A TOOLKIT FOR SUPPORTING SERVICE TRANSITIONS IN MENTAL HEALTH CARE

FOR MENTAL HEALTH CLINICIANS

This resource, which brings together evidence from young people, families, clinicians, subject matter experts and research literature, is designed to help you support young people experiencing service transitions. The toolkit:

- **outlines principles of a best practice approach for transitions;**
- **provides a discussion guide for conversations with young people; and**
- **includes a transition journey plan template to use alongside the young person.**

WHAT ARE SERVICE TRANSITIONS IN MENTAL HEALTH CARE?

Service transitions are the purposeful, planned movement of a young person from their current service or provider to a different service or provider, although sometimes transitions in care can happen suddenly. Ideally, transitions should be thought of as a process, rather than an event, and involve collaboration with the young person and their family (or carers) in order to establish meaningful engagement with the new service.(1,2)

WHY DO TRANSITIONS OCCUR?

Many young people experience transitions in mental health care at some point in their life, and for many reasons, including:

- **Step-up and step-down transitions** – these may be due to changes in the acuity of their presentation, including increased or decreased needs for mental healthcare. For example: from inpatient to community-based care, or from tertiary to primary care providers.
- **Age-related** – this is common when transitioning from child and adolescent services to youth mental health services, or from youth mental health services to adult mental health services.
- **Change in eligibility** – a young person might need to transition because they have left a catchment area for services or because they no longer meet a service's eligibility criteria.
- **Clinician changes** – changes within a service, such as staff leave or temporary positions, can affect a young person's care relationship and should be considered a form of transition.
- **Young person's choice** – a young person can also make the decision to move from one clinician or service to seek care with another clinicians or service, for example, if they think that might better meet their needs, preferences or goals for recovery.

UNPLANNED TRANSITIONS

It is not always possible to anticipate when transitions in care will occur. There are times when a young person's needs and circumstances suddenly change, requiring rapid adjustments to their mental healthcare, for example, when a young person experiences an acute period of mental ill-health that requires admission to inpatient care. In cases where transitions occur on a more condensed timeline, open discussions and increased support can still be provided to them and their family to ensure the process is as safe and transparent as possible.

In these circumstances, developing an Advance Statement of Preferences can help support a young person as they can write down the mental healthcare preferences that are important to them if they become unwell and can't make, or communicate, decisions. This can be helpful if they are under a compulsory (involuntary) treatment order.

To develop an Advance Statement of Preferences, visit **Orygen's Your Choices, Your Voice guide here**

Some unplanned transitions are temporary, for example, admission to inpatient care. In these instances, it can be helpful to review and debrief after the experience to understand what worked well, what didn't work well and how the young person and family would like to plan for future changes in care.

WHY IS THIS IMPORTANT?

Transitions in care are recognised as times when there is increased risk of disengagement. When a service transition occurs, it involves a young person moving from a known care environment to a situation that may be unknown. It can require a young person to familiarise themselves with new processes or a new location. They may also feel the loss of valued relationships in which they felt safe. This places a young person in the position of having to form new care relationships, often requiring them to retell their mental health story.(1,2,4–6)

> "You step away from a person with whom you have built rapport, and you have to start all over again. It is tiring, costly, and when handled poorly leaves you feeling disengaged and despondent."

JEMIMA CRAWLEY, YOUNG PERSON.

Young people may also be experiencing concurrent life transitions, for example, leaving school or moving out of home. This can impact their overall capacity to engage in mental healthcare, adding another layer of complexity to a transition in care.(3) Likewise, service transitions have many unknowns and young people may experience challenges with navigating new services, systems and organisational cultures associated with care.(3,4) Young people also describe experiencing system-level, practical challenges such as increases in cost and wait times, and challenges finding a care provider that suits their preferences, such as clinician gender, modality or location.(5)

The disruption and potential discomfort arising from a service transition can negatively impact a young person's perception of care. Specifically, it can weaken a young person's attachment to care leading to short-term or long-term disengagement from care.(7,8) Out of all service transitions, the one that carries the greatest risk is the youth-to-adult mental health transition. It has been estimated that up to 60 per cent of young people experience discontinuity during this transition, resulting in loss of care.(6,7) For young people experiencing mental ill-health, a poorly managed transition can disrupt key developmental milestones and negatively affect their health, social, educational or vocational trajectories.

