Transition phase in youth with mental health problems

Jörg M. Fegert, 15.02.2018 - Greifswald
Overview

• Definition and characterization of a developmental phase

• Age of majority: legal and structural framework

• Barriers in transition process and transition gap in mental disorders

• EU Milestone Project

• Conclusion
“emerging adulthood”
It is not easy to acquire adulthood …

“The most widely-endorsed criteria for adulthood were
• accepting responsibility for one’s self,
• making independent decisions and
• becoming financially independent”
(Arnett & Padilla-Walker 2015)
Adolescence is a process ... defined as:

- The period following the onset of puberty during which a young person develops from a child into an adult (The Oxford Dictionary).

- Changes (Fegert & Freyberger 2017, Remschmidt 2013; Konrad 2013):
  - age of criminal responsibility, legal age, end of applicability of juvenile law
  - new cognitive skills (abstract reasoning)
  - ability of introspection
  - ethical values and norms
  - internalisation of gained knowledge
  - to cope with developmental tasks
  - maturation of brain structures at a different speed („emotions vs. control“)
  - starting phase of major psychiatric disorders
Definition and Development

- Time span for the transition from childhood to adulthood reaches from age 15-16 to 24-26; however, some authors do not state a fixed age
- **physical development processes, social and individual changes:**
  - School education completed, vocational training or studies, transition to working life
  - Separation from parents, sometimes also marriage and first children
  - “Emerging Adulthood” (Arnett): late teenage years throughout the twenties: age 18-25
  - Relative independence from social roles and normative life expectancies
  - Frequent changes, few normative criteria
  - Culture-specific: especially in post-industrial and highly industrialized countries: Career entry requires higher level of education, higher life expectancy


Neuro - Development

- Brain volume max: women ~ 10.5 years, men ~ 14.5 years.
- Mass of white matter↑; Volume of grey matter: inverted U-curve,
- Volume of white matter max: third decade of life (8,9).
- Synaptic pruning: during childhood and especially in adolescence


Hypothesis of developmental mismatch in structural brain maturation

• Different maturation times of subcortical regions (Amygdala; N. Acc.) and prefrontal cortex: missing balance
• Risk behaviour and sensation-seeking in adolescents
• Longitudinal study (n=33): late childhood, adolescence and early adulthood (7-30a): distinctly different maturation processes
• Volume of grey matter Amygdala approx. 7 % ↑ until adulthood
• Volume of grey matter N. Acc. approx. 7 % ↓
• Volume of grey matter PFC approx. 17 % ↓
• Earlier maturation of the Amygdala

Adolescence according to Dahl 2001
“Starting of an engine by an unskilled Driver“
Developmental issues during transition from adolescence to adulthood

Beginning detachment from parents

→ Parents become advisers, at the same time some topics become taboo (e.g. Talking about sexuality)

Studies in developmental psychology suggest:
later independence of young people in Europe

Orientation…

… towards peers in the identity development

→ Friendships become more important („My Friends are actually the most important thing for me“)

… at rules, boundaries and structures

→ Scaffolding (e.g. desire for structure) and limitations (e.g. transgression of boundaries) in the areas of education, media, family and friends

… towards strategies of selfpresentation

→ „child-self“, „adolescent-self“ and „adult-self“
Around 50% of all psychiatric disorders have their onset during puberty, are manifest at the age of 14 years, almost all at the age of 24.

- treatment delays (e.g. anxiety, depressive disorders)
- development steps delayed (probably)
Onset of Mental Disorders

- National Comorbidity Survey Replication: At age 14 most mental disorders appear first
- 50% of all mental disorders of the life span appear first up to the age of 14
- **75% of new cases of mental disorder appear up to the age of 25**
- Median of the onset for different syndrom patterns at different points in time (interquartile distances first manifestation (25th-75th percentile)
  - Anxiety disorders: 11 years (6-21)
  - Impulse-control disorders: 11 years (7-15)
  - Substance-use disorders: 20 years (18-27)
  - Affective disorders: 30 years (18-43)
- First manifestation of mental illness:
  - Impulse-control disorders: Age 7 to 15
  - Substance-use disorders: Age 18 and 27


