Implementation of Best-practices for Transitioning Youth to Adult Mental Health & Addiction Services

Lauranne Warner
Dr. Hal M. Cain, Ph.D.

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Dedication
For Jackson Cash; my light, my love, my reason.
We can touch the stars.
IMPLEMENTATION OF BEST-PRACTICES FOR TRANSITIONING

Abstract

Considerable research has been done to determine the unique needs of transitional-aged youth and the most effective way for service providers in the mental health and addiction fields to meet these needs. However, there has been limited exploration into the application of these evidence-based recommendations, and no research has been found which examines the use of these protocols within Kingston, Frontenac, and Lennox & Addington counties (KFL&A). This study endeavored to examine the implementation consistency of evidence-based best-practice protocols for transitioning youth into adult mental health and addiction services within KFL&A. A literature review was conducted, which identified three phases of youth service transition: (a) providing youth-specific services, (b) preparing youth for transition, and (c) transitioning youth to adult services. This information was then used to develop the Best-practices for Transitional-aged Youth - Agency Questionnaire, a 69-item survey designed to explore implementation consistency of evidence-based best-practices when transiting youth into local adult mental health and addiction services. An electronic version of the questionnaire was completed by 11 mental health and addiction service providers for youth between the ages of 13 and 24 years old in KFL&A. A descriptive analysis of the data demonstrated that consistent implementation of best-practices was most evident during the preliminary phases of transition, including the provision of youth-specific services and the planning of youth services transitions. The implementation of best-practices during the actual transition of youth into adult services was less consistent. The relationship between access to written best-practice documentation and the implementation of evidence-based protocols was also examined, however, the results demonstrated an inconclusive connection between these factors. Many limitations were identified, including the use of a small and non-representative sample. The study did, however, identify a gap in the research and offered several suggestions for future exploration of youth transitions into adult mental health and addiction services.
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Chapter 1 - Introduction

Mental illness is a common diagnosis among Canadians, with 1 in 5 individuals experiencing symptoms of a mental disorder each year (Smetanin, Stiff, Briante, Adair, Ahmad, & Khan, 2011). While an estimated 1.2 million youth between the ages of 9 and 19 have already experienced major a depressive episode, 3.2 million Canadian youth within this age range are at risk of developing depressive symptoms in their lifetime (Smetanin et al., 2011). Research indicates high instances of previous mental illness diagnoses in individuals who have died by means of suicide (Werth, 2004). The relationship between mental illness and suicide is so strong that recurrent suicidal ideation is listed under the diagnostic criteria for major depressive disorder (American Psychiatric Association, 2013). Not surprisingly, when considering these statistics, suicide is the second leading cause of death for Canadian youth (Smetanin et al., 2011).

Instances of substance abuse, which commonly co-occur with mental illness, are also rising in Canada. In 2012, 6 million Canadians over the age of 15 met the criteria for a substance abuse disorder (Pearson, Janz, & Ali, 2013). With the exception of tobacco, alcohol dependence is the most common example of substance abuse in Canada and poses the greatest risk to both physical and economic well-being (Mood Disorder Society of Canada [MDSC], 2009). According to the MDSC (2009), 20% of Canadians who consume alcohol report personal injury as a result, and 33% report causing injuries to others while intoxicated. Up to 27% of young people under the age of 24 in Canada have used illegal drugs (MDSC, 2009). In addition, youth with addiction to illegal drugs are at far greater risk for various health problems and legal concerns (Cotter, Greenland, & Karam, 2013).

In a study for the Mental Health Commission of Canada, Smetanin et al. (2011) estimated the total cost of mental illness to the Canadian economy as being well over 50 billion dollars, or 2.8% of Canada’s gross domestic product for 2011. This total cost included that of health care, social services, income supports, and lost business revenues due to employee absences and turnover (Smetanin et al., 2011). The study also estimated the total cost to the Canadian economy will be approximately 2.5 trillion dollars by 2041. An estimated 18.6 billion dollars is drained from the Canadian economy each year as a result of substance abuse in the workplace (MDSC, 2009). According to Young and Jesseman (2014), the economic cost of substance-related hospital stays in Canada is 267 million dollars each year. Alcohol was the greatest detriment to the Canadian economy, with a cost of over 145 million dollars each year (Young & Jesseman, 2014).

With 70% of mental illness in Canada beginning in childhood or adolescence and continuing into adulthood, the need for effective transitions from child to adult mental health services has been well documented (Government of Canada, 2006). The lack of integration and communication between Canadian child and adult mental health and addiction services reduces the likelihood of successful youth transitions between service agencies (Pottick et al., 2008). Unfortunately, approximately 60% of youth with continuing mental illness disengage from services during transition (Harpaz-Rotem et al., 2004). Disengaged youth are less likely to develop appropriate, prosocial roles and responsibilities in adulthood (Pottick et al., 2008). As a result, future reengagement in adult mental health and addiction services is most often crisis driven for these individuals (Harpaz-Rotem et al., 2004).

In response to these concerning statistics, extensive research has been conducted in the field of psychology to determine the most effective protocols for providing youth-specific services, and for transitioning youth into adult mental health and addiction services (Gorter, Stewart, & Woodbury-Smith, 2011; Smith, 2011; Williamson, 2009; Williams & Sherr, 2008; Centre for Addiction and Mental Health [CAMH], 2015). While these best-practice protocols have been well validated in the literature, the actual rate of implementation of these recommendations within Canadian communities is somewhat less obvious. This current hole in youth service research is
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unfortunate and is a potentially important area for further investigation. Therefore, the following study aimed to further investigate the utilization of appropriate protocols by posing the question: To what extent are evidence-based best-practices for transitioning youth into adult mental health and addiction services being implemented in the counties of Kingston, Frontenac, and Lennox & Addington (KFL&A)?

Purpose

The purpose of the study was first to develop a clear understanding of evidence-based protocols for youth-specific mental health and addiction service transitions, through a comprehensive review of the relevant literature. The second, but most important, purpose of the research was to examine the degree of implementation of these identified best-practices. To address the research question, a survey was developed to sample staff of mental health and addiction agencies serving youth within KFL&A.

Overview of this Paper

The following Literature Review, Chapter 2, will highlight the relevant literature on evidence-based best-practice for (a) providing youth-specific mental health and addiction services, (b) preparing youth for service transitions, and (c) transitioning youth to adult services. In addition, suggested areas for further research will be discussed. The Method Chapter, Chapter 3, will provide a detailed explanation of the development and distribution of the Best-Practices for Transitional-Aged Youth - Agency Questionnaire. The Results Chapter, Chapter 4, will provide a descriptive analysis of the results of the questionnaire. Finally, the thesis will conclude with the Discussion Chapter, Chapter 5, which includes a summary of the results mentioned in Chapter 4, an explanation of strengths and limitations to the study, contributions to the field of behavioural psychology, and suggestions for future research.
Chapter 2 - Literature Review

Mental Illness in Canada
An estimated 50% of Canadians over the age of 40 have been diagnosed with mental illness at some point, and 8% of Canadian adults have experienced major depressive symptoms (Smetanin, Stiff, Briante, Adair, Ahmad, & Khan, 2011). Fortunately, approximately 80% if people who seek medical attention for mental health symptoms will benefit from treatment (Mood Disorder Society of Canada [MDSC], 2009). While treatment has been shown effective, less than 50% of individuals who have experienced major symptoms have sought formal treatment; and, only 1 in 5 youth with mental illness access supports (Smetanin et al., 2011; MDSC, 2009). Research indicates high instances of previous mental illness diagnoses in individuals who have died by means of suicide (Werth, 2004). The relationship between mental illness and suicide is so strong that recurrent suicidal ideation is listed under the diagnostic criteria for major depressive disorder (American Psychiatric Association, 2013). When considering the prevalence of mental illness among Canadians and the evidence-based relationship between mental illness and suicide, the fact that suicide is a leading cause of death for Canadians of various age groups is not surprising (Smetanin et al., 2011). In fact, suicide accounts for 24% of total deaths among citizens between the ages of 15 and 24 years old and accounts for 16% of all deaths in Canadians between 25 and 44 years of age (Smetanin et al., 2011; MDSC, 2009). Suicide is still the second leading cause of death for Canadian adolescents and claims the lives of 4,000 young people each year (Smetanin et al., 2011; MDSC, 2009).

