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Transitioning youth from child and adolescent mental health services to adult mental health services

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MAIN MESSAGES

- Establishing and maintaining formal transition systems from child mental health services to adult-oriented systems of care is important for recovery, mental health promotion, and mental illness prevention. Lack of integration can jeopardize successful transition for youth.

  o Improving transition should be a priority, across sectors and between systems.

- Increased flexibility is needed when it comes to defining the age of "youth in transition," taking into account chronological age versus developmental age.

  o Accordingly, a more flexible approach to funding services is also needed.

- Transition planning should be initiated earlier, and care plans should be flexible enough to adapt to different service environments and the unique needs of the youth involved.

- Transition planning needs to be viewed as a shared responsibility rather than a risk transfer.

  o Youth and their families should be involved in planning, to ensure that the transition process is appropriate to the needs of the individuals.

- Paving a pathway to seamless care and effective transitions will require effective channels of communication between ministries, agencies, and leadership bodies.

  o This will help ensure that the important perspectives of multidisciplinary collaboration are reflected in decision-making.

- Evidence shows that if transition is to be effective, it needs to use a formalized framework or model. Policy-makers need information and feedback about the best-supported models.

  o However, flexibility in applying the model of care is very important. Mental health transition interventions need to be tailored as appropriate to recognize strengths and meet the needs of youth and their families.

- Outcome data can be used to evaluate transition programs and to develop an effective model of care.

  o Moving forward, all key stakeholders – youth, caregivers and care providers – should be engaged to assess the model and provide feedback.

EXECUTIVE SUMMARY

Evidence

Within healthcare, the development of a coordinated transition system linking pediatric services to adult systems of care is expected to pose one of the most significant challenges this century (Viner & Keane 1998). This is particularly evident in the area of mental health, since achieving continuous care requires the highest degree of interpersonal contact between service users and service providers (Haggerty et al. 2003).

Positive intervention at the transition stage between child/adolescent mental health services and adult mental health services is one of the most important ways to facilitate recovery, mental health promotion, and mental illness prevention. However, in Ontario, there is an absence of an integrated, coordinated system of care between child and youth-serving and adult-serving mental health agencies. A lack of integration is believed to "jeopardize the life chances of transition-age youth (aged 16-25) who need to be supported to successfully adopt adult roles and responsibilities" (Pottick et al., 2008, p. 374).

Ontario is not alone in identifying fragile links between agencies. Research shows that in the United Kingdom, Australia and the United States, for example, the greatest financial and institutional weaknesses in mental health services occur during the transition between child and adolescent mental health services and adult mental health services (Singh et al., 2005; Pottick et al., 2008; McGorry et al., 2007).

Empirical evidence supports the establishment of formal transition services from child services to adult-oriented systems of care. Evidence indicates that using a model of care focused on shared responsibilities in planning is considered necessary to achieve effective transition (McGorry et al., 2007; Hamdani, Kingsworth & Healy., 2006). While the development of transition services needs to be informed by common protocols and best practice guidelines, flexibility in the application of the model of care is important. In other words, mental health transition interventions need to be tailored to fit the needs and strengths of individuals and their families.

Considerations from the Literature on Transitions and Policy Perspectives

In Ontario, the care and support of children and youth is the collective responsibility of many agencies and providers. Youth with mental health concerns interface with many systems, including hospitals, community-based agencies, educational and vocational training institutions, primary care, the child welfare system, and the justice system. In preparing this document, input was obtained from stakeholders representing the ministries responsible for providing mental health services for this population.

The literature and policy perspectives indicate that paving a pathway to effective transitions from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) will require:

1. **Clear channels of communication to be established between Ministerial leadership bodies. This will serve to:**

   A. Make mental health transitions from CAMHS to AMHS a priority.

   B. Facilitate the adoption of a model of care that is informed by best practice guidelines and research on transitional planning for youth.

   C. Align the ministries with the shared goal of adopting a model of care and monitoring outcomes of the selected model.

   D. Encourage inter-ministerial collaborations for CAMHS to AMHS transitions at the policy level.

2. **The selected model of care to maintain a youth-centered approach where transitional planning is completed proactively rather than reactively. The selected model needs to:**

   A. Be collaborative, involving multidisciplinary perspectives and communication between CAMHS and AMHS agencies. This will need an holistic approach that emphasizes the importance of a number of variables, including medical and psychosocial factors.

   B. Provide care that is coordinated, comprehensive and seamless. This care needs to be flexible and should be driven by the needs and developmental age of the youth.

   C. Acknowledge resilience factors and encourage the inclusion of parents and caregivers while balancing/fostering a sense of independence and responsibility in youth.

3. The transition program that is selected should be guided by current evidence in knowledge translation and implementation science. This will serve to:

A. Enhance levels of knowledge of health team leaders and healthcare providers within a developmental context.

B. Encourage all allied health professionals to recognize that acting to improve mental health transitions is a priority.

C. Facilitate future uptake of the program along with the monitoring and evaluation of outcome data.

Recommendations:

Policy-Level Recommendations

1. The CAMHS/AMHS transitional model should reflect the policy goals for mental health in Ontario and Canada.

2. Policy-makers would like to help shape clinical practice rather than impose standards. To make key decisions about which transitional model might work best for CAMHS/AMHS transitions, policy leaders need information about the best-supported models for CAMHS/AMHS transitions as well as feedback from stakeholders.

3. Policy-makers agree there needs to be increased flexibility related to developmental age for youth transitioning from CAMHS to AMHS. Accordingly, a more elastic approach to funding services is needed for services related to transition-age youth.

4. Longitudinal outcome data are required to evaluate future transitional programs/models of care. Changes will need to be made to legislation in order to link ministerial data in an effort to support a coordinated model of healthcare.

5. Policy-makers require more information from youth to determine how to best serve transition-age youth and prevent crisis-driven reconnection.

6. The CAMHS/AMHS transition could be considered as a model for reform in healthcare.

Practice-Level Considerations

1. Developmental considerations should play a major role in helping to direct the transitional process for youth.

2. Transitional planning needs to be initiated earlier, and transitional care plans need to be flexible to adapt to different service environments and the needs of the youth involved.

3. Transitional planning needs to be viewed as a shared responsibility rather than a risk transfer.

4. AMHS perspectives need to be engaged at both the policy and service levels in order to support a successful model of transition for youth.

5. Families are important stakeholders and need to be engaged in the transition process while still respecting the burgeoning autonomy of youth in transition.

Recommended Model of Care

Flexibility is required when selecting an appropriate transitional framework to support youth mental health transitions. The model of choice should be flexible and built around the context of the service environment as well as the transitional goals and needs of policy leaders, care providers and service users in the region. In this region of Ontario, a *shared management model* is being carefully considered. The shared management model has been applied (e.g., The LIFE Span) elsewhere in Canada and is identified as a leading process in healthcare (Accreditation Canada, 2008). Applying the gold standard of care from health focused transitional areas to mental health is a logical extension of the model. Although this model requires a high level of stakeholder investment and necessitates that funds be secured to provide for a transitions coordinator, the selected framework aligns with recent recommendations made by the SCMHA of Ontario (2010) advocating for system navigators to support youth and families moving between CAMHS and AMHS systems of care.

Future Direction

Moving forward, key stakeholders (youth, caregivers and care providers) will need to be engaged to assess the appropriateness of the shared management framework for CAMHS/AMHS transitions. In order for the shared management framework to function as described in the literature, investments must be made in "transition resources, such as (but not limited to) a transition coordinator" (PCMCH, 2009, p. 14). Any transitional model applied to mental health must be monitored. Summative and formative evaluations of short- and long-term outcomes are required to support effective transitional programming from CAMHS to AMHS.

ABBREVIATIONS AND KEY DEFINITIONS

AMHS: Adult Mental Health Services

CAMHS: Child and Adolescent Mental Health Services

MCYS: Ministry of Child and Youth Service

MHCC: Mental Health Commission of Canada

SCMHA: Select Committee on Mental Health and Addictions

Transition: Blum et al., (1993) refers to transition as *"the purposeful planned movement of adolescents with chronic physical and mental conditions from child-centered to adult-oriented health care systems"* (p. 570) the goal of which *"is to provide health care that is uninterrupted, coordinated, developmentally appropriate, psychosocially sound, and comprehensive"* (p. 570). The literature suggests that the ideal transition should be: *"A way to enable and support a young person to move towards and onto a new life stage" (Beresford, 2004, p. 584) and "A dynamic process with a beginning, middle and end" (McDonagh, 2006, p. 3),* that is *"coordinated, planned, efficient and smooth" (Conway, 1998, p. 210).*

Transfer: Two types of transfer processes are described: *formal transfer* and *informal transfer*.

A *formal transfer* of care is synonymous with the definition of a transition described above. An *informal transfer* is regarded as *"termination of care by a children's health provider which is re-established with an adult provider"* (Burke et al., 2008 as cited in Singh et al, 2010). Implicit in the distinction between these concepts is an absence of coordinated movement.

Transition Age: Currently, most mental health researchers subscribe to the dominant view that youth in transition are people between the ages of 16 and 25 who have emotional disorders (Davis, 2003; Pottick et al., 2008). It is important to recognize, however, that some researchers have adopted a more flexible view of youth in transition by identifying them as 12 to 24 year olds (McGorry, 2007; Patel et al., 2007). For the purposes of this paper, "youth in transition" will be described as young people between the ages of 16 and 25. However, there is an understanding that, at the level of policy planning and service provision, flexibility related to chronological age demarcations is necessary, and that developmental age is an important factor that will undoubtedly inform the transition.

1.0 BACKGROUND AND STATEMENT OF THE PROBLEM

It is estimated that at least 70% of mental health problems in Canada have an onset occurring in childhood or adolescence (Statistics Canada, 2002). These results are consistent with reports from the U.S. and U.K. showing that approximately three-quarters of all adult mental illnesses have an age of onset before 24 and 18 years, respectively (Kessler et al., 2005; Kim-Cohen et al., 2003). The outcome data uniformly demonstrate that in the absence of appropriate treatment, children and adolescents with mental health concerns become "more vulnerable and less resilient" with time (Wattie, 2003, Web).

