An exploration of the process and emotional experiences of young people transitioning between child mental health services (CAMHS) and adult mental health services (AMHS)

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A thesis submitted for the degree of Professional Doctorate in Psychoanalytic Child and Adolescent Psychotherapy

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Date of submission for examination: May 2022

Contents

Abstract

This study explores the process and emotional experience of transition from child mental health services (CAMHS) to adult mental health services (AMHS). Following a review of the literature on relevant studies, including those on service-level preparation and planning and psychoanalytic literature, the researcher notes that there are few studies in relation to how YP describe the emotional experience of transition. Therefore, a core aim of this study is to explore the emotional experience of transition for YP within the developmental period of late adolescence.

To fulfil the aims of this mixed-method study, it is separated into two parts. In Study One, an audit that describes the population of YP in CAMHS requiring mental health care transition is given. This also includes which service YP are routinely referred to and by whom. Study Two explores the emotional aspects of transition for three YP. Here, the researcher focuses on the internal worldviews of YP, as demonstrated in their readiness or retreat from transition. Interpretative phenomenological analysis (IPA) is used to analyse the data along with countertransference reflections. Three overarching superordinate themes and six subordinate themes are selected for detailed exploration. The study found that each participant's own personal disposition, the way they used their minds, including psychological defences, and their capacity for emotional development, is a significantly important factor in affecting transition success.

In the conclusion, the researcher's identity and position as a child and adolescent psychotherapist is explored. Strengths and limitations of the study are discussed and potential areas for further research are given.

Introduction

Most young people (YP) in the United Kingdom who develop mental health difficulties are referred to child and adolescent mental health services (CAMHS) for treatment. Although some CAMHS are mandated to treat YP up to the age of 25, the upper age limit for accessing these services is usually 18 years old. If a young person needs ongoing treatment after that age, their care is provided by adult mental health services (AMHS). The transition from CAMHS to AMHS is an area of concern for some YP, their families and the services themselves (Department of Health [DoH] 2014).

This concern was raised, among others, during a Care Quality Commission (CQC) inspection (2017) in the National Health Service (NHS) trust, for which the current researcher was employed as a child and adolescent psychotherapist in training and for which the researcher continues to work as a qualified clinician. The CQC inspection highlighted the need for improvements to ensure optimal transitions for the YP requiring ongoing care. Based on the National Institute for Health and Care Excellence (NICE) guidelines (2016) on the transition from child to adult services, a previous audit aimed to incentivise improvements in the transition experience. However, the audit was never fully completed, nor did it consider YP's transition experiences.

In addition to the trust's drive to improve outcomes for transitional care, during the researcher's clinical training as a child and adolescent psychotherapist, clinical work with two YP, both approaching 18 years old and in need of transition, sparked clinical interest in this area of study. Although both YP received the same intervention in CAMHS over a comparable period – once-weekly psychotherapy for just over a year – and both had similar symptoms, their engagement in the transition process was very different. This led the researcher to take a particular interest in this area of study and consider what, in addition to service delivery and provision, may help or hinder the transition from CAMHS to AMHS.

This study went beyond the quantitative data from the previous audit to understand the inner and emotional experiences of the YP during the transition process between CAMHS and AMHS. A mixed-methods approach with quantitative and qualitative elements was adopted for this study. By using these different methods, the researcher hoped to comprehensively examine both the process and the emotional experience of transition. The researcher's identity and position as a child and adolescent psychotherapist led to a psychoanalytically oriented approach to the study, including an understanding of unconscious dynamics and processes.

It is hoped that this doctoral study will add to the literature in this area and thus enhance existing research.

Aims of the Study

Study 1)

The first study aimed to gather data on the number and characteristics of YP requiring transition from CAMHS to AMHS and the clinician's role in the referral process. A service audit was conducted to collect this quantitative data. Furthermore, the goal of Study 1 was to determine the extent to which the NICE guideline (2016) on transition was followed in transitioning YP between services. This study's data and findings provided the context for the rest of the study.

The second study, building on the data from Study 1, used a qualitative design that allowed the researcher to hear the views of the YP moving between services directly.

Study 2)

This qualitative study was conducted in the form of in-depth and open-ended interviews with three YP who were transitioning from CAMHS to AMHS. The data gathered enabled the researcher to gain a comprehensive overview of the YP's direct experiences.

The data was analysed using interpretative phenomenological analysis (IPA), which aims to understand an individual's relationship to the world through their meaning-making (Smith et al., 2009).

Study 2 aimed to determine how the participants experienced the transition emotionally. This study took into account that the transition process is steeped in an adolescent developmental task that sends the young person back into early, even infantile, states of mind (Diem-Willie, 2021; Waddell, 2002, 2018). Another study goal was to examine the impact of what the YP themselves brought to the transition process and outcome. This included looking at each participant's internal worldview, as manifested in their readiness for or withdrawal from the transition process. This may help explain why some YP do 'better' with the transition process than others and why some of them 'fall through the cracks' of the services provided (Singh & Tuomainen, 2015; Singh, 2009).

Project structure:

The design and findings of the project were structured as follows to address the aims of this study. First, a review of the literature on aspects of service preparation and planning during the transition and on a psychoanalytic understanding of adolescence is presented. The quantitative study design used for the service audit for Study 1 is then introduced and critiqued. The data from Study 1 are then analysed. Study 1 gives a general overview of the characteristics of the YP needing transition, the services they are referred to, and when and by whom.

Next, the intentions for Study 2 and its qualitative study design are presented and evaluated. In this study, the researcher drew directly on the experiences and narratives of the YP through semi-structured interviews with three YP transitioning from CAMHS. The data were analysed using interpretative phenomenological analysis (IPA), which allowed for an exploration of the emotional aspects of the data. After describing and discussing the findings from the second study, the strengths and limitations of the study are noted, and recommendations for future areas of study are provided. In addition, the impact of the researcher's own subjectivity, considering her psychoanalytic background, is contemplated and consideration is given to countertransference reflections.

Finally, a general conclusion is provided. It discusses how the study was conducted, what worked well and what proved challenging and unexpected, such as creating the study design before the COVID-19 pandemic. The study’s key findings are summarised, and the extent to which the results add to the literature in this area is outlined.

Literature Review

This chapter includes a discussion of the relevant literature on the developmental period of adolescence and its implications for the transition from CAMHS to AMHS. The chapter is divided into three parts. Part 1 begins with an operationalisation of the key terms used in the study. These definitions formed the basis for the search strategy and the process of identifying relevant literature. Part 2 then describes and critically evaluates a systematic review of the literature that addresses the service and organisational processes, as well as the personal experiences of this group as they transition from child to adult mental health services. Finally, Part 3 addresses psychoanalytic perspectives on adolescence, and the rationale for and aims of the current study are explained.

A systematic literature search was conducted to examine YP's experiences of transitioning from child to adult mental health services. Databases were explored, hand searches were conducted, and grey literature was consulted. The review was undertaken and compiled to critically appraise existing research to provide current knowledge about the developmental phase of adolescence and the experiences of YP as they move from child to adult mental health services. The following section includes a summary of the search process, a description of the studies reviewed and a critical synthesis of the findings.

Part 1: Operationalisation of Key Concepts and Literature Search Strategy

Keywords and terminology were first identified and explored to contextualise this study's topic of interest. Then, the key terms are placed within a particular social, political and cultural framework related to this study. It is acknowledged that the meaning of some terms will vary depending on the context. Nevertheless, a working definition of each concept is presented, which constitutes the basis of the literature review.

'Adolescence' and 'YP'

The developmental stages of childhood, adolescence and adulthood pose difficulties in terms of their conceptualisation and distinction by age. Development is not a linear process, and there are no clear distinctions regarding the exact age ranges that can be classified as pure adolescence or adulthood. In 1904, the pioneering psychologist and educator Stanley Hall wrote a landmark book on adolescence in which he elaborated for the first time that it was 'more than puberty, extending over a period of years from twelve or fourteen to twenty-one or twenty-five in girls and boys respectively' (Hall, S in Waddell, 2018, 4). Hall thus defined adolescence as a newly designated age group, a stage of life separate from childhood and adulthood, as much a psychological matter as a biological one. Despite this, legal definitions of

‘child’ or ‘children’ are used in the UK to define a person under the age of 18 as a child (Children Act, 1989).

In the UK, the term ‘adult’ is similarly defined, in legal terms, as someone over the age of 18. Yet, becoming an adult can be viewed as a socially constructed process in which legal responsibilities are acquired, such as the right to vote, and expectations are created, such as maturing out of education and leaving the family home (Heinz, 2009). Furthermore, Catty (2021) highlighted the shift away from the term ‘adolescents’ to a preference for ‘young people’, which has been adopted by services such as CAMHS and, to some extent, society more broadly. However, the psychoanalytic emphasis and distinction between the two terms are that ‘adolescence’ involves ‘an understanding of the reworking of infantile drives, traumas or dynamics in this transitional state’ (Catty, 2021, 191). Consistent with this description, ‘adolescence’ will be considered in this sense throughout this chapter and across the study.

Waddell (2018) argued that chronological age did not accurately indicate biological, psychological or social maturity. Instead, progress can be more precisely determined by a psychological state of mind than by a defined notion of ‘age group’. This view was supported by Arnett (2007), who asserted that the pace of maturity and transition to adulthood varied greatly from person to person. However, the World Health Organisation (WHO, 2022) has defined adolescence as a stage between the

ages of 10 and 19. Yet, as Waddell (2018) suggested, the duration of adolescence has increased in recent decades as more YP remain in education longer and continue to live in the family home. Catty (2021) noted the shift from ‘adolescents’ to a preference for ‘YP’, which has been adopted by services such as CAMHS.

Nevertheless, child and adult services are usually differentiated by strict age boundaries. Health services in the UK define ‘adulthood’ as 18 years of age, leading to a transition from child- to adult-oriented services. The literature uses phrases such as ‘transitioning teenager’, ‘late adolescents’ and ‘young adults’ interchangeably. These phrases indicate that for this group moving from adolescence into adulthood, there is no clear definition of when this period ends (Gaudet, 2007). Currently, the health care literature appears to support the view that people transitioning from adolescence to adulthood are between the ages of 16 and 25 (Davis, 2003; Singh et al., 2008). Furthermore, it seems that there is more agreement about the beginning of this stage of development, namely that ‘the dawn of adolescence is marked by the special consciousness of sex’ (Hall, S in Waddell, 2018, 4), while the point at which adolescent development is considered complete and thus adulthood begins is far less clear. As Moses Laufer observed, ‘the end of adolescence cannot be described with the same certainty as the start’ (1975, 13).