Substance Use and Addiction in Canada
While mental illness is a considerable concern for the Canadian population as a whole, the connection between mental illness and substance abuse cannot be ignored. According to the MDSC (2009) approximately 30% of individuals diagnosed with mental illness also experience an addiction, a concurrent disorder. The negative effects of substance addiction on the wellbeing of Canadians of all ages cannot be denied. Alcohol use during pregnancy is the leading cause of preventable birth defects in North America, and over 900 individuals each year are killed in alcohol related vehicle accidents (Pearson, Janz, & Ali, 2013).

In a study by the Government of Canada (2013), the reported use of illicit drugs is three times higher for Canadian youth than for adults. Up to 27% of young people under the age of 24 in Canada have used illegal drugs (Government of Canada, 2013). The adverse effects of substance use and addiction are pervasive in adolescence. The Government of Canada (2013) found that Canadian youth under the age of 24 are four times more likely than adults to report harm as a result of substance abuse. According to Cotter, Greenland, and Karam (2013), the highest rate of drug-related offences was in young people between the ages of 18 and 24 years old. According to the MDSC (2009), only 8% of youth prostitutes in Canada are unaffected by addiction, and approximately 44% engage in prostitution to pay for illicit substances.

Best-practices for Providing Youth-Specific Mental Health & Addiction Services
To ensure the most effective transition for youth entering adult mental health and addiction services, best-practices for the basic provision of youth-specific services must first be considered.

Recommended therapeutic approaches. Principles of psychosocial rehabilitation (PSR) are a recurrent theme in the research on mental health and addiction services delivery in general and are also considered best-practices for youth-specific services delivery (Gorter, Stewart, & Woodbury-Smith, 2011; PSR/RPS Canada, 2017; Smith, 2011; Williams, 2009; Williams & Sherr, 2008). Service delivery with the ultimate goal of community reintegration is a central principle of PSR (PSR/RPS Canada, 2017; Williams, 2009; Williams & Sherr, 2008). Community reintegration involves a combination of behavioral skill training, supportive network development, and
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involvement in extracurricular activities to encourage increased prosocial engagement in the community (Haggerty, Wells, Jenson, Catalano, & Hawkins, 1989). These themes should be woven into each phase of the treatment process and must be flexible to accommodate the strengths and needs of the individual client (King, Baldwin, Currie, & Evans, 2005; PSR/RPS Canada, 2017). The principles of PSR also indicate that youth services should be implemented with an overall respect for the individual (PSR/RPS Canada, 2017; Williams, 2009; Williams & Sherr, 2008). Therefore, service providers should make a consistent and conscious effort to avoid labelling and discrimination when providing youth-specific services (PSR/RPS Canada, 2017; Williams, 2009; Williams & Sherr, 2008). The culture and ethnicity of the young person should be respected and integrated into the treatment plan (PSR/RPS Canada, 2017; Williams, 2009; Williams & Sherr, 2008). Service providers should also strive to respect gender identity of adolescent clients, and gender sensitivity should be incorporated into the treatment process (PSR/RPS Canada, 2017; Simard & Blight, 2007; Williams, 2009; Williams & Sherr, 2008). Finally, the model of PSR specifies that a client-driven and strength-based approach is key to effective youth service delivery (Centre for Addiction and Mental Health [CAMH], 2015; PSR/RPS Canada, 2017; Williams, 2009; Williams & Sherr, 2008).

Williams and Sherr (2008) investigated the effectiveness of the PSR model on the daily functioning of children and youth with severe mental disturbances (SMD). The authors conducted evidence-based outcome assessments to quantify changes in participant’s daily functioning after providing community integration and skill-building interventions (Williams & Sherr, 2008). The children and youth were provided with personalized interventions which were complementary to existing mental disorders and were based on deficits identified through pre-assessments (Williams & Sherr, 2008). Williams and Sherr (2008) demonstrated general improvements in daily functioning with the delivery of individualized PSR interventions and that improvements are dose-dependent. Participants who received more hours of PSR-based treatment showed greater positive effects on daily functioning than participants who received fewer hours (Williams & Sherr, 2008).

In addition to the PSR principles, various other evidence-based approaches have been identified in the research on youth service best-practices. These therapeutic approaches are generally complementary to the PSR model and allow for further program individualization based on client needs. For example, the harm-reduction approach has been demonstrated as effective for youth with substance abuse disorder, primarily when the program has been specifically tailored to the substance use history and experience of the young person (Jenkins, Slenon, & Haines-Saah, 2017; Sloboda et al., 2009). Jenkins et al. (2017) found that the majority of youth using illegal substances already engage in procedures to reduce the likelihood of adverse consequences of substance use. The authors suggest that treatment which incorporates the principles of harm-reduction without the cessation of substance use offer greater relatability, and therefore greater likelihood of positive outcomes, for youth addicted to illegal substances (Jenkins et al., 2017).

As another example, a recent report by the South East Local Health Integration Network (SE LHIN) recommended the incorporation of a client-centered approach, designed to foster collaborative therapeutic relationships with adolescent clients (Lee, 2013). The SE LHIN identified several gaps in available youth services, and recommend an individualized, youth-specific programming focusing on the specific needs of the youth. Cultural differences, transportation issues, rural challenges, and housing concerns should all be considered when developing wrap-around early intervention strategies in a client-centered approach (Lee, 2013). In 2015, CAMH produced the Youth Transitioning in KFL&A: Protocol for Youth Transitioning into Adult Mental Health and Addictions Services (YTP), which was based partially on the 2013 SE LHIN research. The YTP also highlights the necessity for a client-centered, low barrier approach to youth mental health and addiction services (CAMH, 2015). A low-barrier approach to services involves the elimination of obstacles which could impede youth access to supports (CAMH, 2015). For example, services should
be delivered within an environment which is comfortable and convenient for the young person, and programming should incorporate language and activities which are age appropriate (CAMH 2015).