In order to interrupt a cycle perpetuating youth mental health concerns, it is necessary to target families as well as youth, as research clearly demonstrates that parental mental illness is a risk factor for youth mental illness (Rutter, 1989). Recently, the Mental Health Commission of Canada (MHCC) responded to this growing public health concern by formally identifying young people as a vulnerable group. In an effort to improve prevention rates and maintain the well-being of young people, the MHCC is advocating for dedicated resources to be invested in this population (2009). It is the MHCC's belief that this focus will help build the capacity for a more resilient youth population and a future marked by well-being for all Canadians.

It is estimated that between 15 and 21% of young Canadians have at least one diagnosable mental health disorder (Waddell & Shepherd, 2002; Shaffer et al., 1996; Offord et al., 1989). However, evidence suggests that only one out of every six children and youth affected with mental illness in Ontario actually received any kind of mental health service for their condition within the previous six months (Offord et al., 1989). The scope of this problem was highlighted in the Ontario Policy Framework for Child and Youth Mental Health that identified a fragmented youth mental health system fraught with gaps in service delivery (2006). One of the primary concerns articulated in the framework document focused on youth transitions in mental health (MCYS, 2006). Other provincial policy documents have identified the lack of connection between mental health services for children and youth with the adult mental health and addictions sector as a significant systems problem that persists to date (Government of Ontario, 2009; Select Committee of Mental Health and Addictions, 2010).

The absence of an integrated, coordinated system of care between child and youth-serving and adult-serving mental health systems represents one of the weakest linkages within the Ontario mental health care system, resulting in significant barriers at a point when effective transition of services is necessary to achieve the recovery-oriented reform described by the MHCC (Government of Ontario, 2008), the MCYS' framework initiative (2006) and the Select Committee on Mental Health and Addictions in Ontario (SCMHA; 2010). As noted in *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions* (2006), a complex network of mental health services are currently delivered through federal, provincial, and municipal jurisdictions, and private providers. In Ontario, for example, provincial mental health service delivery for transition age youth is diluted across the Ministry of Health and Long-Term Care, the Ministry of Children and Youth Services (2009) as well as several other provincial departments that provide funding for social and community programs that have strong links to mental health and well being. Quite often, however, this spread of resources results in a lack of coordination (http://www.policyresearch.gc.ca/page.asp?pagenm=2009-0018_08) and a diffusion of responsibility (Policy Leader, 2011).

Ontario is not alone in identifying fragility in the linkage between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS). Research in the United Kingdom, Australia and the United States indicates that the greatest financial and institutional weaknesses in mental health services occur during the transition between CAMHS and AMHS, affecting individuals between the ages of 16 and 25 (Singh et al., 2005; Pottick et al., 2008; McGorry, 2007). This is problematic, since this lack of integration is believed to "jeopardize the life chances of transition-age youth (ages 16-25 years) who need to be supported to successfully adopt adult roles and responsibilities" (Pottick et al., 2008, 374). One of the world's leading experts in youth mental health, Patrick McGorry, explains:

> *Public specialist mental health services have followed a paediatric-adult split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the maximum weakness and discontinuity in the system occurs just when it should be at its strongest* (2007, s53).

2.0 PURPOSE AND SCOPE FOR THE MENTAL HEALTH TRANSITIONS PAPER

This report has four principal objectives:

1. To provide an overview of current knowledge on CAMHS/AMHS transitions, including identification of barriers and facilitators to successful CAMHS/AMHS, and to review the current situation in Ontario.

2. To identify bodies of evidence supporting optimal transitional pathways for youth.

3. To engage policy leaders and key stakeholders in a discussion regarding CAMHS/AMHS transitions in Ontario, and report on their perspectives concerning CAMHS/AMHS transitions.

4. To collate information from the literature and policy perspectives and make recommendations for an appropriate model/approach to care for CAMHS/AMHS in Ontario.

This paper addresses mental health transitions for a continuum of youth service users. However, the assumption underscoring the scope of this paper is that at some point in their mental health journey, youth will have had contact with the mental health system through a publicly funded institutional care provider. As a result, this paper and the recommended model of transition are intended to best address the needs of youth who present with moderate-to-severe emotional disturbances as primary diagnoses.

Since this paper aims to address the needs of youth who have had contact with the institutional care providers, it does not focus exclusively on community models of care. Instead, the mental health transitions described in this paper often bridge publicly funded institutional systems of care with community-based systems of care. Although institutional and community systems of care are often dichotomized, this paper takes the perspective that care-providing institutions are part of the larger mental health community, and the recommended model of care reflects this viewpoint.

Findings from this paper are best generalized to youth populations who present with moderate-to-severe mental health concerns, and who have had contact with institutional care providers and potentially bridged care with community providers The results of this policy-ready paper may not be appropriate for more populations with different sets of needs or those who require more specialized care. Such out-of-scope populations include youth who have primary diagnoses of a physical health condition and concurrent mental health concerns, youth with addictions and concurrent mental health disorders, and youth who interface with the justice system.

> **OBJECTIVE 1: To provide an overview of current knowledge in CAMHS/AMHS transitions, including identification of barriers and facilitators to successful CAMHS/AMHS transitions and to review the current situation in Ontario.**

3.0 CURRENT KNOWLEDGE

Youth now demonstrate the highest distress levels in the population (Stephens, Dulberg & Joubert, 1999). Mental health problems are expected to continue to rise dramatically among children and youth, with current predictions estimating increases in incidence rates of at least 50% (European Commission, 2003, U.S. Department of Health and Human Services, 2000) by 2020. A decade from now, mental illness is projected to be one of the five most common causes of morbidity, mortality and disability among children (U.S. Department of Health and Human Services, 2000).

Intervening at the level of the transition represents one of the most important ways to facilitate recovery, mental health promotion, and mental illness prevention. However, the development of a coordinated transition system linking pediatric services to adult systems of care is expected to pose one of the most significant challenges to the healthcare system this century (Viner & Keane 1998). This is particularly evident in the area of mental health, where achieving continuous care is considered the most demanding transition area, since it requires the highest degree of interpersonal contact between service users and healthcare providers (Haggerty et al. 2003). Feedback from stakeholders involved in the transition between CAMHS and AMHS in Canada suggests that the child and adolescent mental health system appears to operate in silos in relation to adult mental health structures (MHCC, 2009; Government of Ontario, 2009). However, despite the complexity of establishing this type of transitional model of care, the research indicates that

> *Early, effective intervention, targeting young people aged 12–25 years . . . is required if we wish to reduce the burden of disease created by these disorders. A strong focus on young people's mental health has the capacity to generate greater personal, social and economic benefits than intervention at any other time in the lifespan and is therefore one of the "best buys" for future reforms* (McGorry, 2007, p. s6).

3.1: COMPONENTS OF THE TRANSITION

The literature on transitions has identified at least three co-occurring transitional components that directly affect the CAMHS/AMHS transition: the *institutional* (systems-level components); the *developmental* transition (individual variables); and *multiple* transition factors (representing the interface between systems, community and individual factors).

3.1.a: Institutional or Healthcare Transition (Systems Level)

At the systems level, the transition can be regarded as an administrative event (Vostanis, 2005). This process is often informed by bureaucratic and legal variables that are intended to direct service delivery and eligibility and assist in the management of service capacity and limitation (Mallory, 1995; Singh et al., 2010). Aging out is an example of the *institutional* transition process, whereby an event results in a change in status that renders the individual ineligible for the previous service and displacement from that service environment follows (Mallory, 1995). While institutional transitions are extremely effective from a management perspective, they also restrict access to services (Singh et al., 2010).

3.1.b: Developmental Transition (Individual Variables)

The institutional process associated with the transition from CAMHS to AMHS often overshadows a separate but equally important transition occurring in the lives of young people negotiating the interface. Most young people navigating institutional transitions will be experiencing a co-occurring developmental transition. This shift is directed by a maturational process and includes a number of social changes intended to increase competence. Within the definition of the developmental transition, there is an explicit acknowledgment of the importance of the developmental age of the client or patient (Singh et al., 2010). Research has demonstrated that understanding the impact of this developmental transition will better inform policy planning and coordination of care involved in the institutional transition (McGorry, 2007; Kirk, 2008).

> *Young people with mental health problems are particularly vulnerable, as evidenced by the fact that they have the highest rates of long-term morbidity and mortality (Royal College of Paediatrics and Child Health, 2003). Among 10-19 year olds, suicide is the second leading cause of death in Canada, representing approximately 19.7% of deaths (Statistics Canada, 2009). In Canada, the suicide rate of 15 to 19 year olds is one of the highest in the world ranking 4th amongst the 29 countries belonging to the Organization for Economic Co-operation and Development (OECD, 2009).*

3.1.b.i: Adolescence.

Adolescence is now regarded as a *process* that is initiated at puberty and that concludes when adult roles are adopted. During this time, changes in emotional, physiological, psychosocial and personal growth represent efforts to assume more adult-based competencies (Lee, 2001). Adolescence is also associated with increased risk-taking behaviours. The etiology of such behaviours is attributed to changing "biological (such as neuroendocrine influences and pubertal events), biopsychosocial (within which risk-taking is understood in relation to exploration, individuation and achieving autonomy) and psychological (related to establishing a locus of control)" factors that affect development (Rolison and Scherman, 2002 as cited in Singh et al., 2010). This period in the lifespan is also marked by higher psychological morbidity, and described as a time when more serious disorders such as psychosis emerge (Lamb et al, 2008). Not only is the transition age a period of heightened risk for the onset of psychological disorders but, for young people with existing mental health concerns, it is also the time when the development of co-occurring disorders, including substance abuse, is most likely (Pottick et al., 2008).

3.1.b.ii: Emerging Adulthood.

Emerging adulthood is a distinct period of lifespan development occurring between adolescence and adulthood, experienced by young people in industrialized societies. This is a culturally constructed transitional period in societies that have observed delays in markers of adulthood such as parenthood (Arnett, 2000). During emerging adulthood, the developmental competencies that began to form in adolescence are continued (Arnett, 2000). Optimal development in this phase is balanced between autonomy from and relatedness to the family of origin, and successful transitions are marked by both capacities (Chisholm & Hurrelmann, 1995; O'Connor et al., 1996). Peak incidence of several types of risk behavior occurs during emerging adulthood (ages 18-25) including unprotected sex, most types of substance use, and risky driving behaviors such as driving at high speeds or while intoxicated (Arnett, 2000; Bachman, Johnston, O'Malley, & Schulenberg, 1996).

