


ORIGINAL ARTICLE

Transitional psychiatry in the Netherlands: Experiences and views of mental health professionals

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Abstract

Background: The majority of psychopathology emerges in late adolescence and continues into adulthood. Continuity of care must be guaranteed in this life phase. The current service configuration, with a distinction between child/adolescent and adult mental health services (CAMHS and AMHS), impedes continuity of care.

Aim: To map professionals' experiences with and attitudes towards young people's transition from CAMHS to AMHS and the problems they encounter.

Methods: An online questionnaire distributed among professionals providing mental health care to young people (15–25 years old) with psychiatric disorders.

Results: Five hundred and eighteen professionals completed the questionnaire. Decision-making regarding transition is generally based on the professional's own deliberations. The preparation was limited to discussing changes with the adolescent and parents. Most transition-related problems are experienced in CAMHS, primarily with regard to collaboration with AMHS. Respondents report that the developmental age should be leading in the transition-decision making process and that developmentally appropriate services are important in bridging the gap.

Conclusion: Professionals in CAMHS and AMHS experience problems in the preparation of, and the collaboration during transition. The problems are related to coordination, communication and rules and regulations. Professionals attach importance to improvement through an increase in flexibility and more specialist services for youth.

KEYWORDS

adolescent psychiatry, child psychiatry, mental health services, the Netherlands, transition to adult care

1 | INTRODUCTION

Seventy-five percent of psychiatric disorders emerge before the age of 24 (Kessler, Chiu, Demler, & Walters, 2005) and mental health problems in adulthood can be predicted from childhood to 24 years

later (de Girolamo, Dagani, Purcell, Cocchi, & McGorry, 2012; Reef, Diamantopoulou, van Meurs, Verhulst, & van der Ende, 2010). Growing awareness that psychopathology that manifests in adolescence continues into adulthood has led to increased attention towards guaranteed continuity of care in this phase of life. The current service

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configuration, with a strict distinction between child and adolescent mental health care services (CAMHS) and adult mental health care services (AMHS), may impede continuation of care (van Amelsvoort, 2014). Previous research, mostly conducted in the United States and the United Kingdom, confirm the existence of barriers to the 'transition' from CAMHS to AMHS (Audit Commission, 1999; Davis, Geller, & Hunt, 2006). Differences in organizational culture and structure as well as the different methods and procedures presumably influence transition negatively (McLaren et al., 2013). Restrictive referral criteria in AMHS are an impediment to effective referral, as are strict age boundaries that both settings apply (Belling et al., 2014; Paul, Street, Wheeler, & Singh, 2014). A recent systematic review on transition indicates a mismatch between the ages at which care at CAMHS ends and the minimum age at which young people can be referred to AMHS. The type of care available at AMHS and CAMHS differs as well, with a lack of services available to young adults with (neuro)developmental disorders (Paul et al., 2014). Additionally, there seems to be a lack of knowledge within AMHS regarding various developmental issues specific to the treatment of adolescents (Singh, 2009; Treasure, Schmidt, & Hugo, 2005). The distinction between CAMHS and AMHS influences the young people's and parents/carers' experiences with mental health care around that transitional period: young people have indicated that they feel insufficiently involved, prepared and supported during the transitional process (Singh et al., 2010). In preparation of referral there is a lack of attention for potentially different therapeutic methods and expectations of AMHS with regard to independence (Hovish, Weaver, Islam, Paul, & Singh, 2012). The TRACK study investigated transition experiences of 154 British young people and showed that most young people experience a poorly planned and executed transition (Singh et al., 2010). Referral to the next service often only entails a written transfer of medical records, when 'transition' should be strived for: a comprehensive process in which the young person and his or her parents are gradually prepared for the changes in the life of and the care for the young person and are involved in the decision-making process regarding where the young person is referred to. In a successful transition, CAMHS and AMHS collaborate and share responsibility for the care of the young person for a short period (Paul et al., 2013). To summarize, 'the current service configuration of a distinct CAMHS and AMHS is considered the weakest link where the care pathway should be strongest' (Singh, 2009). The question rises whether comparable transition problems, as described in studies from England and the United States, also exist in the Netherlands. Despite the increasing attention for transitional psychiatry, no study to date has investigated the situation in the Netherlands. The current service configuration, with a systematic difference between the way care for young people before and after 18 years of age (the transition boundary) is organized and financed, could influence transitional policy and increase problems experienced at the interface between CAMHS and AMHS (van Amelsvoort, 2014). In 2014, a large longitudinal cohort study (MILESTONE; Singh et al., 2017) started that maps the transitional process and its outcomes in a cohort of 1000 young people in eight European countries, as well as the clinical and cost-effectiveness of a new transitional model. Anticipatory of the results of the MILESTONE study, Dutch professionals in mental health care have been consulted about their experiences with transition. The aim of this explorative study

was to map professionals' experiences with and attitudes towards young people's transition from CAMHS to AMHS.

