RESEARCH ARTICLE

Transition at Emerge: evaluating transition practice and elucidating ethnic differences

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Abstract

Background Transition between child and adult services is a notoriously difficult area of mental health provision. This service evaluation was designed to determine the standard of transition practice, as well as analysing any differences in transition between ethnicities at Emerge, a service for 16–17 year olds in Manchester Child and Adolescent Mental Health Services (CAMHS).

Methods This study utilised 68 randomly selected sets of case notes of cases closed to Emerge. The data was collected manually from these case notes using a data-collection tool and analysed using Microsoft Excel.

Results Of the seven cases in the sample that transitioned to adult services, none experienced an optimal transition as defined by the TRACK study.[1] Only seven of the total cases were from a black and minority ethnic (BME) background, so elucidating any ethnic differences in transition was not possible.

Conclusion The results showed that transition practice at Emerge did not meet the standard of practice, prompting a recommendation for better liaison between CAMHS and Adult Mental Health Services (AMHS). Access to Emerge for ethnic minorities was shown to be limited, although the study failed to reveal ethic differences in transition owing to its small sample size.

Aims of the study

- To elucidate any ethnic or demographic differences in service use with particular focus on transition
- To look at the practice of transition at Emerge compared against established standard of a 'good' transition.

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As Emerge is a specialist service that deals with young people in the 16–17 age range, transition is a key process. Many young people are close to adulthood when they are referred and may well turn 18 in the care of Emerge, possibly requiring referral to adult services. One of the main aims of this service evaluation is to look at transition practice at Emerge. Singh et al. propose in the TRACK study, a major study looking at transition between Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS), that there are four major criteria for an 'optimal transition':

(a) information transfer (information continuity): evidence that a referral letter, summary of CAMHS care, or CAMHS case notes were transferred to AMHS along with a contemporaneous risk assessment
(b) period of parallel care (relational continuity): a period of joint working between CAMHS and AMHS during transition
(c) transition planning (cross-boundary and team continuity): at least one meeting involving the service user and/or carer and a key professional from both CAMHS and AMHS prior to transfer of care
(d) continuity of care (long-term continuity) – either engaged with AMHS 3 months post-transition or appropriately discharged by AMHS following transition.[2]

It is against these criteria that transition at Emerge is compared.

This evaluation also aims to look at the demographics of the Emerge caseload. With a particular focus on ethnicity, this evaluation aims to bring to light any link between the background of a young person and their likelihood to transition.

Methods

This service evaluation was begun after informing the trust audit department on 21 January 2014. Data was collected from all the closed case notes in storage at Emerge between 27 and 28 January 2014; notes were collected at random from closed cases in storage at Emerge. Any notes that did not contain information on more than three of the specified criteria were not included, as this was insufficient for analysis; in total information for 68 cases was collected. A data-collection tool was used to collect the data. The data was compiled in a document in Microsoft Excel.

For each case the following were collected: gender, age at referral, ethnic group, referrer, priority, reason for referral, service referred on to, reason for case closure, outcome of case and attendance statistics. Missing data was supplemented if possible using the CORC (Child Outcomes Research Consortium) database. For those cases referred to adult services,

information about whether they had transferred to adult services was sought by phone call to Single Point of Access on 23 January 2014.

The case notes were used to find evidence of transfer of information between CAMHS and AMHS, a period of parallel care and a joint planning meeting. Owing to there being a relatively small amount of data, it was analysed manually, with the use of some of the graph- and table-building tools in Microsoft Excel. No statistical tests were used; the analysis looks purely at frequencies, medians, modes, means and ranges.

Results

The total number of cases in the sample was 68. Females numbered 47 (69%) and males 21 (31%). White British was the most commonly recorded ethnic group with 44 cases (64.7%); in 17 (25%) cases the ethnicity was not recorded. There were 7 (10.3%) cases in which black or ethnic minority was recorded: 2 black Somali, 2 British/Pakistani dual heritage, 1 white Romanian, 1 Arabic and 1 Pakistani (see Table 1).

The median number of offered sessions attended was 3, the most attended was 37 and the least 0. The higher median value for number of sessions listed as 'did not attend' (DNA) than 'could not attend' (CNA) suggests patients were more likely to not attend a session than for the session to be cancelled ahead of time by the patient or his or her practitioner. Of patients referred to Emerge, 20.6% never attended a single session (see Table 2).