3.1.b.iii: Protracted Adulthood and Implications for CAMHS/AMHS

Although critics have argued that considering developmental factors and including emerging adults in the CAMHS/AMHS transition prolongs the transitional process, there is good evidence to suggest that delaying this transition is in the best interest of youth. For instance, the literature on risk-taking behaviours demonstrates that declines in these types of behaviours occur between adolescence and adulthood due to maturation of the cognitive control system (evidenced by structural and functional changes in the prefrontal cortex), which allows for longer-term planning and improved abilities in the inhibition of

impulsive behaviors. Furthermore, maturation of connections between cortical and subcortical regions facilitates the coordination of cognition and emotion. This shift results in increased capacity for modulating socially and emotionally aroused thoughts with deliberate reasoning (Steinberg, 2008). Steinberg (2008) explains:

> "To the extent that improved coordination between the cognitive control and socio-emotional networks facilitates this regulatory process, we should see gains in resistance to peer influence over the course of adolescence that continue at least into late adolescence (when maturation of inter-region connections are still ongoing). This is precisely what we have found in our own work, in which we show that gains in self-reported resistance to peer influence continue at least until 18 (Steinberg & Monahan, 2007), and that the actual impact of the presence of peers on risky behavior is still evident among college undergraduates averaging 20 years in age (Gardner & Steinberg, 2005)" (p. 100).

The neurocognitive evidence presented above, combined with data supporting the developmental trajectory of risk-taking behaviours and the sociological evidence of a protracted adulthood in this culture, all suggest that many young people do not develop the skills necessary to negotiate effective mental health transitions before their mid-twenties. As a result, the expectation that youth can successfully negotiate CAMHS/AMHS transitions without embedded supports and in the absence of an appropriate model of care is a rather unrealistic idea, and one that is not well informed by the literature in the area. Recognition of the importance of mental health system navigation for youth and families has been highlighted by the Select Committee on Mental Health and Addictions (SCMHA) (2010).

3.1.c: Multiple Transitions (The Interface)

For a young person with mental health concerns, the challenge of negotiating the CAMHS/AMHS transition is compounded by a series of transitions that take place in concert with the mental health service transition. These include transitions in personal, interpersonal, and social domains (see below).

Personal	Interpersonal	Social
Developmental	Family	Activities
Personality	Peers	Contexts
Sexuality	Relationships	Vocational
		Housing
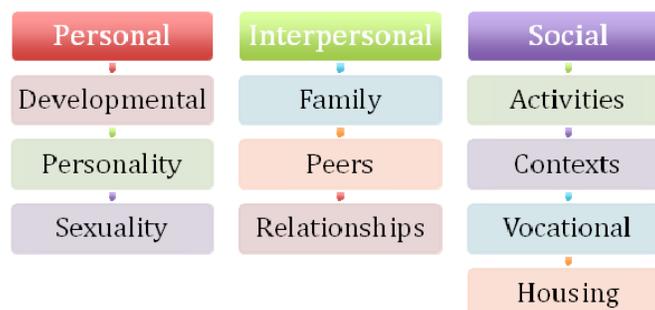
In many respects, the CAMHS/AMHS transition is a significant life event in the world of the young person. In order "to achieve effective transition, it must be recognized that transition in health care is but one part of a wider transition from dependent child to independent adult" (Viner, 1999, p. 271). One of the most significant barriers to successful CAMHS/AMHS transition is a mismatch between the institutional transition and the developmental transition. This lack of fit typically translates to care that is driven by the system rather than by the needs of the client/patient (Singh et al., 2010). Just as supports have been embedded in other systems to help support youth in transition, the mental health system, including hospital and community based care providers, needs to respond accordingly in an effort to recognize the significance of various transitions in the lives of young people.

The Mental Health Commission of Canada's vision, as communicated in its *Framework for a Mental Health Strategy in Canada,* states " the mental health system must respond to the diverse needs that arise from evolution across the lifespan" (2009, p. 61). For young people, this means attending to many transitions in their lives. Bridging the gap between dependence and independence necessitates a good fit between the institutional and developmental CAMHS/AMHS transitions, which invariably translates to attending to the transitions highlighted above. The importance of these transitions is reflected in the vision of the MHCC's framework that specifies "it will be essential to break down silos within the mental health and health care systems and to coordinate efforts with people working in areas that are not usually thought to be part of the mental health system such as broader primary health care services, schools, and workplaces" (MHCC, 2009). Other systems, including housing services, are also considered important to the transitional process.

3.2: THE IMPORTANCE OF FAMILIES AND CAREGIVERS

The vision of a person-centred mental health system necessitates an understanding of the person in their context (MHCC, 2009). This is particularly relevant for youth in transition, since connections to family are often tied to the mental health and well-being of young people (Singh et al., 2010). Families of youth in transition have a "role to play in fostering mental health and well-being, and can be an invaluable resource in promoting recovery from mental health problems and illnesses" (MHCC, 2009, p. 58). The MHCC's framework document recognizes that families can play a critical role in the lives of people with mental illness and should be considered in terms of treatment planning (2009). This vision is supported by research demonstrating that families are often considered the best resource in the lives of transition age youth due to their continuity in the lives of young people (Davis, 2003). However, family involvement must be tempered with consideration of dynamics and youth competency. To prepare for successful transition, it is essential to provide education to youth in transition, as well as to their families, about

changing legal status and factors that should be considered (guardianship and competency, for example).Youth and families must also be educated about the self-advocacy skills required to make mental health decisions and issues related to confidentiality.

3.2.a: Philosophical Shift

In the pediatric system, there is an expectation that families and guardians will be involved with aspects of treatment (e.g., Davis et al., 2003). The perspective concerning family involvement shifts drastically as youth enter the adult systems of care, where the general expectation is one of autonomous decision-making with minimal family involvement. For some youth this can be an intimidating experience and families often report feeling alienated during the transition (Por et al., 2004). This can be a difficult adjustment and youth can sometimes feel unprepared to make treatment decisions as they move to adult-oriented systems of care. However, research evidence clearly indicates that disengagement by youth in the CAMHS/AMHS transition is significantly reduced when collaboration with families occurs (Dixon, Adams and Lucksted, 2000; Pitschel-Walz et al, 2001, as cited in Mottaghipour, Woodland, Bickerton and Sara, 2006).

3.2.b: Competency and Confidentiality

Many youth in transition require ongoing support from their families as they move into the adult system. However, within this group, there exists a great deal of variability in terms of competency to make independent decisions (McGorry, 2007). As young people navigate the CAMHS/AMHS transition, their legal status changes. The effect of this shift is that youth are afforded more responsibility in their care, and the legal decision-making rights of the family decrease and are often eliminated altogether. Tensions are often created between youth and parents over confidentiality and privacy issues; these dynamics can have a powerful impact on treatment and efficacious transition. Sometimes this tension is explicit, such as when legal status changes and structures that were designed to protect the privacy of people living with mental health problems and illnesses are enacted. In many instances, as a result of privacy legislation, "family members have frequently been shut out of the treatment and recovery process. As a result, family members often feel helpless when they are denied access to information about the care and treatment of a loved one, or when information they want to share is dismissed out of hand" (MHCC, 2009, p. 59). However, there is a reluctance to strengthen the mental health act, since this would have an impact on the autonomy of those who interface with this system (SCMHA, 2010).

3.2.c: Complex Family Dynamics

At other times, familial tensions are more implicit. For instance, families differ in terms of their ability to act as a source of strength or resiliency in the life of the young person affected with mental illness. Oftentimes, circumstances within families may affect the level of support they are able to provide a transition-age youth (Perkins, 2001; Garland, Lewczyk-Boxmeyer, Gabayan and Hawley, 2004). It is important to acknowledge the delicate balance between the needs and perspectives of the youth in transition and their families, while recognizing that the relationships youth have with their families are connected to their mental health (Davis, 2003).

Youth and emerging adults may desire an increased level of confidentiality between themselves and their care providers, while parents – many of whom may have acted as advocates for their children when they were younger – may want to provide support to youth, particularly if they are living in the same environment, and have a desire to be included in care as a result. This tension is becoming more salient as adulthood becomes increasingly protracted; many youth continue to live with their parents during the transition.

3.3: FACILITATORS TO EFFECTIVE TRANSITIONS

A single set of empirically supported best-practice guidelines informing service delivery during CAMHS/AMHS transitions has yet to be produced (Pottick et al., 2008). Despite this, the literature scan demonstrated a high level of agreement regarding facilitators engendering more successful CAMHS/AMHS transitions (McDonagh, 2006; Singh et al., 2010). McDonagh (2006; see Table 01) has summarized a set of best practice recommendations currently being applied by various international service providers in attempts to improve the CAMHS/AMHS transition. At present, limited outcome data exist to support the use of these recommendations for mental health transitions. However, findings from a seminal evaluation of the *headspace* transition program evaluating the use of transitional guidelines were promising (Muir et al., 2009). Additionally, empirical outcome studies investigating the impact of *Transition to Independence Process (TIP)*, which is specific to emotional and behavioural disorders, demonstrated that the implementation of these best practice recommendations resulted in improvements in real-life outcomes for young people negotiating a CAMHS/AMHS transition (Clark, Pschorr, Wells, Curtis, & Tighe, 2004; Haber, Karpur, Deschênes, & Clark, 2008; Hagner, Cheney, & Malloy, 1999; Koroloff, Pullmann, & Gordan, 2008).

> *"You know, when you're growing up . . . you're learning. At an adult hospital you get no support and . . . . you don't know who you're supposed to go to, it's really a scarey place if you've never been there before." Youth in Transition, 19 years old.*

Table 1: Facilitators to successful transitions for youth with mental health concerns

1. An active, future-focused process

2. Young-person-centered

3. Inclusive of parents/care-givers

4. Starts early

5. Resilience framework

6. Multidisciplinary, inter-agency

7. Involves pediatric and adult services in addition to primary care

8. Provision of coordinated, uninterrupted health care

   - age and developmentally appropriate

   - culturally appropriate

   - comprehensive, flexible, responsive

   - holistic – medical, psychosocial and educational/vocational aspects

9. Skills training for the young person in communication, decision-making, assertiveness, self-care and self-management

10. Enhance sense of control and interdependence in health care

11. To maximize life-long functioning and potential

(Permission was obtained from Dr. Janet McDonagh and the Department of Health of England for the use of this table).

