Document Number: (QH-GDL-365-5:2015)

Transition of care for young people receiving mental health services

1. Purpose

The Guideline 'Transition of care for young people receiving mental health services' (Transition Guideline) has been developed to provide guidance and specific recommendations to support public sector mental health services in the provision of effective transitional care planning and processes.

The scope of this Transition Guideline is for young people transitioning from child and youth mental health services to other service system elements including:

- adult mental health services
- child and youth mental health services in a different geographical location
- a General Practitioner or other primary health care provider, private practitioner or non-government organisation.

2. Related documents

Authorising Policy and Standard/s:

- National Safety and Quality Health Service Standards (second edition, 2017)
- National Standards for Mental Health Services 2010
- National Practice Standards for the Mental Health Workforce 2013 (particularly standard 8: Transitions in Care)
- *Mental Health Act 2016* (Qld)
- *Hospital and Health Boards Act 2011*.

Procedures, Guidelines and Protocols:

- Information sharing between mental health staff, consumers, family, carers, nominated support persons and others (Queensland Health, 2017)
- Admission of children and adolescents to acute mental health inpatient units (Queensland Health) (pending publication 2021)

Forms and templates:

- Statewide standardised suite of clinical documentation.

Resources:

This Transition Guideline is accompanied with resources to support its application in practice settings and enable broad access to the resources for service providers as well as young people and their families/carers/significant others:

- Transition of Care Flowchart (Appendix 1)
- Transition of Care Promotional video
- eLearning module – iLearn log-in to access for Queensland Health*
- eLearning module – iLearn registration to access outside Queensland Health*

3. Principles for the transition of care for young people

The transition of mental health care for young people* needs to be a planned, systematic and formal process that provides for a gradual and generous timeframe reflective of the young person's needs and strengths. Transition may be between child and youth mental health services and adult mental health services, or other service elements including general practitioners, other primary health care providers, private practitioners, or non-government organisations.

**The term young person/young people is used throughout this document and does not prescribe an age. Age of transition will vary across Hospital and Health Services, dependent on service element availability, but most importantly, dependent on developmental needs and transition readiness of the young person.*

3.1 A systematic and formal transition process that is informed and responsive to the needs and diversity of young people

The transition process will ensure that services are informed and responsive to the needs and diversity of young people. Planning for transition commences as early as practicable and is built around individual needs and strengths and open to, and respectful of diversity. The young person should always be involved in all aspects of the transition process. Other key stakeholders will be included as appropriate including the young person's family, carers and significant others, other community organisations and educational/vocational providers.

It is important to acknowledge population groups with special needs throughout the transition process. Services will seek to ensure that Aboriginal and Torres Strait Islander People and those from Culturally and Linguistically Diverse (CALD), Lesbian, Gay, Transgender, Bisexual and Intersex (LGTBI) and rural and remote areas requiring additional consideration have equitable access to quality mental health care and culturally appropriate service delivery through engagement and collaborative partnerships. Such groups also include young people with a history of trauma, abuse and/or neglect or who are in the care of the Department of Child Safety, Youth and Women.

3.2 The decision to transition is appropriate to the young person's developmental age

Transition between adolescence and adulthood can be a complicated developmental period. Where possible, transition to adult mental health services or other service elements should only occur when appropriate to the young person's developmental age. The 'assessment of readiness' process will involve discussion with the young person, their family, carers, significant others and other support services as appropriate. The decision to

* iLearn not accessible via Internet Explorer browser

transition will be based on a young person's readiness to progress with a focus on education and skills development, titrated to relevant developmental milestones.

To enable developmentally appropriate transition, services will acknowledge the need for flexibility in service provision to ensure continuity of care during transition, and commit to and demonstrate collaboration between services. This will include clear, effective, and timely documented communication between all stakeholders.

3.3 Encourage and support young people to develop self-management skills as part of the transition process

All interactions with the young person support and promote self-determination that facilitates client-centred transition planning reflective of the young person's needs and goals. The young person will be actively engaged in decision making, and encouraged and supported to develop self-management skills, to be able to advocate for themselves, where appropriate.

The young person needs to be given opportunities to self-manage and negotiate their care requirements in a safe and supportive environment. Transition may be at a time of heightened emotions and therefore opportunities are to be encouraged before the transition occurs so that the young person has some positive experiences of achieving or negotiating options. Self-management includes assisting the young person to identify signs of distress within themselves and implementing strategies to actively manage any symptom deterioration. Actively engaging the young person in development of these strategies will assist in ensuring that the young person will use them.

