MINISTRY OF HEALTH
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Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/ Alcohol and Other Drugs Services

2014

Citation: Ministry of Health. 2014. *Transition Planning Guidelines for Infant, Child and Adolescent Mental Health/Alcohol and Other Drugs Services 2014*. Wellington: Ministry of Health.

Published in May 2014
by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-478-42803-2 (print)
ISBN 978-0-478-42804- 9 (online)
HP 5860

This document is available at www.health.govt.nz

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Introduction

This document is intended as a guideline to assist District Health Board (DHB) funded Infant, Child and Adolescent Mental Health (ICAMH)[1] and youth-focused Alcohol and Other Drug (AOD) services in the development and implementation of effective transition planning processes for young people who are transitioning from their services. It has been developed by the Ministry of Health to promote consistency of practice across ICAMH/AOD services nationally and to guide services to support young people to transition between services and in and out of services based upon their level of need at that time.

Although to date there has been little research into the benefits of specific models of transition planning, it is widely acknowledged that processes that enable smooth transitions between services and smooth exits from services are important components in supporting recovery and achieving good outcomes for young people accessing ICAMH/AOD services. Adequate planning is a critical factor in a these transitions. Such planning is commonly called 'discharge planning' or 'transition planning'. In these guidelines, we have used the term transition planning because it reflects the intention to ensure a smooth passage into and between as well as out of services.

Transition planning should begin from the point of engagement with the service, and include the young person, their family/whānau and other key stakeholders as active participants.

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/whānau 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/whānau and not service boundaries
- processes are in place to identify and respond early should the young person experience a re-emergence of any mental health or AOD concern
- ICAMH/AOD service resources are used efficiently, with regular reviews of the flow of young people through the services.

An important element of effective transition planning is the liaison between specialist and primary level services, including general practice teams, school-based health services and other first point-of-contact community health services provided by non-government organisations (NGOs). Timely and effective communication is key to this, and for this reason, the transition planning guidelines in this document emphasise the importance of:

- developing an information sharing plan with the young person and their family/whānau early in the engagement process
- sharing relevant summary level information with the general practice team and other agreed primary level service providers:
  - at entry into the service
  - following each scheduled review

[1] Including community, inpatient and residential services.

- at the time of transition from the service
- ensuring that transition planning is undertaken as part of a stepped-care approach to service delivery that allows young people to move smoothly between ICAMH/AOD services and primary level services as part of a seamless and coordinated continuum of care.

The Ministry of Health has an expectation that DHB s and Primary Health Organisations will work together to form Alliance Arrangements with the aim of:

- providing leadership within a health community
- assessing the needs of their populations
- planning and designing health services for their district at a high level, including decisions about prioritisation
- establishing, setting goals for and monitoring service alliances
- identifying opportunities for evolution and service development
- identifying the need for work streams and service level alliances
- solving problems.

Alliances promote integrated resource management, with decisions about health care services being made by all of the relevant professionals and organisations. As such they provide an excellent mechanism for providing leadership to oversee and monitor the implementation of guidelines such as this one. In this instance the aim would be to ensure joint planning and decision making in order to ensure smooth transitions between primary and secondary services for young people experiencing mental health or AOD problems.

All transition planning activities should be undertaken in the context of cultural competence and be cognisant of the needs of Māori, Pacific peoples and families from other ethnicities. This includes incorporating appropriate cultural support to guide the young person and their whānau/family throughout their service journey from engagement through to the time of transition from the service. Keeping the young person and their whānau/family at the heart of the process and letting them guide decisions about transitions will help minimises barriers to accessing the right supports after leaving the service.

In achieving better outcomes for Māori, the concept of whānau ora is gaining recognition for supporting Māori to take ownership and responsibility for their own health and wellbeing. The principles underpinning whānau ora incorporate a systemic and strengths based approach. This would include partnering with the young person and their whānau in the transition planning process, and encouraging the building of networks in the community based on a strong foundation of Ngā kaupapa tuku iho (the ways in which Māori values, beliefs, obligations and responsibilities are available to guide family/whānau in their day-to-day lives).

Young people transition away from an ICAMH/AOD service for a variety of reasons. The most common are as follows.

