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Guideline for the transition of care for young people receiving mental health services

1. Purpose

This Guideline provides recommendations to support public sector mental health services in the provision of effective transitional care planning and management to meet the mental health needs of vulnerable young people.

Scope

This Guideline provides information for all employees, contractors and consultants within the Department of Health and Hospital and Health Services involved in the transition of young people from child and youth mental health services (CYMHS) to other parts of the mental health system, including but not limited to, transfer from a:

- CYMHS service to an adult mental health service
- specialist and/or more intensive mental health service to a less intensive service, for example, Evolve Therapeutic Services to a Community CYMHS
- CYMHS to another CYMHS in a different geographical area
- CYMHS to a General Practitioner or other primary health care provider, private practitioner or non-government organisation.

2. Related documents

Authorising Policy and Standard/s:

- National Standards for Mental Health Services 2010
- National Safety and Quality Health Service Standards 2012
- National Practice Standards for the Mental Health Workforce 2013 (particularly standard 8: Transitions in Care)
- *Mental Health Act 2000*
- *Hospital and Health Boards Act 2011*.

Procedures, Guidelines and Protocols:

- Information sharing between mental health workers, consumers, carers, family and significant others (Queensland Health 2011)
- Guiding principles for admission to Queensland Health child and youth mental health acute inpatient units
- Guiding principles for the management of adolescents in Queensland Health adult acute mental health inpatient units.

Forms and templates:

- Statewide suite of clinical documentation.

3. Guideline for the transition of care for young people receiving mental health services

Background

Adolescence and young adulthood is a particularly important time for mental health intervention. The prevalence of adolescent mental health problems in Australia is substantial, accounting for more than half of the disease burden in this age group. Of the total population of young people aged between 13 and 18 years of age, it is estimated that 10% have mental health needs and 2.3% have a severe mental illness[1]. In Queensland this accounts for 8,060 young people with severe and persistent mental illness[2].

Primary diagnoses for this vulnerable group of young people are likely to include psychotic illnesses, severe mood disorders, eating disorders and complex trauma with deficits in psychosocial functioning. This group may also include young people presenting with social avoidance, disorganised behaviour, emerging personality vulnerability and risk of self-harm or suicide. Some may experience family dysfunction.

The importance of transitioning vulnerable people from CYHMS to other support services is critical to ensure continuity of care and avoid preventable poor outcomes. Transitioning young people, who may be at risk, from one level of care to another among multiple providers and across settings can be a complex task. Poor transitioning can lead to the re-emergence of symptoms of mental health problems or illnesses, mental health crises, requirements for admission, poor satisfaction with care, unmet needs, medical or treatment errors, and a higher burden of cost.

The key aims of transition planning are to ensure that:

- service provision is matched as closely as possible to the needs of the young person and delivered by the most appropriate service/s to meet those needs
- the young person and their family/carer are the key decision-makers regarding the services they receive
- care is delivered across a dynamic continuum of specialist and primary level services with decisions based on the needs and wishes of the young person and their family/carer and not service boundaries
- processes are in place to identify and respond early should the young person experience crisis or re-emergence of a mental health concern.

Optimal transition will involve adequate planning, good communication between all service providers, the young person and key family members or carers, and continuity of care. Transition between service providers often occurs within the context of a young person's movement to independence from their family of origin/ caregivers and therefore has the potential to be a vulnerable time for all young people.

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[1] General Epidemiology data provided by the Mental Health, Alcohol and Other Drugs Branch
[2] Australian Bureau of Statistics, 2011, Census of Population and Housing

Context

This Guideline was developed following the November 2014 release of the report *Transitional Care for Adolescent Patients of the Barrett Adolescent Centre*. The report's recommendation states that "*transitional mental health care for young people is internationally recognised as a complex and often difficult process and poor outcomes such as disengagement from care are well documented. The Barrett Adolescent Centre process demonstrates positive learnings in relation to good quality transitional planning".* This Guideline captures these learnings.

In developing this Guideline, acknowledgement is given to the work of the Agency for Clinical Innovation in New South Wales, Trapeze, the Sydney Children's Hospitals Network which produced the document: *Key Principles for Transition of Young People from Paediatric to Adult Health Care* and the New Zealand Department of Health *Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs Services 2014.*

Principles and best practice elements for the transition of care for young people

A systematic and formal transition process

The development and documentation of a formal transition process forms the basis of a contemporary approach to the transition of care for young people. This will include steps involved in a smooth transition and the development of an individual transition plan. The transition plan should be developed and communicated to key stakeholders involved in the young person's care and communicated to the young person in a developmentally appropriate way. The multidisciplinary team needs to be aware of their delegated responsibilities for various parts of the transition process. Timeframes will be developed to reflect an individual approach to transition and provide for a gradual and generous timeframe reflective of the young person's needs. 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. Formal transition planning helps to mitigate these risks.

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 referral pathways
- a focus which is developmentally appropriate.

In developing transition plans, including the level and scope of services to be provided, it is important to acknowledge population groups with special needs. Such groups include, but are not limited to, young people with a history of trauma, abuse and/or neglect or who are in the care of the Department of Communities, Child Safety and Disability Services.