When the young person's needs are complex and their capacity to self-manage is limited, greater emphasis on the ongoing role of family, carers and significant others (friends, teachers, peers and mentors) during the transition process should be considered.

3.4 The transition process is family connected and community connected

Engagement with the young person's family, carer and significant others and other community stakeholders during the transition process is important. This includes the decision to transition being made in the context of the broader understanding of the young person, their relationship with themselves, their family, carers and significant others, their peers and their community.

The transition process will focus on collaboration that is family connected and community connected, with a focus on education and skills development to support transition processes.

3.5 Clear, effective and timely communication between all stakeholders is essential to effective transition

Aspects of good communication include:

- identification of all stakeholders relevant to the transition process
- openness, transparency, collaboration, and a willingness to work together
- a culture of working with the young person, their family, carers and significant others, which is reflected in all interactions
- developmentally appropriate language and style/mode of communication including use of age and literacy level appropriate communication tools. This may involve social media modes of communication
- established systems for joint communication between all parties

- comprehensive written communication–in a format and level that all relevant parties understand
- sensitivity and responsiveness to the needs of Aboriginal and Torres Strait Islander People, and those from CALD and LGTBI communities and from rural and remote areas
- alternatives to meet the communication needs of those from CALD backgrounds
- the privacy of the young person and their family/carer/significant others must be respected, and confidentiality obligations adhered to
- all communications and information shared are documented in the young person's clinical record.

4. Best practice elements for the transition of care for young people

The decision to transition care for young people will follow a clear 'assessment of readiness' process that is mindful of the young person's developmental stage and inclusive of the young person, their family, carers and significant others.

All stakeholders, including the young person, their family, carers and significant others and the mental health multidisciplinary team/s (child and youth, and adult) will be aware of their delegated responsibilities for various parts of the transition process.

The young person will be involved in all decision-making processes. Supporting and enabling their decision making in this early phase will help to manage the young person's expectations which will assist in minimising the stress and impact of the transition when it occurs.

All service providers should acknowledge the different service delivery models that may exist between child and youth mental health services, and adult mental health services, and other service providers. Transition planning will include education of the young person, their family, carer and significant others regarding the potential impact of service delivery differences to enable the most appropriate service option choice.

All services involved in the transitioning of young people need to have:

- documented transition guidelines and policies which are accessible to all involved in the transition
- clear 'assessment of readiness' processes
- clear referral pathways
- a focus which is developmentally appropriate, youth engaging, promotes self-determination and is peer driven.

4.1 Transition process

The following section outlines the recommended transition process as demonstrated via the Transition of Care flowchart located at Appendix 1. Services are encouraged to develop their own local procedures to support this process.

4.1.1 Assessment of readiness

An 'assessment of readiness' process will occur that will consider the young person's readiness to transition from a child and youth mental health service with an emphasis on developmental stage and existing support available for the young person from their family, carers and significant others.

'Assessment of readiness' includes the following components:

- the young person's mental health
- the young person's physical health
- the young person's developmental stage (emotional, intellectual and physical) and readiness to progress to adult services
- the young person's relationship with their support network – family, carers, significant others and broader community support services
- psychosocial needs including education and skills development needs, titrated to relevant developmental milestones
- psychoeducation and support needs of the young person's family, carers and significant others
- cultural and spiritual needs
- pharmacological and therapeutic interventions
- educational and vocational requirements
- housing and accommodation needs.

4.1.2 Early preparation and planning

A young person requiring transition needs to be identified as early as possible. Identification ideally occurs (where possible and appropriate) six months prior to the actual transition.

Thorough investigation and identification of suitable service providers will occur in collaboration with the young person and their family, carer and significant others.

Preparation will involve:

- identification of all possible stakeholders – family/carer/significant others, child and youth mental health service, adult mental health service, other service providers
- discussing service options with the young person and their family, carer and significant others
- selecting the most suitable service option and ensuring its availability
- engagement in peer support as appropriate to support transition.

4.1.3 Identification of a local transition coordinator/facilitator

The role of transition coordinator within the transitioning team will be identified at the onset of transition planning and is responsible for the planning and coordination of the transition process. The transition coordinator needs to ensure that:

- the young person will experience continuity of care through the transition
- clear and regular communication occurs with all stakeholders, and that all communication is understood and documented appropriately
- a local transition contact is identified in the receiving service and all plans and communication involve this person.

