Guam Behavioral Health and Wellness Center		
TITLE: Transitioning from Children To Adult Services	REFERENCE #: CL-11	PAGE: 1
DIVISION: Inpatient/Outpatient- Clinical Services		
APPROVED BY: Rey M. Vega 2/10/2014 REY M. VEGA, DIRECTOR	EFFECTIVE: 02/07/2014	
	REVISED:	

PURPOSE:

A. To outline the responsibilities of the Child and Adolescent Services Division (CASD) and Adult Mental Health Services Division (AMHS) as well as the transition process.

POLICY:

A. This policy and procedure assumes the following:
   a. Youth will be capable of living independently given the provision of sufficient treatment and support.

   b. Not all youth of transition age will require residential services.

   c. Youth with mental health diagnoses are by definition vulnerable and attention will be given to the protection of these young people.

   d. As a general principle, transfer of care will not be undertaken when the youth is in acute psychiatric distress.

   e. Transition is a process, not a single event. The transition of duties will be thoughtful and gradual.

   f. Not all youth who reach adulthood will accept adult services.

   g. The strengths of the youth and family shall be emphasized throughout the process of transition and treatment planning.

DEFINITIONS:

1. **Interdisciplinary Treatment Teams (ITT):** A group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the consumer. At GBHWC, AMHS teams consist of some or all of the following disciplines: Psychiatrist, Psychologist, Nurse, Social Worker, WRAP Coordinator, Counselor, Psychiatric Technician, Behavioral Specialist, Community Program Aide, and other providers.

2. **Placement Review Team (PRT):** Designated representatives from AMHS who monitor the referrals and status of consumers on the Residential Recovery Program (RRP) also known as the Residential Waitlist.

3. **Residential Team:** A group of health care professionals responsible for delivering residential care.

4. **WRAP Coordinator:** The young person's assigned care coordinator while receiving services at CASD.

5. **Team Facilitator Meeting:** Regular meetings of interdisciplinary treatment team members to discuss consumers' status and/or concerns, progress, case assignments, treatment planning, interventions, and other issues that impact consumers' care.

6. **Transitioning Youth:** Youth who are receiving or seeking services and who have been determined to meet the maturational stages of development whereby their needs may be met by AMHS.

7. **Team Facilitator:** The individual responsible for facilitating each AMHS interdisciplinary team and the team's primary contact.

8. **Section 504:** Is part of a federal civil rights law known as the Rehabilitation Act of 1973. This law specifically prohibits discrimination against students with disabilities and guarantees them a free and appropriate public education (FAPE). Discrimination, as defined in Section 504, is the failure to provide students with disabilities the same opportunity to benefit from education programs, services, or activities as provided to their nondisabled peers.

RESPONSIBILITIES:

CASD Responsibilities:

A. The WRAP Coordinator will maintain a current list of all youth who are anticipated to require transition to AMHS.
    a. This list will be shared and updated at least once a month with their assigned Team Facilitator.

B. The WRAP Coordinator will present the cases and histories to team members at least a year prior to an anticipated transition.

C. It is the responsibility of CASD along with the WRAP Coordinator to determine and communicate the youth's preference for services.
    a. This preference will be communicated to the assigned AHMS Interdisciplinary Treatment Team (ITT).

    b. If the youth turns 18, and does not want AMHS, the WRAP Coordinator will be responsible for closing the consumer's chart by documenting the consumer's declination of services in a progress note and completing the chart closure form.

D. The WRAP Coordinator will be responsible for obtaining all resources and/or supports for which the youth is eligible. In addition, the WRAP Coordinator

shall schedule and/or provide any evaluations necessary for treatment and behavioral planning.

E. The WRAP Coordinator shall ensure all documentation requested by AMHS is available for review in a timely fashion. Documents may include the following background history with accompanying discharge summaries from recent and previous providers which are also essential to continuity of care and where applicable, include:
   a. family background;
   b. family composition;
   c. living arrangement;
   d. family dynamics;
   e. social support;
   f. significant relationship;
   g. sexual orientation;
   h. sexual history;
   i. history of Special Education services;
   j. developmental history;
   k. behavioral history;
   l. medical history;
   m. history of academic performance;
   n. history of substance abuse;
   o. disciplinary history;
   p. legal history;
   q. history of school attendance and truancy;
   r. history of behavioral and/or mental health history and treatment; and
   s. other assessments/ evaluations.

F. The WRAP Coordinator shall ensure that the family/legal guardian is involved in the youth's treatment and is aware of all transition planning and encourage them to participate, when appropriate.

G. When a young person is placed in specialized service(s) (i.e., off island treatment, eating disorder clinic, etc.), it is the WRAP Coordinator's responsibility to initiate the transition process and involve the specialized service(s) in treatment planning and meetings.

H. While the youth is receiving services at CASD, the WRAP Coordinator will inform any agencies involved in the youth's care of the consumer's transition and anticipated date of transfer into AMHS.

I. The WRAP Coordinator will be responsible for documenting the transition plan; including initial goals, objectives, dates, and responsible parties as well as the Individual Transition Profile (ITP) and the WRAP Plan for the case presentation.

AMHS Responsibilities:

A. AMHS will inform the WRAP Coordinators of team meeting times and locations.

B. The AMHS ITT will work cooperatively with the WRAP Coordinator and the consumer to develop a transition plan to determine the services and level of care needed for the consumer to reach maximum success.