Early recognition of sub-syndromal conditions

- 12M-Follow-up (N = 243, female: 64%; mAge: 18 years at inclusion (15-25 years, SD: 3): every 3 months
- Subsyndromal manifestation of a potentially severe mental illness (affective unipolar or bipolar disorder or psychotic disorder)
- First symptoms appeared on average at age 13
- Transition from sub-syndromal presentation to major mental disorders: 17%
- Symptoms turn into disorder more often when:
  - Not in vocational training or school education (NEET: not in Education, Employment or Training; OR: 5.19)
  - Female participants (OR sex: 0.09)
  - More negative psychological symptoms (such as social withdrawal) (OR: 1.75)

### Normal and abnormal behaviors in the transition phase

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<thead>
<tr>
<th>Crisis</th>
<th>Normal</th>
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</thead>
<tbody>
<tr>
<td>Drug abuse for selfregulation and organiser of identity</td>
<td>Occasional experiments with drugs or alcohol with peers</td>
</tr>
<tr>
<td>(Transient) promiscuous sexual relationships, sexual offensive behavior</td>
<td>Experimental sexual behaviours with peers, feelings of shyness and unsecurity in relationship with others</td>
</tr>
<tr>
<td>Transient school refusal or loss of interest in activities in or outside of school</td>
<td>Little fluctuation of interests</td>
</tr>
<tr>
<td>Hatred towards parents and rejection of fundamental social values and rules</td>
<td>Arguments about music, fashion and leisure activities</td>
</tr>
<tr>
<td>Chaotic thinking, suicidal thoughts</td>
<td>Challenging rules via exaggerated behaviour</td>
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</table>
Age of majority: legal and structural framework of care
The age of 18

- Over the last 30-40 years the threshold for reaching the age of majority has been lowered from 21 (or 20) to 18 years in German-speaking countries.
- Age of criminal responsibility: 14 years (A, D); 10 years (CH)
- Criminal law (A, D): 18-20 or 21-year-olds can be treated as young adults or adolescents
- Transition between child & adolescent psychiatry and adult psychiatry care systems
- Change of legal situation (right of co-determination of guardians, personal responsibility)
- “Cultural“ differences between the areas of child & adoslescent psychiatry and adult psychiatry
- Adult Psychiatry: individual clinical picture of the patient; Child & Adolescent Psychiatry: greater emphasis on family relationships, social experiences and development processes
- Mental illness: Delay in individual or emotional development

Current system of psychiatric care without consideration of developmental maturity

Two groups of specialists need to develop a common understanding and language
Structural demands vs. ideal development
Individual development

Common basis important for provision of care adapted to the individual differences in development
Real maturation

Actual development in the context of psychiatric illnesses: it is important to consider illness specific components in the history, recovery and development of mental illness.
Barriers in transition process and transition gap in mental disorders
Everybody talks about it: as transition to the adult care system is partially rather well established in (somatic) medicine, it is still the exception rather than the rule concerning psychiatry.

RESEARCH AND THEORY

“You Never Know What Happens Next” – Young Adult Service Users’ Experience with Mental Health Care and Treatment through One Year

Marian Ådnanes* and Sissel Steihaug†

Fragmented services are a well-known problem in the mental health sector. Mental health service users’ experiences of treatment and care can provide knowledge for developing more user-oriented continuity of care. We followed nine young adults with mental health illnesses and complex needs, conducting four interviews with each informant in the course of a year. The aim was to capture their experiences and views about treatment and care, focusing on (dis)continuities and episodes occurring through that year. The users’ experiences were affected by shifts and transitions between institutions, units and practitioners while their need was predictability and stability. A good and stable patient-provider relationship was considered highly useful but difficult to establish. The participants had a strong desire for explanation, adequate treatment and progress, but very different perceptions of the usefulness of diagnoses. Some felt rejected when they tried to tell the therapist about their trauma. Lack of user-involvement characterized many of the participants’ stories while they desired to become more engaged and included in important decisions concerning treatment and medication. The participants’ experiences stand in contrast to key policy goals of coherent mental health services. The article discusses what may explain the gap between policy and reality, and how continuity of care may be improved.
Die Transitionslücke

Walking out of security and into uncertainty
Being of age but not mature
Feeling omitted and handling concerns