- They have achieved the agreed goals of treatment/therapy and can maintain their mental health and wellbeing via self-management, family/whānau support and back-up from primary level services as needed.
- They have achieved the agreed goals of treatment/therapy within this service and will be transitioning to a primary level services service for active follow-up.
- They are transitioning to another specialist mental health/AOD service, for example, from an ICAMH service to an adult service, from an inpatient to a community service, from one

community service to a different community service more suited to their needs or because they are living in another location.

- They have decided that they no longer wish to be engaged with this service.
- The family/whānau have decided that they no longer wish for the young person to engage with the service.
- After initial contact with the service (for example, Choice Appointment[2] or initial assessment or telephone screening), it is agreed that the young person will not enter into a partnership with the service because either the service does not consider it can offer what the young person needs or the young person chooses not to engage with the service.

These guidelines are intended to be applicable in each of these circumstances and across a range of service settings. However, transition planning is an individual process that should be personalised to the unique needs and experiences of each young person and their family/whānau. ICAMH/AOD services will need to develop transition planning policies and protocols that incorporate the guidance in this document and address the specific needs of the young people who use their services.

[2] For services that have implemented the Choice and Partnership Approach (CAPA) (Kingsbury and York, 2006).

Background

In April 2012, Prime Minister John Key announced a package of 22 initiatives aimed at improving the mental health and wellbeing of young people aged 12–19 years with, or at risk of developing, mild to moderate mental health problems. These initiatives are designed to help prevent mental health problems developing and improve access to appropriate services if concerns are identified.

The package of initiatives is designed to reach young people in several key settings including: their communities; their schools; their health service; and online. The Ministry of Health has the overall lead on this multi-agency project, with the Ministries of Education and Social Development, and Te Puni Kōkiri each having responsibility for implementation of some initiatives. The package of initiatives will be implemented over a four year period from 2012 to 2016.

These guidelines have been developed in response to initiative 6 of the Prime Minister's Youth Mental Health Project: Improving Follow-up Care of Youth Discharged from DHB Secondary Specialist Services. There are also close links with several other of the Prime Minister's Youth Mental Health Initiatives, including:

- Initiative 3: Youth Primary Mental Health, where funding is being expanded to extend the primary mental health service to all youth aged 12–19 years and their families
- Initiative 5: Primary Care Responsiveness to Youth, where primary level services are being encouraged to develop drop-in services, and funding for Youth One Stop Shops (YOSSs) is being made more secure
- Initiative 7: ICAMHS/AOD Waiting Times, where the focus is on reducing waiting times and integrating case-management systems.

The Prime Minister's Chief Science Advisor's report *Improving the Transition: Reducing Social and Psychological Morbidity during Adolescence* (Office of the Prime Minister's Science Advisory Committee, 2011) summarised the scientific literature regarding ways in which the outcomes for young people could be improved. It points to the importance of an evidence based approach in order to deal with mental health problems and a need for a long-term strategy that is supported by ongoing evaluation. The importance of mental health is highlighted, along with the need to ensure the engagement of primary mental health services to meet the overall need for mental healthcare for this important age group.

The importance of transition planning in achieving positive outcomes for people who use mental health and AOD services has been acknowledged for several decades. The Ministry first published discharge planning guidelines for mental health services in 1993 (*Guidelines for Discharge Planning for People with Mental Illness)*. While the 1993 guidelines focused on the transition of adults from inpatient settings to community services (which is consistent with the move to de-institutionalisation which was predominant within the mental health sector at that time), it nevertheless emphasises the importance of structured processes for planning and facilitating transition from one service to another in order to ensure service users receive the appropriate level and type of services to meet their individual needs.

The Nationwide Service Framework for mental health and addiction services in New Zealand (Ministry of Health, 2012a) sets a clear expectation that transition planning will be an integral part of effective service delivery. The Tier One Service Specification used for all DHB-funded mental health/AOD services stipulates:

> Discharge is a planned process that is part of the recovery plan. It should begin from when the service is accessed. Discharge planning must involve service users and, with their consent, be communicated to all relevant support people. It will include reassessment of risk, the relapse prevention plan and follow-up arrangements. Discharge planning may also include advance directives and will identify medication on discharge and education about this. The Service users, family, whānau and other services and agencies involved should be informed of how to re-engage with the service if required.
>
> Ministry of Health, 2012a, page 11

The *New Zealand Health and Disability Services Standard* (Ministry of Health, 2008), with which all DHB-funded ICAMH/AOD services are required to comply, also clearly expects services to develop effective transition plans, stipulating that service users should 'experience a planned and coordinated transition, exit, discharge or transfer from services' (page 37).

