

POST PRINT VERSION

To cite print version:

McNamara, N., Coyne, I., Ford, T., Paul, M., Singh, S., & McNicholas, F. (forthcoming). Exploring social identity change during mental healthcare transition. *European Journal of Social Psychology, Special Issue 'Social identities and social cures: Advancing the social identity approach to health and well-being.'*

**Exploring social identity change during mental healthcare transition**

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This research was funded by a Health Research Award from the Irish Health Research Board Grant No. HRA\_HSR/2010/27.

The authors declare that there are no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## **Abstract**

Adolescents attending Child & Adolescent Mental Health Services (CAMHS) requiring ongoing care are transferred to adult services (AMHS) at eighteen. Many young people with service needs are not being referred, or are refusing referral to AMHS. This study explored these issues from a social identity change perspective. Transcripts of interviews conducted with young people (n=11), their parents (n=5) and child (n=11) and adult (n=8) psychiatrists were thematically analysed. Transition to AMHS confirmed an illness identity. Young people adopting this identity saw continued service engagement as identity-congruent. Disengagement was attributed to failure to adopt an illness identity or to an emerging adult identity associated with greater independence. Fractious professional relationships hindered transition and delayed the formation of a therapeutic alliance with AMHS staff. Disengagement post-transfer was linked to incompatibility between the AMHS service remit and specific illness identities. This study demonstrates how an intersection between identities shapes service engagement and disengagement.

**Keywords:** social identity change; transition; youth mental health; stigma; service engagement

## INTRODUCTION

Although social identity processes are implicated in service use (see Stevenson, McNamara, & Muldoon, 2014; Walter, Jetten, Parsell, & Dingle, 2015), there has been limited research on how they shape clients' engagement with different types of services or the transition between them. Here, we address an important service transition, namely the transfer of young people with on-going mental health service needs from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). Ensuring effective service transitions is an important determinant of health outcomes for young people (McGorry, 2007; Pottick, Bilder, Van der Stoep, Warner, & Alvarez, 2008). However, recent research reveals that services worldwide are failing to accomplish this (Davidson, Cappelli, & Vloet, 2011; Davis & Sondheimer, 2005; McGorry, 2007; McNicholas et al., 2015; Pottick et al., 2008; Singh et al., 2010). The result is service disengagement and declining health in this vulnerable group (Singh, 2009; Pottick et al., 2008; While, Forbes, Ullman, Lewis, Mathes, & Griffiths, 2004; Williams & Hewson, 2010; Viner, 1999).

Although the importance of transition as a significant event in the care of young people is recognised, it is rarely studied rigorously (Singh, Paul, Ford, Kramer & Weaver, 2008). Research remains at a descriptive level and does not offer a comprehensive insight into why the groups involved in service transition (i.e., young people, parents/carers, and clinicians) report predominantly negative experiences. Drawing on work in the 'social cure' tradition (Jetten, Haslam, & Haslam, 2012), we propose that part of the reason why mental healthcare transition is challenging is that it involves changes in multiple group memberships (i.e., from child to adult and from CAMHS to AMHS service user). It also confirms a move into a stigmatised group defined by a mental illness identity and as such could be considered a 'negative' transition (Haslam et al., 2008; Jetten & Pachana, 2012).

There have been recent calls for evidence-based interventions that will facilitate positive service transitions (Embrett et al., 2016). The development of such interventions should be informed by an established theoretical framework. We argue here that an important first step towards this goal is to examine the service transition as a social psychological process. We apply the Social Identity Model of Identity Change (SIMIC) (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009) to explore the contribution that social identity processes make to adjusting to service transition. We argue that this framework can provide new insights into previously identified facilitators of and barriers to successful transition as well as contributing towards the development of theoretically-informed interventions.

### **The Social Identity Model of Identity Change: How group memberships facilitate & hinder adjustment to life transitions**

Transitions affect individual well-being because they disrupt important social connections (Chick & Meleis, 1986; Haslam, Holme, Haslam, Iyer, Jetten, & Williams, 2008) and pose a fundamental threat to how we make sense of ourselves and the world around us (Meleis et al., 2000). Accordingly, maintaining, re-establishing, or replacing lost connections are important characteristics of a healthy transition (Haslam et al., 2008; Iyer et al., 2009; Jetten & Pachana, 2012; Jones, Williams, Jetten, Haslam, Harris, & Gleibs, 2012; Meleis et al., 2000). Within the ‘social cure’ paradigm, SIMIC (Haslam et al., 2008; Iyer et al., 2009) proposes that an adaptive response to transition involves self-categorising in terms of a new group and deriving a meaningful social identity from this group membership (Iyer et al., 2009).

The new identity promotes adjustment to transition by acting as a source of social support and by providing specific goals and motivations that offer a sense of purpose post-transition (Dingle, Stark, Cruwys, & Best, 2015; Iyer et al., 2009). As illustrated in recent applications of this perspective to recovery from addiction and eating disorders, a sense of

shared identity with others transitioning from an addict or illness identity towards a recovery identity protects well-being through appropriate social support, the collective construction of a new recovery identity, and the sharing of coping strategies (Best, Beckwith, Haslam, Haslam, Jetten, Mawson, & Lubman, 2016; Dingle, Stark, et al., 2015; Frings & Albery, 2015; Hastings, McNamara, Allan, & Marriott, 2016; McNamara & Parsons, 2016). During the recovery process, successfully adopting the new identity (alongside dis-identification with the old identity) is associated with positive health outcomes including treatment engagement (Beckwith, Best, Dingle, Perryman, & Lubman, 2015) and reduced relapse rates (Buckingham, Frings, & Albery, 2013).

SIMIC outlines specific aspects of group membership that facilitate the adoption of a new identity. First, being a member of multiple social groups promotes the development of skills that allow individuals to more readily join new groups and successfully incorporate these into their identity networks (Haslam et al., 2008; Iyer et al., 2009). Furthermore, if the transition involves the loss of a single group membership, the individual's self-concept is not exclusively bound up in terms of the group that they are leaving (Ellemers, 2003) and this attenuates the adverse consequences of identity change (Haslam et al., 2008; Iyer et al., 2009). Multiple group memberships also provide access to several sources of support during transition (Haslam et al., 2008). Finally, there is a greater likelihood that at least some of these group memberships will remain post-transition, providing a sense of identity continuity (Haslam et al., 2008).

However, adopting a new identity is not a straightforward process. Individuals can resist change when the old identity is central to their self-concept (Ellemers, 2003), or when the new identity is perceived as socially stigmatised (Haslam et al., 2008; Jetten & Pachana, 2012). Such 'negative' transitions can have particularly adverse consequences for health and well-being (Haslam et al., 2008). Individuals affected can find themselves without a strong

support network, which can be particularly devastating if the transition is involuntary (Jetten & Pachana, 2012).

