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EDITORIAL

Transitioning from the child and adolescent to the adult mental health services: An unresolved challenge and an opportunity☆

Transición de la atención en salud mental infantil y adolescentes a la atención en adultos: un desafío no resuelto y una oportunidad

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Seventy five per cent of adult mental health issues begin in childhood, adolescence or when the person reaches the age of 18.[1] This indicates the importance of focusing efforts on care during these years.[2] Becoming an adult means gaining independence, with ensuing new pressures and responsibilities, which may worsen or give rise to the appearance of new mental health issues.[3] In our environment a distinction is usually made between the teams caring for minors and those caring for adults. This entails a transition between professionals during a period of great sensitivity on a psychic level. It is also known that this process may worsen the prognosis of mental illness,[4] and it is our belief that the transition between the different teams must be made with the utmost care as a result.[5]

Despite recent advances,[6,7] this transition is still an unresolved area and often involves risk of disassociation.[8,9] The loss of patients may occur when the child healthcare period terminates,[4] or when the adult healthcare period begins.[6] The improvement in survival of chronic somatic diseases (diabetes mellitus or cystic fibrosis, for example) initiates interest in this transition process. In mental health, there is less probing into the issue, comprehension is different and in addition to this, the approach to mental health issues

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between child teams and adult teams is different.[8] There is no clear consensus regarding successful transition, nor any appropriate selection of the patients requiring continuity of intervention.[4] Also, there is a lack of validated tools of measurement.[10] Several studies show that patients, families and even the professionals themselves have a poor perception of this transition.[8,11–13]

The difficulties in this process may give rise to the interruption of follow-up. Aspects relating to the patient and their families, with the professional, or with the execution of the process itself, should be taken into account. In the patient, discontinuity may be understood from ambivalence or negation of mental diseases,[14] from the difficulties attached[15] and experiences of chronicity.[16] It seems that minor symptoms, with no medication, with no admissions and no comorbidity, similarly to those affecting neurodevelopment and emotional disorders and emerging personality are at greater risk of inappropriate transition. This was discovered by Singh et al. in the TRACK study.[4] As far as the families were concerned, the parents appreciated being present throughout the whole process.[17] However, several studies referring to somatic diseases reported that it could be useful to promote patient autonomy for better continuity.[18,19] Understanding mental suffering, the type of intervention or the degree of family intervention in management varied between professionals of children and those of adults, with an impact that could be negative.[4,8] Lastly, the different studies also analyzed aspects which concerned the organization of the transition process in itself. In fact, one essential cause for inappropriate transition is the non-provision of a plan.[4,20] Choosing transition at an inappropriate life moment, based on rigid criteria, without including coordination or adequate information, may lead to its failure.[8,11,16]

Putting the focus on the execution of the transition, the primary initial recommendation is the creation of a plan of action.[4,20] Different studies have demonstrated the effectiveness of the transition programmes, with higher satisfaction for patients and professionals.[17,21] Nieboer et al. found there was an improvement after one year of implementation of appropriate transition measures for different somatic diseases. Special emphasis was placed on coordination between the teams and patient autonomy.[19] Gilmer et al. found that the patients with mental disorders integrated into a transition programme had more follow-up visits when passing to adult teams, compared with those who made the transition without any specific progammes.[22] It should be noted that the Managing the Link and Strengthening Transition from Child to Adult Mental Health Care (MILESTONE) programme, was developed between 2014 and 2019 in several European countries, but did not include Spain. The idea was to improve the transition process.[6] They first detected differences regarding the organization of care[23] and the training of adult and child psychiatrists between different countries. One highly relevant data was that only in Ireland and the United kingdom was the transition something that was specifically heeded.[9] They developed, in turn, tools of measurement for the assessment and detection of patients who, when requiring follow-up, were under great risk of being lost.[24] The result of this assessment was that they confirmed that patients considered to be severe more frequently continued with treatment. Finally, in this project a randomized clinical trial was conducted with 2 groups: in one of them they applied a transition assessment tool they had developed (and reported to patients and clinicians of the results) and in the other a transition of use. Although there was improvement in both groups, over the months, this improvement was faster in the first group.[25]

Several recommendations were made, both in somatic diseases and in mental diseases, for an appropriate transition process. All of them coincided in the importance of including information which had been agreed with the patient and the families, making the changeover at the best possible moment, with a period leading to suitable adaptation and with specific training in management of the process itself. They also recommended simultaneous follow-up between the child team and the adult team for a period of time.[8,16] The involvement of all professionals, always clarifying that responsibility of patient management at all times, is a relevant aspect. The process should be flexible enough to promote the adaptation n to each particular situation, as was determined by Young et al. in patients with activity and attention disorders.[26] The TRACK[27] study recommendations or the NICE guidelines for patients who use social services[28] are similar in nature.

One point to emphasize would be the importance of developing the right skills for appropriate transition, for professionals of children and adults.[29] Spain is practically the only country which does not offer any specific training in child psychiatry, and this discipline is particularly affected by the transition problem.

In an environment of integrated child and adult care in mental health centres, where there is proximity between the different teams involved, we suggest including the following recommendations as a plan of action for the transition process:

- In the months prior to becoming of age, when the child-teenager therapist suggests it, and in keeping with the clinical status (preferably stability) and life stage (beginning of further education, becoming independent, etc.) they will notify the patient in good time, of their intention to transfer them to follow-up with the adult team.[27,28]
- They will explain the process to be followed to the patient and the family from the understanding of the moment. The disadvantages will be discussed regarding time, mode of desired treatment, psychopathological aspects, etc. in a close and empathetic manner.[27,28]
- Case coordination with the adult team will be made in at least one joint meeting.[27,28]
- They will be given an appointment with the adult team, after which a new appointment will be made with the child team so as to devise and design the first experience with the new professional. They will cover the saying goodbye to the previous therapist and initiation into the care of the new one. This period may be extended to encourage con-

tinuity, but without any confusion as to the responsibility of care.[27]
- Family involvement will be encouraged in a manner appropriate and adaptable to the process, from the assumption that the great majority of patients will continue living with their family of origin.[27,28]
- The primary care doctor will be notified of the follow-up transition to the adult team.[28]

These measures may encourage a better transition to the adult team, enhancing continuity of intervention and care, whilst considering both the vulnerability of the patients as they pass into adult life and the persistence of their mental health issues.

Following these general lines of action, this process may always be more flexible, in the search for better continuity of care required by the patient, in keeping with their disorder and their particular characteristics.

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