The UNITE Toolkit

Transition Implementation Workbook

Supporting youth mental health transitions in care

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Acknowledgements

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About the Cleverley Lab

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

The Cleverley Lab is led by Dr. Kristin Cleverley, a Canadian expert in child and adolescent mental health transitions. Using a multi-methods approach to research, Dr. Cleverley works with a team of staff and students to develop and evaluate interventions that support transitions in care across diverse mental health settings. In particular, the Cleverley Lab seeks to improve our understanding of mental health care in order to inform and develop interventions that are proactive, flexible, and efficient.

With extensive collaborations across community and hospital settings, the Cleverley Lab actively partners with youth, caregivers, clinicians, and administrators in all aspects of our work. We lead a research program that produces novel clinical and health system interventions to improve continuity of care for youth with mental illness, addictions, and concurrent disorders.

To learn more, visit www.cleverleylab.com.

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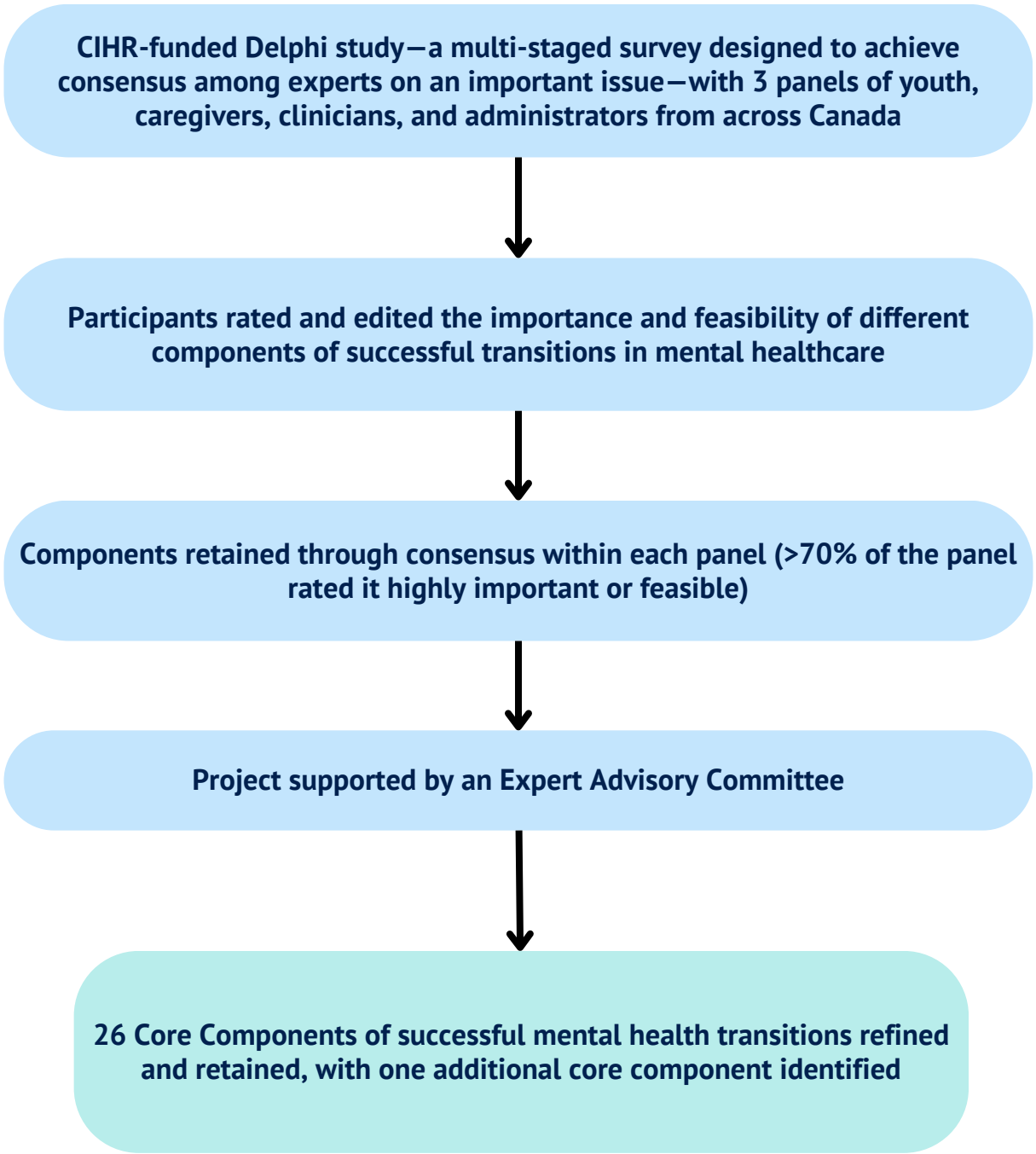
Transition Core Components Development Process

(Cleverley et al., 2022b)

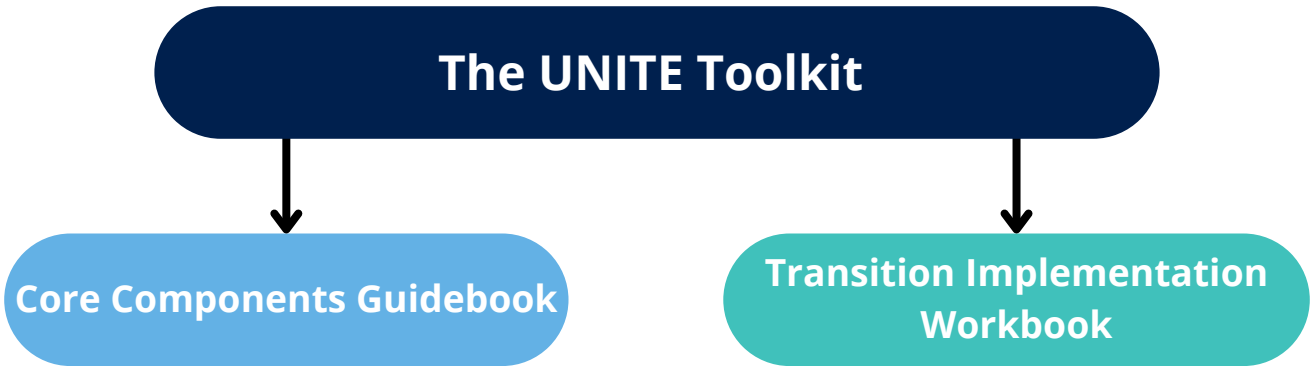


Core Components Dissemination, Application, and Toolkit Development

To date, the results of the Delphi Study (Cleverley et al., 2022b) have been shared with wide-ranging interest-holder groups across Canada and internationally. The research team has also developed and validated, with youth and navigators, the Core Components of Effective Youth Transition (CCEYT) checklist (Cleverley et al., 2020b), which can be used to evaluate the extent to which core components are met from the perspective of youth, caregivers, and navigators. This checklist has been used in a CIHR-funded evaluation of the transition navigator model in child and adolescent mental health services within the Toronto area – the Navigator Evaluation Advancing Transitions (NEAT) study (Cleverley et al., 2021). The integration of the core components in the NEAT study demonstrates their immediate potential as a practical foundation for evaluating and strengthening transition practices within clinical programs.

These requests are in alignment with recent commitments to improving youth mental health transitions by policymakers, such as the development of an Ontario Health Quality Standard on Transitions from Youth to Adult Health Care Services (Health Quality Ontario, 2022), and the Canadian Health Ministers identifying improved transitions for youth leaving child and adolescent mental health services (CAMHS) as a national priority (Government of Canada, 2024; Office of the Auditor General of Ontario, 2016).

In response, the Delphi project team (including researchers, clinicians, youth, and caregivers) developed the **YOUth orieNted Interventions for Transition Excellence (UNITE) toolkit** to support the implementation of the components of successful transitions within interventions and programs. The UNITE Toolkit is made up of the Core Components Guidebook, and the Transition Implementation Workbook (this resource).



Purpose of this Resource

The purpose of this resource is to support the uptake and implementation of the core components of successful mental health care transitions for youth. Specifically, this resource will support healthcare centres, mental health care providers, and youth with the following:

- **Increase knowledge** of the components of successful transitions
- **Support users to define the context** in which they are developing transition interventions, including the facilitators and barriers to be addressed
- **Facilitate uptake and implementation** of the core components as part of a broad transition strategy that considers resources, organizational change, client need, and evaluation from the outset
- **Increase understanding of the transition navigator role** and the interventions navigators can provide, in alignment with the core components of successful transitions

This resource is not meant to be prescriptive. Transition policies and practices vary based on a number of factors, which will be discussed throughout this resource. This resource is meant to be used as a starting place to guide further discussion and development of transition interventions that are fitting for your community. Teams that are aiming to employ the components outlined in this resource should adapt and prioritize their implementation according to the unique needs of the settings and populations they are meant to serve. The Cleverley Lab is currently collaborating with different teams across Canada to appropriately adapt these components based on the unique needs of each setting. The Quality Implementation Framework (Meyers et al., 2012) is currently used as a guide for contextual factors and actions to support implementation, and within a Learning Health Systems approach (CIHR, 2023) to support transitioning knowledge to practice through co-design.

Who is this resource for?

- **Decision-makers**
- **Care navigators**
- **Service provider teams**
- **Youth and family members/caregivers**

Why do youth mental health care transitions matter?

Approximately 1 in 5 Canadian children and adolescents have at least one mental health problem, with up to 70% persisting into adulthood (Solmi et al., 2022). As such, the transition from child (CAMHS) to adult mental health services (AMHS), often mandated at age 18, is widely recognized as a uniquely problematic health systems hurdle (Davidson et al., 2011; Singh et al., 2005; Wilson, 2016). Transitional aged youth who are engaged in CAMHS and require ongoing mental health care are at increased risk of avoidable harm to their mental health and functioning if Continuity of Care (CoC) is not achieved (Islam et al., 2016; Singh et al., 2010). Successful transition from CAMHS to AMHS is contingent on providers supporting CoC, including ensuring patient readiness and care coordination. Unfortunately, the transition process is often a negative experience for youth and their caregivers (Burnham Riosa et al., 2015; Hovish et al., 2012), and as many as 6 of 10 youth disengage from services completely (Singh et al., 2010).

Potential consequences of disengaging from services include increased likelihood of severe and persistent mental health problems, inadequate medication monitoring, and returning to the health care system in crisis (Davis, 2003; Health Canada, 2007; McGorry, 2011). Adu et al. (2022) describe the gap between child and adolescent mental health services and adult mental health services as 'cliffs of care'.