On the other hand, effective transitional care supports ongoing service engagement, promotes recovery and self-management, and can have lasting positive impacts on a young person's long-term health and wellbeing.

> "Safety created by continuity of care and 'good endings' can counteract the impacts of past attachment trauma, which is common for young people in the care system and those with many episodes of mental health care."

SOPHIE RAK,
MENTAL HEALTH SOCIAL WORKER

WHAT ARE THE CHALLENGES FOR FAMILIES?

Families have described feeling excluded from the process, leading to confusion and anxiety about the transition.(19) There may be changes in how families are involved in the care of the young person and in how they are collaborated with and valued as an information source.(4,19) Once again, this is especially the case in transitions from youth to adult services where families may need to adjust to decreased involvement after the transition, which may lead to feelings of being excluded from discussions or decisions. This can create tension in the care of a young person if there are different expectations of family involvement, or if the young person is not developmentally ready to be as autonomous as the service system assumes they are.(19) Families may also experience challenges in service navigation and knowing what to expect when a young person moves from one service to another.

> "Transition to adult services was extremely difficult for our family. We felt that our young person relapsed as a consequence. Improving pathways with open lines of communication is so important."

JODIE MORGAN,
LIVED EXPERIENCE FAMILY/CARER

BEST PRACTICE IN SUPPORTING TRANSITIONS FOR YOUNG PEOPLE

Supporting transitions in care should focus on planning, continuity, building relationships and supporting autonomy. This approach can improve a young person's perception of a service transition and assist them to remain connected with care.(2)

PREPARING EARLY FOR SERVICE TRANSITIONS

It is important that transitions are planned for as early as possible, and that young people and families are provided the opportunity to be involved. This planning involves:

- Starting preparations early by involving young people and families in discussions about expected length of episode of care and possibilities for ongoing care.
- Engaging with primary care providers as their engagement across service transitions can benefit the young person, family and new services by ensuring continuity.
- Discussing transitions sensitively and openly, and understanding that service transitions can increase anxiety for young people and families alike. Allow ample time for preparation, and encourage families and young people to raise questions throughout the planning process.
- Starting discussions, in the case of transitions to adult mental health services, with a young person and family at least 12 months before the transition age. At this point, options and possible eligibility for services should be discussed and documented, and family involvement reviewed.(20–22) If a young person is unlikely to meet eligibility criteria for their preferred option, it is important to ensure alternative supports are identified and communicated clearly to the young person, their family, and their general practitioner before discharge.

STRENGTHS-BASED

Transition planning and support should be strength-based and use hopeful, empowering language. Conversations should actively engage young people and their families in working towards meaningful goals throughout the transition.(16) This can be done by:

- Exploring a young person's preferences for care early, while acknowledging that their needs might change over time.
- Encouraging a young person to consider what their goals are, and how new services might work best with them
- Considering an Advance Statement of Preferences to ensure their needs and preferences are clearly identified and communicated.

INFORMATION SHARING

It is important that services are proactive in effectively handing over information that is meaningful. This can be done through documentation, phone calls, joint meetings, or a range of other communication channels. Whichever method is used to share information, this should be balanced with confidentiality considerations and the level of involvement that a young person and their family require. Some want their views considered and may want to participate actively in the process of sharing information with a new service.(9) This helps a young person know which parts of their story and treatment history have been shared with a new service, and what they may need to retell.

Helpful tips include:

- Involving young people and families in preparing discharge documentation. This should include key treatment history, goals for treatment and therapeutic modalities trialled (including medication history). An Advance Statement of Preferences can be included in this process.
- Arranging for a warm handover, by a phone or in-person meeting, with the new service provider.
- Ensuring that a young person and their family are aware of the details of a new clinician or service providers, including any emergency or crisis support information,
- Clearly documenting consent and information-sharing clearly, including guardianship details where relevant.(23)

BUILDING RELATIONSHIPS

Taking care to build relationships is important through the transition period. More than other age cohorts, young people place a high value in feeling comfortable with service personnel. Building strong relationships between local services can facilitate easier transitions, and flexibility in approach and availability are important aspects for young people.(10–12) In this respect, it helps to:

- Model communication that is open, transparent and respectful, and encourage self-advocacy by young people and their family.
- Focus on facilitating a positive ending with a service and encourage a young person to be as autonomous as possible in the process.
- Provide opportunities to debrief about how a transition has gone, and any learnings for the clinician, service or young person.

