



opinion
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Mind the gap: the interface between child and adult mental health services

Adolescents with mental health problems are poorly served by mental health services, since responsibility for care often falls between child and adult services. Within the UK, there is no consensus on how service boundaries should be delineated. Some services use an age cut-off at some point between 16 and 18 years, whereas others consider child services to be appropriate only for those in full-time education. The Audit Commission (1999) reported that nationally 29% of health authorities commissioned child and adolescent mental health services for young people before their 16th birthday only, although adult services were not considered suitable for those under 17 years old. The report highlighted the poor development of adolescent services and their inadequate links with other agencies, including adult mental health services.

Even though adolescence is a risk period for the emergence of serious mental illnesses such as schizophrenia, it has generally received only patchy attention from services (Reder *et al*, 2000). The Mental Health Foundation report *Bright Futures* suggested that young people generally have a poor image of adult services (Mental Health Foundation, 1999). Admitting young people to acute adult wards is particularly problematic and is likely to set them on a lifelong path of aversion to mental health care. Communication between child and adult services is notoriously poor. Although many young people experience transition to adult services, just under a quarter of services in the UK have specific arrangements for such transfer of care (Audit Commission, 1999).

There is considerable variation across the country in how well this transition is managed. A Select Committee on Health report on National Health Service mental healthcare identified several problems in the transition from child to adult services (Select Committee on Health, 2000). These problems included the failure of services to work together, the need for care management and planning to be led by a single practitioner who can coordinate care across all relevant agencies, the shortage of in-patient services for adolescents, the need for early intervention and the poor liaison between various agencies. In addition, access to psychotherapy is generally more difficult in adult services. There is therefore a serious risk of disruption in care provision for adolescents who are transferred to adult mental health services. A review of continuity in transition from child to adult services highlighted the paucity of high-quality research in this area (While *et al*, 2004).

In this paper we explore the conceptual and practical barriers that exist between child and adult services and recommend strategies for effectively managing this interface, especially in light of the development of

specialist services such as early intervention in psychosis, which bridge the child–adult divide.

Barriers at the interface

The interface between child and adult services is influenced by how the services have evolved in their structure and function and how they differ in their conceptualisation and management of mental illnesses (Reder *et al*, 2000).

Evolution of services

Adult psychiatry has evolved under the successive influences of neurology, phenomenology, psychology and sociology, and has developed treatment strategies which were once entirely asylum-based but are now increasingly provided in the community. The primary focus of adult psychiatry has been the individual's morbid mental state. Treatment strategies are aimed mainly at ameliorating such states by biological and psychological therapies. Child psychiatry, on the other hand, emerged later and primarily within a sociological context, with concerns about vagrant, traumatised or delinquent youth. It gradually broadened its horizons to include developmental concerns and the role of systems such as the family. The assessment focus is therefore on interactions between developmental and emotional processes, family relations and social experiences, with treatments geared primarily towards psychological and systems interventions.

Differing perspectives

These organisational and theoretical differences are most vivid at the interface, where different perspectives collide, such as when a young person with behavioural problems and an unstable family is referred to an adult service that regards an absence of diagnostic phenomenology as a barrier to offering help. The needs of a child envisioned within a family context allow child services to offer help to the family unit; respect for the autonomy of an adult prohibits adult services from intervening where an individual declines help. Young people negotiating the developmental tasks of adolescence, such as independence, sexuality, career and independent living, are therefore caught between two very different services, one that considers them and their problems as part of the family unit, and the other that considers them as adult and autonomous. Concerns about confidentiality also inhibit adult services from sharing findings and plans with family members, unless the young person gives explicit consent. Families who wish to stay involved in treatment plans are often left feeling isolated and removed from major



decisions made by adult services. All these heighten the risk of the young person withdrawing from care at the point of transition.

Diagnostic uncertainty

Many young people have difficulty negotiating adolescence and can experience a wide range of problems, which may persist into adult life if not addressed early. The disturbances of conduct disorders, for instance, can persist into adult life (Scott, 1998) and if such individuals get into trouble with the law or misuse substances, they are likely to fall through the care net. The distress of social problems such as domestic violence, homelessness, unemployment, parental separation or parental mental illness can masquerade as psychopathology, or be ignored as 'reactive' and hence perceived as less serious than a diagnosable mental illness. The diagnostic uncertainty caused by overlap between the 'normal' turmoil of adolescence and the non-specific prodrome of serious mental disorders, combined with frequent drug use in this age-group, is a further barrier to young people receiving appropriate help from adult services.