Managing transition with support
The caring gap

CAP family perspective
GenP individual perspective

Lindgren et al., 2014
Barriers at the transition between Mental Health Services

- Differences in the historical development of services and their separation
- Different perspectives on mental health (e.g. developmental vs. categorical; custodial vs. protective)
- Diagnostic uncertainty with changing phenomenology of psychiatric presentations, e.g. borderline, addiction, eating disorders
- Different support systems (Social/educational services vs. Rehabilitation services) with different funding sources
- Availability of transitional options
- Lack of „common language“ and conceptional desintegration
- Lack of connection between physical and mental health services
Current state of research

Topic has not received much attention in basic and clinical research (nationally and internationally)

High risk group: Young people in transition (16-25 y) with psychiatric disorders have:
• Lower educational and occupational levels
• Higher rates of poverty
• Higher rates of unplanned pregnancies
• Higher rates of substance use
• Higher rates of homelessness and contact with criminal systems
• Higher than chance frequency of parents with mental illness

During the transition phase many young people drop out of the mental health services and end up in supported living or within the forensic psychiatric system. In AMH the in-patient or day-care psychiatric treatments are often less successful, than in other age groups.
Health Care Models

• Review by Reale und Bonati: 33 studies on transition psychiatry
• Use of assistance for the mentally ill between the ages of 18 and 19 only half as high as the rate of use between the ages of 16 and 17
• Transition problems: care for young people with intellectual disabilities: >50% no specific transition plan, a quarter satisfied with treatment in the transition phase; only few offers for adults
• Externalizing disorders: Difficulties in transition:
  • Key components of good transition from the young patients’ perspective:
    • At least one transition-planning meeting with both the child and adult clinicians
    • Continuity in the therapeutic relationship with their CAMHS keyworkers before, during, and after the transition
    • Limited waiting time to initiation of treatment at the adult service
    • Communication between services
    • Flexibility concerning transition-age thresholds

### Effectiveness of Interventions targeting transition between child and adult services for chronic psychiatric disorders

#### Systematic review of 10 studies

<table>
<thead>
<tr>
<th>Patient</th>
<th>Intervention</th>
<th>Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Illness related information giving</td>
<td>Delivered in individual or group settings, printed material, web-based information, Internet or one-to-one;</td>
</tr>
<tr>
<td></td>
<td>Skills-Training</td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>care-coordinator during transition</td>
<td>Administrative support only or more comprehensive support</td>
</tr>
<tr>
<td></td>
<td>Joint clinical service</td>
<td>Presence of representatives of both services</td>
</tr>
<tr>
<td>Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separate ward for young people</td>
<td>„out patient consultation model“</td>
</tr>
<tr>
<td></td>
<td>Telephone support beyond working hours</td>
<td>Telephone consultation or reminder calls for non-attended appointments</td>
</tr>
</tbody>
</table>

Crowley et al., 2011
Psyciatric disorders – almost no continuity of care?

• Prospective population-based study in the USA (Copeland et al. 2015):
  • 1297 participants between 13 and 16 years (1993 and 2000) and 1273 young adults (1999 and 2010) – several surveys:
  • During early adulthood, only 28.9% of the participants fulfilling DSM-IV criteria received any treatment, whereas 50.9% of the adolescents did.

• Northitalian study on clinical and demographic factors linked to a continuity of care (Stagi et al. 2015):
  • Starting from 8239 adolescents who underwent treatment in Child and Adolescent Psychiatry, 821 (19.4 %) moved to the adult system.
  • Frequent diagnoses: schizophrenia, personality disorder, pervasive developmental disorder.
  • Further predictive factors: not to live in the parent’s house, psychiatric inpatient treatment, medical treatment during the last 24 months.
N=154: Transition from CAMHS zu AMHS (in GB):

More likely:
- Severe psychiatric disorder
- Medication

Less likely:
- Neurodevelopmental disorders
- Emotional and behavioral symptoms
- Developing personality disorder

Optimal transition: (<5%): planning, exchange of information between teams, parallel care during least 3 months of treatment after transition
### Table 2  Results of logistic regression: factors predicting actual transition with clustered results accounting for trust-level data