Rising to the Challenge: *The mental health and addiction service development plan 2012–2017* (Ministry of Health, 2012b) sets the direction for mental health and addiction service delivery for the five-year period from 2012 to 2017. A key priority in *Rising to the Challenge* is greater integration and coordination between specialist mental health and AOD services and primary level services, with particular emphasis on developing and strengthening a 'stepped-care' approach.

In a stepped-care approach, services intervene in the least intrusive way across a continuum of primary level and specialist services, enabling entry and exit at any point, depending on the level of need. In order to work within this type of stepped care approach, ICAMH/AOD services will need to ensure that they have effective transition planning processes in place that allow young people to move between their services and primary level services as part of a seamless and coordinated continuum of care. *Rising to the Challenge* further supports this idea by specifying that one of the priority actions for ICAMH/AOD services is to implement transition planning processes that ensure effective hand-over to an identified primary level service provider, with provision for ongoing specialist advice as needed.

Whilst the importance of effective transition planning has been recognised for several decades, no national transition planning guidelines have been developed for ICAMH/AOD services in New Zealand until now. A 2012 Ministry of Health survey identified that very few ICAMH/AOD services currently have written policies or tools to guide transition planning within their services. Similarly, a scan of international literature revealed little in the way of structured transition planning guidelines for adult mental health/AOD services and no specific guidelines for ICAMH/AOD services.

The Victorian Government Department of Human Service in Australia has published some papers relating to transition planning for adult mental health services and protocols for the interface between specialist mental health services and primary level services (Mental Health Branch, 2005a, 2005b; Office of the Chief Psychiatrist, 2002), and these guidelines have drawn on the content of those publications.

The guidelines also draw on information received from New Zealand ICAMH/AOD services regarding current best practice with respect to transition planning processes, and a sector reference group (Appendix I) has provided guidance on the guidelines' content and structure.

While initiative 6 of the Prime Minister's Youth Mental Health Project focuses on transition planning processes for youth aged 12–19 years, it is expected that the principles and guidelines outlined to follow are relevant to services for all age groups who access ICAMH/AOD services (including those younger than 12 years of age).

Principles of transition planning

While current literature lacks empirical evidence for specific models of transition planning, it does highlight a number of good practice principles for transition planning within ICAMH/AOD services.

A structured process that begins at entry	Transition planning is a structured process that begins when a young person first engages with a service and continues for as long as they remain engaged with that service. The service should seek to continually identify and review goals of service delivery with the aim of supporting the young person to progress to a less intensive model of service delivery, including self-care with natural community supports.
Partnership with service users	It is recognised internationally and nationally that health services should actively encourage young people to have a voice and participate in all aspects of planning for their treatment and follow-up. Young people report wanting to have something to aim for to enable them to plan for the future and consider life beyond engagement with mental health/AOD services. Thus, it is essential that services undertake transition planning in partnership with the young person in a way that encourages the young person to have an active voice in developing plans for moving on from the service and the type of services they will access in the future.
Family/whānau involvement	Family/whānau members are important partners in the transition planning process and whenever possible should be actively involved in decisions regarding service transitions. Family/whānau members will usually be the key decision-makers with respect to transition planning processes for children and younger adolescents, with the young person themselves having a greater role in decision-making as they grow older. While young people who have reached mid or late adolescence are able to decide for themselves how much they want their family/whānau involved, a family/whānau inclusive approach should be encouraged whenever possible. If adolescents are unwilling or unable to have their family/whānau involved, consider including friends and other non-family support people in the transition planning process.
Clear, effective and timely communication	One of the most important aspects of transition planning is ensuring that communication is clear between the service, the young person, the family/whānau, primary level services and any other key stakeholders and that this communication takes place in a timely manner. This includes ensuring that the information communicated is clearly documented and relevant to the role and responsibility of the service/person receiving the information and that the young person and their family/whānau agree to the information being shared and who it will be shared with. Services should encourage the use of a strengths-based approach to communicating knowledge and plans and should use service user's wording whenever possible. The management of communications and transitions across the system of care is a significant and essential component of the transition planning process for young people involved with multiple agencies across the health, education and social sectors.