Other evidence-based elements of successful youth programming include trauma-informed, solution-focused, and peer-support approaches (Cherewick et al., 2015; Hopson & Kim, 2004; Leggatt & Woodhead, 2016; Naslund, Aschbrenner, Marsch, & Bartels, 2016). Cherewick et al. (2015) investigated successful coping mechanisms developed by children and youth who had experienced personal, family, or community trauma. These mechanisms consisted primarily of cognitive and behavioural coping strategies. Cherewick et al. (2015) suggest practitioners identify traumatic experiences through structured interviews and use this information to customize cognitive-behavioural treatments. Hopson and Kim (2004) outline central aspects of a solution-focused intervention. The authors explain that each client possesses the skills, traits, and strengths to solve life problems and must merely be guided to these resources (Hopson & Kim, 2004). A peer-support approach to therapy involves a client discussing personal experience and seeking positive support from peers with similar presenting concerns. For example, Naslund et al. (2016) found that youth who engaged in peer-support activities through social media had greater treatment compliance than individuals who did not engage in peer-support activities. This variety of available evidence-based approaches for youth-specific service delivery allows for the implementation of individualized programming and customized treatment planning through the incorporation of multiple complementary perspectives.

**Recommended therapeutic techniques.** In addition to the individualized approach to youth service delivery, principles of various forms of behavioural therapy have been demonstrated as effective for youth-specific mental health and addiction treatment. Cognitive behavioural therapy (CBT), a therapeutic approach which explores the effects of thoughts on feelings and actions, is a long-standing, effective treatment for individuals experiencing mental health illness and addiction, including adolescents (Hides, Elkins, Catania, Mathias, Kay-Lambkin, & Lubman, 2007). A randomized controlled trial, conducted with 182 participants, found both group and individual CBT effective in managing symptoms of anxiety disorders in youth (Wergeland et al., 2014). Cognitive behavioural therapy, in the form of a brief cognitive-behavioural skills training program, has also been shown effective in increasing community integration for youth with a co-occurring mental illness and substance abuse disorders (Hides et al., 2007).

Dialectical behaviour therapy (DBT) is a variation of CBT rooted in acceptance of emotional triggers and control over responses to these triggers. Dialectical behaviour therapy, a common approach to youth mental health and addiction treatment, has also been shown effective (Rakfeldt, 2005). In a study of 15 youth with severe emotional disturbances, Rakfeldt (2005) sought to determine the effectiveness of long-term group DBT on various life-skill domains for this population. Rakfeldt (2005) provided 12 months of individual CBT to each of the two sample groups. The research also delivered weekly group DBT skills-training sessions exclusively to the experimental group for 12 months. The study demonstrated increased positive outcomes for participants who received DBT group counselling than for those who received individual sessions of CBT alone.

Acceptance and Commitment Therapy (ACT), a type of clinical behaviour analysis focused in mindfulness of emotions and control over reactions, was also deemed effective in the treatment of depression in diverse adolescent populations (Hayes, Boyd, & Sewell, 2011; Petts, Duenas, & Gaynor, 2017). In addition, Thurstone, Hull, Timmerman, and Emrick (2017) used a combination of ACT and motivational interviewing to decrease adolescent substance use. The combination intervention yielded reductions in substance use and high levels of participant-reported satisfaction. However, while much of this research related to DBT and ACT demonstrated clinically significant change, small sample sizes in many of the studies suggests these findings should be supported by
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results of additional research. On the other hand, a study of 200 homeless youth based exclusively in motivational interviewing used a much larger sample and still demonstrated positive changes in both substance and condom use (Tucker, D'Amico, Ewing, Miles, & Pedersen, 2017).

Additional recommendations. While therapeutic approaches and treatment models are primary considerations in a clinical setting, additional elements increase positive outcomes in youth mental health and addiction programs. Inclusion of family in the treatment process, access to psychiatric services, and regular use of standardized outcome measures yield positive treatment outcomes and, according to the literature, should be integrated whenever possible (Brann, Alexander, & Coombs, 2012; Cassells et al., 2015; Giles & Martini, 2016; Rigter et al., 2013). Other recommendations include that all therapeutic sessions should be held in a location that is familiar and comfortable to the young person; and, youth-friendly language should also be used throughout the treatment process (CAMH, 2015). Therefore, it appears that best-practices for providing youth-specific mental health and addiction services consist of a customized combination of these evidence-based approaches and techniques based on the individual client.

Best-practices for Preparing Youth for Transitions in Mental Health & Addiction Services

In contrast to the flexibility in best-practices for youth-specific service delivery, best-practices for preparing youth for the transition into adult services consists of a comprehensive list of tasks to be completed universally for each client (CAMH, 2015). This list is based the Youth Transitioning in KFL&A: Protocol for Youth Transitioning into Adult Mental Health and Addictions Services (YTP), a toolkit designed specifically to outline evidence-based best-practices for youth service transitions in KFL&A (CAMH, 2015).

The YTP. The foundation of this protocol is the involvement of the young person in the initial transition planning and decision making throughout the transition process (CAMH, 2015). According to the YTP, the reasoning for the service transition must be explained to youth, prior to initiation of the transition planning. The young person should also be involved in the negotiation of transition timelines and choosing the members of the transition team, including family, teachers, or other mentors (CAMH, 2015). The transition timeline and team must be amenable to the young person, prior to further transition planning (CAMH, 2015). Incorporation of youth opinion into the development of the team and timeline is essential to ensure client engagement and buy-in throughout the transition process (CAMH, 20015). The YTP states that confidentiality should be discussed, and consent obtained, prior to any transition networking between service agency staff. According to the best-practice literature, the responsibility to secure consent for the sharing of documentation lies with the youth agency (CAMH, 2015; Singh et al., 2010b). All collateral information, especially a comprehensive case-note summary from the transitioning agency, should then be made available to the receiving agency (CAMH, 2015). The receiving agency is responsible for the review of collateral documentation and collection of missing information when necessary (CAMH, 2015).

The principles of psychosocial rehabilitation (PSR). In addition to recommendations for proving youth-specific services, the foundations of the PSR model also provide valuable, evidence-based suggestions to improve the success of youth service transitions (Gorter, Stewart, & Woodbury-Smith, 2011; Smith, 2011; Williams, 2009; Williams & Sherr, 2008). The principles of PSR mandate that youth be provided with coping skills to combat life stressors and that staff make a conscious effort to improve resiliency in youth throughout the transition planning process (Williams, 2009; Williams & Sherr, 2008).

Best-practices for Transitioning Youth into Adult Mental Health & Addiction Services

Like the structured best-practice procedures for preparing youth for service transitions, the evidence-based recommendations for transitioning youth between agencies are most effective when
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implemented consistently and universally (CAMH, 2015). Substantial international research has been conducted, and recurring themes emerged in the findings. Four elements of successful youth service transitions have been identified, including (i) continuity of information sharing, (ii) collaborative transition planning (iii) parallel care, and (iv) long-term continuity of care (Singh, Paul, Ford, Kramer, & Weaver, 2008; Singh et al., 2010a; Singh et al., 2010b).

Continuity of information sharing. Once again, the YTP provided by CAMH (2015) provides a clear summary of evidence-based recommendations for information sharing. Following the preparation of the youth for service transition, the YTP specifies that the receiving agency respond to the transition agency within five business days (CAMH, 2015). Research suggests that the receiving agency should offer an outline of relevant services available within their agency or should recommend more suitable services within the community (CAMH, 2015). Service fit (e.g., age requirements and program eligibility) and availability are best assessed by staff from the transitioning and receiving agencies, prior to proceeding with the transitions (CAMH, 2015). Research shows successful transitions are more likely when service providers work collaboratively to plan for possible setbacks and resolve wait-list and eligibility barriers (CAMH, 2015).