However, mental health care providers are uniquely positioned to continue engagement with youth, foster youth independence, and provide youth-centered care in this crucial transition period (Markoulakis et al., 2023). A systematic review concluded that better continuity of care during transitions was consistently associated with improved functioning, reduced health care costs, decreased mortality, and improved quality of life (Puntis et al., 2015). Therefore, the importance of lessening the negative impact of youth mental health care transitions cannot be overemphasized (Adu et al., 2022).

What is a successful transition?

The transition from CAMHS to AMHS is not a one-time event nor a single transfer of patient information and care between health services or providers. Rather, transition is the process of a well-planned and well-supported move from child to adult services (Singh et al., 2010). This transition support is developmentally appropriate and strengths-focused, and the youth is an equal partner throughout the transition planning process (Cleverley et al., 2020a; Farre et al., 2015; Toulany et al., 2022).

Ideally, the transition occurs gradually with opportunities for the youth to identify and develop self-management skills throughout (Farre et al., 2015). This allows for a smooth transfer of care that continues to address the established care needs. This continuity of care requires a collaborative relationship between child and adult services, and flexibility in meeting the needs of the young person throughout the transition (Singh et al., 2010).

In the case of mental health care transitions, a key goal for a successful transition is **for the youth to be able to maintain (prevent decline of) their current level of symptom management and functioning throughout the transition process** (Cleverley et al., 2021).

Elements and Core Components of Youth Mental Health Care Transitions

To learn more about the core components and associated resources, please refer to the UNITE Core Components Guidebook.

Core components are divided into six categories, or "**elements**", intended to support the transition process from beginning to end. Each core component includes a brief description of the component as well as other resources to support your understanding where relevant. This might include:

- Definitions of keywords
- Linked citations
- References to sections of the Implementation Workbook
- Quotes or notes from expert knowledge users

In many of the components, we describe and link to external resources. These resources provide further learning opportunities and implementation support in alignment with that core component. Resources might include:

- Template examples for forms and agreements that can be adapted or used for your unique care setting
- Guides to help you think through your organization's needs and strengths related to transitions
- Existing tools used to support care transitions in mental health and other types of settings

The Core Components can be found on the next two pages.

Core Components of successful transitions in mental health care settings

1.0 Organizational Transition Policy

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

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

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

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

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

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

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

2.0 Transition Tracking and Monitoring

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

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

3.0 Transition Readiness

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

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

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

Cleverley et al., 2022b

CONTINUED ON NEXT PAGE

4.0 Transition Planning

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

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

4.3 Confirm the adult mental health service eligibility criteria.

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

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

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

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

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

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

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

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

5.0 Transfer of Care

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

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

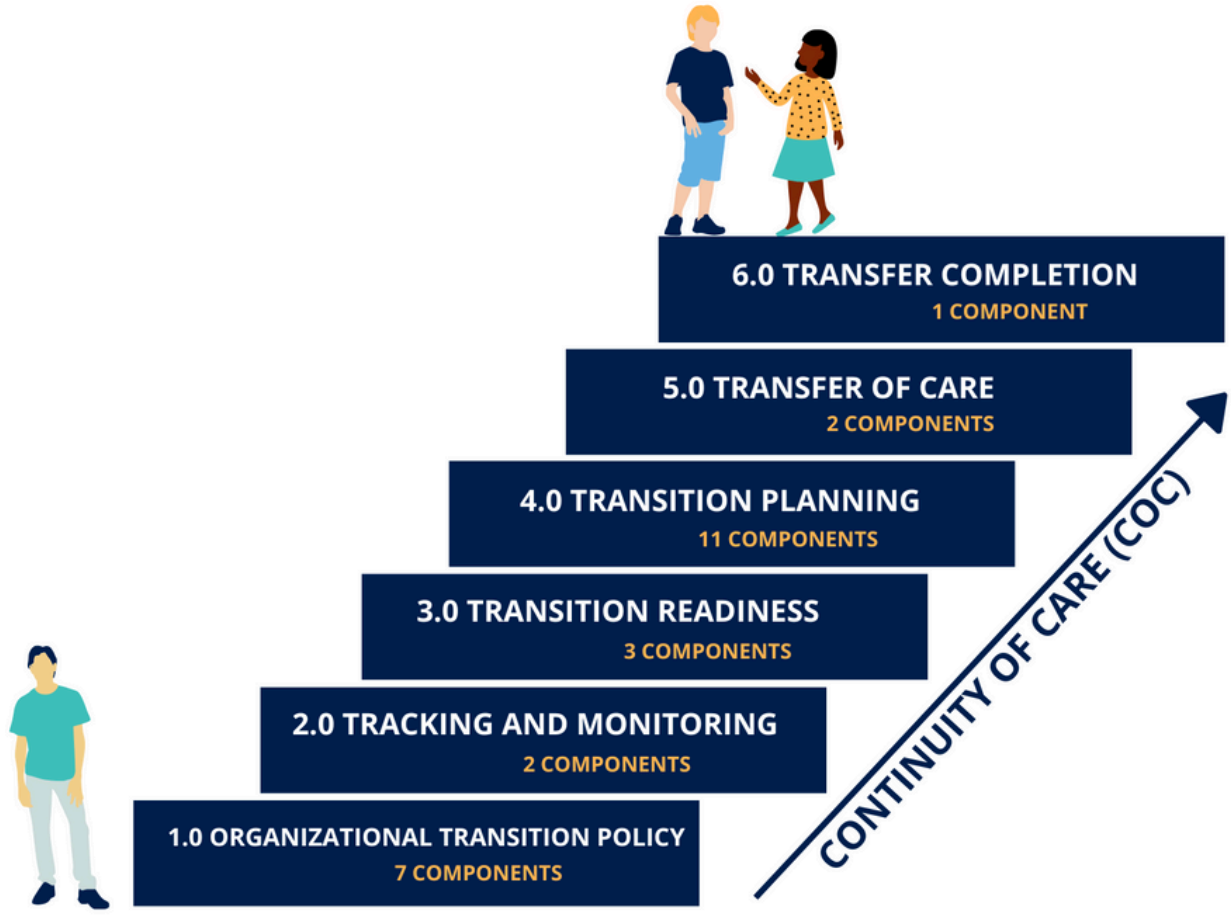
6.0 Transfer Completion

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

1 Implementation at the Organization level

Build a Strong Foundation using the Core Components

Focus on the first three core components (i.e., organizational transition policy, tracking & monitoring, and transition readiness) to ensure your organization has the right frameworks and policies in place to best support transitions. Beginning with these elements, identify the components that are best suited for your organization. From there, you will be better positioned to shift focus to the latter elements that are more individually-driven.



Identifying Components for Your Setting

You don't have to implement every core component in order to facilitate effective transitions. Choose the components that best suit your resources, context, and interest-holder priorities. Use the tips below to identify the components best suited for your organization.

Understand what is most important for your partners.

Youth, family/caregivers, and service providers may all have different perspectives on what a successful transition looks like, and the core components that will best help achieve it. Work with all project partners to better understand the resources that are most suitable.

CLINICIANS 100% HIGHLY IMPORTANT	YOUTH 88.9% HIGHLY IMPORTANT; *94.4%	CAREGIVERS 100% HIGHLY IMPORTANT
1.6 Partner with the youth (and family members/caregivers, if appropriate) at all phases of transition and decision-making	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	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
4.8 With youth's consent, communicate processes with primary care provider (i.e. family physician, nurse practitioner, and pharmacist) to ensure they have consistent up-to-date medication and treatment information	4.2* Collaborate with youth (and family members/caregivers, if invited by youth) to identify adult services that are an appropriate fit	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
	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	

Above are results from the national Delphi survey by Cleverley et al. (2022b), which found youth, caregivers, and clinician/administrators, while agreeing on the importance of the core components overall, may prioritize needs differently when engaged in the transition process. This highlights the importance to consult diverse voices to gain a holistic understanding of your organizational setting.

Consider Your Organization's Context

Before making changes within an organization, it is essential to understand the context in which change will occur and how the context may influence outcomes. Context refers to the environment where change takes place and the people it includes. It can be understood on three levels (Nilsen & Bernhardsson, 2019):

Micro level

- Characteristics of the individual young person in your care
- This includes the preferences, knowledge and needs of the young person's family/caregivers

Meso level

- These are characteristics of the organization and priorities during care transitions
- They may include shared visions and norms within staff, internal resources and patient populations. It also includes beliefs and attitudes about the visible aspects of culture.

Macro level

- These are factors beyond the organization. This includes external programs/services that are receiving services in care transitions, legislation, funding, relationships between organizations and national guidelines.

Care Transition Contexts in Your Organization

Consider a young person going through a "typical" care transition in your setting. Using the space below, think through the different barriers or facilitators at each level that might impact a young person's transition experience.

Micro

Meso

Macro

Care Teams

A care team refers to a multidisciplinary group of health care professionals that work in collaboration to provide care for a patient (Paice, 2011). These teams are made up of a variety of health care members, each with their own role and contribution to promoting positive health outcomes for an individual (Lok et al., 2025; Kuziemsky et al., 2009; Paice, 2011). The combination of these various roles contributes to a holistic approach of delivering health care that can address the different needs of an individual. A list of different health care professionals that might make up a care team to support youth in mental health care transitions is visualized on the next page. Adolescent mental health care teams may closely mirror those of adult mental health service teams.

To promote positive patient outcomes, care team members should prioritize interdisciplinary communication, which involves open dialogue and collaboration among professionals, patients, and caregivers (Nooteboom et al., 2021). Effective communication ensures all team members are aligned, leading to better decision-making and improved patient and family outcomes (Nooteboom et al., 2021).

On the next page are care team members that may be part of a young person's circle of care.

Who might be part of the care team?

Child & Youth Worker
A Child and Youth Worker focuses on the growth and development of children and youth based on direct, day-to-day work in their environments and developing relationships with children, their families, their communities and other inter-disciplinary team members.

Nurse Practitioner
A Nurse Practitioner is a registered nurse with advanced education who provides personalized, evidence-based health care, including assessing, diagnosing, treating, and monitoring various health issues.

Occupational Therapist
Occupational therapists are health care professionals "that help to solve the problems that interfere with a person's ability to do the things that are important to them such as self-care, being productive and leisure activities."

Personal Support Worker
Personal Support Workers provide care to any person who requires personal assistance with activities of daily living (ADL).