A stepped care approach to service delivery	A stepped care approach to service delivery is one where services intervene in an optimally supportive way across a continuum of specialist and primary level services, enabling the young person to enter and exit the service system at any point depending on the level of individual need. Transition planning within this context should ensure continual review of the required level of service, who should provide the service and whether alternative service providers are available. Plans should be developed to enable timely re-entry into services should needs dictate.
Shared decision-making	Transition planning is a collaborative process of shared decision making involving the young person, their family/whānau and members of the multi-disciplinary team. In circumstances where young people and their family/whānau have involvement across a number of agencies, an inter-agency approach to decision making should be taken.

What makes a difference to us?

Young people's views on supportive transition planning

- It has been a big step for us to seek support, and the thought of leaving a service and coping on our own again can be really scary:

  'Often we feel like we don't want to make a fuss so avoid seeking support. We're very aware of pressures on services to discharge people as soon as possible so that new people can be seen. Make sure any conversation about transition lets us know that we deserve support and services are here for us and will make sure we're well supported.'

- Make sure that transitions don't come as a surprise to us.

  'Talk to us early on and throughout our time with the service about transitioning out. Make these conversations positive, focusing on the support available within and beyond the service and the strength that we have/will gain to be able to cope.'

- If we leave the service before treatment has finished, find out why.

  'We might stop using a service for a number of reasons, such as: our family don't approve, it's hard to get there by bus, we are not happy about what is happening in the service, we've moved to another city, things have gotten a lot worse and it's hard to even get out of bed, appointments are during school hours and our teachers are hassling us, we're worried we're wasting the service's time. If we drop out, ring us and find out why, there might be barriers you can help us overcome to re-engage.'

- Keeping things stable and familiar is so important.

  'If other areas of our lives, such as school, work, living arrangements, relationships, are changing, this can make leaving a service especially hard. Try to avoid transitions when lots of other things are changing in our lives. Link us in with other services, groups or supports early so that these can be a stable factor as we transition out of the service.'

- We might not know what other support is out there – help link us in.

  'Provide information about and referrals to NGOs, GPs, community organisations, peer support, cultural support and family support for mental health or addiction. Also provide us with information for other areas of our lives, for example, education, art, culture, parenting, making friends, sexuality or anything else we're interested in.'

- We feel confident about transitions when we have learnt how to look after our own wellbeing.

  'Knowing about how to keep ourselves well and knowing our families whānau friends, partners or other support people have had education around supporting us really helps!'

- Knowing where to turn to if things do go downhill again is also reassuring.

  'Let us know about re-referral, other support options and emergency support. Help us make a transition plan or 'just in case' plan. Help us set achievable goals for after transition and teach us relaxation and problem-solving skills.'

- It can be daunting moving on to another service – staff can help break down these barriers in the transition planning process.

  'If we are moving on to a new service, have a joint face-to-face or phone meeting with us, our families, friends or support people, and staff from the new service. Make a referral with us so we don't have to make contact by ourselves. Give us written copies of information about available support so we don't forget, and make sure that this includes contact details for the service. Give copies to our families, whānau, friends, partners or support people too if we're ok with this. If there are cost barriers, let us know about financial support, for example, disability allowance. A map and bus timetables to get to the new service can be really helpful, too.'

The process of transition planning

Transition planning should not be a rushed process that takes place during the last one or two contacts with the service. Rather, it should begin when the young person first enters the service and continue throughout their entire time with that service. The young person, and whenever possible their family/whānau, should be at the heart of the transition planning process, driving decisions about their mental health and wellbeing.

