

**CAMHS to Adult Transition**

**HASCAS TOOLS FOR TRANSITION**

**A Literature Review for  
Informed Practice**



Making a positive difference



**HASCAS**  
Health and Social Care Advisory Service

“

Adolescents are a critical asset and at the  
centre of social development.

We know what needs to be done.

We know how to do it.

”

World Health Organisation (2002)

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# **CAMHS to Adult Transition**

## **A Literature Review for Informed Practice**

### 1. Introduction

The transition from a child and adolescent to an adult mental health service is necessary for young people whose mental health problems are likely to be both severe and enduring. Given the current age boundaries within service organisation in the UK, that transition, if it occurs, will normally take place around the eighteenth birthday. Since the National Service Framework for Mental Health covers adults of working age, ie from 16<sup>th</sup> birthday, some young people can, in theory, transit earlier.

The issue of concern is that some young people fail to make the transition, usually for reasons of service design, configuration and ethos.

This review of the literature is part of a project funded by the Department of Health and carried out by the Health and Social Care Advisory Service (HASCAS). Its purpose is to collate and coordinate as much learning as possible and to be creative about ways of putting the learning into practice. This is not a systematic review, nor a critical appraisal; the paucity of literature necessitates a more pragmatic approach (See Vostanis, 2005, page 451). The literature search has used broad parameters, drawing in texts and information from a wide variety of sources. Wherever possible, documents relating specifically to mental health issues in UK adolescents were used, but where findings from wider sources offered underlying principles that could be applied, these were also included. <sup>1</sup>

### Working definitions

#### **Young person, adolescent**

Adolescence may be seen as beginning at puberty, around age ten and ending with young adulthood, around age twenty. Conversely when people refer to adolescents they rarely mean either ten year olds, or twenty year olds, but perhaps teenagers, 13-19.

Properly adolescence refers to a definable period of psychosocial development between childhood and adulthood, when independence, identity and sexuality are salient. The Royal College of Paediatrics and Child Health (2003, page 11) suggests:

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<sup>1</sup> Every attempt has been made throughout this document to be transparent about the origins and nature of the various texts referred to. As part of its *Tools for Transition* pack, HASCAS has also produced an annotated bibliography, in which all of the references from this document are outlined, with many including a hyperlink to the source material.

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"Young people" is a phrase used as an alternative to "adolescents" and, in this document, has the same meaning. We have not defined adolescence by age because there would be difficulties in agreeing age limits, when adolescence is essentially a developmental stage. In this report we are particularly interested in the welfare of those young people on the cusp of adulthood, most of whom will be in the age range 13-18. We recognise that many young people can be properly thought of as adolescent before that age and similarly most professionals would agree that adult characteristics are often developing well into a person's twenties.

### **Young adult.**

There is a growing interest in the age group 16-25, which may be termed *young adult*. A House of Commons Select Committee on Health (2000) took evidence from a range of organisations and individuals, noting that provision of CAMHS for adolescents was patchy and that age "cut-off" points were variable and arbitrary. In addition to age at transfer the report also records cultural differences between child and adult services as a barrier. The report, entitled *Transitions between child /adolescent and adult services*, records a strong lobby for youth services designed for 16-25s, though the authors acknowledge these would have boundary problems of their own.


Many voluntary sector youth services cover this age range, specifically the Youth Information and Advice Centres (YIAC), covered by the umbrella organisation Youth Access.<sup>2</sup> The young people's mental health charity, Young Minds, has produced a number of documents within its project on mental health for 16-25s, entitled *SOS - Stressed Out and Struggling*.<sup>3</sup> The Mental Health Foundation published its influential report, *Bright Futures* in 1999, which identified the gaps in provision for young people aged 16-25 with mental health problems. This was followed by *Turned Upside Down* (Smith and Leon, 2001) in which an outline is provided for mental health services for this age group, with an emphasis on responses to crisis. Both reports are predicated on the understanding that the years 16 to 25 encompass a period of rapid transition, both on a personal level from childhood to adulthood, and in moving from child to adult services. The result is that young people find it difficult to access services and are left with little or no support.

The rationale for *Turned Upside Down*, which proposes service models for this age group, is that this period of significant change has a psychological impact on a young person, which may lead to a crisis in their mental health, requiring support and intervention (Smith and Leon, 2001, page 8). The justification for considering young adults as a discrete group may also be inferred from the extract below from *A Work in Progress: the Adolescent and Young Adult Brain* (Young Minds, 2006, page 2).

<sup>2</sup> <http://www.youthaccess.org.uk/>

<sup>3</sup> <http://www.youngminds.org.uk/sos/outputs.php>

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Just prior to puberty a wealth of grey matter is created and, as neurons develop, a layer of myelin is formed which greatly increases the speed of transmission of electrical impulses from neuron to neuron. A period of synaptic pruning then occurs throughout adolescence, a process not completed until the early 20s, which is believed to be essential for the fine-tuning of functional networks of brain tissue, rendering the remaining synaptic circuits more efficient. The frontal cortex [where this development takes place] is essential for such functions as response inhibition, emotional regulation, analysing problems and planning. Many of these aptitudes continue to develop between adolescence and young adulthood', whereas spatial awareness functioning and sensory functions (such as hearing and language processing) are largely mature by adolescence.

Perhaps the most comprehensive and influential document to provide a rationale for the 16-25 age group is the Social Exclusion Unit's (2004) *Breaking the Cycle*, which has found that young people's lives change rapidly and dramatically in a number of areas during this time and has identified "disordered transitions", which are more complex than previously understood.


### CAMHS

Wolpert and Wilson (2003, page 28) pose the question:



The acronym CAMHS - Child and Adolescent Mental Health Services - is now used ubiquitously, but are we all meaning the same thing when we use it? And who do we identify as part of it?