Rigidity of boundaries

The developmental stage at which someone becomes an 'adult' is impossible to define. Services that have clear age-related boundaries may have explicit processes in place for managing the transition, but the rigidity of the age cut-offs can hamper rather than facilitate the ability of services to meet the needs of individuals astride these age bands. Tight demarcations and referral criteria can be ploys to cope with budgetary restraints and managing case-loads, rather than explicit attempts to target services appropriately.

Availability of services

Child services generally have more in the way of individual and family psychotherapy provision, whereas access to local in-patient and day-patient facilities is often limited and is sometimes non-existent. The converse is true of adult services. This can lead to an abrupt disjunction when a young person who has been in psychotherapy, possibly for some years, is abruptly transferred to an adult service where the only readily available non-pharmacological treatment option may be admission to a local day service populated largely by older patients with very different needs.

Lack of a common language

The structural and functional differences between services have also introduced concepts that may be alien to all but those who are directly involved in providing a service. Adult services struggle to understand exactly what is meant, for example, by tiers 1, 2, 3 and 4, or the differences between primary child and adolescent mental health workers and primary care mental health workers. Workers in child services may struggle to understand the

differences between case management, care programme approach and the differences between the standard and enhanced care programme approach.

Managing the interface

How is the interface between child and adult services best managed? Given the barriers identified above, there can be no clear-cut and easy answer, which could be implemented overnight. Several strategies could be considered, dependent upon local needs and priorities, including the following.

Specialist services

Giving evidence to the Select Committee on Health, several organisations such as Young Minds, Sainsbury Centre, Rethink, the Royal College of Psychiatrists and the Royal College of Nursing recommended the setting up of specialist services for young people aged 16–25 years. Despite the obvious advantages of such specialised services, it is unlikely that these will appear nationally in the near future. One interesting area of opportunity is the emerging early intervention services, which are clearly astride child and adult services, and are meant to provide care for young people aged 14–35 years who are experiencing psychosis. 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.

Liaison models

Maitra & Jolley (2000) have described a liaison project in the London Borough of Hammersmith and Fulham in which child and adult psychiatrists routinely attend each other's meetings to discuss cases involving children: either child patients who have a carer with potential mental health problems or children of adult patients who are actually suffering or at potential risk of mental health problems. The authors note several benefits of such liaison, including a higher profile for children within adult services, shaping of the process of referrals across services, improved scope for prophylactic work, possibilities of joint working and the availability of a forum for formal and informal discussions. Given the resource implications of such models, an audit of the process and outcomes would be very useful in helping other services develop similar working patterns.

Joint working

The dilemmas and dichotomies of different perspectives – a child within a family system, as opposed to an adult with a distinct mental health problem – can be effectively dealt with by child and adult services working jointly in



opinion & debate

individual cases. Child services bring the important understanding of developmental processes in the assessment and management of young people; adult services are usually better equipped to provide diagnostic precision and appropriate pharmacological treatments. This approach also facilitates interdisciplinary learning and fosters therapeutic skills in both child and adult services. However, lines of responsibility and accountability must be clear, lest in the hope that the 'other side' is responsible, neither service delivers.

Specialised workers astride service

Specialised workers who are members of both child and adult services can potentially harvest the advantages of both liaison models and joint working. However, there is a paucity of such trained staff. There may also be concerns about clinical responsibilities, supervision, fragmentation of working practice and divided loyalties across teams.

Protocols and guidelines

At the very least, all child and adult services should have written protocols for managing the interface. These should include:

- protocols for transition from child to adult services
- guidelines for admitting young people to adult in-patient units
- emergency provision for young people in crisis
- management plans for young people with mental illness and comorbid drug use.

Training and research

The bodies responsible for training professionals to work in the mental health field should consider the development of a course for specialist workers to enable such staff to work with children from the age of 14 years or so up to young adulthood. This would require adult services to adopt a more family-based and systems approach, and child services to improve their phenomenological and diagnostic skills. Priority should also be given to research into interface issues, problems of transition and effectiveness of different models of joint working and managing the interface.

Conclusion

Despite a number of recent reports on this topic, there has been little progress in improving the interface between child and adult mental health services. Change will require both a 'top down' and a 'bottom up' approach. Regional offices responsible for delivery of both types of service in their area should become central in the development of better interfaces. National bodies should take the lead in developing training for joint workers. On the ground, clinical and managerial professionals from child and adult services need to begin working together to develop protocols to facilitate transition. This is also a fertile area for research, which should be pursued both at local and national level.

Declaration of interest

None.

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