In these guidelines, the term 'young person' is used to describe children and youth up to the age of 19 years. For children and younger adolescents, it is expected that the transition planning process will occur in partnership with the young person and their family/whānau, with the parents or legal guardians having the ultimate decision-making responsibility. As adolescents get older, they should be expected to have a greater say in decisions regarding the services that they use, including decisions regarding transition plans. While the family/whānau should be included as much as possible, in some situations, it will be appropriate for adolescents to make decisions about their service use without involving their family/whānau. In determining how appropriate it is for a particular adolescent to make independent decisions, ICAMH/AOD services will need to take account of the age, developmental stage and personal circumstances of that adolescent. The general principle should always be that the best interest of the young person is paramount.

The key transition planning activities for each phase of service engagement are outlined below.

At entry into the service

During the initial engagement period, the key-worker, the young person and wherever possible the family/whānau should jointly agree on the goals for engagement and intervention, including goals and aspirations with respect to moving on from the service. These goals should be reflected in the personal plan[3] that will be used to guide service delivery. Wherever possible, it is also helpful at this early stage to give a broad indication of the likely duration of the young person's engagement with the service. This discussion needs to be conducted with sensitivity, taking account of the length of time the young person has been waiting to access the service, their level of engagement with the service and their personal circumstances.

Very early in the engagement process, issues of consent and confidentiality should be discussed with the young person and their family/whānau and an information sharing plan (outlining what information will be shared and with whom) agreed. The information sharing plan identifies what primary level services the young person and their family/whānau wish to be involved with and how and what information will be shared with these services, for example, whether information will be shared with the young person's school or NGO services and, if so, whether the information will be passed on by the ICAMH/AOD service or by the young person/family whānau.

[3] Services have different names for these plans; they are commonly called: individual treatment plans, individual care plans, recovery plans, wellness plans and partnership plans.

At the point of entry, decisions will need to be made regarding the respective roles and responsibilities of the ICAMH/AOD service and primary level providers with whom the young person and their family/whānau are engaged. In some circumstances, it may be agreed that the ICAMH/AOD service has a consultation and advice role only. In others, it may be that initially the ICAMH/AOD service will be the lead provider with a planned transition to a primary level service. At all times, information should be shared clearly and quickly between services and with the young person and their family/whānau and, wherever possible, the views and wishes of the young person and their family/whānau should be taken into consideration.

It is recommended that ICAMH/AOD services routinely share relevant information with general practice teams unless the young person (or their family/whānau, in the case of younger children) explicitly states that they do not want information to be shared in this way and it is clinically safe not to do so. Ideally, all DHBs should use a secure electronic information system to share information with the general practice team. This ensures that the information is shared promptly, is secure and can be easily incorporated into the general practice electronic clinical management system.

Where the young person is not currently enrolled with a general practice team, the ICAMH/AOD service should provide information about how to do this and the range of general practice services available locally, including youth specific or youth friendly services and low cost options where these exist. ICAMH/AOD service staff should help the young person with the enrolment process wherever necessary.

Specific consideration will need to be given to issues regarding information sharing with family/whānau taking into account the developmental stage and competence of the young person. Whenever possible, family/whānau inclusive practice should be encouraged. However, the personal circumstances of each young person will also need to be considered, particularly if the young person is itinerant or living independent of their family/whānau. Decisions regarding the degree of information sharing with family/whānau should be based upon the general principle that the best interest of the young person is paramount.

Agreement will also be needed regarding information sharing with other key stakeholders such as:

- school-based health services, school guidance counsellors and other relevant school personnel
- other health services that the young person or family/whānau are engaged with, for example, general health services, well child services and other mental health/AOD services
- other government agencies that the young person or their family/whānau is engaged with such as Child Youth and Family, or Special Education Services.

Explicit discussion is also required regarding the circumstances in which the service will share information without the young person's consent, the types of information that might be shared in these circumstances and with whom, and the process for doing this, for example, where there is likelihood of significant risk to self or others or significant risk by others (care and protection issues).

Once the young person's personal plan has been developed and agreed, the service should write a letter[4] to the young person providing a high-level summary of the agreed decisions about:

- the mental health and/or AOD concerns to be addressed during service engagement
- the key goals and activities that will take place, for example, self-management activities, group therapy, individual therapy, medication, etc
- the preliminary goals and plans for transitioning
- the name and contact details of the key worker the young person will engage with and contact details for after-hours crisis services.

