The Cliff Edge

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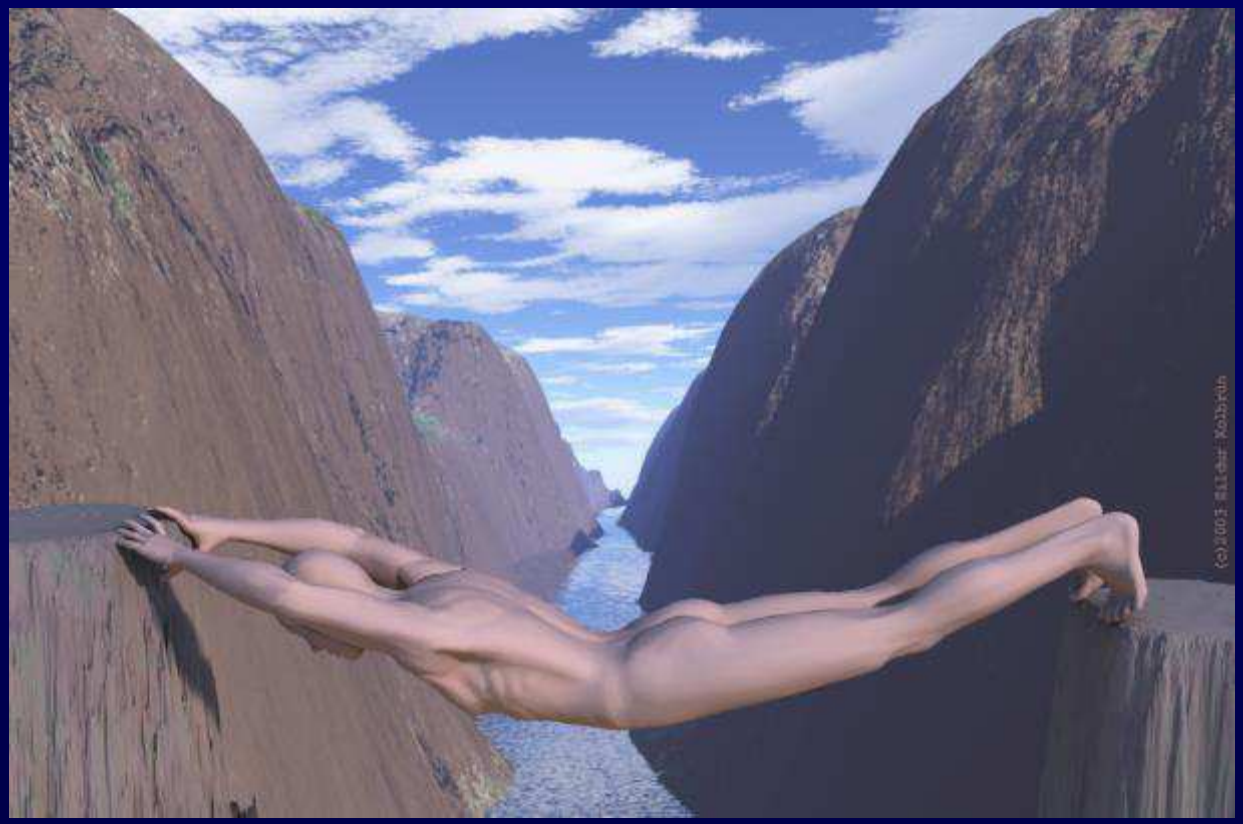
Adolescence represents an inner emotional upheaval, a struggle between the eternal human wish to cling to the past and the equally powerful wish to get on with the future. Louise J. Kaplan, psychoanalyst and author



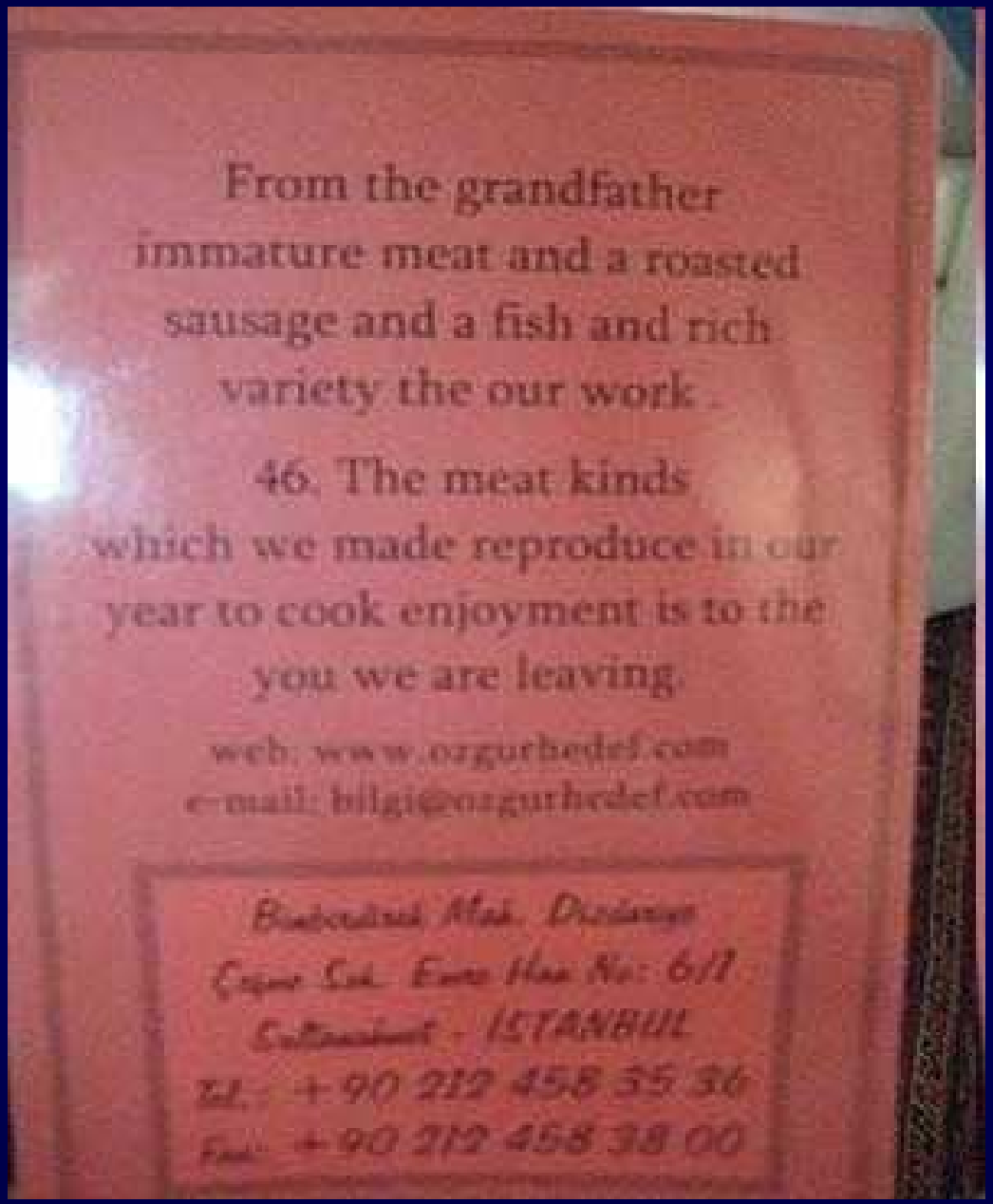
“Mental disorders are the chronic diseases of the young”