For this reason, the terms ‘adolescent’ and ‘YP’ are used interchangeably in this study according to their occurrence in the literature.

‘Transition’

According to the *Oxford Dictionary*, the broadest meaning of the word ‘transition’ is ‘the process or a period of changing from one state or condition to another’. In the context of UK health care services, the definition of ‘transition’ adopted at the policy level is: ‘The purposeful and planned process that addresses the medical, psychosocial and educational/vocational needs of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-orientated healthcare systems’ (NICE, 2016). In the literature on the transition from child to adult mental health services, the concept of transition can be viewed from two perspectives (Singh et al., 2010). First, from a developmental perspective, the transition to adulthood is a crucial stage of emotional, physiological, psychosocial and personal development. YP begin to develop adult roles through tasks such as separating from family, deciding on a career path, and defining their sense of self in a social context. Second, from a health care perspective, the transition involves moving from one service to another when reaching certain age milestones, typically at the age of 18. In this study, both perspectives on transitions are considered. Study 1 is concerned with the latter definition of transition, which is viewed as a temporal event best described as a transfer from one care provider to another (Singh et al., 2008). This definition is a more medicalised way of looking at transitional care as a transaction from one care provider to another.

Search strategy and terms:

Three databases were searched to identify relevant literature for the study's quantitative and qualitative elements: PsychINFO, PEP Archive and MEDLINE. The search was conducted using the appropriate words and phrases discussed above, including synonyms for YP (e.g. ‘adolescent’ or ‘young person’) and acronyms (e.g. ‘CAMHS’ and ‘AMHS’). Boolean operators were used to combine search terms with the words ‘AND’ or ‘OR’. Truncation was used to ensure that all relevant permutations of a word were identified in the search. When searching for documents for Study 1, a date limit of 2000 onwards was applied. However, there was no date limit for psychoanalytic papers relating to Study 2, as these articles are currently relevant, unlike government legislation, policy and guidance, which change over time.

Keywords, their truncations, and relevant database-specific subject headings were used, targeting three subject areas:

Transition: including transition*, interface*, transfer, continuity of care, CAMHS to AMHS, child and adolescent mental health services to adult mental health services, becom* adult.

Age: including young, youth*, teen*, adolescence*, CAMHS, child and adolescent mental health service or age-group criteria

Mental health: including CAMHS, child and adolescent mental health service*, psychiatr*, mental health, youth service.

A separate search was conducted specifically for works with a psychoanalytic perspective on the developmental period of adolescence. The above three databases and search terms or phrases were used, as well as the following:

Psychoanalytic perspectives: psychotherp*, late, adolesce*, teen*.

A hand search was also conducted to identify relevant studies. This involved manually searching the references of identified papers to find articles that may not have been indexed in the journal databases.

Inclusion and exclusion criteria:

As noted above, the purpose of the review was to fulfil both aspects of this project: Study 1 and Study 2. Study 1: to consider the transition from CAMHS to AMHS at the organisational and service level; Study 2: to explore the lived experiences of YP moving from child to adult mental health services.

Qualitative studies and some mixed-methods studies were most appropriate to meet the aims of this study, namely, to explore YP's perspectives on transition, and were

therefore included in the review. All articles were screened using the following criteria:

Inclusion criteria:

-peer-reviewed qualitative and quantitative research;

-studies investigating the experiences or perspectives of YP, adolescents or teenagers; and;

-studies exploring the transitions between child and adult mental health services.

An initial review of the literature revealed a lack of research specifically addressing YP's experiences of transition (only *n* = 6). Consequently, studies that included both YP and the experiences of their relatives and/or professionals (*n* = 3) were also included in the review to best reflect YP's perspectives.

Exclusion criteria:

-not in the English language,

-unpublished studies,

-experiences of parents and/or professionals only and

-studies from before 2000 (only for papers related to Study 1 of the project).

Search process:

The search yielded a total of 83 studies on the transition from CAMHS to AMHS. After duplicates were removed, the total number was reduced to 46. A review of titles

and abstracts using the inclusion and exclusion criteria reduced the corpus to 25 articles for further review. This reduction occurred because most studies evaluated transitions in other contexts, such as generic health care, education, prison or care systems.

The full texts of the 25 studies were examined in detail for inclusion and exclusion criteria, resulting in 18 studies available for in-depth review. After searching the reference sections of the studies, two additional studies were excluded. Therefore, a total of 16 studies were included in the final literature review on YP's experiences of transition, service preparation and planning for transition.

The initial search for journal articles on adolescent development from a psychoanalytic perspective yielded 107 papers. Another search was conducted, adding the term 'late' to psychotherapy* and adolescence* to narrow the search field. This search yielded 15 articles, of which six were included. Nine studies were excluded because they were related to forensic CAMHS or neuroscience. An additional three texts were identified by hand, that is, by reviewing the reference list of the six papers identified in the database. In total, nine texts were included in the final literature review on late adolescent development.

Part 2: Literature on Service Preparation and Planning

Policy and practice guidance:

According to the UK government's mental health strategy, 'No Health Without Mental Health' (DoH, 2011), the transition from CAMHS to AMHS would be improved through early planning and consideration of YP's views by providing appropriate and accessible information and through joint commissioning of services. It has been argued that the government's mental health policy document 'Closing the Gap' (DoH, 2014) ended the 'cliff edge' of lost support by assisting NHS England in developing service specifications for the transition from CAMHS. Furthermore, to address widely documented difficulties, NICE produced the following guidelines on health care transitions, covering both health and social care services, including mental health (NICE, 2016).

Statement 1: Transition planning should begin early.

Statement 2: An annual meeting should be held between services.

Statement 3: A named worker should provide support before, during and after the transition.

Statement 4: Introduction to adult services should occur prior to the young person's transition.

Statement 5: The young person should be given the opportunity to engage in services.

Current policies and NHS directives:

Since the publication of the NICE Guidance on Transitional Care in March 2021, the UK House of Commons Committee has published the 'Health and Social Committee Report: Children and Young People's Mental Health'. This report addressed, among other things, access to health care during the transition to adulthood and compiled the concerns of YP in need of transitional mental health care. These concerns included the abrupt transition to adult services at age 18. In addition, drawing upon the work of Professor Pat McGorry (2007), the enquiry and subsequent report noted that the current approach to transition is outdated and that the current model of care needs to be revised. McGorry (2007) highlighted that 'the transition to adulthood is very different from what it was 40 years ago. It takes a longer period of time. It is much more complex and fragile' (p.21).

The report recommended that NHS England move away from the current model of care (in which age 18 is often the rigid cut-off for CAMHS eligibility) to one that provides care from ages 0–25. In response to the Commons Committee report, the UK government announced (2022) that it would consider the recommendations, including the transition from children to adult services. While the government did not immediately respond to the report's recommendations on transition, it acknowledged that improving access and outcomes for young people in need of mental health care is a national priority and pledged funding to accelerate plans to support YP (including

university students) at risk of falling through the care gap. In addition to financial support, the government conceded that it needed to address the lack of care continuity between services, including the different thresholds. It was also noted that more expertise was needed in a growing workforce to accommodate the increasing YP population requiring mental health care. With this in mind, the government pledged that by the end of the 2023–2024 fiscal year, there would no longer be age-based thresholds and that all services would be equipped to meet the needs of 18- to 25-year-olds. However, the outcome of this commitment remains to be seen.

Existing literature on service provision:

The organisation and delivery of mental health services involve transitional care and management, particularly when considering the transition from CAMHS to AMHS, which coincides with the developmental period of adolescence. During adolescence, existing psychological problems can become increasingly complex. In addition, because this age group has a greater propensity to engage in risk-taking behaviour, they are at greater risk of non-engagement with services (Singh & Tuomainen, 2015). Furthermore, Paul (2014) argued that adolescence represents a risk period for the onset of serious mental health difficulties such as depression and psychosis; therefore, good continuity of care is needed. Yet, according to McGorry (2007),

‘discontinuity in the care system often occurs at the time when it should be the strongest' (p.53).

A major study looking at the transition from CAMHS to AMHS in the UK is the TRACK study conducted by Singh et al. (2010) in 2007–2009. TRACK was a multimethod study of YP’s transition between CAMHS and AMHS in the NHS. This large-scale study was conducted in six mental health trusts in England. It included an investigation of policies, procedures and service provisions related to the transition of adolescents with mental health difficulties. The findings from this comprehensive study have been interpreted by several authors (including those cited in this chapter), highlighting its importance and pioneering nature in an otherwise under-researched area.

The results of the TRACK study revealed that despite guidelines for the transition of YP with mental health difficulties, there were several differences in practice. For example, the age at which conversations about transition began varied across services, as did the time it took to transition (Singh et al., 2010). In addition, Singh et al. (2010) found that although guidelines and protocols placed service users at the centre of the transition process, there was nothing specific in the services studied to prepare YP for their transition. Instead, services focused on practical and procedural processes rather than the experiences and needs of the individual.

Singh et al. (2010) found that, in a sample of 154 YP, 58% were accepted by AMHS, while 42% of those who had been identified as potential referrals to AMHS did not transition. Of those who did transition (*n* = 90), only four YP experienced a successful transition. In this case, transition success was characterised as meeting the following criteria: continuity of care (including post-transition engagement with the new service), at least one transition planning meeting and evidence of cooperation between the new and previous services. Several reasons were given for not transferring to AMHS. According to Singh et al. (2010), the most commonly cited reason was that it was believed that the referrals would not be accepted by AMHS, which discouraged many CAMHS practitioners from even considering referrals. However, Singh et al. (2010) determined that more than 88% of referrals to AMHS were accepted, suggesting that misinformation and misunderstanding about referral criteria and thresholds could be a barrier to YP accessing appropriate ongoing support. Singh et al. (2010) asserted that the most predictive factors for the acceptance of referrals included a diagnosis of a severe and enduring mental disorder, a prescription for medication at the time of transition and/or if a YP had been hospitalised for their mental health while in CAMHS care.

