



Transition Guidelines for Youth Experiencing Mental Health Disorders¹

Purpose

To support positive mental health services experiences and improve mental health outcomes of youth transitioning from community pediatricians to adult care.

Transition vs. Transfer

Transfer is considered “the termination of care by a children’s healthcare provider and its re-establishment with an adult provider”², whereas **transition** is a process requiring therapeutic intent, which may be expressed by the young person’s preparation for transition, a period of handover or joint care, transition planning meetings, and key transfer of case notes and information summaries. Transition ultimately results in established engagement of the young person with adult services and therefore includes vital aspects of continuity of care³.

Collaborative Planning Process

In support of positive and effective transitions for youth and families, this document strongly promotes a collaborative planning process as evidence based transition practice. This process should begin by the time the youth is 17 years of age.

This care may be provided by a family physician, a psychiatrist, a community based mental health service provider, and/or the Health Authority Adult Mental Health and Substance Use services.

If the transitioning youth is an active client of MCFD’s Child and Youth Mental Health services, there is a Mental Health Transition Protocol Agreement in place – please see

http://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/child-teen-mental-health/y2a_protocol.pdf. In this case, the CYMH Clinician would act as

¹ Mental disorder refers to psychiatric disorder including substance use disorders, but does not include developmental or intellectual disability disorders

² Paul M, Fort T, Kramer T et al. Transfers and transitions between child and adult mental health services. *British Journal of Psychiatry*. 2013;202(s54): s36-s40.

³ Ibid.

the case manager, and take many of the steps included in this document. Please note however, that HA Adult Mental Health and Substance Use services are typically reserved for those experiencing lifelong severe and complex mental illness, which may not be the case for all young people with a MH diagnosis who are being monitored by a paediatrician. Neither involvement with CYMH nor a referral from a paediatrician grants automatic acceptance into AMHSU.

Assumptions

Youth who are transitioning between systems benefit from effective transition processes that are:

- Youth and family centred
- Coordinated, continuous and responsive
- Planned and supported over an adequate period of time
- Monitored and evaluated

Youth experiencing a mental health/substance use service transition and their families require:

- Information about the mental health disorder(s) or illness(es) and how to support health and wellness
- Time to develop relationships and trust with new service providers; and
- Assistance to navigate the mental health and substance use system of services

Principles

Coordinated, continuous and responsive mental health transition planning services and supports should include:

- The provision of services provided to the youth and their family by the most appropriate service provider or program, and should use the principle of “best fit” rather than chronological age alone
- Services that involve families⁴ or other natural supports the youth identifies in the transition process. Depending on individual circumstances, it is sometimes appropriate to further engage youth who indicate they do not wish their family to be part of their service provision, as the evidence indicates family involvement promotes positive outcomes for youth with mental health and substance use problems
- Service planning and treatment that adaptively responds to youth’s changing needs for support and independence

⁴ The level of family/natural supports involvement is based on the youth’s informed consent and the family’s desire and capacity to be involved.

Guidelines

When the need for transition services is determined, AMHSU practitioners, the youth, their family, other supports and service providers identified by the youth, should engage in a collaborative planning process to agree on what services will best meet the strengths, needs and preferences for the youth

During the transition period, the community pediatrician, family physician, families, and other involved service providers should work to:

- Establish who/which agency will assume the lead role coordinating the transition process
- Minimize access barriers related to intake procedures (and provide additional support to respond to the developmental needs of the youth)
- Minimize the need for the youth to provide information already provided to other professionals
- Prepare the youth for the differences in the adult service environment
- Locate youth friendly environments (offices and staff)

FYI: Consent for Information Sharing

The Canadian Mental Health Association - BC Division (through the Child and Youth Mental Health and Substance Use Collaborative) has developed a set of Best Practices around Privacy and Information Sharing. A short document on this can be found at <http://cmha.bc.ca/wp-content/uploads/2016/07/Information-Sharing-Best-Practices-2016-FINAL.pdf>. For fact sheets and further information, please visit <http://cmha.bc.ca/documents/privacy-and-information-sharing-resources/>. These documents have been widely circulated and feedback taken into account.

These guidelines are adapted (with thanks) from the MCFD/MoH guidelines for patients who are transitioning from the MCFD CYMH clinics into the HA Adult Mental Health and Substance Use services.