Collaborative transition planning. With the input of the youth client, a transition team is created consisting of the young person, a staff member from the transitioning agency, a staff member from receiving agency, and any other allies desired by the client (CAMH, 2015). A single staff member is chosen from one of the agencies to coordinate the transition (CAMH, 2015). The time and location of each meeting of the transition team should be verified with the young person in advance by the transitioning agency, and at least one of these meetings should be held at the receiving agency’s location, for purposes of orienting the youth within the new agency (CAMH, 2015).

All members of the transition team, including the youth, should be contribute to the creation of a written transition plan (CAMH, 2015). According to the YTP, the written transition plan should be reviewed a second time with the youth, and the young person should be given the opportunity to ask questions of all members of the transition team. Input from all transition team members must be considered, and the written plan should be agreed upon and consistently available to each member of the transition team (CAMH, 2015).

Parallel care. Following the completion of the written transition plan, the YTP requires that a single staff member is identified within the adult service agency to welcome and support the youth through the transition process (CAMH, 2015). The young person is provided with an orientation of the adult service agency building and made familiar with the structure of adult services (CAMH, 2015). Time should be designated to answer youth questions related to the structure and expectations associated with adult services, and a member of the transitioning agency’s staff should serve as advocate for the young person throughout the process (CAMH, 2015).

Long-term continuity of care. Ideally, the service transition should be completed within the recommended three to six-month timeline (CAMH, 2015). Best-practice protocol dictates that the transitioning agency schedule regular follow-up appointments with the young person to assess transition success (CAMH, 2015). The receiving agency should consult with the transitioning agency with concerns related to service-fit or disconnect throughout the transition process, and for up to six months after the transition is completed, according to the YTP. The transitioning agency should participate in efforts to re-connect the youth with adult services in the event of disengagement during this six-month period (CAMH 2015). This combination of principles, including (a) continuity of information sharing, (b) parallel care (c) collaborative transition planning, and (d) long-term continuity of care, ensure successful transitions for youth into adult mental health and addiction services transition when adhered to consistently.
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Summary

Evidence-based protocols for youth services and transitions should be implemented consistently in Canadian mental health and addiction service models. Extensive research has been conducted to determine effective best-practice in this area, and three main themes emerge when the literature is summarized. First, youth-specific mental health and addiction services must draw on a variety of evidence-based approaches and techniques to develop an effective service program and set the stage for a successful transition to adult services. Second, a transition team should be elected to adequately plan and prepare for the young person’s shift to adult mental health and addiction services. Third, and finally, the transition process should be conducted in a consistent and timely manner through the collaboration all members of the transition team. Despite the vast available literature on the specific protocols which produce the most effective youth service transitions, there appears to be a lack of published literature on implementation consistency. Further research is needed to determine the extent to which these protocols are being applied in Canadian communities.
Sample
A comprehensive list of community mental health and addiction agencies servicing the counties of Kingston, Frontenac, and Lennox & Addington (KFL&A) was created with the assistance of an agency supervisor. Forty-two of these agencies’ staff were identified as having regular contact with transitional-aged youth during structured service delivery. These youth services included, but were not limited to, case management, vocational, housing, shelter, and mental health and addictions counselling services. Each of these 42 identified service providers was invited to participate in the study through email correspondence. The invitation specified that participation was voluntary, and that consent was inferred through completion of the questionnaire.

Best-Practices for Transitional-Aged Youth - Agency Questionnaire
The Best-practices for Transitional-aged Youth - Agency Questionnaire (BPTAY-AQ) is a 69-item online survey developed to explore whether community agencies implement evidence-based best-practices when transiting youth into adult mental health and addiction services. The tool was created by the researcher based on a review of 37 peer-reviewed resources related to best-practices for youth transition procedures. The format for the questionnaire was inspired primarily by the structure of the ITRACK questionnaire, developed by McNamara et al. (2014) as a service mapping tool for mental health and addiction supports in the Republic of Ireland. The ITRACK questionnaire was developed using a similar process to the BPTAY-AQ. McNamara et al. (2014) conducted a review of the literature related to transitioning youth between child and adult mental health and addiction services from English-language electronic research databases in Europe and North America. In the ITRACK study, the researchers also incorporated the results of 57 clinical interviews with consulting psychiatrists for both child and adult mental health and addiction services in Europe (McNamara et al., 2014). Findings from the literature review and the clinical interviews were compiled into the ITRACK questionnaire and distributed to mental health and addiction service agencies in Ireland to assess implementation of various protocols for youth services transitions (McNamara et al., 2014). The Youth Transitioning in KFL&A: Protocol for Transitioning Youth to Adult Mental Health and Addiction Services (YTP), developed by the Centre for Addiction and Mental Health (2015), was consulted extensively when developing the tool. The YTP is an evidence-based toolkit designed to map the ideal transition path for youth entering adult mental health and addiction services in the KFL&A counties.

Identified best-practice procedures from these resources were compiled into a master list of 59 items, and then organized into three groups for the questionnaire. This allowed for the exploration of three individual facets of the youth transition process, specifically (a) best-practices for providing services to youth, (b) best-practices for preparing youth for transition, and (c) best-practices for youth transition procedures. The first of these survey sections, which related to best-practices for providing services to youth, was focused on effective approaches for engaging young people in age-appropriate mental health and addiction services. The second section, which focused on best-practices for preparing youth for transition, addressed evidence-based techniques for the coordination of various logistics of the service transitions in advance. The third, and final, section of the questionnaire, which related to best-practices for youth transition procedures, addressed the recommended procedures for effectively transitioning youth into adult mental health and addiction services. These three sections of the questionnaire contained 24, 11, and 24 items respectively. Each of these 59 items provided four response options, including (0) Unknown, (1) Never, (2) Sometimes, and (3) Always.

Finally, a 10-item Agency Information section was added to the beginning of the questionnaire to collect demographic information about responding agencies. This section contained
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Qualifying questions to identify the agency and extract information related to youth specific programming within the agency (e.g. numbers of youth-specific programs and staff, wait-list times, and accessibility of best-practice documentation within the agency). The items on the Agency Information section of the survey allowed respondents to input eight open-ended answers and required two yes or no option responses. Agency names were collected for categorization purposes and for better interpretation of results. For purposes of confidentiality, respondent’s names and agency identifiers were not included in this document.

Data Collection and Analysis

The Best-practices for Transitional-aged Youth - Agency Questionnaire was input into the SurveyMonkey™ (2017) online survey creator. The SurveyMonkey service enabled the researcher to create a digital copy of the questionnaire and collect unlimited digital responses. The survey was distributed through email invitation to each of the 42 service providers identified by an agency supervisor. The questionnaire was available for a total of six weeks, and reminder emails were sent during the second and fifth weeks of the study. Thank you notes were also distributed electronically to each respondent upon the closure of the survey. A descriptive analysis was conducted to interpret the data.
Chapter IV – Results

A total of 42 agency contacts were identified for electronic distribution of the Best-practices for Transitional-aged Youth - Agency Questionnaire (BPTAY-AQ). A total of 11 completed surveys (26% response rate) were returned. One survey was only partially completed and was therefore not used in the descriptive analysis. Ten unique service agencies were represented within the sample of 11 respondents. Agencies serving clients between the ages of birth and 12 years old were considered to provide child services for purposes of this study. Youth services were considered to be offered by agencies serving clients between 13 and 24 years old. Agencies providing services to clients of ages 25 and over were classified as providing adult services. Respondents were labeled with more than one age category as necessary. For example, an agency with clients between the ages of 12 and 24 years old was classified as providing both child services and youth services. An agency with clients aged 16 and older was classified as providing both youth services and adult services. Therefore, the sample consisted of 27.27% (n=3) exclusively youth services, 27.27% (n=3) child/youth services, 36.36% (n=4) youth/adult services, and 9% (n=1) child/youth/adult services. All respondents were identified as providing some type of mental health and addiction services to youth and having regular contact with young people between the ages of 13 and 24 years old.

