

The differences in care and treatment that may influence suicide risk during the transition of care from child and adolescent to adult mental health services

Introduction: You have been contacted as you work as a clinician in a secondary mental health service, have experienced the tragic death by suicide of a patient that you worked with in a clinical context and have previously completed the NCISH questionnaire on this patient's death.

In order to improve suicide prevention, we would like to better understand how the transition from CAMHS/Youth services to AMHS can be improved from a suicide prevention perspective. We would like to ask you in particular about the patient's transition, care settings, family involvement, safety planning and how this potentially impacted their suicide. We will not publish anything that could identify you or your patient. Please only share details you are comfortable sharing.

Thank you for taking time to take part. The interview will be audio recorded for research purposes and will last for about 45 minutes. You are free to keep your camera on or off during the interview: this will not affect recording of audio. The audio recording will be deleted straight after transcription. You will be asked about a patient's suicide which we acknowledge can be distressing. Therefore, you can ask to stop for a break, if needed. You are also free to stop the interview at any point.

As a reminder, if during the study, you disclose information about any current or future illegal activities, we have a legal obligation to report this and will therefore need to inform the relevant authorities.

Do you have any questions at this point?

Job role

1. What is your current job role?
2. What kind of service do you work in? (note: We will still be asking you about CAMHS/AMHS, but we do recognise that you may not know and that is okay)
3. How long have you worked there?

Patient's mental health and treatment

4. Do you know which treatment and support the patient was receiving for their mental health, whilst under the care of CAMHS/Youth services (i.e., before the transition)? Were there any gaps/delays in the transition?
(probe: Neurodiversity? Treatments offered? How was the patient responding to treatment? Were there any specific psychological factors present in this patient's care? Any other services involved?)
5. Did the patient's treatment change once their care moved to AMHS (or was expected to change during the transition to AMHS)? If yes, how?

(probe: Referral? Diagnosis change? Still supporting neurodiversity (if applicable)? Did the treatment modality change, i.e. medication vs psychological treatment? Did it present any challenges? How were these challenges approached?)

Patient safety

6. During the transition, were there any warning signs or changes that indicated that this patient's suicide risk increased, such as self-harm?
(probe: How were these communicated between services?)
7. Was there anything else going on in patient's life (life events/changes)?
8. Was a crisis or safety plan in place (including who to contact in suicidal crisis) in CAMHS and AMHS? To your knowledge, how were patient's risk factors addressed in CAMHS compared to AMHS?
(probe: Any gaps in crisis support? Was the crisis/safety plan developed collaboratively? Was the crisis/safety plan shared with anyone?)
9. If yes, were there any changes to the care plan once the transition was completed?
(probe: Did frequency of contact/staff contact change as a response to patient's suicidal ideation or self-harm?)

Care settings

10. To your knowledge, did the frequency of patient's appointments change between CAMHS and AMHS?
11. Where was the patient seen in CAMHS and where in AMHS?
12. Was there continuity in the care team that the patient saw in CAMHS and AMHS?
(probe: Did the patient experience any challenges with specific care settings or approaches)

Family involvement and decision-making

13. Was the patient and/or their family/carer involved in the planning of their care while the patient was under the care of CAMHS? Did this change when the care moved to AMHS? Was the patient asked how they wanted their family to be involved?
(probe: In what way were they involved?)
14. To your knowledge, how involved were patient's family or carers in their care when their care was under CAMHS, and did this level of involvement change between CAMHS and AMHS?
(probe: Were family members present at transition planning meetings? Did the patient want more or less family involvement?)

Transition process

15. Was the patient involved in the decision to be transferred? Are they aware if anything else was going on in patient's life that coincided with the transition process?

(probe: Did they meet new care team before hand?)

16. In your service is there a procedure in place to support young people who are transferring from CAMHS to AMHS?

(probe: i.e. Extra contact, a designated worker during transition? In your opinion is this effective?)

17. We have discussed factors (personal to the patient or linked to the service) that might have played a role in the patient's suicide. Which would you consider most important?

18. Looking back, is there anything about this patient's transition that you feel could have been handled differently or improved?

(probe: What are some examples of good practice in this case? What didn't go well? Were there any communication breakdowns between services? Any systemic issues? Lessons learned?)