Changes in group memberships bring about changes in an individual's identity networks, which are themselves embedded in a wider social context (Iyer et al., 2009; Jetten & Pachana, 2012). The challenges associated with impoverished identity networks are exacerbated if the new identity is perceived as incompatible with existing identities (Haslam et al., 2008; Iyer et al., 2009). For example, Iyer et al. (2009) found that first year students who did not adjust to the transition to university were more likely to come from a lower social class background. These students did not perceive the university student identity as compatible with their existing group memberships. Situations like this can mean that the individual undergoing transition cannot rely on support from either their existing identity network or the new group they are joining (Iyer et al., 2009). Incompatibility within an identity network also threatens the individual's sense of identity continuity, resulting in a reluctance to embrace a new identity (Iyer et al., 2009).

In summary, the SIMIC model provides a clear framework for understanding why transitions are experienced as challenging alongside detailing aspects of group membership that protect well-being. In the following section, we consider research on experiences of mental healthcare transition before articulating how SIMIC can contribute to understanding, and improving, these service transitions.

### **The mental healthcare transition experience for young people**

The service transition process comprises three stages (NICE, 2016). First, there is the planning stage whereby the CAMHS clinician determines the future care needs of the young person. If they have an on-going service need and meet certain eligibility criteria, the clinician obtains consent for a referral to AMHS. Not everyone with mental health service

needs progress past this stage (Singh et al., 2010; McNamara et al., 2013; McNicholas et al., 2015). Those presenting with an unconfirmed diagnosis or one that falls within the categories of emotional/neurotic disorders, eating disorders, conduct disorders, emerging personality disorders, or neurodevelopmental disorders are less likely to be referred to AMHS than those with a diagnosis of serious and enduring mental illness (e.g., schizophrenia or bipolar affective disorder) (Singh et al., 2010). The former diagnostic groups are also more likely to have suboptimal transition experiences when they are referred (McNicholas et al., 2015; Singh et al., 2010). There are instances of young people refusing a referral to AMHS (McNicholas et al., 2015), however previous research has not yielded any insight into the reasons for this.

The second transition stage, the transfer period, involves preparing the young person for the handover of care to AMHS. Fractious relationships between clinician groups have been consistently cited as contributing to problems encountered at this stage (Davis & Butler, 2002; Davis & Sondheimer, 2005; Embrett et al., 2016; Hovish et al., 2012; McLaren et al., 2013; Paul, Street, Wheeler, & Singh, 2015). Negative experiences are also more likely for young people undergoing multiple simultaneous transitions (Singh et al., 2010). This period is also negatively experienced by parents who find it difficult to adjust to the idea of reduced involvement in their child's care (Hovish et al., 2012).

The third and final transition stage is post-transfer engagement which comprises the initial appointments with AMHS staff. This is an important period for consolidating a new therapeutic relationship. While the initial development of this relationship should occur during the transfer period, given poor levels of interagency collaboration (Hovish et al., 2012; McLaren et al., 2013), it is often the case that the young person does not meet the new team until their first appointment. Singh et al. (2010) noted that one-fifth of cases transferred to AMHS in their study were later discharged without being seen. Few studies have considered

factors impacting on engagement post-transfer, however McLaren et al. (2013) suggest that subsequent disengagement might represent a “reluctance to embrace change” on the part of young people (p.259). A failure on the part of AMHS to engage earlier in the transition process is also likely to contribute to poor attendance at the initial appointments.

In the next section, we outline the benefits of exploring service transitions as a site of identity change.

### **Applying SIMIC to mental healthcare transition**

Figure 1 details the main constituents of the SIMIC model. We have adapted the model to the current study to illustrate where concepts need to be extended and developed in order to understand the identity changes involved in mental healthcare transition.

**(Figure 1 here)**

Here we characterise mental healthcare transition as involving dual identity change. This is one area where the current study could contribute to the development of SIMIC, which has so far considered one identity transition at a time. In the current context, access to AMHS is dependent on adoption of a serious and enduring mental illness diagnosis (Singh et al., 2010). Thus, the service transition makes salient a (potentially) permanent move into a socially stigmatised group. However, this potentially negative life change occurs in the context of the developmental transition to adulthood. This could be considered something of a positive change, particularly for young people involved with mental health services. Previous research has found that young people feel their voices are not heard in the decision-making process in CAMHS and desire greater input into their care (Coyne, McNamara, Healy, Gower, Sarkar, & McNicholas, 2015). While a move to AMHS might be seen as a negative life change, the fact that it occurs in the context of a positive life change may in some way buffer adverse effects on well-being. Specifically, the young person in AMHS will

achieve their desire of having greater input into their care pathway, as well as having reduced parental involvement in their care. However, this assumes a willingness to adopt a mental illness identity and also viewing entering adulthood as positive. It might be the case that a mental illness identity is not something which young people see as fitting with their potential future identities as they step into adulthood. Thus, young people's reluctance towards continued service engagement in adulthood could be a self-protective response to being potentially labelled mentally ill. We propose therefore that it is important to explore young people's feelings about moving into adulthood alongside how they self-categorise in response to their diagnosis in order to understand service (dis) engagement.

As suggested by SIMIC, the composition of the young person's identity networks will impact on service transition. We see multiple group memberships as remaining important in this transition, as per previous SIMIC research (Haslam et al., 2008; Iyer et al., 2009; Jones et al., 2012). For some young people living with chronic physical illness and transitioning between services, family has been shown to be a vital source of support (Hilliard et al., 2014). So maintaining this connection is important, implying that involving parents in an appropriate way in the transition process is essential (NICE, 2016).

Regarding clinician groups, the fact that many young people form a strong therapeutic alliance with their CAMHS teams suggests this group (like parents) can also act as a source of support during transition. Unfortunately, this group membership cannot be maintained post-transfer for obvious reasons. Nonetheless, the AMHS clinician group can be a new clinical team that can replace this lost connection and provide additional support during the transition process. NICE guidelines suggest a period of joint working during the transfer period to support the building of relationships with the new team (NICE, 2016). However, it is clear from previous research that the quality of support received during this stage is heavily dependent on the quality of interagency relationships. While SIMIC has considered ways in

which some groups can hinder successful transition (specifically, the need to move away from ‘negative’ groups during addiction recovery, see Dingle et al, 2015) as well as the benefits of possessing multiple group memberships, the impact of these groups’ relationships with each other on transition outcomes have yet to be considered. We propose that exploration of this in the current context could provide valuable insights into an aspect of multiple group membership yet to be considered by the SIMIC model.

Finally, we suggest here that it is important to consider the young person’s perceptions of the compatibility of the pre- and post-transition identities (Iyer et al., 2009). SIMIC suggests that greater compatibility between these identities facilitates adopting the new identity. In the current context, if the young person sees their CAMHS and AMHS illness identities as compatible, it is possible they will adopt the new group membership which will hopefully promote long-term service engagement.