A separate and more recent study by Appleton et al. (2019) systematically reviewed the literature on post-transition outcomes. The criteria included literature dated December 2017 relating to mental health or service user outcomes for YP. The initial

search yielded 18,287 papers, of which 213 were screened in full text, and a further 13 papers were included in the review, representing 10 cohorts of YP post-transition. Exclusion criteria included research on YP with various comorbidities such as physical illness, neurological conditions or severe learning difficulties. Overall, most transitions were rushed and lacked coordinated care. Many YP did not engage in the transition process, and of those who did, very few had good post-transition outcomes. However, as this study was only concerned with service use outcomes, it is not clear what impact these outcomes had on service users and their mental health. Appleton et al.'s (2019) findings suggested that YP were often ill-equipped for transition. Several studies on YP's experiences have highlighted their poor preparation for transition. These will be discussed in the next section (Broad et al., 2017; Singh et al., 2010).

Facilitation and barriers to a successful transition:

Several barriers to a successful transition from CAMHS to AMHS have been identified. One such obstacle is the age barrier between services. For example, some adult mental health services do not accept referrals for youth under the age of 18. On the other hand, some child and adolescent mental health services do not accept referrals for YP approaching 18. This has led to inconsistencies and confusion about where YP should be referred to and when. In a review of the

literature and policy (from 2006–2008) on mental health care transitions, Singh (2009) found that, unlike physical health care, for which there were new practice models to improve the transition between services at the time, there was comparatively little guidance for adolescent mental health care in the UK.

More recent studies (Appleton et al., 2019; Paul et al., 2018) have suggested that this is still the case, although there is growing awareness of the need to take a holistic view of the experience of transitioning from CAMHS to AMHS. Singh (2009) argued that the concept of ‘transition’ has two distinct meanings that are not always complementary: developmental transition and health care transition. These critical distinctions still seem to impact understanding of the transition from the CAMHS to the AMHS and its wider implications. For example, Paul et al. (2014) contended that transitional care in mental health was often viewed in medical terms rather than as a human experience for consideration on an individual basis.

Paul et al. (2014) analysed data from TRACK’s retrospective case-note analysis (Singh et al., 2008) of YP’s progression through CAMHS to AMHS to determine what could be considered a ‘transfer’ instead of a ‘transition’ and how both could be evaluated. The authors used three criteria in their evaluation: continuity of care, joint planning and care and clear information transfer. These areas were identified as prerequisites for optimal transition in the original TRACK study. The authors distinguished that transfer was often ‘discussed as a suboptimal version of transition’

but was ‘distinct from transition’ and therefore ‘should be investigated alongside transition’ (Paul, 2014, 8). This seems to be the first time such a distinction between transition and transfer has been made in the literature. For example, a transfer is seen as the termination of care by one provider and transfer to another, similar to an event or transaction between services.

Furthermore, Paul et al. (2014) argued that a transition is a therapeutic process. As such, a transition is more likely to provide YP with continuity of care successfully. Nevertheless, the study provides evidence of the inferior quality of transitions: less than 5% of transfers met the criteria for an optimal transition. However, the case notes examined may not have taken into account the quality and content of service delivery for a larger population, as case notes can be idiosyncratic and do not always accurately reflect the nature of the engagement.

Hovish, et al. (2012) aimed to describe the experiences of CAMHS users, parents and professionals in relation to the transition from CAMHS to AMHS in the UK. A qualitative methodology consisting of semi-structured interviews and thematic analysis was used to analyse the data. The study was also part of a wider TRACK study (Singh et al., 2008), which aimed to explore the transition process from CAMHS to AMHS. A total of 27 participants were interviewed for this study: 11 YP, six parents, three CAMHS keyworkers and six AMHS keyworkers. Ten YP were interviewed individually. The findings suggested that the YP had mixed and varied

experiences of transition. Positive experiences of transition included gradual preparation with the support of consistent workers. Abrupt changes and inconsistencies between workers were perceived as negative.

Similarly, Singh et al. (2010) found that other life transitions strongly influenced the transition experience. These included changes in housing, pregnancy and beginning a career. Singh et al. (2010) concluded that the cumulative impact of multiple transitions on YP influenced their transition experience. The experience was likely more positive if the transition to mental health care was a gradual process tailored to the YP's needs. The study also highlighted the need for CAMHS and AMHS to work collaboratively to improve the transition experience and outcomes for YP.

These findings were supported by Paul et al. (2013), who sought to identify the organisational factors that might facilitate or impede an effective transition from CAMHS to AMHS. Thirty-four semi-structured interviews were conducted with health and social care professionals working in CAMHS and AMHS in four NHS mental health care trusts in the UK to explore cultures, structures, processes and resources that impact the staff and therefore influence YP's transition from CAMHS to AMHS. This study formed the organisational strand of the TRACK (2008) study, and a multi-perspective, mixed-methods approach was adopted. The researchers identified a cultural disconnect between CAMHS and AMHS that could adversely affect the collaboration between services and ultimately lead to poor quality transitions.

Differing beliefs, misconceptions and ways of working were seen as barriers to effective joint working practices. For example, CAMHS was seen as more person- or family-centred, while AMHS spoke ‘a different language’ and focused more on medication and diagnosis. Both CAMHS and AMHS acknowledged the challenges YP and their families faced during and after the transition. The services also agreed that disruption to care had negative consequences. However, more positive signs of joint work were evident in collaboration with external agencies.

In the literature reviewed, little attention was paid to the factors that facilitate a successful transition. It was noted that a successful transition occurs when YP have the opportunity to be introduced to the new adult service, including the worker responsible for their transitional care (Paul et al., 2014). In addition, a successful transition was found to be facilitated by informing YP about what to expect from the new service (Singh et al., 2010; Broad et al., 2017). Singh and colleagues (2010) suggested that successful transitions were more frequently cited when YP had clearer insights into their ongoing treatment needs. Furthermore, as highlighted in several studies (Singh, 2010; McLaren, 2013; Hovish, 2012), care transfers were successful when there was collaboration between the two services and open communication.

Without communication between services and coordinated care planning, the limited research available for study in this chapter suggests that the transition from CAMHS

to AMHS can be problematic for both YP and professionals (Singh et al., 2010; Paul et al., 2014). However, research findings should be interpreted carefully and objectively. For example, because the TRACK study focused on samples from only six sites in London and the Midlands, the findings may only be generalisable to service provision in these areas. There were also limitations in the selection of cases from clinicians on which the findings of the TRACK study were based. The researchers were concerned that clinicians would be more likely to remember problematic transitions and therefore select cases that could bias the results (Paul et al., 2014). Nevertheless, research findings (Singh et al., 2010; Appleton, 2019) have demonstrated that there are efforts to explore what factors contribute to successful and unsuccessful transitions, based on which policy and practice guidelines have been and can be further developed (Singh et al., 2010).

Literature on Young People's Experiences of Transition from the CAMHS to the AMHS:

Broad et al. (2017) aimed to provide comprehensive insight into YP's experiences of transition from CAMHS to AMHS through a qualitative thematic synthesis of the literature in this area. Through a review of both published and unpublished literature, the authors included 18 studies with 14 datasets and the experiences of 253 YP. They found that YP had positive experiences when the transition was timely and

flexible. YP also valued joint work and continuity of care between services. Interestingly, they also noted that YP's experiences of moving from CAMHS to AMHS were influenced by concurrent life transitions and their individual worldviews and expectations. Finally, the researchers found that most YP experienced a dramatic culture shift when transitioning from CAMHS to AMHS, which can be mitigated by involving the YP in the transition process. The culture change in AMHS was characterised by an individually oriented approach that was unlikely to involve the YP's wider network. Furthermore, there were different conceptual understandings of diagnostic categories and treatment between CAMHS and AMHS. The authors argued that YP had valuable perspectives that could be integrated into the construction and design of mental health services and that their viewpoints should be an integral part of informing transitional service delivery.

Wilson, et al. (2015) drew on the experiences of three YP who used CAMHS before moving on to AMHS to understand youth perspectives on mental health care transitions. An example given was a house move due to flooding. In this metaphor, the idea of choice – thinking about where to move and all the choices this encompassed – disappeared and was replaced by hurried and pressured decisions about an unfamiliar terrain. In the talk given at a conference, all three YP spoke about how well-intentioned efforts to hold pre-transition planning meetings often left them feeling excluded and that their voices were not being heard. This exclusion has

been widely reported (Singh, 2010; McNamara, 2014). It is often the result of poor planning, including late planning, to help YP prepare to leave one service and all that is familiar there for another. Furthermore, in this transition, it is often the responsibility of the YP themselves to negotiate the complicated routes of service referral, unlike CAMHS services, which are family-oriented (Mulvale et al., 2016). According to the three YP who shared their experiences, services need to work in an individualised way to ensure they are fully involved and informed at all stages of the transition between mental health services.

Following the TRACK study and, as noted above, as part of a wider study evaluating the transition process from mental health to continuing care, Singh et al. (2010) conducted semi-structured interviews with 11 service users who had completed the transition from CAMHS to AMHS. The interviews revealed that planning was considered a key prerequisite for transition, although most YP interviewed reported attending only one meeting before the transition. In addition, most participants shared the experience of not being adequately informed and only finding out about the transition at their last meeting at CAMHS. However, one of the most significant factors was the other transitions taking place in parallel, such as leaving home, pregnancy, and educational status. The concurrent transitions faced by YPs in this age group were thought to impact the mental health care transition. The study suggested that to better understand the mental health care transition, YP's lives

need to be considered in context, taking into account a young person's broader social situation.

McNamara, et al. (2014) explored the facilitators and barriers to transition by examining the impact of social identity change on YP moving from CAMHS to AMHS. The study suggests that the transition between health services is more than a process of clinical change and involves adjustments for the YP in multiple group memberships, particularly the shift from a child to an adult identity. Furthermore, the authors argued that the identity of an adult requiring mental health support places YP in a stigmatised group as opposed to a child without mental health difficulties, which in itself could be considered a negative transition. Using the social identity model of identity change (Iyer et al., 2009), the authors investigated the impact of social identity processes on transition. They found that those YP who could see themselves as adults needing mental health care were more successful in engaging with services.

Some YP were more accepting of being viewed in this way, while others in the study were unwilling to submit to labelling that met clinical diagnostic criteria or had incompatible illness identities and were therefore more likely to have negative transition experiences. Overall, the authors concluded that, in addition to effective service planning and the continuation of effective therapeutic relationships, how a young person could adapt to an emerging adult identity was critical to greater

independence and thus increased their ability to manage this healthcare transition. This suggests that the resources a young person has prior to this critical life transition impact their ability to cope with this change. The extent to which the personality can accommodate such change, which is likely to stir infantile impulses, is the focus of the next section of the literature review, in which internal processes are described from a psychoanalytic perspective.