In addition to these guidelines, Viner recommends that in order for this transition to be successful, "institutional and management support must be assured at both ends of the . . . chain" and that "resources such as administrative . . . support must be available to ensure the efficient organization of appointments and the transfer of medical records" (1999, p. 273).

SECTION 3.4: BARRIERS TO EFFECTIVE TRANSITION

The interface between CAMHS and AMHS is composed of a number of barriers that create challenges for stakeholders – youth in transition, families, and service providers – in negotiating the gap between systems. Silver (1995) has demonstrated that youth between the ages of 17 and 20 are more interested in receiving mental health services than are their younger counterparts. However, the largest declines in service utilization are found in people between the ages of 17 and 24 (Government of Alberta, 2006). Given the enormous disparity between this desire and actual service provision, Davis (2003) asserts that the missing link is most likely to be a result of barriers to appropriate supports encountered by youth as they exit child-based service environments. Table 2 summarizes the most common barriers and provides strategies to improve transitional pathways:

> *I think at CAMHS its more of a 'lean on me and we'll walk down this road together' where out of CAMHS its kind of like, 'take a hike, there's the road- that's all you get' " – Youth in Transition, 18 years old.*

Table 2: Barriers to CAMHS/AMHS transitions and strategies to improve transitional pathways

Barrier	Strategy
1. Time	**1.** Time is one of the most significant barriers to providers being involved. Clinic appointments for adults are often shorter than pediatric/youth appointments and are not always tailored to the complex needs of youth in transition. Some flexibility is needed related to scheduling appointments for youth and developing realistic treatment plans for their developmental stage.
2. Different Care Philosophies	**2.** Youth in transition often feel displaced between the pediatric model of service delivery (where responsibilities are limited and family is considered a central part of delivery of care) and adult-oriented systems (that privilege autonomy and often disregard family concerns). This lack of fit between the model of care and the service can result in disengagement and poor transition in young people with mental health concerns (Davis, 2003). The most significant limitation of a mental health system that follows a pediatric/adult split in service provision is that it ignores emerging adulthood as an important period of development. This inevitably leads to the service environments that are not youth-centered by CAMHS and not family-oriented by AMHS.

3. Training	**3.** The pediatric/adult split in the system is exacerbated by training programs for mental health professions that emphasize this split in their educational models. The result is that most service providers, upon graduating from programs, lack the necessary competency to work with youth in transition. Many mental health professionals may lack an understanding of the approaches of the professionals on the opposite side of the split. A complicating factor in this process is a documented lack of communication between pediatric and adult health service environments. The combined effect of these variables is often that 1) service providers feel unprepared or unable to provide adequate mental health services for youth in transition; and 2) a culture of mistrust between pediatric- and adult-based providers is likely to develop (Sawyer et al., 2007; Davis, 2003; Blum et al., 1993; Singh et al., 2010; Por et al., 2004).
	Health professionals require training regarding evidence-based practices for transitions. It is necessary to disseminate information about the developmental period of emerging adulthood and how we can best serve this population.
4. Financial – insurance, resources for service provision	**4.** One of the biggest challenges faced by the mental health system is bridging the financial split between pediatric and adult mental health services. Funding is a critical issue; just as the responsibility for transitions needs to be shared, so too does the funding envelope.
5. Different perceptions of young person, parents, providers **6. Attitudinal**	**5 & 6.** People involved in care often have different goals for treatment and outcomes. Developing a transition plan represents a necessary step in identifying shared goals and in providing education about rights and responsibilities of stakeholders engaged in the transition.
7. Discomfort of professionals involved	**7.** Fostering a dialogue about the importance of mental health transitions within the healthcare system is necessary and will lay the foundation for mutually shared goals across the pediatric/adult split.
8. Difficulty accessing resources	**8.** To promote successful transitions, an elastic approach, whereby the changing needs and perspectives of youth are privileged over institutional factors, is preferred.
9. Poor intra-agency coordination	**9.** Developing common goals will facilitate streamlined communication within, and between, service environments (Por et al., 2004).

10. Poor interagency coordination	**10.** There is a great deal of diagnostic uncertainty for youth in transition since this developmental period marked by an overlap of normative turmoil, prodromal symptoms, and, in many cases, substance use (Singh et al., 2005). Even when the diagnosis is clear and recognized by CAMHS, there are no guarantees that it will result in service provision in AMHS. Oftentimes, the nomenclature fails to translate across the split, meaning the threshold for severity is not reached or the mandate of the AMHS does not recognize a diagnosis. In these cases, the most common outcome is a loss of service. In most instances this inspires a crisis-driven reconnection with the mental health system that proves costly for the individual as well as for the system. For the CAMHS/AMHS transition to be successful, the system-level responsibility has to be shared by pediatric and adult service environments.
11. Difficulties addressing parental issues	**11.** Families are often one of the best resources, but their involvement must be tempered with consideration of dynamics and youth competency. Research has demonstrated that families of youth in transition feel ignored and disrespected (Davis & Vander Stoep, 1996).
12. Adolescent resistance	**12.** Young people commonly endorse feelings of being misled and misunderstood by care providers during the transition (Hatter, Williford & Dickens, 2002). Patients and families must be educated in the self-advocacy skills required to make mental health decisions.
13. Family resistance	**13.** It is essential to provide education to youth in transition, as well as to their families, about the changing legal status and factors that should be considered (guardianship, competency) in preparing for the transition.
14. Lack of institutional support /lack of local protocols and procedures to guide transition	**14.** A number of administrative supports are needed to guide the transition process, including: 1) a formalized transition checklist or plan for the individual client; 2) agreements between service systems regarding transitions; 3) accessible communication channels for service providers; and 4) resources such as administrative support to manage appointments and to ensure that pertinent case information is shared amongst appropriate mental health professionals.

15. Lack of planning	**15.** All stakeholders (youth, parents, care providers) need to be made aware of the transition and be informed about roles and responsibilities in this process. For youth identified with childhood diagnoses, care should be taken to make sure that they receive the proper assessments in advance of the transition so that their eligibility for service provision is maintained. In addition to the need for flexibility, there has to be a period of preparation. This should target the needs of youth in transition, families, as well as professionals at both ends of the CAMHS/AMHS transition. This preparation period should be characterized by 1) didactic counseling for youth and families; 2) anticipation of assessments and changes in nomenclature to help ease the transition; and 3) a formal transition plan that is agreed to by all parties involved.
16. Lack of appropriate adult specialists	**16.** Limited training opportunities in adolescent mental health are available in Canada and there are shortages of health professionals who are knowledgeable about transitions (Kirby, 2006). In order to create a pathway for effective transitions, training opportunities must be created that emphasize the important goal of having adult providers who can meet youth at the transition.
17. Arbitrary age restrictions	**17.** Flexibility is required related to age cut-offs to ensure that the system is not driving the needs of the client, rather than the other way around. This approach respects the developmental period of emerging adulthood rather than serving to pathologize it, particularly in cases when diagnoses are not straightforward. Maintaining this elastic approach demonstrates a more youth-driven focus, whereby the changing needs and perspectives of youth are given priority over institutional factors. Although consideration of developmental age is certainly important, there remains a lack of understanding about how to assess readiness for CAMHS/AMHS transition. Some groups have suggested that asking young people to operationalize adulthood, and then using those individual definitions to determine readiness to transition, is a viable option (Government of Alberta, 2006).

SECTION 3.5: THE EFFECTS OF POOR TRANSITIONS

The institutional transition can pose a significant threat for youth with mental health concerns if the developmental transition is not accounted for (Vostanis, 2005). In these cases, the transition appears to be an administrative event rather than a pathway to well-being (Vostanis, 2005). The evidence demonstrates that the most common outcome of poor transition is that young people with enduring mental health concerns and continuing needs disengage from service (Crawford et al, 2004; Harpaz-Rotem et al., 2004). Estimates suggest that this occurs in as many as 60% of known cases (Harpaz-Rotem et al., 2004). The most vulnerable youth disengage at higher rates. For example, young, socially isolated males with high levels of service needs are the group most likely to disengage from services (Crawford et al, 2004). Disengagement is more likely in young people, since they are typically less likely to collaborate with clinicians about treatment-related issues both during the pre-transition and transition phases (Laugharne and Priebe, 2006).

> *It's kind of a cold water in the face feeling when you first hear that you're not going to have anything here and you're going to start fresh with someone else. You don't know what to expect, you don't know who it is and they don't know who you are. – Youth in Transition, 18 years old*

> **OBJECTIVE 2: To identify bodies of evidence supporting efficacious CAMHS/AMHS transitional pathways for youth**

4.0: HEALTHCARE MODELS OF TRANSITION FOR YOUTH

4.1: MODELS OF TRANSITION IN HEALTHCARE

While et al (2004) identified four models of transition that are commonly applied in a health care context (see Table 3):

Table 3: Transitional models applied in health service environments

> **1. Direct transition (communication and information sharing only)**
>
> **2. Sequential transition (includes the development of new services)**
>
> **3. Developmental transition (includes skill training and support system development)**
>
> **4. Professional transition (transfer of expertise only)**

Research on healthcare transitions clearly demonstrates that selecting one approach to transitions in isolation from others actually exacerbates the split between pediatric and adult-oriented healthcare. The MHCC goal of continuity of care can be achieved only when the individual models described are collapsed. According to Blum et al., 1993, the most efficacious healthcare models to support transition of young people share seven common principals:

1) Start early; foster healthy development in all domains
2) Involve child/youth and family in transition planning
3) Use a planned and coordinated approach
4) Ensure progressive movement towards active participation in health management
5) Ensure excellent information transfer
6) Reframe "leaving pediatrics" as an achievement
7) Continually evaluate programs/services

Section 4.1.a: The Healthcare Team Model

Section 4.1.a.i: Transition Team/Shared Management Approach.

The shared management approach has previously been applied in several healthcare contexts to direct the transitions of youth with chronic conditions from child service environments to adult service environments. Recently, the application of this framework by Bloorview KIDS REHAB and Toronto Rehab was recognized as a leading practice by Accreditation Canada (Accreditation Canada, 2008).

The model is typically composed of 1) a transition team to facilitate the movement of youth; and 2) a transitions coordinator (like nurse or social worker) who is hired by both organizations to direct the "development of a transition program while also assisting with training, evaluation, and even management of a transition clinic, among other tasks." (PCMCH, 2009, p.14). In a shared management framework, creating partnerships between adult healthcare providers, child providers, and family physicians is considered necessary to identify the most appropriate adult programs and services for youth in transition. Typically, clinics operate out of both pediatric and youth service locations; however, in some cases, stand-alone transitional clinics that interface with youth and adult service environments have been created.

