

# TRANSITIONAL CARE INITIATIVE WITHIN MENTAL HEALTH SERVICES IN QATAR: DESCRIPTION AND EVALUATION OF AN INNOVATIVE CARE MODEL

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received: 17.8.2021;

revised: 9.11.2021;

accepted: 9.12.2021

## SUMMARY

*The importance of effective health care transitioning of young people from adolescent to adult health services is well established in general and within mental health services in particular. There is no previous literature focusing on the implementation of the transitional care model within mental health services in the Arabian Gulf region. We outline details of how the international best practice of effective transitioning of young people from Child and Adolescent to Adult mental health services was adopted and implemented in the State of Qatar. The impact of this crucial initiative on patient care and service delivery is also explained.*

**Key words:** transitional care - mental health service - Qatar

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## INTRODUCTION

Care transition refers to a purposeful and planned process that addresses young people's various needs as they move from child-centred to adult-centred health-care systems (Blum et al. 1993). It emphasises the significance of transfer of care to adult services in a manner that addresses the medical, psychosocial, educational or vocational needs of adolescents and young adults. It has largely replaced the conventional process of ordinary 'transfer' which is considered merely an administrative event and involves the termination of care by a children's healthcare provider and its re-establishment with an adult provider (Paul et al. 2013). This process of change in the care-provider, if not executed appropriately through an effective transition process, can lead to disengagement, better known as "falling through the gap between services".

The significance of effective transition within mental health services is well recognised. Mental disorders account for 16% of the global burden of disease and injury in people aged 10–19 years (World Health Organization. Adolescent mental health, 2018). Almost half of these disorders start by the age of 14 years and majority of them manifest in early adulthood and are therefore considered as extensions of adolescent disorders (Kessler et al. 2007). There is overwhelming evidence to support the notion that mental health problems emerging during adolescence can go undetected and untreated (McGorry 2013). The long-term socio-economic impact of these undetected and untreated psychological disorders is far more detrimental than physical health problems (Goodman et al. 2011). The deployment of effective strategies in a timely manner has the potential

to identify mental disorders in children and young people promptly (Nelliel-Ghazal et al. 2020) and mitigate their eventual impact resulting in a better socio-economic outcome.

It is therefore crucial that young people with mental health problems, who require continued care, must have a planned and coordinated transition as their care is passed on from adolescent to adult mental health services. It is understood that only a quarter of young people continue to access care at the Adult Mental Health Service after reaching the upper age limit of the Child and Adolescent Mental Health Service (Appleton et al. 2019).

Transition-related challenges and problems exist across a diverse range of healthcare services and across different continents (Davis et al. 2006, Lamb et al. 2008). A study conducted in the United States concluded that a lack of clear transition procedures and shared planning impacted on continuity of care (Davis & Sondheim, 2005). A study from Australia found that a significant number of young people referred from CAMHS for transition of continued substantial mental health needs were not accepted by the adult service (Cosgrave et al. 2008).

There is no literature on implementation of transition model of care within mental health services in the Arabian Gulf Region. Our initiative is the first of the kind in this region. We present the description and implementation of the transition model and its role in determining clinical outcomes for patients discharged from a child and adolescent mental health service in Qatar. We explore whether a managed transition results in enhanced clinical care compared to ordinary transfer in a region with very different demography and cultural milieu.

## **INTERFACE BETWEEN ADOLESCENT AND ADULT MENTAL HEALTH SERVICES IN QATAR**

### **Setting**

Qatar has witnessed tremendous economic, educational, and demographic reforms in the last few decades. It has predominantly a state funded healthcare system. Primary Health Care Corporation (PHCC) provides primary healthcare services through health centres existing across the country (Elzamzamy et al. 2020). The main public provider of secondary and tertiary healthcare has a growing number of general and specialised hospital and community services under its domain, including the mental health services (Wadoo et al. 2020). Qatar National Health Strategy places a clear focus on provision of integrated, high-quality mental health services in both community and inpatient settings, provided by the appropriate number and skill-mix of mental health professionals across all settings (Saeed et al. 2020).