Insel TR, Fenton WS. Psychiatric epidemiology: it's not just about counting anymore. Arch Gen Psychiatry. 2005; 62(6): 590-2.


OTHER
PLACES


NO LEFT
TURN
ONLY


One way system


From the grandfather
immature meat and a roasted
sausage and a fish and rich
variety the our work .
46. The meat kinds
which we made reproduce in our
year to cook enjoyment is to the
you we are leaving.
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Adolescence: age or stage

Adolescence begins with puberty and completes with 'highly variable social transitions' which are no longer prescribed
(Patton and Viner 2007)

The transition to adulthood involves crossing (and re-crossing) a series of boundaries; seen as a series of parallel transitions

- Leaving school
- Starting work
- Living away from parental home
- Setting up an independent home
- Beginning a family

The Mismatch of biological (mature reproductive capacity) and psychological transitions ('adult roles')

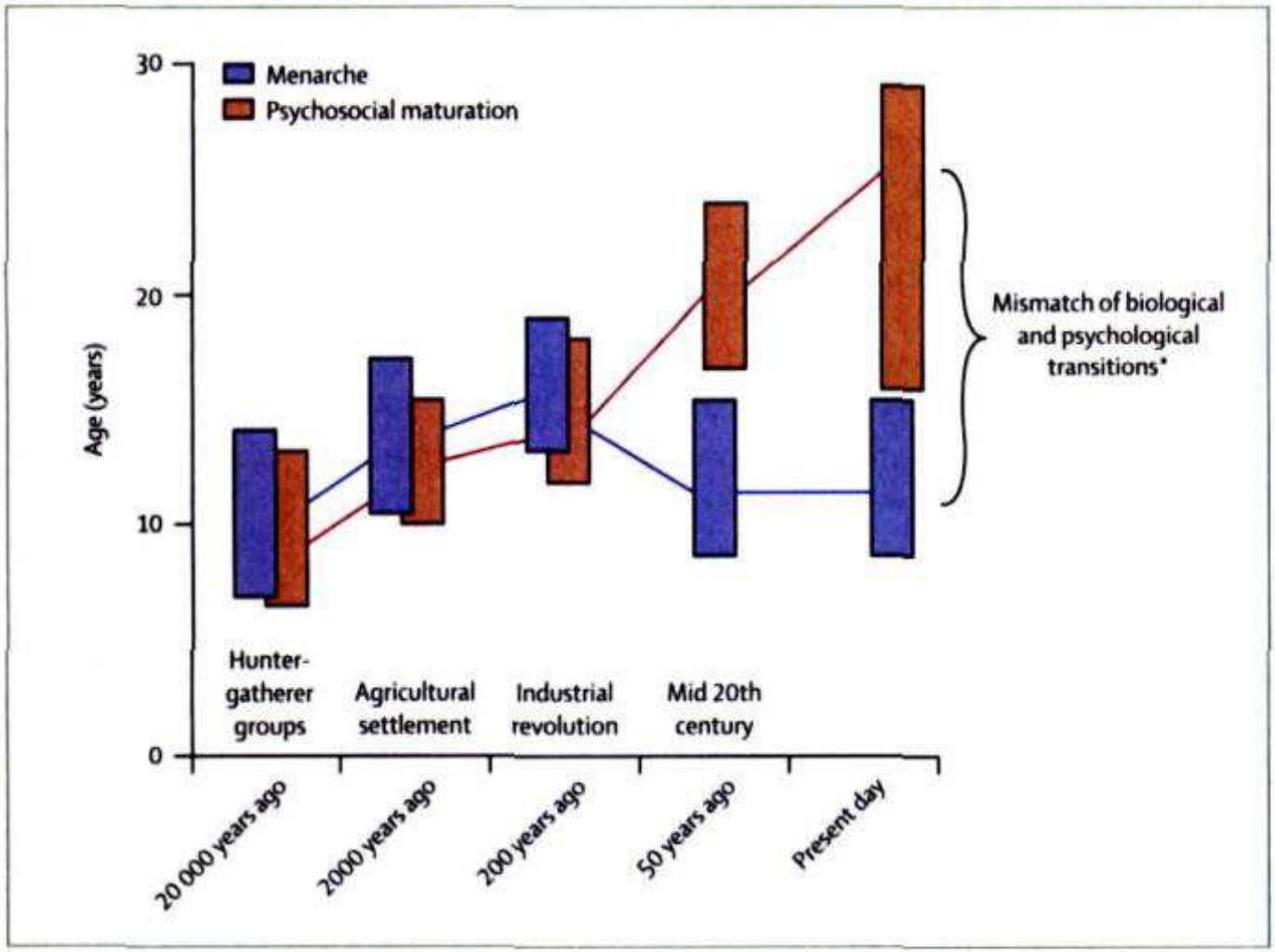


***Figure 2:* Changing relation between probable range of menarcheal age and psychosocial transitions into adulthood**

Adapted from Gluckman and Hanson.[10] *Psychosocial transitions range from first sexual activity through to marriage and parenthood

Emerging adulthood?