Part 3: Psychoanalytic Perspectives on Personality Development

This section explores and outlines adolescent development from a psychoanalytic theoretical viewpoint. Such a perspective illuminates the developmental process of adolescence at a time of physiological and biological change as well as immense emotional shifts in states of mind. Psychoanalytic psychotherapy, with its focus on the individual's interior world, can be a rich and exploratory way of thinking about the complex and bewildering experiences of adolescence. By doing so, the 'inside' story of the challenges and vicissitudes of adolescent emotional life can be examined. In the third part of the literature review, those aspects of adolescent development from a psychoanalytic perspective relevant to transition issues are explored. Other areas of adolescent development, such as sexuality, are not addressed, despite the centrality of the adolescent process of forming a sexual identity, as this topic is beyond the scope of this study.

Case studies in psychoanalytic inquiry:

In psychotherapy, particularly child psychotherapy, there is a long tradition of researchers using clinical case studies that include a narrative of interaction between the patient and therapist (Midgley, 2006). However, in his paper exploring the use of case studies as a research methodology, Midgley (2006) pointed out that one of the repeated criticisms of single case studies is that they lack scientific rigour and representativeness. Furthermore, due to their anecdotal nature, single case studies cannot be used for comparative purposes, nor can the findings be easily generalised to a broader population. Another limitation of this method of enquiry is that the case study method does not lend itself to investigating certain types or patterns of behaviour (Rustin, 2008).

Nevertheless, case studies offer rich insights into development, and the 'technique of observation in a single case is both searching and revealing' (Miller, 1989, 70). A detailed case report can also allow for events to be viewed with the depth and breadth of an investigation. The intensive nature of observations associated with case studies allows for a rigorous and comprehensive examination. Unlike a research laboratory experiment, direct contact with real-life experiences is the cornerstone of the case study approach. In addition, single case studies, as opposed to multiple cases, can provide the opportunity to present an extreme or exceptional case that interests the researcher (Willig, 2013). The authors of the studies

considered in Part 3 of the literature have essentially used clinical case studies to investigate aspects of the clinical encounter and what this can tell us about the individual or phenomenon.

Psychoanalytic inquiry as a theory of mind:

A psychoanalytic approach to personality development can illuminate what is conveyed, such as the nature of anxieties and the defence mechanisms used to combat them. The ‘object-relations’ approach within psychoanalytic theory taken here, to which Melanie Klein, Donald Winnicott, Wilfred Bion and others have all made their own unique contributions, is concerned with the relationships between people in the service of emotional development. Klein described ‘positions’ as a way of thinking about how someone sees themselves and relates to others in the world that are imbued with unconscious phantasy. From here, Klein (1940, 1946) contrasted the states of mind associated with what she called the ‘paranoid-schizoid position’, which is narcissistic in nature, with the ‘depressive position’, in which love and concern for the other or object may be present. Klein held that these positions were in effect from the beginning. Despite her assertion that the first position precedes the second, it was acknowledged that the complete working through of these positions could never be fully achieved. Rather, there is an interplay between the positions in response to the challenges that arise throughout life.

Oscillations between these structures are perhaps never more present than in the transitional world of adolescents. Waddell (2002) described the ‘psychic agenda’ in the adolescent period as the ‘negotiation of the relationship between adult and infantile structures’, the ‘transition from life in the family to life in the world’ (191). Such a psychic agenda is also associated with impending external transitions, as discussed in Part 2 of this chapter. For example, moving from school to university or work, moving out of the family home into independent living, and, for those who wish, moving from child- to adult-oriented services. The purpose of this section on psychoanalytic perspectives is to explore these parallels between ‘external’ world changes and adjustments in the outside world and the inner emotional lives and experiences of adolescents theoretically.

Infantile experiences and the adolescent:

The theories of Klein, Bion and others have their roots in infantile experience. The concept of the ‘container-contained’ was introduced by Bion (1962b) to describe the infant’s ordinary need to relieve their anxieties caused by frustration and fear. For Bion, the infant needs another person's mind, usually, the mother or primary caregiver, to contain their feelings on the infant’s behalf. Only in this way can emotional experiences be processed, thought about and later learned from. Fundamental to this container-contained relationship is the primary caregiver’s own

emotional responses and capacity to contain their own infantile emotions in response to the projections and communications of the infant. In good-enough circumstances, the infant experiences a mind that can register and process these experiences.

The Kleinian conceptualisation of an internal world moved away from Freud's 'stages' of psychic development towards what Klein called 'positions', the perspective from which a person can view themselves in relation to the world. Klein contended that the infant experiences the world from a paranoid-schizoid position from the very beginning. As noted earlier, this position represents a state of mind in which self-interest and self-preservation are paramount (Klein, 1946). The term 'paranoid' refers to the anxiety and fear of persecution and the defence against the nature of these fears. 'Schizoid' describes the defensive split that occurs in the mind so that the world is experienced as good or bad in extreme and polarised ways. To that end, good can be kept separate from bad and vice versa. In this predominant state, the integration of good and bad is unachievable. A person in this state of mind focuses on self-preservation at all costs (Waddell, 2002). Nevertheless, paranoid-schizoid states are natural and essential in the earliest years, when an infant does not yet have the emotional capacity to process feelings and experiences on their own.

If the projections of the infant's fears can be contained, such anxieties become bearable. If this is a repeated experience, it enables the infant to connect and

integrate the experience of being understood with the ability to think for themselves. This, in turn, allows the infant to continue to develop. If, on the other hand, the anxiety is felt too intensely or is misunderstood too often by the mother or infant, defence strategies against the mental pain may be used to avoid, deny or control these anxieties. Such defensive strategies are characterised by the paranoid-schizoid position (Klein, 1946).

Paranoid-schizoid defences in relation to adolescent states of mind:

Adolescence is a time of great angst and turbulence. The adolescent may employ unconscious or conscious defence mechanisms to endure this period. The developmental picture cannot be easily divided into purely developmental or anti-developmental mental mechanisms. Some defensive mechanisms seen in the paranoid-schizoid position, such as splitting, narcissism and omnipotence, may, at times, be more exploratory in nature and preclude development (Waddell, 2018). However, excessive or persistent use of this paranoid-schizoid defence mechanism dominates the adolescent's developing personality or restricts it to parts of the self that are split off and unavailable.

If development goes well in adolescence, an 'objecting-relating' mindset that is genuinely concerned about the feelings and well-being of others will counterbalance

a more self-centred worldview. Waddell (2002) suggested that in adolescents whose defences against anxiety are primitive and operate mainly in the paranoid-schizoid position, the attitudes are all or nothing – either idealisation or denigration – aspects that occur both in the infant and the adolescent. While the healthy infant, as discussed, may be unable to cope and be supported by the containment of the mother, the adolescent may angrily turn away from the very person or persons on whom they depend. Importantly, turning away is ultimately the task of adolescence – to forge a separate identity of one's own. However, the angry and defensive turning away, even if related to developmentally appropriate development, can be the product of disturbed object relations, resulting in a reversion back to paranoid-schizoid defences.

Waddell (1999) suggested that the ability to 'think about and suffer emotional experiences feeds the mind and promotes growth'. Yet, in the adolescent psyche, this capacity is 'constantly opposed by the intolerance to frustration and emotional pain' (Waddell, 217). Waddell (2002) also described the importance of having an internal container when one is dominated by strong impulses and sensations related to physical changes and emerging sexuality. The lack of an internal container can lead to an inability to process and think about feelings and thus develop emotionally. Adolescents may then be more likely to engage in self-destructive states of mind in which projective tendencies are prominent.

By projecting (often undesirable) states of mind into another, that other is perceived as embodying that feeling and is therefore identified accordingly. However, as Bion (1962b) argued, the evacuation of ‘badness’ is almost always a germ of communication, a method of communicating states of pain or distress by evoking them in another. Adolescents, like infants, may use splitting and projection as effective ways of alerting others to their needs and suffering. Given the turbulence of adolescence, Laufer (1995) and Anderson (2000) both contended that projective tendencies are likely to dominate the adolescent years.

In her 1993 book *The World of Adolescence*, Copley (1993) illustrated the primitive, infantile and paranoid-schizoid anxieties that one adolescent, ‘Lucy’, struggled with in late adolescence. The psychoanalytic intervention was brief and took place in a counselling service for adolescents. However, it was extensive enough to allow this adolescent and her therapist to reflect on her anxieties about separation and endings, which were linked to her early fears of abandonment. Following Bick (1968), Copley (1993) suggested that Lucy seemed to be dominated by infantile, primitive anxieties about being dropped without a skin to hold her together. In infancy, the skin, felt both in itself and by demarcation from the skin of the mother or caregiver, is experienced as holding the personality together (Bick, 1968). Without such containment, the infant is in a disintegrated state and experiences its most primitive parts of the personality as having nothing to hold them together. Copley

(1993) asserted that Lucy's central preoccupations and anxieties could also be seen in the infant – the fear of disintegration and loss of identity as observed by Bick in infants.

Over time and with maturity, adolescents may be able to engage in the process of re-owning projections and relinquishing identifications of this more superficial and imitative kind. However, doing so would involve the painful disillusionment of acknowledging separation and loneliness (Waddell, 2018). Furthermore, as Rhodes (2004) suggested, the adolescent may not yet have formed an adequately developed identity like the infant, 'leaving him without the necessary emotional equipment to sustain reciprocal relationships' (288). Instead, self-sufficiency and even omnipotence prevail.

Alongside opportunities for creativity and growth, the individual in adolescence is once again faced with loss and separation, the painful reality of which may be attempted to be mentally mitigate against. By creating a split, as discussed, the self becomes idealised, whereas dependency on another is replaced with omnipotence, cutting contact with reality and thus an ability to think (O'Shaughnessy, 2014). Diem-Willie (2021) argues that less discernible is the defence of 'pseudo-adulthood' in late adolescence, where adult behaviours are exhibited but not as yet integrated as part of the personality. This defensive manoeuvre of omnipotently becoming an 'all-knowing pseudo-adult' can be one way of functioning as if one has assimilated

parental qualities (Waddell, 2018). However, it is instead a type of ‘second-skin’, functioning, in the way Bick (1986) describes, as first observed in the infant in the absence of a psychic container to hold and transform projections. The infant desperately seeks a psychic equivalent to actual skin in which to contain parts of the personality that can be felt to be, albeit superficially, held together (Bick, 1968; Symington, 1985). Within the adolescent, primitive fears of disintegration are once again set in motion when emotional states are in flux. Omnipotence, that can become addictive and exciting, provides a sense of manic triumph to defend oneself against the renewed agitations of regressive infantile states in the adolescent.