### **Current model of care**

The service configuration in the local mental health service, as in any other service, is linked to age boundaries. Patients under the care of the Child and Adolescent Mental Health Service (CAMHS) upon reaching 18 years of age and needing ongoing care are referred to Adult Mental Health Services (AMHS).

### **Adapting the “transition care model” in Qatar based on International Best Practice**

The need of developing and implementing an effective transition care model between CAMHS and the Adult Community Mental Health Team (CMHT) within the organisation was formally recognised in 2018 by the clinicians working in both services. The overall aim of the new transition model was to ensure that young people don't fall through the care gap when transferred from CAMHS to CMHT. It thus aimed at promoting the process of engagement of patients and their families which is at the heart of patient-centered care.

We adopted the six essential elements of a successful transition programme, as identified in an international Delphi Study (Suris & Akra 2015) to develop and implement an effective transition model between CAMHS and CMHT. We put into place effective communication channels for adequate information exchange and flexible transition clinics to improve engagement and the quality of care provided to young people and their families during the crucial period of transition. Patients who have persisting health needs requiring ongoing support from AMHS are identified by clinicians in CAMHS three months prior to their 18<sup>th</sup> birthday. Referral information is emailed securely

to the CMHT. This is followed commonly by a transition planning meeting offered to the young person/family jointly with clinicians from both teams or occasionally by the young person/family meeting with the CMHT clinicians only depending on their needs and preferences. The transition planning meeting helps the young person to engage with their new healthcare worker from CMHT with less difficulty. It also allows for the CMHT clinician to establish suitability of the individual for a certain arm of their service which includes outpatient follow-up only, day-care service and/or outreach service, based on the needs of the individual. The care is then formally transitioned to adult mental health services.

## **FINDINGS FROM THE NEW TRANSITION CARE MODEL**

We reviewed the case notes of all patients (26) who were discharged from CAMHS during one calendar year (2019) having reached 18 years of age. We therefore included all eligible young people instead of choosing a sample from the target population.

We followed all these twenty-six young people up for 6 months post-discharge. The data of young people transitioned formally from CAMHS to CMHT was compared with young people who were transferred without a managed transition process. This service evaluation initiative was approved by the hospital directors of mental health services. Data used was aggregated and anonymised. Demographic characteristics, diagnosis on discharge, clinical features and other related characteristics of the patients are shown in Table 1.

The number of patients receiving their first appointment from Adult mental health services (AMHS) within 4 weeks of discharge from CAMHS was higher (75%) in the transitioned group compared to the transferred group (61%). Engagement with AMHS was found to be higher in patients who were transitioned (8/8, 100%) than the transfer group (14/18, 77.8%). Crisis presentations to emergency department (ED) while following up with AMHS were observed to be lower in patients who were transitioned than the transfer group (12.5% vs 22.2%). In contrast, the occurrence of inpatient admission whilst following up with AMHS was noted to be higher in patients who were transitioned than the transfer group (12.5% vs 5.5%) (Table 2). This may be explained by the fact that transitioned patients are monitored more closely and therefore are less likely to lose contact with services and admitted promptly when indicated.

Another interesting observation was that the group of patients who had a history of inpatient admissions under the care of CAMHS were more likely to be transitioned to adult services. This finding reiterates the importance of a managed transition process for young people with complex needs to manage the associated

**Table 1.** Participants characteristics

	Frequency	Percentage (%)
Gender		
Male	13	50.00%
Female	13	50.00%
Age Group		
18 years	12	46.20%
19 years	14	53.80%
Diagnosis on discharge from CAMHS to AMHS		
Anxiety Disorder	5	19.23%
Major Depressive Disorder	4	15.38%
Intellectual Disability	5	19.23%
Psychotic Disorder	4	15.38%
Others	8	30.77%
ED-Visits while following under CAMHS		
None	16	61.54%
1 or more	10	38.46%
ED-Visits while following under AMHS		
None	21	80.77%
1 or more	5	19.23%
Admissions while following under CAMHS		
None	21	80.77%
1 or more	5	19.23%
Admissions while following under AMHS		
None	24	92.30%
1 or more	2	7.70%
Engagement with CAMHS		
Engaged	23	88.50%
Not engaged	3	11.50%
Engagement with AMHS		
Engaged	22	84.60%
Not engaged	4	15.40%
Contact years with CAMHS prior to discharge		
More than 1	19	73.10%
Less than 1	7	26.90%
Duration between last CAMHS contact and 1st AMHS contact		
≤4 Weeks	17	65.38%
>4 Weeks	9	34.62%
Disposition Service		
West Doha CMHT (Transition)	7	26.90%
Other Adult mental health Services (Transfer)	19	73.10%