The shared management framework posits that the implementation of transition teams requires establishing mechanisms to support accountability and training to all levels of healthcare providers. Whenever possible, investments should be made in "transition resources, such as (but not limited to) a transition coordinator" (PCMCH, 2009, p. 14). If dedicated resources to support the hiring of a transitions coordinator or establishing a clinic are unavailable, then time needs to be allocated to select individuals or a team of individuals within the organization who can work collaboratively to support youth in transitions.

Examples of Healthcare Transition Teams in Canada

Hamdani, Kingsnorth & Healy (2006) developed the *Living Independently and Fully Engaged Service Model* (LIFEspan), a holistic framework for providing continuity of care to youth transitioning to adult services. The guiding principles include partnership, collaboration, communication, and shared expertise. In 2006, Bloorview Kids Rehab and Toronto Rehab partnered to form a specialized clinic, LIFEspan, to assist youth with disabilities to transition to adulthood. The LIFEspan clinic was designed to fill gaps in adult services that put youth with disabilities at risk of developing preventable, secondary health conditions as they transition from pediatric to adult service systems. The clinic is located at Toronto Rehab and offers a single point of access for youth to receive coordinated services from a rehabilitation team that includes a nurse practitioner, a physiatrist, occupational, physical and speech therapists, and a social worker. The clinic is currently functioning as a demonstration project for individuals with cerebral palsy and acquired brain injury and a program evaluation is forthcoming.

The *Growing Up Ready* program at Bloorview Kids Rehab also prescribes to the shared management framework of service provision and functions as a multi-faceted program the goals of which is to provide youth and families the tools and skills for transitioning into adult services. This program is family-centered, and transitional planning is envisioned from an early age. Program tools include checklists designed to assess skill development necessary for transitional planning, along with the formal program itself, which assists youth transition into an adult rehabilitation centre with the support of a nurse practitioner who works with the client and family across both the paediatric and adult centres, as well as with the multidisciplinary team is in place at the adult centre. A complementary tool called *MyHealth Passport* is a portable, customized document that provides patient education. The tool was designed to foster self-advocacy, with the intention that the youth who use it will tool will gain experiences as they complete their own medical passport (Bloorview Website, 2010)

5.0: MODELS OF TRANSITION SPECIFIC TO MENTAL HEALTH

5.1: PROTOCOL AND RECIPROCAL AGREEMENT MODEL.

Recent policy initiatives in the U.K. have highlighted the importance of serving transition-age youth in the healthcare system. To support service providers in multiple health care areas, tools including protocols and reciprocal agreements were recommended by policy leaders and introduced by government (HASCAS, 2006). Policy-makers also advocated for the use of performance indicators to assess transitional outcomes (Commission for Health Improvement, 2003). To date, however, the uptake of practices to help inform transition at the level of service programs has been limited. Research has demonstrated that less than a quarter of mental health services in the U.K. have specific agreements to inform the CAMHS/AMHS transition (Singh et al., 2010). This lack of uptake occurs despite the dissemination of national service framework tools that are intended to support transitions. The TRACK study – Transitions of care from child and adolescent mental health services to adult mental health services (Singh et al., 2010) – indicated that while the model of transition used most often for CAMHS/AMHS is a protocol-based structure, it is not being implemented in an effective manner. Available protocols lacked specificity and many were inappropriate to the service context. Moreover, when protocols were available, there was a lack of awareness about their existence, and very few sites had reciprocal agreement structures in place with partnering AMHS provider. Singh and colleagues (2008) note that this approach to transitions reflects a pervasive policy-practice gap which, combined with the "complexity of service structures, arbitrary service boundaries . . ., all contribute to . . . a discontinuity of mental health care for a significant number of young people who experience no or poor transition of care across services" (Singh et al., 2008, p.5). According to the TRACK study, the largest gaps were noted in service for 16-18 year-olds (Singh et al., 2010).

Statistical Analysis of Factors Leading to Optimal CAMHS/AMHS Transition.

Logistic regression analyses of the protocols revealed that the variable most predictive of transition to AMHS was a severe and enduring mental illness that required pharmacotherapy interventions and admission to hospital. Singh and colleagues (2010) noted that those considered "at highest risk (Simmonds, Coid, Joseph, Marriott and Tyrer, 2001) and arguably most in need of adult mental health services seem more likely to be achieving transition" (p. 84). However, this raises significant concerns about the outcomes for other transition-age youth with conditions like emotional problems who have ongoing needs but do not reach the severity thresholds to ensure transition. TRACK findings also revealed that referrals accepted to AMHS and who remained in the system for at least three months were significantly more likely to have attended CAMHS with their parents. This provides evidence for best practice guidelines emphasizing the importance of family support in the lives of many young people negotiating the CAMHS/AMHS transition. The most surprising finding to come out of the TRACK study was that only a small percentage (4.4%) of referrals accepted from CAMHS to AMHS services experienced optimal transition. However, TRACK results indicated that AMHS accepted most of the referrals initiated by CAMHS. Misconceptions about the willingness of AMHS to accept referrals from CAMHS are pervasive in the field; however, the TRACK study revealed that these misconceptions were largely responsible for the failure of CAMHS to initiate referrals, thereby eliminating the possibility of successful transition altogether (Singh et al., 2010).

5.2: THE TRANSITION PROGRAM MODEL

Globally, the best-known transition program for CAMHS/AMHS is *headspace*. This program evolved as a community based model of care to complement Australia's Orygen program, which is composed of a specialized youth mental health clinical service, an internationally renowned youth mental health research centre, and a youth mental health training and communications program (Orygen, 2010). *headspace* was launched by the National Youth Mental Health Foundation of Australia in 2006 and is funded by the Government of Australia as part of its commitment to the Youth Mental Health Initiative (YMHI). The program was created to address gaps in service delivery, provide integrated, community-based care for youth, and facilitate improvements in the mental health, social well-being and economic participation of Australian youth aged 12–25 years. The goals of *headspace* include: 1) increasing the community's capacity to assist in the early identification of young people with mental health and related problems; 2)

encouraging help-seeking by young people and their caregivers 3) providing quality services that are evidenced-based and delivered by well-trained, appropriate professionals; and 4) enhancing coordination and integration within communities as well as at and state/territory government policy level (e.g., Muir et al., 2009; *headspace* Website, 2010).

headspace consists of service delivery sites called Communities of Youth Services (CYS) that provide dedicated services for young people. Recently, a formative program evaluation of *headspace* was completed by a group of independent researchers (Muir et al., 2009). Results revealed that the most successful *headspace* sites, both in terms of client outcomes and fiscal responsibility, 1) offered all four key service areas (mental health, physical health, AOD, social/ vocational) as part of a holistic treatment plan; 2) had attached private practitioners; 3) contained strong leadership with both clinical and business expertise; and 4) typically had a governance structure where a general practitioner-based agency acted as the lead with a smaller number of consortium members. The CYS's ability to provide a smooth, coordinated, high-quality service experience for young people from referral to service exit was identified as the single most important factor related to positive outcomes.

5.3: COMMUNITY CARE MODEL

SAMHSA is a co-ordinated network of community based services and supports organized to respond to the needs of children and youth with serious mental health needs and their families. Responding to the needs of youth and families requires many different strategies and agencies. Types of services that are funded under SAMHSA include care co-ordination (case/care management), community-based care, inpatient psychiatric care, and family support. One of the key components to ensuring the success of SAMHSA programming has been its family-driven and youth-guided approach (United States, SAMHSA, n.d.). However, the challenge for SAMHSA is supporting interagency communication at the CAMHS/AMHS transition when services are sparse (e.g., Davis et al., 2004). The TIP framework is a 'practice model,' meaning that it can be delivered by personnel within different 'service delivery' platforms, such as case management or in a team format (e.g., Assertive Community Treatment [ACT]). At the heart of the TIP practice model are proactive case managers with small caseloads (i.e., transition facilitators, aka: life coaches, transition specialists, or coaches, serving 15 or fewer youth/young adults). The TIP transition facilitators use core practices in their work with young people (e.g., rationales, social problem solving, in-vivo teaching, prevention planning on high-risk behaviors), to facilitate youth making better decisions, as well as improving their progress and outcomes (Clark et al., 2008, p. 2).

Community-Based Model for Transition: The Transition to Independence Process (TIP)

The Partnerships for Youth Transition (PYT) was a SAMSHA-funded initiative involving five community sites in Washington, Utah, Pennsylvania, Maine, and Minnesota. This program was designed to provide a one-year period of transitional planning followed by three years of implementation, to examine the progress and outcomes for youth and young adults transitioning from CAMHS to AMHS. The Transition to Independence Process (TIP) was the model that was applied to prepare youth and young adults with emotional and/or behavioural difficulties as they move into adult roles. This model privileges an individualized process and engages youth in the planning process. Providing developmentally appropriate services for youth between 14 and 25 is one of the cornerstones of the TIP framework.

"We're discharging you and I had never heard that term before, I didn't know what it was. You're in the middle of a crisis – you're in the hospital- and because your birthday comes when you're in there they'll wheel you away" – Youth in Transition, 20 years old

> **OBJECTIVE 3: To engage policy leaders and key stakeholders in a discussion regarding CAMHS/AMHS transitions in Ontario and report on their perspectives concerning CAMHS.AMHS transitions in the province.**

6.0: WHO OWNS THE TRANSITION PROBLEM IN ONTARIO?

The available evidence indicates that a "blind spot" in dedicated care and funding for youth in transition persists for two reasons. First, services required by youth in CAMHS/AMHS transition are spread across numerous ministries and public agencies, meaning that no single agency is mandated to serve this population. As a result, accountability is diluted across agencies (Davis, Fick, & Clark, 2000). Second, there is a financial issue related to pressures experienced in the pediatric/adult split that amounts to "funding jealousy" between service environments (e.g., Davis, 2003).

