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Belfast Health and
Social Care Trust

caring supporting improving together

Policy Code: BHSCT/MH/CAMHS (05) 2026

Title:	Transition Protocol between CAMHS and Adult Mental Health Services for the Belfast and South Eastern Trusts			
Policy Author(s)	[REDACTED] Transitions co-ordinator [REDACTED]@belfasttrust.hscni.net [REDACTED] ASM CAMHS Specialist Teams [REDACTED]@belfasttrust.hscni.net [REDACTED]			
Responsible Director:	[REDACTED] Director of Adult Mental Health, Intellectual Disability and Psychological Services [REDACTED] Director of Adult Mental Health, Learning Disability and Psychological Services and Prison Healthcare			
Policy Type: (tick as appropriate)	*Directorate-specific ☒	Clinical Trustwide ☐	Non-clinical Trustwide ☐	Regional Policy ☐
If *Directorate-specific please list the name and date of the local Committee/Group that policy was approved		Does this policy have Workforce implications? No		
Name: SM Step 3 Leadership group Date: 02/10/25 Name: SM Step4/5 Leadership group Date: 14/10/2025		Date: Collective Leadership 23.03.2026		
Approval process:	Policy and External Guidance Assurance Group Executive Team Meeting		Approval date:	17/08/2026 25/08/2026
Operational Date:	September 2026		Review Date:	September 2031
Version No.	V1	Supersedes	Standing Operating Procedure (SOP)	
Key Words:	Transitions Policy CAMHS to AMHS			
Links to other policies	The Working Together: A Pathway for Children and Young People through CAMHS (2018) Regional Inpatient operational policy			

1.0 INTRODUCTION / SUMMARY OF POLICY

1.1 Background

The Belfast and SET Child and Adolescent Mental Health Services (CAMHs) and Adult Mental Health Services (AMHs) aim to provide high quality, safe and effective services to all young people. The purpose of this policy is to provide staff with the principles of good practice regarding the transition of young people from CAMHs to AMHs on or after their 18th birthday.

Several studies have acknowledged that this transition can be a challenging time for young people. They may be managing other changes, including moving on from school to further education or employment, changes in accommodation, developing self-identity and the maturation from childhood to adulthood, all of which can result in uncertainty, anxiety and stress. Young people who experience mental ill health, typically face greater challenges in the transition to adulthood than their peers who do not. This leads to poorer transition related outcomes such as (but not exclusive to) unemployment, involvement with the criminal justice system, homelessness and early or unplanned pregnancies.

1.2 Purpose

1.2.1 It has been evidenced that poorly planned transitions increases the risk of non-engagement with follow up services. Although the number of transitions cases being presented to the panel are relatively small, they are often complex in presentation and require multi-disciplinary working in order to ensure a timely and effective transition.

Transitions that demonstrate efficiency, service user/family involvement and effective MDT (Multidisciplinary Team) working can lead to improved service user outcomes.

1.2.2 Arrangements for young people transferring from the Acute Regional Adolescent Inpatient Unit are also outlined in the operational policy for Step 4 and 5, notably the *Operational Policy for Beechcroft Inpatient Unit*.

The policy outlines the transfer protocol to acute services in Adult Mental Health and the Community Mental Health Outpatient teams for all Trusts.

1.3 Objectives:

- Timely and safe transfer from CAMHs to AMHs when required.
- To better serve the needs of young service users by promoting collaborative and flexible working practices, between CAMHs and AMHs.
- To clarify and define roles and responsibilities within the transition process.
- To provide clarity not only to CAMHs and AMHs, but also to GP's, Social Services and other practitioners.
- To ensure that the range and extent of services within Adult Mental Health are clearly understood by both the young person and CAMHs services.
- To ensure that the young person is aware of the roles and responsibilities of AMHs and their ethos.

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- To identify gaps and areas for improvement in service provision and planning.

