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”

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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One way system

No left turn
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. "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 diminishing 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

- Non-acceptance
- CAMHS did not expect acceptance
- Refusal by patient
- No further clinical need
- Disengagement
- With CAMHS
- Immigration/asylum issues
- Other

Number of cases

Reasons for non-referral to AMHS
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 variables

Number of cases

None | One only | Two only | Three only | All four (optimal)
**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

Service differences
- 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

Resource limitations
- 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
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
- Clustser randomised trial of Managed Transition versus TAU
- Training models for improved transition
What should we do: status quo

“This is the nicest conversation we’ve had in weeks. Let’s not spoil it by talking.”
Youth early intervention streams

Youth Access Team

YouthSpace

Schools, colleges

Looked after kids

Website

Youth agencies

Primary care

CAMHS

Youth agencies

Secure care

Admission

Respite

Opinions

SLAs

YouthSpace

Psychosis

Depression/suicide (BPD)

Emergent PD

Eating disorders

ADHD

ASD/Asperger’s

‘At risk’ groups

Transitions
Setting and methodology

Youth Access 16-25 service

July 4th to Jan 4th, 2011/2

Longbridge/Yewcroft CMHTs

April 4th to July 3rd, 2011
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

<table>
<thead>
<tr>
<th></th>
<th>YOUTHSPACE 16-25</th>
<th>CMHT</th>
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<tbody>
<tr>
<td>Waiting time to first assessment (days)</td>
<td>16</td>
<td>45</td>
</tr>
<tr>
<td>Waiting time to first contact (days)</td>
<td>1.98</td>
<td>11.5</td>
</tr>
<tr>
<td>DNA and discharged</td>
<td>5.3%</td>
<td>27.5%</td>
</tr>
<tr>
<td>Duration from referral to discharge, average days (of those receiving treatment)</td>
<td>29.25 days</td>
<td>110 days</td>
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## Outcome of Assessment

<table>
<thead>
<tr>
<th>Outcome</th>
<th>YOUTHSPACE 16-25</th>
<th>CMHT</th>
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<tbody>
<tr>
<td>Face-to-face assessment</td>
<td>72%</td>
<td>58%</td>
</tr>
<tr>
<td>Signposted</td>
<td>33%</td>
<td>11.5%</td>
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<tr>
<td>Received BSMHFT treatment (following assessment)</td>
<td>83%</td>
<td>56%</td>
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<tr>
<td>Meds initiated by psychiatrist (as % of those receiving treatment)</td>
<td>16%</td>
<td>65%</td>
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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!”
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
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