At present, the mental health care system in Ontario is composed of disparate entities. This inhibits effective service integration and clearly affects youth in transition, who are often moving between mental health systems. The Select Committee on Mental Health and Addictions (SCMHA) recently released the final report, *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Plan for Ontarians* (2010). One of the key recommendations made by the SCMHA was for the restructuring of mental health care in Ontario to "ensure that a single body is responsible for designing, managing, and coordinating the mental health and addictions system and that programs and services are delivered consistently and comprehensively" (2010, p. 19). This type of shift would help eliminate service boundaries and foster dialogue between care providers from both the CAMHS and AMHS systems. Systems change is important, but in order to fully address the complexity of the transition dilemma, training programs for mental health professions must also be targeted.

Many mental health professionals lack an understanding of the approaches of the professionals on the opposite side of the split. In part, this is a result of current mental health training/educational programs that emphasize a pediatric/adult split. The combined effect of a lack of accountability/communication and insufficient training results in 1) service providers that feel unprepared or unable to provide adequate mental health services for youth in transition; and 2) the development of a culture of mistrust between pediatric and adult based providers (Sawyer et al., 1997; Davis, 2003; Blum et al., 1993; Singh et al., 2010; Por et al., 2004). By collecting mental health services together under the umbrella of a single organization, it may be possible to recognize that mental health is a lifespan journey, and to place

emphasis on the shared importance of working collaboratively during the CAMHS/AMHS transition in an effort to produce better long-term outcomes for youth.

The research evidence also suggests that the split between pediatric and adult mental health services is perpetuated by funding animosity between pediatric- and adult-oriented systems of as well as hospital-based versus community models of service. In the Canadian context, where mental health care systems are chronically underfunded (Ramanow, 2002; Kirby Report, 2006), this split places youth in transition at significant risk (Vostanis, 2005). In order for a CAMHS/AMHS transitional model to be applied in a public service context, the literature unequivocally supports the use of core public funding (Muir et al., 2009). This requires a significant shift in perspective and necessitates that the rigidity of funding boundaries be reassessed for this population. Just as the responsibility for transitions needs to be shared between CAMHS and AMHS along with hospitals and communities, so too, does the funding envelope.

7.0: PROVINCIAL POLICY PERSPECTIVES

With the collaborative spirit of provincial contacts in Ontario, the research team was able to conduct a meeting with a panel of policy officials occupying various roles up to the position of assistant deputy minister from the provincial ministries of health, education, and child and youth services, as well as training, colleges and universities in Ontario. The research evidence was presented and policy officials provided their informed perspectives on transitions. Several key policy- and practice-level considerations emerged from the discussion.

7.1. MENTAL HEALTH AS A MOVING TARGET

7.1.a: Acknowledging developmental needs and special populations

Most youth who make contact with the system are treated similarly despite their differing developmental needs. This approach lacks a best fit for the client/patient that may result in care or treatment plans that are not well-suited to the concerns of the youth or the families involved. The lack of fit between the needs of the youth and the potential of the system is especially compromised during the CAMHS to AMHS transition and represents a systemic weakness in the mental health system. Moreover, the enormous philosophical shift between youth-serving and adult-serving organizations makes the co-occurring transition period a particularly fragile time for youth navigating mental health transitions.

7.1.b: Transitional Planning

Concerns about delays in the planning of the CAMHS/AMHS transition and the lack of coordination between youth-interfacing institutions including hospitals, colleges, universities, housing services, and employment were identified. Improvements to transitional planning were highlighted at both the policy and service levels. In particular, closer communication between transitional planning groups at the ministerial level and a more proactive approach to planning were identified as desired goals.

7.1.c: Roles and Responsibilities

Roles and responsibilities in the transition are not always salient. The danger is that communication concerns and role confusion often accumulate at the interface between CAMHS and AMHS. When this occurs, youth transitioning from CAMHS to AMHS may be perceived as *"a risk transfer rather than a shared responsibility."* Of note, the panel composition was primarily CAMHS in orientation and concern over the lack of representation of AMHS perspectives was expressed. In order to promote a shared care approach, it will be necessary to engage AMHS perspectives as well.

7.2: RISKS AND CONSEQUENCES OF POLICY IMPOSITION

There was a reluctance to mandate professional practice in youth mental health transitions. Indeed, the work of Singh and colleagues (2010) supports the notion that simply advocating for a protocol structure does not translate into a better system of care. However, some policy direction at the ministerial level was identified as a desirable output of the current project. In order for policy recommendations to be useful for policy leaders, stakeholders (service managers, care providers, youth, families) must be involved in the process of generating recommendations, and empirical data and information about the best available models in the field is required. The ministries need to 1) understand what the best practices for transitions are; and 2) evaluate the financial incentives and disincentives in order to determine feasibility and course of implementation before any action may be taken at a policy level.

7.3: MOVING MODELS INTO PRACTICE

7.3.a: Chronological versus developmental age

Concerns were expressed about the lack of flexibility in terms of funding youth in transition, given the chronological age demarcations that currently act as barriers within the system. An acute awareness about the impracticality of these types of arbitrary age restrictions was identified, and other programs and community level agencies that recognize the importance of the developmental model of care were noted. Applying developmental age as a context for the transition was discussed, and evidence from international groups, particularly in Australia, was convincing enough to encourage thought about some modification to the current system. Applying developmental age as a context for the transition appeared to be valued target for future policy development in this area.

7.3.b: Funding and accountability

Some uncertainty exists related to how implementation of a transitional model might be funded. However, a pilot project to help determine feasibility of the desired transitional model is considered the best first step. For a transitional model to exist in the long term, it must be appropriately supported by outcome data. A systematic evaluation, combined with interdisciplinary and cross-ministerial data convergence of mental health-related outcomes, would be necessary and longitudinal outcomes must be tracked. This level of information-sharing would challenge some of the current privacy laws in Canada and require amendments to current legislation. However, this is a central part of moving healthcare forward in Canada and would make Ontario a leader in this regard. Denmark has adopted a leadership role in this type of information-sharing since 1968, with personal information being stored electronically in the *Det Centrale Personregister*, permitting cross-ministerial data exchange.l It is possible to use this system as a model.

7.4: HOW TO BEST SUPPORT STAKEHOLDERS

7.4.a: The rights and needs of youth

Despite the costly nature of crisis-driven reconnection in the system some youth desire a "fresh start" as they move forward to AMHS. Discussions surrounding ongoing projects aimed at bridging connections between education and healthcare to support young people who are transitioning have taken place and, at the present time, policy leaders suggest that more information from youth is required to determine how they can be best supported in their mental health journey. Eliciting this kind of feedback from youth currently transitioning and from those who have recently transitioned was considered essential in informing the selection of a transitional model for CAMHS/AMHS. This policy recommendation aligns with targets discussed in the MHCC framework with regards to the development of a person-centred mental health system. The MHCC framework notes the importance of the engagement and empowerment of people with a lived experience of mental health problems. To improve transitions from CAMHS to AMHS, youth with mental health concerns must be encouraged to "actively participate in all aspects of the design, implementation and evaluation of a comprehensive, person-centred mental health system" (2009, p.17).

7.4.b: Being accountable to the mental health strategies that are in place

Leaders suggested that using a model to help facilitate the CAMHS/AMHS transition would target key policy-based goals, including 1) the development of a coordinated system of care with clearly delineated service plans that are appropriate to the service user; 2) involving families in the process; and 3) reducing stigma about mental health.

> *"You have to depend on yourself a whole lot more [when you enter AMHS] and that can be hard when you're young and you don't have a lot of trust for yourself or faith in yourself." – Youth in Transition, 21 years old.*

OBJECTIVE 4: To collate information from the literature and policy perspectives in an effort to generate recommendations for an appropriate model/approach to care for CAMHS/AMHS in Ontario.

8.0: RECOMMENDATIONS, CONCLUSIONS, AND FUTURE DIRECTIONS

SECTION 8.1: RECOMMENDATIONS

A list of policy and practice recommendations to support efficacious CAMHS/AMHS transitional pathways has been compiled using evidence from the literature, best practice standards for transition, and the perspectives of policy leaders in Ontario (see below):

Policy-Level Recommendations

1. The CAMHS/AMHS transitional model should reflect the policy goals for mental health in Canada and Ontario.

2. Policy-makers would like to help shape clinical practice rather than impose standards. To make key decisions about which transitional model might work best for CAMHS/AMHS transitions, policy leaders need information about the best-supported models for CAMHS/AMHS transitions, as well as feedback from stakeholders.

3. Policy-makers agree there needs to be increased flexibility related to the developmental age for youth transitioning from CAMHS to AMHS. Accordingly, a more elastic approach to funding services is needed for the funding of transition-age youth.

4. Longitudinal outcome data is required to evaluate future transitional programs/models of care. Changes will need to be made to legislation in order to link ministerial data in an effort to support a coordinated model of health care

5. Policy-makers require more information form youth to determine how to best serve transition-age youth and prevent crisis-driven reconnection.

6. The CAMHS/AMHS transition could act as a model for reform in healthcare.

Practice-Level Considerations

1. Developmental considerations should play a major role in helping to direct the transitional process for youth.

2. Transitional planning needs to be initiated earlier in the process, and transitional care plans need to be flexible to adapt to different service environments and the needs of the youth involved.

3. Transitional planning needs to be viewed as a shared responsibility rather than a risk transfer.

4. AMHS perspectives need to be engaged at both the policy and service levels in order to support a successful model of transition for youth.

5. Families are important stakeholders and need to be engaged in the transition process while still respecting the burgeoning autonomy of youth in transition.

8.1: MODEL SELECTION

The transitional models described in this report all provide a foundation for building a system of care that is driven by the needs of youth and their families. The selection of an appropriate transitional framework will depend largely on the context of the current service environment as well as the transitional goals of policy leaders, care providers and service users in the region. In this region of Ontario, a *shared management model* is being considered for recommendation as a framework for approaching youth mental health transition. Depending on the service contexts, available resources, goals, and needs of other regions, other transitional models discussed in this paper may be considered a better fit.

The shared management model has been applied (e.g., The LIFE Span) elsewhere in Canada and is identified as a leading process in healthcare (Accreditation Canada, 2008). Applying the gold standard of care from health focused transitional areas to mental health is a logical extension of the model. Although this model requires a high level of stakeholder investment and necessitates that funds be secured to provide for a transitions coordinator, the selected framework aligns with recent recommendations made by the SCMHA of Ontario (2010) advocating for system navigators to support youth and families moving between CAMHS and AMHS systems of care.