4.1.4 Develop individual transition plan

An individualised transition plan will be developed in partnership with the young person and their family, carer and significant others. All the relevant people need a copy of the

plan and need to understand all the elements of the plan. The transition plan will identify and promote self-determined goals.

During development of the transition plan, services will acknowledge the young person's need to experience safety, cultural sensitivity, inclusiveness and the minimum possible disruption to their family, educational, social and community networks. The transition plan will be trauma-informed and reflect the ability of systems and care providers to work collaboratively.

Timeframes will be developed to reflect an individual approach to transition. The process should recognise that poor handover, and the loss of supportive and sometimes long-term relationships due to the changing of care arrangements, can have a negative impact on a young person's mental health.

The transition plan will be formalised and documented, highlighting any special needs of the young person. It will reflect the process of monitoring the progress of transition including strategies to promote engagement of the young person with the new service provider and identification of which service (original or receiving) will follow up disengagement. It will also ensure that introduction of the young person to the receiving service or care arrangement occurs in advance of the transition and that the young person is aware of who their key contact is.

A crisis management plan will be incorporated within the transition plan with clear management strategies that identify which service (original or receiving) will manage the crisis and at which point. Transition can be a challenging time and may precipitate a crisis, so it is important to be aware of early warning signs of distress and develop corresponding management strategies, in collaboration with the young person and their family, carers and significant others.

4.1.5 Follow up, evaluation and monitoring

Follow up is essential to ensure young people have effectively engaged with the receiving service. Monitoring and evaluation processes will ensure young people are supported in providing clear and honest feedback about the transition process, and whether the receiving service is the most appropriate service for their needs. If the young person is not engaging with the receiving service, the original service and transition coordinator will work with and support the young person and as appropriate, their family, carers and significant others, to make alternative arrangements.

With the young person's consent, the original service will maintain contact with the young person and the receiving service for a period of time after transition. This contact can be gradually reduced as the young person settles into their new service. When all parties including the young person, their family, carer and significant others, agree that the transition has been successfully completed, contact can be ceased.

Monitoring and evaluation of the young person's experiences and outcomes following transition can inform future planning for the young person, and inform service development to continue to identify best practice principles and transition process improvement. Both the original and receiving service will undertake monitoring and evaluation.

To inform service development, monitoring and evaluation will also include the experiences and outcomes for the young person's family, carers and significant others.

4.2 Transition process in acute settings

Some young people present to acute settings for mental health assessment and treatment, such as Emergency Departments, child and youth acute care teams or those young people accessing briefer targeted interventions.

In these circumstances, it is still important to consider the transition principles as outlined in section 3 above, adapting the transition process to support high quality considered transitions of care for young people in acute settings, particularly ensuring connection and communication with the receiving service/clinician prior to ceasing engagement. The use of existing standardised clinical documentation can assist to support a modified transition process.

4.3 Research, education and training

Services will enhance education, training and research capacities to support effective transition. This will include:

- training and education for both child and youth mental health service, and adult mental health service clinicians regarding developmental needs of young people, 'assessment of readiness', support and empowerment for the young person, their family, carers and significant others during transition processes
- psychoeducation for young people, their family, carers and significant others regarding transition processes
- education and training needs for peer workers and mentors
- supporting young people, their family, carers and significant others to engage in service development and research to support engagement, learning and continuity of service
- practice supervision for mental health clinicians and peer workers.

5. Background

The Queensland Government established a Commission of Inquiry (COI) into the closure of the Barrett Adolescent Centre (BAC) on 16 July 2015. The Honourable Margaret Wilson QC, Commissioner, provided the BAC COI final report to the Premier on 24 June 2016.

The COI Report made six recommendations which were all accepted in principle as part of the Government response endorsed by Cabinet on 18 July 2016. The Department of Health led the implementation of the Government response.

Health Outcomes International (HOI) was subsequently engaged to conduct an independent review of the alignment and transition arrangements between adolescent and adult mental health services in Queensland and provided their final report 'Review of the alignment and transition arrangements between adolescent and adult mental health service in Queensland'[1] (HOI report) to the Department of Health in June 2017.

The HOI report considered the Department of Health Transition Guideline (published in September 2015) and found that it broadly aligned with evidence-based best practice principles identified in the literature. The HOI report also identified a number of factors to improve uptake of the Transition Guideline.

