

Special article

The divide between child and adult mental health services: points for debate

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Summary

This discussion paper outlines our personal views for debate on some of the complexities inherent in the crucial task of improving mental health services for young people in the UK.

Declaration of interest

None.

The issue of how young people move from child and adolescent mental health services (CAMHS) to adult mental health services (AMHS) has been the subject of a number of policy documents and studies over the past 20 years.^{1–11} Yet despite this work and some positive changes, recent research demonstrates that problems persist.^{8,11–13} Lin *et al*, Jones and Chanan & McCutcheon in this supplement have described the developmental context and nature of mental disorders in late adolescence and early adulthood;^{14–16} here we focus more narrowly on the nature and context of the services themselves.

The debate about the so-called ‘CAMHS–AMHS divide’ is generally focused on reported difficulties in transition from CAMHS to secondary care AMHS.^{7–10} For the purposes of argument this is where we start our discussion, but in terms of considering potential solutions we shall not confine our thoughts to these traditional service structures. Difficulties in transition from one service to another are not confined to mental health services,¹⁷ nor to the adolescent–young adult transition. In considering the CAMHS–AMHS divide and potential solutions it is important to understand the nature of the services on either side of that divide. There are differences in the remits of the two types of service that have contributed to differences in theory and practice, including differences in eligibility thresholds for referral and in the level and style of intervention.^{3,7}

The CAMHS population

Child and adolescent mental health services in the UK are grouped into:

- universal services, such as general practitioners (GPs), health visitors and school nurses;
- targeted services, such as Mental Health in Schools projects and mental health services for children who are ‘looked after’ by the local authority;
- specialist services such as specialist multidisciplinary mental health teams.

These different layers of service are commissioned and provided by government departments of health, education and social care. Funding streams and organisation are subject to a degree of local variation. Children and young people with mental disorders may be provided for at any of the three levels. Many young people and their families may be receiving services from several agencies simultaneously; in addition, the adults in the household may have mental or physical health problems.

Specialist CAMHS provides care for children and young people with established mental disorders. However, the profile of disorders treated differs from that for secondary care AMHS.

This is in part a consequence of the pattern and nature of mental disorder in children and young people. Children’s mental health services provide for children and young people with a wide range of disorders, including mental illnesses such as depression, anxiety, eating disorders, obsessive–compulsive disorder and psychosis, as well as autism spectrum disorders, intellectual disabilities, attention-deficit hyperactivity disorder (ADHD) and conduct disorder. In addition, specialist and targeted services provide for children and young people in difficult circumstances that put them at risk of mental disorder, for example those in the care system, young people involved with the criminal justice system, and children and young people who have experienced abuse and neglect. Services also provide interventions for children with high levels of impairment related to mental health difficulties, but who might not reach diagnostic criteria for mental disorder.

The remit of secondary care AMHS is narrower in the main, focusing on adults with more severe mental illness. The majority of adults with mental disorders are cared for within primary care. These differences in remit occur alongside a range of other differences between child and adult services. There are differences in training between professionals working in the two services. Specialist and targeted CAMHS and AMHS are often provided by different organisations. Current commissioning models generally place CAMHS and AMHS commissioning within different frameworks and structures. This has the potential for AMHS and CAMHS commissioning strategies and care pathways to develop separately. At government policy level CAMHS and AMHS have previously been planned separately. For example, in England, Scotland and Wales there are separate national service frameworks and national plans involving different government departments.^{18–22} Unlike adult policy, CAMHS health policy links to the Department of Education.

The consequence of these service differences is that young people in receipt of a service from CAMHS may find that on reaching adulthood their condition and presentation has not changed but secondary care AMHS are not configured to provide for them. If there is no alternative service available in primary care or the voluntary sector, young people and their families are left to cope alone.

The transitions cohort

Many young people will experience some form of transition from CAMHS and there are a number of possible transitional trajectories:

- young people who have a severe mental illness and who are accepted by secondary AMHS;⁸

- (b) young people who have received a service from specialist CAMHS and are likely to have ongoing problems but who are not accepted by AMHS or not referred because it is believed they would not be accepted;⁸ this group often includes young people with autism spectrum disorders, ADHD and emergent personality disorder and some young people with depression, anxiety disorders, obsessive-compulsive disorder and eating disorders;^{11–13}
- (c) young people experiencing a high degree of impairment in the context of mental health problems that may not clearly fulfil criteria for a particular disorder; they have received a service from either specialist or targeted CAMHS, but might not be referred to or accepted by secondary care AMHS because they do not have a severe mental illness;^{7,8}
- (d) young people who have mental health problems but whose needs have been met outside the healthcare system, in settings such as special schools and pupil referral units, and/or by social care;
- (e) young people who would not require transition if CAMHS worked with them for longer.