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>Odds ratio</th>
<th>95% CI</th>
<th>P</th>
<th>95% CI, clustered</th>
<th>P, clustered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known broader social risk (score)</td>
<td>1.38</td>
<td>0.9-2.1</td>
<td>0.14</td>
<td>1.1-1.8</td>
<td>0.02</td>
</tr>
<tr>
<td>English as first language</td>
<td>0.76</td>
<td>0.3-2.3</td>
<td>0.62</td>
<td>0.4-1.3</td>
<td>0.30</td>
</tr>
<tr>
<td>Parents attend CAMHS</td>
<td>0.56</td>
<td>0.2-1.3</td>
<td>0.19</td>
<td>0.2-1.3</td>
<td>0.16</td>
</tr>
<tr>
<td>Admitted as psychiatric in-patient</td>
<td>5.05</td>
<td>1.0-26.8</td>
<td>0.05</td>
<td>0.2-147.3</td>
<td>0.34</td>
</tr>
<tr>
<td>Admitted under the Mental Health Act</td>
<td>5.0</td>
<td>0.5-48.3</td>
<td>0.165</td>
<td>1.6-15.5</td>
<td>0.01</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>0.24</td>
<td>0.0-2.4</td>
<td>0.22</td>
<td>0.0-3.4</td>
<td>0.29</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>1.66</td>
<td>0.3-11.0</td>
<td>0.59</td>
<td>0.3-8.7</td>
<td>0.55</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>2.82</td>
<td>0.9-9.4</td>
<td>0.09</td>
<td>0.8-9.6</td>
<td>0.01</td>
</tr>
<tr>
<td>Serious and enduring illness</td>
<td>7.85</td>
<td>1.6-37.8</td>
<td>0.01</td>
<td>1.5-40.9</td>
<td>0.01</td>
</tr>
<tr>
<td>On medication at the time of transition</td>
<td>2.36</td>
<td>1.1-5.3</td>
<td>0.04</td>
<td>1.7-3.4</td>
<td>&lt;0.01</td>
</tr>
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CAMHS, child and adolescent mental health services.
Care Systems and Transition

• Transition: systematic, planned process, away from a child-centered to an adult-oriented health care system

• “Transition is a lengthy and seamless process with a beginning, middle, and end marked by joint responsibilities in multidimensional and multidisciplinary work to ensure a way to enable and support young patients continuing on into adult care.”

• 4 Ps: (Paul et al.)
  • People: Adolescents/young adults in transition, as well as the participating guardians or parents, caregivers, as well as physicians
  • Process: Process of transition itself and its evaluation
  • Paper: Informational resources and administrative support
  • Place: Place where the transition can take place

Barriers in the transition process

- Logistical (costs, system communication), organizational (incentives) factors
- Cultural and clinical governance issues (clinical responsibility) which resulted in a lack of communication and collaboration between the systems of child and adolescent psychiatry and adult psychiatry
- Lack of experience working with the other mental health system
- Differences in beliefs, approaches, attitudes and last but not least language
- Child and adolescent psychiatry: more proactive, family-oriented, inclusive and holistic
- Adult psychiatry: exclusively focused on the individual and how s/he deals with the illness

Factors that facilitate transition:

- Transition-related meetings between caseworkers, youth and parents
- “Wrap around“ process: medical issues, school and work topics.
- Training opportunities
- Transition facilitators: between the systems of child and adolescent psychiatry and adult psychiatry: provide a forum for these concerns: Case manager: improved level of life functioning, reduced risk of homelessness and increased chances of employment

Review necessary factors for a successful transition process:

• Youth and their families must be actively engaged in every step of the transition process.
• Services must be tailored to developmental needs and personal goals.
• Young people must also be assisted in dealing with other areas of life: Education, social security, housing supports, rehabilitation.
### Pre-, peri- and post-transition

#### Review of qualitative studies (n=40) on adolescents transition phase

<table>
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<tr>
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<th>Recommendations</th>
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</table>
| **Pre-Transition**                                     | • CAMHS clinician qualities (ex. tenacity, flexibility, instilling hope, providing support and reassurance, non-judgmental, good listener)  
  (Child and Adolescent Psychiatry)                     |                                                                 |
|                                                        | • Preparation (ex. early notification of transition to AMHS)                   |                                                                 |
|                                                        | • Youth involvement in transition planning                                    |                                                                 |
| **Peri-Transition**                                    | • Individualized care plans geared towards youth goals of functioning         |                                                                 |
| (Child and Adolescent Psychiatry, Adult Psychiatry)    | • Increased autonomy in decision-making                                        |                                                                 |
|                                                        | • Community supports and primary care physicians who provide “scaffolding” across the transition from CAMHS to AMHS |                                                                 |
|                                                        | • Gradual and flexible timing of transition                                    |                                                                 |
|                                                        | • Care continuity (ex. “Joint working” or “Parallel Care” between CAMHS and AMHS) |                                                                 |
|                                                        | • Relational care continuity to reduce fear of losing relationships with pre-transition staff and to promote comfort with AMHS |                                                                 |
|                                                        | • System-level continuity to reduce gaps                                       |                                                                 |
| **Post-Transition**                                    | o Staff support and practical structure                                        |                                                                 |
| (Adult Psychiatry)                                     | o Autonomy in treatment decisions                                             |                                                                 |
|                                                        | o Choice about parental involvement                                           |                                                                 |
|                                                        | o Physical care environments geared toward young adults                         |                                                                 |
|                                                        | o Informational continuity (ie. sharing of clinical information between CAMHS and AMHS) |                                                                 |