Consistency in Implementation of Best-practice Protocols

The total scores for the entire sample (n=11) were combined, and responses from the three sections of the questionnaire (i.e., providing youth-specific services, preparing youth for transition, and transitioning youth to adult services) were compared (see Figure 1). Based on the scores, implementation of best-practices was most consistent during the providing youth-specific services section of the questionnaire, with 94% of responses indicating that best-practices are implemented at least some of the time during this preliminary phase of transition. Similar scores were found for the preparing youth for transition section of the questionnaire, with 92% of responses indicating that best-practices are implemented at least some of the time during this second phase of transition. The extent of implementation of best-practices during the transitioning youth to adult services phase was less consistent. Twenty-six percent of responses from this final section of the questionnaire indicated that professionals were unsure whether or not best-practices were being implemented during the actual transition period. In addition, only 23% of responses suggested that best-practices were implemented consistently throughout the final transition phase. In comparison to the two previous sections, only 69% of responses to the transitioning youth to adult services portion of the questionnaire indicated that best-practices were being implemented at least some of the time during this transition phase.
Youth-specific services. A secondary analysis of the sample data compared the scores of respondents who did have access to best-practices documentation for providing youth-specific services with those respondents who did not (see Figure 2). Through question nine of the survey, which assessed access to best-practice documentation for youth-specific services, 54.55% (n=6) of respondents confirmed access to written protocols related to providing youth specific services, while 45.45% (n=5) of the respondents reported they did not. Total responses to the providing youth-specific services portion of the questionnaire were compared for these two groups to determine whether agencies which had access to best-practices documentation tended to implement these procedures more consistently than those agencies who did not.
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The results of this analysis revealed similar scores for both groups (i.e., those who had access to best practice documentation and those who did not). A total of 94% of responses from agencies with access to relevant documentation confirmed implementation of best-practice procedures for youth-specific services at least some of the time, in comparison to 93% of responses from agencies without access. Notable in these findings is the slightly more consistent pattern of implementation of protocols by agencies without access to written documentation than those agencies with access. Agencies without access to written protocols selected *always* for 54% of responses to the *providing youth-specific services* section of the questionnaire, while agencies with access to documentation selected *always* for only 51% of responses.

**Preparing & transitioning youth to adult services.** A third and final analysis of the sample data compared the scores of respondents who reported access to best-practices documentation for transitioning youth to adult services with those respondents who reported no access (see Figure 3). Through question ten of the survey, which assessed access to best-practice documentation for youth service transitions, 81.82% (n=9) of respondents confirmed access to written protocols, while 18.18% (n=2) of respondents reported no access. Total responses to the *preparing youth for transition* and *transitioning youth to adult services* portions of the questionnaire were compared between these two groups to determine whether agencies which had access to best-practices documentation tended to implement these procedures more consistently than those agencies who did not.

![Figure 3. Comparison of best-practice protocol implementation for the preparing youth for service transitions and the transitioning youth to adult services sections of the “Best-practices for Transitional-aged Youth Questionnaire”](image)

Greater differences in the implementation consistency of best-practices were demonstrated during examination of the final two sections of the questionnaire (i.e., *preparing youth for service transitions* and *transitioning youth into adult mental health and addiction services*). Respondents without access to written protocols were almost twice as likely as likely as respondents who had documentation to indicate that they were unsure whether best-practice procedures were implemented during the preparation and transition stages of service; 34% for those with access to documentation and 18% for those without access. In addition, agencies without access to written protocols were
more than five times as likely to respond that the items in the final two sections of the questionnaire were never implemented than agencies with documentation; 11% for agencies with access to documentations and 2% for those without access. Both groups of respondents chose sometimes with similar frequency throughout these sections of the survey; 44% for agencies with access to documentation and 39% for agencies without. Finally, respondents with access to written protocols were more than twice as likely as respondents without documentation to indicate that best-practice procedures were always implemented during the preparation and transition stages of service; 37% for those with access to documentation and 15% for those without access.
Chapter V: Discussion

Although the sample population used for this study was limited in size, the group of local agencies which participated in the research did provide a variety of mental health and addiction services to individuals of all ages in the community (i.e., Kingston, Frontenac, and Lennox & Addington [KFL&A]). Within the small group of respondents, child, youth, and adult service providers were all represented. In addition, each agency featured in this research was identified as offering some type of mental health and addiction services to youth in the age range of 13 to 24 years old. These variations and consistencies in service eligibility within the sample were essential to provide the most accurate possible picture of transitional services for youth in KFL&A.

Implementation of Best-practices

Scores of all responding agencies were totaled for each of the three sections of the questionnaire, and response rates were calculated for each response option. According to the findings of this study, best-practice protocols were implemented most consistently when providing youth-specific services and when preparing youth for service transitions. Less consistency was observed when analyzing response rates from the closing section of the questionnaire, which evaluated the implementation of best-practice protocols during the transition of youth to adult services. Due to the limited sample size and the type of data collected with the questionnaire, few conclusions could be made as to the cause of these differences in consistency across the phases of youth service transition.

While definitive conclusions cannot be made as to the cause of these inconsistencies, various factors could have contributed to these findings. For example, agency staff may receive more support and reward from managers for providing youth-specific services and for planning service transitions than for proper execution of transition plans. Staff may feel pressure to take on new or additional clients, due to agency mandated caseloads and waitlists. In addition, the completion of the transition to adult services requires detailed, reciprocal communication and follow-through from all parties involved in the transition process. This level of collaboration required between families and the multiple service providers required for successful transition may be more challenging to achieve than what is necessary to simply plan the service transition. Finally, differences in adherence to evidence-based best-practices across phases of the transition process may be explained by variations in staff training and access to reference materials related to best-practice protocols. To further explore possible contributing factors to implementation consistency, a further comparison was done between respondents with and without access to best-practice documentation within the service agency.

Access to best-practice documentation for youth-specific services. Approximately half of the responding agencies indicated that they had access to written best-practice protocols for provision of youth-specific services. According to responses on the BPTAY-AQ, implementation of these protocols was slightly higher for respondents without access to best-practice documentation. Superficially, these findings indicate that access to written documentation has a negative effect on implementation consistency of these protocols. However, other factors may have influenced these findings. For example, respondents without access to written protocols may have worked for agencies which seamlessly incorporate best-practices for youth-specific services into initial employee training and job descriptions. Best-practices may become second nature for these respondents and were therefore implemented more consistently than in agencies which may have provided written protocols, but not necessarily incorporated them into workplace training or expectations. Documentation may have been used as part of the initial staff training process but was not provided for future reference in the workplace. Items related to training procedures were not included in the current questionnaire (i.e., the BPTAY-AQ), but could offer insight into a possible explanation for these findings.
Access to best-practice documentation for preparing youth & transitioning to adult services. Findings of this research revealed that access to written protocols related to planning and implementing youth service transitions was more common among respondents than protocols related to the general provision of youth-specific services. Agencies without best-practice documentation for planning and executing transitions had less knowledge of whether these protocols were being regularly implemented during youth-specific service delivery and transition planning. Furthermore, survey respondents without access to written documentation were more likely to select always throughout the final two sections of the questionnaire (i.e., best-practices for preparing youth for transition and best-practices for the youth transition procedures). These findings suggest that respondents who do not have regular access to written best-practice protocols related to preparation and implementation of transitions tended to implement those protocols less consistently than respondents who do have access.