The current study is part of the multidisciplinary, multi-study ITRACK project (McNamara et al., 2013; McNicholas et al., 2015) which examined the policies, procedures and process of transition from CAMHS to AMHS in the Republic of Ireland. The qualitative stage of this project investigated the perceived facilitators of and barriers to successful transition. The study aims were informed by the literature on transition as well as the findings of preceding quantitative ITRACK studies concerning (1) the discrepancy between the number of young people considered suitable for transfer to AMHS and those who transitioned and (2) young people’s refusal of an AMHS referral. To that end, the current analysis addressed the following research questions:

1. What social identity changes are implicated in mental healthcare transition?
2. How do social identity processes influence the transition experience and subsequent service engagement?

## METHOD

### Participants and Data collection

The study was reviewed and approved by an institutional ethics board and local service ethics committees where relevant. Lead clinicians from CAMHS and AMHS teams nationwide identified in Stage 1 of the ITRACK study (McNamara et al., 2013) were contacted by post requesting both their participation in the study and their assistance in identifying young people from their service who had transitioned from CAMHS to AMHS.<sup>1</sup> Follow-up emails and telephone calls were used to increase participation rates. Participating clinicians forwarded letters of invitation, participant information sheets, and consent forms to young people who met the study inclusion criteria. In addition, recruitment posters and information leaflets were made available in the waiting rooms of participating services and were distributed by voluntary service organisations involved in youth mental health support. Young people responded directly to the research team indicating their decision to participate in the study. They were subsequently asked for permission to contact their parents or carers and invite them to interview.

Thirty-five semi-structured interviews were conducted with young people (n=11), their parents (n=5), and lead clinicians from CAMHS (n=11), and AMHS (n=8). Table 1 illustrates relevant demographic and service information for the young people interviewed alongside information relating to diagnostic category and the stage of transition reached. The sample was predominantly female (91%, n=10) with a mean age of 19 years. All but three participants were engaged with mental health services at the time of interview, with the majority (73%, n=8) having completed the transition to AMHS. (This was defined as being engaged with AMHS three months' post-transfer as per Singh et al., 2010). Two participants

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<sup>1</sup> General Practitioners and staff from voluntary service organisations involved in support youth mental health were also interviewed in this study but this data is not reported here.

were interviewed during Stage 2 of transition (i.e., the transfer period) and one participant had not progressed past stage 1 as she had refused a referral to AMHS. These critical cases helped to inform the analysis. Participants' self-reported diagnoses were classified per the classification system used by Singh et al. (2010). Most of the sample (36%, n=4) had multiple presenting issues (comorbidity), 27% (n=3) received diagnoses of serious and enduring mental disorders and 18% (n=2) were diagnosed with emerging personality disorders. One participant received a diagnosis of an emotional/neurotic disorder and one participant did not report a diagnosis.

Written informed consent was obtained from all participants prior to interview. Interviews were conducted in a private space by the first author and lasted between 28 and 133 minutes (mean = 47 minutes). The interview schedule was used flexibly and the interviewer was responsive to issues emerging from participants' accounts. A 'funnelling approach' (Guba & Lincoln, 1981) was followed whereby participants were initially asked general questions relating to transition (e.g., how did you realise that you (your child) would have to move to adult services; how do you decide whether to refer a young person to adult mental health services?). These questions allowed for a full discussion of participants' views and experiences before using a series of probes to explore experiences in more depth in line with previous literature and our theoretical perspective (e.g., what impression did you have of the adult service? What would you see as the main differences between the child and adult services?). This approach identifies which facilitators and barriers to transition are spontaneously mentioned by participants themselves (Dingle, Cruwys, & Frings, 2015) before specific questions on areas of interest to the researcher are introduced (Cinnirella & Loewenthal, 1999). All interviews were audio-recorded, transcribed verbatim, and entered into NVivo 10 for analysis.

**(Table 1 here)**

## **Analytic Procedures**

A contextualist epistemological approach was adopted in this study whereby participants' accounts were viewed as "(reflecting) multiple realities (and) the context-bound nature of reality" rather than reflecting an external reality that can be perfectly captured through coding (Braun & Clarke, 2013, p.279). This approach sees knowledge as reflecting the researcher's theoretical stance and experience but also as valid (or 'true') within the context in which it was collected (Braun & Clarke, 2006).

Data were analysed using a theoretically-guided thematic analysis (Braun & Clarke, 2006). First, transcripts were read repeatedly for data familiarisation purposes. All instances in the data which pertained to the process of transition, interagency relationships, service collaboration and planning, developmental changes, group memberships (including diagnostic categories), and service engagement and disengagement were identified. These extracts were analysed following the steps outlined by Braun and Clarke (2006). Coding and theme generation were completed by the first author. Similar codes were grouped to form themes which articulated the most salient patterns occurring across the dataset. Themes were reviewed and refined through discussion within the research team where necessary. In addition, deviant case analysis (Silverman, 2001) was used to further develop the thematic structure. In this process, identified instances which did not fit with the emerging thematic structure were used to revise it, ensuring that it accounted for the data in its entirety.

## RESULTS

Our data reflected the literature's conceptualisation of the transition process as comprising three stages – planning, the transfer period, and post-transfer engagement. Service protocols are written based on these stages, clinicians understand their roles in terms of these stages, and young people experience service transition itself in these stages. We examined the social identity processes implicated at each of these stages as articulated by our participants. These processes are represented in the three themes identified from the data: (1) initiating service transfer and identity change; (2) scaffolding identity during the handover of care; and (3) building an identity-based therapeutic alliance. A visual representation of the thematic structure is represented in Figure 2. This map provides an overview, not of the ideal transition process, but as it was experienced by our participants. Each theme is described in detail with extracts used for illustrative purposes.

**(Figure 2 here)**

### **Theme 1: Initiating service transfer and identity change**

#### *Ascertaining compatibility with the adult service*

It was clear from the data that mental healthcare transition was closely linked to changes in social group memberships. First, becoming an adult (primarily signified by turning eighteen and leaving second-level education) marked the beginning of the end of the young person's time in CAMHS and raised the question of whether to transition to AMHS. Moreover, this developmental change also marked an expected shift in the mode of engagement with mental health services. Clinicians perceived a clear distinction between the capabilities and responsibilities of children and those of adults. Children required protection, were not competent decision-makers, and should be viewed within the family context. In contrast,

adults were autonomous individuals who were primarily responsible for their mental health. These conceptualisations of ‘child’ and ‘adult’ inform service configuration and delivery and the crossing of the developmental boundary between child and adult necessitated transition to a more ‘adult-type’ service, as illustrated in Extract 1 below:

### **Extract 1**

**CAMHS11** ...a key difference [between CAMHS and AMHS] would be, you know, the lack of parental involvement unless explicitly, you know, requested by the adult themselves. Yeah, those kind of things and that really, that the onus is on them you know, in CAMHS a lot of the onus is on maybe parents to, to bring about change in their child whereas in adult the onus is more on them, the responsibility for meds, you know, I suppose it's in keeping with lots of changes from child and it's really about their own responsibility

CAMHS clinicians were quite clear that to ensure a positive outcome, young people needed to adopt an adult approach to their care. There needed to be evidence that the individual has displayed this developing maturity while at CAMHS. Only then could the clinician feel confident that the transfer would be a success, as CAMHS 11 explains below when outlining the “ideal” conditions for transition to AMHS:

### **Extract 2**

**CAMHS11** ...the child themselves has developed into a kind of a, I suppose a responsible adult who's going to be responsible for their own health going forward and be keen to engage

In addition to reaching adulthood, CAMHS clinicians emphasised that a referral to AMHS would only occur in the context of serious and enduring mental illness (Singh et al., 2010):

**Extract 3**

*Int.* ...what kind of cases would you tend to send to adult services?

*CAMHS05* They would be mostly the kids with maybe a recurrent depression with possible emerging bipolar, the kids who have had a clear psychotic episode, so, you know, most of them will have clear identified mental health difficulties.

There was a clear distinction made between childhood ‘disorders’ and adult ‘mental illness.’ Childhood and CAMHS were associated with temporary emotional, developmental and behavioural difficulties, whereas adulthood and AMHS were associated with significant and enduring mental illness. So not only do young people need an adult type service but more importantly they needed a service that had the expertise to handle a serious, long-term mental illness. The position from clinicians was that mental illness did not emerge until late adolescence or early adulthood – some CAMHS clinicians in our sample were hesitant to confirm a diagnosis of serious and enduring mental illness in children. CAMHS was viewed as a service that assisted young people in moving back towards a “health trajectory” rather than assisting them in recovering from an illness (which was the remit of AMHS):

**Extract 4: CAMHS07**

*what adult services are dealing with is adults, who have obviously had a lot of influences of growing up, developing, they’ve reached a point in it and they now are, you know, more likely to have a disorder or a, an illness which requires treatment and it’s maybe more about treating that than sort of deconstructing all the factors that are*

*playing a part or have played a part, because they're dealing historically and we would be, easier for us to be saying well let's see if we can, you know, sort of help to get this right, maybe things won't actually continue to go wrong, so it's a bit of a privilege for us if you like. You know, we can maybe get there you know, before too much damage is done*

During transition, the conceptualisation of a mental illness diagnosis for the young adult changes from a temporary (developmental) condition (which fits the remit of CAMHS) to a more permanent and enduring illness (which is compatible with AMHS). Thus, the transfer itself emphasises that the young person's problems are long term and confirms a permanent move to an illness group.

### ***Initiating identity change***

The referral criteria cited by clinicians all have implications for identity as they require a change in the young person's group memberships. The meaning of these categories and the degree to which they were seen as self-defining by young people had consequences for their acceptance (or not) of the AMHS referral (Meleis et al., 2000).

Parents and young people reacted quite differently to the developmental transition. Most young people embraced it and the associated reduction in parental involvement in their care. Others initially found the prospect of taking on greater responsibility to be daunting; but often felt a sense of pride in achieving greater independence. These participants did however appreciate the continued support of their parents. In contrast, parents found their transition a more difficult adjustment to make. While most parents acknowledged that their role must change as their child enters adulthood, there was a fear that they would not be privy to important information about their child's well-being post-transition, as exemplified below by the mother of Participant A:

### **Extract 5: Parent 01**

*I'm just afraid maybe with the new team, [Mary] is an adult now that I'm not going to be told anymore. I'm concerned about that, I have to say, that's a worry I have that I won't be told.*

Clinicians suggested that a key issue influencing referral acceptance by young people (and, in some cases, parents) was their degree of “buy-in” to the process. They emphasised the importance of choice on the part of the young person and explained the refusal of a referral in two ways. First, refusal was articulated as an instance of the individual exercising their right as an adult to choose their care pathway. Thus, the young person was reported to be acting in a way that would be expected of someone who is becoming an adult with all the rights and responsibilities that goes with this:

### **Extract 6**

**CAMHS02** *I suppose for a lot of them, you know yourself, a lot of the young people that come here, they didn't make the choice to come here, and now they have a choice as to whether or not to enter the next service and some of the, that's a very, that's a, that's a good place for them to be, you know, they, they kind of want to exert their own choice in that.*

As illustrated above, clinicians respected that gaining adult status brings with it the right to decide one's own care pathway (within some limits) and suggested that is one reason why a referral to AMHS is declined.

In addition, the refusal was seen by clinicians as a choice on the part of young people to reject joining a socially stigmatised group (Jetten & Pachana, 2012; Meleis et al., 2000). In

the data, the typical AMHS service user was viewed as someone who is perceived to be particularly vulnerable with significant and relapsing mental health difficulties:

**Extract 7**

**CAMHS11** *...I wonder is there a fear amongst young people transitioning that they're going to be sitting there in a waiting room with chronic schizophrenics or you know, what their idea of a chronic schizophrenic is as well, you know. And I'm sure that can be, I'm sure that happens at times*

**CAMHS04** *I think there's still some issues about eh, the em, the power and kind of, the meaning, the implications of joining a big thing like the adult mental health service.*

The social stigma surrounding AMHS was cited by Participant E as the reason she refused a referral:

**Extract 8: Participant E**

*...there was maybe four people who had ever gone to [local AMHS] and they were proper – like this is going to sound very harsh – they were loopers like, they were people who would like jump out in front of trains, or usually had very severe alcohol problems, and I just didn't want to be in that*

Those who tended to accept a referral were predominantly those young people who self-categorised as having a mental illness. (Although it should be noted that young people's mental illness identities encompassed a broader range of diagnostic categories than were included as part of clinicians' category of serious and enduring illnesses). These young people did not perceive that they had a choice in being referred to AMHS but agreed to a

referral as they recognised their need for support from a service given their move to adulthood and their diagnosis, particularly if they required on-going access to medication:

### **Extract 9: Participant F**

*Int.* *did [CAMHS] give you a list of different things you could do or was it a recommendation for the adult service?*

*PtF* *No, I had to do the adult service.*

*Int.* *Okay, all right.*

*PtF* *Because I have to, over being bipolar like it's not gonna go away.*

Participant F's self-definition as "being bipolar" suggests she is self-categorising in terms of an illness identity and recognises the need for continued engagement with mental health services on this basis ("it's not gonna go away"). Consenting to an AMHS referral was behaviour that is congruent with this identity (Turner & Oakes, 1986). However, even though most young people in our sample progressed past this first transition stage, had given their consent to the referral, and indicated their willingness to continue to engage with services, the transition process was still experienced as challenging and required support from those around them.

