Facilitating Effective Transitions from Hospital to Community for Children and Adolescent Mental Health Services: Overview of the Transition Support Worker Role and Function

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Abstract

Transitions between hospital and community services and from child and adolescent to adult services have been identified as a priority for improvement in the child and adolescent mental health and addictions sector across Canada and internationally. Despite widespread recognition of the issue, there is very little in the way of evidence to guide policy and programming to improve transitions. Transition support workers have been identified as a promising intervention to facilitate successful transitions, and innovative programs involving transition workers are currently operating in the Canadian mental health sector. This commentary presents two case studies of existing transition worker programs in the Greater Toronto Area that link hospital and community mental health sectors for youth ages 12-18. We discuss program characteristics, the transition worker role, recommendations to organizations considering creating a similar service, and areas for future research. The goal of this commentary is to contribute to knowledge exchange and ultimately strengthen the evidence base for the transition worker role in child and adolescent mental health services.

Key Words: transitional care, child psychiatry, adolescent psychiatry, patient transfer, mental health services

Résumé

Les transitions des services hospitaliers aux services communautaires, et des services pour enfants et adolescents aux services pour adultes ont été désignées comme étant une priorité pour améliorer le secteur de la santé mentale et des toxicomanies des enfants et des adolescents dans tout le Canada et sur la scène internationale. Malgré que cet enjeu soit largement reconnu, il y a très peu de données probantes pour guider les politiques et les programmes aptes à améliorer les transitions. Les transitions des services hospitaliers aux services communautaires, et des services pour enfants et adolescents aux services pour adultes ont été désignées comme étant une priorité pour améliorer le secteur de la santé mentale et des toxicomanies des enfants et des adolescents dans tout le Canada et sur la scène internationale. Malgré que cet enjeu soit largement reconnu, il y a très peu de données probantes pour guider les politiques et les programmes aptes à améliorer les transitions. Les travailleurs de soutien des transitions sont estimés constituer une intervention prometteuse pour faciliter les transitions réussies, et des programmes innovateurs qui emploient ces travailleurs de transition sont actuellement en activité dans le secteur canadien de la santé mentale. Ce commentaire présente deux études de cas de programmes de transition existants dans la région du Grand Toronto qui relient les secteurs hospitaliers et communautaires de la santé mentale pour les adolescents de 12 à 18 ans. Nous présentons les caractéristiques des programmes, le rôle des travailleurs de transition, les recommandations aux organisations qui envisagent de créer un service semblable, et les domaines de la future recherche. Ce commentaire vise à contribuer à l’échange de connaissances et finalement, à étloigner les données probantes concernant le rôle du travailleur de transition dans les services de santé mentale pour enfants et adolescents.

Mots clés: soins de transition, psychiatrie de l’enfant, psychiatrie de l’adolescent, transfert des patients, services de santé mentale

Introduction

Transitions have been identified as a priority for improvement in the child and adolescent mental health and addictions sector across Canada and internationally. This is particularly true in the child and adolescent mental health and addictions sector, where the problem is often compounded by the long-term, complex, and multidisciplinary nature of care for this population (Feldman, 2010). The Canadian Institute for Health Information (CIHI) (2013) and the Canadian Centre for Addiction and Mental Health (CCAMH) (2013) identified transitions between hospital and community services and from child and adolescent to adult services as a priority for improvement in the child and adolescent mental health and addictions sector across Canada and on a global scale. This can lead to service fragmentation, a lack of continuity of care, and a failure to foster a sense of identity and belonging for young people as they transition (Mental Health Commission of Canada, 2013). Transitions refer to the purposeful, planned process of movement from one service to another, whether it is from child and adolescent mental health services (CAMHs) to adult mental health services (AMHS) or from one sector of care to another. Transitions are often characterized by the lack of coordination and communication between services, and the result of which was a consensus statement that called for the removal of barriers to inter-agency and inter-sectoral collaboration to promote continuity of care for young adults as they transition (Mental Health Commission of Canada, 2017). Transitions between different mental health care services and sectors are notoriously challenging owing to long wait lists, varied eligibility criteria and siloed approaches to working that don’t permit for planned coordination of transitions. This can lead to service fragmentation, a lack of continuity of care, and a failure to foster a sense of identity and belonging for young people as they transition (Mental Health Commission of Canada, 2013). Transitions are often characterized by the lack of coordination and communication between services, and the result of which was a consensus statement that called for the removal of barriers to inter-agency and inter-sectoral collaboration to promote continuity of care for young adults as they transition (Mental Health Commission of Canada, 2017).