In the case of children, this letter will be addressed to the family/whānau, while adolescents will usually receive their own letter with a copy sent to the family/whānau. Copies should also be sent to the general practice team and anyone else agreed to by the young person and/or their family/whānau.

These letters should be written in plain English avoiding medical jargon using strengths based language and be as short as possible, ideally no more than two pages summarising the relevant information – too much detail can be overwhelming for both the young per and the general practice team.

Some young people attend an ICAMH/AOD service for only one session (often referred to as a 'choice appointment' or 'initial assessment') at the end of which either they choose not to engage with the service or the service determines that they are not able to offer the type of services that the young person requires. These guidelines should still be applied to this group of young people, in particular:

- goals and plans for engagement with the service should be discussed and alternative service options considered
- a discussion regarding information sharing should take place
- a letter summarising the outcomes of the initial session should be sent to the young person (with copies sent to the general practice team, family/whānau and other key stakeholders as agreed). This letter should include explicit recommendations regarding alternative service options (including contact details) and self-management strategies/resources.

Sometimes, especially in AOD services, interventions will be brief and time-limited (three or less sessions). In these cases, a single client letter at point of transition from the service, summarising presentation, goals, progress and plans may fit better with the young person's experience of the service, especially if engagement has been the key focus.

If a young person does not attend their first scheduled appointment, the ICAMH/AOD service must actively follow up with that young person and their family/whānau in an attempt to engage with them. The ICAMH/AOD service should also inform the referrer that the young person has not attended the scheduled initial appointment and seek their assistance to make contact with the young person and find out why they have not attended the appointment.

[4] Whilst the format of the letter may vary somewhat for inpatient and residential services, the same principles around providing written information to young people and their families regarding goals and plans for discharge still apply.

Key points

1. Keep the young person at the heart of the process.
2. Transition planning is a structured process that starts at the time of entry into the service.
3. Agree on an information-sharing plan when the young person first enters the service.
4. Agree early in the process on goals and aspirations for transitioning from the service.
5. Define the roles and responsibilities of ICAMH/AOD and primary health care services and, where appropriate, other government agencies.
6. Write a letter to the young person summarising the agreements reached, including preliminary plans and goals for transitioning.

During engagement with the service

Key workers at ICAMH/AOD services should regularly review progress with the young people they are seeing including specific scheduled reviews to assess progress against goals and ensure that personal plans are responsive to changing needs. A key focus of this review process should be identifying what needs to be achieved for the young person to be able to transition from the service and how. As with all aspects of service delivery, the young person should be at the heart of this process, along with their family/whānau whenever possible.

Following each review, a letter should be written to the young person updating progress and summarising any agreed changes to their personal plan. The contents of the letter should be discussed with the young person (or the family/whānau for children and younger adolescents) before it is sent.

A copy of this letter should also be sent to the general practice team and any other key stakeholders (including family/whānau) as identified in the agreed plan for information sharing. There may be times during the period of engagement where additional letters or reports are sent to the general practice team or other key stakeholders, for example, summarising results of formal evaluations or testing, and again, the content of these should be discussed with the young person and their family/whānau before they are sent.

Services should also conduct multi-disciplinary reviews for young people who have been using a service for a significantly longer time than the average for that service. These reviews assess the reasons for the longer service use, identifying whether or not this is appropriate and possible alternatives for supporting the young person to achieve their transition goals.

Key points

1. Keep the young person at the heart of the process.
2. Review progress regularly. Consider what needs to be achieved – and how – for the young person to transition from the service.
3. Write a letter to the young person following each review, and send copies to the general practice team and anyone else listed in the young person's information sharing plan.

Transitioning from the service

Transition from an ICAMH/AOD service is a critical point in the recovery process and, unless carefully managed, there is a risk that it may impact negatively on the mental health and wellbeing of the young person. Whether a young person is transitioning to another mental health or AOD service, a primary level service or self-management, there is a need to ensure that adequate preparation and planning takes place.

As the time of transition approaches, a written transition plan should be developed in partnership with the young person. Whenever possible, family/whānau should also be involved in this process and receive a copy of the transition plan. The transition plan is a written document that can be used by the young person to help them maintain their mental health and wellbeing after they have moved on from the service, and they can share it with other relevant people and services who are involved in supporting them. A copy should be sent to the general practice team and any other mental/health AOD service to which the young person is transitioning. An example template for a transition plan is included in Appendix II.