2 | METHODS

A call for completing an online questionnaire, the Experiences and Attitudes Survey on Transition (EASY-Transition), was distributed in November 2014, among roughly 8000 mental health care professionals throughout the Netherlands that were on a mailing list of an organization for post-master education in mental health care. Recipients of the call were requested to distribute the call further. The questionnaire was targeted at professionals providing mental health care to youth/young adults (15-25 years old) with psychiatric disorders, whatever the type of service. Completing the questionnaire was estimated to take around 20 minutes.

2.1 | The EASY-Transition

The EASY-Transition consisted of 44 closed questions on experiences with and attitudes towards transition of youth from CAMHS to AMHS. The EASY-Transition was based on a previously developed questionnaire used in a study into transition of somatic care (van Staa, Eysink Smeets-van de Burgt, Eysink Smeets-van de Burgt, van Stege, & Hilberink, 2010) and adjusted for application within the psychiatric setting, based on (international) research (Belling et al., 2014; Hovish et al., 2012; McLaren et al., 2013; Paul et al., 2013; Paul et al., 2014; Singh et al., 2010) and consultation with experts.

The EASY-Transition consisted of three parts, the structure is presented in Figure 1. All respondents were asked for general sociodemographic information, after which respondents indicated with which groups of youth and/or young adults they worked. Depending on the target patient group(s) the respondents worked with, different questions with answers on a five-point Likert scale (1 = 'never' to 5 = 'always') were presented on the *transitional process* and *transitional activities*. Respondents were also asked about *problems with the transitional process* (seven-point Likert scale ranging from 1 = 'no problems' to 7 = 'a lot of problems') and completed a question regarding *important aspects* of good transition (seven-point Likert scale ranging from 1 = 'not important at all' to 7 = 'very important'). The EASY-Transition ended with prioritizing a number of *statements* on the necessity of improving health care transition.

2.2 | Statistical analysis

Data was analysed with IBM SPSS 21 (IBM Corp 2012). To establish differences in the way the transitional process was applied between the different groups of respondents (respondents working at CAMHS; AMHS; a service offering both Child and Adolescent as well as Adult Mental Health Care Services: CAMHS&AMHS and; adolescent or young adult team that offers care for youths specifically in the ages of 15 to 25 years old: ADO), an ANOVA was used. Standardized residuals and the Games-Howell-test (because of unequal group sizes and

