CMHO
Children's Mental Health Ontario
Santé mentale pour enfants Ontario

2020 CMHO Virtual Conference

Innovating and Advancing Child and Youth Mental Health

November 23 to December 4

Sponsored by

Ontario Centre of Excellence for Child & Youth Mental Health
Centre d'excellence de l'Ontario en santé mentale des enfants et des adolescents

CMHO
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2020 CMHO Virtual Conference

Building Stronger Bridges

Successful Transitions from Child Mental Health Services

Kristin Cleverley RN PhD CPMHN

Emma McCann HBSc

camh
mental health is health

BLOOMBERG
LAWRENCE S. BLOOMBERG
FACULTY OF NURSING
UNIVERSITY OF TORONTO

Cleverleylab.com
@clevkristin

The Cleverley Lab partners with youth and caregivers to co-design research that will improve mental health service access, transitions, and continuity of care.

What hat are you wearing?

Polling Question

Do you have personal and/or professional experience navigating mental health care transitions?

Polling Question

Are you aware of resources to support mental health care transition?

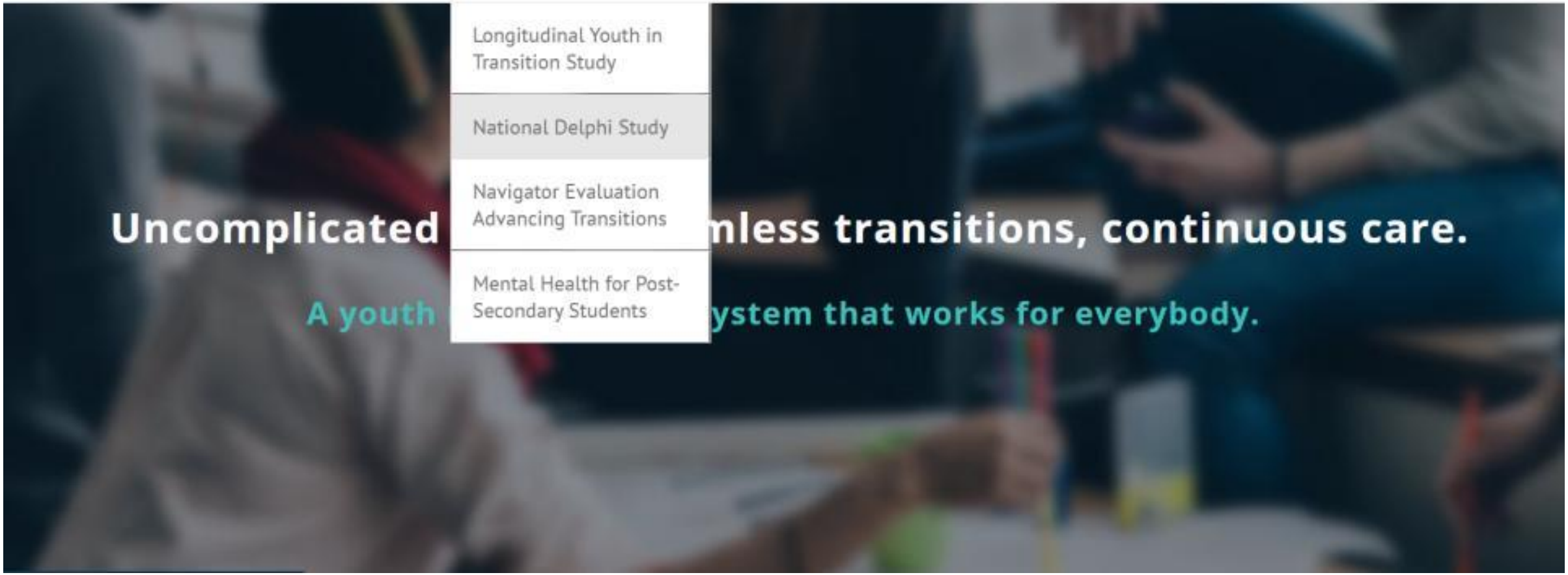
Polling Question

Objectives

1. Learn about a national study identifying priorities in youth mental health transitions with youth, parents/caregivers, and clinicians/administrators.
2. Understand the core components of successful mental health transitions prioritized by these stakeholder groups.
3. Discuss the implementation of core components through transition policies and interventions, including key tools and resources to support their adaptation in your context.

Overview

1. Why Transitions Matter
2. Core Components of Transitions
3. Identifying Core Components
4. Operationalizing Core Components
5. What's Next?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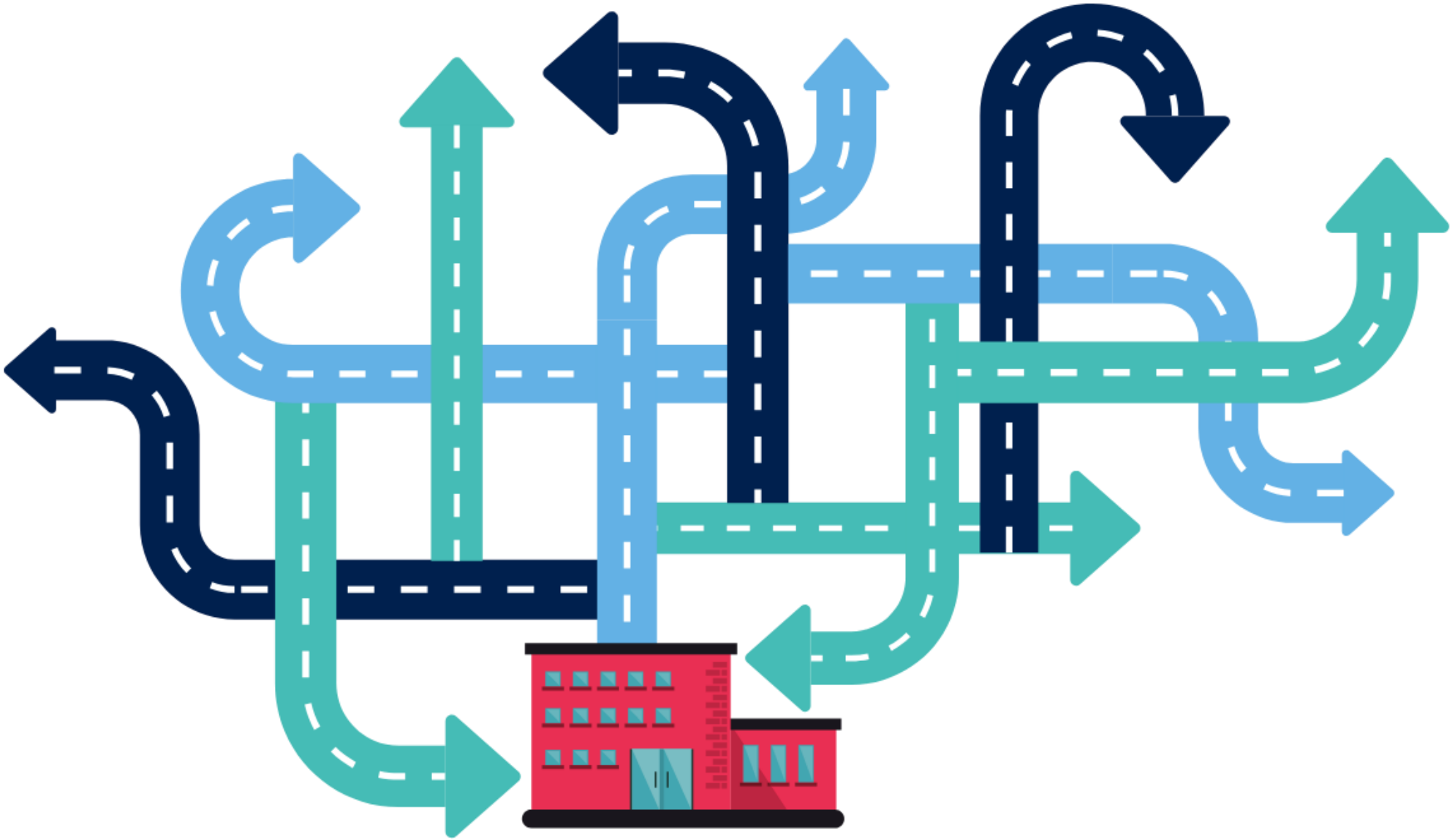
Home
Projects
Team
Resources
Contact Us
Longitudinal Youth in Transition Study
National Delphi Study
Navigator Evaluation Advancing Transitions
Mental Health for Post-Secondary Students
Uncomplicated
mless transitions, continuous care.
A youth
ystem that works for everybody.