2.0 SCOPE OF THE POLICY

2.1 This protocol is aimed at all professionals working in CAMHs and AMHs. A range of specialist services are also included. These are; Psychology, Addictions, Forensics, Eating Disorders, Personality Disorders and Autistic Spectrum Disorders Services. The principles of Best Practice outlined in this Protocol equally apply to all of these services. Furthermore, it is applicable to service users 17 years and 6 months (17.6), who are receiving services from CAMHs and require ongoing support within AMHs. All CAMHs practitioners should be considering suitability for a referral to AMHs for each young person at 17 years and 5 months (17.5), with view to submitting a referral at 17.6.

3.0 ROLES AND RESPONSIBILITIES

3.1 Medical Directors/Co-Directors

Responsible for providing clinical leadership.

Responsible for solving issues where there are differing opinions that cannot be solved at local level with Clinical Directors of CAMHS/AMHS.

Clinical Director

Potential to provide second opinion for patients with complex needs where there are professional differences of opinion.

Divisional Nurse/Social Worker

Responsible for clinical assurance.

Responsible for supporting implementation of the policy through clinical audit.

Service Manager

Responsible for implementation of policy within local area.

Point of escalation in cases where there are differing opinions.

Monitor that all staff have access to relevant mandatory training.

Assistant Service Managers

Responsible for implementation of policy within local area.

Team Leads CAMHS

Responsible for case load supervision and supporting clinicians to identify young people for transition.

Ensure all staff aware of protocol and how to implement.

Team Lead AMHS

Responsible for allocating cases to keyworkers.

Responsible for supporting clinicians to manage transition cases.

Practitioners

Responsible for presentation at transition panel.

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Preparing young person for transitions process.

Transition Co-Ordinator

Responsible for co-ordinating transition process.

Acting as an intermediary between CAMHs and AMHs.

Adult Psychiatry

Responsible for attending panel to discuss cases as required.

CAMHs Psychiatry

Responsible for presentation/attendance at transitions panel as required.

4.0 KEY POLICY PRINCIPLES

Definitions

The Working Together: A Pathway for Children and Young People through CAMHs (2018) is an integrated care pathway, which details to young people and their families/carers what is expected at any point along their journey of care in CAMHs. The document specifically outlines four key areas that are integral to transition planning from CAMHs to AMHs services in Northern Ireland.

The four key areas are:

Preparing Early – CAMHs Practitioners need to consider transition to AMHs in conjunction with the young person and their family at 17.5, to present to adult services at 17.6.

Future Needs - Timely preparation in advance of a young person turning 18, supports information sharing to identify any future needs. CAMHs and AMHs colleagues will discuss what therapeutic work has been completed in CAMHs and what support may need to be considered in the future. Having these discussions will help identify appropriate pathway/services for young people regarding their specific needs.

Transition Plan – The transition plan is documented on Encompass under the Child to Adult Transition area. This is identified following transition panel. CAMHs and AMHs colleagues will work alongside the young person and their family to ensure agreement about the best arrangements for the young person's transition to AMHs. Any changes to the plan can be updated as required in line with the young person's presentation. Timescales for transition must be considered and detailed in the transition plan following discussion with the accepting clinician. The referral form for transition to AMHs refers to the young person's views on transition to AMHs and any specific requirements to be considered during transfer (for example but not exclusive to – request for male/female keyworker, request for appointments later in the day, request for appointments not to be offered on a specific day). The transition plan should be reflective of any specific wishes, requests or goals identified by the young person and/or their family

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Transfer Arrangement – The transition plan will include transfer arrangements from CAMHs to AMHs – details re allocation of keyworker, date of first appointment and any joint working or shared care arrangements in support of transition into AMHs must be included within the transition plan.

Transitions Panel - The transition panel is organised by the transitions co-ordinator. The role of the transition co-ordinator is to establish and maintain effective working relationships with colleagues in both CAMHs and AMHs that will support safe and effective transitions for young people.

There is one transition panel per month or as required for each area – Belfast, North Down and Ards, Lisburn and Downpatrick. The days/times of the panel have been identified in conjunction with CAMHs/AMHs colleagues. They are setting based on the majority of those who confirmed suitability.