Jeffrey Arnett (2000) –USA – young people in their twenties are on the '*threshold*' of adulthood

Individualisation in extended transition

- Individualised transitions are more open to risks, especially the risk of failure
- risks are unevenly distributed in society
- Education becomes a significant marker for success, widening but also diminshing choices and
- Loss of responsibility and autonomy: increased dependence on parental support, especially financial
- ?Increased vulnerability to mental ill health: impact of uncertainty, variability of supports 'shaky scaffolding'

Barriers at CAMHS-AMHS Interface

(Singh et al, 2005)

Organisational differences

- Historical evolution of services: *asylum vs sociological context*

Differing perspectives

- Individual pathology vs systems approach
- Family involvement: consent and confidentiality
- Medication vs psychotherapy

Rigidity of boundaries

- *Helping services target appropriately or manage case loads?*

Availability of services

- Psychotherapies, day care provision, in-patient services etc.

Lack of a common language

- Tiers 1, 2, 3 and 4 vs standard and enhanced CPA

TRACK study *(Singh et al BJPsych 2010)*

- Multiple sites, mixed methods
- Four stages
  - *Stage 1- Policy:* Mapping CAMHS services in 6 NHS Trusts and audit of transition protocols
  - *Stage 2- Practice*: Tracking actual and potential referrals from CAMHS to AMHS over 1 year
  - *Stage 3- Organisational perspective:* Qualitative interviews with organisational leads
  - *Stage 4- User experience*: Experience of transition of service users, carers and mental health professionals

TRACK 1 Findings

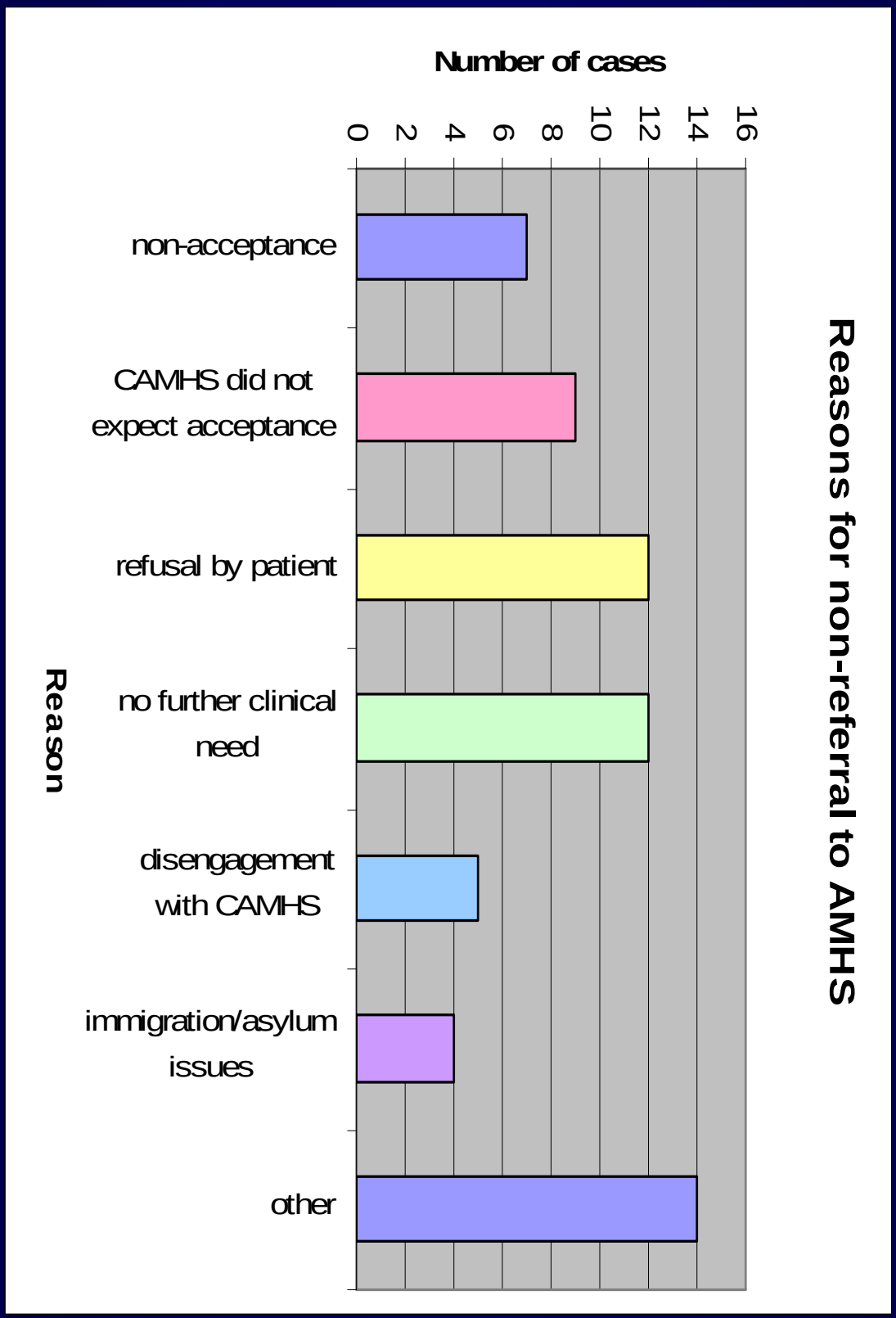
- West Midlands: 3 services
- London: 15 services
- Wide variation in service in transition boundary
- Broadly similar in stated principles: seamless transition, continuity of care, flexibility, information exchange, joint working etc.
- only 3 protocols described procedures in relation to young people referred to but not accepted by AMHS