Using the clinical case material of ‘Natalia’, Brady (2015) showed how this young woman in late adolescence struggled to relate to both the external mother and an inner maternal object that she experienced as oblivious and turned to magical omnipotent thinking to counter her feelings of frustration and hatred. Brady (2015) also argued that an unconscious object relationship involving oblivion is often present in late adolescence and can be accompanied by an unconscious phantasy of a manic and self-destructive self. For Natalia, the process of differentiation and individuation from her mother also led to a better understanding of her mother’s oblivion. The painful awareness of separateness can lead a young person to reach

for a false sense of independence that might look like a solid separation when it might just be a move out of the house.

Brady (2015) suggested that many late adolescents resort to manic defence mechanisms, such as denial of the need to make changes. In Natalia's case, there was a contrast between the strong communication of a baby ego that needed more care and nurturing and the manic high of wanting to be left alone and insisting that she could cope on her own. Brady (2015) recognised that this patient was struggling with multiple psychosomatic symptoms with no guarantee that her parents would recognise them, which can be complex at a time when parents are often pushed away and yet very much needed. This also seems to relate to the cases of 'John' and 'Jane' (Brenman-Pick, 1988), who both struggled with the unwelcome awareness of being unable to manage alone.

Brenman Pick (1988) described two cases presenting with underlying infantile problems and manic defences against the inevitable loss and change of adolescence: 'John' and his dependent attachment to adolescent culture, and 'Jane', who had seemingly moved into competent adulthood until the façade cracked, and in desperation, she attempted suicide. Both cases illustrate the pressure on the late adolescent to be an adult and to pretend that they can cope or are coping, a practice often reinforced by the expectations of the adult world. Through work on the transference of these two adolescents, Brenman-Pick (1988) described the pressure

on the therapist not to be swept away by the bravado typical of manic defence mechanisms.

Moreover, Brenman-Pick (1988) observed that adolescents are often acutely sensitive to rejection. It is very typical and, to some extent, normal in adolescence to merge with a group or sexual partner, which can interfere with real development when adulthood is imminent. An example is John's desire for constant merging (a never-ending pop concert) and his fear of thinking as a separate person. Brenman-Pick (1988) noted that the task of the late adolescent is primarily 'to find his identity, not just as the child of his parents, but more clearly as an individual' (187). At this stage of development, the individual is faced with a crucial separation from primary objects while hopefully (if all goes well) retaining a sense of connectedness to the inner world. Brenman-Pick (1988) emphasised that the ability to detach from external dependency and attachment figures is more important in late adolescence. At this stage, there is a greater shift towards installing a version of this dependency within the self that can encourage and support development.

However, in adolescence, the resistance to the awareness of vulnerability is difficult to tolerate, as it is throughout life. When this intolerance is extreme, the personality may be structured by a belief in self-sufficiency and a disdain for dependence. Difficulties of this kind could be considered narcissistic. Indeed, narcissism in itself has been described as an adolescent disorder (Diem-Wille, 2021; Waddell, 2018).

This narcissistic attitude of self-engrossment has manic and obsessive preoccupations beyond all else. As with much development, the basis for this lies in early life and is associated with defensive but self-protective processes of projection and the development of the superego (Britton, 2003; Waddell, 2002). As Waddell (2018) suggested, however, it is an oversimplification to view narcissism as purely defensive. As goes the original ancient Greek story, Narcissus pines for a twin image of himself after rejecting or losing the other. Nevertheless, he does this to bolster an otherwise fragile sense of self, perhaps because adolescent narcissistic identifications act as a façade against the insecurity and vulnerability of this period of developmental change (Diem-Wille, 2021). People with difficulties that could be described as narcissistic idealise autonomy and have a hatred and fear of vulnerability that must be projected elsewhere. However, when these defensive modes dominate the personality less and the pain of loss is not denied, other forms of identification based on love and concern represent different capacities to relate to a thinking figure, characteristic of the depressive position.

The move towards the depressive position:

So far, the paranoid-schizoid position has provided the infant and infantile states in the adolescent with the necessary defensive structures to protect the person from powerful feelings triggered by loss and frustration. However, if development

progresses relatively smoothly, the infant moves away from this position and develops the capacity for love and concern for others. This new state of mind, in which guilt and worry predominate, is called the ‘depressive position’ (Klein, 1935, 1940, 1945). This position is seen as a development from a more narcissistic frame of mind (in the paranoid-schizoid states) to a state of mind that can consider the needs of others (depressive position).

From a depressive position, Klein conceptualised that the infant could now envision the mother as a whole person. That is, the realisation that the ‘good’ and the ‘bad’ mother are one and the same. Thus, in phantasy, the infant has caused terrible harm to the mother, whom they rely upon, love and hate. The infant and mother are now seen as separate individuals with independent needs and priorities. The infant experiences guilt and concern due to the realisation that the loved object has been attacked. This leads to a new kind of experience and, in turn, to new anxieties and defences against mental pain and awareness. The idea that the infant was once in the sole possession of an idealised mother or caregiver must now be given up and mourned, leading to feelings of rage, confusion and sometimes despair.

Adolescent development in relation to the depressive position:

In the case studies discussed, Copley (1993), Brady (2015) and Brenman-Pick (1988) all seemed to suggest that the anxiety about coping as a separate person, although necessary for development and growth, is considerable for this age group and could manifest primarily as hypersensitivity in relation to belonging, identity and relationships with primary caregivers. For adolescents, dependence on parental figures, both past and present, to help negotiate current problems is acute but not readily acknowledged and can create a false maturity (Copley, 1993). This phenomenon relates to Winnicott's (1965) idea that immaturity is a valuable part of adolescence, essential for good mental health in this age group, but often vehemently resisted. Thus, if the adolescent cannot be immature while depending (unconsciously) on adult maturity, the late adolescent may develop pseudo-maturity.

Through the case of 'Maria', Miller (1995) also noted that for some YP, becoming an adult can only take place on the superficial level of social conformity. 'Internal change and development may be a much more gradual and hard-won process, not necessarily located in the early 20s' (*ibid*, 220). Similar to Waddell (2002), Miller (1995) distinguished between introjective and projective identification, as discussed above. In the latter mode of functioning, 'the young person would be jumping into the parents' shoes' and thus, in a sense, be acting as an adult without having matured inwardly. One could say that the young person was becoming a pseudo-adult (Miller,

1995, 221). However, the introjective process involves a ‘gradual taking in of appreciated parental qualities, a learning through experience; and this depends upon respect and concern for the actual parents’ (*ibid*). It is marked by the capacity to bear uncertainty and not being helped by external contact with loving and supportive figures, but also with a sense of an internal mature parental couple within the self.

According to Klein (1959), an increased capacity to live in a depressive position is the cornerstone of maturity and development. Other psychoanalytic theorists have described this capacity to grow up not only chronologically but also emotionally in different ways. Winnicott (1965) referred to the adolescent’s need to face a life-and-death struggle in which growing up means psychologically taking the parents’ place. While Bion (1962a) held that emotional development is based on a capacity to accommodate different and sometimes conflicting states of mind in the personality without evading or evacuating these states of mind, Waddell (2002) stressed that ‘the difference between maturity and immaturity hinges not on the fact of chronological years, but on the extent to which it is possible to think about and reflect on psychic pain’ (196). Klein acknowledged that the infantile permeated the adult world at every age or stage of development. This is also true of the developmental period of adolescence, where the predominant state(s) of the adolescent mind oscillate with more infantile states of mind, no matter how concealed they may be (Waddell, 2002).

In the case of ‘Maria’, becoming oneself involves relinquishing denigrated and idealised versions of oneself and others, especially parents. Nonetheless, Maria was able to relinquish external figures of dependence and install a version of them that signified courage and hope for the personality, whatever the external reality. As Miller (1995) noted, in the course of therapy, Maria reflected with regret on ‘forgotten’ sessions. She was better able to tolerate her own guilt, suggesting a shift from the paranoid-schizoid to the depressive position of functioning.

However, for Maria, the gradual integration of different parts of her personality meant she could take responsibility for her actions. This also meant that she had to face opportunities lost, roads not taken, and painful conflicts when moving forward while also letting go. Such difficulties, as noted by Waddell (2002), confront us at every stage of life, but especially so in late adolescence, ‘whether it be first going to school or finally retiring from work, or, as in this case, embarking on the rest of one’s life’ (177). Yet the finality of entering adulthood and leaving behind the acquaintances of childhood may be the most demanding and intractable transition of all.

Summary:

The third part of the literature review chapter focused on a psychoanalytic understanding of development, particularly in adolescence. The literature reviewed

and the case studies demonstrate the close link between the transitional years of adolescence and infancy and the defence mechanisms employed at each age against the intense anxiety and often primitive mental pain experienced in both transition periods. Not unlike the infant, who soon learns of its separateness from the primary caregiver, the adolescent needs to forge their own identity in the world (Copley, 1993; Diem-Wille, 2021; Waddell, 2018).

Developmental milestones of the adolescent period involve accepting the idea of separateness and acknowledging the differentiation of one's

self and identity from one's parents or caregivers. As seen in Natalia's case (Brady, 2015), such loss and separation can leave adolescents feeling vulnerable to feelings of rejection or that their existence is somehow not noticed or taken seriously amidst the uncertainty of becoming a separate person. In addition to the much-needed process of relinquishing external dependency and attachment figures, adolescents may resort to defensive ways of relating to avoid the pain and confusion of loss and separation. This is the sort of omnipotent phantasy that can be managed alone or presented outwardly in a pseudo-adult way to mask feelings of insecurity about impending changes both outwardly and inwardly, as with John and Jane (Brenman-Pick, 1988). However, if there is the capacity to endure uncertainty and not knowing, with the help of external supportive contacts and a sense of an internal parental couple within the self, adolescents may feel that they have space to develop inner

resources to face the challenges and changes that lie ahead on the road to adulthood. The way all this is negotiated is rooted in early development and depends primarily on the extent to which anxiety has been tolerated, modified or evaded from the beginning.

Rationale for the current project:

From a developmental perspective, adolescence is a time of great change. Emotional, psychosocial and physiological developments take place. At the same time, the young person turns to adult-related tasks such as separation from family, starting a career and identifying in a social or cultural context (Arnett, 2007; Laufer, 1975; McGorry, 2007; Waddell, 2002; 2018). From a healthcare perspective, YP with ongoing mental health needs must move from CAMHS to AMHS when they reach a certain age, which is often aligned with the legal definition of adulthood in the UK when they turn 18. These two transitions usually occur simultaneously. Nevertheless, needs relating to developmental transition may remain unmet if the transition is viewed as a one-off organisational event in health care (Singh, 2009). Transition is often centred on service transfer rather than being part of a holistic process of moving to adulthood and independence, and yet ‘discontinuity in the care system often occurs at the time when it should be the strongest’ (McGorry, 2007, 53).