The term *CAMHS* may be used as a shorthand to refer to the (normally) health based, specialist multidisciplinary teams, often known as child and family consultation services. Increasingly, however, the term is being broadened, as described below (Wolpert and Wilson, 2003, page 29):



To develop the idea of comprehensive provision we would like to see the term "CAMHS" taken to mean all dedicated service provision that aims to meet the mental health and emotional well being needs of children and young people in a given locality. It does not imply a particular form of service organisation. It assumes all such provision in a given area will link up to be able to form a coherent, multi-professional, multi-agency strategy. Other workers, whose primary role is not mental health provision, will also have a role to play promoting the health and well being of children and will therefore need to be involved in creating a comprehensive Child and Adolescent Mental Health strategy.

In this document the broad definition of CAMHS will be intended, unless a point is made specifically about "specialist" or "Tier 2-3" (NHS Health Advisory Service, 1995)<sup>4</sup> CAMHS, referring to community based multidisciplinary teams offering specialised mental health services to children and young people with complex and severe mental health problems.

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<sup>4</sup> For readers without formal knowledge of the organisation of CAMHS, an explanation of the four tier system is provided in the appendix.

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Guidance on the shape and nature of a “comprehensive CAMHS” is provided in the National Service Framework for Children, Young People and Maternity Services (Department of Health and Departments for Education and Skills, 2004).

## Adult Services

The term *Adult Services*, as it is used in this document, refers broadly to any provision made for adults that makes a key contribution to their positive mental health.

This then could include housing departments/associations, counselling groups and primary care services, as well as specialist mental health services. The rationale for including a possible wide range of adult services was based on the assumption that many young people do not make a transition to adult mental health *per se*, but do go on to use other, related provision, particularly that provided by the voluntary sector.

Where reference is made to specialist adult mental health services, these will be denoted by the acronym AMHS. The service models and practice guidance for AMHS are provided in the Mental Health Policy Guide (Department of Health, 2001).

## Transition

Throughout the literature, transition is conceptualised as a process, distinguishing it from life events, or turning points, which may be seen as the pre-cursors of transitions. Newman and Blackburn (2002, page 1) have taken a broad view, taking (children’s) transition as,



...any episode where children are having to cope with potentially challenging episodes of change, including progressing from one developmental stage to another, changing schools, entering or leaving the care system, loss, bereavement, parental incapacity or entry to adulthood.

### SUMMARY BOX 1

- Adolescence refers to the period of psycho social development between childhood and adulthood.
- Young people is an alternative phrase to adolescent and is usually taken to include those in the age range 13-18.
- The period of young adulthood spans 16-25 years. This age group has received a great deal of interest in recent years.
- Child and Adolescent Mental Health Services (CAMHS) may be taken broadly to include all services that contribute to the psychological well being of children, young people and families.
- “Tier 2-3 CAMHS refers to multidisciplinary teams offering specialist services to children, young people and families with complex and severe mental health problems.
- Adult services may include any health or social care provision for people of working age.
- Adult Mental Health Services (AMHS) offer a specialist service to people of working age with severe and enduring mental health problems.
- Transition is described as a process, distinct from life events, or turning points.

## 2. The (mental) health of adolescents

### The European dimension

The mental health of adolescents is addressed specifically by two of the World Health Organisation's (WHO) seven priorities for action on child and adolescent health in the European context. These are provided in the *European strategy for child and adolescent health and development* (World Health Organisation, 2005, page 5) ,

Adolescent Health, specifically tackling risky behaviours, the establishment of health related preferences for adulthood and the need for participation and youth-friendly services.

Psychosocial development and mental health, focusing on investment in parenting programmes and psychological well-being throughout the life-course and identifying aggression, self-harm, suicide, depressive illness and eating disorders.

The strategy provides as its opening statement:



Children are our investment in tomorrow's society. Their health and the way in which we nurture them through adolescence into adulthood will affect the prosperity and stability of countries in the European Region over the coming decades.

(World Health Organisation, 2005, page 1):

Good health is seen as a social resource and poor health a social cost. The rationale for the strategy has three strands:

Moral and legal obligation, enshrined in the UN Convention on the Rights of the Child  
Investment in the future, with consequent personal, social and community benefits  
Promotion of economic sustainability.

The guiding principles that informed the development of the strategy are:



**Life-course approach.** Policies and programmes should address the health challenges at each stage of development from prenatal life to adolescence.

**Equity.** The needs of the most disadvantaged should be taken into account explicitly when addressing health status and formulating policy and planning services.

**Intersectoral action.** An intersectoral, public health approach that addresses the fundamental determinants of health should be adopted when devising policies and plans to improve the health of children and adolescents.

**Participation.** The public and young people themselves should be involved in the planning, delivery and monitoring of policies and services.

(World Health Organisation, 2005, page 4)

### The national picture

*Bridging the Gaps, Health Services for Adolescents*, a report into adolescent health conducted by the Royal College of Paediatrics and Child Health (2003), concludes that young people constitute a significant social group with major health needs.

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The authors find that adolescents between the ages of 10 and 20 make up 13-15% of the total population of the UK and that the proportion is considerably higher among black and minority ethnic (BME) communities, particularly those from Pakistani and Bengali groups. Unlike other age groups, mortality among adolescents did not fall significantly in the second half of the twentieth century. The main causes of death are accidents and self-harm, with a recent rise in suicide among young men.

The report notes that ill health within this age group is largely due to chronic disease and mental health problems. Furthermore it is concluded that patterns of health behaviour and service usage during adult life are established in adolescence. A British Medical Association (2003) report states that up to one in five adolescents may experience some form of psychological problem, ranging from behavioural disorders to depression, eating disorders, self-harm and neurosis. Mental health problems that develop in adolescence frequently persist into adulthood and may deteriorate over time. There is a strong association between mental health problems in adolescence and risk taking behaviour.

*Bridging the Gaps* was presaged by and acknowledges a report from the USA, which had reached similar conclusions almost twenty years earlier (Irwin, 1986) and an address to the Society for Adolescent Health six years later (Hein, 1992). Clearly these issues have been receiving attention for some time.