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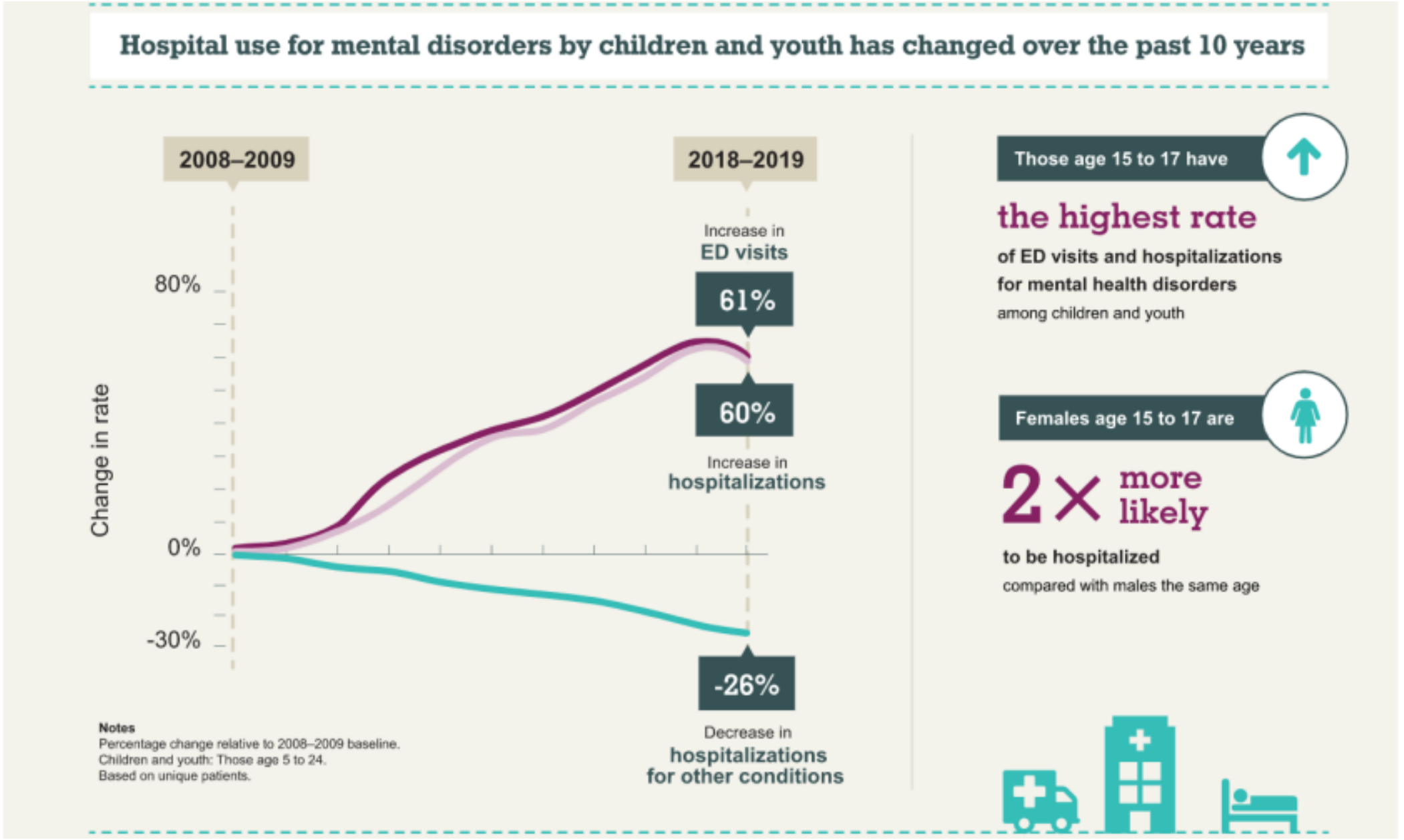
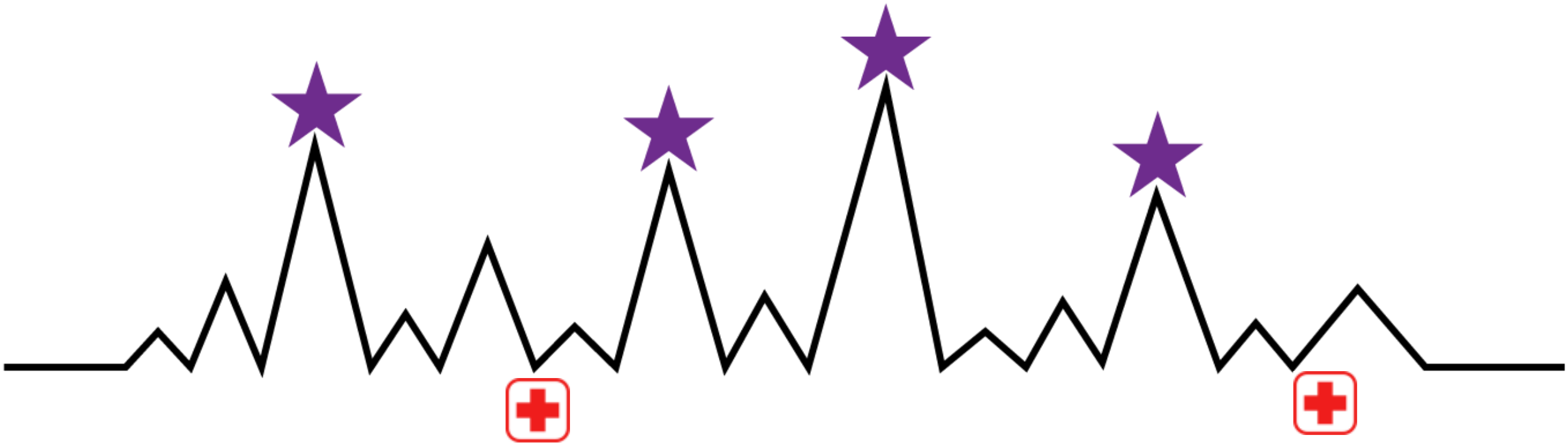


Canadian Institute for Health Information, Child and youth mental health in Canada [infographic]. 2020.

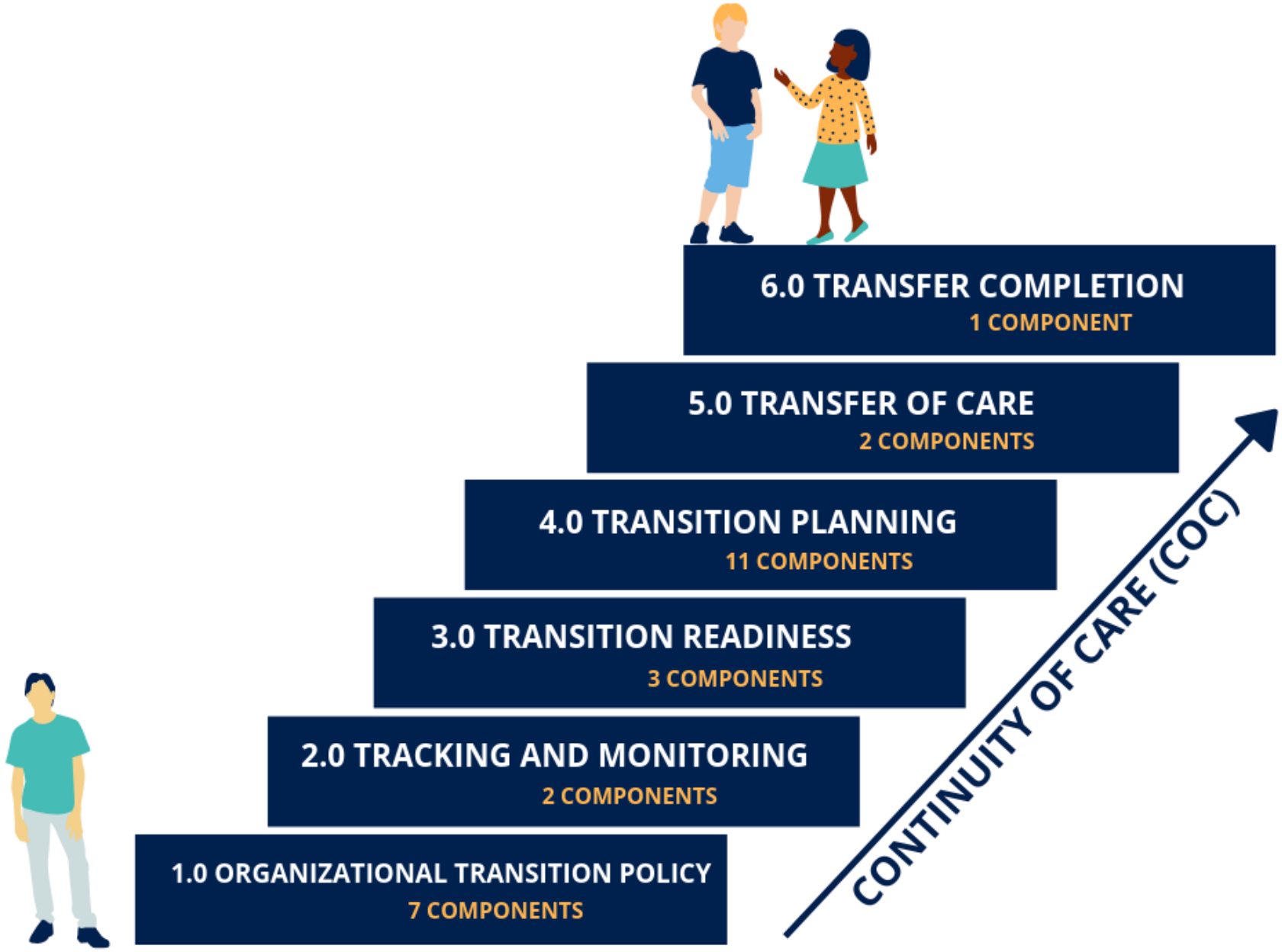

Building Stronger Bridges | 2020 CMHO Virtual Conference | cleverleylab.com

"My appointment will be in May. However, as of right now I have no idea what will be happening **because of the pandemic**." *[LYiTS Study Participant, 2020]*