An obvious explanation for this pattern is simply that staff without access to documentation were less likely to implement best-practices because of the lack of reference material available within the agency. The absence of reference material may have resulted in limited understanding of evidence-based youth transition protocols among staff. Agency staff without access to written protocols may also have responded unknown more frequently throughout the preparing youth for transition and transitioning youth to adult services sections of the questionnaire because consistency of implementation was not standardized or expected to the same degree within these agencies.

Making Connections

The results of the first analysis of the data, which examined overall best-practice implementation consistency, were somewhat echoed in the secondary analyses, which compared implementation consistency between agencies which did or did not have access to best-practice documentation. Implementation of best-practice protocols were reported to be more consistent during the provision of youth-specific services and while preparing youth for service transitions, than implementation during the phase of actual transition to adult mental health and addiction services. Based on the secondary analysis of the data, which compared implementation consistency between agencies which did or did not have access to best-practice documentation, the connection between the presence of written best-practice documentation and the implementation of best-practice protocols was inconsistent. A more likely explanation for these inconsistencies would be a lack of a strong network between local mental health and addiction agencies providing services to various age groups. Poor connections (i.e., limited inter-agency communication, lack of overlapping service eligibility, and administrative oversight) among agencies servicing different demographics could prevent the efficient transition of youth into adult services, regardless of the presence of best-practice documentation or the implementation of evidence-based protocols during the earlier phases of transition. Gaps in the age-ranges for service eligibility between agencies may also result in difficulty with the completion of effective transitions.

Another possible explanation for the lack of consistent evidence-based protocols being implemented during the final phase of transition could simply be that these steps are not required as part of the regular procedures of some agencies. The questionnaire used for this research inquired specifically whether best-practices were currently being implemented, and not whether these protocols were a required part of service delivery within the agency. Respondents may have been unable to meet expectations outlined in the literature because those procedures were not part of the standard discharge or transition process for youth accessing services within that agency. Oversized caseloads could also have resulted in agency staff being overwhelmed with meeting the needs of youth who were currently accessing services. Staff may therefore be forced to disconnect with transitioning youth earlier than would be ideal.
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Comparison to the best-practice literature. Results from the current study were mixed in terms of how they compare to the evidence-based literature. Responses to some questions on the survey demonstrated impressive consistency when implementing best-practice protocols during the youth transition process, while other questions revealed areas of concern. For example, the principles of psychosocial rehabilitation (PSR) indicate that services should be individualized based on the needs of the young person and that a strength-based approach is effective when providing youth-specific services (Williams, 2009; Williams & Sherr, 2008). Each respondent who completed the questionnaire confirmed that these protocols were used throughout the delivery of youth-specific services. Each respondent also reported that youth are always involved in discussions of confidentiality, planning, and decision-making related to the service transition (CAMH, 2015). While these findings were consistent with recommended protocols for transitioning youth to adult mental health and addiction services, some results of the questionnaire were less consistent.

Implementation consistency of some evidence-based best-practice protocols were more varied among the respondents. For example, responses indicated that principles of dialectical behaviour therapy, Acceptance and Commitment Therapy, and applied behaviour analysis were infrequently incorporated into youth-specific mental health and addictions treatment. These findings were in contrast to the current body of literature, which recommends that these therapeutic techniques be woven into individualized treatment plans for youth as needed (Hayes, Boyd, & Sewell, 2011; Petts, Duenas, & Gaynor, 2017; Rakfeldt, 2005: Thurstone, Hull, Timmerman, & Emrick, 2017; Tucker, D'Amico, Ewing, Miles, & Pedersen, 2017). In addition, several procedures outlined in the Youth Transitioning in KFL&A: Protocol for Youth Transitioning into Adult Mental Health and Addictions Services (YTP) (CAMH, 2015) were implemented inconsistently across the responding agencies’ youth-specific programming. The YTP recommendations related to timeline, pace, and structure of the transition, as well as suggestions for various staff roles within the transition, also received mixed responses on the agency questionnaire. Finally, the four elements of successful youth service transitions identified in the literature (i.e., continuity of information sharing, collaborative transition planning, parallel care, and long-term continuity of care) were also implemented with limited consistency, according to this study (Singh, Paul, Ford, Kramer, & Weaver, 2008; Singh et al., 2010a; Singh et al., 2010b). Questionnaire items related to these four elements demonstrated the greatest variation in scores across the responding agencies. According to the results of this study, these four elements were often not effectively integrated into the transition of youth to adult mental health and addiction services.

Causes for the lack of implementation of these evidence-based protocols are unclear. The current survey did not inquire about the content of employee training programs with local services agencies. A lack of effective staff training related to the evidence-based best-practices for youth-specific service delivery and service transitions could contribute to these inconsistencies. Further research is needed to explore the relationship between training protocols for youth-serving agencies and the implementation of evidence-based best-practices. In addition to a possibly lack of training for services providers, workplace access to relevant documentation related to evidence-based best-practices may be inconsistent or absent in some agencies.

Comparison to the hypothesis. The study sought to determine to what extent evidence-based best-practices for transitioning youth to adult mental health and addiction services were being implementing within the community of KFL&A. Based on the study findings, best-practice procedures tend to be implemented more consistently during the provision of youth-specific services and the preparation of youth for transition than during the actual transition of youth into adult mental health and addiction services. Written best-practice documentation was relatively common among responding agencies and was most commonly comprised of evidence-based procedures for transitioning youth to adult services (i.e., suggestions related to transition timeline, access to the
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written transition plan, and re-engagement procedures). Overall, the presence of written documentation was shown to have a limited connection to the implementation of best-practice protocols, except that agencies with documentation were slightly more consistent in the use of best-practice procedures while transitioning youth to adult services than those agencies without.

Significance of the Results

As a result of the small sample size, no conclusive results related to the implementation consistency of evidence-based best-practice while transitioning youth to adult mental health and addiction services could be obtained from this study. The sample was also not selected randomly, and therefore was not necessarily a true representation of the population of mental health and addiction service providers in KFL&A. The data from the questionnaire was not suitable for statistical analyses as a result of the sample size and composition. The questionnaire created for this study (i.e., the BPTAY-AQ) was designed primarily as a feedback tool and was not necessarily intended to extract data which would be suitable for statistical analyses. However, visual analysis of the survey results did suggest that agencies with written documentation on the best-practices for transitioning youth to adult mental health and addiction services tended to implement these protocols more consistently than those agencies without this documentation.

Contributions to the Field of Behavioural Psychology

While the findings of this study may not be representative of other agencies or practices, the research did provide a variety of contributions to the behavioural psychology field. First, the thesis potentially provides a review of evidence-based best-practices for all phases of transition from youth to adult mental health and addiction services through an overview of the related peer-reviewed literature. First, the literature review itself serves as an evidence-based resource for youth service providers to encourage compliance with best-practice protocols throughout youth-specific service delivery and transition to adult services.