TRACK 2: Findings

CAMHS DATA bases less than useless

154 total cases tracked:

- 90 actual referrals: patients who made it across
- 64 potential referrals: did not transition

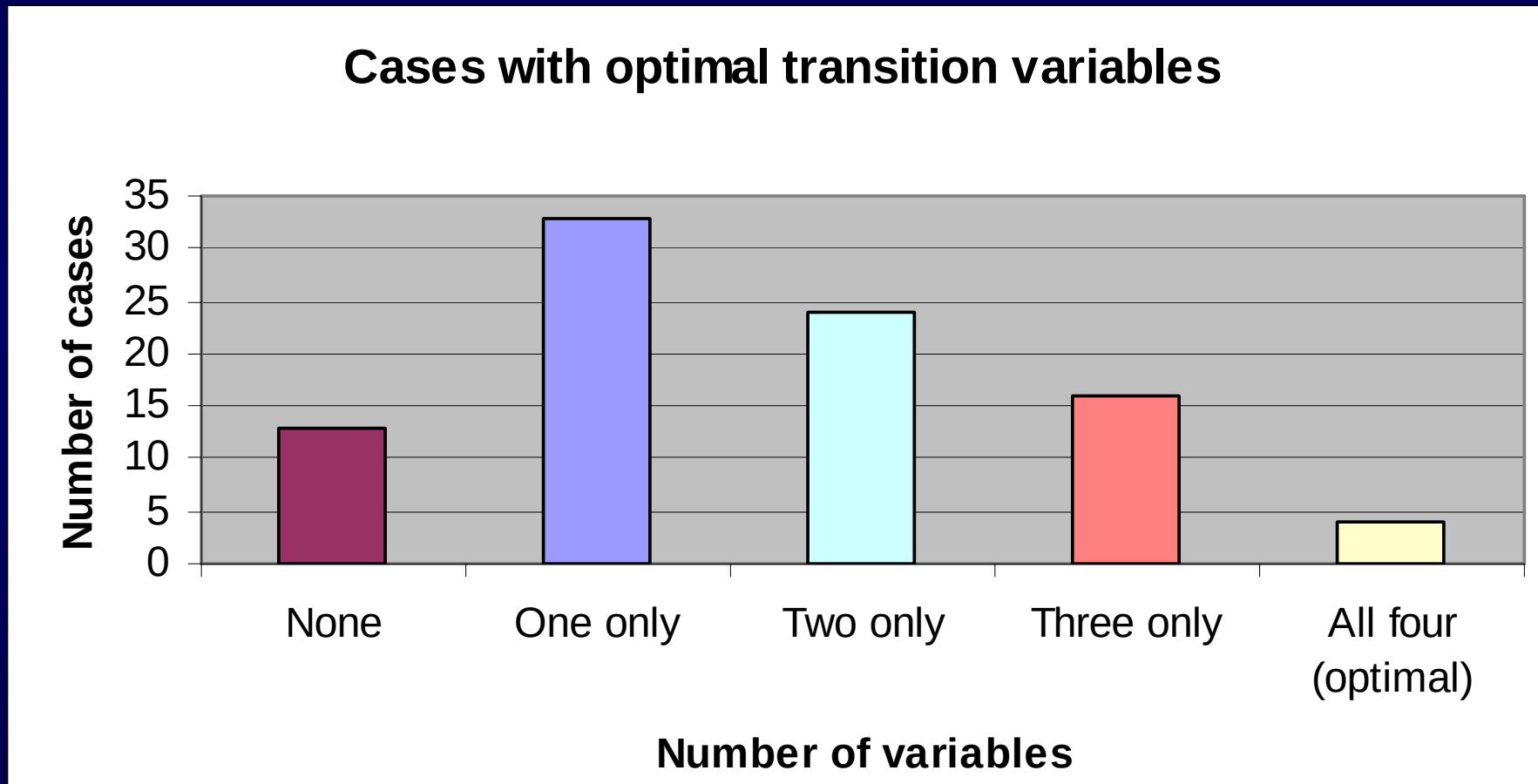

Reasons for non-referral to AMHS
Number of cases
0
2
4
6
8
10
12
14
16
Reason
non-acceptance
CAMHS did not expect acceptance
refusal by patient
no further clinical need
disengagement with CAMHS
immigration/asylum issues
other

Predictors of referrals: logistic regression

- On medication (OR=2.7, 95% CI: 1.1, 5.3, p=0.04).
- Hospital admission (OR 4.97, 95% CI: 1.0, 24.8, p=0.05)
- Serious and enduring mental disorder (OR 7.85, 95% CI 1.63,37.8, p=0.01)

Optimal transitions n=90

- Definition:
  - Period of parallel care between CAMHS & AMHS
  - At least one transition planning meeting
  - Information transfer (any of the following: referral letter, case summary, case notes)
  - Engagement/appropriate discharge at 3 months post-transition


Cases with optimal transition variables
Number of cases
35
30
25
20
15
10
5
0
None
One only
Two only
Three only
All four (optimal)
Number of variables

Other Stage 2 findings

- Over 80% of cases were considered suitable for transfer by CAMHS, but a third were not referred.
- 25% of cases accepted by AMHS were discharged without being seen.
- Cases most likely to fall through the gap:
  - Neurodevelopmental disorders (ADHD, LD, Autism)
  - Emotional/neurotic disorders
  - Emerging personality disorder

Stage 3 Findings

- 34 semi-structured interviews with managers, clinicians and voluntary sector

<u>Service differences</u>

- a lack of clarity on service availability
- operation of different eligibility criteria between child and adult mental health services
- variable service provision for neurodevelopmental disorders

<u>Resource limitations</u>

- High workloads
- staff shortages
- lack of funding allocated to disorders such as ADHD

Stage 4: Transition Preparation

- *“Transfer planning meeting, period of parallel care & Information transfer”*
- Very few service users had experienced such preparation
- Optimal transition cases from stage 2 felt very positive about the process

- Dilemma of parental involvement

"…even though he is an adult, it's still your child and I would still like to have, you know, to know what is going on. Because I feel I'm left in the dark."