Core Components of Transitions from Child & Adolescent Mental Health Services

What do we mean by **core components**?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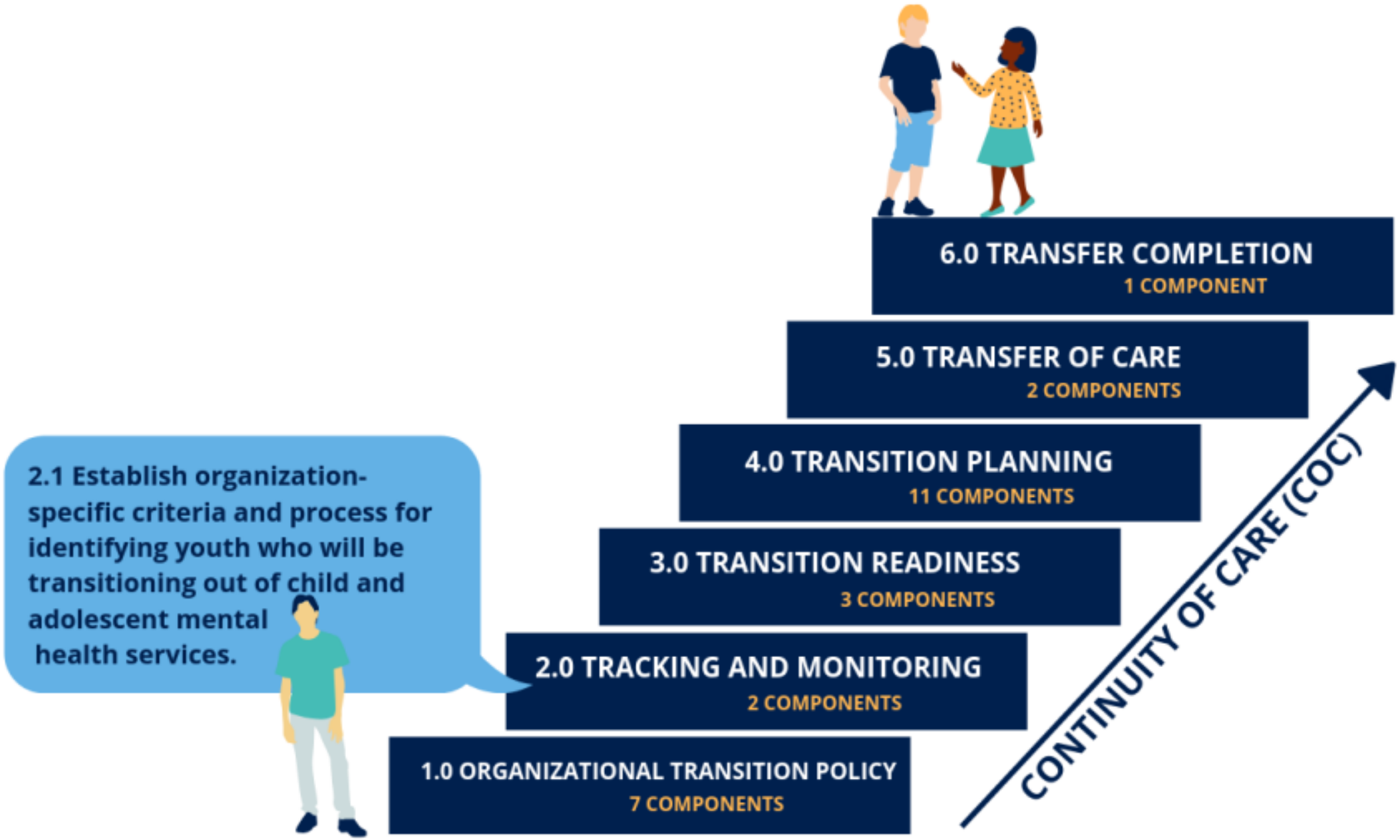
2 COMPONENTS
4.0 TRANSITION PLANNING
11 COMPONENTS
3.0 TRANSITION READINESS
3 COMPONENTS
2.0 TRACKING AND MONITORING
2 COMPONENTS
1.0 ORGANIZATIONAL TRANSITION POLICY
7 COMPONENTS
CONTINUITY OF CARE (COC)

1.4 Ensure that all staff have the knowledge, skills and training to effectively support the agency/ service's approach to transitions.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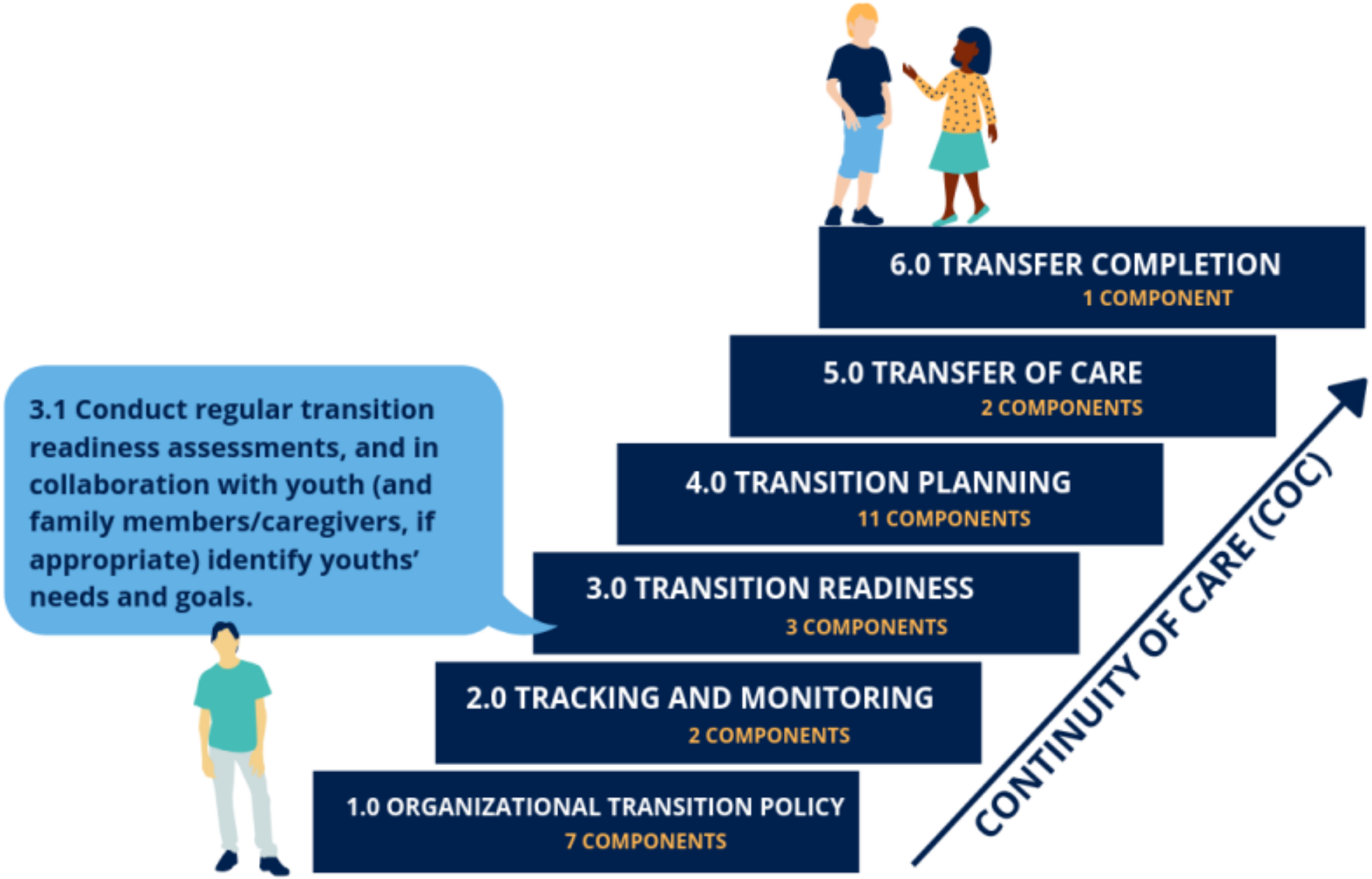
CONTINUITY OF CARE (COC)
2.1 Establish organization-specific criteria and process for identifying youth who will be transitioning out of child and adolescent mental health services.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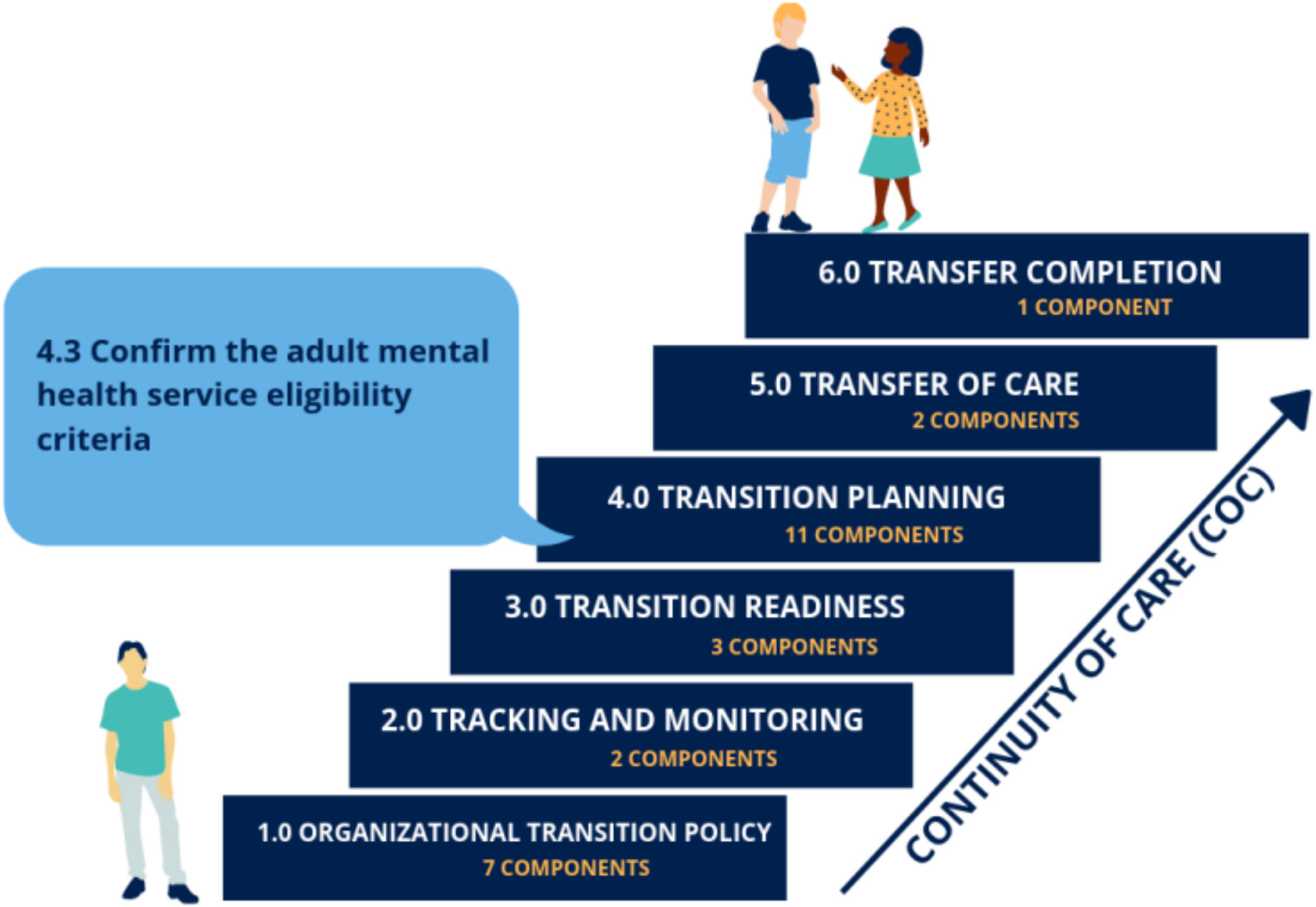
3.1 Conduct regular transition readiness assessments, and in collaboration with youth (and family members/caregivers, if appropriate) identify youths' needs and goals.
CONTINUITY OF CARE (COC)