Under the chapter heading, *Young people have major health needs*, the following rationale is offered (Royal College of Paediatrics and Child Health, 2003, page 18),



It is clearly important that young people are nurtured so that they may become healthy adults and contributors to society. This is increasingly important for sound economic reasons in an ageing society.

This echoes much of the rationale behind WHO documentation on adolescent health, including the *European Strategy* cited earlier: the significance of young people as a defined group is conceptualised through their potential in becoming contributing adults. An alternative and complementary view enshrined in much of the literature (Kay, 1999; Smith and Leon, 2001; Street, *et al*, ) is that young people are not simply adults in the making, but are people in their own right, with entitlements, rights and responsibilities of their own.

### **Trends in adolescent mental health**

In 2001 a research team at the Institute of Psychiatry was commissioned by the Nuffield Foundation to undertake a research project on time trends in adolescent mental health. The team analysed data from national surveys undertaken in 1974, 1986 and 1999, looking at trends across same kinds of problems in UK adolescents over the entire 25 year period. At each time point the focus of the study was 15-16 year olds.

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The results, reported to the foundation (Hagell, 2003) and subsequently published (Collishaw, *et al*, 2004), showed clearly that the mental health of adolescents in the UK had declined overall across this period. This was a significant study, set against a backdrop of increasing concern over a long period about the perceived increase in adolescent mental health problems, specifically regarding conduct problems, hyperactivity and suicide. The authors note (page 1350),



However methodological limitations make it difficult to provide conclusive answers. The comparison of rates of disorder assessed at different time points is complicated by changing diagnostic criteria, differences in assessment methods, and variations in official reporting practices.

The two main aims of the study were to:

Discover whether there had been any increases in parent-rated emotional and behavioural problems over the 25 year period

Examine whether any changes observed were actually corroborated by real changes in children or due to changes in reporting thresholds.

The major finding of the study was of a continuous rise for adolescent males and females over the whole 25-year study period in conduct problems. Emotional problems in adolescence (such as depression and anxiety) had increased for both girls and boys from the mid 1980s. Conversely there were few systematic trends in adolescent hyperactivity over the 25 years for either girls or boys.

The strength of associations between these problems and poor outcomes later in adulthood had remained similar over time. This would suggest that the findings were not attributable to changes in the reporting thresholds, but the outcome of real changes in problem levels.

Significantly, a later study by Simonoff, *et al* (2004) demonstrated that disruptive behaviour in childhood is a powerful predictor of anti-social behaviour in adult life, enduring at least into middle adulthood. The authors conclude (page 118),



The importance of number of symptoms, the presence of disruptive disorder, and intermediate experiences highlight three areas where interventions might be targeted.

Intermediate, or “stepping stone” experiences were found to mediate partially between childhood disruptive behaviour and subsequent adult outcomes. Between adolescence and early adulthood the authors propose a transitional period in which negative intermediate experiences include early age at school leaving, involvement in crime, especially violent crime, between the ages 17-21. With the caveat that longitudinal studies do not prove causality, they state (page 126),

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Reducing subsequent high-risk experiences among those with early disruptive behaviour might alter their life trajectory away from antisocial behaviour.

In England and Wales about 600 (10 per 100,000) 15–24 year olds take their own life each year (more than 10,000 since 1982) and up to 20,000 teenagers go to hospital each year as a consequence of deliberate self-harm (Social Exclusion Unit, 2000, page 20).

Changes in access to higher education over recent years also reflect the trend in adolescent/young adult mental health. The Royal College of Psychiatrists (2003, page 6) reports that the number of higher education students presenting with symptoms of mental ill health is increasing and furthermore there is a rise in the number presenting with more severe mental health problems.

### Policy

National policy should provide a framework for prioritising and implementation. In response to the wealth of evidence that young people leaving school with low levels of educational attainment have a higher risk of experiencing social exclusion throughout their lives, policy aimed at 13–24 year-olds has focused on education, training and employment opportunities. New policies to increase young people's participation in learning and employment include Connexions, Education Maintenance Allowances (EMA), the New Deal for Young People, and Modern Apprenticeships (Social Exclusion Unit, 2004, pages 48-9) Whilst there is no specific policy, either for adolescent health, or for 16-25s as a discrete group, there are four major, over-arching policies that complement one another both implicitly and, in a few instances, explicitly. These are:

*National Service Framework for Mental Health: Modern Standards and Service Models.* (Department of Health, 1999)


*National Service Framework for Children, Young People and Maternity Services,* (Department of Health, Department for Education and Skills, 2004)

*Every Child Matters, Change of Children* (Department for Education and Skills, Department of Health, 2004) The Children Act 2004 provides the legal foundation for Every Child Matters

*Youth Matters: Next Steps* (Department for Education and Skills, 2005).

The *National Service Framework for Mental Health* covers adults of working age, starting at age sixteen. It makes specific reference to provision for young people at several points, first identifying the need for services that bridge the interface between child and adult provision (Department of Health, 1999, page 5):


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The Framework also touches on the needs of children and young people, highlighting areas where services for children and adults interact, for example the interface between services for 16-18 year olds, and the needs of children with a mentally ill parent. A major programme of service development, supported by the Mental Health Grant and Mental Health Modernisation Fund, is addressing the mental health needs of children and adolescents.


It is of particular note that this policy for adults, published in 1999, highlighted the interface between child and adult services, because the issues around transition from CAMHS to adult services could conceivably be understood as more problematical for CAMHS than for adult practitioners. The rationale for this would be that CAMHS staff are left with the problem when a young person fails to meet the criteria for a transition to an adult service, whereas their colleagues in adult services continue in ignorance. The service transition is, after all, linear and directional (White, 2003, page 37). Few other transitions to adulthood are linear, however. Many transitions involve an aspect of 'backtracking' in which young people revert to some form of dependence. This may be termed the 'yo-yo' transition between youth and adulthood (Social Exclusion Unit, 2005, page 53).

A group of young people at particularly high risk of developing mental health problems is identified as those with accommodation difficulties (Department of Health, 1999, page 18).