The transition panel is routinely made up by Consultant Psychiatry, CMHT Team Lead, Psychology and Assessment Centre Team Lead, with speciality teams invited as and when required. Clinicians may attend on a rota basis within their role. Clinicians attending the transition panel must be competent and confident with their decision making, in order to make decisions for their equivalent colleagues.

Where there is a complex mental health presentation or the young person takes multiple medications that cannot be reviewed solely by the GP, the transitions co-ordinator will contact psychiatry colleagues for further discussion outside of panel.

CAMHs practitioners attend as and when required to discuss their referred young person. There may be occasions where those who routinely attend panel are unable to attend – if that is the case then appropriate cover should be arranged by the Clinician who is unable to attend.

Decisions made at transition panel must stand, as otherwise this can be anxiety provoking for young people and their families/carers.

4.1 PROCESS FOR TRANSITION TO ADULT MH SERVICES FROM CAMHS

The CAMHs Practitioner will identify the young person who requires transfer to adult mental health services 6 months in advance of their 18th birthday.

There may be occasions where a young person has come into CAMHS at 17.6 or in the lead up to their 18th birthday, where identification of needs may not yet be known or consideration of whether a short-term piece of work in CAMHS may prevent a transfer to adult services. In this scenario, the CAMHs practitioner should liaise with the Transition Co-ordinator and identify at the earliest opportunity if the young person may require transfer to Adult Mental Health (AMH) services.

In circumstances where the young person may turn 18 years old whilst concluding treatment within CAMHs, this can be considered and deemed suitable if it best meets the needs of the young person.

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The CAMHs Practitioner will discuss referral with the young person and family in order to gain consent to refer to AMHs services.

The CAMHs Practitioner will refer the young person through Encompass to the Transition Co-ordinator. The young person must also have an up-to-date FACE or equivalent safety risk assessment completed on Encompass.

The Transition Co-ordinator will pick up the referral and prepare to co-ordinate the transition panel.

AMHs colleagues will be notified on who will be presented at the transition panel two weeks in advance. With the rollout of Encompass, AMHs practitioners will have access to information (referral/FACE risk assessment/supplementary information) required regarding the young person in preparation for the meeting.

The young person will be discussed at transition panel, where the transition plan will be identified.

The transition co-coordinator will document the minutes, upload to Encompass and action any referrals or follow ups as required. There may be outcomes for other Clinicians that will need followed up within their own area.

At times, it may not be possible to agree a transition plan. As a result, a young person may need to be discussed at panel on more than one occasion.

The Transition Co-ordinator will act as a point of contact and set up any additional meetings as required between CAMHs/AMHs to ensure continuity for contact.

Prior to the first appointment with AMHs services, a transition handover meeting must be arranged to have a discussion that provides an update about the young person, their current mental state, risk management etc. At the handover meeting the first appointment should be agreed. This should be in line with regionally agreed transfer protocols and be within 9 weeks of transition panel. Where a young person is transitioning to multiple services within AMHs, a meeting will be co-ordinated, and all services involved will be invited to participate in the handover meeting.

AMHs colleagues will send a letter to the young person to let them know of appointment. CAMHs Clinician will also advise of meeting and appointment agreed. CAMHs will keep the young person open until they have engaged with this appointment.

If a young person has particularly complex needs, a joint appointment between the two services, with the young person would be beneficial where feasible.

When considering frequency of contact for the young person during transition – AMHs should agree frequency of contact when co-working during the transition period. The total contact for both teams should equate to no less than contact frequency before transition.

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The CAMHS Clinician will plan for CAMHS ending appointment(s) in the lead up to the first appointment with AMHS services.

Once the AMHS Clinician has confirmed engagement with the service then CAMHS will proceed with discharge from CAMHS.

The NHS **Triangle of Care** ensures collaboration between the young person, their carers, and professionals, beginning no later than age 17. Joint transition meetings will be convened involving CAMHS, AMHS, the young person, and identified carers (with consent), with a documented transition plan detailing risk history, medication, crisis pathways, and ongoing therapeutic needs. Carers will be recognised as partners in care, offered appropriate support and information regarding changes in confidentiality and service thresholds, ensuring continuity, risk mitigation, and sustained engagement with adult mental health services.