Early preparation

A young person requiring transition needs to be identified as early as possible. Evidence suggests that identification ideally occurs (where possible and appropriate) six months prior to the actual transition. The identification process will involve notifying the young

person, their family and or carers, and services, including cultural support services where relevant, of the impending transition.

The young person must be involved in all decision making processes regarding the transition. 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.

Preparation will involve:

- identification of all stakeholders
- negotiating service options with the young person and their family or carer
- selecting the most suitable service option and ensuring its availability
- development of plans–these need to be formalised and documented highlighting any special needs of the young person
- in advance of the transition, introduction of the young person to the receiving service or care arrangement and their key contact, such as the person responsible for receiving the young person
- a focus on recovery and relapse prevention.

The timing of the transition, where possible, needs to avoid any crisis the young person may be experiencing including consideration of relapse of symptoms.

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 must have sufficient seniority to facilitate authoritative decision making and action.

The transition coordinator or lead professional responsible for the transition needs to ensure that:

- the young person will experience continuity of care throughout the transition
- clear and regular communication occurs with all stakeholders, and that all communication is understood; this may include a requirement that all written communication is followed up verbally
- a lead professional or local transition key contact is identified in the receiving service/care arrangement and all plans and communication involves this person.

Good communication

Clear, effective and timely communication between all relevant stakeholders is essential to effective transition. Aspects of good communication include:

- identification of all those relevant to the transition process
- openness, transparency, collaboration, and a willingness to work together
- a culture of working with the young person and their family or carer which is reflected in all interactions

- developmentally appropriate language and style/mode of communication. This will be different for the young person, their family or carer and the service and professionals involved in the young person's care. 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. Age and literacy level appropriate communication tools must be used.
- sensitivity and responsiveness to the needs of Aboriginal and Torres Strait Islander people
- alternatives to meet the communication needs of those from culturally and linguistically diverse backgrounds
- the young person and family/carer's privacy must be respected and confidentiality obligations adhered to
- all communications and information shared are documented in the young person's clinical record.

Information to assist professionals understand their confidentiality obligations can be sourced from the *Hospital and Health Boards Act 2011* and the Information sharing between mental health workers, consumers, carers, family and significant others document.

Individual transition plan

All young people need an individualised transition plan which is developed in partnership with the young person and family/carer. All the relevant people need a copy of the plan and need to understand all the elements of the plan.

Managing an effective transition process with a young person involves a comprehensive assessment which includes the following components:

- the young person's mental health
- the young person's physical health
- psychosocial needs including support for family/carers
- cultural and spiritual needs
- pharmacological and therapeutic interventions
- educational and vocational requirements
- housing and accommodation needs.

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. The young person, family or carer and the receiving service are to be made aware of these risks including signs of distress or deterioration in the young person's mental health. It is important to identify and work with the young person's strengths to assist in making the transition a positive experience.

Thorough investigation and identification of suitable supporting services and coordinated care will occur in collaboration with the young person and their family and or carer.

Encourage and enable young people to self-manage

The process of teaching and encouraging young people to self-manage, be actively engaged in decision making, be able to advocate for themselves, and navigate their environments must be carefully planned and developmentally appropriate. Equivalency of service is to be adopted only where it is demonstrated that this level of service needs to be maintained.

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 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 at 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 and carers in the transition process should be considered.

Follow up and evaluation

Follow up is essential to ensure young people have effectively engaged with the receiving care arrangement.

Contact is to be maintained with the young person from their original service after transition. This contact can be gradually reduced as the young person settles into their new environment. When all parties agree that the transition has been successfully completed, contact can be ceased. This must be well prepared for and understood by the young person and their family or carer.

Monitoring and evaluation of the young person's outcomes after transition is required to inform future planning. Future planning may be for another transition the young person may need to face, for example as their service needs change or as they recover. This monitoring and evaluation may also assist to inform future planning for other young people.

Monitoring and evaluation is to occur by both the transferring and receiving service until the transition is completed and contact with the originating service is no longer required.

Monitoring and evaluation after transition is to be undertaken by the receiving service.

5. Review

This Guideline is due for review on: (Note: date to be inserted upon endorsement)

Date of Last Review: Not applicable

6. Business Area Contact

Mental Health Alcohol and Other Drugs Branch

7. Definitions of terms used in the policy and supporting documents

Term	Definition / Explanation / Details	Source
young people	Any person receiving a mental health service from a child and youth mental service or a service that targets young people, e.g. specialist youth services with an age range of 16- 24 years.	
parent and/or carer	Refers to the parent(s) or person(s) that take legal responsibility for the adolescent and provides direct care. This includes birth parents, step parents, adopted parents, foster parents, legal guardians, custodial parents or other appropriate primary care givers.	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.
transfer	The act of moving the young person from one care facility to another, or to another care arrangement.	
transition	The process and period of changing care arrangements for a young person.	

8. Approval and Implementation

Policy Custodian:

Director, Clinical Governance, 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

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Version Control

Version	Date	Prepared by	Comments
V.01	08/04/2015	F Ward	Initial draft
V.02	04/06/2015	K McLachlan-Murphy	consultation with HHS
V.03	16/06/2015	K McLachlan-Murphy	consultation with MHAOD Clinical Network
V.1	07.09.2015	L Wagner	Final Version