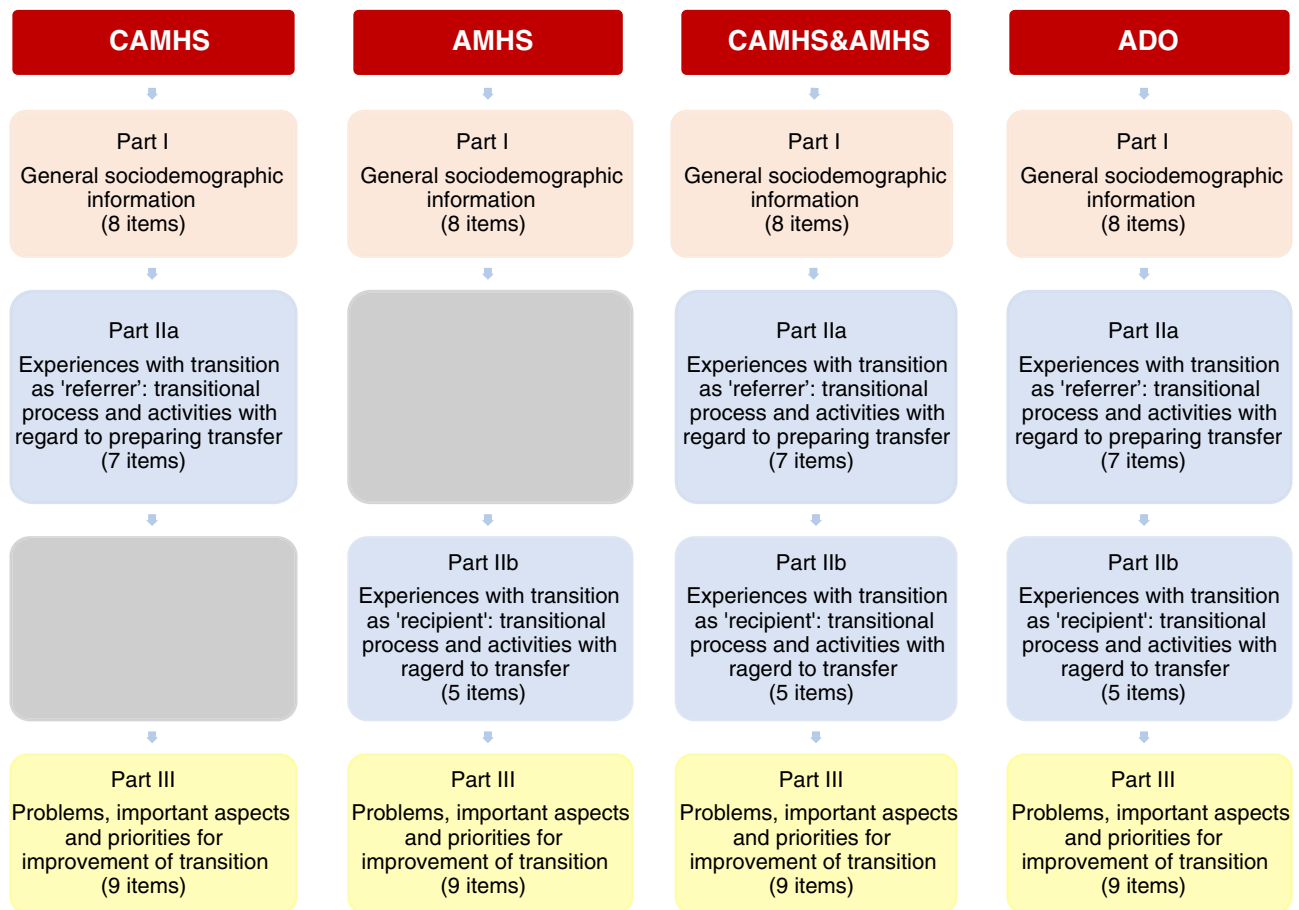


FIGURE 1 Structure of the EASY-Transition. *Note.* ADO, adolescent team (or young adult team, care for youths specifically in the ages of 15-25 years old); AMHS, adult mental health care service (after transfer); CAMHS, child and adolescent mental health care service (before transfer); CAMHS&AMHS, offering both child and adolescent as well as adult mental health care services

variances) were used to run post hoc analyses to detect significant differences between groups. The problems experienced with and the important aspects of transition were mapped with two scales: the 'transitional problems'—scale and the 'important aspects'—scale on which a principal axis factor analysis (with Oblimin rotation) was applied, were used to establish potential underlying subscales. Internal consistency was also calculated (Cronbach's alpha). Group differences at item-level and between (sub)scale totals were determined with an ANOVA and/or Kruskal-Wallis-test (for non-normal distributions).

3 | RESULTS

3.1 | Respondents

A total of 622 people completed the EASY-Transition. Those who did not deal with youth/young adults with a psychiatric disorder in their daily work as a health care professional ($n = 31$), or who closed the questionnaire immediately ($n = 58$) were excluded, as well as general practitioners (GPs; $n = 15$) who did not work in mental health care. This resulted in a net response of 518 professionals. It was not possible to calculate a response rate because we could not establish how

many health care professionals had received the call to complete the EASY-Transition.

Table 1 presents the demographic information of the respondents. The largest group consisted of psychiatrists. The respondents worked mainly within specialized mental health care (91.8%), whereas 6.8% worked only in generalist basic mental health care. Most respondents worked in a mental health care service with both children and adults. Professionals who worked in CAMHS or AMHS only were more or less equally represented. Almost everyone (98.5%) worked in patient care.

3.2 | Transitional process

Respondents were administered questions as 'referrer' (CAMHS) or 'recipient' (AMHS) if they had indicated to be involved in the transitional process, see Figure 1. Only 1.2% referred to AMHS before the age of 18 years, 25.3% referred around the age of 18 years and 42.7% referred after the 18 years of age. Roughly one in three (30.8%) referring respondents indicated that in general they did not refer to adult care (especially professionals in the CAMHS&AMHS and ADO group). Over 30% (32.6%) of referring professionals made their decision regarding referral based on individual deliberations, 11.2% followed the service's policies and 24.6% discussed transitional decisions with their professional team.