### **Theme 2: Scaffolding identity change during the handover of care**

As illustrated in the previous section, joining AMHS means adopting a new adult identity *and* an illness identity. The transfer period is therefore an opportunity to prepare for a move to adulthood as well as joining a new clinical team who will play a key role in supporting a move towards recovery.

Despite recommendations that such preparation is conducted collaboratively by both services (Hovish et al., 2012), it was typically perceived as the responsibility of CAMHS

clinicians. Clinicians primarily focused on supporting or scaffolding the transition to adulthood:

**Extract 10**

*CAMHS01 we do a lot of work on kind of the WRAP<sup>2</sup> model and keeping them safe and part of their own management of the care plan and things, yeah. So the more autonomy they can take the more they get and we always ask parents to let them do that, even if they're younger, we start that early on.*

During their time in CAMHS, a familiar environment with multiple supports in place, the adolescent is able to model an adult role by having separate appointments from their parents and by taking greater responsibility for their care by, for example, making their own appointments. Although this work was typically undertaken with all adolescents attending CAMHS, it was viewed as essential for those transitioning to AMHS so they would successfully engage with an adult service that was more “individualised” than CAMHS. This activity also assisted parents in gradually adjusting to a change in their role.

This preparation work was also motivated by CAMHS clinicians’ beliefs that AMHS had limited follow-up for those who missed appointments and that families were excluded from the treatment process. However, AMHS clinicians suggested that there was a protocol for contacting high-risk individuals if they missed appointments and that families, while not having the same degree of involvement in decisions around care, were included in the treatment process with the client’s permission.

This lack of knowledge of the AMHS service on the part of CAMHS extended to the care package the young person would receive post-transfer. This limited the helpfulness of the support provided by CAMHS clinicians in relation to scaffolding the illness identity transition. Across the interviews, young people stated that one of the primary stressors that

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<sup>2</sup> Wellness Recovery Action Plan

they experienced during transition was uncertainty about the recovery supports they would be offered and a lack of information about AMHS. At times the information provided by CAMHS clinicians increased, rather than reduced, young people's anxiety at entering a new service. Clinicians provided minimal information on AMHS and largely emphasised that it had a very different service delivery approach:

**Extract 11: CAMHS02**

*I suppose say that I, I'm not sure what will be on offer, but that, that they would be treated, like it's an adult service so they're going to be treated slightly differently, that there'll be more kind of personal responsibility around you know, recognising things for themselves, making their, you know, making their appointments and following up on them because they may not get the same outreach, and they may, but there's no point in pretending that they, that they will.*

Some of the young people noted that their parents (and carer in the case of one participant) were a key source of support in helping them cope with the anxiety associated with the transition. For Participant F, her mother's support was in stark contrast to the quality of support provided by her CAMHS clinician:

**Extract 12: Participant F**

*I was asking [CAMHS clinician], do you know, sort of what's it like, do you know, will it be the same thing like and she said no, she said they wouldn't have someone like [psychologist], so then I started to worry because I knew that was my cognitive therapy gone and she was like and you'll have to start, you know, doing it on your own, but they didn't really sit down like and say well this, this, this, this and this, do you get me, they just sort of, my mother told me most of it really, to be honest.*

As illustrated above, there was a very strong message articulated by CAMHS that AMHS is a completely different organisation, reinforced by CAMHS clinicians' admissions of a lack of knowledge about AMHS service provision. The perceived disconnect between both services is articulated below by Participant F's mother in response to a question about the extent of the information about AMHS provided by CAMHS:

### **Extract 13**

**Parent03** *Just that she'd be treated as an adult and that, you know, she'd still have her medication and she'd still be treated for her illness, you know, there'd be no doubt about that but they didn't know, they really didn't know what other back-up services were available to her.*

**Int.** *So CAMHS didn't really know anything about -*

**Parent03** *No, it seems to be a 'them and us' kind of a scenario.*

The service divide suggested here featured across clinician interviews as a significant barrier to successful service transitions, hindering collaboration between clinical teams:

### **Extract 14**

**CAMHS02** *...there is a gap of communication and collaboration between CAMHS and adult services, there is, and I think that, that drips into [Int. **Everything**] into everything, em, and then like lots of things, once you make, once you make personal human contact, it's okay.*

**AMHS01** *[the] reality is that there's very little communication or liaison between child psychiatry and adult services, they are quite different. You know we don't have in my view we don't have enough joined*

*working, we don't do things together, and there's very much a...I mean there's very much a bit of a fight really you know, it's always maybe the only time when there's any discussion is about this controversial sixteen to eighteen year and there's a lot of resentment on both sides I would say about that. So I think that's a real difficulty. You know, once people go into trainees, you know we might have trainees they go into child psychiatry that's it, and child psychiatry, as I say we rarely meet if ever, I don't know if we ever meet.*

Historical disputes centred on the changing age boundary between services put professional relationships under strain. CAMHS upper age limit had been 16 years, and this was changed under the Mental Health Act (2001) to 18 years without provision of additional resources. This “dispute”, as it was termed by clinicians, hindered willingness to collaborate. This was particularly noticeable during the second transition stage.

The mental health literature recommends a period of parallel care and joint working during the transfer period so that the young person can begin to establish a rapport with their new team whilst being supported by their CAMHS team (Hovish et al., 2012; NICE, 2016). Our data suggest an almost total absence of transition planning meetings involving clinicians from both services, parents and young people. Consequently, young people did not have any opportunity to meet and form connections with AMHS staff until their first appointment. This contributed to the anxiety experienced by young people during the transfer period:

#### **Extract 15**

*Int. So you were saying that you'd kind of prefer to stay with [CAMHS clinician] because you know them. What do you*

*think about talking to [AMHS clinician], do you have any particular worries about going to them or anything that you're nervous about?*

**Pt A** *Well it's just mostly that he's a new person, I don't know what he's like, that kind of, so I'm a bit nervous for talking about stuff to him.*

In response to a question about what would have been helpful for her during this stage of her transition to AMHS, Participant H suggested the creation of a formal “transfer programme” which seems to be very much centred on the idea of supporting identity change:

#### **Extract 16**

**Pt H** *...you'd get to go with the person you see here, like actually visit the place. [Int.OK] and then like shown around and told who you're gonna see there and introduced to them and then visit another couple of times and then eventually the person from here won't come anymore and then you'll be fully in the service.*

**Int.** *Yeah. And how do you think that would help you, if you had someone going with you?*

**Pt H** *Because, well just that the people come here because you feel like you have both for a certain time so like they're actually transferring you rather than just throwing you from one to the other. [Int. Okay. Yeah. Okay, so it would be good to have -] It would kind of feel like a bridge.*

In summary, the main challenge of the transfer period is to ensure a smooth handover of care and this should involve a deliberate effort on the part of clinicians from both services

to scaffold or support the identity change process for young people in such a way that they feel confident in assuming greater ‘adult’ responsibility for their care and in managing their illness. It was clear from our data however, that fractious professional relationships are a significant barrier to effectively supporting identity change. As illustrated in the following section, this failure to collaborate and establish connections with the new AMHS team had serious implications for post-transfer engagement.