Homelessness among young people also brings significant problems. Off to a Bad Start, a study of homeless young people in London aged 16-21 years, found that almost two thirds had suffered recently from psychiatric disorders. A third also reported at least one attempted suicide at some point. Only one fifth, however, had been in contact with psychiatric services in the past year.

Moreover, the needs of young people with a first episode of psychotic illness are addressed specifically (Department of Health, 1999, page 44).



Prompt assessment is essential for young people with the first signs of a psychotic illness, where there is growing evidence that early assessment and treatment can reduce levels of morbidity. Clinical responsibility for the mental health care of older adolescents can sometimes lead to disagreements between child and adolescent mental health services and adult services if working arrangements between the two services have not been addressed. Variations exist for the 'cut-off' point for referral to adolescent services, for example, 16, 18, 21 years or school leaving. Local arrangements should be agreed to avoid confusion and possible delays.

In fact the NHS Plan (Department of Health, 2000) promised that all young people aged 14-35 with a psychosis should be able to receive early intervention via the establishment of 50 teams by 2004. The service model was subsequently described in chapter 5 of the Mental Health Policy Implementation Guide (PIG), (Department of Health 2001).

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The *National Service Framework for Children, Young People and Maternity Services* addresses the health needs of adolescents within a number of its standards. Standard four addresses development and growing up (Department of Health, 2004, page 119),

**Standard 4 Growing Up into Adulthood**

Markers of good practice:



5. All transition processes are planned in partnership and focussed around the preparation of the young person.
6. Young people up to eighteen years of age with mental health problems have access to age-appropriate services.
7. All services for young people contribute towards assisting young people to take on increasing responsibility for their own lives.
8. Services seek to support parents, in particular providing information and advice on how they can appropriately support their child's transition to adulthood.

A significant number of children and young people with a disability will also have a mental health problem. Because of organisational responses to the primary health need, some of these young people may not have had access to a specialist CAMHS. The marker of good practice emphasise multi-agency planning for transition:

**Standard 8 Disabled Children and Young People and those with Complex Health Needs**

Marker of good practice:



8. Multi-agency transition planning and services focus on meeting the hopes, aspirations and potential of disabled young people, including maximising inclusive provision, education, training and employment opportunities.

(Department of Health, 2004, page 6 of Standard 8).

The major strand of the NSF in relation to mental health is Standard 9, in which one marker of good practice highlights the need for continuity of care during service transition:

**Standard 9 The Mental Health and Psychological Well-being of Children and Young People**

Marker of good practice:



10. When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the 'care programme approach'


Department of Health, 2004, Page 5 (of Standard 9)

The reference to the care programme approach<sup>5</sup> in the NSF for children, young people and maternity services may be cross-referenced to the NSF for Mental Health (Department of Health, 1999, page 41), which states:

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<sup>5</sup> CPA has been used routinely by adult mental health services since the publication of the NSF in 1999 and has started to be introduced within Tier 4 CAMHS as a model of good practice.

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 All mental health service users on CPA should: ~ receive care which optimises engagement, anticipates or prevents a crisis, and reduces risk ~ have a copy of a written care plan which:

- includes the action to be taken in a crisis by the service user, their carer, and their care co-ordinator - advises their GP how they should respond if the service user needs additional help - is regularly reviewed by their care co-ordinator - be able to access services 24 hours a day, 365 days a year.


*Every Child Matters, Change for Children* is a holistic, all embracing national strategy for children's services, which emanates from the Laming inquiry into the death of Victoria Climbié.

The *outcomes framework* (Department for Education and Skills, 2004, page 40) encapsulates the objectives and consequences for children and young people of new, integrated ways of working. Those outcomes relating to the mental health of young people are:

 **Outcome: BE HEALTHY**

6. Children & young people's mental health is supported.

**Outcome: MAKE A POSITIVE CONTRIBUTION**

 2. Children & young people are helped to manage changes and respond to challenges in their lives

2.1 Children & young people are supported at key transition points in their lives


3. Children & young people are encouraged to participate in decision making and to support the community

3.4 Children & young people are encouraged to participate in the planning and management of services and activities

*Youth Matters, Next Steps* covers the age range 14-19, in keeping with the *Education and Skills White Paper* and subsequent implementation plan and the *Better Schools White Paper* – described as “the transformation of the life chances of young people.”

*Youth Matters Next Steps* reports that many people responding to the green paper consultation expressed concern about young people's emotional health and resilience and the document testifies to “the inseparable link between good physical and mental health and young people's ability to learn and achieve” (Department for Education and Skills, 2006, page 20). Of the initiatives outlined in the document, a significant commitment is to “the development of an adolescent health specialism and, in some areas, dedicated young people's health and support services.” (Department for Education and Skills, 2006, page 20). Its vision is encapsulated in this statement (page 5)

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The Youth Matters proposals provide a balance of opportunity, support and challenge to ensure a successful transition for every young person to adulthood. We want young people to thrive and prosper, and to mature as active, healthy and responsible citizens. As they progress through their teenage years we will ensure that they receive impartial, personalised advice to make the right choices; have access to a wider and better range of opportunities; and get extra help when they need it.

Other national drivers that create an impact on services for young people, particularly those in transition, include the annual performance indicators that determine the star rating of a Trust and thus affect the extent to which it can act and invest autonomously.

These performance indicators contain an increasing number of criteria relating to comprehensive CAMHS. The then Commission for Health Improvement (CHI) performance indicator for mental health trusts 2002-3 was:

PCT-agreed and established (written) arrangements to ensure transition of care for service users between child and adolescent mental health services and adult mental health services.

Of the 95 trusts recorded by CHI, 53 had an agreed protocol.<sup>6</sup> This was echoed by a separate survey of CAMHS partnerships, in which 41% claimed to have a CAMHS to AMHS protocol (Health and Social Care Advisory Service, 2004). But as Phimister (2004, page i executive summary) states:



However recent care pathway analysis, most notably documented in the experience of young people with first episode psychosis, contrasts starkly with this apparently rosy picture. It is our experience in the West Midlands that the needs of older adolescents, particularly those between 16 and 18, are met in an ad-hoc fashion.