It is usual for the frequency and intensity of contact between the young person and the service to reduce as the time of transition from the service approaches.[5] The exact amount of time involved will vary depending on the nature of the service, the length of the young person's engagement with that service and the individual needs of each young person.

Where the young person is transitioning to another mental health/AOD service or a primary level service that will have an active role in providing follow-up, there is an expectation that the new service provider will be involved in the transition planning process. The degree to which the new service provider is involved should be dictated by the individual circumstances and needs of the young person and the planned intensity and frequency of contact with that new service (the greater the expected intensity and frequency of contact with the new service, the greater the degree of involvement the new service provider should have in the transition process). The new service provider may be involved in transition planning in a variety of ways, including:

- face to face meetings with the key worker, the young person and their family/whānau
- telephone conversations with the key worker and the young person and their family/whānau
- inter-agency meetings to agree roles and responsibilities in providing ongoing support to a young person who has complex needs and multi-agency involvement.

Ideally transitions between ICAMH/AOD services and primary level services should occur within a dynamic service continuum with decisions based on the needs and wishes of the young

[5] Where a young person's needs are intensifying and they are transitioning to a more acute or intensive service, the frequency and intensity of contact with the service may increase in the period immediately before transfer.

person and their family/whānau and not service boundaries. This should include a system which supports close consultation and liaison between specialist and primary level services. Equally transition planning decisions for young people who have multi-agency involvement across the health and social services (including those with co-existing problems) should not be made in isolation. For this group of young people transition planning decisions should take account of the wider system of care and should be made a part of a joined up cross-sector planning process which puts the needs of the young person at the heart of the process.

A formal transition from the service should only occur after the transition period and after confirmation that engagement with the new service has occurred.

A key element in the transition planning process is ensuring that provision is made for the ICAMH/AOD service to provide some level of advice or telephone support for a period of time after transition (eg, the first three months) should the need arise. This may include provision for:

- the primary level service seeking telephone advice from the ICAMH/AOD service
- the young person re-engaging with the previous service without being re-referred should they experience a re-emergence of any mental health or addiction problems.

Each service will have specific practices and processes in place to formalise the transition process. These should include:

- ensuring that the clinical record includes information regarding transition plans
- writing a letter to the young person (and sending a copy to the general practice team and any other agreed stakeholders) summarising the agreed transition plan and follow-up arrangements
- any other service-specific administrative requirements relating to completing documentation, closing files and measuring outcomes.

Some young people will choose to leave a service part way through an agreed treatment/therapy programme and may or may not inform the service of this decision. Services should have guidelines in place for staff on how to respond in these situations, including making an effort to follow up with the young person in order to understand why the young person disengaged. These guidelines should take into account the young person's level of need and their age and personal circumstances. Where a young person's decision to disengage with a service has not put their safety at serious risk, the key worker should follow usual transition planning processes as closely as possible, including:

- ensuring reasonable effort has been made to contact and re-engage with the young person and their family/whānau
- writing a letter to the young person, formalising their transition from the service, summarising the progress they have made, suggesting options for self-management and inviting them to re-engage with the service in the future should they wish to do so (with a copy of this letter sent to the general practice team and other key stakeholders in line with the agreed information sharing plan)
- updating the clinical record.

It is important that transition plans and letters include details on how to prevent relapses and recognise early warning signs and list the appropriate plans and responsibilities for responding to signs and relapses.

Key points

1. Keep the young person at the heart of the process.
2. Transitions from ICAMH/AOD service require adequate planning and preparation.
3. As the time of transition approaches, develop a Transition Plan in partnership with the young person.
4. When a young person is transitioning to another service, the new service provider should be actively involved in the transition planning process.
5. Write a letter to the young person that summarises the transition and follow-up plans.
6. Make provision for the ICAMH/AOD service to provide consultation liaison support and advice to the new service provider.

Implications for service managers and clinical leads

To develop effective transition planning processes within ICAMH/AOD services, service managers and clinical leaders need to ensure that the following policies and procedures are in place to support staff.