TABLE 1 Demographic information respondents (n = 518)

	n (%)
Sex, male	175 (33.8%)
Profession:	
Psychiatrist	121 (23.4%)
Child- and adolescent psychiatrist	104 (20.1%)
Healthcare psychologist	83 (16.0%)
Clinical psychologist	64 (12.4%)
Nurse	62 (12.0%)
Psychotherapist	39 (7.5%)
Pedagogue/youth worker (vocational education)	14 (2.7%)
Psychologist/pedagogue (with a master of science)	14 (2.7%)
Medical doctor	11 (2.1%)
Other	6 (1.2%)
Service type (multiple answers possible):	
Mental health care service (general)	237 (45.8%)
Private practice	151 (29.2%)
Specialized mental health care service	118 (22.8%)
General hospital	20 (3.9%)
Academic hospital	18 (3.5%)
Service for people with an intellectual disability	17 (3.3%)
Other ^a	14 (2.7%)
Working at:	
(service offering) both CAMHS and AMHS (CAMHS&AMHS)	172 (33.2%)
AMHS	139 (26.8%)
CAMHS	131 (25.3%)
Adolescent team (ADO)	76 (14.7%)

^aOther, like: GPs practice assistant for mental healthcare, Youth Care, Public Health Service, Rehabilitation Centre, Youth prevention.

Most professionals indicated to bring up the topic of transition to AMHS with youths and parents between a half and one year before the youth is expected to make the transition to adult care (36.7%), 32.7% does this less than a half year in advance and 10% more than a year in advance. A fifth (20.6%) stated to do this 'differently' (open-ended answer option to this question: 'I do it differently, namely...'), with answers indicating mostly that the timing of referral was dependent on the type of problems or that no transfer took place.

In preparing youth and their parents for transition (Table 2), referrers often provided a written referral and consulted the new clinician by phone, in contrast with activities such as applying a transitional protocol and appointing a transition coordinator (rarely to never). There were no significant differences between the different groups of respondents in the extent to which they prepare for transition. The 'recipients' paid attention to guiding transition as well, although differences between CAMHS and AMHS were discussed less frequently by 'recipients' than by 'referrers'. Compared to the other respondents, those working in AMHS paid the least amount of attention to differences in care ($F[2.152] = 16.340; P < .001$).

3.3 | Problems and important aspects of transition

Respondents indicated the amount of problems they experience as well as the importance of 13 aspects of transition (Table 2). The 'transitional problems'-scale and the 'important aspects'-scale have a (very) high internal consistency (Cronbach's alpha's of .94 and .96). Based on two 'principal axis' factor-analyses, two factors were identified in the problem-scale (Eigenvalue >1): one subscale (eight items, $\alpha = .91$) regards problems with the preparation for transition, the other (five items) regards problems with collaboration ($\alpha = .89$). In the important aspects-scale, no factors were identified.

The CAMHS respondents experienced more problems with transition than the CAMHS&AMHS group (means of respectively 3.9 and 3.4 on a 1-7 scale; $F[3.356] = 2.812; P = .039$). Professionals in AMHS experienced more problems with the preparation for transition than the CAMHS&AMHS group (means of respectively 3.7 and 3.2; $H[3] = 8.518; P = .036$). CAMHS professionals experienced more problems in collaboration than AMHS and CAMHS&AMHS (means of respectively 4.4, 3.8 and 3.7; $H[3] = 12.344; P = .006$). This specifically concerned a lack of clarity with regard to coordination, responsibilities at the time of transfer and the question to whom the youth can be referred. Respondents in the CAMHS and ADO group also reported problems with the knowledge of and experience with this specific age group in AMHS (means of 4.5 and 4.6). The AMHS professionals recognized the importance of this aspect (mean = 6.0) but viewed this as less of a problem (mean = 3.6). There were no group differences with respect to the importance of these 13 aspects (established with a Kruskal-Wallis-test because of a non-normal distribution).