risks as ordinary transfer may result in disengagement and disruption of care. On the contrary, young people with a history of crisis presentations to ED whilst under the care of CAMHS were more likely to be transferred than transitioned. The most plausible explanation for this finding be the lack of well-established transition arrangements across the different mental health catchment teams. This finding identifies the need of expanding the transition model currently established between the CAMHS and CMHT to other catchment teams.

Young people with a primary diagnosis of psychosis formed the largest group to be transitioned effectively between the two services. This finding is consistent with clinical practice as it is more likely for clinicians to seek and ensure continuity of care for patients with psychosis

given their unique individual needs and the risks associated with disengagement.

## CONCLUSIONS

The implementation of the transition model between CAMHS and Adult CMHT has improved patient engagement resulting in an increasing number of young people opting for continuation of their care and a reduction in the number of dropouts. The continued engagement has also resulted in a reduced burden on services through planned care and minimisation of illness relapse due to disengagement. It also allows for utilisation of saved resources to meet other important service needs.

**Table 2.** Associations between Disposition status (transfer vs transition) and participants' characteristics

	Transfer n (%)	Transition n (%)
Gender		
Male	9 (50.0%)	4 (50.0%)
Female	9 (50.0%)	4 (50.0%)
Diagnosis on discharge from CAMHS to AMHS		
Anxiety Disorder	3 (16.7%)	2 (25.0%)
Major Depressive Disorder	3 (16.7%)	1 (12.5%)
Intellectual Disability	4 (22.2%)	1 (12.5%)
Psychotic Disorder	2 (11.1%)	2 (25.0%)
Others	6 (33.3%)	2 (25.0%)
ED-Visits while following under CAMHS		
None	10 (55.6%)	6 (75.0%)
1 or more	8 (44.4%)	2 (25.0%)
ED-Visits while following under AMHS		
None	14 (77.8%)	7 (87.5%)
1 or more	4 (22.2%)	1 (12.5%)
Admissions while following under CAMHS		
None	16 (88.9%)	5 (62.5%)
1 or more	2 (11.1%)	3 (37.5%)
Admissions while following under AMHS		
None	17 (94.4%)	7 (87.5%)
1 or more	1 (5.5%)	1 (12.5%)
Engagement with CAMHS		
Engaged	16 (88.9%)	7 (87.5%)
Not engaged	2 (11.1%)	1 (12.5%)
Engagement with AMHS		
Engaged	14 (77.8%)	8 (100.0%)
Not engaged	4 (22.2%)	0 (0%)
Duration between last CAMHS contact and 1st AMHS contact		
≤4 Weeks	11 (61.1%)	6 (75.0%)
>4 Weeks	7 (38.9%)	2 (25.0%)
Disposition Service		
West Doha CMHT	1 (5.6%)	6 (75.0%)
Other Adult mental health Services	17 (94.4%)	2 (25.0%)

The replication of the model of care transition has the potential to transform and enhance clinical care when applied effectively irrespective of demographic and cultural characteristics of the patient population. This model of care and the findings from our service present Qatar as a model for other countries in the Arabian Gulf region when developing and enhancing their own mental health services.

#### **Contribution of individual authors:**

Yasser Saeed Khan, Ovais Wadoo & Mohamed Siddig Ahmed were involved in the conception of the project.

Mohamed Hassan was involved in data collection.

Prem Chandra provided support with data analysis

Majid Alabdulla provided overall supervision.

All authors reviewed and approved the final manuscript

**Acknowledgements:** None.

#### **Conflict of interest:**

OW reports honorarium from Janssen outside of the submitted work.

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