4.3 Confirm the adult mental health service eligibility criteria
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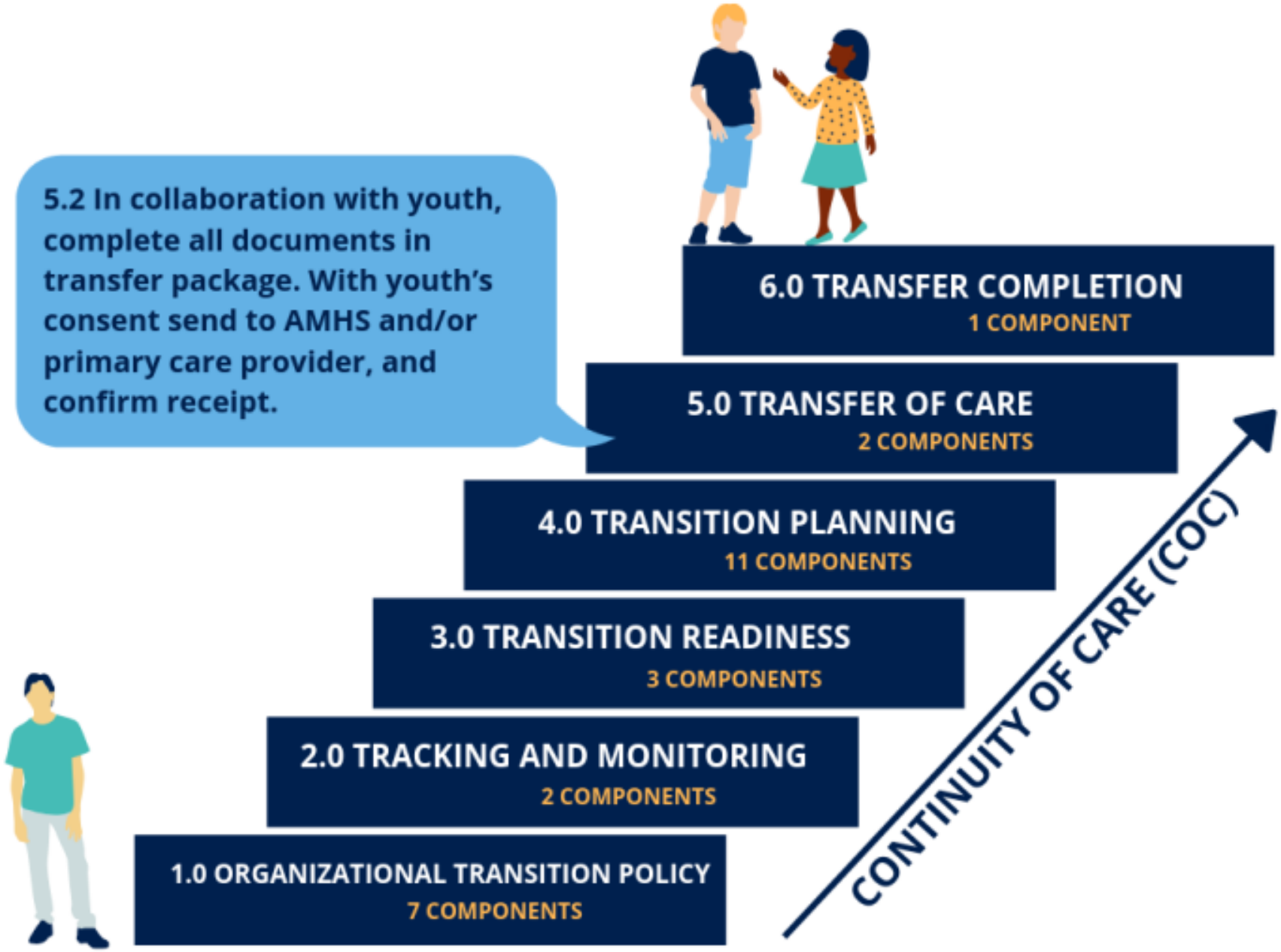
5.2 In collaboration with youth, complete all documents in transfer package. With youth's consent send to AMHS and/or primary care provider, and confirm receipt.
6.0 TRANSFER COMPLETION
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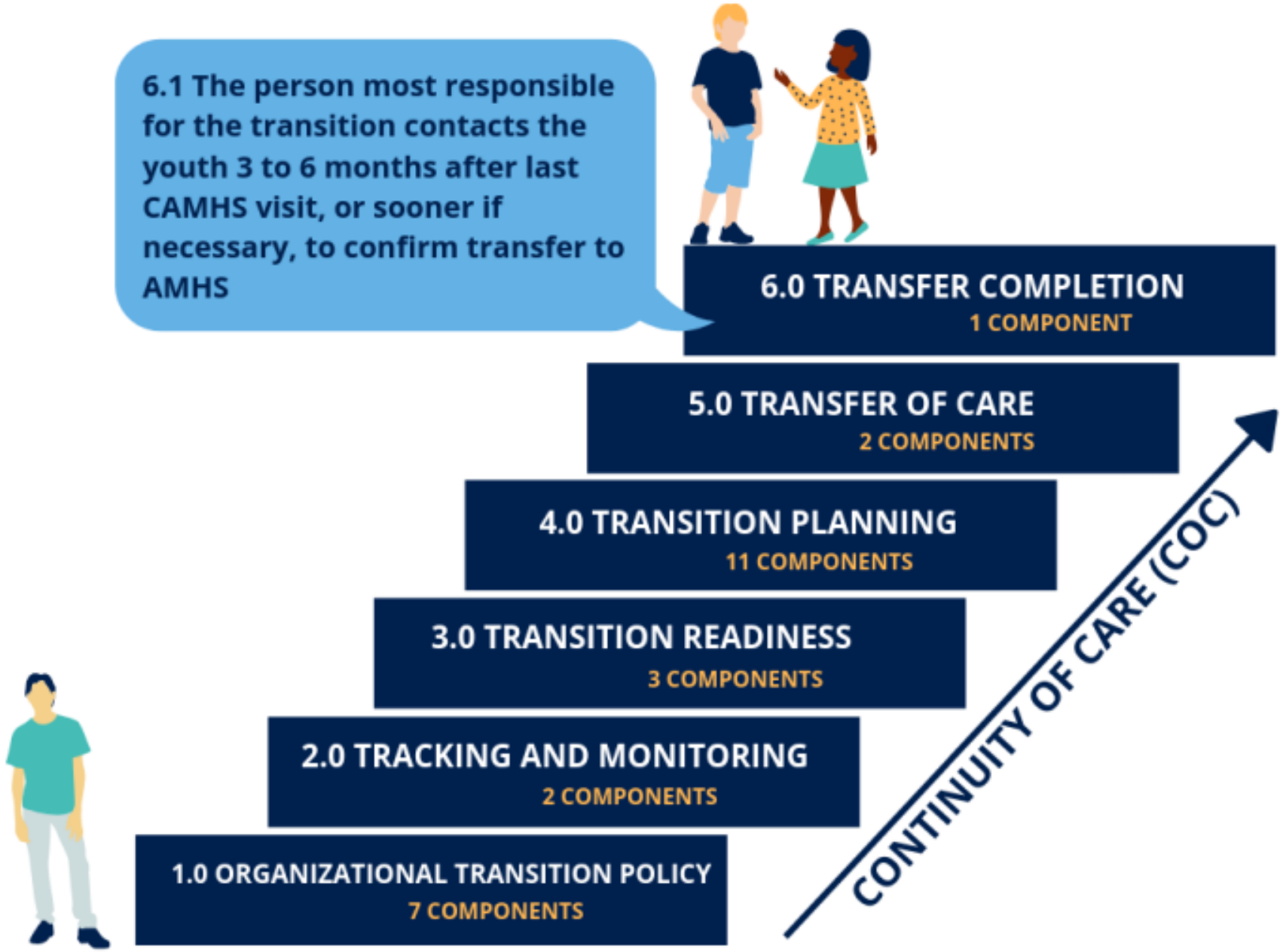
6.1 The person most responsible for the transition contacts the youth 3 to 6 months after last CAMHS visit, or sooner if necessary, to confirm transfer to AMHS
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7 COMPONENTS
CONTINUITY OF CARE (COC)