Clinicians view: AMHS nurse

"…we've had a period where both of us [CAMHS and AMHS] are involved and I think it's probably good for the client but also for me personally really, really useful because you're getting to know this new person but you've got everyone that knows him or her well guiding you as well so it seems to work well, it should probably be in the policy to be honest and be a regular thing."

Stage 4: Outcomes of transition

- Most young people experienced improvement in mental health after transfer to AMHS
- Most stayed engaged with AMHS
- Many experienced multiple transitions: moving home, pregnancy (3 out of 5 women), involvement with multiple agencies etc.

Case study: actual referral

- Male, ADHD, depression, behavioural problems:
- Referred from CAMHS to psychotherapy service, on medication, psychological treatment needed, risk to self
- Waited 49 weeks for first appointment
- Discharged after 2 appointments
  - Did not meet referral criteria (not severe enough)
  - Given contact details of counselling service for young people to contact himself

Case study: potential referral

- Male, referred from CAMHS to adult ADHD service and CMHT – both rejected referral
  - CMHT advised it had no ADHD provision
  - ADHD service requires *referral from clinician with ongoing contact*

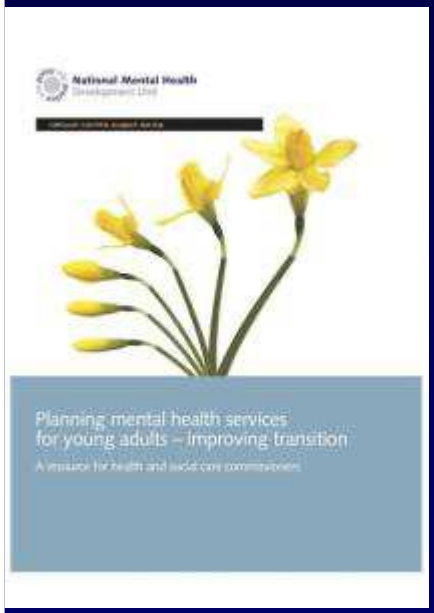
- CAMHS had ongoing input (14 sessions at time of data collection)
  - GP not happy managing medication
  - CAMHS sent letter to clinical director of adult health services for further help (outcome unknown)

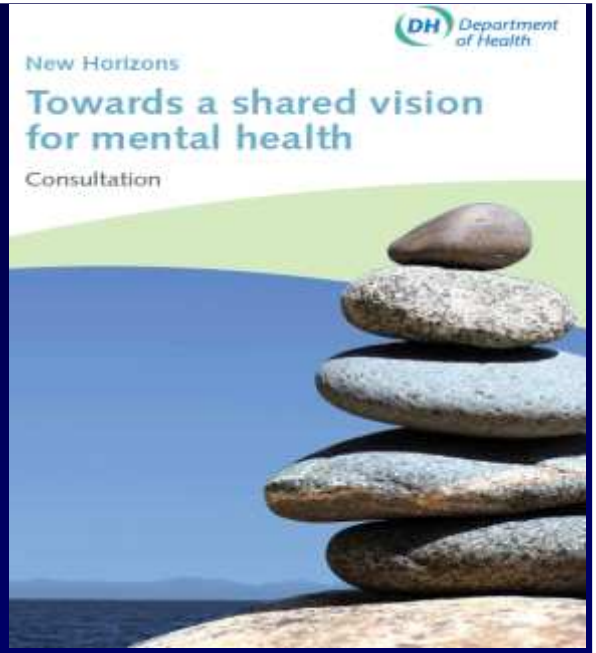
Conclusions: Mind the gap

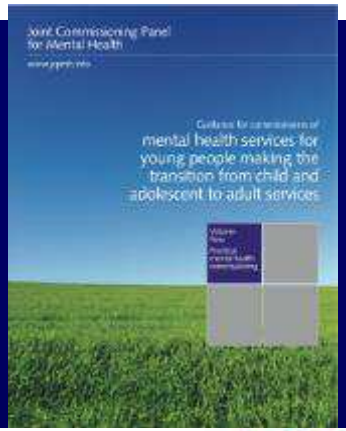
- For majority of service users, transition is poorly planned, poorly executed and poorly experienced
- Mutual misperceptions between CAMHS and AMHS accentuate pre-existing barriers
- Even where protocols exist, there is a policy-practice gap