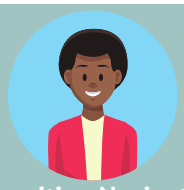
Pharmacist
Pharmacists are the medication management experts of the health care team and collaborate with patients, their families and other health care professionals to benefit the health of Canadians

Psychiatrist
Physicians who provide "psychiatric assessment, treatment and rehabilitation care to people with psychiatric disorders in order to prevent, reduce and eliminate the symptoms and subsequent disabilities resulting from mental illness or disorder".

Social Worker
Social workers work with individuals, families, groups and communities to improve individual and collective well-being. They respond to social issues like racism, poverty and unemployment., and advocate for social justice, human rights and fair access to health and social service

Psychotherapist
A psychotherapist uses counselling and psychotherapy which is "the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth and the optimal development of personal resources."

Registered Nurse
Registered nurses (RNs) are health care professionals who work to enable individuals, families, groups, communities and populations to achieve their optimal levels of health.



Transition Navigator
A professional or peer support worker who assists young people in navigating the transition from CAMHS to AMHS by providing information, guidance, and practical assistance in accessing services and managing their mental health

The role of the Transition Navigator in mental health settings will be discussed in-depth in Chapter 3: The Navigator Model of this workbook.

Who is part of your care team?

Thoughtfully consider, in your present state, the roles and responsibilities of each care team member in your organization during each step of the transition process. Doing so will allow you to identify any gaps in care coverage that may exist in your organization's transition process. Download the fillable copy of this worksheet.

Care Team Member	Before Transition	During Transition	After Transition
Child and Youth Worker			
Family Physician			
Nurse Practitioner			
Occupational Therapist			
Personal Support Worker			
Pharmacist			
Psychiatrist			
Psychologist			
Psychotherapist			
Registered Nurse			
Social Worker			
Peer Support Worker			
Transition Navigator			

Communication

Between Organizations

In order to properly and securely share personal health information (PHI), as is required to facilitate a successful transition, organizations will need to create and sign a data sharing agreement (DSA). A DSA is reviewed by each party's legal representation and privacy office to specify terms and conditions for the collection, use, retention, exchange, or disclosure of data for a defined purpose within a specific timeframe (Healthcare Insurance Reciprocal of Canada (HIROC, 2017). DSAs also specify who owns the data being shared, parameters for maintenance of confidentiality, and steps taken by each party entering the agreement to protect the data during and after sharing occurs, and in storage (HIROC, 2017). Consent should ideally be obtained prior to sharing individual personal information, for example consistent with the requirements of the Child, Youth and Family Services Act, 2017 in Ontario, Canada (Government of Ontario, 2021).

DSAs should include specifications surrounding (Beamish & Barrette, 2019; Parghi, 2020):

- Clear definition of the information to be shared, and the purpose for sharing
- Definition of limited members of staff to have access to and permission to use the data, and imposition of access restrictions
- Implementation of policies, procedures, and safeguards to address privacy and information security, and ensuring these are consistent with current best practices
- Training staff members on privacy and information security
- Regulation of individual user access to PHI
- Implementation of detailed logging and monitoring methods
- Ensuring a protocol is in place in the event of a privacy breach

Template example of a DSA:
https://www.interiorhealth.ca/sites/default/files/PDFS/isa-hcp.pdf

Handover Meetings

One method to ensure continuity of care during a transition is to host a **specific meeting or case conference** with everyone involved in the transition to handover care. The purpose of this "handover" meeting (or series of meetings) should be to develop a shared understanding of the young person's care up to this point, and their continuing care needs (Markoulakis et al., 2023; Paul et al., 2013). The handover meetings may include everyone previously identified as being part of the care transition and is organized and led by the **most responsible provider** at that point in time.

It is important to ensure that youth understand the purpose and goals of the meeting, and that they can choose how they would like to be involved. Note that some young people may want to take part in the handover meeting, while others may prefer that the teams conduct this meeting without them present. Discuss the young person's preference with them ahead of time and ask them to identify if there are specific items or concerns they would prioritize for discussion during the handover meeting.

On the next page you will find a template for an agenda that can be used to guide a handover meeting.

Handover Meeting Agenda

Download the fillable copy of this worksheet.

Meeting Date:

Youth Name:

Referring Mental Health Service:

Receiving Mental Health Service:

Most Responsible Person:

Attendees *E.g., Anyone involved in the transition in care, including youth, child and adolescent mental health services and adult mental health services clinician, transition navigators, and family members/caregivers if appropriate)*

Discussion Items

1. **Review of Referral**
2. **Care History**
3. **Future Care Needs**
4. **Transition Plan Review**
    a. **Roles and Responsibilities During Transition**
    b. **Anticipated Transition Timeline**
    c. **Safety Plan and Alternative Resources**
5. **Next Steps**

Action Items *E.g., Any next steps, deliverables, or tasks that require further action following the meeting*

Next Meeting (if needed):

Important Dates:

Community Partnerships

Using the space below, consider the different partnerships and partnership opportunities that are part of your organization's transition pathway.
Download the fillable copy of this worksheet.

Where do most young people go after leaving your care?

What partnerships exist between your service setting and your community?

What partnership opportunities exist in your community?

Identify Resources

In the previous worksheet, you identified existing transition partnerships and pathways in your organization. Using the space below, consider the different resources that are part of your organization's transition pathway. Reflect on resources that are lacking which will provide you with a starting point to consider how to support organisational readiness and build capacity to support transitions in the next section.

Resource Name	Resource Type	Frequency of use	Possible barriers	Alternatives

Are there any resources that serve a similar purpose? If so, how are they different?

Are there any resource types that are lacking in your community connections?

Supporting Organizational Readiness

Change Management

Change management is defined as practices and processes that are put in place to support people through a change, and to ensure that changes remain successful long-term for all involved (Phillips & Klein, 2023).

Weiner's (2009) Theory of Organizational Readiness for Change is most suited for changes to healthcare organizations that require collective behaviour change by several members. Adopting novel transitional policies into practice can be an example of this kind of collaborative change. Weiner (2009) defines organizational readiness as "organizational members' change commitment and change efficacy to implement organizational change". This theory emphasizes an understanding of organizational members' value of the change (change commitment) and confidence in the organization to implement a complex change (change efficacy).

Barriers

Barriers to change implementation can present themselves in various stages of the process, and can be related to different elements that influence change, including at the organizational, professional, interventional, and external contextual levels (Lau et al., 2016). An important part of change implementation, and ensuring successful care transitions, is having clear and open conversations among teams in an effort to anticipate potential barriers, and how to circumvent them where possible.

Examples of barriers can include ineffective change advocacy, such as improper management of the implementation process or ineffective prioritization (Eisner et al., 2011), inadequate time to plan or properly train staff, or insufficient administrative support (to assist with paperwork processing, data entry, etc.) (DiCenso et al., 2010), and a lack of clarity regarding roles and responsibilities (Yusof et al., 2007).

For further reading, see Weiner's (2009) Theory of Organizational Readiness for Change.

Building Capacity

Successful practice change is an iterative process that will require buy-in from staff across an organization. The Registered Nurses' Association of Ontario (2012) provides a toolkit for implementing their Best Practice Guidelines. These processes can be applied when considering how to integrate the transition core components into your organizational setting.

Examples of facilitators to guideline implementation (RNAO, 2012)

- Group interaction
- Positive staff attitudes and beliefs
- Leadership support
- Champions
- Inter-organizational collaboration and networks

Examples of barriers to guideline implementation (RNAO, 2012)

- Negative staff attitudes and beliefs
- Limited integration of guideline recommendations into organizational structures and processes
- Organizational and systems level change
- Policy awareness
- Integrating interventions into care provision

Knowledge of facilitators and barriers to implementation of guideline-focused change can be applied in conjunction with the Core Components to support youth mental health transitions. For example, in the element Transition Planning, it is recommended to communicate and collaborate with external health care providers, echoing the RNAO recommendations to facilitate inter-organizational collaboration and networks.

Staff Training

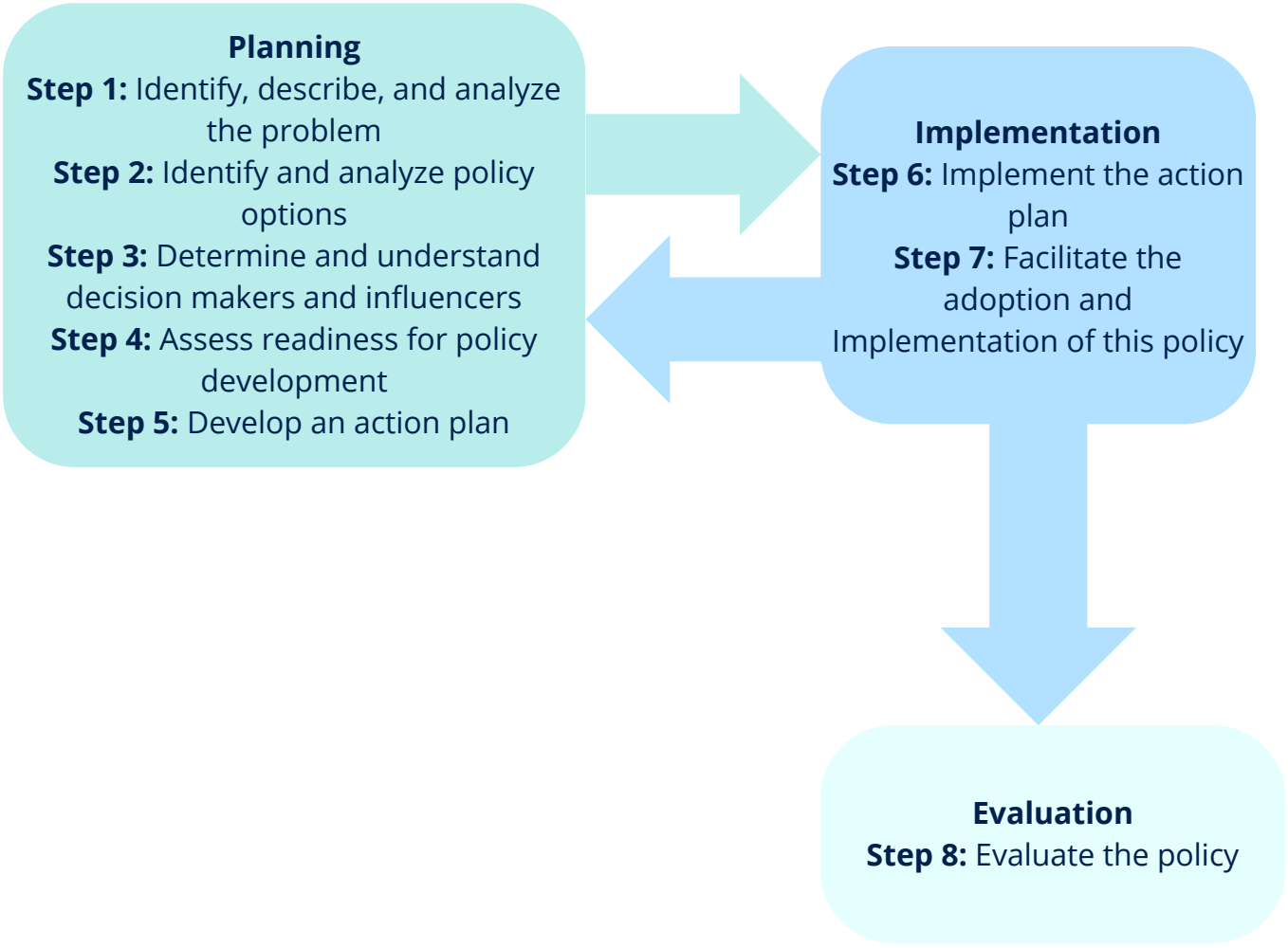
Many child/adolescent and adult mental health professionals lack an understanding of each others' approaches, which is a result of programs that emphasize age-specialized care (Davidson & Cappelli, 2011). Insufficient training and communication result in professionals that feel unprepared to support youth in transition to AMHS, and a culture of mistrust between child- and adult- based providers (Davidson & Cappelli, 2011).

