# Bridging the gap: The role of transition clinics in headache care

# Discussion

- What is a transition
- Role of the clinic
- Prevalence
- Benefit and role of the clinic
- Barries and challenges
- Strategies for successful transition clinic
- Future directions

**Transition** is defined as a multi-faceted, active process that attends to the medical, psychological and educational/vocational needs of adolescents as they move from child to adult centred care

- share information effectively between adult and Paediatric services
- 'importance to on-going engagement' (CQC 2014)
- empowering the young person in leading on their care. Such as, appointment times, knowing their medications, communication with professionals
- 'A pivotal moment in the lives of young people living with long term health conditions' (QNI 2018)

# Why are transition clinics so important?

## 1. Continuity of care

Without a structured transition, patients may fall through the cracks leading to disrupted treatment or a complete loss to follow up.

## 2. Models of care

- **Paediatric** is often family centre, supporting and involves more guidance
- **Adult** expects self management, independence and self advocacy
- Transition involves teaching patients how to manage their condition effectively

## 3. Headaches begin young and can persist

- Symptoms often being in childhood
- Effective early management improves quality of life and reduces long term disability
- Transition ensures patients stay on a consistent and effective treatment path into adulthood

## 4. Co-morbities and psychological stressors

- Often coexisting anxiety, depression and sleep issues
- Impact of school, peer relationships and family expectations
- Transition clinics can help screen and address these issues early and ensure appropriate referrals for further support are made

## 5. Preventing medication overuse

- Without ongoing care, may use OTC or prescription medication incorrectly
- Adolescents at increased risk of MOH

## 6. Empowerment and self-management

- Promote autonomy
- Re-education around trigger management, lifestyle changes, medication timing and how to advocate for themselves within school and their workplace.

## 7. Improved outcomes and satisfaction

- Studies have shown patients in transition programs have better health outcomes, fewer complication and higher stratification of care
- Patient more likely to remain engage in treatment and care decisions.

# *Headache is the most prevalent neurological manifestation in adults and one of the leading causes of disability worldwide*

- Prevalence increases with age, for example 37- 51% at the age of 7 to 57%-82% by the age of 15 in European studies with similar patterns observed in the UK

- Globally, nearly 60% of children and adolescents experience significant headache, and 7.7% to 9.1% have migraine.

- Studies suggest that around 60 per cent of children aged between seven and 15 experience headaches, but a diagnosis of migraine may be delayed because tummy pain, vomiting, travel sickness, limb pain and episodic dizziness can all confuse the picture.

- Headache affect boys and girls equally before puberty, but migraine becomes significantly more common in females after puberty

**Highlighting the need for transition:**

✓ High prevalence in adolescents indicates the need for effective transition and ongoing care
✓ Gender difference emerge during puberty making tailored intervention and management essential
✓ Frequency of headache and migraines disrupts schooling, social development and quality of life

# The benefit and role of transition clinics in Headache care

**Continuity**: Maintains therapeutic relationships and care plans.

**Education**: Empowers patients to understand and self-manage their condition.

**Monitoring**: Ensures appropriate medication use and follow-up.

**Psychosocial support**: Addresses anxiety, depression, school/work stress.

**Care coordination**: Between family, school, and healthcare providers.

**Decreased:** healthcare costs long-term

**Higher:** patient satisfaction

# Challenges and barriers to transition care

- Risk of loss to follow up
- Psychosocial and development factors (autonomy, medication adherence, mental health)
- Communication barrier between paediatric and adult health care providers
- Funding/resources
- Variations in models between regions/ centres
- Difference in patient and parent expectations

**Young Person**

- A consistent lead (welcoming, available, supportive and communicate)
- Be involved
- Central to plan
- Regular discussions
- Empowerment
- Independence

VS

**Parents**

- A link person to contact
- Involvement and gradual relinquishing of responsibility
- Parents place adulthood at university leaving age, or when established at work
- Expect holistic, individualised transition for their child
- Should be an extended process from 16 – 21 years (QNI 2018)

# Strategies for Successful Transition Clinics

- Early planning (start in early adolescence, not just at 18)
- Use of transition readiness tools (e.g. ready steady go, GUGI)
- Joint paediatric-adult clinic visits
- Digital tools (apps, virtual clinics)
- Feedback (QR code for patient feedback, continually reflection and improvement on service)

## Future Directions

- Patient-led transition plans
- Expanding to underserved areas
- Research and standardisation of care models

## Summary

- Transition clinics are key to ensuring seamless, effective headache care across the lifespan
- They empower patients, reduce healthcare burden, and improve outcomes
- Emphasis on the need for institutional support and tailored implementation