3.4 | Priorities in improving transition

The EASY-Transition ended with 10 statements on points of improvement and a control-statement that no improvements were necessary (prioritized by two AMHS respondents, Table 3). Respondents were asked to select three statements that they prioritized. Most respondents indicated that not the calendar age, but the developmental age should be leading in determining where a young person receives care (CAMHS or AMHS). The ADO group prioritized that more specialist adolescent/young adult services should be provided to bridge the gap between CAMHS and AMHS (chosen as a second-place priority by all other groups). More than a third of the professionals felt that financial and organizational impediments to a smooth transition should be removed (primarily the AMHS and the CAMHS&AMHS groups). CAMHS and ADO professionals indicated that it is crucial that AMHS increase involvement of parents in their child's care.

4 | DISCUSSION

This study gives a first overview of the experiences with and attitudes towards transition between CAMHS and AMHS in the Netherlands. Referral from one health care provider to another when youth reach the age of 18 does not always take place, especially when care is

TABLE 2 Applied transitional activities and problems experienced with transition

Discussion and activities (means on a five-point scale)	CAMHS (n = 199) (mean [SD])	AMHS (n = 159) (mean [SD])
Announcing the (upcoming) transfer to AMHS	3.9 (1.2)	
Announcing the timing of the transfer to AMHS	3.9 (1.2)	
Discussing who the youth will be transferred to	3.9 (1.2)	
Discussing the (clinical) course of the disorder	3.9 (1.1)	
Discussing the changing roles and responsibilities for the youth and his/her parents in AMHS	3.6 (1.2)	3.1 (1.2)
Discussing the differences between CAMHS and AMHS and the consequences for the youth	3.5 (1.2)	2.5 (1.2)
<i>Mean 'discussion'</i>	3.8	3.0
Making/asking for a written referral	4.2 (1.2)	4.3 (1.1)
Consultation (by phone or face-to-face) with the new/last clinician(s)	4.0 (1.0)	3.8 (1.0)
Provide (a copy of) the medical records of the youth/request transfer of the medical records	2.5 (1.4)	3.9 (1.2)
Make use of/apply a transitional protocol/programme	1.4 (0.8)	1.5 (1.0)
Appoint a transition coordinator/worker	1.4 (1.0)	1.5 (1.1)
<i>Mean 'activities'</i>	2.6	2.8
	Problems (n = 360) (mean [SD])	Important aspects (n = 360) (mean [SD])
Aspects of transition (means on a seven-point scale)		
Flexibility in the timing of transfer	3.8 (1.9)	5.9 (1.5)
Willingness of the youth and parents to take/transfer responsibility	3.9 (1.6)	5.4 (1.5)
Promoting a good relationship and involvement between youths and parents	3.3 (1.7)	5.8 (1.5)
<i>Mean subscale 'preparation'</i>	3.5	
Structural collaboration and communication between CAMHS and AMHS	4.4 (1.9)	6.0 (1.4)
Knowing who the youth can be transferred to	4.0 (1.9)	6.0 (1.4)
Presence of sufficient knowledge of and experience with this specific age group in AMHS	4.1 (1.9)	6.0 (1.4)
<i>Mean subscale 'collaboration'</i>	4.0	
<i>Mean (all aspects)</i>	3.7	5.7

Note. Points of discussion and activities that were most and least frequently applied are presented; only the top-3 aspects of transition with the highest problem and importance scores are presented; means on a five-point Likert scale (1 = never; 5 = always) or on a seven-point Likert scale (1 = no problems/not important at all; 7 = a lot of problems/very important); SD = standard deviation; CAMHS: n = 98, AMHS: n = 91; CAMHS&AMHS: n = 116; ADO: n = 55.

TABLE 3 Top five statements on priorities in improving transition (n = 353)

Statements	n (%)
Not the calendar age, but the developmental age should be leading in determining where a young person receives care (CAMHS or AMHS)	213 (60.3%)
More specialist adolescent/young adult services should be provided to bridge the gap between CAMHS and AMHS	186 (52.7%)
Financial and organizational impediments to a smooth transition should be removed	132 (37.4%)
It's crucial that AMHS increase involvement of parents in their child's care	122 (34.6%)
More attention should be paid to the social and societal challenges that young people with psychiatric problems face	106 (30.0%)

Note. Respondents were allowed to prioritize a maximum of three statements; the table presents the five statements (from 10) that were prioritized most.

organized in adolescent teams. If referral does take place, this is usually after the age of 18. In contrast to what a study on transitional policy and practice in Ireland shows (McNamara et al., 2014), the age boundary in the Netherlands seems less strictly applied.