Element one of the Core Components to support youth mental health transitions in care recommends to ensure that all staff have the knowledge, skills and training to effectively support the agency/services approach to transitions.

Building Capacity

Policy & Process

According to Public Health Ontario (2023), building health care policy is a complex process that involves organization, community, and policy-maker partners. This 3-phase process includes defining a problem and potential solutions, knowledge transfer to influence policy outcomes, and implementing and evaluating the policy.



Note: Adapted from "Eight Steps to Building Healthy Public Policies," by Public Health Ontario, 2023.

Also see Public Health Ontario (2018) Supporting Policy-Making Workbook: https://www.publichealthontario.ca/-/media/documents/S/2018/supporting-policy-making.pdf

2 Implementation at the Client level

Patient & Family Engagement

What is Youth Engagement in Care?

Patient or youth engagement is about working with young people as partners in their own care. Through partnering with youth (and their families if desired by youth), care providers can better understand the experiences, needs, and priorities of the individual and work with them to tailor their care (Ontario Centre of Excellence for Child and Youth Mental Health, 2021b). During a transition in care, this can include working with youth to understand what resources and transition pathways are most important to them, and supporting them in developing the skills to advocate for themselves.

What is Family Engagement in Care?

A family can be defined as a circle of care made up of individuals who may be legally, emotionally, biologically or culturally tied to the individual receiving care (Ontario Centre of Excellence for Child and Youth Mental Health, 2021a). Provided that youth have identified family to be significant, families should also have the opportunity to contribute to this process and be engaged in the transition of care.

Families usually play a substantial role in the lives of youth and have significant influence on their development (Ong et al., 2021). For youth living with mental illness, support from family members is especially beneficial in helping to achieve health outcomes, particularly in improvements in functioning and impairment (Haine-Schlagel & Walsh, 2015). Some of the ways in which family engagement can benefit youth patients include: better adherence to treatment, early detection of concerns, more diverse perspective on patient health, better access to mental health services, and better quality of life (Ong et al., 2021). In addition, continued family involvement past transition to adult mental healthcare services is beneficial as transitional age youth often continue to rely on their caregivers even after a transition in care and into adulthood (Markoulakis et al., 2023).

Also see the Ontario Centre for Excellence for Child and Youth Mental Health (2021) Quality Standards for Youth Engagement and Family Engagement for further reading on youth and family engagement at the systems level.

Opportunities for Engagement in Transition Process Design

When engaged at the organization level, youth and families work alongside leadership to inform the approach to mental health care transitions. Youth and family might use their lived experiences to inform how transitions in care can be improved for the broader community. By engaging youth and family, organizations can ensure their policies and practices best address the needs and priorities of the community and that their approach to communication is accessible and youth-friendly. Below we have leveraged the core components to successful transitions to demonstrate opportunities for youth engagement at the organizational level.

Element 1: Organizational Transition Policy	• Collaborate with youth and family in developing organizational policy for transitions (gather feedback from youth and family) • Work with youth and families to develop youth-centred appropriate protocol for transition • Ask youth and families about the skillset/training needed by staff (many identified poor training to be an issue) • Identify roles for both youth and family during the process • Measurement tool that youth and family can complete to evaluate transition protocol
Element 2: Transition Tracking and Monitoring	• Create organization-specific criteria and policies for appropriate transitioning of youth • Establish standard protocol for monitoring transition with youth • Share transition flowsheet and logbook with youth and family to track transition process • Collaborate with youth and family to develop a standardized transition tracker based on what they identify to be the most important points to include
Element 3: Transition Readiness	• Identify and establish organizational standards for transition readiness • Readiness assessment with youth and family prior to transition • Collaborate to identify goals and needs • Create individualized transition plan with youth and family
Element 4: Transition Planning	• Work with youth and family to identify all important people in transition • Collectively work to find the most appropriate adult services to suit the needs of youth • Find the most appropriate time for transition • Complete individualized transition plan • Identify the most responsible person as per the youth and family • Include youth and family in frequent meetings prior to transfer of service
Element 5: Transfer of Care	• Complete all transfer documents with youth and family • Include youth and family in transfer handover meeting
Element 6: Transfer Completion	• Contact youth and family after transfer to ensure transfer went well • Feedback from youth and caregivers about transfer experience • Contact at 3 months and 6 months

Opportunities for Engagement in Personalized Care

When engaged at the individual level, youth and families work with their care team to inform decision-making in their own care throughout the transition process. Actively engaging youth from the beginning of the transition process provides opportunities for them to advocate for themselves and actively contribute to their care and transition. Youth can specify the resources and services that will best suit their unique mental health context. Below we have leveraged the core components to successful transitions to demonstrate opportunities for youth engagement at the individual level.

Element 1: Organizational Transition Policy	• Informing youth and families that an organizational policy exists • Providing youth and families with an opportunity to share feedback on the current organizational policy and what can be improved
Element 2: Transition Tracking and Monitoring	• Share transition flowsheet and logbook with youth and family to track transition process • Create opportunities (or routine meetings) for youth and families to share their transition experience and whether they think it is going well (address concerns) • Keeping the youth and family updated with changes and given them an opportunity to direct the next steps in a way that suits their needs
Element 3: Transition Readiness	• Readiness assessment with youth and family prior to transition • Collaborate to identify goals and needs • Create individualized transition plan with youth and family
Element 4: Transition Planning	• Work with youth and family to identify all important people in transition • Collectively work to find the most appropriate adult services to suit the needs of youth • Find the most appropriate time for transition • Complete individualized transition plan • Identify the most responsible person as per the youth and family • Include youth and family in frequent meetings prior to transfer of service • Identify the most important areas of concern that the youth would want to address in transition
Element 5: Transfer of Care	• Complete all transfer documents with youth and family • Include youth and family in transfer handover meeting • Provide youth and family with updates along the transition process
Element 6: Transfer Completion	• Contact youth and family after transfer to ensure transfer went well • Feedback from youth and caregivers about transfer experience • Contact at 3 months and 6 months

Assessing for Transition Readiness

Transition readiness refers to the knowledge and self-management skills required to function within the adult mental health system (Johnson et al., 2021). Examples of skills required include medication management, scheduling and attending health care appointments, and communicating with health care providers.

The Transition Readiness Assessment Questionnaire (TRAQ) 6.0 was developed and refined as a self-assessment tool for youth aged 16-24 on the management of their health and health care (Johnson et al., 2021). Administering the TRAQ to transitioning youth can demonstrate competency in key skills for entering adult health care.

The TRAQ is divided into four domains related to knowledge of health care: *managing medications, keeping appointment, tracking health issues, and talking with providers*. Specific questions are answered on a 5-point Likert Scale, ranging from '*No, I do not know how*' to '*Yes, I always do this when I need to*'. The Likert scale is based on the five Stages of Change in the Trans-Theoretical model of behaviour change: Pre-contemplative, Contemplative, Initiation, Action, and Mastery. For example, an answer of "*No, but I want to learn*" indicates an individual in the contemplative stage. A higher score indicates greater readiness and ability to negotiate the adult health care system.

The TRAQ is a valid tool to assess the transition readiness of youth in outpatient mental health services, found through psychometric evaluation (Cleverley et al., 2023). The full questionnaire can be found on the next page.

Resources

TRAQ 6.0

This resource is a 20-item measurement-based tool to objectively assess adolescent and youth's understanding and readiness for transition into adult health care.

Transition Readiness Assessment Questionnaire

(Wood et al., 2014; modified with permission)

Directions: Please check the box that best describes your skill level in the following areas that are important for health care transitions. There is no right or wrong answer and your answers will remain confidential and private.

Managing Medications	No, I do not know how	No, but I want to learn	No, but I am learning to do this	Yes, I have started doing this	Yes, I always do this when I need to
Do you fill a prescription when you need to?					
Do you reorder medications before they run out?					
Do you explain any medications (name and dose) you are taking to health care providers?					
Do you tell your health care provider whether you followed their advice or recommendations?					
Do you speak with the pharmacist about drug interactions or other concerns related to your medications?					

Appointment Keeping					
Do you call your health care provider's office to make an appointment?					
Do you follow-up on referrals for tests or check-ups or labs?					
Do you arrange for your ride to medical appointments?					
Do you call your health care provider about unusual changes in your health (for example: allergic reactions?)					

CONTINUED ON NEXT PAGE

Tracking Health Issues	No, I do not know how	No, but I want to learn	No, but I am learning to do this	Yes, I have started doing this	Yes, I always do this when I need to
Do you fill out the Medical History Form, including a list of your allergies?					
Do you keep a calendar or list of medical and other appointments?					
Do you contact your health care provider when you have a health concern?					
Do you make or help make medical decisions pertaining to your health?					
Do you attend your medical appointment or part of your appointment by yourself?					