As the work of Singh and colleagues (2010) has demonstrated, establishing protocols to inform service delivery, although fiscally responsible, does not ensure continuity of care or collaboration during the CAMHS/AMHS transition. The failure of the protocol structure was largely due to a policy-practice gap resulting from policy imposition. However, the protocol structure is still considered important since it provides policy leaders and care providers with a map to facilitate how care will be directed. When applied as intended, the protocol structure can engender a sense of responsibility within the system. Perhaps one way to close the practice-policy gap is to elicit youth, family, and caregiver feedback to help generate protocols and tools that may be more specific to the needs of stakeholders in particular regions and which could be used to help direct service. The shared management framework often supports that use of "tools" that are intended to act as treatment plans and protocols adapted for the individual service user. The adaptation of youth-, family-, and careprovider- driven tools/protocols for service users in the mental health sector should be carefully considered as an important adaptation to the shared management framework for CAMHS/AMHS. The protocol framework could be used as an adjunct to the shared management model in this region.

Although the *headspace* program provides the most comprehensive care to youth in transition, the public health care context cannot currently support this type of transitional model of care since the funding model is not appropriate. Despite this, the *headspace* program has been extremely effective in bridging primary and community-based care, and this level of collaboration is an important target for CAMHS/AMHS transitions in Ontario (SCMHA, 2010). Although the shared management framework considers the bridge between primary and community care, further collaboration through the transition teams is considered especially important in the context of mental health (Haggerty et al., 2003). Involving community partners as part of the transition team will be a necessary adaptation to ensure that the shared management framework is applied successfully. The importance of including community providers in models of care is supported by outcome data from SAMHSA's community care program.

SECTION 8.2 FUTURE DIRECTIONS

In order to ensure that the shared management model will be a good fit for all stakeholders involved in the CAMHS/AMHS transition, more research is needed. Our group is currently in the process of conducting a research project involving surveys and focus groups of youth, parents, and mental health providers. Combining the literature scan and policy perspectives collated in this document, combined with the views of stakeholders that are directly involved in CAMHS/AMHS, will inform the selection of the framework and any adaptations that may be required to promote effective transitions.

A future initiative is envisioned for this project and would consist of an applied component. Combining the best practice recommendations emerging from this literature scan with the perspectives of stakeholders involved in the CAMHS/AMHS would inform a shared management framework for CAMHS/AMHS. The next phase would be implementation of this framework in a pilot study to assess the efficacy of a partnership program for transitions in youth mental health. A group of professionals bridging expertise in community and primary mental healthcare would be assembled and these people would act collaboratively as a transition team. The composition of the group should include a transitions coordinator, a psychiatrist, a psychologist, a community mental health worker, and a social worker. Apart from the coordinator position, all other professionals attached to the project would be working in kind.

The primary goal of this project would be to facilitate the successful transition of youth between institutional and community agencies by applying the knowledge gleaned from study phases 1 and 2. Objectives of the third phase include 1) identifying a group of youth to transition; 2) providing didactic counseling for the youth and parents; 3) facilitating the transition; and 4) ensuring that the transition was successful for the stakeholders involved (youth, families, service providers, and community). Focus groups of parents, youth, and providers would be conducted at the end of the pilot to help evaluate outcomes and identify strengths and limitations of the community program. Results from this pilot study would be used to guide the development of the permanent transition teams in mental health – a first in Canada.

Establishing this kind of team transition program would be a first in Canadian mental health and would fit the model of service proposed by the MHCC (2009) by helping " to break down silos within the mental health and health care systems and to coordinate efforts with people working in areas that are not usually thought to be part of the mental health system such as broader primary health care services, schools, and workplaces" in an effort to provide youth in transition with a better standard of care. The proposed transition program is informed by best practice guidelines, empirical research in the field, and stakeholder contributions that, if implemented, may help establish a better standard of mental health care. If successful, this framework could hold enormous potential to act as the launching point for future program development in the area of youth mental health transitions. Such an event would undoubtedly position Canada as an international leader in mental health care for young people and their families.

REFERENCES

Accreditation Canada. 2008. *Leading Practices Survey Year 2007*. Accreditation Canada: Ottawa.

Arnett, J.J. 2000. Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55: 469-480.

Bachrnan, J. G., Johnston, L. D., O'Malley, P., & Schulenberg, J. (1996). Transitions in drug use during late adolescence and young adulthood. In J. A. Graber, J. Brooks-Gunn, & A. C. Petersen (Eds.), *Transitions through adolescence: Interpersonal domains and context*. Mahwah, NJ: Erlbaum.

Beresford, B. 2004. "On the road to nowhere? Young disabled people and transition." *Child: Care, Health and Development*, 30: 581-587.

Bloorview. 2010. Website: http://www.hollandbloorview.ca.

Blum, R., D. Garrell, C. Hodgman, T. Jorissen, N. Okinow, D. Orr et al., 1993. "Transition from child-centered to adult health-care systems for adolescents with chronic conditions: a position paper for the Society of Adolescent Medicine." *Journal of Adolescent Health*, 14: 570-576.

Burke, R. M. Spoerri, A. Price, A.M., Cardosi, P. Flanagan. 2008. "Survey of primary care pediatricians on the transition and transfer of adolescents to adult health care." *Clinical Pediatrics*, 47: 347-353.

Chisholm, L., & Hurrelmann, K. (1995). Adolescence in modern Europe: Pluralized transition patterns and their implications for personal and social risks. *Journal of Adolescence*, 18, 129-158.

Clark, H. B., Karpur, A., Deschênes, N., Gamache, P., & Haber, M. 2008. Partnerships for Youth Transition (PYT): Overview of community initiatives and preliminary findings on transition to adulthood for youth and young adults with mental health challenges. In C. Newman, C. Liberton, K. Kutash, & R. M. Friedman. (Eds.). *The 20th Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base* (pp. 329-332). Tampa, FL: University of South Florida. The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Clark, H.B., Deschênes, N., Sieler, D., Green, M., White, G., & Sondheimer, D. 2008. Services for Youth in Transition to Adulthood in Systems of Care. In B.A. Stroul & G.M. Blau (Eds.). *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families*. Baltimore, MD: Paul H. Brookes.

Clark, H.B., Pschorr, O., Wells, P., Curtis, M., & Tighe, T. 2004. "Transition into community roles for young people with emotional behavioral difficulties: collaborative systems and program outcomes." In D. Cheney (Ed.) *Transition of secondary approaches for positive outcomes* (pp. 201-226.). Arlington, VA: The Council for Children with Behavioral Disorders and

The Division of Career Development and Transition, Divisions of The Council for Exceptional Children.

Commission for Health Improvement. 2003. *Transition of care between CAMHS and adult services*. www.chi.nhs.uk.

Conway, S. P. 1998. Transition from paediatric to adult-oriented care for adolescents with cystic fibrosis. *Disability and Rehabilitation,* 20: 209-216.

Crawford, M.J., E. de Jonge, G.K. Freeman, T. Weaver. 2004. Providing continuity of care for people with severe mental illness: a narrative review. *Social Psychiatry and Psychiatric Epidemiology*, 39: 265-272.

Davis, M., S. Banks, W. Fisher and A.J. Grudzinskas. 2004. "Longitudinal Patterns of Offending During the Transition to Adulthood in Youth from the Mental Health System. Journal of Behavioural and Health Services Research 31: 351-366

Davis, C., Fick, K., & Clark, H.B. 2000. Strategies to finance transition services. In H.B.Clark & M. Davis (Eds.). *Transition to adulthood: a resource for assisting young people with emotional or behavioral difficulties*. Baltimore, MD: Brookes Publishing

Davis, M. 2003. Addressing the needs of youth in transition to adulthood. *Administration and Policy in Mental Health*, 30: 495-509.

Davis, M., & Vander Stoep, A. 1996. *The Transition to Adulthood among Adolescents Who Have Serious Emotional Disorders: At Risk for Homelessness.* Report published by the National Resource Center for Homelessness and Mental Illness, Delmar, NY.

Dixon L, Adams C, Lucksted A. 2000. Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, 26: 5–20.

DOH. 2006. *Transition: Getting It Right for Young People*. Department of Health: London.

European Commission. 2003. *The Health Status of the European Union. Narrowing the health gap*. Luxemburg: European Communities.

Gardner, M and L. Steinberg. 2005. Peer Influence on Risk Taking, Risk Preference, and Risky Decision Making in Adolescence and Adulthood: An Experimental Study. *Developmental Psychology*, 41: 625–635.

Garland, A.F., C.M. Lewczyk-Boxmeyer, E.N. Gabayan, K.M. Hawley. 2004. Multiple stakeholder agreement on desired outcomes for adolescents' mental health services. *Psychiatric Services*, 55: 671-676.

Government of Alberta. 2006. Positive Futures – Optimizing Mental Health for Alberta's

Children Youth: A Framework for Action. http://www.health.alberta.ca/documents/Mental-Health-Framework-Child-06.pdf

Government of Ontario. 2009. Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy A Discussion Paper.

Haber, M., Karpur, A., Deschênes, N. & Clark, H.B. 2008. Community-based support and progress of transition-age young people with serious mental health problems: A multi-site demonstration. *Journal of Behavioral Health Services & Research.* 35: 488-513.

Haggerty, J.L., R.J. Reid, G.K. Freeman, B.H. Starfield, C.E. Adair, and R. McKeandry. 2003. Continuity of Care: A Multidisciplinary Review. *British Medical Journal* 327: 1219-1221.

Hagner, D., Cheney, D., & Malloy, J. 1999. Career-related outcomes of a model transition demonstration for young adults with emotional disturbance. *Rehabilitation Counseling Bulletin,* 42, 228-242.

Hamdani, Y., S. Kingsnorth & H. Healy. 2006. Consensus on best practices for transition to adult service: Summary of Pre-Conference Workshop. Transitions Conference 3: Growing Up Ready

Bloorview Kids Rehab.
http://www.hollandbloorview.ca/resourcecentre/transitions/documents/transitionsbestpractices.pdf.

Harpaz-Rotem, I., D. Leslie, R.A. Rosenheck. 2004, Treatment retention among children entering a new episode of mental health care. Psychiatric Services, 55:1022-1028.

HASCAS. 2006. *HASCAS: CAMHS to Adult Transition: A Literature Review for Informed Practice.* Health and Social Care Advisory Service: London.