C. After the case has been presented to the ITTs, AMHS will engage the youth and develop rapport with WRAP Coordinators to begin the transition process.

PROCEDURE:

A. WRAP Coordinators will be assigned to an ITT through the Team Facilitator's Meeting.

B. WRAP Coordinators will attend meetings with their assigned AMHS ITT at least monthly on dates agreed upon by the team and the WRAP Coordinator.

C. Dialogue between the WRAP Coordinators and their assigned ITT regarding the anticipated transition of a youth shall begin when the youth reaches the age of sixteen (16), but no later than the age of seventeen (17).
   a. If the youth is known to CASD, the transition shall begin as outlined in this policy and procedure.

D. Chronological age for transition from CASD to AMHS is less relevant than the young person's level of developmental functioning (i.e.., physical, emotional, academic, and social), current treatment needs, and risk to self or others.
   a. The youth will be no younger than sixteen (16) years of age.

   b. Exceptions to transition of youth at the age of eighteen (18) may include:
      i. The youth is in the middle of treatment and the AMHS ITT determines transition would be detrimental to the youth.

      ii. The youth's needs may continue to be best met by CASD due to their level of maturity based on a clinical evaluation.

E. The youth's needs will be assessed and determined through collaboration between the CASD and AMHS.
   a. In order for the transition to be successful, it is essential that the WRAP Coordinator and their assigned ITT work together to ensure that appropriate services, including those in the community, are available to the transitioning youth.

F. If the WRAP Coordinator has enough evidence that the youth may require residential care upon entry to AMHS, the WRAP Coordinator will present the case, in conjunction with the AMHS ITT, to the residential team.

a. If residential placement is deemed appropriate, coordination will continue with the AMHS ITT and residential team or appropriate other treatment facility and a meeting will be scheduled with the WRAP Coordinator, the assigned AMHS ITT, the residential team, the youth, and his/her guardian(s).

b. A referral to the Placement Review Team (PRT) will be submitted, as well as an ITP as required by the PRT protocol.

c. A determination regarding appropriate placement will then be forthcoming.

d. Upon determination of the GBHWC treatment facility as an appropriate placement for the youth to meet their needs, the WRAP Coordinator shall be responsible for completing the application packet.

e. If the youth is to be placed in a GBHWC treatment facility, the CASD therapeutic or other community providers may provide conjoint therapy until such time it is determined that youth has fully transitioned.

D. The transition plan shall be completed no less than six (6) months prior to the youth's transition and may be modified as needed through ongoing collaboration between the WRAP Coordinator, assigned ITT, the youth, family/guardians, or any other individual or organization involved in the youth's transition.

Youth with Court Involvement:

A. All youth whose status includes legal concerns (i.e., Child Protective Services, Department of Youth Affairs, Juvenile, Probation, etc.) will be monitored closely to ensure services provided by CASD and AMHS are appropriate and provided on a timely basis.
   a. In addition, it is essential that all court requests, mandates and/or orders are shared to ensure compliance with the Court.

B. Should treatment be court-ordered and the consumer and /or guardian decline services, not-attend scheduled appointments, or not-comply with treatment recommendations, the Court and probation officer (if available) shall be notified immediately.

Youth Medical Records:

A. Medical records for the youth receiving services at CASD shall be handled in a way that both AMHS and CASD have full access to all the information necessary to make good clinical decisions as well as to provide appropriate services on a timely basis.
   a. All original records, including subsequent progress notes, shall be filed and stored at GBHWC's main facility in the medical records office.

b. Safeguards to ensure accessibility and security are essential throughout the transition period.

c. Medical records kept at both medical records and CASD have to be complete.

d. A copy of all progress notes written by AHMS will be provided to CASD on a timely basis for their records.

Youth with History of Admission to the Inpatient Unit:

A. Transitioned age youth with a recent history (last 6 months) of admission to the inpatient unit will require increased collaboration to ensure all necessary services are provided by both CASD and AMHS personnel.

Youth Attending High School:

A. Continued support from the WRAP Coordinators is necessary for youth who turn eighteen (18), whose academic development is delayed or who are currently enrolled in school and are determined to meet the criteria for particular adult services.

B. The continued CASD services include monitoring attendance, behaviors in the school setting, academic performance, and continue to attend IEP or Section 504 meetings as mandated by law.

C. AHMS shall be notified of meetings and will also attend.

Quality Improvement:

A. On a monthly basis, the CASD Administrator or his/her designee shall ensure that the WRAP Coordinators submit a list of all youth who are anticipated to require transition to AMHS within the next year to their assigned Team Facilitator by the last working day of each month.

B. The Team Facilitators will review the degree to which this policy and procedure is meeting expectations, including seeking feedback from CASD on a monthly basis for the first six (6) months of implementation, and then as needed thereafter.

C. On a quarterly basis, the CASD Administrator and Team Facilitators will gather data on the following:
   a. The number of youth in the process of transitioning from CASD and AMHS;

   b. The number of youth with ongoing legal concerns including monitoring by the court;

   c. The number of youth transitioned from CASD to AMHS;

d. The number of youth who continued to use AMHS after the transition period;

e. The number of youth living independently in the community or with their families/guardian(s);

f. The number of youth transitioned from residential treatment facility to another treatment facility; and

g. The number of youth who refuse AMHS services (e.g., counseling, medication, residential, social work, etc.).