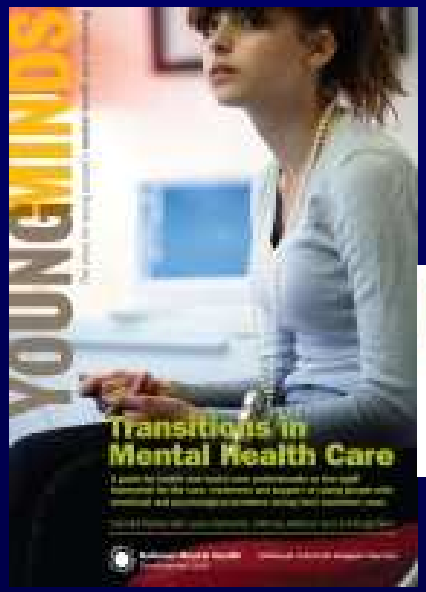
Conclusion: Mind how you cross the gap

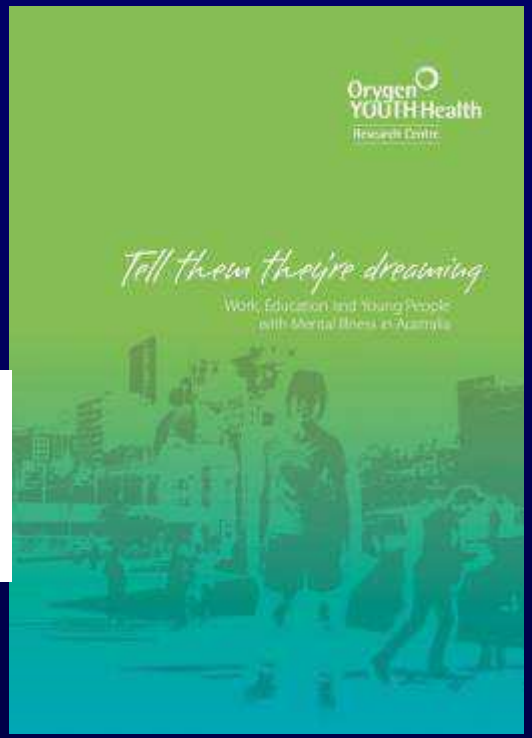
- Young people with neurodevelopmental, emotional and emerging PD fall though the care gap.
- Their outcomes should be a major cause for concern
- Those who cross the gap experience improvement in mental health











scie social care institute for excellence

PSSRU Personal Social Services Research Unit

research in practice

ePPI CENTRE

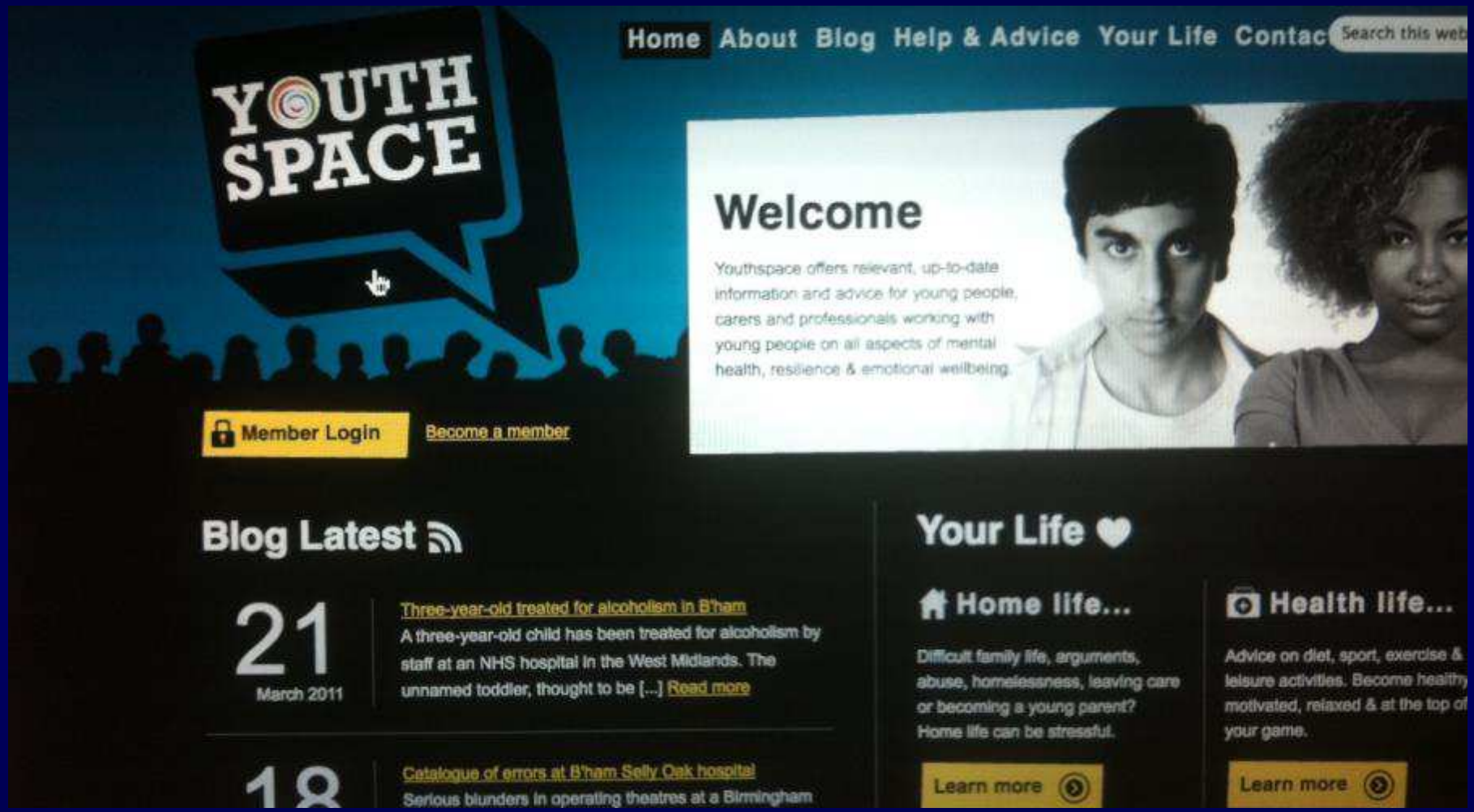
research in practice for adults

NHS National Institute for Health and Clinical Excellence

MILESTONE Project

- EU funded 8 country 5 year project
- UK, Ireland, Germany, Belgium, Italy, France, Holland, Croatia
- Mapping transition policies across all EU
- Epidemiological cohort study (n=1000) of transition age youth, with 1 year follow-up
- Clutser randomised trial of Managed Transition versus TAU
- Training models for improved transition

