Abstract

The debate about what constitutes successful or optimal transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) has continued amongst practitioners for the last twenty years. Transition takes place across mental health systems and is not restricted to the adolescent population, occurring between sectors and services across the life-course. However, whilst public health systems continue to fail individuals who are moving between CAMHS and AMHS at what is developmentally a crucial phase (in relation to life opportunities, and the average age for onset of mental disorder), for some young people that transition is successful.

This poster looks to re-examine the debate about the nature of transition from a social policy perspective. Drawing on doctoral research conducted with young people aged between 16-25 years who are accessing public mental health services in Australia and the UK, the paper explores transition as both a concept and how it is managed in practice. The paper looks at the nature of transition between CAMHS and AMHS as well as any specialist youth services such as Early Intervention Services set up in the areas studied; highlighting both young people’s experiences of and their perceptions about transition.

Introduction and background to the study

This study addresses the idea purported in a growing body of literature, that the mental health needs of young people as they journey from adolescence to adulthood are not being met, (Vasilou, 2006). This is particularly the case with provision of mental health services in both the UK, (Golightly, 2006; Hagell, 2002; Kerfoot et al., 2004; Mental Health Foundation 1, Mental Health Foundation 2, 2005; Rogers & Pilgrim, 2003, Social Exclusion Unit, 2004; Svanberg & Street, 2003; Vasilou, 2006; Young Minds, 2005), and to a certain extent in Australia (Kavanagh, et al., 2000; Zubrick, et al., 2000). Lewis, (2000, in Hagell, 2002) states that young people aged 16-18 fall between Child and adolescent mental health services and that this is a fundamental problem with existing treatments for adolescents in the NHS. Mental health services for older adolescents are particularly difficult to find in the UK in both CAMHS (where they are often regarded as too old) and in adult sector services (where, compared with adult patients, they are not sufficiently ill), (Kerfoot et al., 2004).

In light of this, a multi-site, international, qualitative doctoral research project was designed in order to glean a textured perspective about the policy and services for 16-25 year olds in England and Australia. Australia was identified for comparison as it was a pioneer alongside the UK for work in mental health in the 1990s and both countries have developed an important evidence base, particularly around early intervention.

The research took place at three sites in the UK (in Scotland, in Wales; and in England); and three sites in Australia (in the Australian Capital Territory; in Queensland; and in Victoria).

Research aims

The principal aims of the study were to investigate:

- What is policy framed for the 16-25 age group and does this match what exists in practice?
- How are services delivered to this age group and what different models of service delivery are there?
- What are the barriers to accessing services/things that facilitate service access for this age group?

Methods

As part of the research design, a multi-layered interview strategy was developed based on a critical realist approach outlined by Bhaskar & Danermark (2006). Interviews took place at the seven levels in the diagram.

The research fieldwork took place in 2013-2014. Interviews that took place at what they term the ‘sub-individual psychological level’, constituted the majority of interviews. These were thematically analysed and is the early findings from these interviews that are presented in this poster.

Preliminary findings from the analysis of these interviews show that:

- There are issues of access and equity for 16-25 year olds that need to be addressed across boundaries, particularly where people move between jurisdictions such as States, or even Health Boards and Trusts.
- Young people’s notion of transition is often different to that of professionals, in particular the transitions identified as difficult by young people are often not the same as those perceived as difficult by professionals.
- The transitions young people experience as being most difficult are not solely linked to the transition between CAMHS and AMHS.
- There is limited acknowledgement in policy and practice of the difference between a transition issue and a service gap. These two things are often conflated and poorly understood both locally, nationally, and internationally. This can lead to the mis-tailing of services and resources, and ultimately fails to resolve either process issues or fill holes in service for 16-25 year-olds.

Discussion

For over twenty years debate has raged about the transition, (which has been called the ‘great divide’ in the UK) between CAMHS and AMHS. There are similar debates, although not communicated in this way, between physical health services between paediatric and adult specialisms. Research into this area and reviews of these have focused on transition and suggest that difficulties arise because of:

- Different terms of reference
- Different diagnosis
- Different service structures
- Communication across the boundary

This thesis explored the idea that if no solution can be found to solve this ‘great divide’ in over twenty years, then there is the possibility that the wrong question is being posed, leading to a mislabelling and consequent misunderstanding of the problem.

Transitions are inherently problematic, and transition is particularly complex as a concept in mental health where there are no perspectives on what constitutes or is experienced as a transition between clinical staff and service users. The way that policy filters into practice and is implemented also affects transition and how it is managed. The research explored policy from national to state or health authority level, then through to local implementation. At each of these levels, a series of negotiations takes place in order to transmute the policy directive into a local practice.

The interview data showed that transition is differently socially constructed by different groups. The research indicated where:

- There are successful transitions in mental health, but that these essentially take place when there is a clearly identified service to move to, so where there is no service gap.
- How transition is managed in practice is where transition specific issues arise due to misunderstandings about concerns such as the services that are offered; expectations; role and accountability; and poor communication.

Future Directions

When looking at mental health policy and services that support the ‘transition’ population of 16-25 year olds we need to consider if this group’s needs are sufficiently identified, particularly in all age mental health policy or strategy. This research and the findings based on the experience of interviews with young people aged 16-25 forms part of the wider doctoral research project looking at mental health policy and practice. Further work needs to be undertaken to elucidate the way in which policy changes in relation to the different layers of organisational and bureaucratic structure through which it passes; and further investigation is needed into patient’s understandings of transition at different points in their treatment journey i.e. between inpatient and outpatient settings, or transition between teams, and the impact this has on their recovery.

Diagram depicting the use of Critical Realist strat to design research exploring adolescent mental health policy and service delivery

- Planetary level: International policy strategy for adolescent mental health and illness.
- Mega level: National dimension to policy strategies for adolescent mental health and illness.
- Macro role: Country/State specific policy for adolescent mental health/disorder.
- Meso level: Localised specific policy and strategy for adolescent mental health.
- Level of micro and small group analysis: Practitioner experiences of working in adolescent mental health, policy and practice.
- Individual or biographic level: Individual experiences of adolescent mental health and illness.
- Sub-individual or psychological level: This layer identified by Bhaskar and Danermark (2006) was not included in research design but could be interpreted in a psychosocial way for future projects.

Table depicting the total number of interviews in the study

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Chart depicting the number of service users interviewed in each case site.

Total interviews: 168

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Table depicting the total number of interviews in the study

Total UK practitioner and policy maker interviews 82 Total Australian practitioner and policy maker interviews 42 Total overall practitioner and policy maker interviews 124 Total overall service user interviews 25 Total Australian service user interviews 10 Total overall service user interviews 35 Total interviews included 218