-18 years Pathway Flowchart



18-25 years Pathway Flowchart



Coventry Moving On Events

15. Transfer from Children's to Adult NHS Continuing Health Care (CHC)

- Clinical Commissioning Groups (CCGs) should use the National Framework for NHS Continuing Healthcare and supporting guidance and tools (especially the Decision Support Tool) to determine what on-going care services people aged 18 years or over should receive.
- CCGs and Local Authorities should have systems in place to ensure that appropriate referrals are made whenever either organisation is supporting a Young Person who, on reaching adulthood, may have a need for services from the other agency.
- The framework sets out best practice for the timing of transition steps as follows:
    - Children's services should identify young people with likely needs for NHS Continuing Health Care and notify the relevant CCGs when such a young person turns 14;
    - There should be a formal referral for adult NHS Continuing Health Care screening at 16;
    - There should be a decision in principle at 17 years so that a package of care can be in place once the person turns 18 years (or later if agreed more appropriate).
- Where a Young Person has been receiving children's continuing health care from a relevant CCG, it is likely that they will continue to be eligible for a package of adult NHS Continuing Health Care when they reach the age of 18. Where their needs have changed such that they are assessed as no longer requiring such a package, they should be advised of their non-eligibility and of their right to request an independent review and mediation. The CCG should continue to participate in the transition process, in order to ensure an appropriate transfer of responsibilities, including consideration of whether they should be commissioning, funding or providing services towards a joint package of care.
- Where there is a change in Continuing Health Care provision, this needs to be recorded in the Young Person's EHC plan, where they have one, and advised of their rights to ask the local authority for mediation (this is in the SEND Code of Practice and applicable up to age 25).

16. Transfers between Mental Health (MH) Services

- Coventry and Warwickshire Partnership Trust (CWPT) is the key provider for health services for Coventry's young people and for adults in the City. CWPT and other health service providers support transition to adult health services for post 16-year olds with health needs by working with special schools' transition arrangements or on a case by case basis. This is to enable the young person's self-care where possible or identify the appropriate adult health providers.
- If a young person known to social care requires care and support relating to their mental health when they turn 18, a referral can be made to Coventry and

Warwickshire Partnership Trust's (CWPT) Mental Health Service via the Central Booking Service by the Social Worker, GP and/or CAMHS. For those children/young people where MH Social Work input is requires the referral should be clearly marked for the attention of Social Care and to be passed to Integrated Practice Unit (IPU) 3-8.

- If a young person requires support from the Integrated Practice Units and is already open to the Crisis Intervention Team, then they can be referred internally.
- If the young person receives support from Children and Adolescents Mental Health Service (CAMHS) and need continued support post-18, CAMHS will begin the transition process to adult mental health services or third sector services before the young person turns 17 years old. If it is felt that the young person's needs can be met outside of specialist services, support will be provided to access appropriate targeted services.
- For more information, see the Rise website (www.cwrise.com).