The Mental Health, Alcohol and Other Drugs Branch subsequently completed a review and revision of the Transition Guideline (2015) to incorporate evidence-based best practice transition principles. A working group including consumers and carers with a lived

[1] https://www.health.qld.gov.au/__data/assets/pdf_file/0031/668218/rec-5-final-report.pdf

experience and representatives from 11 Hospital and Health Services progressed the review and revision of the Transition Guideline. The working group agreed on evidence-based, best practice Transition Principles (Appendix 2) to guide the review.

This review has occurred within the context of a recent change to the *Queensland Child Protection Reform Amendment Act 2017* with additional support for young Queenslanders transitioning from state care to adulthood to be offered until they reach 25 years.

6. Review

This Guideline is due for review in June 2023
Date of Last Review: May 2021
Supersedes: Version 2 - Guideline 'Transition of care for young people receiving child and youth mental health services (QH-GDL-365-5:2015).

7. Business Area Contact

Mental Health Alcohol and Other Drugs Branch

8. Definitions

Term	Definition / Explanation / Details
Young people / young person	Any person receiving a mental health service that targets young people, e.g. child and youth mental health services, adult mental health services, specialist youth mental health services or other service elements.
Parent / carer	Refers to the parent(s) or person(s) that take legal responsibility for the young person and provides direct care. This includes birth parents, step parents, adopted parents, foster parents, legal guardians, custodial parents or other appropriate primary care givers. Source: The Royal Australasian College of Physicians (RACP). Standards for care of children and adolescents in Health Services 2008, Paediatrics and Child Health Division, RACP, Sydney Australia.
Child and youth mental health service	Queensland Health child and youth mental health services, including, but not limited to community Child and Youth Mental Health Service, Assertive Mobile Youth Outreach Service, Adolescent Day Program, adolescent inpatient mental health units, Youth Step Up Step Down service, Youth Residential Rehabilitation service and Evolve Therapeutic Services.
Receiving service	Adult mental health service or other service elements.
Other service elements	General Practitioner or other primary health care provider, private practitioner or non-government organisation.
Transition	The process and period of changing care arrangements for a young person.
Case manager	Person/s who coordinate the care offered by the specialist mental health service.
Transition coordinator	Designated person/s who coordinates the transition of care from child and youth mental health services.
Peer driven	Support young people to engage in peer support and support young people to engage in service development and research to support engagement, learning and continuity of service.

9. Appendices

Appendix 1: *Transition Process Flowchart*

Appendix 2: *Transition Principles*

10. Approval and Implementation

Policy Custodian:

Child and Youth Team, Strategic Planning and Partnership Unit, Mental Health Alcohol and Other Drugs Branch

Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Responsible Executive Team Member:

Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch

Approving Officer:

Executive Director, Mental Health Alcohol and Other Drugs Branch

Approval date: 14 May 2021

Effective from: 01 June 2021

Version Control

Version	Date	Prepared by	Comments
V.1	07.09.2015	Mental Health Branch	Final Version
V.2	19.11.2019	Mental Health, Alcohol and Other Drugs Branch	The revised Guideline incorporates evidence-based, best practice Transition Principles (Appendix 1) including: planned, systemic and formal transition process including an 'assessment of readiness', and acknowledgement of the young person's developmental age.
V.3	01.06.2021	Mental Health, Alcohol and Other Drugs Branch	Updated version with live links to 'Transition of Care' eLearning module and related promotional video of resources.

Appendix 1: Transition Process Flowchart

Appendix 2: Transition Principles

Introduction

The Mental Health, Alcohol and Other Drugs Branch, in collaboration with Hospital and Health Services, consumers and carers have reviewed and revised the Department of Health '*Guideline for the transition of care for young people receiving mental health services*'. Agreed evidence-based best-practice '*Transition Principles*' (outlined below) were used to guide the review process. The development of these '*Transition Principles*' considered the 'transition principles' as reported by Cappelli (et al 2012) and supported by around 50 international experts at the 2012 Summit, An International Focus on Youth in Transition; Development and Evaluation of a Mental Health Transition Service Model.[2][3]