The literature suggests that adolescent mental health problems will likely persist into adulthood (Singh, 2010; Broad, 2017). Therefore, those YP who require CAMHS intervention are also expected to need to be in the care of the AMHS. Seen as a potentially vulnerable group, YP with mental health difficulties require a good transition to ensure that mental health needs continue to be met (McGrath, 2010; SCIE, 2011). Yet CAMHS and AMHS often use rigid age cut-offs to specify service boundaries, sometimes creating gaps in care provision for those YP transitioning (Paul, 2015). In addition, it has been found that poorer transition leads to nonengagement with services and is likely to lead to poor clinical outcomes (Singh & Tuomainen, 2015). Research has revealed that the consequences of poor transitions include broken relationships with health and social care practitioners, disengagement with services and deteriorating mental health (Young Minds, 2006; Singh, 2009; Singh et al., 2010).

The current literature addressing transition has mainly focused on the perspectives of practitioners and policymakers. The focus has been on quantifying the number of individuals who successfully completed the transition and identifying the organisational and service factors that hinder the transition process (McNicholas et al., 2015; Paul et al., 2018; Singh et al., 2010). Despite the wealth of policy- and guidance-focused literature in the area, a systematic review highlighted a lack of studies exploring the lived experiences of YP who transition. Currently, there does

not appear to be any research focusing on YP's negotiation of separation between services in relation to other separation issues in their lives, including the negotiation of separation required for adolescent development.

Therefore, this project seeks to fill this gap by considering the mental health transition as a procedural process and exploring the meaning of the transition experience from a psychoanalytically informed perspective. A service audit is first presented to address these two areas of investigation. This is to provide an overview of protocols focused on procedural processes. This will explore aspects of service provision at transition, such as which professionals are involved, the timing (e.g. age) of transition and what types of adult mental health services YP are routinely referred to. This focus on the practical aspects of transition provides a backdrop for the whole study. However, there has been little exploration of the lived experiences of YP moving from one service to another. Therefore, interviews were subsequently conducted with YP undergoing the transition to explore, from a psychoanalytic viewpoint, how these YP did or did not feel prepared for their transition on an emotional level.

Study 1) Research Methodology

Introduction and context

The service presented in this chapter builds on a previous audit that followed recommendations from a Care Quality Commission (CQC) inspection in 2017. The inspection highlighted the need for improvements in transitional care within the NHS Mental Health Care Trust, where the researcher is based. This earlier audit considered whether the NICE Guidance on Transition (2016) was followed before, during and after the transition to adult mental health services (AMHS), aiming to raise standards and improve transition experiences and outcomes in the Trust. The previous audit looked at whether the four overarching principles of NICE Guidance on Transition (2016) had been followed and found that this was true for more than 80% of cases. However, the audit also revealed that post-transition, only 11% of YPs who had transitioned reported a 'good' transition. It should be noted that the audit did not take into account demographic information about these YP, nor which AMHS services they were referred to and why. Therefore, the results cannot be directly linked to this current audit, although the NICE Guidance (2016) provided a framework for this study.

The NICE Guidance (2016), ‘Transition from children's to adult services for YP using health or social care services’, covers the period before, during and after a young person moves from children's services (CAMHS) to adult services (AMHS). It aims to help YP and their parents or caregivers have a better transition experience by improving the planning and delivery of the transition. In order to provide YP with the ‘best possible transition experience’, in accordance with the guidance, the following overarching principles should be adhered to (see Appendix 1 for more detail on the guidance):

- adequate time for transition,
- involvement of the young person,
- transition action plan and planned point of transfer and
- the designation of a named worker to ‘oversee’ the transition.

These four components informed the aims of Study 1.

Aims of the audit:

In response to the previous audit, the first aim of this service audit was to understand more about the characteristics of the population of YP requiring a transition between CAMHS and AMHS (acronym AMHS to include third-sector equivalent services for the purpose of this study). The second aim of this study was to understand which services YP are transitioned to and to determine the role of the referring clinician in

the transition process. Finally, the audit examined to what extent NICE guidance on transition was adhered to when transitioning YP between services, similar to how the previous service audit had been conducted.

Study 1 aims to answer the following questions:

- Component 1) How many YP are classified as potentially requiring transition, and from this group, who gets referred (presenting difficulties and characteristics) and who does not?
- Component 2) Of the YP who do transition, where are they referred and by whom in CAMHS?
- Component 3) Is there evidence that NICE Guidance on Transition (2016) was followed, and to what extent?

Audit as a research tool for this study:

The Department of Health states that ‘clinical audit involves systemically looking at the procedures used for diagnosis, treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient’ and usually involves measuring care ‘against predetermined standards’ (benchmarking) (Twycross & Shorten, 2014). This study's case note audit was undertaken to examine whether NICE Guidance (2016) on best practices for transitional mental health care from CAMHS to AMHS is routinely adhered to. This audit revealed information on the number of YP requiring transitional care, what the presenting conditions or diagnoses in CAMHS are for these YP, and which services AMHS clinicians in CAMHS refer to.

Ethical considerations:

Approval to conduct the service audit from the Trust Research and Development Department was sought and given. Clarification was provided by the Trust's R&D department that the project was not classified as 'research', as the study intends to investigate the local context and not derive generalizable findings. Furthermore, the trust confirmed that the audit would not be required to apply to the NHS Research Governance or the NHS Research Ethics Committee.

No identifying staff or patient information was included in the collection and presentation of audit data. At the time of data collection, the information collected during the audit was anonymised, and the cases were numbered. Prior to the data analysis, the data was held on a Trust-approved laptop and saved in an encrypted file that only the researcher could access. Once the data analysis had been conducted, these secured files were deleted.

Study design:

The design of this study focuses on the following questions:

- How many YP require a transition, who gets referred (presenting difficulties and characteristics), who does not, and why?
- Which services do YP get referred to, who chooses them, and why?

- Is there evidence that NICE Guidance (2016) on Transition was followed, and to what extent?

Sample:

Records between August and November 2020 were accessed from online electronic medical notes from the CAMHS team of an NHS Mental Health Trust to capture data on how many YP, at any given time, require transitional mental health care. This time period, chosen for the audit, reflects Trust proportions for each third of the calendar year. Between August and November 2020, 73 YP were aged 17.3 and over in CAMHS.

Study One: Findings and Discussion

Component 1: How many YP require transition, who gets referred (presenting difficulties and characteristics) and who does not, and why?

1i) How many YP potentially require transitional mental health care?

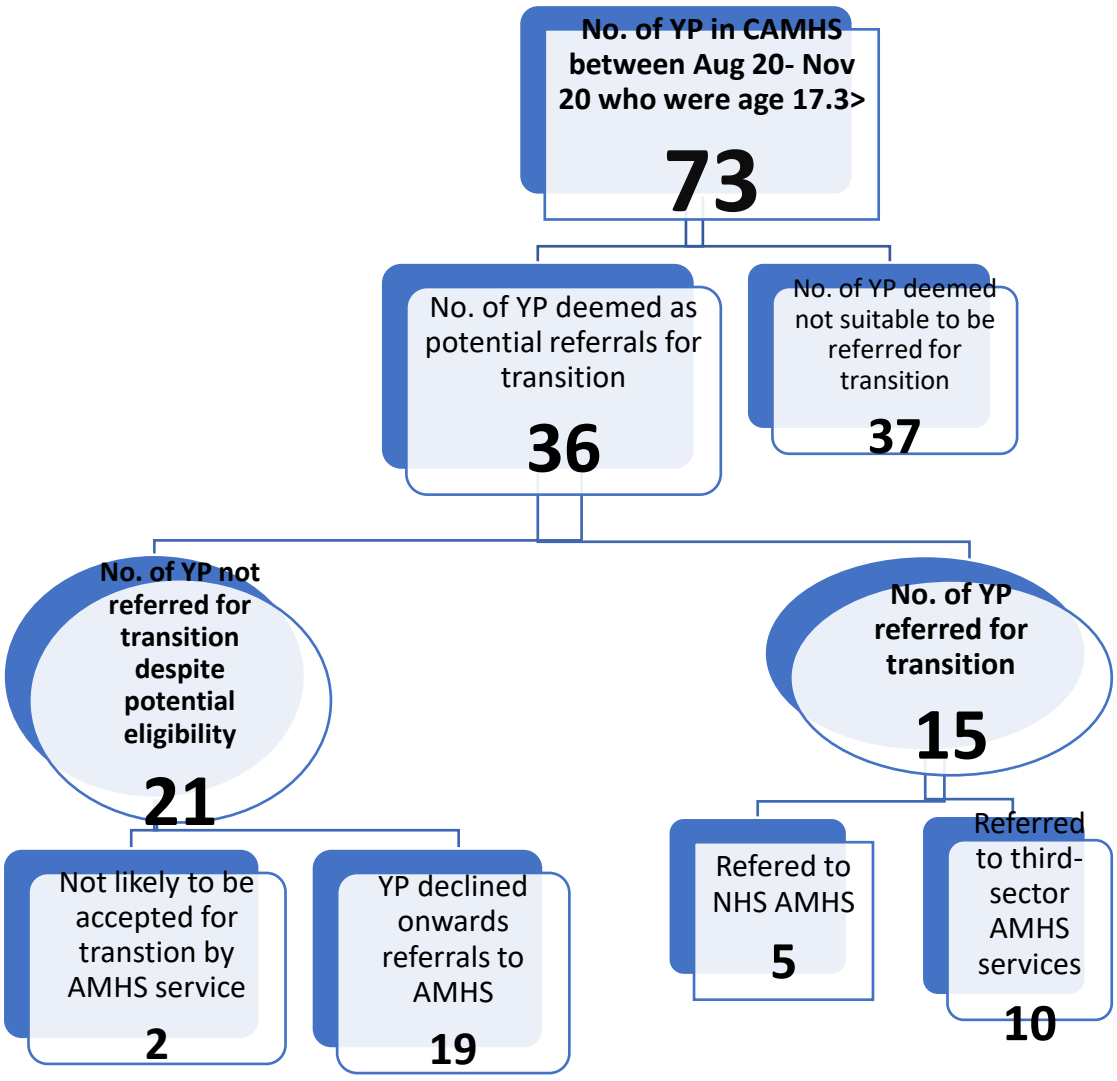

Fig. 1.1. Overview of the no. of YP referred/not referred for transition between Aug-Nov 2020

Firstly, the audit looked to see how many YP aged 17.3 years> were in the CAMHS service within the selected time frame. This age group was selected despite NICE Guidance (2016) suggesting transition conversations should begin in year 9, as this is the upper limit of the cut-off point at which transition should always be a consideration for YP in CAMHS, according to Trust guidelines. The audit showed that there were a total of 73 YP in this age group in CAMHS.