CAMHS and AMHS recognise both the important role of Carers and the support they may also need to promote the optimum mental health of both patient and carer.

In line with our Carers legislation, Carers and significant others will be offered all the relevant information to enable them to support their young person during the transition experience. These will include Carer advocacy and support services and Carer Information Packs.

This might include even those groups who: -

- **are not accepted (see 4.3 below)**
- **those who decide not to transition (see 4.4 below)**
- **those not consenting (see 4.5 below)**

The service will write to the young person providing them with contact details of how to access services including Community and Voluntary (C&V).

4.2 YOUNG PEOPLE DISCHARGED TO THE CARE OF THE GP

Not all young people open to CAMHS will require transfer to AMHS. For those young people who have completed a final piece of work in CAMHS and do not require transfer to AMHS, the CAMHS practitioner should discharge back to the care of the GP as soon as feasibly possible but must ensure clear signposting is provided regarding how the young person may access services again as required.

4.3 YOUNG PEOPLE NOT ACCEPTED AT TRANSITION PANEL

Young people not accepted at transition panel should be supported to access suitable community and voluntary supports and ensure that clear signposting is provided regarding how the young person may access services again as required. If changes in presentation occur, the young person can be re-presented to panel.

4.4 YOUNG PEOPLE WHO DECIDE NOT TO TRANSITION TO ADULT MH SERVICES

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Some young people may decide that they no longer wish to transition to AMHs – alternative sources of support within the community or voluntary sector may be suggested to allow the young person to make the best choice about the care and help they wish to receive when they leave CAMHs at 18.

4.5 YOUNG PEOPLE WHO ARE NOT CONSENTING FOR TRANSFER TO AMHS

Young people who do not consent for transfer to AMHs must be carefully reviewed and considered by CAMHs colleagues.

4.6 YOUNG PEOPLE WHO DNA DURING TRANSITION PLANNING

Where a young person who is or has been referred by CAMHs to AMHs does not engage with the transition process, the CAMHs Clinician should ensure that the CAMHs disengagement policy is followed.

If the young person continues to 'Does Not Attend' (DNA) and does not engage in the transition process, a summary of the attempts made to engage and involve the young person in the process should be documented, including potential risks and the likelihood of future presentation to AMHs. The GP should also be advised of this via discharge letter and the option to re-refer at later stage, if the young person would benefit from any future interventions with AMHs.

The CAMHs Clinician should also write to the young person informing them of their discharge from the service, providing them with the contact details of how to access service, including community and voluntary services in the future if they should wish.

4.7 YOUNG PEOPLE WHO ARE OVER 18 AND REMAIN OPEN TO CAMHS PENDING TRANSITION TO ADULT MH SERVICES

Where there is a delay in the transfer to AMHs or the young person has been presented close to their 18th birthday – it is possible for a young person to remain open to CAMHs pending transfer to AMHs.

CAMHs practitioners must have identified interim risk management planning if an 18-year-old remains open to CAMHs, this should detail how the young person and their family/carer should access AMHs in the event of crisis. If the young person presents in crisis post-18, then AMHs must respond in line with their own escalation protocols to assess, as CAIT do not respond to those who are 18, even if open to CAMHs.

4.8 YOUNG PEOPLE WHO ARE LOOKED AFTER CHILDREN (LAC)

CAMHs practitioners and Children's Community Services need to work in conjunction when transition planning for young people who are LAC. The young person who is LAC should be aware of their post 18 accommodation plans, in advance of turning 18. The Trust of origin is responsible for identifying a suitable placement when the young person turns 18 years old.

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AMHs are aligned either by GP practice or post code. For transition planning to commence, the accommodation and GP practice details must be confirmed at the point of considering transfer to AMHs. This is to identify which mental health team the young person requires presentation to. It has already been highlighted the impact and uncertainty around transitions for young people to AMHs, which can be more so for those young people who are LAC.