Program 1: East Metro Youth Services and Scarborough and Rouge Hospital Partnership

This brief report presents descriptions of two existing transition worker programs in the Greater Toronto Area that link hospital and community mental health sectors for youth ages 12-18, with the understanding that these programs offer an opportunity for frontline practice to inform and enrich evidence about transition workers. Although we use each program’s unique characteristics, it is important to note that the roles are similar across programs. For a summary of program characteristics please see Table 1. The goal of this report is to describe the two programs, with the intent of contributing to knowledge exchange and ultimately strengthen the evidence base for the transition worker role in child and adolescent mental health services.

Program 2: Humber River Hospital Partnership

This brief report presents descriptions of two existing transition worker programs in the Greater Toronto Area that link hospital and community mental health sectors for youth ages 12-18, with the understanding that these programs offer an opportunity for frontline practice to inform and enrich evidence about transition workers. Although we use each program’s unique characteristics, it is important to note that the roles are similar across programs. For a summary of program characteristics please see Table 1. The goal of this report is to describe the two programs, with the intent of contributing to knowledge exchange and ultimately strengthen the evidence base for the transition worker role in child and adolescent mental health services.
Multiple mental health diagnoses
First hospitalization
Not connected to community services
12-18 yrs, Dual diagnosis and/or mental health concerns, Griffin Centre referral, high risk behaviours (self-harm, suicidality), minimal connection to community supports/services, behavioral and learning challenges
12-18 yrs with some limited outpatient clients, Dual diagnosis and/or mental health concerns, minimal connection to community supports/services, behavioral and learning challenges

6 months: transition to EMYS
TSST works to identify and coordinate long-term community supports and advocates for clients and their families to make sure that they have the necessary support and resources they need. The TSST needs to be flexible and comfortable to support their mental health needs within their daily environment including school, home and other community domains. Educational hiring requirements for the TSST role include a Masters in Social Work or a Master of Arts in Counselling Psychology, complemented by 3-5 years of experience working with youth that have moderate to severe persistent mental health issues. The role requires strong case management and advocacy skills, with extensive knowledge of community mental health resources. It also requires strong clinical skills with children, youth and families, with particular expertise in short-term therapies such as cognitive behavioural therapy, solutions focused brief therapy and motivational interviewing. Perhaps most critical is the therapist’s ability to balance the diverse roles that this position demands, while quickly engaging clients and family members and supporting them to transition to other services.

Table 1. Comparison of Transition Programs

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Care Pathways
This program is aimed at children on the inpatient mental health unit who will need to be connected to East Metro Youth Service or other community services upon discharge. A child or youth’s involvement with the transition program begins when they are still in hospital. If clinicians believe the client would benefit from the program, the inpatient social worker discusses a referral with the client and their family and then faxes it to EMYS. The initial service coorination meeting takes place in hospital between the TSST, client, family members, and dedicated internal care management. The TSST works to identify and coordinate long-term community services and advocates for clients and their families to get the support they need. The TSST needs to be flexible and comfortable to support their clients’ mental health needs within their daily environment including school, home and other community domains. Educational hiring requirements for the TSST role include a Masters in Social Work or a Master of Arts in Counselling Psychology, complemented by 3-5 years of experience working with youth that have moderate to severe persistent mental health issues. The role requires strong case management and advocacy skills, with extensive knowledge of community mental health resources. It also requires strong clinical skills with children, youth and families, with particular expertise in short-term therapies such as cognitive behavioural therapy, solutions focused brief therapy and motivational interviewing. Perhaps most critical is the therapist’s ability to balance the diverse roles that this position demands, while quickly engaging clients and family members and supporting them to transition to other services.