### **Theme 3: Building an identity-based therapeutic alliance post-transfer**

Clinicians suggested post-transfer AMHS engagement varied per diagnostic category:

#### **Extract 17**

*Int.*                    *how is their level of engagement with the Service?*

*AMHS04*            *Gosh, that depends I would say on the diagnosis. Some of them don't engage at all, particularly if they've got addiction problems or, or personality problems. The ones who come along with diagnoses of depression, significant depression or the ones that come along with a diagnosis of schizophrenia or bi-polar, they tend to engage quite well because they seem to know that they've got a significant illness and they need to do certain things to deal with it, like get blood tests taken or, you know, see the doctor or see whoever. So they tend to engage quite well. The addiction people, personality disorders and ADHD as well, but I think that might be our fault, don't engage well.*

AMHS04 alludes to a problem within the service that might be contributing to disengagement amongst particular diagnostic groups when he notes “that might be our fault.” Exploring the young adults’ accounts revealed that engagement could not be directly linked to membership of a particular diagnostic category. Our sample included a range of individuals with serious



were feeling which was not facilitated by short appointments. This reduced level of input was seen by AMHS clinicians as a consequence of an over-stretched service but was viewed by young people as signifying a lack of empathy:

### **Extract 19**

**AMHS07**                    *I mean obviously we have larger numbers so that definitely affects the kind of work you do, the quality of work you do, the types of relationships you form with people.*

**Pt C**                            *...we visited the place the other day and we were in it for a good while and then when we went in we only got about five minutes with the doctor and she was, it was very fast, I didn't really like it...*

Denhov and Topor (2012) highlight the importance of the use of time in the building of therapeutic relationships. They suggest that it is “interpreted as an expression of the relationship between the institution, the professional, and the user” (p.421). Here it would appear that short appointments communicated a negative message about the adult service’s interest in young people’s recovery, or interest in building a therapeutic alliance similar to that experienced in CAMHS.

While many did eventually develop a rapport with AMHS staff, those whose relationships remained strained or who completely disengaged from services typically reflected instances where young people felt that AMHS did not offer the support they needed to manage their condition. AMHS interactions often became a site of identity conflict (Stevenson et al., 2014). This was particularly evident in the case of participants who

transferred to AMHS with co-morbid neurodevelopmental issues or diagnoses that were incompatible with the AMHS service remit. These participants felt that AMHS clinicians were not interested in them or in an element of the issues with which they struggled.

Participant I, who eventually disengaged from the service during the post-transfer stage, was re-diagnosed with borderline personality disorder on joining AMHS. She was quite resistant to 'losing' her ADHD diagnosis and resented what she perceived as a lack of empathy from AMHS:

**Extract 20: Participant I**

*...they were like right you're an adult now, ADD doesn't exist when you're an adult, get off Ritalin, and my life just went back to this kind of like chaos. That was one thing that, that was kind of the main thing that I absolutely hate about [AMHS], they basically were just like, you know, it's time to grow up, get over your whole scatterbrain-ness...*

Participant J who transferred with co-morbid Asperger's and depression felt AMHS treatment did not address all her issues:

**Extract 21: Participant J**

*...that's the only one [negative] thing I'd have to say about the adult services, is that they don't really talk much about the Asperger's*

To access and have the full support of AMHS staff, service users need to adopt the identity imposed by clinicians (Hastings et al., 2016; Walter et al., 2015). It was not enough to self-categorise in terms of a mental illness identity (as most of our sample did), rather this illness identity should be one that corresponds with a diagnostic category that is perceived to be

compatible with the service. Re-defining that illness identity through re-diagnosis can have serious implications for engagement if the individual does not self-categorise in those terms, as seen in the case of Participant I who ultimately disengaged from AMHS.

Nonetheless, it was evident from the data that having a good rapport and developing a relationship with AMHS staff can help the individual overcome perceived deficits in service provision (Haslam, Branscombe, & Bachman, 2003). For Participant J, AMHS' sole focus on her depression diagnosis to the exclusion of her Asperger's diagnosis did impact somewhat negatively on her overall care experience. However, she remained engaged, possibly due to the fact that she reported enjoying a good relationship with her AMHS clinician and had had an overall positive transition experience. In contrast to Participant I, Participant G, who was also re-diagnosed with borderline personality disorder post-transfer, did not resist the change in diagnostic category and remained engaged with AMHS. Similar to Participant J, Participant G reported a more positive overall experience in joining AMHS whereby she maintained the support of her parents, was allowed a greater degree of control over her care pathway, and was developing a good rapport with AMHS clinicians. Unlike Participant I, she did not seem as attached to her previous diagnosis and referred to her new diagnosis as "just a label."

## DISCUSSION

### Summary of findings

Our data suggest that successful mental healthcare transition depended on the individual self-categorising as a responsible adult *with* a serious mental illness requiring on-going care. This initially manifested itself as “buy in” to the referral process. Disengagement at stage one was attributed to reluctance to self-define in terms of a stigmatised group *or* as acting in terms of an adult identity characterised by greater independence. Uncertainty and anxiety during the transfer period was fuelled by fractious professional relationships which hindered the smooth development of a therapeutic alliance between young people and AMHS staff post-transfer. A lack of close connections with the new AMHS team compounded problems emerging from a disagreement between young people and clinicians as to the extent to which their illness identity was compatible with the AMHS service remit, leading to disengagement or intentions to disengage.

These findings support previous research suggesting mental healthcare transitions are challenging for young people and poorly planned by services (Davidson et al., 2011; Davis & Sondheimer, 2005; McGorry, 2007; McNamara et al., 2013; McNicholas et al., 2015; Singh et al., 2010). Using the SIMIC framework in the current study allowed us to build on this and articulate how social identity processes contribute to the success (or otherwise) of transitions. In the next section, we explore this further and suggest some developments of the SIMIC model as well as suggestions for service development and clinical practice.

### Theoretical and practical implications

*Multiple group memberships, intergroup leadership, and identity change management*

In accordance with SIMIC, young people's identity networks both facilitated and hindered successful transition (Haslam et al., 2008; Iyer et al., 2008; Iyer et al., 2009; Jetten & Pachana, 2012). Our findings draw attention to the powerful role of the trusted other in enabling (or impeding) transition. Information obtained from in-group sources has the potential to influence appraisals of stressful circumstances such that events thought to be stressful can be re-appraised as relatively benign (Haslam, Jetten, O'Brien, & Jacobs, 2004). The current data suggest that family members were a source of effective support for some (Hilliard et al., 2014), particularly in coping with the anxiety experienced during the transfer period. The perceived lack of informational support from clinicians intensified young people's anxiety. We suggest that it is not just the absence of information per se that is stressful but rather that a trusted other suggests that AMHS might not fully meet the individual's needs (Haslam et al., 2004).