Hatter, R. A., Williford, M., & Dickens, K. 2000. Nurturing and working in partnership with parents during transition. In H. B. Clark & M. Davis (Eds.), *Transition to adulthood: A resource for assisting young people with emotional or behavioral difficulties* (pp. 209-228)*.* Baltimore, MD: Paul H. Brookes.

headspace. 2010. Website: http://www.headspace.org.au.

Health Canada. 2002. A Report on Mental Illnesses in Canada. Retrieved April 18, 2010 from http://www.phac-aspc.gc.ca/publicat/miic-mmac/

Kessler, R.C., W.T. Chui, O. Demier, and E.E. Walters. 2005. Prevalence, Severity and Comorbidity of 12 Month DSM-IV Disorders in the National Comorbidity Survey Replication.*Archives of General Psychiatry* 62: 617-627.

Kim-Cohen, J., A. Caspi, T.E. Moffitt, H. Harrington, B.J. Milne, and P.J. Poulton. 2003. "Prior Juvenile Diagnoses in Adults: Developmental Follow Back of a Prospective Longitudinal Cohort. *Archives of General Psychiatry* 60: 709-717.

Kirby Report. 2006. *Committee on Social Affairs, Science and Technology. Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada.*

Kirk, S. 2008. "Transitions in the lives of young people with complex healthcare needs." *Excellence in Paediatrics*, 34: 567–575.

Koroloff, N., Pullmann, M., & Gordon, L. 2008. Investigating the relationship between services and outcomes in a program for transition age youth. In: Newman C, Liberton C, Kutash K, Friedman RM (eds.). *The 20th Annual Research Conference Proceedings: A System of Care for Children's Mental Health: Expanding the Research Base.* Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health, 326-329.

Lamb, C. D. Hall, R. Kelvin, M. Beinum. 2008. *Working at the CAMHS/Adult Interface: Good practice guidance for the provision of psychiatric services to adolescents/young adults: A joint paper from the Interfaculty working group of the Child and Adolescent Faculty and the General and Community Faculty of the Royal College of Psychiatrists.*

Laugharne, R. and S. Priebe. 2006. "Trust, choice and power in mental health: A literature Review." *Social Psychiatry and Psychiatric Epidemiology*, 41: 843-852.

Lee, N. 2001*. Childhood and society: Growing up in the age of uncertainty*. Buckingham: Open University Press.

Mallory, B.L. 1995. The Role of Social Policy in Life-Cycle Transitions. *Exceptional Children,* 62.

McDonagh, J.E. 2006. *Growing up ready for emerging adulthood: An evidence base for professionals involved in transitional care for young people with chronic illness and/or disabilities*. Cambridge: Eastern Region Public Health Observatory.

McGorry, P.D. 2007. "The Specialist Youth Mental Health Model: Strengthening the Weakest Link in the Public Mental Health System. *Medical Journal of Australia* 187(7 Suppl): S53-6.

Mental Health Commission of Canada (MHCC). 2009. *Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada.*

Ministry of Child and Youth Services. 2006. *A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health.*

Mottaghipour, Y., L. Woodlan, A. Bickerton and S.Grant. 2006. "Working with families of patients within an adult mental health service: development of a programme model." *Australasian Psychiatry*, 14: 267-271

Muir, K., A. Powell, R. Patulny, S. Flaxman, S. McDermott, I. Oprea, S. Gendera, J. Vespignani, T. Sitek, D. Abello and I. Katz. 2009. "*headspace* Evaluation Report: Independent Evaluation" *headspace*: the National Youth Mental Health Foundation." Social Policy Research Centre: University of New South Whales.

OECD. 2009. *Doing Better for Children*.

O'Connor, T. G., Allen, J. P. Bell, K. L., & Hauser, S. T. (1996). Adolescent-parent relationships and leaving home in young adulthood. *New Directions in Child Development*, 71, 39-52.

Offord, D.R. and Boyle, M.H. 1989. Ontario Child Health Study: Correlates of disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28: 856-860.

Offord, D.R., M.H., Boyle, J.E., Fleming, H. Munroe Blum, and N.I. Rae-Grant. 1989. "Ontario Child Health Study: Summary of Selected Results." *Canadian Journal of Psychiatry*, 34:483-491, 1989.

Orygen. 2010. Website: http://oyh.org.au.

Patel, V., A.J. Flisher; S. Hetrick, McGorry, P. 2007. "Mental health of young people: A global public health challenge." *The Lancet*, 369: 1302-1313.

PCMCH. 2009. *Transition: A Framework for Supporting Children and Youth with Chronic and Complex Care Needs as they Move to Adult Services.* Provincial Council of Maternal Child Health: Toronto.

Perkins, R. 2001. "What constitutes success? The relative priority of service users' and clinicians' views of mental health services. *British Journal of Psychiatry,* 179: 9-10.

Pitschel-Walz G, Lencht S, Bauml J et al. 2001. The effect of family intervention on relapse and rehospitalization in schizophrenia: a meta-analysis. *Schizophrenia Bulletin*, 27: 73–92.

Por, J. B. Goldberg, V. Lennox, P. Burr, J. Barrow, L. Dennard. 2004. Transition of care: Health care professionals' view. *Journal of Nursing Management*, 12: 354-361.

Pottick, K.J., S. Bilder, A. Vander Stoep, L.A. Warner, and M.F. Alvarez. 2008. US Patterns of Mental Health Service Utilization for Transition-Age Youth and Young Adults. *The Journal of Behavioral Health Services and Research* 35(4): 373-389.

Roberts, R.E., C.C. Attkinson and A. Rosenblatt. 1998. Prevalence of Psychopathology Among Children and Adolescents. *American Journal of Psychiatry* 155: 715-725.

Rolison, M.R., A. Sherman. 2002. Factors influencing adolescents' decisions to engage in risk-taking behaviour. *Adolescence*, 37: 585-597.

Romanow, R. and the Commission on the Future of Health Care in Canada. 2002. *Building on Values: The Future of Health Care in Canada – Final Report*

Royal College of Paediatrics and Child Health. 2003. *Bridging the Gaps Health Care for Adolescents.*

Rutter, M. 1989. Isle of Wight revisited: Twenty five years of child psychiatric epidemiology. *Journal of the American Academy of Child and Adolescent Psychiatry*, 28: 633-653.

Sawyer, S.M., S. Drew, M.S. Yeo, M.T. Britto. 2007. Adolescents with a chronic condition: challenges living, challenges treating. *The Lancet*, 369: 1481-1489.

Select Committee on Mental Health and Addictions. 2010. *Final Report: Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians.*

Shaffer, D., Fisher, P., Dulcan, M. K., Davies, M., Piacentini, J., Schwab-Stone, M. E., et al. 1996. The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. J*ournal of the American Academy of Child & Adolescent Psychiatry*, 35, 865-877.

Silver, S. K. Unger, B. Friedman. 1995. *Transition to adulthood among youth with emotional disturbance. Report 839* Tampa University of South Florida, Mental Health Institute, Research and Training Centre for Children's Mental Health.

Singh, S., N. Evans, L. Sireling, H. Stuart. 2005. "Mind the Gap: The Interface Between Child and Adult Mental Health Services." *Psychiatric Bulletin*, 29: 292-294.

Singh, S.P., M. Paul, T. Ford, T. Kramer, and T. Weaver. 2008. "Transitions of Care from Child and Adolescent Mental Health Services to Adult Mental Health Services (TRACK Study): A Study of Protocols in Greater London." *Biomed Central Health Service Research* 8: 135.

Singh, S.P., M. Paul, Z. Islam, T. Weaver, T. Kramer, S. McLaren R. Belling T. Ford, S. White, K. Hovish, K. Harley and TRACK Project Steering Committee members: J. Dale, N. Evans, N. Fung, D. Hayes, B. Jezzard, A. Rourke, M. Zwi. 2010. *Transition from CAMHS to Adult Mental Health Services (TRACK): A Study of Service Organisation, Policies, Process and User and Carer Perspectives Report for the National Institute for Health Research Service Delivery and Organisation Programme.*

Simmonds S, Coid J, Joseph P, Marriott S, Tyrer P. 2001. Community mental health team management in severe mental illness: a systematic review. *British Journal of Psychiatry* 178: 497-502.

Statistics Canada. 2009. *Mortality, Summary List of Causes 2005 (Release date: March 30, 2009) Catalogue no.: 84F0209XWE. Table 2 Deaths by selected grouped causes, age group at time of death and sex, Canada.* Statistics Canada.

Statistics Canada. 2002. *Canadian Community Health Survey: Mental Health and Well-being, 2002.*

Steinberg, L. 2008. A Social Neuroscience Perspective on Adolescent Risk-Taking. *Developmental Review*, 28, 78–106.

Steinberg L, Monahan K. 2007. Age differences in resistance to peer influence. *Developmental Psychology,* 43: 1531-1543.

Stephens, T. C., Dulberg & N. Joubert. 1999. Mental health of the Canadian population: A comprehensive analysis. *Chronic Diseases in Canada*, 20: 118-126.

U.S. Department of Health and Human Services. (2000). *Report of the Surgeon General's conference on children's mental health: A national action agenda.* Washington, DC: U.S. Government Printing Office.

United States, SAMHSA (Substance Abuse and Mnetal Health Services Association). Deprtment of Health and Human Services. nd.
http://systemsofcare.samhsa.gov/newinformation/docs/SOCfactsheet.doc

Viner, R. 1999. Transition from paediatric to adult care. Bridging the gaps or passing the buck?. *Archives of Disease in Childhood*, 81:271-275.

Viner R and Keane M. 1998. Youth Matters: Evidence-based Best Practice for the Care of Young People in Hospital. *Caring for Children in the Health Services*: London.

Vostanis P. 2005. Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? *Current Opinion in Psychiatry,* 18: 449-454.

Waddell, C. and C. Shepherd. 2002. *Prevalence of Mental Disorders in Children and Youth: A Research Update Prepared for the British Columbia Ministry of Children and Family Development*

Wattie, B. 2003. The Importance of Mental Health In Children. Canadian Mental Health Association, Ontario Children and Youth Reference Group. Retrieved April 12, 2010, from http://www.ontario.cmha.ca/children_and_youth.asp?cID=6880

While, A., Forbes, A., Ullman, R., Lewis, S. Mathes, L. and Griffiths, P. 2004. Good practices that address continuity during transition from child to adult care: synthesis of the evidence. *Child: Care, Health and Development*, 30 (5): 439–452.

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