All half of the professionals bring up the topic transition more than half a year before the 18th birthday. According to the NICE guidelines (National Institute for Health and Care Excellence, 2016) on transition, planning of transition should start from the beginning of adolescence. Half of the clinicians in this study make decisions regarding transition based on own deliberations. There seems to be a lack of transitional policy, similar to the situation in Ireland (McNamara et al., 2014) and somatic care (Sonneveld, Strating, van Staa, & Nieboer, 2011). Most professionals, however, do give an active interpretation to the preparation for transition, although limited to discussing different aspects of transfer with the young person: joint CAMHS/AMHS clinician meetings being organized and CAMHS and AMHS aligning procedures (NICE, 2016) are exceptions. There is also room for improvement in the process after referral: AMHS professionals rarely pay attention to changes in care, such as the expected increasing independence and the more individualistic and less family-oriented approach. Similar to the UK (Hovish et al., 2012), collaboration between CAMHS and AMHS is limited to written referrals and telephone consultations. Compared to Irish professionals, Dutch professionals are less inclined to involve youth in the preparation of transition (McNamara et al., 2014). In line with conclusions Paul et al. (2013) drew about transition in the UK, referral in the Netherlands does not seem to entail more than ending care at one service and starting at another. However, like their colleagues in the UK (Hovish et al., 2012), collaboration and joint working was deemed important by Dutch professionals, but seem difficult to achieve in practice due to financial and organizational issues.

Most respondents experience moderate problems with organizing transition. Clinicians at CAMHS feel that professionals in AMHS are

less familiar with the problems and needs specific to young adults (in line with studies by Treasure et al., 2005). However, there seems to be a rise in knowledge of developmental disorders and processes in AMHS and the care available in the adult setting has expanded. The finding that mostly CAMHS professionals seem to have concerns about transition, can be understood from the perspective that child and adolescent psychiatrists are responsible for the referral of youth to AMHS. Nonetheless, transition in care is a responsibility for 'referrers' as well as 'receivers'. A lack of clarity with regard to criteria AMHS apply to referral (like described by Belling et al., 2014; Hovish et al., 2012; Paul et al., 2014) and the coordination of referral and responsibilities are barriers to good transition in the Netherlands as well. AMHS professionals mostly report problems concerning insufficient preparation of youth for transition. Investing in collaboration, aligning procedures, extra schooling on problems typical for young adulthood and synchronizing referral criteria and age would contribute to bridging the gap.

All groups of respondents consider good transition for young people between CAMHS and AMHS to be important. Respondents emphasize that the calendar age should be less rigidly applied to determine timing of transition and the importance of specialized age specific services (similar to wishes voiced by clinicians in the study by Hovish et al., 2012). By organizing care in adolescent teams and targeting youth in this vulnerable period specifically the gap between CAMHS and AMHS can be avoided. Youth tend to stay in care longer in adolescent teams, until there is no longer a need for care, eliminating the necessity of transfer. However, this study indicates that adolescent teams also experience problems with transition. The respondents that offer care from '0 to 100' seem to experience the least problems, although half of this group is made up of professionals with a private practice who treat patients of all ages in small independent services, who might not be very representative for all mental health care professionals. These respondents indicated to struggle with financial and legal obstacles that should be eliminated in order to better organize transition.

The current study also has limitations: although many clinicians have completed the EASY-Transition, the response rate is unclear. The EASY-Transition may have been completed primarily by professionals with an affinity with transition, potentially overestimating the importance of transition. Additionally, half of the group of CAMHS&AMHS professionals is made up of professionals with a private practice (where transition is mostly an administrative process). Despite these limitations, this study provides a first overview of what transitional activities Dutch mental health professionals apply and what they consider relevant in the planning and organization of transition.

Another limitation is that this study only maps experiences and views of mental health care professionals. The experiences and preferences of youth and their parents are more virgin territory. Problems with transition can influence the (appropriateness) of care youth receive and with that, potentially, their long-term mental health. To establish whether a gap between CAMHS and AMHS influences youths' mental health, longitudinal research needs to be conducted.

The MILESTONE study aims to map experiences of youth and adults and the long term effects on mental health, whereas assessing potential ways to improve the transitional process. Academia and clinical practice should join forces in the future to guarantee continuity of care for youth who maintain a need for mental health care throughout their transition into adulthood.

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CONFLICT OF INTEREST STATEMENT

There were no conflict of interest.

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