In a study of transition processes to AMHS, Singh *et al* reported that over 80% of cases were considered suitable for transfer by CAMHS, but a third were not referred.⁸ The adult services accepted 93% of all referrals but 25% of cases accepted by AMHS were discharged without being seen. Even among those who crossed the gap few experienced 'optimal transition', defined as at least one transition planning meeting, a period of joint working between CAMHS and AMHS, good information on transfer and being engaged with AMHS 3 months following transfer.⁸

The problem of transition of young people who meet the criteria of current adult services can and should be solved by improved working between current service providers. However, the problem of how to improve the experiences of young people with transition trajectories that do not meet current eligibility criteria for AMHS is challenging for our current service structures. Tackling these problems requires action on the part of those commissioning and planning services as well as those providing services.¹² The key issue for young people who do not meet eligibility criteria for AMHS is that no service currently exists to meet their needs. The improvement of mental health services for these young people requires extension of adult services to offer interventions for young adults with developmental problems, high-risk behaviours associated with emerging personality disorders and those with severe anxiety and affective disorders. This requires new resources whatever the service design. It also requires the creation of more collaborative links with primary care and other agencies.²³

What young people and their families tell us

Studies show that young people, their families and carers want their views to be taken seriously and to participate actively in the process of transition.^{24–26} Studies have elicited the views of young people and of parents and carers about what they want from services.^{4,27–30} Young people value good information, consistent support from a keyworker, and flexible, non-stigmatising community-based services appropriate for their age group.

'Young people have a lot of problems and it is easier for them to walk into one place where they sort everything out. I wouldn't want to keep explaining my situation over and over again. It's just too upsetting.'²⁹

'Before I moved here, I didn't go to anyone for help . . . when I did try to go to someone for help, they would turn me away, so I ended up drinking, cutting myself,

finding myself in arguments. But since I've been here my keyworker, she's brilliant, I love her to bits and I could go to her about anything.'³¹

Young people and their parents describe the change in service philosophy between child and adult services confusing, especially in relation to the role and involvement of families. Professionals can experience difficulties in meeting the expectations of young people and families at transition. These problems are not unique to mental health services as they also occur in physical medicine.¹⁷ Parents have expressed concern about the lack of services for specific groups of young people, including those with ADHD, autism spectrum disorders and emerging personality disorders.¹³

'The lady at CAMHS kept everyone together, but everything was lost completely through the transition phase. She had meetings with the adult teams and got absolutely nowhere. As soon as it stopped, as soon as she was out of the picture, everything went to pieces.' (Parent of a young adult)¹²

'I am the carer of a now adult son . . . with Asperger's syndrome . . . My son's transition into adulthood was a nightmare both for him and for the rest of the family. There was no transition from CAMHS to adult mental health services and there was no clinician in my local health trust with any expertise regarding Asperger's syndrome . . . no service exists where I live, so I just struggle on supporting him, looking for more appropriate help.'¹³

'It's sometimes said from the adult services that CAMHS transfers are quite difficult because they've been pampered by CAMHS services . . . maybe the care coordinators in the adult teams feel a wee bit inadequate by comparison . . . definitely CAMHS transfers that come to us are really disappointed by what we can offer and can get really upset initially because they feel their needs aren't being met.' (AMHS keyworker)⁸

In the past decade, in order to combat the gaps in service and inequity of provision, there has been considerable impetus in the development of innovative services across the UK that promote greater working between CAMHS and AMHS. However, many practice developments and service models for improving transitions are at an early stage of development and there are few robust, effective studies currently available.^{11,13}

In England the Department of Health and the Department for Education sponsored the National Mental Health Development Unit and National CAMHS Support Service to work in partnership with the Social Care Institute for Excellence on a project to provide a series of resources to improve transitions for young people with mental health problems.¹² The project identified a series of case examples of services in the UK for older adolescents and young adults. These included clinical liaison/link posts, disorder-specific services (e.g. early intervention in psychosis) and in-reach to primary care. At an international level there has been considerable interest in developing youth mental health services, often spanning an age range of 16–25 years. Examples include Orygen Youth Health in Australia, Headstrong in Ireland, and in England Youthspace in Birmingham and the City & Hackney CAMHS Extended Service in London (see McGorry *et al*, this supplement).³² In some areas non-statutory youth services lead multi-agency resourced and managed young people's centres which bridge the traditional transition age gap.³² These services, such as 'The Zone' in Plymouth (www.thezoneplymouth.co.uk), operate flexible opening, drop-in facilities which link to statutory mental health services in a variety of ways. All these services have required significant new investment.