What should we do: status quo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Youthspace offers relevant, up-to-date information and advice for young people, carers and professionals working with young people on all aspects of mental health, resilience & emotional wellbeing.
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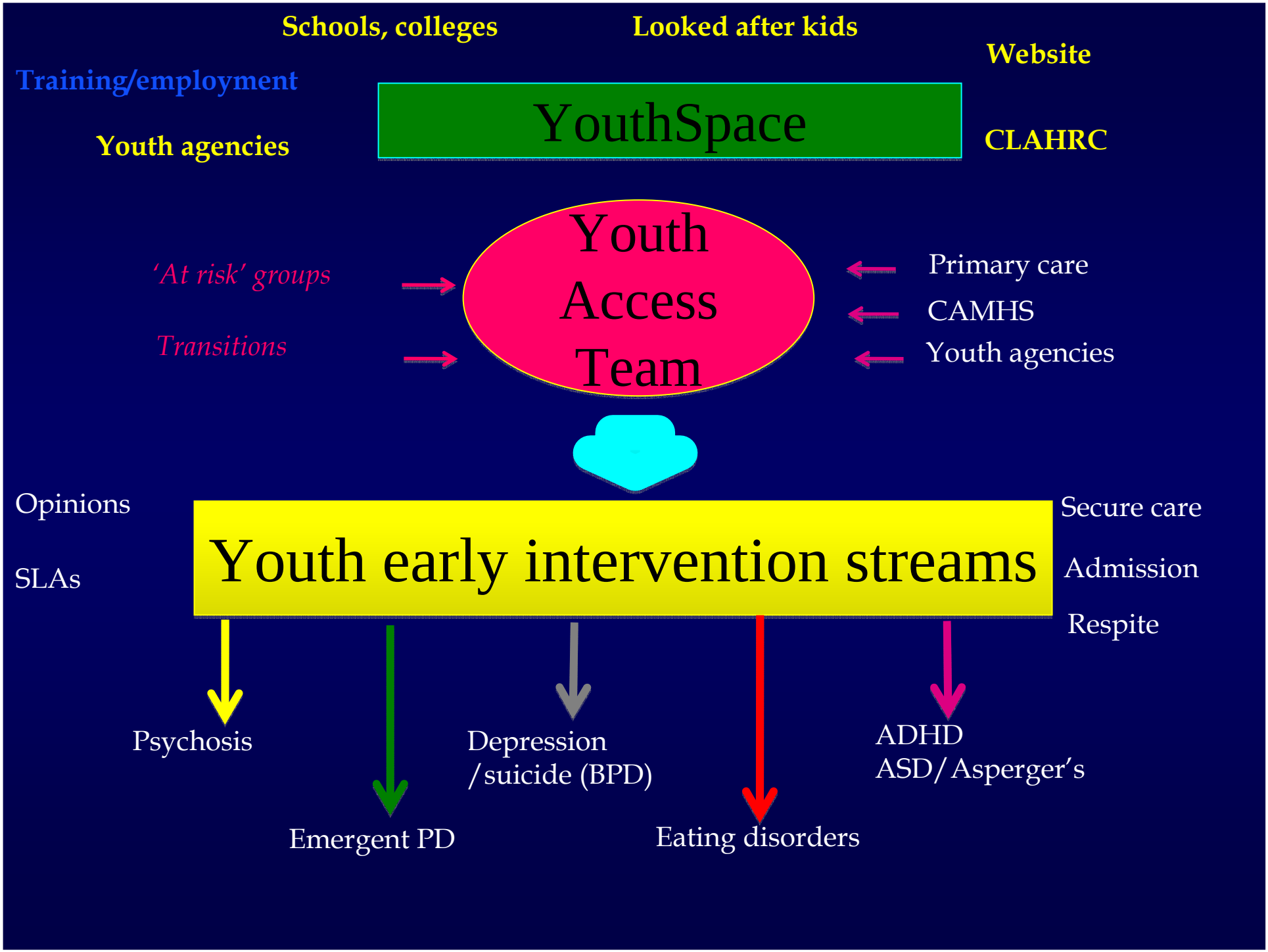

Schools, colleges
Looked after kids
Website
Training/employment
YouthSpace
Youth agencies
CLAHRC
'At risk' groups
Transitions
Youth Access Team
Primary care
CAMHS
Youth agencies
Opinions
SLAs
Youth early intervention streams
Secure care
Admission
Respite
Psychosis
Emergent PD
Depression /suicide (BPD)
Eating disorders
ADHD
ASD/Asperger's