Next, the audit looked to see how many of these 73 YP were ‘eligible’ for transition. The NICE Guidance (2016) does not specifically state criteria for ‘eligibility’ and instead says that each individual YP’s needs should be considered on a case-by-case basis. The guidance refers to services being required to undergo a ‘gap analysis’ to identify the needs of those YP who get support from children’s services but who may not be able to get support from adult services. A ‘gap analysis’ is further defined as ‘an exercise carried out to understand the difference between the amount and type of services needed and the amount and type of services available. This could also be extended to understand the difference between the services people expect and those that are available’ (NICE, 2016).

1ii) Eligibility for transition?

Due to the ambiguity of a definition within the NICE Guidance (2016) on eligibility, this study considered ‘eligible’ as being those YP for whom the primary clinician(s) involved in their care had identified a need for on-going mental health care, as stated in the medical notes. Out of the 73 YP of 17.3 years in the CAMHS service at the time of the audit, 36 had recommended as potential referrals to AMHS. The researcher had defined this ‘recommendation’ as being written notes in the YP’s medical record where transition had been referred to and/or discussed. This left a further 37 YP for whom transition to AMHS was not indicated as being potentially required. It was not clear from the medical records why this was for these YPs. In line with the NICE Guidance (2016), the audit of the 36 YP looked to see if consideration for the young person’s capabilities, needs, and hopes for the future had been noted, evidence of which was found in written form.

Of note, although the NICE guidance (2016) stipulates that transition should not be based on a rigid age threshold, the audit found that for all 36 YP that were potential referrals to AMHS, the matter of transition appears only to have been raised due to an impending 18th birthday, a transition boundary at which point CAMHS involvement would cease to continue within the NHS trust in which the study was conducted.

Out of these 36 YP seen as potential referrals for transition, 33 (91.6%) had received a mental health diagnosis, such as depression, anxiety, post-traumatic stress disorder (PTSD) or had neuro-development disorders such as ASD (autistic spectrum disorder) and/or ADHD (attention deficit hyperactivity disorder) and 12 (33.3%) of these YP presented with two or more conditions/diagnosis, comorbidity.

Who goes on to be referred for transition?

However, further investigation of the data found that only 15 (41.7 %) out of the 36 YP potentially eligible for mental health care transition went on to be referred. As shown in the table below:

Number of YP over 17.3 yrs in CAMHS between August - November 2020	73
Number of records identified as potential referrals for transition	36
Number of records indicating the young person was eligible for transition	15 (41.7 %)
Number of YP not eligible and therefore to be discharged from CAMHS and referred back to the care of the GP	21 (58.3%)

Table 2.1. No. of YP eligible for transition who went on/didn't go on to be referred.

Presentation of those YP referred to CAMHS:

All 15 (100%) presented with comorbidity (had two or more mental health diagnosis/conditions) when referred for transition. Of note, all 15 (100%) had at some point during their time in CAMHS seen a psychiatrist and had previously been, or were currently, prescribed medication at the time of referral for transition. Assertation of presentation and diagnosis was found through medical notes and care plans and risk assessments. More serious and enduring mental health diagnosis such as suicidal ideation, (20%) eating disorder (13.3%) and depression (13.3%) were among lower rated conditions for transition according to referring clinicians. Those who were prescribed medication at the point of referral, or previously was 33.3%. Two of the lower-level mental health conditions as classified by Trust risk assessment guidance, low-mood (53%) and anxiety (60%), were cited as being two of the most common reasons for requiring transitional mental health care. The graph shows the range of presentations and diagnosis of these YP.

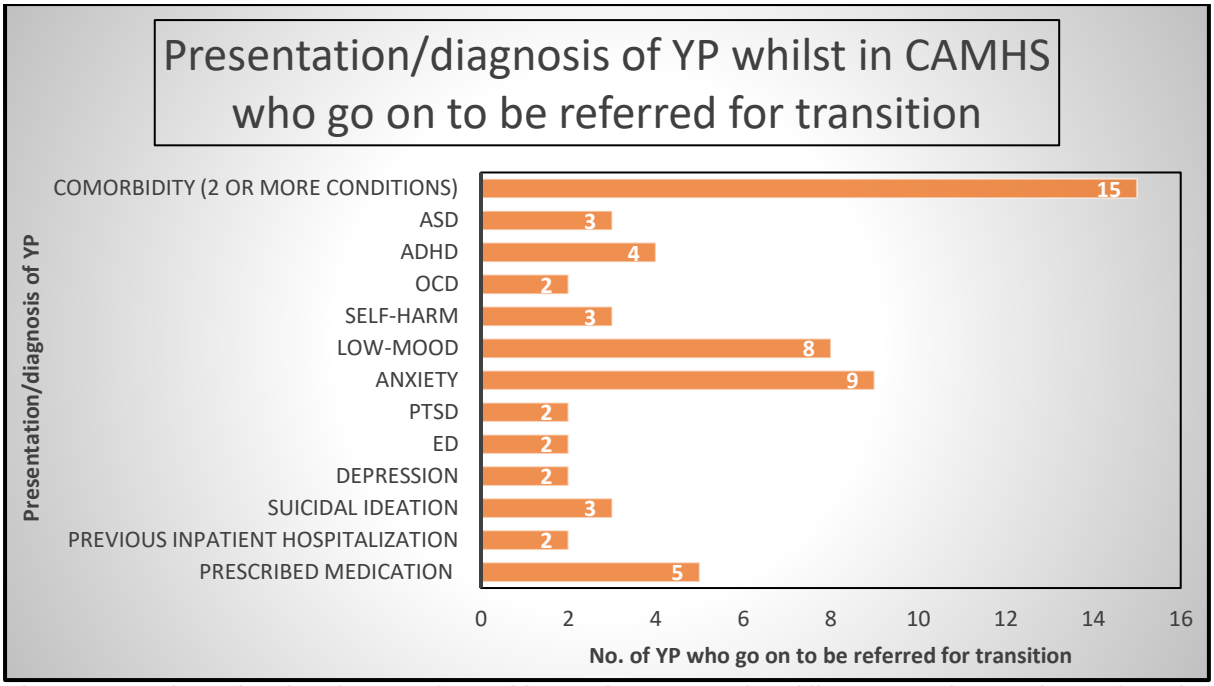

Fig. 2.1. Bar chart showing the no. of YP with certain presentations/diagnoses who are then referred for transition.

1iii) YP who do not get referred, despite potential eligibility for transition-

Presentation of those YP not referred:

This resulted in the remaining 21 (58.3%) (of which 11 YP had comorbidity of two or more mental health conditions/diagnoses 52.4%) YP being discharged back to the care of the GP. These YP were far more likely than the referred group to have a diagnosis of neurodevelopmental disorders such as Autism-spectrum disorder (ASD) (28.6%) and Attention-deficit/hyperactivity disorder (ADHD) (38.1%). There was, however, a high percentage (33.3%) of YP with a presentation/diagnosis of anxiety related difficulties. The graph shows these presentations and diagnosis of YP who were potentially eligible for transition, but then were not referred for transition.

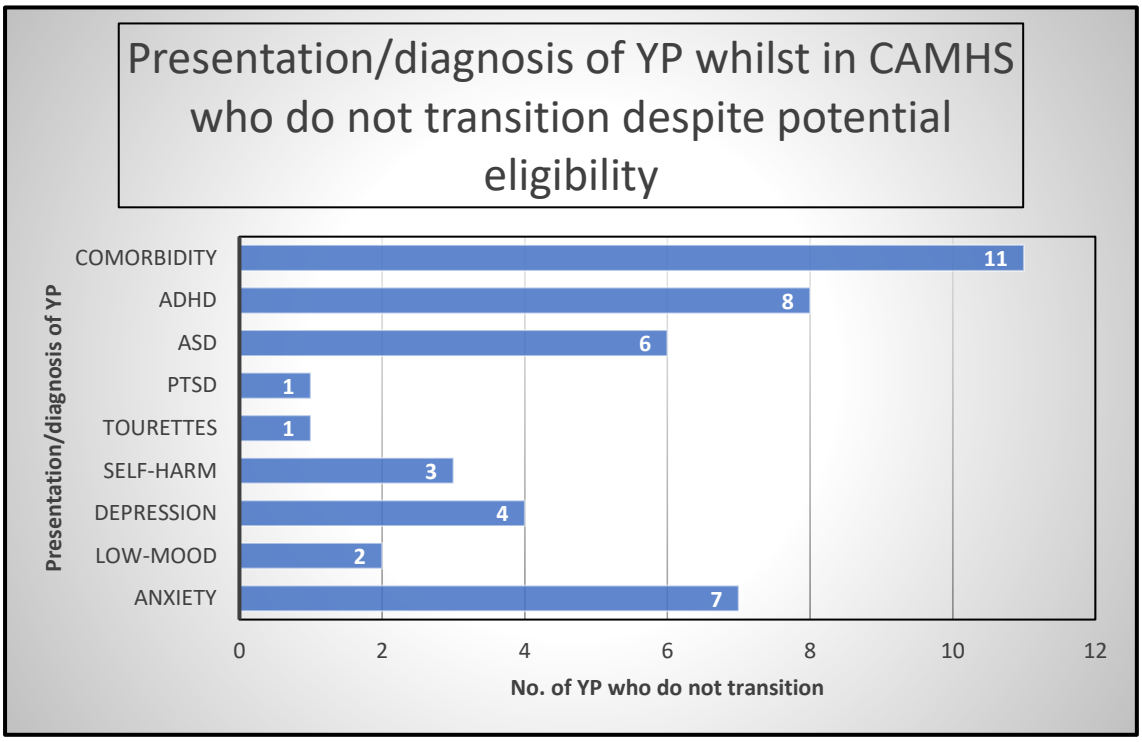

Fig. 2.2. Bar chart showing the no. of YP with certain presentations/diagnoses who do not transition.