4.9 INPATIENTS

Transition from Beechcroft Child and Adolescent inpatient unit (*Regional Adolescent inpatient unit*) CAMHs setting will be either:

The young person will be discharged from Beechcroft to the care of their AMHs Team shortly after their 18th birthday.

The young person will require on-going inpatient treatment beyond their 18th birthday and will require transfer to adult inpatient service.

Young people who are inpatients within Beechcroft Inpatient Unit prior to their 18th birthday and who require transfer to inpatient adult mental services, should be discussed in conjunction with transition coordinator and the Beechcroft Patient Flow coordinator.

All young people should be referred by the CAMHs community clinician for all transitions through Encompass.

If a young person has been admitted to Beechcroft and was not previously known to a community team, then it is the responsibility of Beechcroft staff to initiate the referral.

However, in some cases, it may be more appropriate to refer from Beechcroft and this should be agreed between the inpatient service and the CAMHs community team as clinically appropriate.

Such circumstances may include:

- If the young person has been an inpatient for a significant period, such that the in-patient team have more knowledge than the community team.
- If the young person was not known or only very briefly known to the community team prior to admission e.g. admitted following an emergency assessment.

Once the referral is received, the Transition Co-ordinator will contact bed flow to arrange a meeting with AMH inpatient colleagues and also the AMH community team or specialist services as required.

This will allow for transition planning for two alternatives:

1. If the young person is deemed fit for discharge to the community.
2. If an inpatient pathway is required.

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The meeting will be arranged to discuss suitable options for transfer to AMHs that best meets the needs of the young person.

Where possible, the Consultant Psychiatrist from AMHs will come to meet and assess the young person in Beechcroft and will then share feedback with the team at the transition planning meeting.

The young person and their family/carer will remain updated throughout.

The Beechcroft patient flow coordinator/ward staff will make daily contact with the allocated adult inpatient ward to assess the bed situation and whether a bed is available for the young person to transfer to.

Transfer planning to an AMH inpatient ward will be considered on an individual basis. If an Extra Contractual Referral (ECR) is being considered for a young person who turns 18 years old while they remain an inpatient in Beechcroft to AMHs out of area inpatients, responsibility for referral for ECR lies with the local AMHs. The staff team in Beechcroft can assist in completion of ECR paperwork, given their knowledge of the case and can agree to be part of any arranged transfer meetings as appropriate.

In exceptional circumstances, CAMHs may deem it appropriate to request the transfer of care prior to a service user's 18th birthday, due to their needs being better met by AMHs. These cases should be discussed on a case-by-case basis by the CAMHS and AMHs clinical teams and the reasons for this decision are clearly documented within the young person's Encompass records.

Delayed Transfer

There may be times where a young person turns 18, whilst awaiting transfer to an AMH inpatient ward.

In the event of an undue delay in the transfer to an adult inpatient ward, Service Manager for acute CAMHS will alert Senior Management within Belfast Trust.

A Datix (adverse incident) will be completed.

The SPPG and RQIA will be notified via Early Alert process.

Regional CAMHS Service Managers will be updated via regional weekly update communications.

The Beechcroft Bed Manager will keep daily communication with the receiving Trust to seek a transfer.

Appropriate safeguarding procedures must be in place to ensure the safety of other young people in Beechcroft. Consideration should be given to supervision levels of an adult patient in a children's ward.

4.10 INTELLECTUAL DISABILITIES

Where the young person has a suspected or confirmed mild intellectual disability and where their prevalent need is mental health, they should be presented to transitions panel to discuss with AMH colleagues.

4.11 SPECIALITY SERVICES

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During the transitions process various specialist services may be considered. These include, Adult Eating Disorder Team, the Trauma Resource Centre, the Self-Harm Personality Disorder Team, Psychology Service, Psychotherapy Service, Brackenburn Gender Service, Intellectual Disability Service, Community Mental Health Team, Early Intervention Team and Community Addiction Team. These will be considered on an individual case by case basis.