# References


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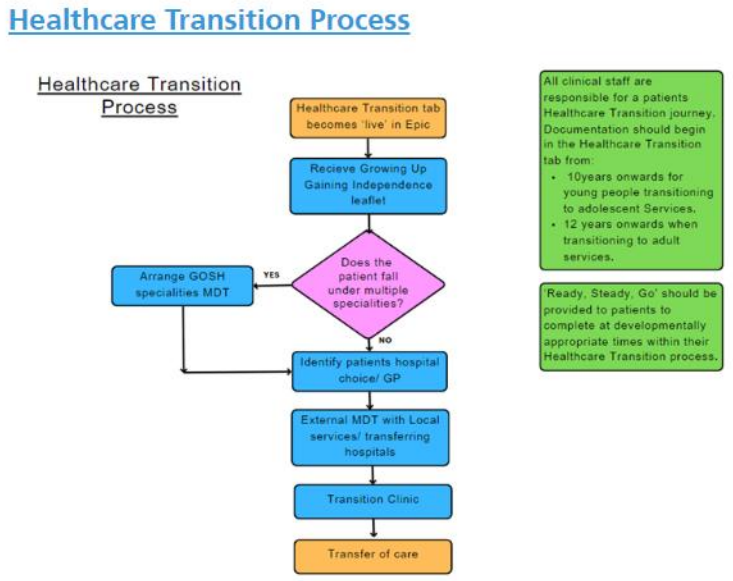
NHS
Great Ormond Street Hospital for Children
NHS Foundation Trust
Celebrating
25
YEARS
CHILDREN'S HEADACHE SERVICE

# Thank you

# KHP/GOSH transition service

- Expected discussions usually commence at 12 years of age
- GUGI – influenced by GOSH Young people's forum
- Ready steady go
- Involving young people and families in their care decisions, our patients are encouraged to use ‘My GOSH’ to complete aspects of the ‘Ready, steady, Go’ document  which can then be used in their clinical appointments to plan transition




# KHP/GOSH transition service

- As the school years are usually the trickiest for our headache patients, we usually wait to discuss transition after they've turned 16 years old
- Discussions in clinic/ GONI app
- Encourage families to use Migraine Trust map to see clinics in local area

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# KHP/ GOSH Transition service

## Establishing the service

1

Established service need

Created work group

2

Develop patient information sheets, clinic feedback QR codes and clinic design

3

Monthly MDT meeting to discuss referrals.

Monthly clinic held F2F at Guys Hospital

4

First Clinic August 2022

Patients first app after their 17th Birthday

5

Quarterly service reviews to establish what is working well and what can be improved

# KHP/GOSH Transition service

## Referral Criteria

**Inclusion:**

- Chronic migraine with 3 failed preventatives
- TAC
- CSF related Headaches
- Other headache disorders requiring specialist headache care

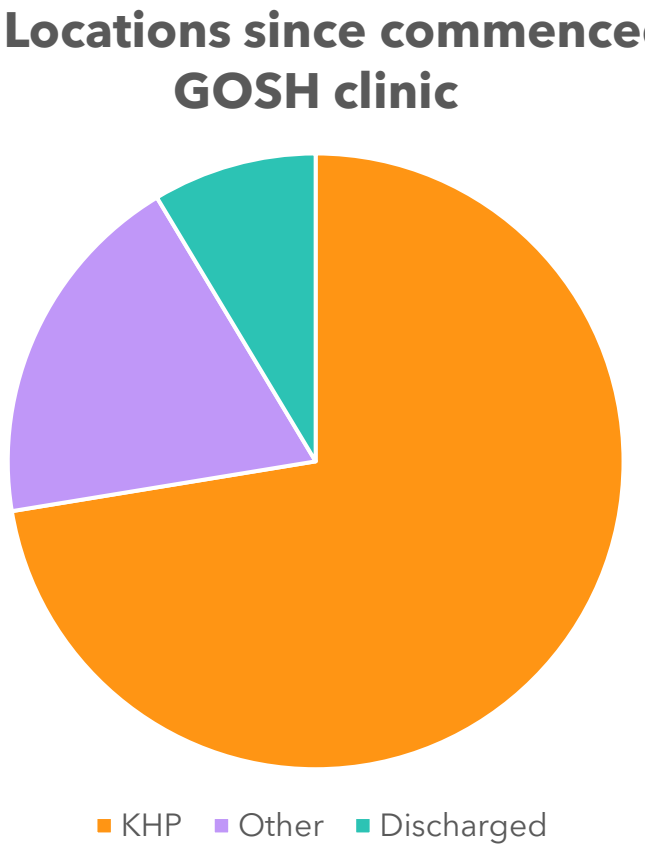
**Tricky points**

- Patients accessing MABS through clinical trials for episodic migraines.
- Patients under alternative specialities ensuring adult service care is under the most appropriate team
- Patient geographical location
- After being in specialist clinic patient (families) expect that to continue

# KHP/GOSH transition service

## Summary:

- Patients report they feel more supported
- Smoother process
- Greater working relationships between GOSH/ KHP teams
- Transition clinic/service is ‘gold standard’




*72% of our patients have opted to complete the KHP transition route instead of being referred locally through their GP*