Transition Principles

1. Services* are **informed** and **responsive** to the needs and **diversity** of young people:
    a. built around individual needs and strengths, open to, and respectful of, diversity
    b. honour and promote self-determined goals
    c. acknowledge the need for young people to experience safety, cultural sensitivity, inclusiveness and the minimum possible disruption to their family, educational, social and community networks
    d. seek to ensure that Aboriginal and Torres Strait Islander People and those from Culturally and Linguistically Diverse backgrounds requiring additional consideration have equitable access to quality mental healthcare and culturally appropriate service delivery through engagement and collaborative partnerships
    e. are trauma-informed
    f. cross transitional domains
    g. reflect the ability of systems, care providers, researchers to work collaboratively to deliver services
    h. are proactive and prepare for transition early
    i. are fluid, coordinated, seamless and invested.
2. Services* are **developmentally appropriate**:
    a. acknowledge that the transition between adolescence and adulthood is a complicated developmental period
    b. appropriate to a young person's developmental age
    c. decision to transition to adult services is based on a young person's readiness to progress
    d. focus on education and skills development, titrated to developmental milestone.
3. Services* are **family connected** and **community connected**:
    a. decision to transition to adult services is made in the context of the broader understanding of the young person, their relationship with themselves, peers, family/carers/significant others and their community
    b. acknowledge the importance of engagement with family/carers/significant others and other relevant community stakeholders
    c. focus on collaborative transition planning supported by education and skills development
    d. facilitate engagement with family/carers/significant others, peers and broader community.

[2] Cappelli, Davidson S, Vloet M, Gillis K, Addington J, Kates J, and Mckenzie K (2012) An International Focus on Youth in Transition: Development and Evaluation of a Mental Health Transition Service Model. Ottowa, ON: Canadian Institutes of Health Research.
[3] Mental Health Commission of Canada. (2015). Taking the Next Step Forward: Building a Responsive Mental Health and Addictions System for Emerging Adults, Ottawa, ON: Mental Health Commission of Canada.

4. Services* are **youth engaging** and **peer driven**:
    a. promote self-determination
    b. facilitate client-centred transitional planning reflecting the young person's individual needs and goals
    c. provide young people with choices and help empower them to be actively engaged in decision making
    d. mobilise supportive networks present in the lives of young people (such as friends, teachers, parents, carers, significant others, peers and mentors) when it is in the best interest of the young person
    e. provide youth friendly ways of communication
    f. support young people to engage in peer support
    g. support young people to engage in service development and research to support engagement, learning and continuity of service.

5. Services* are **recovery-oriented**:
    a. support young people to live healthy, hopeful and fulfilling lives
    b. are resiliency-building, recovery-based, and peer inclusive
    c. consider wellness, health, and meaningful role outcomes, rather than being limited to service engagement and symptom management/relief
    d. commit to and demonstrate youth-driven individual and program practices
    e. offer opportunities for youth to be involved in community building with their peers
    f. advocate for and support young people in self-advocacy to ensure their needs are understood, and self-identified outcomes are achieved, within a framework of hope, meaningful roles, and recovery.

6. Services* are **flexible**, work **collaboratively** and have clear **monitoring** frameworks:
    a. acknowledge the need for flexibility in service provision to ensure continuity of care during transition
    b. commit to, and demonstrate, collaboration between services
    c. clear, effective and timely communication between all stakeholders
    d. collaboration includes clear processes regarding monitoring and evaluation of transition.

7. Services* are informed by **research, education and training**:
    a. include enhanced education, training, and research capacities to support effective transitional care
    b. improve training and education for professionals regarding developmental needs of young people and factors that promote readiness for transition and factors that support and empower the young person, their families/carers/significant others during the transition process
    c. promote education and training needs of peer workers and mentors
    d. include a dimension of accountability on the part of researchers and administrators
    e. strive to identify critical research questions and appropriate outcome variables
    f. encourage collegial interactions and collaborations between research groups, evaluate programs, and identify best practices
    g. allow for the participation in knowledge exchange activities that identify both the strengths and weaknesses of practices
    h. are anchored in best practice guidelines and oriented around identifying evidence based practices.[4]

**Services refers to all services that work with young people who are transitioning between adolescence and adulthood, for example, child and youth mental health services, adult mental health services, youth specific mental health services, and primary health care service providers*

[4] Cappelli M (2014) Shaping the Future of Transitional Mental Health & Addition Service for Young People https://www.champlainpathways.ca/wp-content/uploads/2014/06/Nov_14-Primary-Care-nov-20th-transition-meeting.pdf