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• Youth involvement in transition planning |
### Transition phase

**Peri-Transition (Child and Adolescent Psychiatry, Adult Psychiatry)**

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|                           | • Autonomy in treatment decisions                                                |
|                           | • Choice about parental involvement                                              |
|                           | • Physical care environments geared toward young adults                           |
|                           | • Informational continuity (ie. sharing of clinical information between CAMHS and AMHS) |
Transition in German-speaking countries

- Overall: significant increase in in-patient treatments (F-diagnoses)
- No significant increase in F0 (organic, including symptomatic, mental disorders) and F5 (behavioral syndromes associated with physiological disturbances and physiological factors)
- Decrease: F2 (schizophrenia, schizotypal and delusional disorders).
- F5, F8 and F9: significantly more frequently in-patient treatment in 15-<20-year-olds

- Survey with employees of the health care system in Austria (N = 86):
  - Transition system: 98.8% "unfavourable", 16%: expressed at the workplace: a well-planned and regulated procedure.
  - Child and Adolescent Psychiatry 85 %: transition from child and adolescent psychiatry to adult psychiatric treatment was poorly or soemwhat poorly tolerated by patients: Adult Psychiatry: 61 %.
  - Child and Adolescent Psychiatry : more frequently confronted with transition issues (17-24 times per year)
  - Complication: 63% of the Adult Psychiatry patients: insufficient information: unnecessary repetition of diagnostic and therapeutic measures led to inadequate information.

EU milestone project
MILESTONE – Managing the Link and Strengthening Transition from Child to Adult Mental Health Care – European research project

• Assessing the state of transitions from CAMH to AMH within Europe
• Consideration of ethical aspects
• Development of tools for assessing and quantifying the need for care during transition

Purpose of study: Results will form basis for development of cost-effective models for transition

• Dissemination: communication with service users, relatives, service providers, politicians
• Teaching: Integration of new knowledge into specialist training

Projektcoordinator: Prof. Swaran Singh
(University of Warwick, U.K.)

Duration: 5 years (until 31.01.2019)

Cooperation with:
UK, Netherlands, Croatia, Ireland, Italy, Belgium, France, Germany
(http://milestone-transitionstudy.eu/de)

The research leading to these results has received funding from the European Community’s Seventh Framework Programme (FP7/2007–2013) under grant agreement n° 602442
The MILESTONE project

• Coordination: University of Warwick, Prof. Swaran Singh
• Start: February 2014
• Time span: 5 years

This project has received funding from the European Union's Seventh Framework Program for research, technological development and demonstration under grant agreement no 602442
The research leading to these results has received funding from the European Community’s Seventh Framework Programme (FP7/2007–2013) under grant agreement no 602442
Development of (measurement) instruments TRANSITION

**TRAM (Transition Readiness and Appropriateness Measures)**
- Evaluation of the need for transition: on the basis of different risk and protective factors the clinician can estimate the need for transition and help the young person direct to further caregiving
- Result: no further psychiatric care necessary or a low, moderate, or high care need

**TROM (Transition Outcome Measures)**
- Evaluation of the outcomes of transition: to measure the quality of transition and to register the evolution of the young people in this phase of life.

**Risk & protective factors**
- Psychiatric problems
- Suicide
- Care trajectory
- Place of living/residence
- Hospitalisation: residential and crisis
- Risky behaviour
- Addiction problems
- Justice problems
- Autonomy of the patient
- Self-care, knowledge of disease
- Knowledge of care landscape
- Care continuity – care withdrawal
- Social embedding

Assessment among patients, parents (or informal caregivers) and clinicians.