Developing Core Components

Expert Advisory Committee (EAC)

Project Leads/ Researchers

Kristin Cleverley
Researcher; Principal Investigator

David O'Brien
Principal Knowledge User

Peter Szatmari
Researcher

Kathryn Bennett
Researcher

Lianne Jeffs
Researcher

Joanna Henderson
Researcher

Patient Partners

Joshua Miller
Youth Engagement Initiative (YEI) - NYAC Lead

Jessica Rong
Youth Engagement Initiative (YEI) - NYAC Lead

Lynn Courey
Sashbear Foundation

Emily Rowland
Sibling

Emma McCann
Youth Engagement Initiative (YEI) - NYAC Lead

Knowledge Users (KUs)/ Partners

Kimberly Moran
Knowledge User - CMHO

Antonio Pignatiello
Knowledge User - SickKids

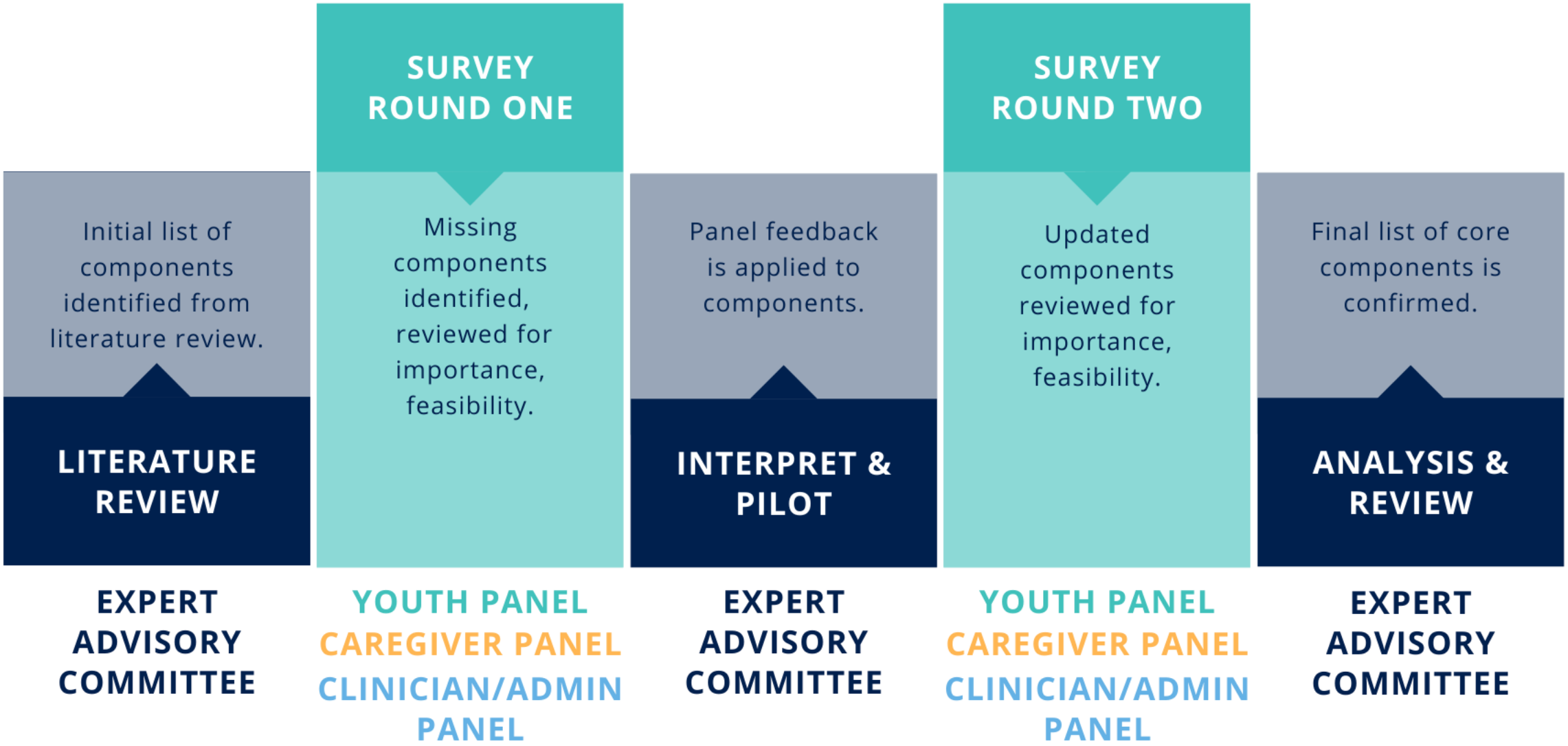
Gloria Chaim
Knowledge User - CAMH

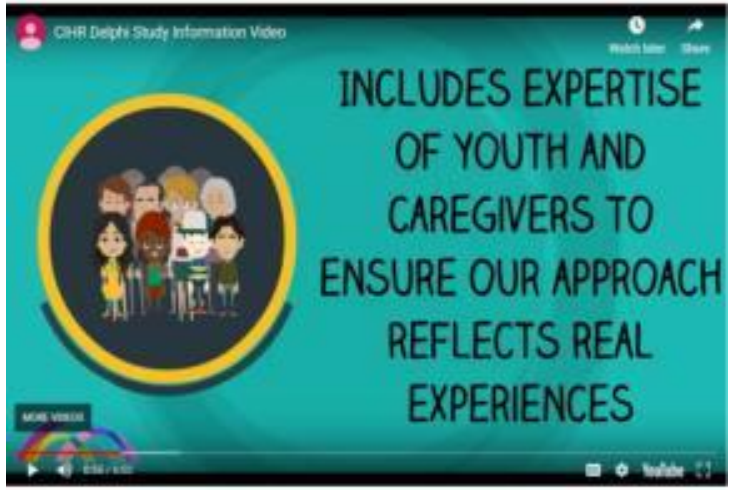
SISC - PSSP
Partner - CAMH

EENet
Partner

CIHR IRSC
Canadian Institutes of Health Research | Instituts de recherche en santé du Canada