Talking with Providers					
Do you ask questions of your health care provider about your health or health care?					
Do you answer questions that are asked by your health care provider or clinic staff?					
Do you ask your health care providerto explain things more clearly to you if you do not understand their instructions to you?					
Do you tell your health care provider whether you followed their advice or recommendations?					
Do you explain your health history to your health care providers (including past surgeries, allergies, medications)					

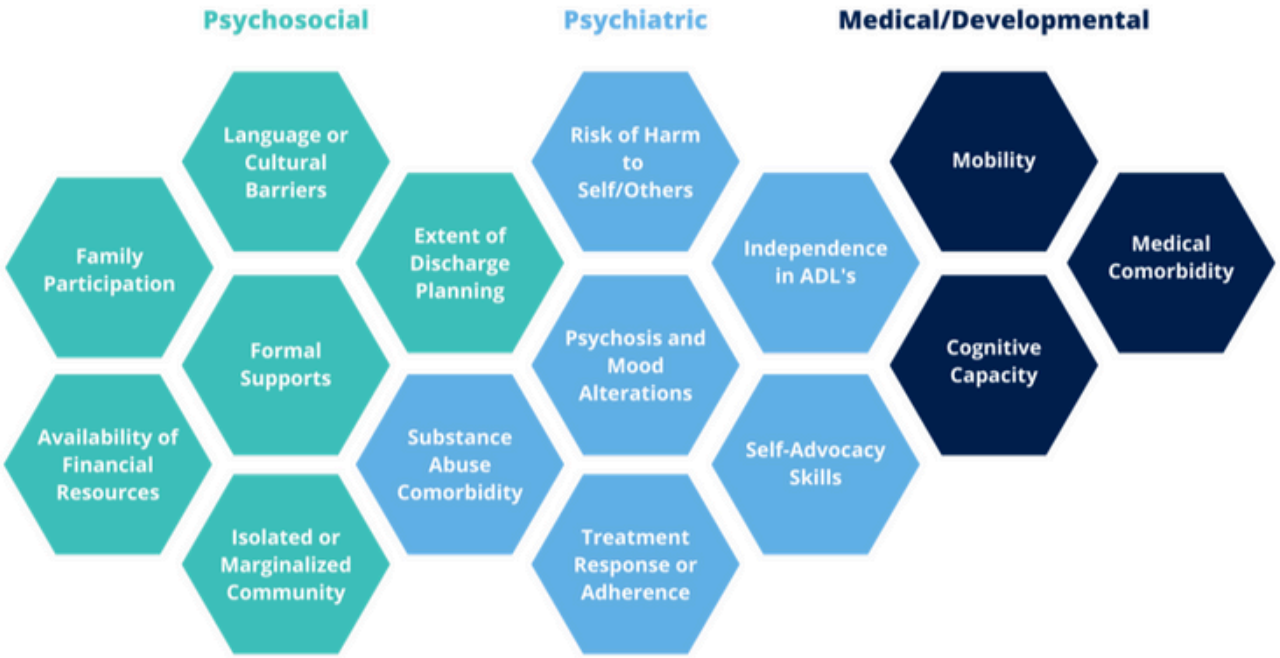
Complexity

In youth mental health, **complexity** refers to the combined and interacting challenges relating to the young person's mental and social needs, care providers' capacity to engage and respond, and service system structure (Orygen, 2021). Complexity can manifest in various ways, such as co-morbidities, multimorbidities or a history of trauma or adverse life events (Manning & Gagnon, 2017).

Mental healthcare has also been described as a complex adaptive system, as the clients, providers and organizational structures interact dynamically (NASEM, 2018). Complexity here arises when youth mental healthcare is impeded by the system's structure, which includes multiple providers and services (Gask & Coventry, 2012). For example, the clinician's confidence and competence working with youth, or the infrastructure for communication between different health services may be sources of complexity (Orygen, 2021).

Overall, the concept of complexity underscores the importance of tailored mental health care that responds to the diverse and interconnected factors affecting youth mental health and well-being. highlights the need for personalized and collaborative approaches to mental health care that address the interconnected and diverse factors that contribute to mental health and well-being (Durand & Fleury, 2021).

See below potential sources of complexity at the individual level for youth.



What does this mean for transitions?

While the concept of 'complexity' in mental illness and mental health is not always well defined (Kapustianyk et al., 2024), there are potential sources of complexity in mental health care that may impact the transition experiences of the youth and families you work with. Below we identify some examples of sources of complexity at the level of the youth.

Psychosocial complexity: Youth may experience barriers to continuity of care during the transition period that are related to factors such as culture, gender, language, financial resources, rurality, among others. For example, youth and families experiencing unaddressed language barriers experience problems with care coordination and incomplete discharge instruction (Arya et al., 2024; Flores, 2020; Platter et al., 2019). Interpretation services are often under-utilized and clinicians need training and education to support their regular use (Arya et al., 2024; Jimal et al., 2022). At the organizational level, implementing policies and education programs on the use of interpretation services can then support more effective transitions at the point of care.

Psychiatric complexity: Psychiatric complexity can arise from multi-morbidity (i.e. experiencing multiple diagnoses at the same time), experiencing serious mental illness such as psychosis, or co-occurring substance use. Psychiatric complexity can also be a result of symptoms that are resistant to usual treatment, high use of services and resources, or safety concerns such as suicidality. These factors may impact where youth will be able to access adult care, or it may also qualify them for specific programs (e.g. Early Intervention in Psychosis programs).

Medical and Developmental Complexity: Complexity may arise from the presence of co-occurring medical conditions or developmental disorders which may impact the treatment or management of the individual's health and well-being. For example, youth who experience mobility issues may face challenges in accessing adult mental health services due to geographical, transportation, or physical barriers.

Vignette - Aisha

Review the case study on page 73 for full details on this case.

What about Aisha's case adds complexity for the care team to consider?

What are Aisha's psychosocial concerns? Psychiatric concerns? Medical and developmental concerns?

Are there anticipating complexities for Aisha navigating the mental health care system?

Complexity in Your Setting
Using the space below, consider...

What does a typical patient look like in your setting?
Consider age, diagnosis, culture, family involvement, and other characteristics.

What are some factors at the level of your workforce (clinicians and other team members) as well as the healthcare system which may interact with youth characteristics to create more complex transitions in care?
Consider things like clinician confidence in transitions care, access to mentorship and supervision, case load demands, existence of referral pathways, etc.

How will your transition policies and practices need to change to reflect the specific complexities of your population, workforce, and service system?

Resources

Working with complexity in youth mental health
We suggest referring to this resource on complexity in youth mental health developed by Orygen to help guide your reflection on different sources of complexity.

Journey Mapping

Reflecting the complexity of health care systems, journey (or process) mapping is a project to document and visualize the patient's navigating experience (Davies et al., 2022). The visualization of sequential events in a patient's health care experience shows the actual pathway or process of care (Joseph et al., 2023; Trebble et al., 2010). Journey mapping can help providers understand, from a patient-centred approach, the facilitators and barriers to effective health care (Davies et al., 2022). The exercise of journey mapping most often involves these steps: preparation and planning, data collection, mapping the information with the appropriate method, data analysis and problem solving, and finally redesigning the patient journey (Bulto, et al. 2024; Trebble et al., 2010).

A scoping review by Davies et al. (2022) found 8 justifications for patient journey mapping. As a clinician supporting youth in mental health care transitions, the following may be relevant reasons to use patient journey mapping when working with youth in transitions:

- Inform health service redesign/improvement
- Evaluate continuity of care across health services and regions
- Understand how people are navigating health systems
- Develop a deeper understanding of a person's entire journey through the health system(s)

A visual example of a journey map depicting a youth accessing and transitioning through mental health services is depicted on the following page.

JOURNEY MAPPING EXAMPLE

Child Adolescent Mental Health Service

APPROACHING AGE 18 OR CUT OFF AGE IN <6 MONTHS OR YOUTH NEEDS

DECISION POINT: Are services still needed past 18? Does the youth still want to continue services?

Yes

Transitions outside the organization

Coordinate and facilitate transfer of accountability, set up with navigation services if available

Discharge from current CAMHS

Transitions within the organization

DECISION POINT: Which service within the organization is most appropriate for this youth?

Transitional Aged Youth Services for older youth

Transition Navigation Services

No

Interventions focused on self-management skills, understanding how to access care, develop safety plan, provide resources for re-access to care

Discharge from CAMHS when ready

CONSIDER:

- 'Soft' transition points. Does the organization allow for a few post-discharge sessions?
- Is the youth currently receiving other services (e.g., Primary Care Provider)?

Create your own patient Journey Map.
Download this worksheet.

Using the space below, draw out the typical pathway of a youth who transitions from child adolescent mental health services to adult mental health services. Identify key pain points and facilitators at each stage to help understand the journey from a patient-centered approach.

3 The Navigator Model

The importance of having a "Most Responsible Person" through the transition

As part of the care team, the designated "most responsible clinician" who is the primary contact person throughout the transition, ensures **continuity of care**, and acts as the coordinator of the transition in care. This person may or may not be the same individual as the "most responsible provider," who is the physician or other registered health professional that is responsible for overseeing the treatment and care of the patient or client while they are receiving care within your organization. This person may be the youth's child and adolescent mental health services clinician or the organization's **transition navigator** (Cleverley et al., 2018) .

The Transition Navigator

A **transition navigator** is a registered health professional who has expertise in transition coordination and case management, who provides short term support (often 1-6 months) during the transition period (Cleverley et al., 2021). They work with youth (and family member/caregivers, if appropriate) and members of the clinical team to identify needs post-discharge as well as goals for transfer of care. They have a strong understanding of community programs and resources and are able to work with youth to identify and connect with appropriate services. They continue to provide support and are a point of contact for the youth post-discharge and throughout the referral or access process to AMHS or other appropriate services. They may also provide psychoeducation and some short-term bridging therapeutic support while the youth is between services.

Included on the next page is a short scenario depicting roles a transition navigator may be responsible for within the transition process.

Navigator Vignette

Alex, a 16-year-old female admitted to the child and youth inpatient psychiatry unit for to active suicidal ideation. Alex is newly diagnosed with major depressive disorder (MDD). The inpatient team refers Alex to the transition navigator.