Policies and guidelines	Develop: • transition planning policies and guidelines specific to each service, including transition planning checklists and templates for transition plans and letters • information sharing guidelines, including guidelines for communicating with other professionals • guidelines for actively following up young people who do not attend scheduled appointments and criteria for when and how to transition these young people from the service, ensuring communication with relevant primary level services where appropriate. Ensure that all policies and guidelines are clearly communicated to staff and that staff have the appropriate systems in place to support implementation.
Systems	Develop systems that ensure service user lists are current and updated regularly, with dates of proposed and completed reviews clearly specified.
Criteria	Develop criteria for transitioning to active primary level services follow-up.
Review processes	Implement multi-disciplinary review processes that routinely consider the level of service required, who should provide the service and whether alternative service providers are available and appropriate.
Audits	Conduct regular audits of transition planning processes, including audits of clinical records. Develop processes to ensure that staff receive direct feedback on audit results.
Links to primary level services	Develop mechanisms for effectively linking with local primary level service providers, including seeking feedback from those providers on their experience of how well the ICAMH/AOD service keeps them informed of and involved in transition planning. Develop and maintain a list of local NGO and social support services for young people and their families/whānau.
Electronic information systems	Ensure that electronic information systems are in place to support information sharing with primary level services while maintaining privacy and confidentiality.
Supervision	Ensure that staff are adequately supervised in using their knowledge and skills to provide the most effective treatment/therapy for service users.

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Appendix I
Sector reference group membership list

Liz Carrington	Clinical nurse manager, ICAMHS, Lakes DHB
Dr Grant Christie	Psychiatrist, Altered High Youth AOD Services, Waitemata DHB
Dr Hamish Howie	GP liaison Youth Health/Youth Mental Health, Counties Manukau DHB
Dr Harith Swadi	Child and adolescent psychiatrist, Canterbury DHB
Pip Matthews	Service manager, ICAMHS, Counties Manukau DHB
Robyn Girling-Butcher	Clinical lead, ICAMHS, MidCentral DHB

Appendix II

- Transition planning template: ‘My transition plan’
  (Example appended to be revised in consultation with sector)
- Transition planning checklist
  (Example appended to be revised in consultation with sector)
- Checklist for service managers and clinical leads
  (Example appended to be revised in consultation with sector)

My transition plan

Name: ______________________________

The things that I have been working on:

The things that I have achieved since I first came here:

The things that have supported my wellbeing:

Things I can keep doing to support my wellbeing:

My plans for follow-up with other services after I finish here:

Service name	What they do	Key contact person	Phone number

What I need from these other services:

My early warning signs:

My just-in-case plans:

If I need support, I can contact:

Urgent:

Non-urgent:

My medications:

Medication name	What it does	Dose	How to take it	When to take it

My appointments:

Appointment with	Date	Phone number

Transition planning checklist

To be filed in front of personal record

At entry:	Initials and date of completion
☐ GP contact details recorded	
☐ Information provided re PHO enrolment for those not currently enrolled	
☐ Goals agreed and documented	
☐ Information sharing plan documented	
☐ Summary letter sent to young person	
☐ Copy of summary letter sent to GP and other agreed stakeholders	

During engagement:

Activity	Initials and date of completion	Initials and date of completion	Initials and date of completion	Initials and date of completion
Transition goals / plans updated				
Summary letter sent to young person				
Copy of letter sent to GP / other stakeholders				

At time of transition:	Initials and date of completion
☐ Transition planning meeting with young person and family/whānau	
☐ Transition plan developed	
☐ Meeting/conversation with new service (where needed)	
☐ Follow-up phone call/s to young person (where needed)	
☐ Letter sent to young person	
☐ Copy of letter sent to GP (and other key stakeholders)	
☐ Transition documentation completed	

Checklist for service managers and clinical leads

Activity:	Date
☐ Transition planning guideline reviewed and updated	
☐ Information sharing guideline reviewed and updated	
☐ DNA follow-up guideline reviewed and updated	
☐ Criteria for transition to active primary care follow-up reviewed and updated	
☐ Staff update on policies and guidelines	
☐ List/directory of local primary level services for children and youth updated	
☐ Audit of transition planning processes (including clinical records) completed	
☐ Outcome of transition planning audit fed back to staff	