Strategy for Patient-Oriented Research
SPOR
Putting Patients First

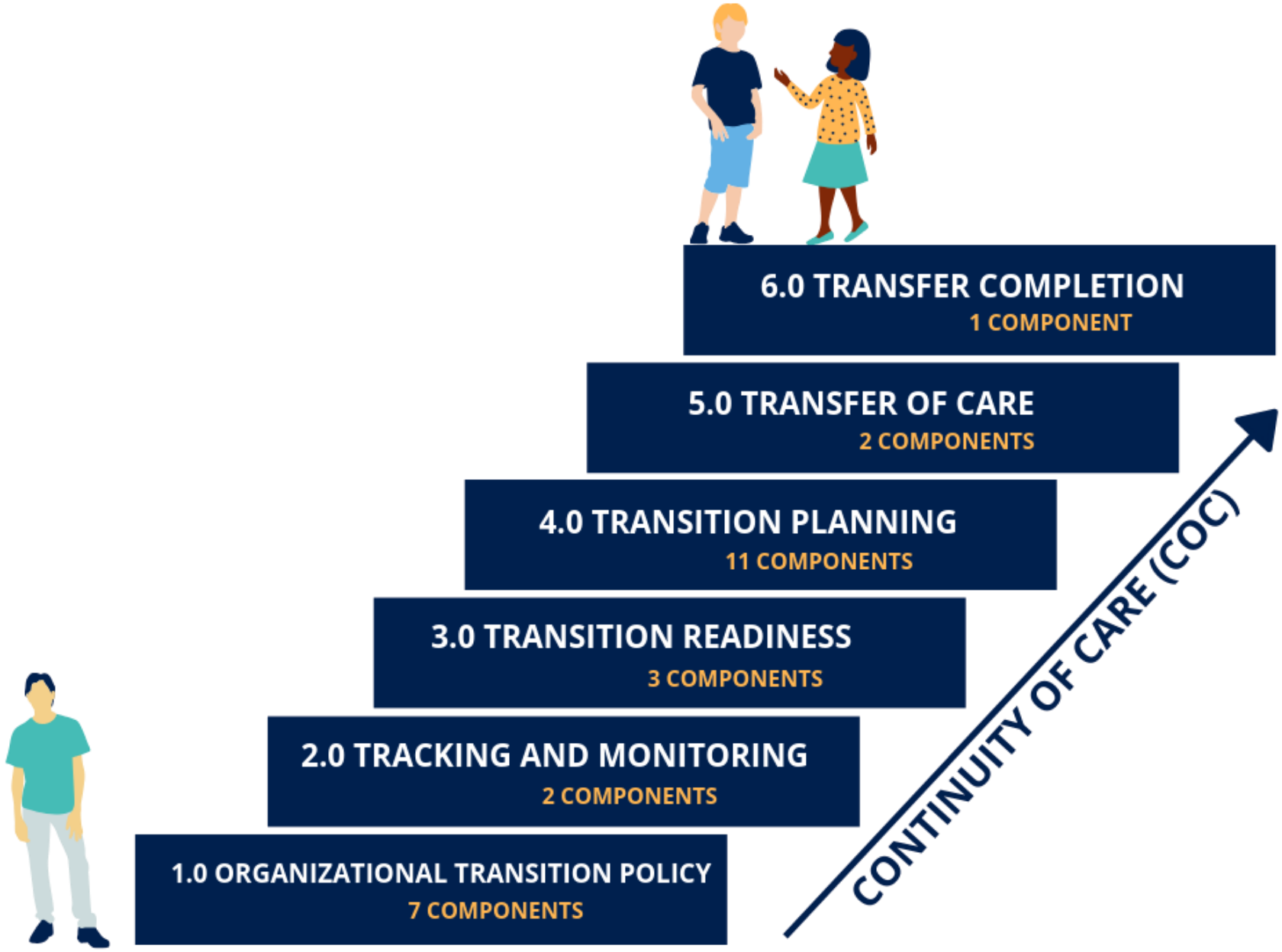

LITERATURE REVIEW
Initial list of components identified from literature review.
EXPERT ADVISORY COMMITTEE
SURVEY ROUND ONE
Missing components identified, reviewed for importance, feasibility.
YOUTH PANEL
CAREGIVER PANEL
CLINICIAN/ADMIN PANEL
INTERPRET & PILOT
Panel feedback is applied to components.
EXPERT ADVISORY COMMITTEE
SURVEY ROUND TWO
Updated components reviewed for importance, feasibility.
YOUTH PANEL
CAREGIVER PANEL
CLINICIAN/ADMIN PANEL
ANALYSIS & REVIEW
Final list of core components is confirmed.
EXPERT ADVISORY COMMITTEE


CIHR Delphi Study Information Video
INCLUDES EXPERTISE OF YOUTH AND CAREGIVERS TO ENSURE OUR APPROACH REFLECTS REAL EXPERIENCES


CIHR Delphi Study Information Video
expert
people that have experience with the mental health transition process
experts


CIHR Delphi Study Information Video
Youth
Caregivers
All groups have equal impact.
Administrators
Clinicians

Original Core Component	Round 1 Revisions	Round 2 Revisions
1.5 Determine clear role for all individuals (youth, caregivers, CAMHS and AMHS staff) involved in the transition process	Determine clear role for all individuals (e.g. youth, **child and adolescent mental health services and adult mental health services staff, peer support workers, transition workers, and family members/ caregivers, if appropriate**) involved in the transition process	Determine a clear role for all individuals (e.g. youth, child and adolescent mental health services and the adult mental health services staff, peer support workers, transition workers, and family members/ caregivers, if appropriate) involved in the transition of care, **informed by the needs of each youth**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CONTINUITY OF CARE (COC)

CLINICIANS
100% HIGHLY IMPORTANT

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

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

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

YOUTH
88.9% HIGHLY IMPORTANT; *94.4%

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

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

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

CAREGIVERS
100% HIGHLY IMPORTANT

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

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

ROUND 2, IMPORTANCE

OUTCOMES	PROPORTION 7-9 SCORE		
	CLINICIANS	CAREGIVERS	YOUTH
1.1			
1.2			
1.3			
1.4			
1.5			
1.6			
1.7			
2.1			
2.2			
3.1			
3.2			
3.3			
4.1			
4.2			
4.3			
4.4			
4.5			
4.6			
4.7			
4.8			
4.9			
4.10			
4.11			
5.1			
5.2			
6.1			

ROUND 2, FEASIBILITY

OUTCOMES	PROPORTION 7-9 SCORE		
	CLINICIANS	CAREGIVERS	YOUTH
1.1			
1.2			
1.3			
1.4			
1.5			
1.6			
1.7			
2.1			
2.2			
3.1			
3.2			
3.3			
4.1			
4.2			
4.3			
4.4			
4.5			
4.6			
4.7			
4.8			
4.9			
4.10			
4.11			
5.1			
5.2			
6.1			