Program Evaluation
Monitoring of outcomes for the program takes place through follow-up by the TSST post-intervention to identify if there has been a reduction in hospitalizations, as well as satisfaction surveys with clients and referring resources. The program is also evaluated internally by EMYS on an annual basis and the reports are sent to Scarborough and Rouge Hospital. Moving forward, EMYS would like to develop a longitudinal research or evaluation plan to assess outcomes of the program, at six months, one year and two years post-discharge.

Program 2: Griffin Centre and North York General Hospital/Humber River Hospital Partnership
Griffin Centre’s transition program works in partnership with both North York General Hospital (NYGH) and Humber River Hospital (HRH). The goal of the service is to assist children and youth up to 18 years of age with development disabilities and/or mental health challenges to transition from the hospital to the community. The transition program links youth participating in hospital day programs, outpatients and inpatient mental health services with a wide range of community services including but not limited to Griffin Centre programs. It also facilitates referrals of Griffin Centre clients to mental health programs in these hospitals. The transition program began in 2001. Originally the partnership was between Griffin Centre and North York General Hospital, and then expanded to include Humber River Hospital. The partnerships are formalized in Memorandums of Understanding with both hospitals, and the program is funded by the hospital budget at both sites. Resources allocated to the transition program involve two 0.5 FTE TSSTs, each dedicated to inpatient and outpatient roles. The program is operationalized slightly differently at NYGH and HRH reflecting the unique structures and processes of each.

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Care Pathways

At both hospitals, TSWS become involved in the transition planning of children and youth from the time of admission to the inpatient unit. The TSWS participate in patient rounds or the hospital intake meeting with the family and client, providing clinical input as well as information about external resources and services. As a group, the team decides on next steps for that client, whether it is transitioning to the hospital day program, outpatient services, or community services. At HRH, the TSW is involved for three to six months. Clients typically receive support from the TSW program for four to six weeks, however this support may extend to several months for cases that are more complex or when clients are waitlisted for community services.

Transition Worker Role

The TSWS at both NYGH and HRH have diverse roles and functions. At both sites, they support the hospital teams with their clinical expertise of developmental disabilities, knowledge of community resources, and facilitate intake of discharged clients to Griffin Centre. They also support their colleagues in the community by educating them about available hospital programs and facilitate the intake of Griffin clients to hospital programs. At NYGH, the TSW works in an involved way with clients discharged from the inpatient unit that are on a waitlist for services from Griffin Centre; providing intensive case management, system navigation support, and individual and family therapy. Interventions are varied and tailored to individual needs; ranging from trauma assessments to ODSP application support to advocating for education or the school system. The transition worker role is critical to the adult mental health sector. At HRH, the TSWS provide case management and counselling support to families that are referred both to Griffin Centre and to other external agencies. The TSW also supports clients in the program and assists the hospital team with intake to inpatient and day programs. For children and youth discharged from the transition day program at HRH, the TSW assists the client to re-integrate into the regular school system through community exposure and desensitization training. Hiring qualifications for this TSW role include a Master of Social Work or a Bachelor of Social Work, and/or a similar degree in the field with relevant additional years of experience. A background in Child and Youth work with knowledge of dual diagnosis is preferred. Strong individual and family assessment skills, counselling skills, awareness of community resources and ability to navigate complex systems such as children’s aid, school boards, and youth justice systems are essential. The TSW must be accessible and flexible to effectively respond to the individuals and families with complex needs and advocate on their behalf.