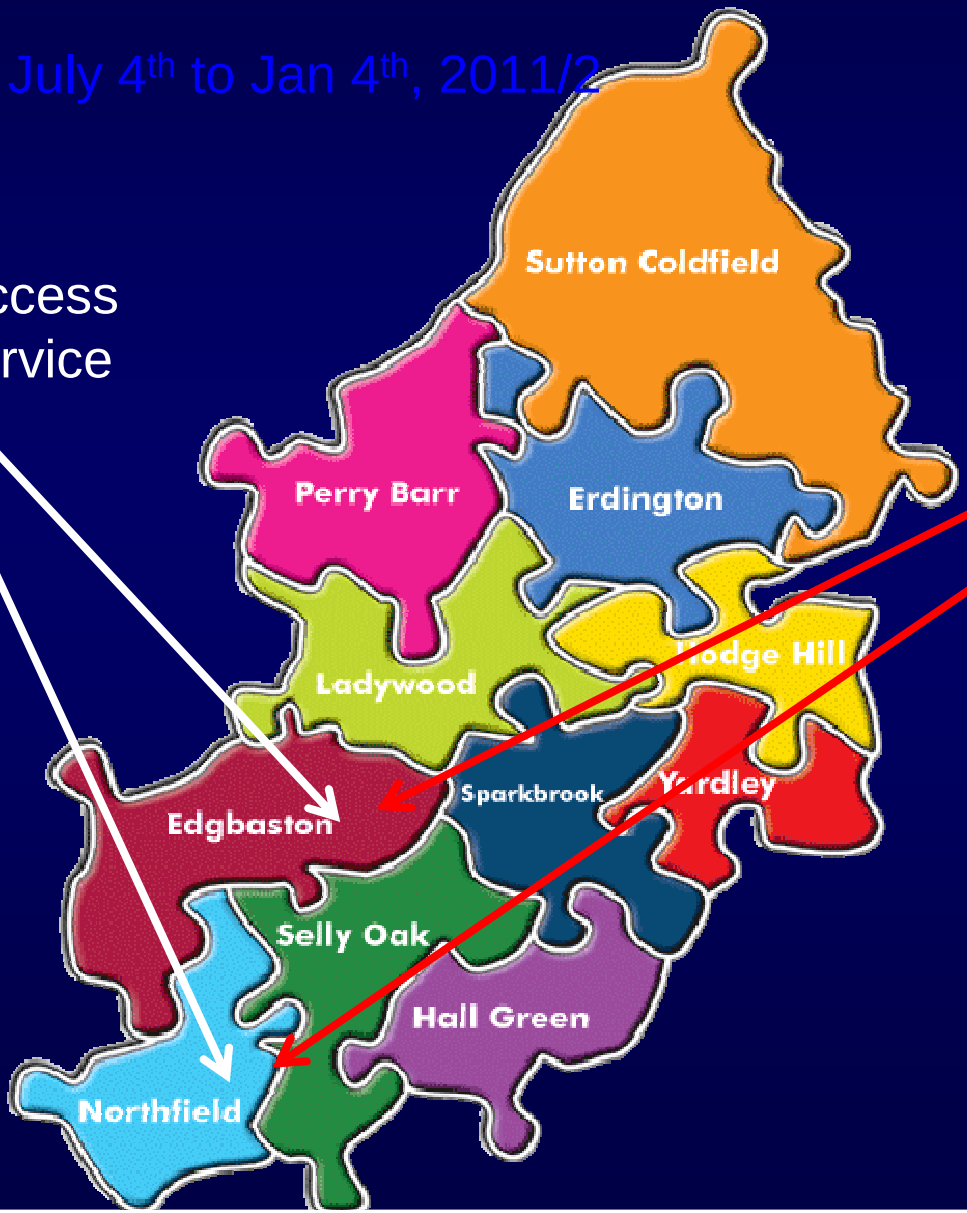
Setting and methodology

July 4th to Jan 4th, 2011/2

April 4th to July 3rd, 20

Youth Access
16-25 service

Longbridge/Yewcroft
CMHTs



Referrals

- N=247 62% female; Average age=22yrs

[broadly similar to CMHT; 25% of all referrals]

- Mood disorder – 33.3%,

  Social/emotional difficulties – 10.1%

  Learning disability/difficulties with mental health issues – 9.9%.

Access

	YOUTHSPACE 16-25	CMHT
Waiting time to first assessment (days)	16	45
Waiting time to first contact (days)	1.98	11.5
DNA and discharged	5.3%	27.5%
Duration from referral to discharge, average days (of those receiving treatment)	29.25 days	110 days

Outcome of Assessment

	YOUTHSPACE 16-25	CMHT
Face-to-face assessment	72%	58%
Signposted	33%	11.5%
Received BSMHFT treatment (following assessment)	83%	56%
Meds initiated by psychiatrist (as % of those receiving treatment)	16%	65%

Acceptability: GPs

'What I'm impressed with is the, I suppose, the ability to understand what is important in terms of engagement approached when you're dealing with young people'

'as a GP you often find an enormously variable response to your request for help and that can be for a number of reasons…with Youthspace if I phone up I have a certain degree of trust in them that if I phone up and ask for help I'll get help'.

Service Users

"Team has been very considerate, waiting times have been amazing. I have been ill since 2007 and this is the best service I have ever received".

"I was offered two different locations - 10 minutes by bus and I could even walk it there. Excellent!"

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RC PSYCH

The British Journal of Psychiatry

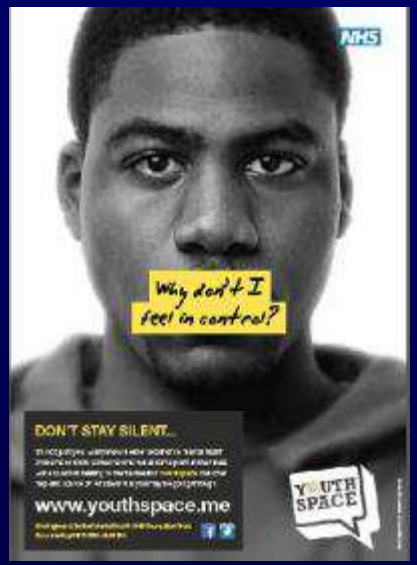
BJPsych

Youth mental health: appropriate service response to emerging evidence

Edited by Swaran P. Singh and Max Birchwood

Fulfilling Lives: HeadStart

The BIG Lottery Fund has committed to invest up to £75m over a period of 5+ years in a programme to improve the mental health of young people in England



Nick Clegg promises £120m boost for mental health care waiting time targets

Mental illness treatment must be on level with physical health and taboo over issue must end, says deputy prime minister

Nick Clegg, deputy prime minister, visits the Scottish Association for Mental Health. Photograph: Christopher Furlong/Getty Images

Most popular

Patrick Modiano wins the Nobel prize in literature 2014 - live

The youth of today……..

"The children now love luxury; they have bad manners, contempt for authority; they show disrespect for elders and love chatter in place of exercise. Children are now tyrants, not the servants of their households. They no longer rise when elders enter the room. They contradict their parents, chatter before company, gobble up dainties at the table, cross their legs, and tyrannize their teachers. You would agree with me? Yes."

Attributed to SOCRATES by Plato
Plato's Republic , book 4