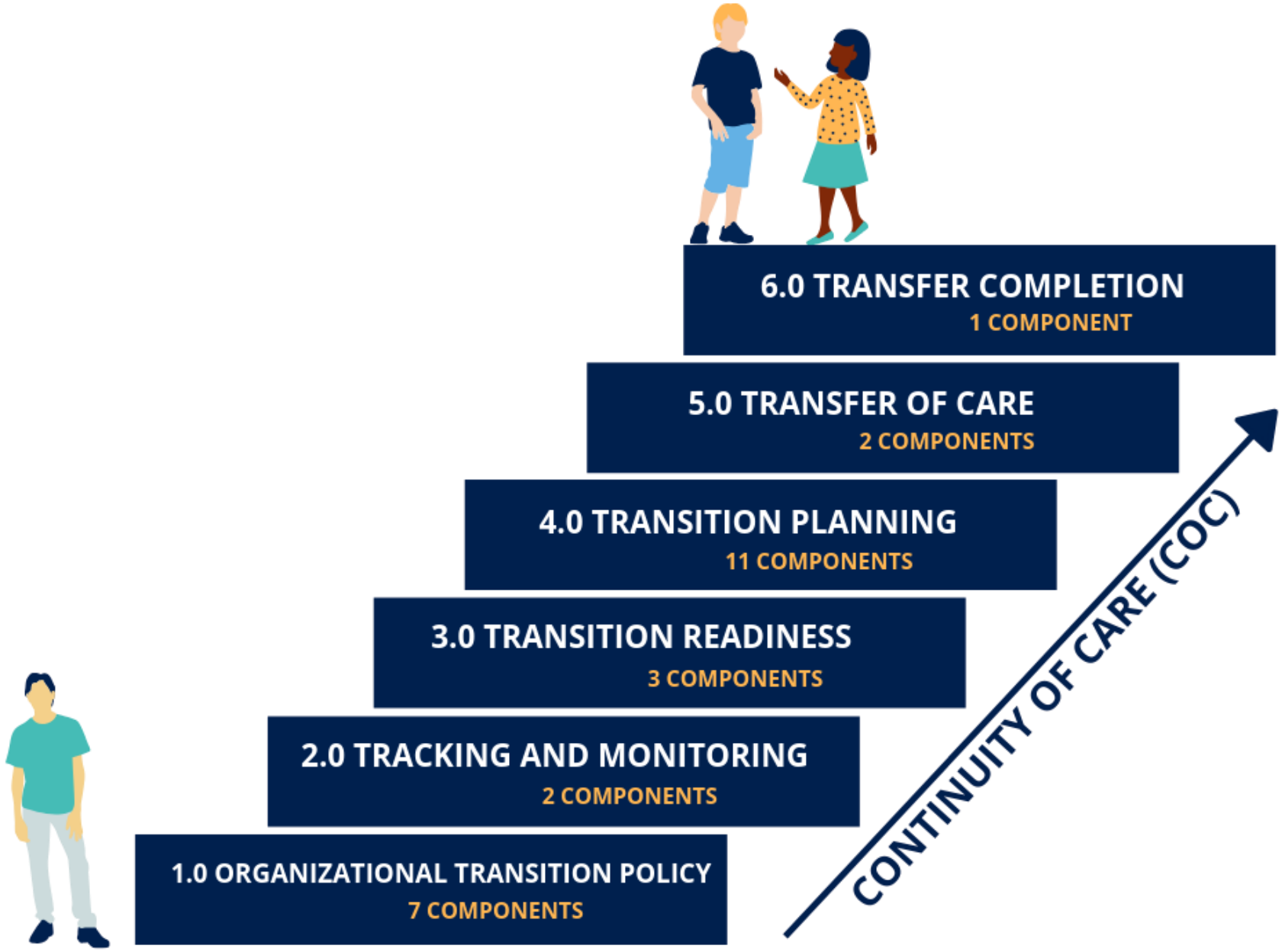
Implementing Core Components

CHALLENGES AND FACILITATORS

in the implementation and uptake of core components

Challenges in Care Transitions

Shifting awareness of the meaning of transition	Ready or not to transition	Mixed reaction to the transitional age of 18	Lack of information, preparation, and involvement in the transition planning process	Confusion around roles and responsibilities within the transition process	Concern over transition gaps leading to poor mental health service outcomes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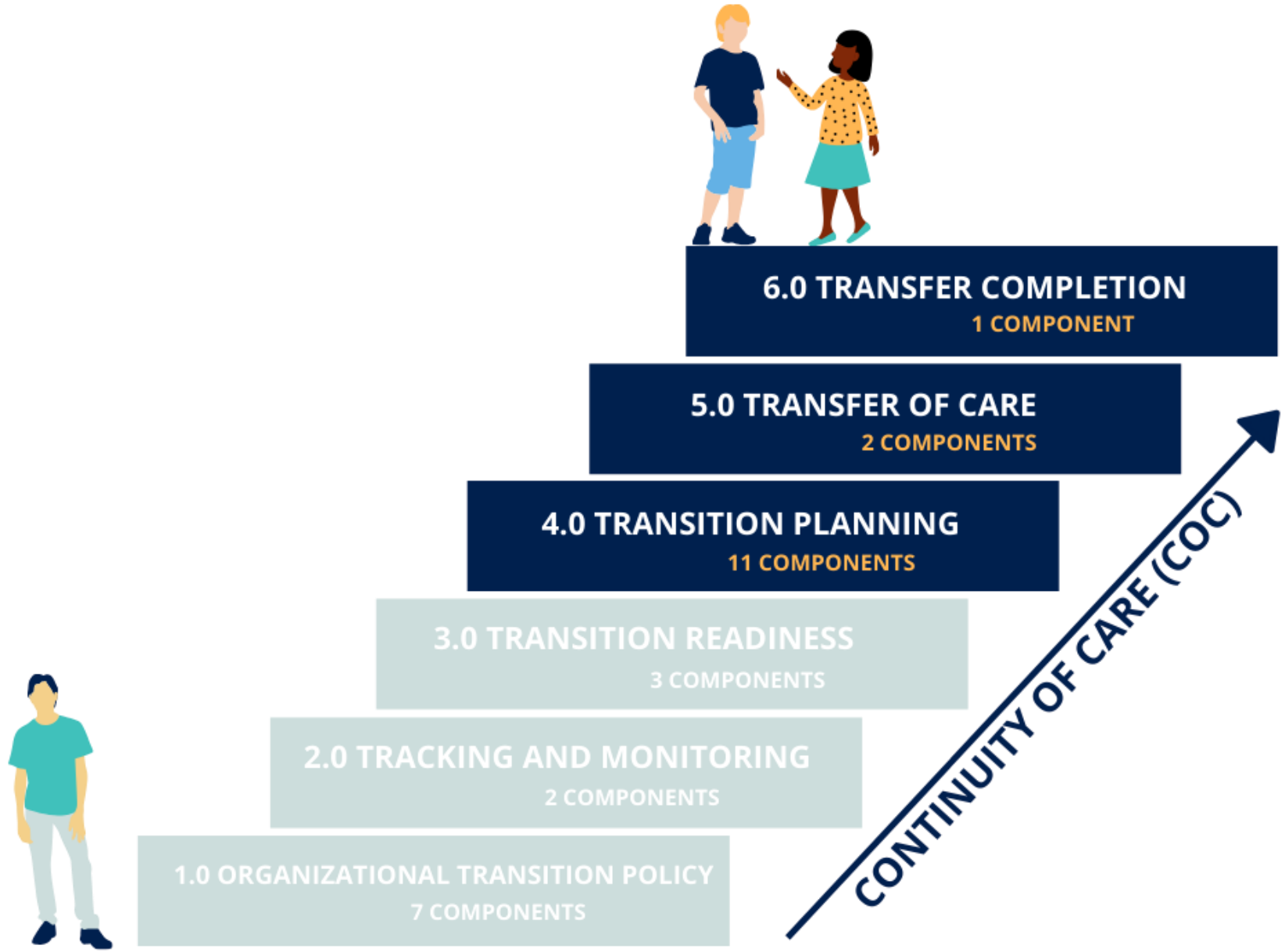
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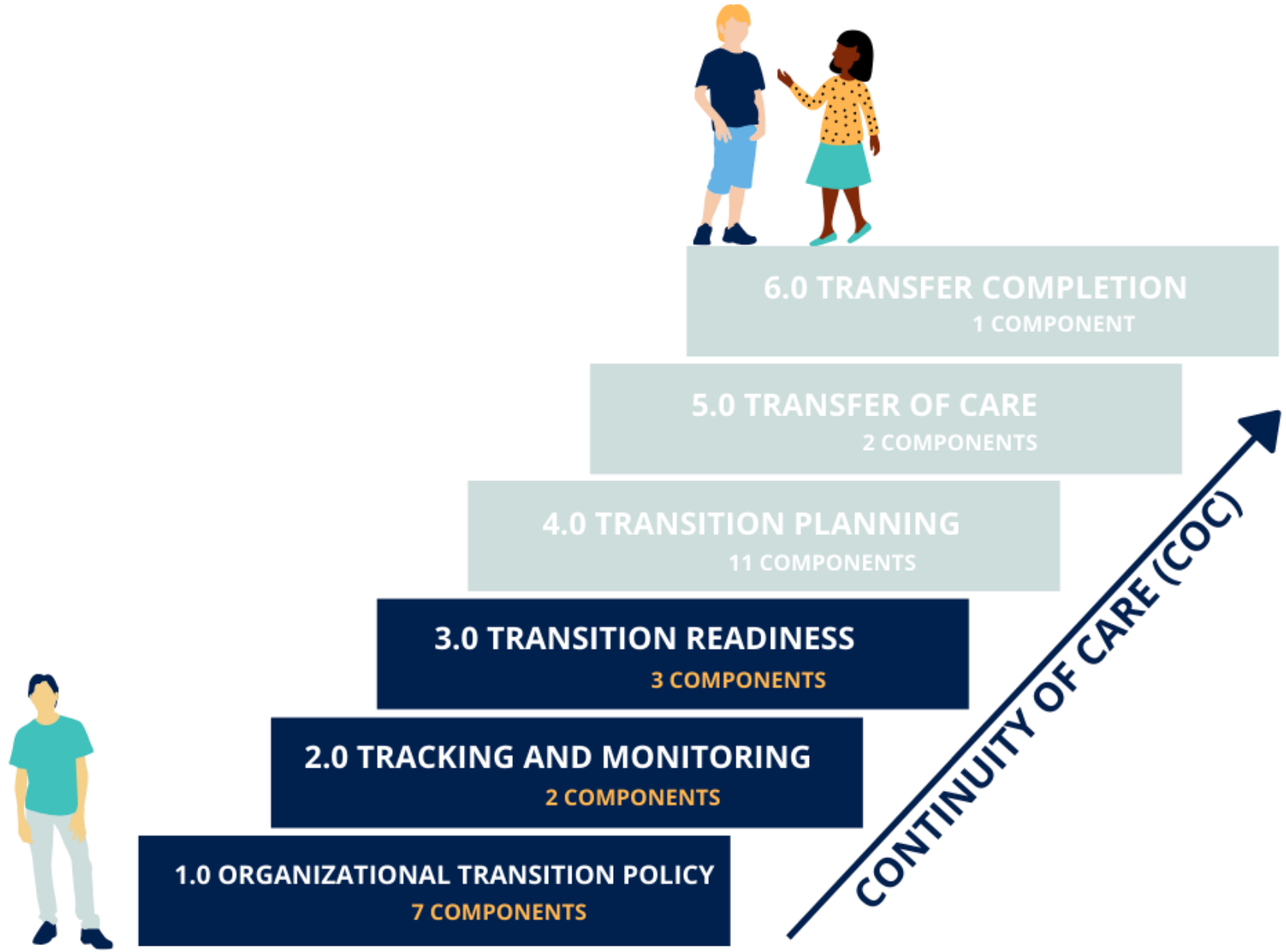
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CONTINUITY OF CARE (COC)

Facilitators in care transitions

- Strategic integration of stakeholder perspective
- Cross-sectoral lens
- Focus on whole community readiness
- Transparency of process
- Equal voice to all stakeholders

5 recommendations for implementation

Components do **not** need to be implemented all at once.

Identifying Components to Implement in Your Setting

Engage with youth, family, and clinicians throughout the process

Consider patient population and intervention components

Include feasibility when selecting indicators

Look to other standards of care - don't reinvent the wheel

Components should be adapted to **suit your context**.

Organizational

Community

Context matters!

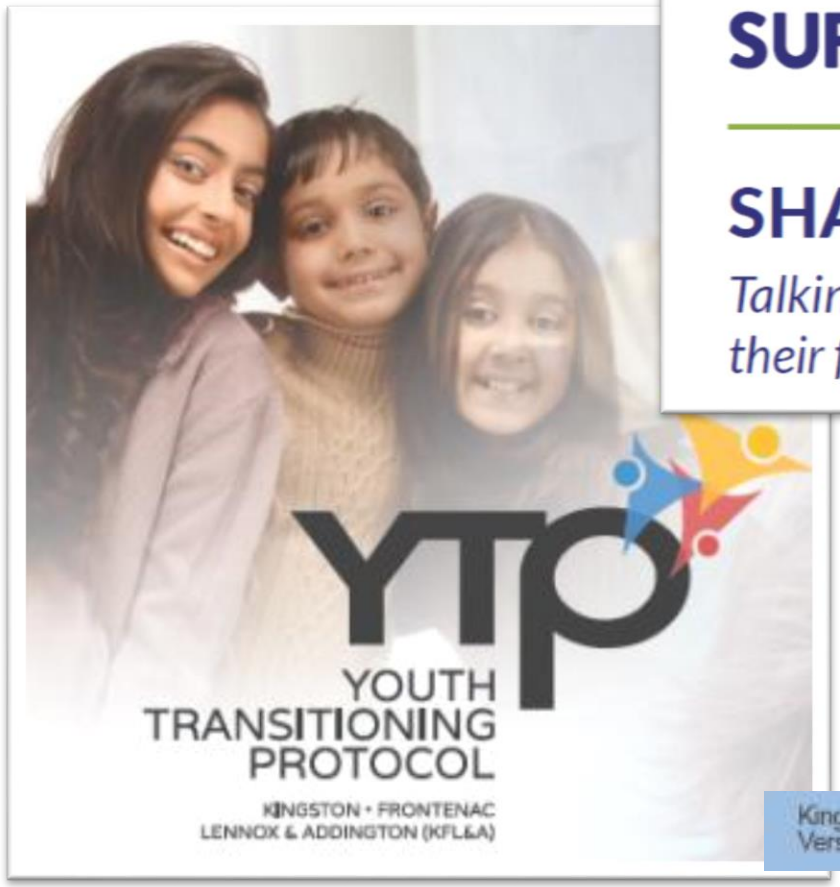
Individual

Global

Transition Protocols

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.