### SUMMARY BOX 2

- The World Health Organisation (WHO) has addressed the mental health of adolescents in two of its seven priorities for child and adolescent health.
- The WHO European Strategy for Child and Adolescent Health and Development states that children should be nurtured through adolescence into adult life, with a rationale of moral and legal obligation and investment in the future.
- The mental health of adolescents in the UK has declined over the past 25 years, with a clear rise in conduct problems and emotional problems, though no rise in hyperactivity.
- Mental health problems in childhood and adolescence have been found to be good predictors of mental health problems later in life.
- There are four over-arching, complementary national policies, which together address the mental health needs of young people. These are the NSF for Mental Health, NSF for Children, Young People and Maternity Services, Every Child Matters, Change for Children and Youth Matters.

<sup>6</sup> Table of results accessed at:

<http://www.chi.nhs.uk/Ratings/Trust/Indicator/indicatorDescriptionShort.asp?indicatorId=3555>

### 3. The nature of transition

#### Life stage approaches

The spectrum of adolescent developmental transitions is given by McClure (2000, page 69) as including, biological, cognitive, emotional, identity and social components. These form the pathway from childhood to adult life and include turning points at key transition points.

The American Academy of Pediatrics, *et al*, (2002, page 1304) echoes a number of established life cycle theories stating:



Transitions are part of normal, healthy development and occur across the life span.

This is an important consideration, which belies the idea that adolescence is the only period of significant change within the life cycle. Two major theories in the field of life span and transition were introduced by Erikson (1950) in *Childhood and Society* and Levinson, *et al*, (1978) in their publication *Seasons of a Man's Life*.

Erikson took Freud's theory of psycho-sexual development, elaborated it by adding a social dimension and extended the stages, continuing from where Freudian theory ends at the genital stage (adolescence), by adding three further life stages of early, middle and late adulthood. Erikson, less deterministic than Freud, stressed the need for the individual to actively engage in the dilemmas that occur at each stage, leading to the development of human virtues. During adolescence the dilemma is of identity *versus* role confusion and the active resolution of the dilemma promotes the development of fidelity.

Levinson proposed a theory of human development in which the individual's life structure, or the underlying pattern and design, is the central concept. Levinson *et al* introduce the idea of *stable phases* of life, in which the underlying structure is being built and *transitional phases*, in which structures are changed and rebuilt. The early adult transition is a developmental link between childhood and adulthood, in which a key theme is separation. Internal separation refers to the formation of the adult identity.

The idea that people pass through various stages has appeal as a way of handling the idea of development. People are seen as making systematic progress in a particular order, as, step by step they move closer to some level of maturity. There are however a number of concerns with such theories.

The first relates to the fact that these are universal theories and inevitably this generality overlooks important aspects of cultural difference. Secondly, life stage theories may be seen as mechanistic and reductionist with,

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a mechanical predictability that is out of keeping with the dynamics of change, the extent of the flux over time and the degree of individual variability that seems to be the case.

(Rutter and Rutter, 1992, page 2)

Finally, when we construct our own narratives of our lives, they are rarely likely to follow a predictable, universal path.

### **Life course approaches**

McAdams *et al* (2005) are focused on the ways that the stories we tell about ourselves help us to make sense of the major transitions in our lives. They contrast life stage theorists such as Erikson and Levinson with life course theorists, those who favour explanations of the socially contingent nature of human development. Whilst life stage theorists suggest a relatively fixed structure for development, life course theorists tend to emphasise the importance of roles, social context and timing. What they all share, however, is a focus on both on-time, anticipated transitions, such as early or mid adult marriage, later life retirement, etc., and off-time events such as divorce and unexpected bereavement.

This is exemplified below (McAdams, 2005, page xv)



Some transitions, some periods of change, stand out as especially significant in the life course. We may see them as turns in the road, changes in the direction or the trajectory of our lives.

McAdams and Bowman (2005) used Erikson's concept of generativity to select participants for their life story research. Generativity *versus* stagnation is the dilemma for the seventh stage of development, in midlife. Following the establishment of identity in adolescence, then intimacy in early adulthood, the individual is psychosocially ready to be involved in projects that will benefit future generations.

The authors state, (page 11)



With respect to mental health, highly generative adults report lower levels of depression and higher levels of life satisfaction, happiness, self esteem, and sense of life coherence, compared to adults low in generativity.

### **Adolescent health transitions**

It is suggested that childhood and adolescence are being extended within the familial and social structures of the UK. The increasing numbers of young people entering further and higher education and the concomitant rise in tuition fees have encouraged many students to remain in the family home until they secure a job at age 21-2, whereas a few decades earlier many young people had effectively left home at eighteen.

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In the 1970s approximately 70% of those aged sixteen were in paid employment, now the figure is closer to 5%. (Office for National Statistics, 2000)

This is echoed in a report by Youth Access (White, 2003, page 32), which states,



For most of the population, youth transitions have been extended well into their middle to late 20s.

This has implications for services: as discussed above, some organisations and agencies are now choosing to focus on the 16-25 age group, partly because of the extension of youth transition into the twenties, but also because the age 18 entry point into adulthood is seen as either arbitrary and/or abrupt and not allowing for a genuine period of transition. (Youth Access/White, 2003, Social Exclusion Unit, 2005, Young Minds, 2006, Mental Health Foundation/Kay 1999, Smith and Leon 2001).

A Social Exclusion Unit report (2005, page 52) also highlights that whilst most young people are now taking longer over the transition to adulthood, a disadvantaged minority experiences an accelerated transition, which is often chaotic and difficult.

In the USA the Adolescent Health Transition Project (2005) has identified a number of concerns for young people with any chronic health condition, needing to transit to adult services.



Youth with chronic health conditions face two simultaneous transitions: a developmental transition (from childhood to adolescence to adulthood) and a situational transition (from pediatric to health care). They may also have a third transition, from relative health to illness, depending on the progression of their illness.