4.12 ADHD SERVICES

At present, any young person remaining on ADHD medication requires ongoing monitoring as noted in NICE guidance. They should be referred through transition panel for the coordinator to liaise with ADHD services.

4.13 CONSENT AND INFORMATION SHARING

As part of the agreed transition, referral consent is explicitly sought from the young person. Consent to the transitions process is consent for information sharing with appropriate AMHs.

5.0 IMPLEMENTATION OF POLICY

5.1 Dissemination

5.1.1 The procedures will be disseminated throughout both CAMHs and appropriate clinicians in AMHs. This will be facilitated through team meetings, shared drive folder, induction and email communications.

5.1.2 Authors of Policy to be notified of any barriers and if timescales are not being met.

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martha.campbell@belfasttrust.hscni.net

5.2 Resources

5.2.1 No additional resources required.

5.3 Exceptions

5.3.1 None

6.0 MONITORING

This is a live document which will continue to be reviewed by Belfast Health Social Care Trust. This will be reviewed in 5 years from the date of submission or earlier if there are any service changes.

7.0 EVIDENCE BASE/REFERENCES

NICE (QS140)

[Overview | Transition from children's to adults' services | Quality standards | NICE](#)

Working Together – A Pathway for children and young people in CAMHS
[CAMHS-Pathway.pdf \(familysupportni.gov.uk\)](#)

8.0 CONSULTATION PROCESS

This Policy has been developed following consultation with:

Step 3-5 CAMHS- BHSCT/SET

Adult CMHT and Psychiatry- BHSCT/SET

9.0 NURSING AND MIDWIFERY STUDENTS

Nursing and/or Midwifery students on pre-registration education programmes, approved under relevant 2018/2019 NMC education standards, must be given the opportunity to have experience of and become proficient in Transition Protocol between CAMHS and Adult Mental Health Services for the Belfast and South Eastern Trusts, where required by the student's programme. This experience must be under the appropriate supervision of a registered nurse, registered midwife or registered health and social care professional, who is adequately experienced in this skill and who will be accountable for determining the required level of direct or indirect supervision and responsible for signing/countersigning documentation.

Direct and indirect supervision

- Direct supervision means that the supervising registered nurse, registered midwife or registered health and social care professional is actually present and works alongside the student when they are undertaking a delegated role or activity.
- Indirect supervision occurs when the registered nurse, registered midwife or registered health and social care professional does not directly observe the student undertaking a delegated role or activity. (NIPEC, 2020)

This policy has been developed in accordance with the above statement.

10.0 APPENDICES

Appendix 1: Protocol for preparing to transition young person at 17 and 6 months

Appendix 2: Protocol post panel for AMH services

Appendix 3: Protocol if young person not engaging

Appendix 4: How to refer to Transitions Panel on Encompass

11.0 EQUALITY SCREENING

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Under Section 75 of the Northern Ireland Act 1998 the Trust has a legal responsibility to undertake an equality screening of all policies. To fulfil this duty an equality screening template must be completed by the policy author.

To complete an equality screening use this template: (LINK)

For support with completion of the template go to: **Equality Screening Toolkit**

For any queries and/or to obtain approval contact the Planning and Equality Team contact: equalityscreenings@belfasttrust.hscni.net or 028 95 048734

Equality Screenings are public documents and previously completed documents can be viewed at [Equality and Human Rights Screening | Belfast Health and Social Care Trust \(hscni.net\)](https://www.belfasttrust.hscni.net/equality-and-human-rights-screening)

12.0 DATA PROTECTION IMPACT ASSESSMENT

New activities involving collecting and using personal data can result in privacy risks. In line with requirements of the General Data Protection Regulation and the Data Protection Act 2018 the Trust considers the impact on the privacy of individuals and ways to mitigate against any risks. A screening exercise must be carried out by the Policy Author to ascertain if the policy must be subject to a full assessment. Guidance is available on the Trust Intranet or via this [link](#).