Program evaluation

Evaluation for this program poses a challenge in part due to the fluid nature of the program and the TSW role; the TSW consults on and is involved in many more clients’ cases than the TSWS program is involved in. It is difficult to track long-term outcomes because the TSW is only involved in an interim capacity and ceases service when the client is connected to a long-term mental health provider. Program statistics that provide insight into the program’s effectiveness are in the process of being compiled.

Discussion

Although the transition programs at Scarborough and Rouge Hospital, North York General Hospital and Hum- ber River Hospital structure the transition worker role in unique ways, they also share notable commonalities. For all programs, shared pathways are realized between the hospital and community agency, with the transition worker providing short-term intensive support to bridge the two sectors. The transition worker also acts as a bridge between CAMHS and AMHS for transition-aged youth that are discharged from the hospital program. At each site, the transition worker role requires a similar blend of qualifications, knowledge and clinical skills, although hiring qualifications vary based on the program’s structure, client population, and current staffing complement of the agency and the hospital programs. All transition workers provide a combination of therapeutic clinical interventions, case management, and system navigation support to the client and family. Their shared characteristic of flexibility is what enables them to individualize their services to clients and families with unique diagnoses and needs. Commonalities also arose when TSWS participated in focus groups. The programs have received positive feedback from clients, and have found that the caseload merits a full-time rather than a part-time FTE for the transition worker role. Adequate resources to meet the needs of transitional youth highlight the importance of increasing staffing for their program in the future.

Another challenge unique to these programs include ensuring the safety of both clients and transition workers. As a large amount of work takes place once youth are discharged from hospital prior to obtaining ongoing care in a community mental health service, the transition worker must work quickly to ensure that adequate supports are in place to maximize safety of clients at high risk of self-harm or suicide. Programs can provide additional community services that youth transition to can pose difficulties for transition workers, particularly when the wait time for the service extends beyond the transition worker’s mandate, or if geographic boundaries are limited that prioritize limited emergen- cy room visits, days spent in hospital and estimated saved mental health costs, although important, are simply not available. This highlights the need for robust research and program evaluation that quantifies the contribution of transition support programs in child and youth mental health services.

To date, there is very little research that has rigorously evaluated the role of transition workers in promoting continuity of care among adolescents with mental health issues (Naert, Roose, Rapp, & Vanderplasse, 2017). The majority of literature on this topic rests in the adult mental health sector. Other evaluations of transition pathways in the community. While several studies report reduced hospital readmissions (Reynolds et al., 2004; Vidog et al., 2013), earlier discharge (Forclink, Martin, Chas, & Jensen, 2005), increased connections to community services (Dixon et al., 2009), and high patient satisfaction with the program (Armitage, Mackintosh, & Ward, 2004), other studies show mixed results (Bosnack et al., 2016; Heppner et al., 2016). One program described in the literature, called the Bridge Program, uses a transition worker role to help adolescent mental health patients make a successful transition from the hospital to a residential community setting in Calgary, Alberta (Cameron, Birnie, Dharna-Wardene, Ravio, & Marriot, 2007). An internal evaluation of the program found that it contributed to a reduction in the average length of hospital stays but frequent readmission rates and emergency room visits, and both staff and parents felt that the transitional program was key to the ado- lescent’s successful transition back into the community. In the Bridge program, the emphasis was on maintaining the natural environment of the patient, and providing a strong primary care contact at the hospital end who oversees all inpatient transitions to the community. Griffin Centre recommended that community and hospital partners find ways to take full advantage of each other’s knowledge, expertise and programming. They also recommended that careful thought be given to the scope of the transition worker’s counselling role, considering that clients and families may require intensive therapy for complex issues, as well as ongoing community counselling. More robust research on transition programs and the transition worker role is needed to form a strong bridge.
Acknowledgments / Conflicts of Interest: Kristin Cleverley held the CAMH Chair in Mental Health Nursing Research at the University of Toronto during the completion of this commentary. The authors have no financial relationships to disclose.

References

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