The most common referral route was from a GP practice, in 32 (47.1%) of cases, followed by another trust, 8 (11.8%), a school or pastoral care in 7 cases (10.3%), and from Connexions, Youth Offending Service (YOS) or A & E, all noted in 5 cases (7.4%). More detail on referral route is shown in Table 3.

Table 1: Ethnicity vs gender of cases in the study sample.

	Male	Female	Total
White British	10	34	44
BME	4	3	7
Not recorded	7	10	17
Total	21	47	68

BME: black and minority ethnic.

Table 2: Mean, median and range for numbers of sessions attended, not attended and cancelled.

	Mean	Median	Range
Attended	5.19	3	0–37
CNA	1.06	0	0–13
DNA	1.8	1	0–9

CNA = could not attend; DNA = did not attend.

Table 3: Frequency of recorded referrer and ethnicity.

Referrer	Number of cases		Total
	White British/ethnicity not recorded	Black and minority ethnic	
A & E	5		5
GP	28	4	32
Connexions	5		5
Other trust	8		8
School/pastoral care	7		7
Self referral	3	1	4
Youth Offending Service	4	1	5
Other	1	1	2
Total	**61**	**7**	**68**

The most common reason, in 24 (35.3%) cases, for a case being closed was at the mutual consent of the patient and/or his or her family and their practitioner. Never having attended a session offered by Emerge, or disengaging with the service after attending at least one appointment, was the next most likely reason, attributable in 14 (20.6%) cases. In 7 (10.3%) instances, cases were closed when the patient turned 18 and were recorded as not being transferred to AMHS, and 5 (7.4%) patients were recorded as being transferred when they turned 18 (see Figure 1).

After initially collecting data from CORC, seven cases were found in which the recorded case outcome was 'turned 18, not transferred to AMHS'. However, on examining the case notes, it was found that in two of these cases a referral to AMHS had in fact been made. This discrepancy is probably due to administrative error, but it should be taken into account when looking at the graph in Figure 1.

After correcting for the errors on CORC, of the 12 cases in which the patient had turned 18, 7 were referred to adult services, 1 of which was from an ethnic minority background. A total of 5 were not referred on to AMHS. Of those 5 not referred, 3 were not considered for transition to AMHS and 2 declined onward referral.

Of those that were referred, all case notes showed evidence of transfer of information between CAMHS and AMHS. None indicated a period of parallel care. There was no evidence of joint planning meetings involving CAMHS and AMHS practitioners. Over three months after their discharge from CAMHS, five cases were still open to AMHS (see Table 4).

Discussion

Of the cases in the study sample where ethnicity was recorded, 12% were from a non-white ethnic minority, a figure three times lower than the

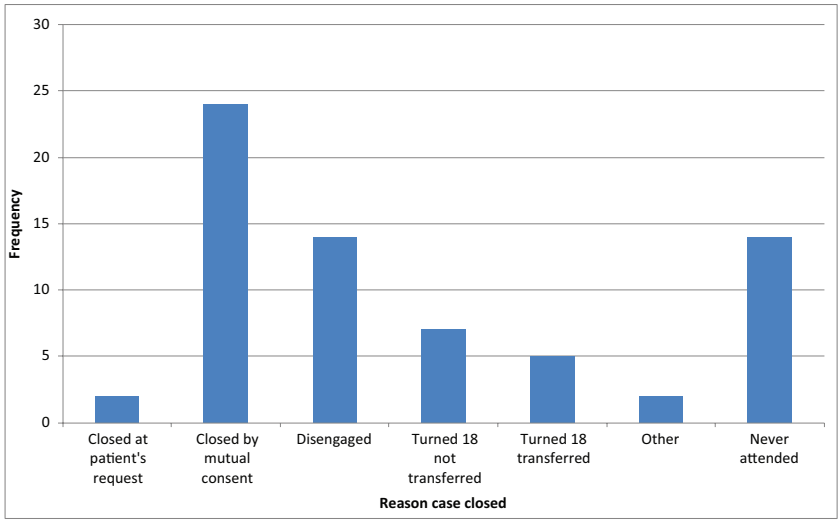

Figure 1: Bar chart showing reason for case closed and frequency.

Table 4: For all cases referred to AMHS, criteria for optimal transition as defined by TRACK study.[1]

	Criterion			
	Transfer of information	Parallel care	Joint planning	Continuity of care
Yes	7	0	0	5
No	0	7	7	2

general population. Mental health problems in children and young people do not vary much in prevalence between ethnicities, with the exception of the Indian population, where the prevalence is significantly higher.[4] It is therefore worrying that the proportion of ethnic minorities in the sample is so much lower than in the population. This could be because of variation in having such a small sample, but the difference is very large and more likely represents a gap in access between the white and non-white population. This is the type of gap that initiatives such as the Delivering Racial Equality in Mental Healthcare initiative are aimed at reducing on a national level; the results of this survey show that there is still a large divide in access at Emerge.

