Core Components of Transitions from Child and Adolescent Mental Health Services

You don't have to implement every component in order to facilitate effective transitions. Choose the components that best suit your resources, context, and stakeholder priorities.

1.0 Organizational Transition Policy

1.1 Develop an integrated care pathway that describes the steps that make up the transition process.

1.2 Develop an organization-specific transition policy with youth (with input from family members/caregivers) that describes the organization's approach to mental health care transitions, and make it publicly available.

1.3 Develop a youth-centered and developmentally appropriate transition protocol in collaboration with both the child and adolescent mental health services and the adult mental health services, that outlines standards for communication and information sharing.

1.4 Ensure that all staff have the knowledge, skills and training to effectively support the agency/services approach to transitions.

1.5 Determine a clear role for all individuals (e.g. youth, child and adolescent mental health services and adult mental health services staff, peer support workers, transition support workers and family members/caregivers if appropriate) involved in the transition of care, informed by the needs of each youth.

1.6 Partner with the youth (and family members/caregivers, if appropriate) at all phases of transition and decision-making.

1.7 Establish a plan to evaluate the organization's transition protocol.

2.0 Transition Tracking and Monitoring

2.1 Establish organization-specific criteria and process for identifying youth who will be transitioning out of child and adolescent mental health services.

2.2 Establish a transition flow sheet or log book that tracks the completion of important steps as youth transition out of child and adolescent mental health services.

3.0 Transition Readiness

3.1 Conduct regular transition readiness assessments, and in collaboration with youth (and family members/caregivers, if appropriate) identify youths' needs and goals, update regularly.

3.2 Provide youth (and their family members/caregivers, if appropriate) information about what to expect from adult mental health services.

3.3 Develop individualized transition plan in collaboration with youth (and their family members/caregivers, if appropriate) a minimum of 6-months before planned transition, or as early as possible.

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4.0 Transition Planning

4.1 Identify everyone involved in the transition (e.g. child and adolescent mental health services, adult mental health services, youth and family members/caregivers, transition workers, primary care practitioners, etc.).

4.2 Collaborate with youth (and family members/caregivers, if invited by youth) to identify adult services that are an appropriate fit.

4.3 Confirm the adult mental health service eligibility criteria.

4.4 Agree on optimal timing of transfer with youth and other relevant service providers in the circle of care (and family members/caregivers, if appropriate).

4.5 In collaboration with youth (and their family members/caregivers, if appropriate), complete the individualized transition plan and keep it up-to-date (including, for example: readiness assessment findings, goals and prioritized actions, clinical summary, crisis plan).

4.6 Identify the most responsible person (i.e. child and adolescent mental health services clinician, transition worker) to coordinate the transition process, act as the main contact, and ensure continuity in the youth's care.

4.7 At least 6-months prior to transfer of care child and adolescent mental health services clinician initiate transition planning with the adult mental health services provider, which may include joint working meetings or a period of parallel care; include youth (and their family members/caregivers, if appropriate) in meetings.

4.8 With youth's consent, communicate processes with primary care provider (i.e. family physician, nurse practitioner, and pharmacist) to ensure they have consistent up-to-date medication and treatment information.

4.9 Provide youth and caregiver(s) with up-to-date contact information for developmentally appropriate self-care management resources, community supports, and community mental health resources.

4.10 Provide developmentally appropriate community and health resources to the youth (and their family members/caregivers, if appropriate), in the event that the youth does not transition to adult mental health services, withdraws from adult mental health services, or only desires episodic contact with adult mental health services.

4.11 If desired by youth, facilitate connections to peer support during the transition process.

5.0 Transfer of Care

5.1 A specific meeting or case conference should be held with everyone involved in the transition to handover care (i.e. youth, child and adolescent mental health services and adult mental health services clinician, transition workers, and family members/caregivers if appropriate).

5.2 In collaboration with youth, complete all documents in transfer package (e.g. referral letter, individualized transition plan, clinical records). With youth's consent send to adult mental health services and/or primary care provider, and confirm receipt.

6.0 Transfer Completion

6.1 The person most responsible for the transition, contacts the youth (and family members/caregivers, if appropriate) 3 to 6 months after last child and adolescent mental health service visit, or sooner if necessary, to confirm transfer to adult mental health services.

Learn more at www.cleverleylab.com, or contact Dr. Kristin Cleverley at k.cleverley@utoronto.ca.
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