UNDERSTANDING GOALS AND NEEDS THROUGH A DEVELOPMENTALLY RESPONSIVE APPROACH

Service transitions should be contextualised to the young person, their goals, and developmental stage. Service transitions are more likely to be successful when planning is flexible and developmentally appropriate. This involves actively seeking to understand and align with a young person's evolving circumstances, autonomy and personal goals.(13–16) It is important to:

- Clearly communicate a young person's achievements, improvements and future goals with a receiving service.
- Empower a young person and their family to advocate for their needs and preferences.

The Australian Commission on Safety and Quality in Health Care describes principles for safe, high-quality transitions in care. This includes comprehensive and secure record systems to document and ensure access to information about a person's current and ongoing care.(8) This is important for service-level decision makers to consider as part of ensuring safety in their processes and systems that support smooth transitions in care.

RECOGNISING FAMILIES AND SUPPORTERS

Families are an important resource for support during service transitions. If families and supporters are involved, they can provide stable support for a young person over the transition period. This can help protect against disengagement from care,(17,18) which is why it is important to:

- Involve families in transition planning often and early.
- Ensure that families are aware of key contacts of a new service or any other supports that they might be able to access for themselves.

A PERIOD OF PARALLEL CARE

Service transitions will generally involve a young person moving from a known to an unknown care relationship. To ease this change, a period of parallel care should be considered where the care professional from an outgoing service is present, or otherwise involved, in the early stages of care at a new service. (7) Planned overlap helps prevent disengagement from services. (20,21) To this end:

- Don't discharge until a first appointment at a new service is confirmed. At the point of transition, ensure the safety plan is up to date and the young person understands where to go for support.
- Follow up after transition by proactively checking engagement with the young person and/or the receiving service.

DISCUSSION GUIDE AND JOURNEY MAPPING

Service transition discussions can be challenging for young people, especially when they feel they are being redirected at a time when their condition is worsening or becoming more complex. These conversations are not simply an administrative step, but a meaningful part of the therapeutic journey and should be approached with care, sensitivity, and intention. It is important that a young person is ready to receive information, which means discussions should be paced appropriately, introduced early and revisited over time.

This discussion guide and journey map were developed in collaboration with young people and clinicians to help open discussions between young people, families and clinicians, and capture information that all these stakeholders viewed as important for planning a service transition. Using these resources can help young people reflect on their experiences, explore preferences and needs for future care, and clarify what will happen next.

You can use the discussion guide and journey map together with a young person and their family, or start with a discussion and introduce the journey map later.

POSITIVE TRANSITION DISCUSSIONS

The following strategies can be used in establishing positive transition discussions:

- **Considering the timing** – gradually introducing the idea of the transition into sessions can gently ease a young person into the change. Allowing these discussions to occur mid-session allows the conversation to build naturally without leaving it to the end of the session, which risks leaving the young person with unanswered questions. Building transition conversations into multiple sessions helps set expectations, reduce the risk of overwhelm a young person, and support their gradual adjustment.
- **Being respectful and transparent** – clinicians should be clear in explaining the 'why' and 'how' of the transition. This includes being transparent about why questions may need to be re-asked and what information is being shared.
- **Creating safety** – a transition conversation should create space for curiosity, allowing a young person to ask questions, explore the 'why', and express uncertainty without fear of judgement.
- **Acknowledging that it is a big change** – clinicians should openly recognise that transitions can be challenging, disruptive and emotionally demanding. It is important to provide a young person with space to feel their emotions (such as fear, anger and sadness) and have them validated.

You can use the discussion points and prompts below to talk with young people about a service transition. If you feel they may benefit from engaging in a shared and supported decision-making process around their care (for example, selecting a new clinician), see Orygen's Your Choices, Your Voice Guide.

TOPICS	SUGGESTED PROMPTS AND QUESTIONS FOR CLINICIANS	
Introducing transitions Explore feelings and expectations about transitions	I wanted to spend a bit of time today talking about what the next steps in your care might look like. At some point we'll be thinking about transitioning to another service, and I'd really like to hear your thoughts and questions about that. What would you like to know about transitioning or the new service?	I want to acknowledge that changing services can feel like a big shift. It's common to feel unsure about starting with someone new or moving to a new service, especially after building relationships here. How do you feel about the upcoming move to a new service? It's okay if you feel worried. What can we do about any worries you may have?