Second, the questionnaire developed from the consolidation of this literature (i.e., the BPTAY-AQ) is a valuable tool which may be used for various purposes outside of the current study. The survey could serve as a clever training tool for mental health and addiction staff servicing youth between the ages of 13 and 24 years old. Items on the BPTAY-AQ could be used as a checklist for youth service standards or discharge procedures, for training of inexperienced staff, or in performance evaluations of current employees. A youth version of the questionnaire may also be used as a resource for youth entering the transition process to provide a source of direction and encourage youth participation throughout all phases of the transition. Various applications of a BPTAY-AQ, like the one in this study, may encourage uniformity of service delivery and accountability of service providers throughout mental health and addiction programming.

Finally, the results of this current research provide an overall picture of the implementation consistency of best-practices for youth transitioning to adult services in KFL&A. This general mapping of the transition process allows local mental health and addiction agencies to fortify and expand service networks with other local agencies providing similar or complementary services. Community-wide gaps in best-practice implementation were identified that may prompt local mental health and addiction agencies to modify service delivery and transition procedures to provide more effective mental health and addiction services to youth in KFL&A.

Limitations of the Study

The main limitation of the research was the small and unrepresentative sample. Therefore, the available data was insufficient for statistical analysis and no conclusive results could be drawn from the study. The questionnaire (i.e., the BPTAY-AQ) was implemented through a single online
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platform and may have yielded a higher response rate if a multimedia approach had been taken to
distribution of the survey and recruitment of participants. The limited timeline for research during
the undergraduate thesis process also restricted the window for data collection, which was likely a
factor in the limited sample size. Additional methods of survey distribution (e.g., circulation of hard-
copies of the questionnaire), an extended time-line for distribution of the BPTAY-AQ and collection
of data, and increased preparation for the research (e.g. use of media outlets to attract respondents)
may all contribute to a larger, more representative sample.

Responses to the BPTAY-AQ also depend on a participant’s interpretations of both the
survey questions and the response options. For example, several of the items on the questionnaire
asked whether respondents regularly incorporated various techniques and approaches (e.g., client-
centered, harm-reduction, and trauma-informed services) into youth programming, however, these
terms were not objectively defined within the questionnaire. Creation of an accompanying manual,
or further descriptions of these concepts within the survey, would likely improve the specificity of
the questionnaire results.

In addition, knowledge of agency programs and procedures was not evaluated prior to
inviting respondents to participate in the research. Respondents also completed the BPTAY-AQ at an
individual pace in an uncontrolled environment. Variation in any of these factors could have resulted
in variations in responses on the questionnaire. Repeat implementation of the questionnaire over time
and in varied contexts would also allow for the possibility of validation of the survey instrument, as
the tool has not yet been validated. Validation of the BPTAY-AQ would increase credibility of the
tool and the current study by ensuring the questionnaire accurately assesses the implementation
consistency of evidence-based best-practice protocols within youth-serving addictions and mental
health agencies. Research on the validity of the BPTAY-AQ would likely yield feedback to improve
the validity of the questionnaire and would allow the survey to be used effectively in more large-
scale studies related to youth service transitions in the future.

In addition, the design of the survey could be modified to provide a more efficient and
effective tool. The BPTAY-AQ was developed with a numerical value ranging from 0 to 3 attached
to each response option (i.e., unknown, never, sometimes, and always). These values were originally
intended to aid in coding and interpretation of data in the event of a larger sample size. In retrospect,
no absolute values were assigned to response options, and the attached numbers were irrelevant and
possibly confusing to respondents.

Finally, a secondary questionnaire was originally developed as part of the current research
but could not be administered because ethical approval was not secured prior to beginning the study.
This secondary survey was designed to be completed by youth who were currently accessing
addictions and mental health services in KFL&A. The purpose of this survey was to collect data on
the youth perception of the consistency of implementation of best-practice protocols throughout
mental health and addiction service transitions. The opinions and views of youth accessing these
services would have made a valuable contribution to the current research, however, the time and
effort devoted to the development of the youth survey may have been better spent on other areas of
the research.

Multilevel Challenges to Research Implementation

Client level. Client rights and issues of confidentiality are common concerns when
conducting research within the mental health and addiction service community. Access to clients and
confidential information is strictly monitored and regulated for the benefit of the client, and often to
the detriment of the research. A secondary questionnaire developed as part of the current study could
not be implemented due to time and ethical restrictions, particularly confidentiality. The research
approaches and objectives must shift to accommodate the situation. Intimate knowledge of informed
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consent procedures and ethical research responsibilities is necessary to maintain clients’ rights and privacy during youth-specific service research.

**Program level.** The developed questionnaire was distributed electronically to prospective participants, and participation in the study was strictly voluntary. Service providers are not mandated or required to participate in the study or to fully complete the questionnaire. The researcher must develop creative ways to engage service providers in the study and increase response rates. Researcher flexibility and compassion are assets, when dealing with challenges at this level.

**Organizational level.** Clients frequently access multiple services, programs, and groups throughout an addictions and mental health agency, and the community. Effective consultation between staff is crucial when providing the most efficient, individualized services. These networks between service providers inside and outside the agency are also essential when mapping agency services. Service providers who were unaware of the nuances of other programs within their agency were unable to complete the questionnaire with the same accuracy as those who had adequate knowledge. The ability to communicate effectively and network efficiently are assets at this level and allow the researcher to access multiple programs and viewpoints within the same agency.

**Societal level.** Clients of addiction and mental health services sometimes experience the stereotypes that surround these specific supports. As a result, service providers and researchers in this field must be consistently aware of stereotypes and labels and work to avoid these service roadblocks. The attitudes and influence of the education system, law enforcement, healthcare providers, and the public in general are integral to the success of the research in this field. Clients of mental health and addiction agencies also frequently access a variety of community supports outside of the agency. Consistent professional behaviour and language are necessities when developing research tools and promoting a positive image to professional colleagues and within the community.

**Recommendations for Future Research**

The current study provided a good foundation for future research on best-practice protocols for transitioning youth to adult services. One obvious direction for future research would be the re-implementation of the developed questionnaire (i.e., the BPTAY-AQ) within KFL&A for the purpose of acquiring an increased response rate. A higher response rate may be achieved through various avenues. For example, increased community networking and advertising prior to the distribution of the questionnaire could have resulted in more responses. In addition, the distribution of the BPTAY-AQ in multiple formats, as well as a larger window of time for data collection, would likely have secured a more favourable response rate to the survey. The introduction of some type of motivator or reward for completion of the questionnaire may also have resulted in more usable data. In addition, relevant local agencies may be approached to request that the BPTAY-AQ be completed throughout the agency as part of job requirements. The survey could also be used in other communities to identify holes in youth transition procedures and inform change in service structure. Implementation of these suggestions would likely result in higher response rates for the questionnaire, and therefore increase the chances of statistically significant results.

Repeat implementation of the BPTAY-AQ over time and in various contexts would also allow for validation of the survey instrument, which is another possible area for future research. Validation of the survey would increase the credibility of this study and of the questionnaire itself, by ensuring the BPTAY-AQ accurately assesses the implementation consistency of evidence-based best-practice protocols within youth-serving addictions and mental health agencies. Research on the validity of the BPTAY-AQ would likely yield feedback to improve the validity of the questionnaire and would allow the survey to be used effectively in more large-scale studies related to youth service transitions in the future.
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In addition to acquiring a larger sample size and validating the BPTAY-AQ through future research with the questionnaire, other viable options exist for further exploration of the youth transition process. A secondary questionnaire was originally developed as part of the current research to be implemented with youth. The purpose of this survey was to collect data on the youth perception of the consistency of implementation of best-practice protocols throughout mental health and addiction service transitions. This youth questionnaire was not administered as part of the current research. However, a future study which implements the youth questionnaire would provide a valuable opportunity to compare the youth-view of protocol consistency to that of service providers.