If a full impact assessment is required, the Policy Author must carry out the process. They can contact colleagues in the Information Governance Department for advice on Tel: 028 950 46576

The outcome of the Data Protection Impact Assessment screening for the policy is:

Not necessary – no personal data involved	☒
A full data protection impact assessment is required	☐
A full data protection impact assessment is not required	☐

13.0 STATUTORY RURAL IMPACT ASSESSMENT DUTIES

The Trust has a legal responsibility to have 'due regard' to rural needs when developing, adopting, implementing or revising policies, and when designing and delivering public services. For more information go to [Rural Needs Duties](#)

To satisfy this 'due regard duty' Trust staff must consider the impact of any policy, proposal or decision on the social and economic needs of people who live in a rural community. For Belfast Trust, this is particularly so when the policy/proposal/decision impacts regional services.

Please tick the box to indicate that you have paid 'due regard' to the social and economic needs of the rural community when developing, adopting, implementing or

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revising policies, strategies and plans and when designing and delivering public services and that a rural impact assessment is not required. ☐

OR

Please complete a Rural Needs Impact Assessment Template if there is an impact on the social and economic needs of people who live in a rural community.

Please go to the: Rural Impact Assessments Toolkit for HSC NI to find out how to undertake a rural impact assessment.

Contact Estella.Dorrian@belfasttrust.hscni.net for further advice

14.0 STATUTORY EQUALITY DUTIES – MAKING REASONABLE ADJUSTMENTS AND INFORMATION ACCESSIBLE

Under the Disability Discrimination Act 1995 (as amended) the Trust has a statutory duty to **make reasonable adjustments** in respect of disabled patients/service users/carers/visitors. This includes making all communication (in person, by phone, via email) *and* any information provided (in writing, verbally) accessible using alternative formats. The aim of the reasonable adjustment duty is to reduce or remove any barrier a person with a disability faces when accessing or using goods, facilities and services. This is a non-delegable duty.

Accessible/ Alternative formats can include, for example, information translated into Easy Read format or into Audio format - when a patient/service user/carer/visitor has a learning disability or is visually impaired.

In addition, if a patient/service user/carer/visitor does not speak English as their first language or has poor English, the Trust has a statutory duty **to provide an interpreter** and to **translate written information**. This facilitates informed consent, better understanding and greater independence.

For information, advice and guidance about these duties contact the Trust Planning and Equality Team equality.team@belfasttrust.hscni.net

Please tick the box to indicate that you have developed the policy in accordance with the Trust's legal equality duties and that all staff will make reasonable adjustments and information accessible as appropriate. ☒

SIGNATORIES

(Policy – Guidance should be signed off by the author of the policy and the identified responsible Director).

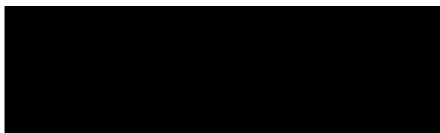


28/01/26

Date: _____

Policy Author

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Date: _14.07.2026_

**Appendix 1: Protocol for preparing to transition young person at 17 and 6
months**

CAMHS keyworker
discusses transition of YP at
partnership/supervision

CAMHS keyworker discusses
this with YP and family (*ideally
provides transition pack with
information for the YP and family*)

CAMHS staff complete referral (*with
consent*) with YP/family and other
professionals involved – collaborative
information sharing

CAMHS clinician presents referral to panel
for open discussion about referral, needs
and what service may be best for the YP
and what would meet their needs

Referral accepted at panel

CAMHS clinician awaits contact from AMHS
keyworker as referrer to share information and agree
timeframe

CAMHS clinician works in partnership
with YP and family about first appt and
support during this time – can agree
needs of YP and what will work best