As part of facilitating Alex's transition out of the hospital, the Transition Navigator:

- Goes to meet with Alex on the inpatient unit to get to know her, discuss Alex's goals, and start assessing her transition support needs.
- With Alex's consent, calls Alex's parents at home and continues her assessment and creates a transition plan.
- Returns to the inpatient team and discusses possible community service options that would be appropriate for Alex.
- Reaches out by email to a couple of community services to confirm their eligibility criteria and updates the transition plan.
- Speaks with Alex and her parents regarding community service options, providing education about the available services.
- Based on Alex's discussion, moves forward with starting the referral process to a youth community centre and updates the transition plan.
- Prior to Alex's planned discharge, goes through the completion of Alex's safety plan with her, and reviews her discharge and transition plan in order to make sure Alex doesn't have further questions before she leaves hospital.
- Speaks with Alex over the phone to make sure she is prepared for the first community centre appointment and has everything she needs.

The Navigation Process

Building on the identified need for a "most responsible person," our team co-designed the Navigator Model. This model has previously been evaluated in hospital-based child and adolescent mental health settings (Cleverley et al., 2021; Cleverley et al., submitted). It has been adapted for the post-secondary context in collaboration with students and is currently being evaluated for its effectiveness in facilitating transitions from hospital-based mental health care to campus (e.g., the NavigateCAMPUS study, see Cleverley et al., 2025).

IDENTIFICATION

1. CAMHS clinical team identifies youth requiring transition support & discusses case with navigator through: a) joint clinical rounds or b) referral to navigator

PRE-TRANSITION

2. Initial appointment with navigator (prior to discharge from CAMHS) including initial discussion and prioritization of transition goals and assessment of transition readiness
3. Navigator liaises with CAMHS clinical team and caregivers/family supports (if applicable) to further assess transition and ongoing service needs post-discharge
4. Navigator confirms level of need and options for receiving services (e.g., primary care, community mental health services, campus Health & Wellness clinics) and initiates conversation with potential services
5. Navigator acts as liaison between CAMHS clinical team and receiving services to ensure all necessary information (e.g., clinical/treatment history, medication management, plan for ongoing services)
6. Navigator continues to meet with youth and CAMHS team prior to discharge. Navigator addresses transition readiness needs with youth, and develops plan in partnership with youth for:
   - Crisis management & safety planning
   - Identifying resources for interim period between discharge and initiating receiving services

POST-TRANSITION

7. Post-discharge, navigator provides ongoing brief psychological support and psychoeducation to youth through as needed and iaises with receiving services to monitor when services will be initiated
8. Navigator supports youth through initial meeting with receiving services as needed (warm handover, supporting youth with attending initial appointment)

Navigator Interventions

An initial list of navigator interventions was developed through a literature review on best practices for facilitating mental health care transitions. This included core elements identified as essential for facilitating successful health care transitions from child to adult mental health services (Cleverley et al., 2020b). Transition navigators reviewed and refined this list based on their experiences working with clients. Their feedback included validating interventions identified from the literature and modifying language describing certain interventions for clarity. The finalized list was incorporated into a clinical tracking Excel database (see page 62 for more information), enabling navigators to document the interventions used for each client.

On the next 6 pages are examples of what navigators report their interventions are, and the related core components of successful mental healthcare transitions. These interventions are reflected in our downloadable clinical tracking database that can be adapted and used in your own setting.

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Intervention	Transition plan – Needs assessment
Description	To develop a transition plan, begin by assessing and identifying the needs of the youth. This involves determining the appropriate services for them and identifying the health management skills they need to develop or enhance in order to transition successfully to AMHS.
Core Component	Component 3.1- I conduct regular transition readiness assessments, and in collaboration with youth (and family members/caregivers, if appropriate) identify youths' needs and goals, and update them regularly.

Intervention	Transition plan – Create
Description	Collaborate with youth and if applicable, their family members or caregivers involved in the transition process, to create the transition plan, which is a living document outlining the goals of transition, individual care needs, and interventions throughout the transition process.
Core Component	Component 3.3- I develop individualized transition plans in collaboration with youth (and their family members/caregivers, if appropriate) a minimum of 6-months before planned transition, or as early as possible.

Intervention	Transition plan – Share documents with patient/caregiver
Description	Share all pertinent information regarding the youth's transition, including relevant documents, to both the youth and, if applicable, their family members or caregivers engaged in the transition process. For example, this can involve providing them with details about the referring agency and a list of community resources that the youth can access.
Core Component	Component 3.2- I provide youth (and their family members/caregivers, if appropriate) information about what to expect from adult/community/outpatient mental health services. Component 4.9- I 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. Component 4.10- I 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/community/outpatient mental health services, withdraws from adult mental health services, or only desires episodic contact with adult mental health services.

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Intervention	Transition plan – Update
Description	Based on the youth's ongoing progress including their readiness to transition and mental health needs, update the transition plan as needed.
Core Component	Component 3.1- I conduct regular transition readiness assessments, and in collaboration with youth (and family members/caregivers, if appropriate) identify youths' needs and goals, and update them regularly. Component 4.5- In collaboration with youth (and their family members/caregivers, if appropriate), I complete individualized transition plans and keep them up-to-date (including, for example: readiness assessment findings, goals and prioritized actions, clinical summary, crisis plan).

Intervention	Patient/caregiver – Build rapport/engagement
Description	Establish effective and transparent communication with the youth, and if applicable, their caregivers or family members engaged in the transition process. This ensures active collaboration between the youth and their family, if applicable, throughout the transition process.
Core Component	None specific

Intervention	Patient/caregiver – Receive/provide update on transition process
Description	Ensure that both the youth and, if applicable, their caregivers or family members engaged in the transition process are regularly informed about the youth's progress. This includes timely updates, such as notifying them when the referral has been sent.
Core Component	None specific

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Intervention	Interprofessional teams – Collaborate/discuss
Description	To discuss the youth's transition process and outcomes, collaborate with other health care professionals, such as psychiatrists, psychologists, and/or social workers, who are also involved in the youth's care.
Core Component	Component 4.4- I collaborate with youth and other relevant service providers in the circle of care (and family members/caregivers, if appropriate) on deciding the optimal timing of transfer for the youth.

Intervention	Academic supports – Review accommodations with patient/caregiver
Description	Review and verify whether the youth is receiving necessary support at school. For example, review whether a psychoeducational assessment has been completed and whether the youth has an Individual Education Plan (IEP)
Core Component	None specific

Intervention	Patient/caregiver – Build rapport/engagement
Description	Review and verify whether the youth is receiving necessary support at school. For example, review whether a psychoeducational assessment has been completed and whether the youth has an Individual Education Plan (IEP).
Core Component	Component 5.1- I ensure that a specific meeting or case conference is held with everyone involved in the transition to handover care (i.e. youth, child and adolescent mental health services and adult mental health services clinician, transition workers, and family members/caregivers if appropriate).

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Intervention	Community support systems – Investigate/research options
Description	Conduct research to identify appropriate mental health programs (e.g. community mental health services within the youth's catchment area) for youth
Core Component	None specific

Intervention	Community support systems – Confirm eligibility criteria
Description	To discuss the youth's transition process and outcomes, collaborate with other health care professionals, such as psychiatrists, psychologists, and/or social workers, who are also involved in the youth's care.
Core Component	Component 4.3- I confirm the adult/community/outpatient mental health service eligibility criteria (i.e. age, diagnosis)

Intervention	Community support systems – Prepare/submit referral
Description	Complete the agency's referral procedure. For example, completing required forms, sending clinical records, etc.
Core Component	Component 5.2- In collaboration with youth, I complete all documents in the transfer package (e.g. referral letter, individualized transition plan, clinical records). With youth's consent I send it to the adult/community/outpatient mental health services and/or primary care provider, and confirm receipt.

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Intervention	Community support systems – Advocate
Description	Advocate with mental health agencies regarding providing timely support to youth. Examples of advocacy work may include requesting that agencies accept the youth's referral and/or reduce wait times when needed.
Core Component	None specific

Intervention	Community support systems – General communication/ information sharing
Description	Maintain consistent communication with the youth, and if applicable, their family member or caregiver involved in the transition process, regarding their transition progress.
Core Component	Component 4.9- I 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

Intervention	Community support systems – Warm handover during initial appointment
Description	If possible, attend the youth's initial appointment with their new mental health provider to facilitate handover to their new mental health agency.
Core Component	Component 5.1- I ensure that a specific meeting or case conference is held with everyone involved in the transition to handover care (i.e. youth, child and adolescent mental health services and adult mental health services clinician, transition workers, and family members/caregivers if appropriate).

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Intervention	Psychotherapy – Short-term
Description	Provide youth with short-term mental health support based on their needs, for example, individual and/or family therapy.
Core Component	None specific

Intervention	Psychotherapy – Safety planning and crisis support
Description	Assess the youth's risk level for self-harm and/or harm to others. Collaboratively create a safety plan with the youth, and if appropriate, involve family members or caregivers. This plan should include a list of potential risk factors to recognize, coping strategies to use, and crisis support resources to reach out to if necessary.
Core Component	None specific

Intervention	Follow-up – Address barriers and confirm transfer of services
Description	Address any challenges that youth experience during their transition process. Confirm that the youth has been able to gain access to their new mental health agency.
Core Component	Component 6.1- As a navigator, I, contact the youth (and family members/caregivers, if appropriate) 3 to 6 months after their last child and adolescent mental health service visit, or sooner if necessary, to confirm transfer to adult/community/outpatient mental health services.

4 Evaluating Transitions in Care

Interventions, Outcomes, Indicators

In the context of youth mental health care transitions, **interventions** are the specific practices or actions put in place by the organization to support continuity of care during the transition process. Each intervention should have an intended **outcome**, the resulting measurable effect of that specific practice (Fraser Health Authority, 2009).

In order to ensure that interventions are effective and result in the intended outcomes, evaluation should be part of the intervention design (Fraser Health Authority, 2009). Consider how you will measure an outcome of a particular intervention. Outcomes evaluation requires that program or intervention goals be transformed into measurable **indicators** (Beacoms Fellow Program, 2021). For every outcome of interest, an indicator that will be used to collect and track data should be identified (Beacoms Fellow Program, 2021). A logic model may help simplify complex relationships between outcomes, indicators, and evaluation (Public Health Ontario, 2016).