In this context it can be argued that CAMHS consultant psychiatrists are effectively ingroup leaders. Haslam, Reicher and Platow (2011) propose that leaders are influential in building perceptions of a shared identity between the leader and his/her group. Our findings extend this to suggest that leaders' communications about outgroups are influential in shaping group members' own perceptions of those outgroups. In the current context of strained interagency relationships and ever-shrinking resources (McNicholas et al., 2015), negative views or misperceptions of AMHS held by CAMHS clinicians can potentially build negative impressions of that service in the minds of those transitioning.

In light of this, we suggest one development to the SIMIC model is to consider the nature of the intergroup relations that exist between the pre- and post-change groups when considering how existing group memberships influence the individual's ability to adopt a new group membership during transition. Strained intergroup relations between CAMHS and AMHS clinicians undermined the quality and level of support offered to those transitioning.

To counteract this in practice, we propose drawing on Hogg, van Knippenberg and Rast's (2012) work on intergroup leadership. This form of leadership is required where collaboration between multiple groups is necessary to achieve an organisation's key goals or ensure its successful operation. In such situations, leaders must be in a position to exert influence within and across group boundaries. Central to this is the leaders' communication and creation of a positive *intergroup relational identity* (Hogg et al., 2012), whereby the self is defined in terms of a collaborative relationship between his/her ingroup and a specific outgroup (Hogg et al., 2012). The way in which leaders model collaborative intergroup relations has implications for those for whom they have influence (Hogg et al., 2012). Therefore, we suggest that within the mental health service, modelling collaborative relationships between CAMHS and AMHS at national level might encourage local collaboration. This in turn would attenuate anxiety and influence the views of those transitioning as they experience both groups working together during the transition period. Formal collaboration between services would also aid existing work undertaken by clinicians during the planning and transfer stages. As part of an identity change management programme, service collaborations could inform the preparation work for adopting an adult role and managing a serious and enduring mental illness. Transition planning meetings and preparation work could draw on techniques used in social identity interventions for those in transition (e.g., Groups 4 Health, Haslam et al., 2016) whereby young people are encouraged to plan how existing groups can assist them during transition and also what additional groups they might wish to join to support them in managing their illness and achieving recovery (Best et al., 2016; Haslam et al., 2016; McNamara & Parsons, 2016).

### ***Identity compatibility, intergroup relational identity, and service engagement***

The issue of compatibility featured prominently during the planning and post-transfer engagement stages. During the former, clinician referral decisions were guided by

judgements of compatibility between diagnostic category and the AMHS service. Confirmation of an illness identity provoked divergent responses from young people. Young people who self-categorised in terms of serious and enduring diagnoses saw continued service engagement as identity-congruent (Turner & Oakes, 1986). However, for one participant, the suggestion of a transition to AMHS represented an identity threat (Branscombe, Ellemers, Spears, & Doosje, 1999; Haslam, 2004) by proposing a permanent move to a stigmatised group (Haslam et al., 2008; Iyer et al., 2009; Jetten & Pachana, 2012). Service disengagement occurred as a result of resistance to adopting an illness identity, in line with SIMIC predictions (Haslam et al., 2008; Iyer et al., 2008; Jetten & Pachana, 2012). However, this disengagement could be viewed not just as a rejection of a stigmatised identity but also as acting in terms of an adult identity.

To date, SIMIC research has only considered changes in one social group membership during transition. Here our data suggest a dual identity change. Consequently, we suggest that SIMIC needs to not only consider multiple identity changes during a single life transition but also the intersection between these new identities in order to fully articulate the implications for transition outcomes. In the current context, the developmental transition was closely intertwined with the service transition (which confirmed an illness identity) and shaped individual responses to the service transition. Most notably, becoming an adult was embraced by young people. It opened up the option of disengaging in response to the identity threat posed by the referral or as a response to a re-diagnosis by AMHS. Thus, in some instances, reasons for engagement (or disengagement) with mental health services could only be fully understood in the context of this ‘intersection’ between adult and illness identities.

The issue of compatibility also impacted on post-transfer engagement. Previous research in the mental health literature found that individuals with diagnoses that were not compatible with an AMHS service remit had suboptimal transition experiences (Singh et al.,

2010). This was somewhat supported in our data which suggested that in order to successfully access AMHS and perceive that the support available was appropriate, young people's illness identities should correspond with a service-compatible diagnostic category. However, there were participants who possessed 'incompatible' illness identities who nonetheless reported satisfactory transition experiences and remained engaged with the service. Their continued engagement appeared to be supported by a strong therapeutic alliance with their AMHS clinical team which not only helped them 'forgive' perceived service shortcomings (Haslam et al., 2003) but also adjust to a re-diagnosis during the transition process.

This implies a second benefit of effective intergroup leadership, namely, the creation of meaningful connections between young people and AMHS staff in a context where young people can draw on the support provided by a member of a valued identity group (i.e. their CAMHS clinician) (Haslam et al., 2008). We also propose a novel conceptualisation of the therapeutic alliance between clinicians and service users as an intergroup relational identity. Previous work has suggested that service interactions could be enhanced by promoting the development of a sense of shared identity (Haslam et al., 2003; Stevenson et al., 2014). We suggest that clinicians and service users might struggle to accomplish this given their distinct group identities (Hogg et al., 2012). However, they could be in a position to develop an intergroup relational identity based on a sense of trust and common purpose that relies on collaboration to reach the ultimate goal of recovery. Such alliances are key to both short- and long term health outcomes (Denhov & Topor, 2012; Schön, Denhov, & Topor, 2009).

### **Strengths, limitations and suggestions for future research**

Our work is a first step in exploring mental healthcare transition from an identity change perspective. Our findings illustrate that SIMIC can be usefully applied to understand

the social psychological consequences of the mental healthcare transition process. It offers additional insights into some of the barriers and enablers to successful transition experienced by young people and their parents. We also outlined ways in which SIMIC constructs can be further developed. Specifically, we suggest consideration of multiple simultaneous changes in group memberships during a single life transition and the need to explore how these identities intersect as well as understanding the individual's perceptions of their compatibility (with each other and with aspirational identities) to determine their impact on transition outcomes. We also further suggest considering the intergroup relationships between pre- and post-change groups when conceptualising how existing group memberships influence transition to new groups. Additional research is needed to examine more closely and provide additional empirical support for the developments suggested here.