A consensus statement on health care transitions for young adults with special health care needs (American Academy of Pediatrics, *et al*, 2002, page 1304) states,



The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood.

Evidently the above reports relate to adolescent health and chronic conditions in general and any extrapolation to adolescent mental health should be made with this limitation in mind. Significantly, a recent publication from the Department of Health (2006), which also focuses on health transitions, deliberately excludes mental health with the explanation that,


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The guide specifically does not seek to describe the approach or approaches for improving transition for young people that are users of Child and Adolescent Mental Health (CAMH) services. While there are similar concerns about how best to improve the transitions between CAMHS and adult mental health services, there are a number of current developments in CAMHS provision, notably improving the access to services for 16 and 17 year olds and the development of services providing early intervention for young people with psychoses which requires a partnership between CAMHS and adult mental health services. In addition we are aware of a number of joint child and adult mental health services around the country, that provide a model for how transition for young people with mental health problems can work well.

(Department of Health, 2006, page 6).

Implicit in the literature being considered in this review is the need for a smooth, uninterrupted transition of care, in which the transition is understood as a process, not an event. In the report of a study into the transition from child to adult services by children with long term chronic conditions, Forbes *et al*, (2001, page 13) offer a conceptual framework for continuity of care,



**Experienced continuity** – the experience of a co-ordinated and smooth progression of care from the service user's point of view.

**Continuity of information** – excellent information transfer following the service user.


**Cross-boundary and team continuity** – effective communication between professionals and services and with service users.

**Flexible continuity** – flexibility and adjustment to the needs of the individual over time.

**Longitudinal continuity** – care from as few professionals as possible, consistent with other needs.

**Relational or personal continuity** – one or more named individual professionals with whom the service user can establish and maintain a therapeutic relationship.

The research, using review and systematic review methods, critically appraised a range of literature, research and examples of reported practice, identifying key aspects of effective practice, as well as emerging themes. The authors (Forbes, *et al* 2001, page 7) identify four models of transition, or “continuity promotion”,



**1 Direct transition** – focusing on good and communication and interagency collaboration.

**2 Sequential transition** – developing special services for young people to help them adjust to adult care.

**3 Developmental transition** – providing specific support to help young people develop physically, psychologically and socially in adapting to their new care role and in maximising their potential.

**4 Professional transition** – flexibility in moving expertise between child and adult services.

The models are not mutually exclusive and the research found that a combination of the four approaches could be used effectively.

An investigation that incorporated surveys, literature review, outcomes from study days and observation of different models of practice was conducted in the West Midlands.

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One of the findings was that rigid entry criteria and service boundaries do not promote the ability of practitioners to collaborate across service settings, thus preventing young people and their families from receiving a good service. Specifically the authors (Gillam *et al*, 2005, page 5) state,



Transition between CAMHS and AMHS services was seen as 'difficult' by over 90% of respondents working in children's services.

**SUMMARY BOX 3**

- Transitions occur throughout life.
- One approach to understanding the nature of transitions is to describe life stages or phases, which are fixed and predictable.
- An alternative or complementary way to conceptualise transition is through a life course approach, with a greater emphasis on the socially contingent nature of transition.
- The transition from childhood (dependence) to adulthood (independence) has been extended because of social changes.
- There is agreement among authors that service transitions during adolescence should be smooth processes that offer uninterrupted continuity of care.
- A survey of services in one region of England found over 90% of contributors felt the CAMHS to AMHS transition was difficult.

## 4. Barriers to transition

### **Age boundaries and service configuration**

Richards and Vostanis (2004, page 120), quote a respondent as saying that society has changed, but services have not. Since the entry point into adult (mental health) services lies between ages 16-18, the fact that many of the young people in that age group may still be living at home with their families raises questions about the differences in approach between CAMHS and AMHS. In CAMHS the child is assessed and treated within the context of the family and parents/carers are likely to be involved or at least consulted in decision-making, whereas the approach within AMHS is focused on the needs of the client and parent/carer involvement will be at the client's behest.

There is agreement among authors about the lack of clarity regarding where CAMHS ends and adult services begin. In recent findings the Social Exclusion Unit (2005, page 52) reports,



There is little consistency or continuity – some services end abruptly for people of a particular age, and in other areas there is not enough support for the transition between youth and adult services. And if you have a troubled life, you may well want to start accessing services just at the point where they are no longer available to you – there is not enough support for 'second chances'.

The Lifeline (substance misuse) project describes how it is particularly important during the child to adult service transition period to attend to those issues relating to the “(dis)continuity and (in)consistency” of care,



Because the threshold at which one can access an intervention tends to be much lower for young people than it is for adults, once individuals become an adult, they may not be able to access interventions or support for the same things that they were able to as a young person, for example life skills or befriending projects. Thus the interventions and support that they were receiving may stop, regardless of their needs.

Phimister, (2004) has produced a baseline assessment of current provision for young people in the transitional age range within two health economies in England. A significant finding was that in those areas, a determinant of access to CAMHS was based on the criterion of being in full time education for young people aged 16 and over. Additionally many AMHS were found to set an implicit minimum age of 18 for access to services. Clearly this creates a gap in provision, which, since the publication of the report, has been addressed by the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004).

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Continuity in the transition of care must be considered in parallel with the young person's physical, social and psychological growth and development, according to Forbes *et al* (2001, page 10), who go on to state,



Service configurations are sometimes unhelpful to the achievement of continuity of care between child and adult services because they frequently involve different care plans, care teams and funding arrangements. Further, an arbitrary age point assumes that chronological age alone indicates a readiness for transfer, which may disregard the complexity of adolescent development.

A report by Youth Access (White, 2003, page 12) asserts of its Youth Information and Advice Centres (YIAC), which generally serve 16-25 year olds,



YIACs have been bridging the gap between CAMHS and AMHS for the past 25 years.