Types of Indicators

- **Input indicators** – The organization's investments for implementation of the program or intervention. Inputs enable activities (Beacoms Fellow Program, 2021)
  - *Example: Adequate staffing; creating time release or adding some additional funding so that a clinician can have a half-day a week specifically focused on transition work.*

- **Process indicators** – Measurements of the program or intervention's activities, outputs and deliverables. They identify how well a program or intervention has been implemented and identify areas of improvement (Health Quality Ontario, 2023)
  - *Example: Utilizing a standard template for handover meetings specific to your organization to ensure proper discussion and documentation of transfer of care and reviewing its' usage.*

- **Outcome indicators** – Measurements to identify if the program or intervention is accomplishing the intended short- or long-term goals (Health Quality Ontario, 2023)
  - *Example: An increase in Transition Readiness Assessment Questionnaire (TRAQ) scores by a specific amount across the 3-month time period prior to the actual care transition, indicating that transition readiness has improved.*
  - *Example: Percentage of youth who have fully transitioned to a new adult or other appropriate service.*

Guidance for indicator selection is available through Health Quality Ontario and the CDC.

Evaluation Frameworks & Resources

Health Quality Ontario has developed the Innovative Practices Evaluation Framework through Health Links, an integrated, patient-centered care approach that is geared towards the improvement of care experiences and coordination for patients with complex needs. The Framework is used by the Health Links Clinical Reference Group to systematically assess the implementation of innovative clinical practices and programs. A worksheet is also available to use for assessment of local innovations.

The **Knowledge Institute on Child and Youth Mental Health and Addictions (CYMHA)** has a program evaluation toolkit specifically for child and youth mental health. It includes content on how to develop a logic model, how to identify evaluation questions and the indicators/outcome measures of interest, a budget worksheet, as well as conducting the evaluation and using the data obtained.

The **U.S. Centers for Disease and Control and Prevention (CDC)** has a framework for evaluating programs which summarizes the necessary aspects, outlines required steps, and reviews standards for and methods of conducting a program evaluation.

The **University of Calgary** has a program evaluation toolkit that outlines foundations of conducting an evaluation, program and evaluation planning practices, as well as data collection, analysis, and dissemination guidelines.

The remainder of this chapter utilizes work from the Cleverley Lab to provide examples of how to evaluate youth transitions in mental health care services.

The Core Components of Effective Youth Transitions (CCEYT)

The **Core Components of Effective Youth Transitions (CCEYT)** is a 27-item checklist of core components and different stages of effective youth transitions identified through a literature review (Cleverley et al., 2020b), and validated through a National Delphi Consensus study (Cleverley et al., 2022b). It is a self-report measure with youth, parent/caregiver, and service provider versions where participants can select ratings on a 5-point Likert scale from "Strongly Agree" to "Strongly Disagree" in relation to whether the component being measured is true, or has occurred.

The following is an example of an evaluation section of the CCEYT:

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) to identify 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 adult/outpatient/community mental health services.					
1.3 **Developed** an individualized transition plan in collaboration with me (and my family members/caregivers, if appropriate) a minimum of 6-months before planned transition, or as early as possible.					

The full Core Components of Effective Youth Transitions Checklist can be found in the Appendix, pages 64 to 67, at the end of this document.

The Satisfaction with Mental Health Navigator Tool (NAVSAT)

The Satisfaction with Mental Health Navigator Tool (NAVSAT) is an 11-item self-report scale adapted with permission from the Navigation Satisfaction Tool (Fishman et al., 2018). It is used to assess satisfaction of youth experiences with Navigation services, and the Navigators themselves, on a 7-point Likert scale from "Extremely Dissatisfied" to "Extremely Satisfied".

	Less than every 2 months	Once every 2 months	Once every month	Once every 3 weeks	Once every 2 weeks	Once per week	More than once per week
1. How frequently did you have contact with the navigator?							

	Extremely dissatisfied	Dissatisfied	Somewhat dissatisfied	Not dissatisfied or satisfied	Somewhat satisfied	Satisfied	Extremely satisfied
2. How satisfied are you with the Navigator's ability to listen and understand your concerns?							
3. How satisfied are you with the information given to you about potential treatment options (e.g. possible outpatient clinics, family doctor, etc.)?							
4. How satisfied are you with how the Navigator understood the impact of your mental health on your wellbeing and service needs?							
5. How satisfied are you with how the Navigator maintains your confidentiality (e.g. keeping personal health information private)?							

See this article by Fishman et al. (2018) for the original Navigation Satisfaction Tool.

The Satisfaction with Mental Health Navigator Tool (NAVSAT)

	Extremely dissatisfied	Dissatisfied	Somewhat dissatisfied	Not dissatisfied or satisfied	Somewhat satisfied	Satisfied	Extremely satisfied
6. How satisfied are you with how the Navigator respects your rights (e.g. right to be treated with respect, right to effective communication)?							
7. How satisfied are you with the intake procedures (e.g. collecting key pieces of information from you prior to your first appointment, such as contact information, medical history, and payments)?							
8. How satisfied are you with your type of contact (e.g. phone calls, in-person, virtual, email, etc.) with the Navigator?							
9. How satisfied are you with the frequency of contact you had with your Navigator?							
10. Overall, how satisfied are you with the Navigator?							

	Very unlikely	Unlikely	Not sure	Likely	Very likely
11. How likely are you to recommend these navigation services to friends and family if they needed similar care or treatment?					

Example of an evaluation of an intervention to support transitions

Navigator Evaluation Advancing Transitions (NEAT)

The NEAT study involved collaboration with patients, referring clinicians, and navigators to evaluate the transition navigator model being implemented at two hospital sites in the Greater Toronto Area. This included a mixed-methods evaluation of the model by youth who received transition navigation services at the two hospital sites (Cleverley et al., 2021). See below the study design and research findings (Cleverley et al., submitted).

Inclusion Criteria: 1) Participants aged 16-18, 2) Receiving transition navigation services from hospital-based child and adolescent mental health services

Quantitative arm

43 Participants completed questionnaires on transition readiness, mental health symptoms and functioning at baseline (pre-intervention) and 6-month follow up (post-intervention).

Qualitative arm

At the 6-month follow up (post-intervention), 20 participants took part in semi-structured interviews, focused on experiences and satisfaction with the navigator model.

Research Findings

- **Transition readiness scores improved significantly improved over time**, highlighting the navigator's role in preparing youth for adult services.
- **Emergency department visits decreased,** suggesting the model supports continuity of care and timely mental health access.
- Youth reported inconsistent communication with their navigator, **including service disruptions due to staff turnover,** which future programs should plan to mitigate.

Sources of Data for Evaluation

An organization may have several different sources of data to draw upon when measuring against your outcome and process indicators. The following list was developed based on the evaluation and research done at the Cleverley Lab, specifically the NEAT study (Cleverley et al., 2021), LYiTS study (Cleverley et al., 2022a), NavigateCAMPUS (Cleverley et al., 2025).

Medical records:

1. Numbers and records of clinical encounters and referrals
2. Changes in recorded TRAQ scores prior to transition
3. Presenting diagnosis or clinical symptoms
4. Changes in clinical symptoms across the transition point
5. Intervention tracking records (see clinical tracking sheet on next page)
6. Intake and discharge date or length of time in service

From youth and/or caregivers:

1. Survey measures of satisfaction with interventions and experience of transition interventions (e.g. CCEYT or NAVSAT)
2. Self-report measures of service use to capture out-of-organization services
3. Qualitative interviews for more in-depth understanding and feedback on experiences of transition interventions and services

From clinicians and service providers:

1. Survey measures of service provider perspectives on transition interventions (e.g. CCEYT)
2. Qualitative interviews for more in-depth understanding of the clinician perspective on implementation of transition interventions and transition processes

Organization-wide tracking outcomes:

1. Wait times/timelines
2. Completed referrals to receiving services and timelines to access of new service
3. Demographics information about youth and families who need or receive a transition to new services
    a. Directly from clinicians (e.g., CCEYT, clinical assessments, qualitative interviews to understand how processes change with intervention)
    b. From organization-wide outcomes tracking that is already happening (wait times/timeliness, access to what services and when)

Tracking Sheet

The **Clinical Tracking Excel Database** was developed in collaboration with transition navigators working across mental health agencies in the Greater Toronto Area. Transition navigators have been using the database to track transition interventions implemented (e.g., prepare/submit referral) and outcomes attained (e.g., referral completed) at each of their appointments with youth and/or interest-holders involved in the transition process (e.g., caregivers, current and new mental health providers). Along with clinical appointments, the database is being used to add and track all forms of communication, such as e-mail, phone calls, and texts, with youth and/or involved interest-holders. Other information tracked within the database includes the youth's diagnosis and their status at the mental health agency (e.g., receiving outpatient services, discharged from mental health services), the duration of the navigator's each contact with the youth and/or interest-holder, the number of youth's missed appointments, and their total time in the transition navigation program.

A supplementary usage guide was also developed, which includes instructions on how to use and edit the database content if needed.

Appendices

The Core Components of Effective Youth Transitions 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) to identify 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 adult/outpatient/community mental health services.					
1.3 **Developed** an individualized transition plan in collaboration with me (and my family members/caregivers, if appropriate) a minimum of 6-months before planned transition, or as early as possible.					

Element 2. Transition Planning					
Component	Strongly Agree	Agree Somewhat	Unsure	Disagree Somewhat	Strongly Disagree
My navigator...					
2.1 **Identified** everyone involved in the transition (e.g. child and adolescent mental health services, adult mental health services, me and my family members/caregivers, primary care practitioners, etc.).					
2.2 **Collaborated** with me (and my family members/caregivers, if invited by me) to identify adult/community/outpatient services that were an appropriate fit for me.					

CONTINUED ON NEXT PAGE

The Core Components of Effective Youth Transitions Checklist

Element 2. Transition Planning					
Component	Strongly Agree	Agree Somewhat	Unsure	Disagree Somewhat	Strongly Disagree
My navigator…					
2.3 **Confirmed** the adult/community agency/outpatient mental health services eligibility (i.e. age, diagnosis) criteria.					
2.4 **Agreed on/discussed** the timing of transfer with me and other relevant health care clinicians on my care team (and my family members/caregivers, if appropriate).					
2.5 In collaboration with me (and my family members/caregivers, if appropriate), my navigator **completed i**ndividualized transition plan and kept it up-to- date (including, for example: readiness assessment findings, goals and prioritized actions, clinical summary, crisis plan).					
2.6 **Coordinated** the transition process, acted as the main contact, and ensured continuity in my mental health care.					
2.7 Prior to my discharge/transfer of care, **started** transition planning with the adult/community agency/outpatient mental health services provider, which included joint working meetings or a period of parallel care; and included me (and my family members/caregivers, if appropriate) in the meetings.					
2.8 With my consent, **communicated** my discharge/transfer with my primary care provider (i.e. family doctor, nurse practitioner, and pharmacist) to ensure they have consistent up-to-date medication and treatment information.					