Furthermore, while samples in the mental health literature tend to focus on the engaged service user, our sampling methods actually obtained a number of disengaged clients as well as collecting data from all groups involved in the transition process. Nonetheless, we were unable to fully document the experiences of those who initially refused a referral to AMHS (as only one participant in our study had this experience). Thus, while we are able to propose some reasons underlying refusal and disengagement, these primarily derive from an analysis of clinician responses. Including the voices of those young people, with an on-going mental health service need who disengaged from services on leaving CAMHS, is an important avenue for future research.

In conclusion, we believe that this study represents an important addition to the mental healthcare transition literature as well as to the social cure literature. The aim of the study was to explore the facilitators of, and barriers to, transition from CAMHS to AMHS within a social identity change perspective. Adopting this perspective allowed us to understand why previously identified factors act as facilitators or barriers to transition and

also to suggest some service developments that have the potential to improve the transition experience for all involved.

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<b>Young Person ID</b>	<b>Gender</b>	<b>Age</b>	<b>Approximate length of time engaged with AMHS at time of interview (months)</b>	<b>Transition Stage</b>	<b>Self-reported Diagnosis</b>	<b>Diagnosis Category</b>	<b>Diagnosis change during transition</b>	<b>Parent interviewed</b>
A	Female	18	Not yet attended 1 <sup>st</sup> AMHS appointment at time of interview	2	Paranoid Schizophrenia	Serious & Enduring	No	Yes
B	Male	18	2	2	OCD/Anxiety/Substance Misuse	Comorbidity	No	No
C	Female	19	6	3	Schizophrenia	Serious & Enduring	No	Yes

D	Female	19	8	3	ADHD/Bipolar Affective Disorder	Comorbidity	No	No
E	Female	-	Refused referral	1	Depression	Emotional/Neurotic	No	No
F	Female	19	12	3	Bipolar Disorder	Serious & Enduring	No	Yes
G	Female	19	12	3	Borderline Personality Disorder	Emerging Personality Disorder	Yes	No
H	Female	-	14	3	PDD-NOS/Self-harm/Depression	Comorbidity	No	No
I	Female	20	Disengaged	3	Borderline Personality Disorder	Emerging Personality Disorder	Yes	No
J	Female	20	15	3	Asperger's/Depression	Comorbidity	No	Yes (both)
K	Female	-	Disengaged	3	Not specified	Unclassified	-	No

**Table 1: Demographic and clinical characteristics of young people interviewed**

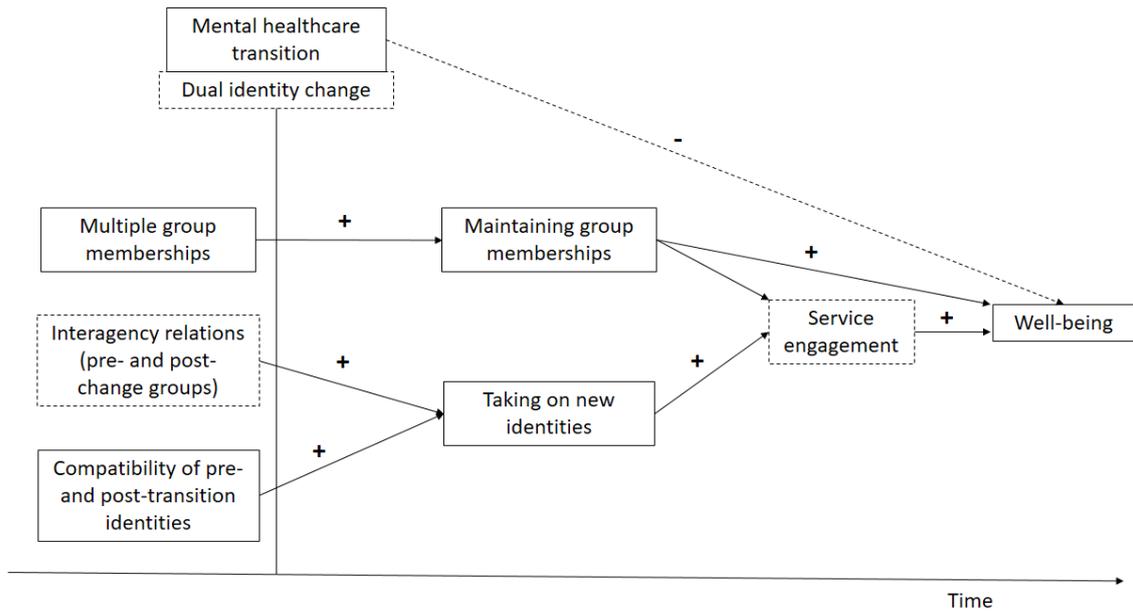


Figure 1: The Social Identity Model of Identity Change applied to mental healthcare transition (adapted from Jetten & Pachana, 2012)

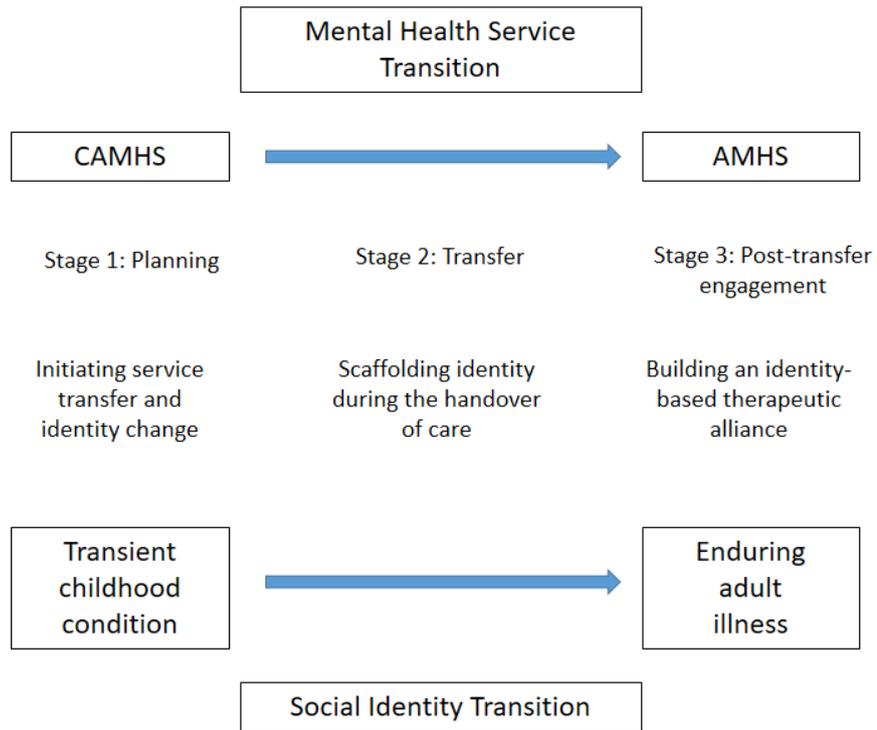


Figure 2: A visual representation of the thematic analysis findings