Within the same document, in calling for timely, appropriate services for young people, Baroness Howarth of Breckland, (White, 2003, page 5) relates,



Working with children throughout my career, culminating in listening to their concerns in ChildLine has reinforced my view that present structures make many services unapproachable or inaccessible to them.

### **Differing thresholds and eligibility**

The threshold for access to young people's services is generally much lower than that to adult services so that a young person's need or problem may be less severe and enduring than an adult's in order to be eligible for a specialist service. This means that some or many of the young people receiving a service will be unable to continue as an adult. Hence, it is suggested, work with those young people at the upper age limit of a service should,



...incorporate an exit strategy that allows for the ending of an intervention, as well as an exit strategy that allows for the move to adult services.

(Lifeline, 2003, page 2)

Some young people are at higher risk of developing mental health problems in adult life, yet may not be eligible at age 18 to receive a specialist adult mental health service. This group of vulnerable young people includes those looked after by the local authority, those who are homeless and those seeking refugee or asylum seeker status. Many of these young people may not even be accessing CAMHS, as illustrated by Street *et al*, (2005, page 3),



For example, some of the identified barriers preventing Black and Minority Ethnic groups from accessing services included language problems, poor staff training, limited information, racism, fear and mistrust of services, inappropriate provision/interventions and issues such as socio-economic disadvantage.

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This finding was set within a context of increased risk of developing mental health problems among some BME groups of young people, due to disproportionate rates of exclusion from school, being looked after by the local authority or being homeless. The report also highlights the very significant role played by voluntary organisations in meeting the needs of young people from BME groups (Street et al, 2005, page 34). Street's report reiterates Rodriguez *et al* (2002, page 306) who note that identity formation for young people from BME groups has the added dimension of an exploration of their cultural heritage.

Care leavers face the additional challenges of learning to live independently and often have lower levels of educational achievement. They may also have special needs and/or behavioural concerns (Lifeline, 2003).

Mapping of services for young people (Pugh and Meir, 2006) has found that over 50% of CAMHS commissioners identified specific areas of unmet need, listed below,

- dual diagnosis
- self-harm
- young people looked after
- Attention Deficit Hyperactivity Disorder, (ADHD) autistic spectrum disorder (ASD), learning difficulties (LD) and disabilities
- support for carers
- user-led initiatives
- services for young people from Black and Minority Ethnic (BME) communities.

In an overview of the evidence Maughan, (2005) shows that the majority of young adults with a psychiatric disorder had diagnosable problems much earlier in life and that furthermore, of those with mental health problems at the age of 26, half had first met the criteria for the disorder when they were aged 15. The author suggests that many adult disorders could be re-constructed as extensions of juvenile problems.

### **Different professional cultures**

A detailed analysis of the differences in professional culture between CAMHS and AMHS has been provided by Reder *et al* (2000), who describe the contrasting developmental histories and evolution of the two branches of mental health specialism. The genesis of adult psychiatry within the "paternalistic milieu" of the asylum is compared with the emergence of mental health services for children and adolescents in the early years of the twentieth century, concerned with vagrancy, destitution and offending behaviour (Reder *et al*, 2000, pages 6-7).

The authors summarise that the different histories, leading to diverse theories and practices have,



...prevented areas of common concern from being recognised or addressed. The training of professionals has also exaggerated differences between specialities rather than areas of mutual interest.

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On a positive note, the authors suggest that a point has been reached where it is possible to leave behind the traditional polarities, a point echoed by Maitra and Jolley (2000, page 289), who assert that there has been a considerable impetus in the development of innovative services that promote greater working between child and adult mental health services.

Youth Access (White, 2003, page 37) calls for joint training between AMHS and CAMHS, on informal referral, consent and confidentiality and service ethos. It identifies a huge need for a review of professional attitudes, prejudices and preconceptions, particularly between the statutory and voluntary sector, but also within organisations, claiming,



It is a horrible business when egos between different professions clash.

(White, 2003, page 44)

**SUMMARY BOX 4**

- The age boundaries for access to services are found to be arbitrary and not reflective of individual differences in development.
- Transition between CAMHS and AMHS can be difficult because of the different service configurations.
- Thresholds for access into CAMHS tend to be lower than for AMHS, which creates a gap in service for some young people.
- There is a group of vulnerable young people, some of whom neither access CAMHS, nor will be eligible for AMHS.
- Traditionally CAMHS and AMHS had different professional cultures, based upon both different training profiles and also on their separate evolutions, but there is evidence of a will to bring CAMHS and AMHS closer together.

## 5. Planning, delivering and improving services for adolescents and young adults


### Service structure and components

The Lifeline (substance misuse) project identifies a set of risk factors for adolescents in transition, which includes becoming lost in the system, having nobody to ensure attendance, low expectations and becoming independent at an early age. Conversely the protective factors that promote an effective transition are:

- Having a transitional key worker
- Experiencing a gradual transition
- Access to wide range of services
- Supportive adult friend(s)
- Access to life skills services


(Lifeline, 2003, page 1).

The transitional key worker highlighted in the Lifeline briefing is echoed in the lead professional role advocated in non statutory guidance emanating from *Every Child Matters, Change for Children* (Department for Education and Skills, 2006, page 3) which states,



The lead professional role is not a job title or a new role, but a set of functions to be carried out as part of the delivery of effective integrated support. These functions are to: ~Act as a single point of contact for the child or family, who they can trust and who can engage them in making choices, navigating their way through the system and effecting change. ~ Co-ordinate the delivery of the actions agreed by the practitioners involved, to ensure that children and families receive an effective service which is regularly reviewed. These actions will be based on the outcome of the assessment and recorded in a plan. ~ Reduce overlap and inconsistency in the services received.

The notions of both lead professional and transitional key worker resonate with the findings of the Social Exclusion Unit (2004, page 4), which found the benefits of a holistic service were underpinned by,



...somebody to guide and advise the young person: this could be a personal adviser, key worker, mentor or an independent visitor. Such individuals can help ensure there is continuity of support, and promote trust between the young person and particular services. They can also develop relationships with local services to allow them to act as a broker for their clients, introducing them to a range of specialist provision relevant to their personal needs.