CONTINUED ON NEXT PAGE

The Core Components of Effective Youth Transitions Checklist

Element 2. Transition Planning					
Component	Strongly Agree	Agree Somewhat	Unsure	Disagree Somewhat	Strongly Disagree
My navigator…					
2.9 **Provided** me (and my family members/caregivers, if appropriate) with up-to-date contact information for developmentally appropriate self-care management resources, community supports, and community mental health resources.					
2.10 **provided** developmentally appropriate community and health resources to me (and my family members/caregivers, if appropriate), in case I did not transition to adult/community agency/outpatient mental health services, withdrew from mental health services, or only desired episodic contact with mental health services.					
2.11 If desired by me, facilitated connections to peer support during the transition process					

CONTINUED ON NEXT PAGE

The Core Components of Effective Youth Transitions Checklist

Element 3. Transfer of Care					
Component	Strongly Agree	Agree Somewhat	Unsure	Disagree Somewhat	Strongly Disagree
My navigator...					
3.1 **Initiated** a specific meeting or case conference was held with everyone involved in my discharge/transition to handover my care (i.e. child and adolescent mental health service provider, adult mental health services provider, me and my family members/caregivers, primary care practitioners, etc).					
3.2 In collaboration with me, **completed** all documents in transfer package.					
3.3 With my consent, **sent** my navigator to the program/services I was being transitioning to and/or my primary care provider, and confirmed receipt.					

Element 4. Transfer Completion					
Component	Strongly Agree	Agree Somewhat	Unsure	Disagree Somewhat	Strongly Disagree
My navigator...					
4.1 contacted me (and my family members/caregivers, if appropriate) 3 to 6 months after my last child and adolescent mental health service visit, or sooner if necessary, to confirm transfer to program/services.					

Case Studies

Case studies are effective teaching strategies that encourage critical thinking and decision-making (Sprang, 2010).

This section includes three case studies to consider. Each one involves youth transitioning from CAMHS to AMHS. Review the case study content, getting to know the clients. Below are thought-provoking questions to think about related to their care. Consider the 6 Core Components to successful transition in the mental health care setting when reviewing the cases.

Samuel

Demographics: 16 years old, Male
Referral Source: Hamilton General Hospital Emergency Department
Diagnoses: Major Depressive Disorder (MDD), Attention Deficit Hyperactivity Disorder (ADHD), and Oppositional Defiant Disorder (ODD)
Cultural/Religious consideration: Irish-Canadian, Agnostic
Presenting Issues: Difficulty in academic performance, history of substance abuse, strained family relationships, aggressive outbursts, lack of motivation, social isolation.
Medications: Bupropion 150mg, Methylphenidate 20mg

Family History:

- Parents divorced when Samuel was 10 years old, both have since remarried
- Samuel has a younger sister (age 13) and a stepbrother (age 15) from his father's remarriage
- Lives primarily with his mother and stepfather, with occasional visits to his father's home
- Samuel's mother has a history of anxiety and depression, father has a history of alcohol abuse
- Tension between family members, particularly between Samuel and his stepfather

Community/School:

- History of poor academic performance and truancy, has been suspended multiple times for aggressive behavior
- Receiving support from school counselor and special education services for ADHD
- Struggles with peer relationships, often isolates himself from others
- No involvement in school activities or clubs, prefers to spend time alone

Treatment History: Hamilton General Hospital Child & Adolescent Inpatient Unit (February 2022), McMaster Children's Hospital Outpatient Program (March 2022 - June 2022), Woodview Mental Health and Autism Services (July 2022 - Present)

Think about the following questions related to Samuel's transition from adolescent to adult mental health services:

- Who should be involved in the care transition?
- Are there anticipated challenges to Samuel's transition to AMHS?
- How can these anticipated complexities and challenges be addressed?

See next page for ideas on how to approach Samuel's transition care.

Samuel

Who should be involved?

- Samuel and his caretakers (e.g., mother, father, stepfather, stepmother)
- Care team at child adolescent mental health services
- Care team at adult mental health services
- Care team at Autism Services

Anticipated challenges

- Inconsistent family involvement:
  - Discrepancies in the level of family participation and support can lead to difficulty in implementing treatment plans effectively.
- Conflict between family members:
  - Ongoing tension between Samuel and his family members may impede progress in therapy and contribute to his mental health struggles.
- Limited understanding of mental health issues:
  - Family members may not fully understand the severity of Samuel's mental health issues or may dismiss them, leading to inadequate support.
- Diverging treatment goals:
  - Different family members may have different expectations and goals for Samuel's treatment, making it difficult to establish a cohesive plan.
- Navigating complex family dynamics:
  - Mental health professionals may face challenges in addressing the needs of Samuel while managing the various dynamics and relationships within his family.

To better address these challenges, mental health professionals should consider:

- Engage in family-centered care
- Involving all family members in treatment planning and decision-making
- Family therapy, psychoeducation, and fostering open communication between family members can help promote a supportive environment and facilitate a smoother transition from CAMHS to AMHS.

Jacqueline

Demographics: 15 years old, Female
Referral Source: The Ottawa Hospital Emergency Department
Diagnoses: Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), and Substance Use Disorder (SUD)
Cultural/Religious consideration: French-Canadian, Atheist
Presenting Issues: Chronic low mood, excessive worry, substance abuse (primarily alcohol), difficulties in relationships, school avoidance, and self-harming behaviors.
Medications: Escitalopram 10mg, Propranolol 20mg

Family History:

- Parents divorced when Jacqueline was 12 years old, both are currently unemployed
- Jacqueline has an older brother (age 18) who left home after a conflict with their mother
- Lives with her mother in a low-income neighborhood, father has limited contact with the family
- Family is struggling financially, with limited access to resources and support

Community/School:

- History of poor academic performance, often skips school
- Receiving support from school counselor, but limited access to mental health resources due to financial constraints
- Difficulty maintaining friendships and often isolates herself from peers
- Limited involvement in extracurricular activities, as the family cannot afford associated costs

Treatment History: The Ottawa Hospital Child & Adolescent Inpatient Unit (June 2022), The Royal Ottawa Mental Health Centre Outpatient Program (July 2022 - September 2022), Youth Services Bureau of Ottawa (October 2022 - Present, on a sliding scale fee)

Think about the following questions related to Jacqueline's transition from adolescent to adult mental health services:

- Who should be involved in the care transition?
- Are there anticipated challenges to Jaqueline's transition to AMHS?
- How can these anticipated complexities and challenges be addressed?

See next page for ideas on how to approach Jacqueline's transition care.

Jacqueline

Who should be involved?

- Jacqueline and her caretakers (mother)
- Care team at child adolescent mental health services
- Care team at adult mental health services

Anticipated challenges

- Limited access to care:
  - Financial constraints may limit the family's ability to access appropriate mental health care, leading to inadequate treatment and support.
- Affordability of medications:
  - The cost of medications can be a significant barrier for families with limited financial resources, impacting treatment adherence and outcomes.
- Access to specialized services:
  - Specialized services may have higher costs or limited availability, making them inaccessible to families with financial constraints.
- Lack of transportation:
  - Limited financial resources may impact the family's ability to provide transportation to appointments and treatment facilities.
- Socioeconomic stressors:
  - Financial difficulties can contribute to increased stress and exacerbate mental health issues.

To better address these challenges, mental health professionals should consider:

- Work with clients and their families to identify affordable and accessible treatment options.
- Community-based services, sliding scale fees, and financial assistance programs can help to improve access to mental health care.
- Increased funding and advocacy for mental health services can help to reduce financial barriers and facilitate a smoother transition from CAMHS to AMHS.

Aisha

Demographics: 14 years old, Female
Referral Source: St. Michael's Hospital Emergency Department
Diagnoses: Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), and Type 1 Diabetes
Cultural/Religious consideration: Syrian, Muslim
Presenting Issues: Nightmares, flashbacks of war, social withdrawal, pervasive sadness, difficulty concentrating, and poor diabetes management.
Medications: Sertraline 50mg once a day, Insulin therapy

Family History:

- Aisha and her family fled the Syrian war in 2021 and sought refuge in Canada.
- Parents remain together and supportive of Aisha and her two younger siblings (ages 10 and 8).
- Father suffers from hypertension and mother has a history of anxiety.
- No known history of substance related disorders in the family.

Community/School:

- Aisha attends a school with a diverse student population, including other Syrian refugees.
- Struggles to make friends due to language barriers and cultural differences.
- Performs below grade level in school, partially due to language difficulties and trauma.
- School provides additional support for English language learning and counselling services.

Treatment History: St. Michael's Hospital Inpatient Unit (June 2022 - July 2022), New Beginnings Refugee Mental Health Clinic (August 2022 - February 2023), Mount Sinai Hospital Diabetes Clinic (March 2023 - Present)

Think about the following questions related to Aisha's transition from adolescent to adult mental health services:

- Who should be involved in the care transition?
- Are there anticipated challenges to Aisha's transition to AMHS?
- How can these anticipated complexities and challenges be addressed?

See next page for ideas on how to approach Aisha's transition care.

Aisha

Who should be involved?

- Aisha and her caretakers (parents)
- Care team at child adolescent mental health services
- Care team at adult mental health services
- Care team at Diabetes Clinic

Anticipated challenges

- Need for integrated care:
  - Aisha requires care that addresses both her mental health and medical needs, necessitating a multidisciplinary team of professionals.
- Complex treatment planning:
  - The presence of medical comorbidity can complicate treatment planning and require more frequent monitoring and adjustments.
- Access to appropriate services:
  - There may be limited availability of specialized services and programs designed to address the unique needs of clients with medical co-morbidities.
- Stress on family resources:
  - The family may experience increased financial and emotional strain due to the need to manage both mental health and medical issues.
- Cultural and language barriers:
  - Aisha's background as a Syrian refugee may present additional challenges in accessing culturally sensitive care and navigating the health care system.

To better address these challenges, mental health professionals should consider:

- Provide comprehensive and integrated care that addresses the specific needs of clients with medical co-morbidities.
- Closely monitor and evaluate the effectiveness of interventions, making adjustments as needed.
- Collaboration with other service providers, family members, and the client is essential to ensure appropriate care and support.
- Improve access to specialized services and programs tailored to address the unique needs of clients with medical co-morbidities.
- Providing comprehensive and coordinated care will help ensure a smoother transition from CAMHS to AMHS and improve overall mental health outcomes

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