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TOPICS	SUGGESTED PROMPTS AND QUESTIONS FOR CLINICIANS	
Goals and timing of transition • Timing of the transition • Young person's goals for the next 6–12 months.	I want to talk a little about timing. This isn't something that would happen immediately, but it's helpful to start thinking about it early so we can plan the transition in a way that feels right for you. I want you to be part of this process and I want to understand what a good transition looks like to you. How involved do you want to be in the transition process?	What does the next period of your life look like? (Consider mental health but also study/work, social life/identity, housing/finances.) What is going on outside of your mental healthcare that may influence your preferences for the transition? (This may be things like moving to a new suburb, starting to study.) What are your goals? How have they changed?
Preferences • Young person's preferences and options for new services • Family/carer goals and preferred involvement • Information sharing	Your preferences really matter in planning what happens next, so I'd love to hear what you would like in the next stage of support. What have you liked and disliked about this service? Where will you be living? How can I help you to assess the best services near you? Would you feel comfortable being connected to a [insert service type]? (For example, LGBTQIA+, culturally specific.)	What information do you want me to write down for you to keep and what do you want me to share with the new service? What is your preferred communication style? (For example, text messages, regular calls.) How autonomous do you want to be throughout this process and is your independence changing? How much family involvement do you want going forward? (For example, the same level of involvement or more or less?) Can you tell me a bit more about what you hope this transition will look like?
Readiness for transition • Understanding of condition and treatment • Self-management skills • System navigation • Practical considerations • Building readiness skills	When we're planning transitions, we often talk about a few things that can help people feel more ready. This may be understanding things about their care, managing appointments or medications, and knowing how to access support. We could go through some of those together if that feels okay? (Be led by the young person and what will support them to feel ready for the transition.)	What supports do you currently have? Who can help you through this transition? How would you like to have a conversation with your family about your mental health and the transition? Where can you go for help and future questions?

TRANSITION JOURNEY MAP TEMPLATE

The journey map is intended to be completed over one or more sessions, alongside a broader discussion about the transition. Take the time to explore each section in a way that feels comfortable and relevant to the young person. The aim is for the young person to leave the session with a copy of their completed journey map feeling informed, confident and ready for the next stage of their care.

Why is the transition happening?

When is transition happening?

What has worked for me in care?

What are my preferences?
(e.g. type of therapy, online vs face to face)

What's most important to me?

Mental health goals

Other life goals

What will happen?

What information about me will the new clinician have?

When will I meet them?

PRACTICAL DETAILS

How am I getting there?

Accessibility requirements

Cost

Appointment date

What are my next steps?

MENTAL HEALTH SNAPSHOT

Diagnosis

What we have worked on in our sessions

MEDICATION

Current

What has been tried in the past?

YOUR CURRENT MENTAL HEALTH PROVIDER

Name

Contact details

Address

YOUR NEW MENTAL HEALTH PROVIDER

Name

Contact details

Address

Strength/skills

Key supports

What can I do in an emergency?

PRACTITIONER CHECKLIST

- [ ] Complete transition journey map with young person and provide them with a copy.
- [ ] Book a warm handover (one where you, as the current provider directly introduces the young person to their next provider, for example, via a joint meeting).
- [ ] See **Referral Template here**.
- [ ] Current treating psychiatrist to call future treating psychiatrist (if applicable).
- [ ] Check-in with the young person following their first meeting with the new service.
- [ ] Complete a discharge summary and forward it to the new service, as well as any other treating practitioners (for example, the young person's general practitioner).
- [ ] Send a discharge letter to the young person (and their family, if applicable) confirming that their care has been transferred.

TRANSITIONS TO ADULT MENTAL HEALTH SERVICES

- [ ] Consider completing a transition readiness checklist with the young person, for example, the **Agency for Clinical Innovation's Transition Readiness Checklist**.
- [ ] Consider providing additional information about working with young people to the adult service. (24)

SUMMARY

Transitions in care are periods of increased risk for young people receiving mental health support. A focus on continuity, relationships, communication and autonomy can improve a young person's perception of a service transition and assist them to remain connected with their care. You should have planned, supportive conversations that leave a young person feeling confident and ready for the transition.

RELATED RESOURCES

- **Transtitions in mental health care: A guide for young people**
- **Toolkit. Your Choices, Your Voice.**
- **Smart goals: Building readiness template** - use with young people to develop goals when building readiness for the service transition.
- **Referral template** - supports information sharing between services during a transition.

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