This project has received funding from the European Union’s Seventh Framework Program for research, technological development and demonstration under grant agreement no 602442
Aims of the Study

• To validate TRAM and TROM

• To study ‘transition’ processes
  • Outcome on psychiatric level but also on the level of different life areas
  • During 27 months
  • To detect important predictive risk and protective factors

• Cohort of 1,000 adolescents in Europe – we were able to include 1146 participants!

• 200 young people = « intervention » arm
• 800 young people = « control» arm
This project has received funding from the European Union's Seventh Framework Programme for research, technological development and demonstration under grant agreement no 602442.
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* Due to a prolongation of the recruitment phase, reduction to 24 months
MILESTONE – Managing the Link and Strengthening Transition from Child to Adult Mental Health Care – in Europa

To understand and to improve transition for patients from CAMHS to AMHS in different health systems *

* Overall objective should be a flexible system of care, which doesn’t stick to rigid age boundaries, but rather is oriented to the individual needs of the young people

The research leading to these results has received funding from the European Community ‘s Seventh Framework Programme (FP7/2007–2013) under grant agreement n° 602442

- Is the interface between CAMHS and AMHS everywhere a problematic one?
- Europe-wide, there are different age boundaries – between 16 and 21 years – determined by capacities and limitations of care
- public / private access
- enormous differences with regard to the quality of care
Aims – goals (~ work packages): TRANSITION MODEL

Pre-conditions transition
- Inventory national CAMHs/AMHs
- Ethical dilemmas involving transition
- Training caregivers

Transition research
- Development of (measurement) instruments regarding transition
- Longitudinal cohort study
- Case-control study

Development of guidelines - recommendations
- Clinical recommendations
- Ethical recommendations
- Training-related recommendations
- Cost-effectiveness

This project has received funding from the European Union’s Seventh Framework Program for research, technological development and demonstration under grant agreement no 602442
conclusion
Conclusion

• The transition from Child and Adolescent (CAMH) to Adult mental health (AMH) services represents a challenge from many perspectives (theoretically, legally, ethically and developmentally)

• Consideration needs to be given to the specific needs of young people with mental health problems between the ages of 16 to 25 including interindividual variations in developmental processes and environmental conditions

• The disruption in care caused by the transition between services has far reaching consequences
different philosophies
(systematic review, Mulvale et al. 2016)

• “Findings reveal consistent differences in care philosophies between CAMHS (developmental approach, involving families and nurturing) and AMHS (clinical/diagnosis-focus, emphasis on client autonomy and individual responsibility)”.

cultural separation
(Mc Laren et al. 2013)
“A cultural divide appears to exist between CAMHS and AMHS, characterized by different beliefs, attitudes, mutual misperceptions and a lack of understanding of different service structures. This is exacerbated by working practices relating to communication and information transfer which could impact negatively on transition, relational, informational and cross boundary continuity of care”.
Key Issues Paper by the DGKJP and DGPPN
June 23, 2016

Transition from adolescence to adulthood:
The challenges to establish “transition psychiatry”

Authors: Jörg M. Fegert, Iris Hauth, Tobias Banaschewski, Harald J. Freyberger
The main demands of the DGKJP and DGPPN at a glance:

- Interdisciplinary outpatient, day-patient, inpatient and complementary services are to be created in patient care that take into account the specific features of the transition from adolescence to adulthood and consider the additional need for therapeutic services aimed at development-specific problems.

- These approaches are to be transferred to the complementary care system, or separate approaches to the provision of services are to be developed and promoted for this system.

- Programmes on transition psychiatry are to be established in medical education, especially training, and continuing medical education in order to provide the professional groups involved with specific, previously missing expertise.

- The transition phase should be given greater consideration in the revision of the professional training regulations for both child and adolescent psychiatry and general adult psychiatry. Innovative, interdisciplinary, cross-specialization continuing education opportunities and rotations are to be promoted.

- There is a special need for basic neurobiological research, care research and intervention research. So far, systematic research funding programmes that focus on transition processes are lacking.

- Political action is required in the areas "care structures", "cross-sector care models", "complementary care offerings" and "specific research funding".
Thank you for your attention

&Dazugehoeren

• „Dazugehören e.V.“
• Improve participation
• Integration and inclusion
• Against stigma and mobbing

„Ich stecke noch tief in meiner Krankheit ... Ich wollte zur Gruppe dazugehören“