Current context

There is some room for optimism in that the new English mental health strategy and parallel developments in the other UK jurisdictions recognise the importance of effective intervention early in life and have focused attention on the transitions issue. However, this should be balanced against the recognition that the UK is in a period of financial austerity when the level of resources available to specialist CAMHS and AMHS will become

an even greater challenge, with planned public sector savings, particularly in social care and education in many areas.³⁴ The potential consequences of lower investment in AMHS and CAMHS could include adult secondary care mental health and adult social care services needing to raise thresholds consequent to decreased resources; voluntary sector providers, who provide many aspects of youth services, experiencing instability as funding becomes more difficult; specialist CAMHS experiencing reductions in resource, which could lead to reduced capacity and increased thresholds; and reductions in the capacity and provision of local authority services for children and young people through youth service cuts. In addition, young people are particularly affected by the current economic recession. It is known that there are strong links between mental well-being and employment and it is of great concern that the highest unemployment rates in the UK are experienced by those aged 16–24 years.³⁵ The lack of opportunities for work and the consequent increased stress that many young people face leave them at greater risk of developing mental health problems and pose further difficulties for those recovering from pre-existing mental disorders.

Ways forward

It is clear from the available research that significant improvements are required in the implementation of high-quality policy and practice around transition from CAMHS to AMHS.¹¹ In the case of young people who meet current eligibility criteria for AMHS, this can be achieved through providers working together more effectively, and involving young people and their families in improving transition processes.⁸ However, if we are to provide services for young people who currently have no service to progress to, a broadening of eligibility criteria and reduction of threshold of referral for young people to adult services are required. It is important to consider whether broadening the eligibility for adult-led mental health services for young adults would result in a reduction in services for the very young. It might be possible to achieve improved access and a broader range of interventions for young adults through working more closely with the Youth Information Advice Counselling and Support services,²⁹ and with GP-led primary care services such as the Young People's Clinic in Herne Hill, South London.²³

Alternatively, should we consider separate youth services that provide a broad range of evidence-based interventions up to the age of 25 years? If this is the case, then what should be the lower age range for a youth service? Some argue for 12 years, the age soon after transfer to secondary school in the UK. Others argue for 16 years, the age at which compulsory education ends, at which a young person can give consent to medical interventions and can consent to sexual relations. There is also an argument for a model of youth service within AMHS that commences at 18 years, when a young person is no longer viewed as a child under the Children Act 2004 and is considered an adult by the UK legal system. It is important to consider the developmental age of an individual young person in addition to chronological age and the need for flexibility across any age boundary. Flexibility across age boundaries requires agreement between commissioners and effective collaboration and good working relationships between professionals. Attendance at local regular joint meetings and joint training events by CAMHS and AMHS professionals have been shown to improve working relationships and create opportunities for collaborative work.

We must be sure to improve the accessibility and range of mental health interventions in a youth-friendly context while

avoiding difficulties inherent to the creation of new boundaries. New age boundaries could act as barriers and create the need for new transitions that do not match those of other agencies working to meet the needs of young people, including education and social care. This could lead to fragmentation of important multi-agency links. In solving one set of problems we must ensure we do not create others, and be alert to the risk of unintended consequences.

We need to develop services for our young people but be mindful not to do this at the expense of universal early intervention and prevention with the very young. Any solution regarding service models or service re-design is unlikely to be a 'one size fits all' solution, both at individual and service level. Different solutions will fit different local situations. What is not in doubt is that clinicians and commissioners of both AMHS and CAMHS need to work together. Resources are tight and each will need to support the other at different times in order to achieve the best services for young people. It is worth acknowledging that for clinicians working with adolescents and young adults there are more similarities than there are differences, and we can achieve great things for our young people by working closely together and with the respective other agencies that engage with this population. However, in all circumstances if we are to improve transitions and provide interventions to meet the needs of those not currently eligible for adult services, new resources and different commissioning structures will be required. Professionals from both CAMHS and AMHS must work collaboratively with each other, with primary care and with commissioners to find new ways to achieve the services our young people need.

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