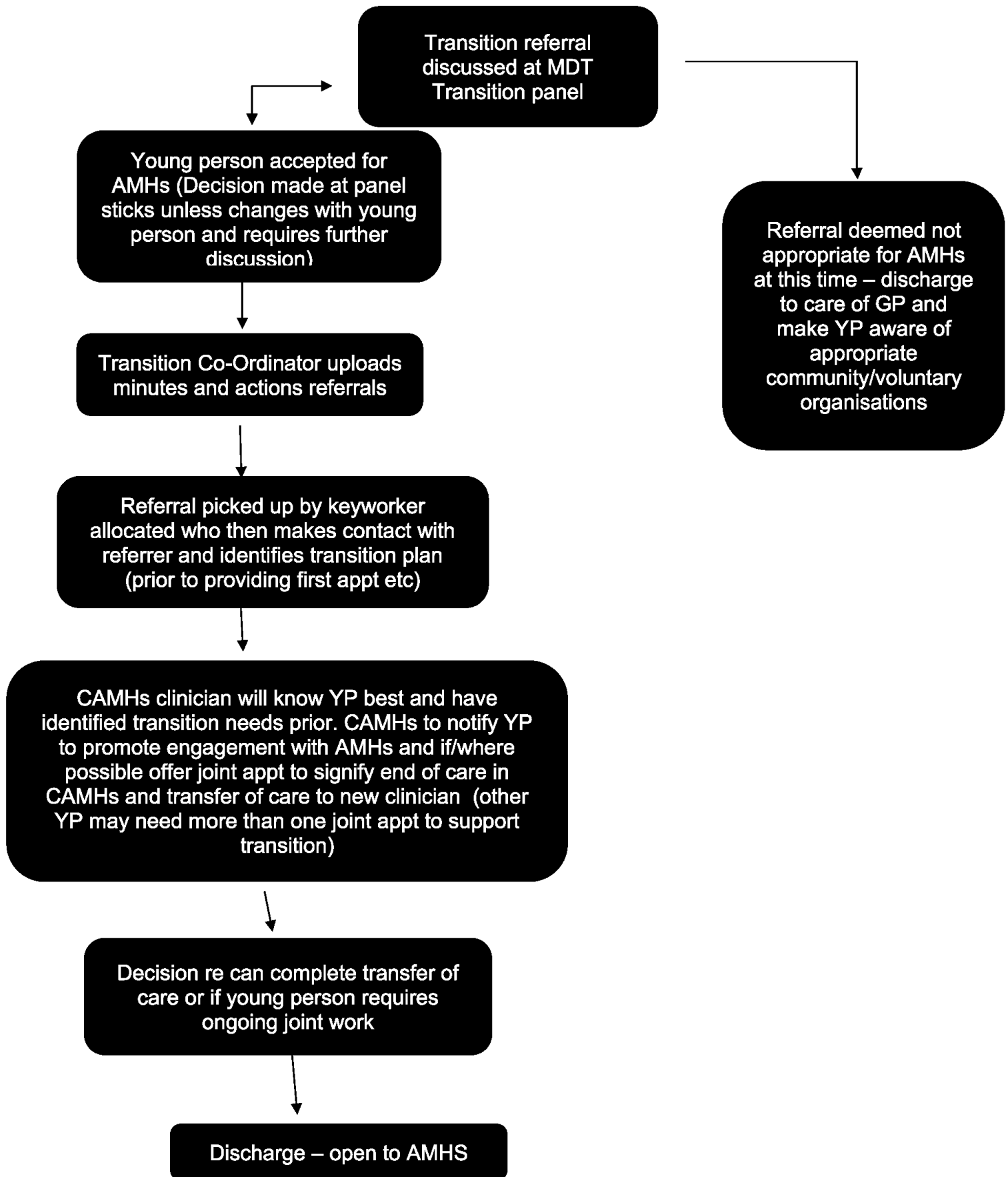
Joint working process between
CAMHS and AMHS with YP and

When deemed appropriate
discharge CAMHS and then
Open to AMHS

Transition not deemed
required as no
transition need or
support of ongoing
AMH need? Discharge
to GP and signpost to
appropriate comm/vol
organisations

Referral not accepted at panel –
discharge to care of GP and
signpost to appropriate comm/vol
organisations

Appendix 2: Protocol post panel for AMH services



Appendix 3: Protocol if young person not engaging



Appendix Four: How to refer to Transitions Panel on Encompass