The data shows how big an issue attendance is for Emerge, with a fifth of patients referred to the service never even attending an opening appointment, and a further fifth disengaging with the service after at least one appointment. Patients failing to attend sessions without cancelling beforehand waste practitioners' time and drain the resources of the service. However, for a service that deals with mentally ill teenagers, these problems come with the territory. Emerge already offers appointments at

locations around the city, even visiting patients in their homes to try to deliver the help patients need. Although patients disengaging is worrying if they have an ongoing need, if patients do not want to engage with the service that is their prerogative. An audit of cases at Emerge, looking at whether young people who disengage have been offered a full and appropriate service before their cases being closed, would ensure that Emerge is doing all that it can to meet the needs of young people.

Of the seven cases studied that transferred to AMHS, none experienced an optimal transition. The transfer of information was the strongest aspect of transition practice, with detailed referral information sent to AMHS through specified referral channels. Also, positively, five of the patients were still in adult services when this was checked; this is a demonstration of the fact that transfer can happen quite successfully without a good transition. However, worryingly, in one case that was closed and apparently referred on, it appeared adult services had never received a referral at all.

Whilst there was evidence in some cases of planning meetings for transition involving CAMHS practitioners, there was no evidence of joint working between AMHS and CAMHS practitioners to hand over a patient. This echoes other studies into transition between CAMHS and AMHS that show although joint working is often specified in transition protocols, in reality it does not happen owing to a lack of time, poor communication and misunderstanding of opposite services.[2] For practitioners at Emerge, time is of the essence; there is often very little time between a referral being made and a referral to adult services being considered. The poor attendance of patients increases this time pressure to try to implement joint work with AMHS. Whilst difficulties clearly exist in making joint planning meetings part of standard practice, improvement in this area needs to be made to provide good transition experiences to patients.

A dearth of joint working is also shown by the lack of periods of parallel care. A patient referred to AMHS is unlikely to be offered an appointment in the near future; so often by the time they have attended their first appointment with AMHS, their case has been closed by CAMHS. The worry is that if patients were to then miss their first adult appointment, they may well fall into the gap between services if they are not re-referred. The age limits of transition boundaries could be flexible, allowing for the period of parallel care that is essential in the transition process.

Conclusions and recommendations

Transition practice is suboptimal at Emerge. Although transition practice is followed broadly and transfer into adult services is usually successful, improvements could be made to make the process smoother for the young people involved. The creation of new posts for specific transition workers

or liaison officers seems unrealistic, given the stretched resources within mental health services, but is a possibility that has been suggested elsewhere.[3] Alternatively, better lines of communication and liaison could be opened up between people already working at Emerge and in AMHS. Practitioners could be given the specific task of organising a regular meeting with a worker within AMHS to discuss cases approaching the transition stage, to decide whether they are suitable for transition and to plan for the process if so.

A checklist for a good standard of transition practice agreed by Emerge could be created and inserted into the notes at the close of a case. This would aid good practice, as well as audit of transition practice in the future. This checklist could demand a joint planning meeting, evidence of a referral and risk assessment, and a follow-up of patients transitioned to ensure they are still receiving the care they require.

Attempts to engage with ethnic minorities in Manchester should also be made or increased. Creating links with the community, through religious groups, third-sector organisations or any group concerned with improving services for ethnic minorities, could help improve mutual understanding and possibly provide new routes for referral. Providing new training for staff may be necessary to create a more culturally sensitive service, so that ethnic minorities enjoy a good standard of service with Emerge.

The major limitation of this study is in the sample size. The small proportion of ethnic minorities within the already small sample made it redundant to look at variations in transition practice between ethnic groups. Although the study highlighted a problem with access for ethnic minorities, it failed to look at the way they use the service and are transferred from it. A larger, perhaps longitudinal, study would be required to do this. The problems inherent in a small sample also apply to the examination of those cases that did transition; as there were so few of them it makes it difficult to draw solid conclusions about transition practice at Emerge. Future audits that focus purely on those cases that have transitioned would shed more light. This study is also subject to a significant amount of error, as the data was compiled and analysed manually. The use of CORC to collect some of the data may also have introduced some bias, as this data is known to be inaccurate in places, which in itself is a possible target for audit.

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