In their recommendations for future services, Forbes *et al*, (2001, page 80) suggest that transitional workers and/or transitional teams can enhance the process.

Other beneficial service structures include continual professional development (CPD), information, use of existing continuous services, inter- and intra-organisation liaison and agreements, organisational planning and frameworks and fostering equity and accessibility.

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The authors also specify process components, including specific actions, which they find to be as important as service structures. These are reproduced below (Forbes *et al*, 2001, page 80)

- Preparation for transition
- Active management of transition
- Case management
- Accountability for the process
- Strong therapeutic relationships
- Advocacy
- Joint management of care
- Flexibility regarding point of transfer
- Specific communication systems
- Regular audit of service provision.

Further agreement with some of the core principles is contained within the report of UK wide qualitative research, which recommends any or a combination of the following types of transition service:

- Designated transition service
- Designated transition team within a service
- Designated staff trained in adolescent work seconded to adult teams

(Richards and Vostanos, 2004, page 127).

A key recommendation of the Youth Justice Board for England and Wales (2005) is to promote continuity of care by the use of the care programme approach (CPA). Maitra and Jolley (2003, pages 289-90) comment that CPA has required adult services to address a broader spectrum of clinical and social functioning.

Singh *et al* (2005, page 293) see potential in the early intervention services that already span the age range 14-35, suggesting,



Early intervention services that successfully manage the interface may provide a template for other youth and even adult services dealing with a broader range of mental disorders. One element, which could be adopted relatively rapidly, would be for a reciprocal arrangement whereby staff from child services are seconded for perhaps two sessions a week to work in the early intervention service, and vice versa.

More broadly, a substantial project in the USA found the following to assist transition, across a number of settings:

- Building in and on what is stable in the young person's life, particularly within the family and others who are providing support.

- Services that are family and young person-driven, taking into account their unique situations and their particular capacities, needs, cultural values and goals.

- Anticipation and preparation for transition well in advance with supports in place beyond the actual point when a setting or situation changes.

(Walker, 2001).

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Another USA report (Reiss, 2005, page 119) was based on the lived experience of child to adult health transition and found that participants understood it as a long-term developmental process, involving the family, child, professionals, as well as the broader health care system.

Reiss' assertion that the transition process should start in childhood or at the time of diagnosis by "envisioning a future" refers to those with chronic conditions and disabilities, but the underlying principle of careful forward planning may be applied to a wider group of young people.

The World Health Organisation, (2002, page 38) in international research on programmes for adolescent health find common denominators for success ,

- Programmes based on a clear understanding of the problems faced by adolescents.
- A multi-sector, multi-disciplinary approach, understanding that there is no single solution.
- Attention paid to how, when and where services are provided, ensuring that programmes are acceptable to young people and to communities.
- Attention paid to the social environment in which young people grow and respect cultural values.
- Challenge of social customs which limit the ability of adolescents to develop successfully.
- Outcomes monitored to demonstrate that what they do makes a real difference.

## Young people's involvement and participation

Article 12 of the United Nations (UN) Convention on the Rights of the Child states:



State parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

The guidance paper, *Building a Culture of Participation* (Department for Education and Skills, 2003) is predicated upon Article 12 and is referenced in the *National Service Framework for Children, Young People and Maternity Services* and across a range of documents that support *Every Child Matters, Change for Children*.

Forbes et al (2001, page 81) specify components of good practice regarding young people to include:

- Development of skills of self- management and self-determination
- Supported psychosocial development
- Involvement of young people
- Peer involvement
- Support for changed relationships with parents/carers
- Provision of choice
- Provision of information
- Focus upon young person's strengths for future development.

The Mental Health Foundation (Smith and Leon, 2001, page 30) found that young people had rarely been asked about the services on offer.

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Although the report focused on crisis, it contains useful pointers from young people themselves on what sorts of help they would like; these are given below,

Someone to talk to and listen  
Support provided by staff with experience of mental health problems  
Emotional support  
Activities to get involved in, including outdoor activities  
Safe spaces in which to meet  
Practical help and support  
Involving young people and users in the service.

(Smith and Leon, 2001, page 31)

All UK government policy of recent years has enshrined the concepts of patient/client led services, stressing choice, voice and participation. *Every Child Matters, Change for Children* emphasise the role of children and young people as key partners in service delivery, stating,



If they are encouraged to generate the ideas themselves and feel properly involved in the creation of solutions, they are more likely to invest time and effort to ensure their successful implementation.

(Department for Education and Skills, 2005).

A commitment of *Youth Matters: Next Steps* is for young people to have more influence over what is being provided in their locality, with greater opportunity to be involved in the planning and delivery of services. (Department for Education and Skills, 2006, page 7).

Within the *National Service Framework for Children, Young People and Maternity Services* (Department of Health 2004) each of the standards is permeated with endorsements of service user involvement and for CAMHS states,



The views of service users are systematically sought and incorporated into reviews of service provision.

(Department of Health, 2004, page 13 of Standard 9).

**SUMMARY BOX 5**

- There is a need for a trusted adult to take on the key role of transition worker or link worker, to be the sole point of contact for the young person experiencing CAMHS to AMHS transition.
- Continuity of care can be effected by use of case management, care programme approach (CPA), provision of choice and provision of information.
- Services should focus and build upon young people's strengths and resilience.
- Young people should be involved in shaping the services of their choice.
- All the key policies and guidance related to adolescent mental health specify the full participation of young people.

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## Glossary of abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Services
ASD	Autistic Spectrum Disorder
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CPA	Care Programme Approach
EMA	Education Maintenance Allowance
HASCAS	Health and Social Care Advisory Service
NSF	National Service Framework
PIG	Policy Implementation Guide
UN	United Nations
WHO	World Health Organisation
YIAC	Youth Information and Advice Centre

# THE TIERED FRAMEWORK FOR CAMHS