Transition Protocols



SURREY PLACE

Developmental Disabilities
Primary Care Program

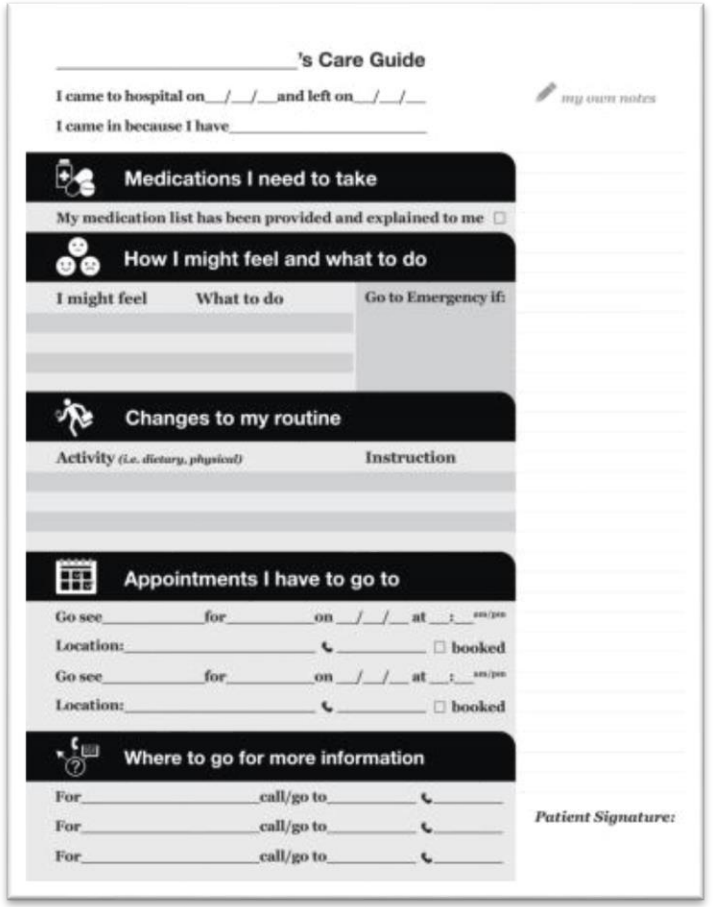
SHARE Transition Plan

Talking about transition with young people with developmental disabilities and their families

Kingston, Frontenac, Lennox & Addington | October 2015
Version 6.5

PODS Discharge Summary

The PODS ToolKit



_____'s Care Guide

I came to hospital on__/__/__and left on__/__/__

I came in because I have_____

my own notes

Medications I need to take

My medication list has been provided and explained to me ☐

How I might feel and what to do

I might feel	What to do	Go to Emergency if:

Changes to my routine

Activity *(i.e. dietary, physical)*	Instruction

Appointments I have to go to

Go see_____for_____on__/__/__ at __:__am/pm

Location:_____ _____ ☐ booked

Go see_____for_____on__/__/__ at __:__am/pm

Location:_____ _____ ☐ booked

Where to go for more information

For_____call/go to_____ _____

For_____call/go to_____ _____

For_____call/go to_____ _____

Patient Signature:

Focus on **readiness** & capacity building.

Care Navigator

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.

Prioritize through policy and **process**.

Transition Policy

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.

got transition | Sample Transition Policy
Six Core Elements of Health Care Transition 2.0

[*Pediatric Practice Name*] is committed to helping our patients make a smooth transition from pediatric to adult health care. This process involves working with youth, beginning at ages 12 to 14, and their families to prepare for the change from a "pediatric" model of care where parents make most decisions to an "adult" model of care where youth take full responsibility for decision-making. This means that we will spend time during the visit with the teen without the parent present in order to assist them in setting health priorities and supporting them in becoming more independent with their own health care.

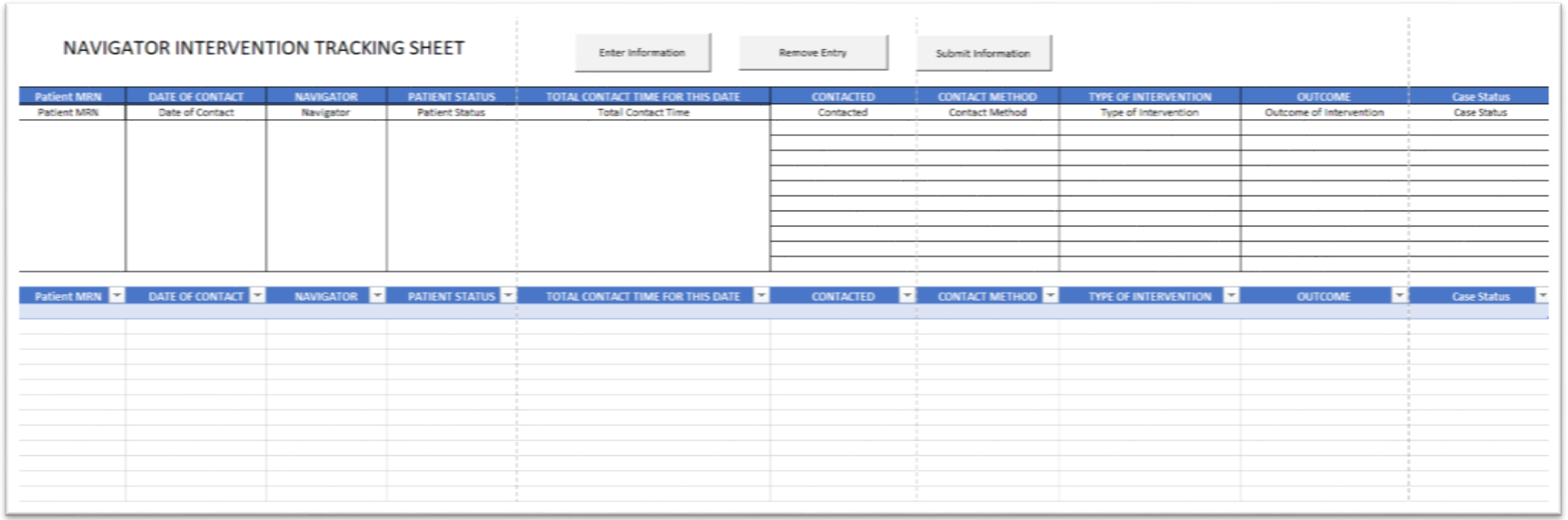
At age 18, youth legally become adults. We respect that many of our young adult patients choose to continue to involve their families in health care decisions. Only with the young adult's consent will we be able to discuss any personal health information with family members. If the youth has a condition that prevents him/her from making health care decisions, we encourage parents/caregivers to consider options for supported decision-making.

We will collaborate with youth and families regarding the age for transferring to an adult provider and recommend that this transfer occur before age 22. We will assist with this transfer process, including helping to identify an adult provider, sending medical records, and communicating with the adult provider about the unique needs of our patients.

As always, if you have any questions or concerns, please feel free to contact us.

Care navigator tracking database

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.



NAVIGATOR INTERVENTION TRACKING SHEET

Enter Information | Remove Entry | Submit Information

Patient MRN	DATE OF CONTACT	NAVIGATOR	PATIENT STATUS	TOTAL CONTACT TIME FOR THIS DATE	CONTACTED	CONTACT METHOD	TYPE OF INTERVENTION	OUTCOME	Case Status
Patient MRN	Date of Contact	Navigator	Patient Status	Total Contact Time	Contacted	Contact Method	Type of Intervention	Outcome of Intervention	Case Status

Patient MRN	DATE OF CONTACT	NAVIGATOR	PATIENT STATUS	TOTAL CONTACT TIME FOR THIS DATE	CONTACTED	CONTACT METHOD	TYPE OF INTERVENTION	OUTCOME	Case Status

Evaluate at every stage.

Care Transition Measures

Core Components Of Effective Youth Transition (CCEYT) Checklist

Element 1. Transition Readiness					
Component	**Strongly Agree**	**Agree Somewhat**	**Unsure**	**Disagree Somewhat**	**Strongly Disagree**
My navigator…					
1.1 **Conducted** regular transition readiness assessments, and, in collaboration with me (and my family members/caregivers, if appropriate), identified my needs and goals and updated them regularly.					
1.2 **Provided** me (and my family members/caregivers, if appropriate) information about what to expect from the program/services where I was being transitioned to.					
1.3 **Developed** an individualized transition plan in					

Care Transition Measures

Navigation Satisfaction Tool (NAVSAT)

Family Navigation Project at Sunnybrook

Part I: Navigation Service

Item	1	2	3	4	5	6	7
1. How satisfied are you with the Navigator's ability to listen and understand your concerns?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely Satisfied
2. How satisfied are you with the information given about potential treatment options for your child/family member?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely Satisfied
3. How satisfied are you with how the Navigator understood the impact of the situation on your family?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely Satisfied

Transition Follow up

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.

Next Steps

cleverleylab

Home Projects Team Resources Contact Us

Our Publications

Our Presentations

Resource Toolbox

Below are some external resources we recommend if you are interested in learning more about youth mental health and healthcare transitions. Clicking on the links will open the resource or website in a new tab.

UNDERSTANDING THE YOUTH MENTAL HEALTH LANDSCAPE +

YOUTH MENTAL HEALTH TRANSITIONS +

GUIDELINES FOR TRANSITIONS IN CARE +

ENGAGING YOUTH AND FAMILY PERSPECTIVES +

POST-SECONDARY TRANSITIONS +

TRANSITIONS TOOLKIT

Operationalizing the Delphi core components in collaboration with youth, caregivers, and clinicians.

IMPLEMENTATION TRAINING

SickKids Centre for Community Mental Health Learning Institute

April 21 & 28, 2021

Health Quality Ontario

Let's make our health system healthier

Transitions From Youth To Adult Health Care Services

KRISTIN CLEVERLEY, RN, PHD, CPMHN(C)

K.cleverley@utoronto.ca
@clevkristin
www.cleverleylab.com

EMMA MCCANN, HBSC

Emma.mccann@utoronto.ca
www.cleverleylab.com

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UNIVERSITY OF TORONTO

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