Finally, additional research may use novel methods to assess other aspects of the youth transition process. The current research focused on the implementation consistency of best-practice protocols, however data on successfully completed service transitions would be an interesting comparison to the current findings. Similarly, the current study highlighted the need for further research into which factors influence implementation consistency of the best-practice protocols.
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## Appendix A: Best-Practices for Transitional-Aged Youth - Agency Questionnaire

### Best Practices for Transitional-Aged Youth Services_Agency Questionnaire

#### Agency Information

1. **Name of agency:**

2. **Client age range for service eligibility:**

3. **Estimated number of youth specific programs currently within agency:**

4. **Estimated number of youth specific staff within agency:**

5. **Estimated number of transitional-youth specific programs currently within agency:**

6. **Estimated number of transitional-youth specific staff within agency:**

7. **Estimated wait-time for youth specific agency services:**

8. **Estimated number of youth currently on agency wait-list:**

9. **Does your agency have written and accessible documentation outlining best practices for providing youth specific services?**
   - [ ] Yes
   - [ ] No
10. Does your agency have written and accessible documentation outlining best practices for transitioning youth to adult services?

- Yes
- No

### Best Practices for Transitional-Aged Youth Services_Agency Questionnaire

#### Best Practices for Providing Services to Young People

11. Services are provided with the ultimate goal of reintegration into community life.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

12. Service providers make a conscious effort to avoid labeling and discrimination.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

13. The culture and ethnicity of the young person are respected and integrated into treatment process.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

14. The gender identity of the young person is respected and gender-sensitivity is integrated into the treatment process.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always
15. Services are individualized based on the unique needs of the young person.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

16. A client-centred approach is taken when providing youth services.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

17. A client-driven approach is taken when providing youth services.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

18. A strength-based approach is taken when providing youth services.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

19. A harm-reduction approach is taken when providing youth services.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

20. A low-barrier approach is taken to providing youth services.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always
21. A solution-focused approach is taken when providing youth services.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always

22. A trauma-informed approach is taken when providing youth services.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always

23. A peer-support approach is taken when providing youth services.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always

24. Principles of cognitive behavioural therapy are incorporated into treatment planning.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always

25. Principles of dialectical behaviour therapy are incorporated into treatment planning.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always

29. Principles of Acceptance and Commitment Therapy are incorporated into treatment planning.
   (0) Unknown  
   (1) Never  
   (2) Sometimes  
   (3) Always
27. Principles of applied behaviour analysis are incorporated into treatment planning.
   ○ (0) Unknown
   ○ (1) Never
   ○ (2) Sometimes
   ○ (3) Always

28. Principles of motivational interviewing are incorporated into treatment planning.
   ○ (0) Unknown
   ○ (1) Never
   ○ (2) Sometimes
   ○ (3) Always

29. Principles of family therapy are incorporated into treatment planning.
   ○ (0) Unknown
   ○ (1) Never
   ○ (2) Sometimes
   ○ (3) Always

30. Mental health and/or addictions counselling are incorporated into treatment planning.
   ○ (0) Unknown
   ○ (1) Never
   ○ (2) Sometimes
   ○ (3) Always

31. Access to a psychiatrist and/or pharmacological intervention is incorporated into treatment planning.
   ○ (0) Unknown
   ○ (1) Never
   ○ (2) Sometimes
   ○ (3) Always
32. Meetings are held in a location that is convenient and comfortable for the young person.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

33. Language used in meetings is youth-friendly and age-appropriate.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

34. Outcome assessments are conducted prior to client discharge.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always
39. The written transition plan is reviewed with the young person and questions are answered.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

36. The timing, duration, and pace of the service transition is negotiated with the young person.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

37. Service providers discuss issues of confidentiality with the young person.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

38. The young person is involved in the transition plan and the decision making.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always
IMPLEMENTATION OF BEST-PRACTICES FOR TRANSITIONING

40. Parents/caregivers are members of the transition team and are involved in the care plan and decision-making.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

41. A staff member is identified in the receiving agency to welcome and support the young person entering their care.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

42. The young person is made familiar with the structure of the adult service.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

43. The young person has the opportunity to visit the new service agency setting.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

44. Service providers make a conscious effort to improve the resilience factors in young people (i.e. parental involvement, positive relationships, and physical health).
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always
45. Service providers teach each young person individualized coping skills to combat personal stressors associated with the transition to adult services (i.e. organization skills training, social role-plays, and relaxation exercises).
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

**Best Practices for Transitional-Aged Youth Services_Agency Questionnaire

Best Practices for Youth Transition Procedures**

46. Consent to share documentation and to proceed with the transition process is secured by the transitioning agency.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

47. The receiving agency responds to the transitioning agency request for service information within five business days.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

48. The receiving agency outlines appropriate services within the agency and the information required for intake OR recommends other more suitable services within the community.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always
49. A transition team is created consisting of the young person, the transitioning agency, the receiving agency, and any other members identified by the young person.

   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

50. A single staff is identified from one of the service agencies to coordinate the transition.

   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

51. Service fit and availability are assessed by the transitioning agency and the receiving agency prior to mapping the transition plan.

   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

52. The time and location of all transition team meetings are confirmed with young person in advance by the transitioning agency.

   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

53. One or more of the transition meetings are hosted at the receiving agency.

   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

54. An initial joint meeting is held with all transition team members.

   (0) Unknown
   (1) Never
55. A written transition plan, including a transition timeline, is created with input from all transition team members.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

56. The transition timeline ranges from three to six months.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

57. Each member of the transition team has agreed on, and has access to, the written transition plan.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

58. All professionals are aware of each other's role in the transition and the services each offers.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always

59. The receiving agency outlines the structure of adult services with the young person and answers questions.
   - (0) Unknown
   - (1) Never
   - (2) Sometimes
   - (3) Always
60. Possible setbacks are discussed and potential solutions are generated, prior to beginning the transition process.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

61. The transitioning agency and the receiving agency are able to work together to resolve wait-list and/or eligibility barriers.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

62. Care is handed over through one or more meeting(s) between at least one key professional from both services and the young person.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

63. All collateral documentation, including a comprehensive summary of the transitioning agency’s case notes, is made available to the receiving agency.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always

64. The receiving agency reviews and identifies holes in the collateral documentation, and collects missing information when necessary.

- (0) Unknown
- (1) Never
- (2) Sometimes
- (3) Always
65. The transitioning agency staff serve as the young person's advocate throughout the transition process.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

66. The transitioning agency schedules regular follow-up appointments with the young person to assess success of the transition.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

67. The process is completed within the proposed transition timeline of three to six months.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

68. The receiving agency consults with the transitioning agency on concerns with disconnect or service-fit throughout the transition process, and for up to six months after the transition has been completed.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always

69. If the young person does not engage fully in adult services, the transitioning agency participates in re-engagement efforts with the receiving agency for up to six months after the transition has been completed.
   (0) Unknown
   (1) Never
   (2) Sometimes
   (3) Always