Reasons for non-referral to AMHS?

As is shown (Fig 1.1) there were two reasons why this group were not referred to AMHS, despite being potentially eligible. As stated in the medical records, when asked about transition, all 21 (100%) had themselves declined to be referred on to AMHS and receive mental health transitional care, or not engaged with the process.

<u>Component 2</u>: Which services do YP get referred to, who chooses and why?

2i) Where do they go?

Out of the 15 YP requiring mental health care transition between CAMHS and AMHS, the audit looked to see which services these YP were referred to.

Three main services were identified. These were: the statutory NHS Adult Mental Health Service (AMHS) along with two third sector organisations, Well Women Centre and Turning Point.

Service referred to	Number of YP referred:	Mean age of young person at point of referral:
NHS Adult Mental Health Service (AMHS)	5	17.7
Well Women Centre	2	17.5
Turning Point	8	17.5

Table 3.1. Table showing which service YP are referred to and at what age.

Referral to AMHS:

The first service looked at was the statutory NHS Adult Mental Health Service. The graph below shows the diagnosis and characteristics/presenting difficulties of these 5 YP referred to AMHS at the point of referral:

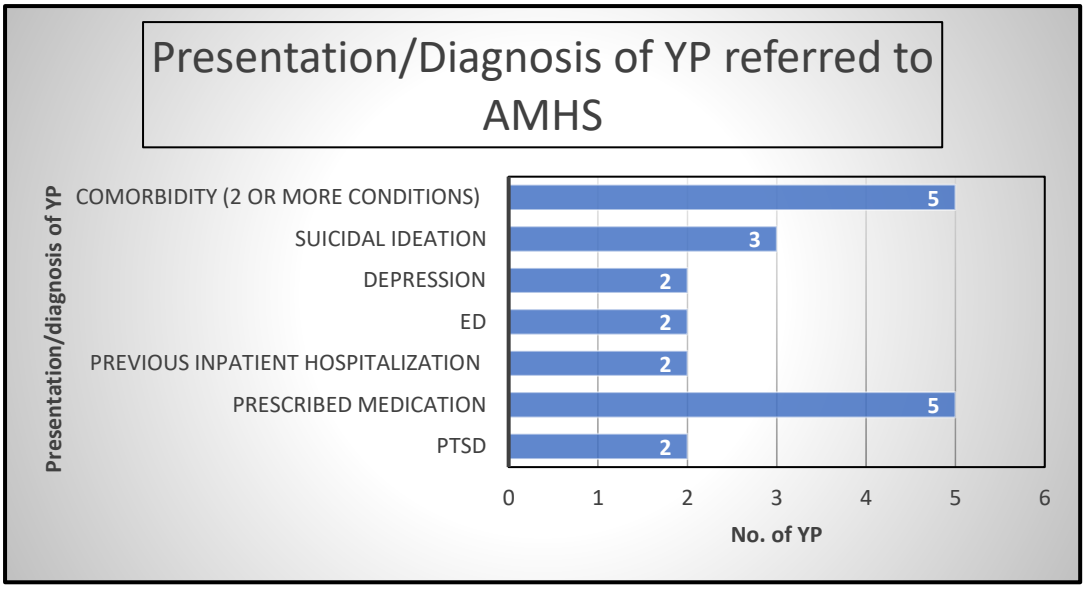

Fig. 3.1. Bar chart showing the no. of YP with certain presentations/diagnoses who are referred to adult mental health services (ED=eating disorder. PTSD= Post Traumatic Stress Disorder).

Referrals to third-sector services and organisations:

Third-sector services appear to have different criteria and have separate thresholds in terms of accepted referrals from CAMHS. However, these services are still required to comply with the NICE Guidance (2016) for transition. The graph below shows the characteristics of the 10 YP referred to these third- sector adult mental health services:

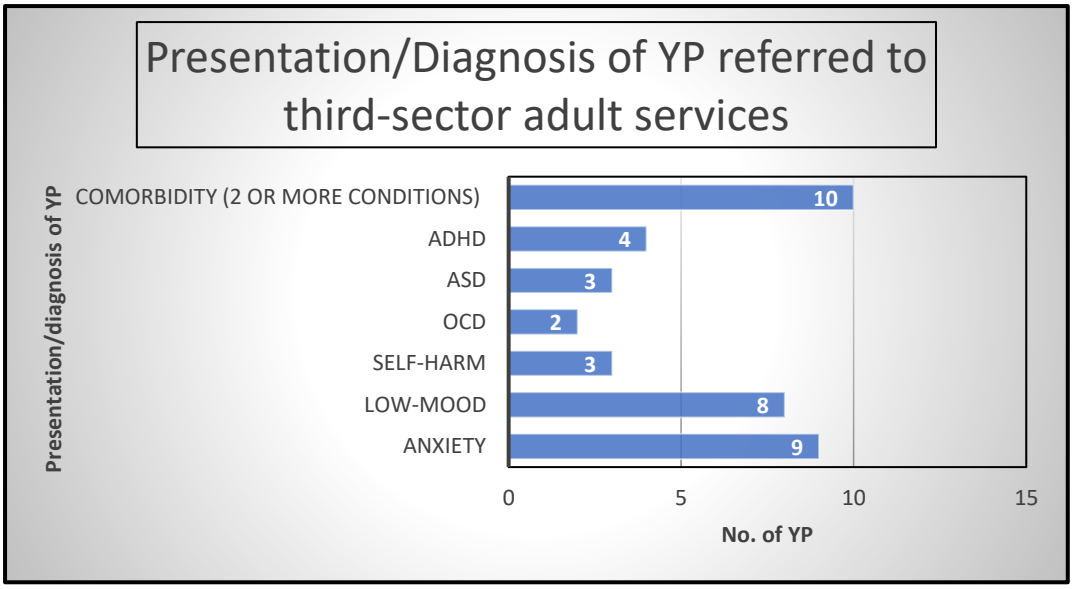

Fig 3.2. Bar chart showing the no. of YP with certain presentations/diagnoses who are referred to third-sector adult mental health services.

2ii) Who refers?

Alongside determining the presenting conditions and diagnosis of YP referred for transition, the audit explored the roles of the referring clinicians and which services different job roles within CAMHS referred onto.

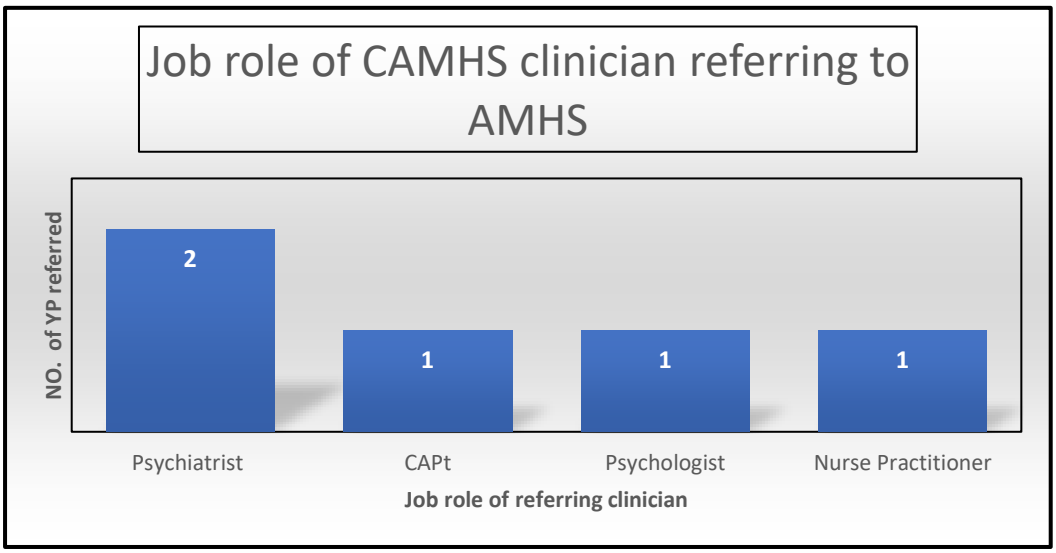

Fig. 3.4. Bar chart showing the job role of referring clinician in CAMHS to AMHS.

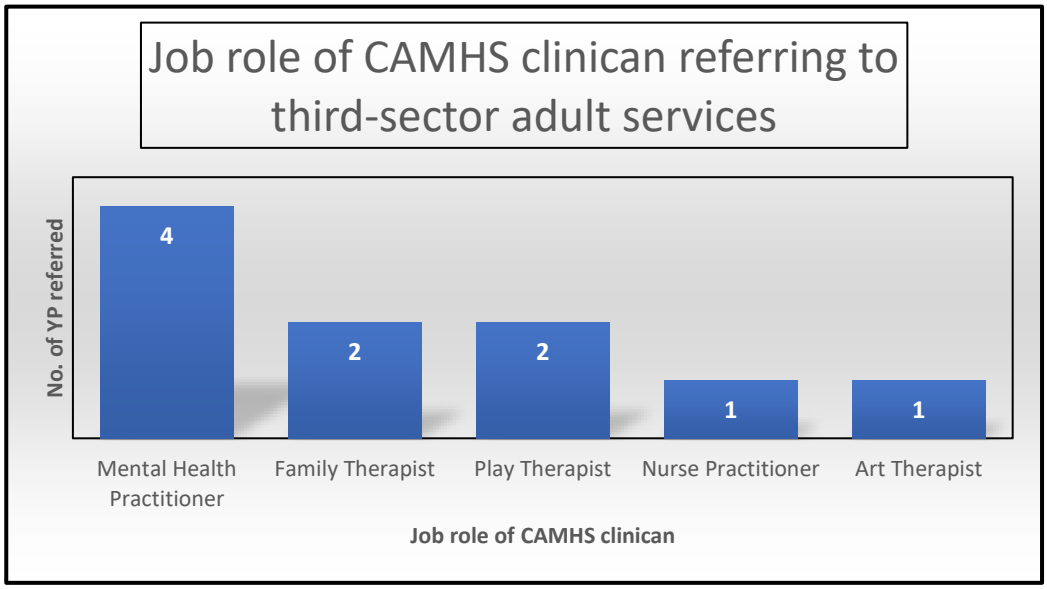

Fig. 3.5. Bar chart showing the job role of referring clinician in CAMHS to third sector adult mental health service.

Length of time referring clinician knew the young person in CAMHS before referring:

Next, the audit looked to see how long (on average) the young person referred to AMHS had known their referring worker in CAMHS before being transitioned. The graph shows the findings below:

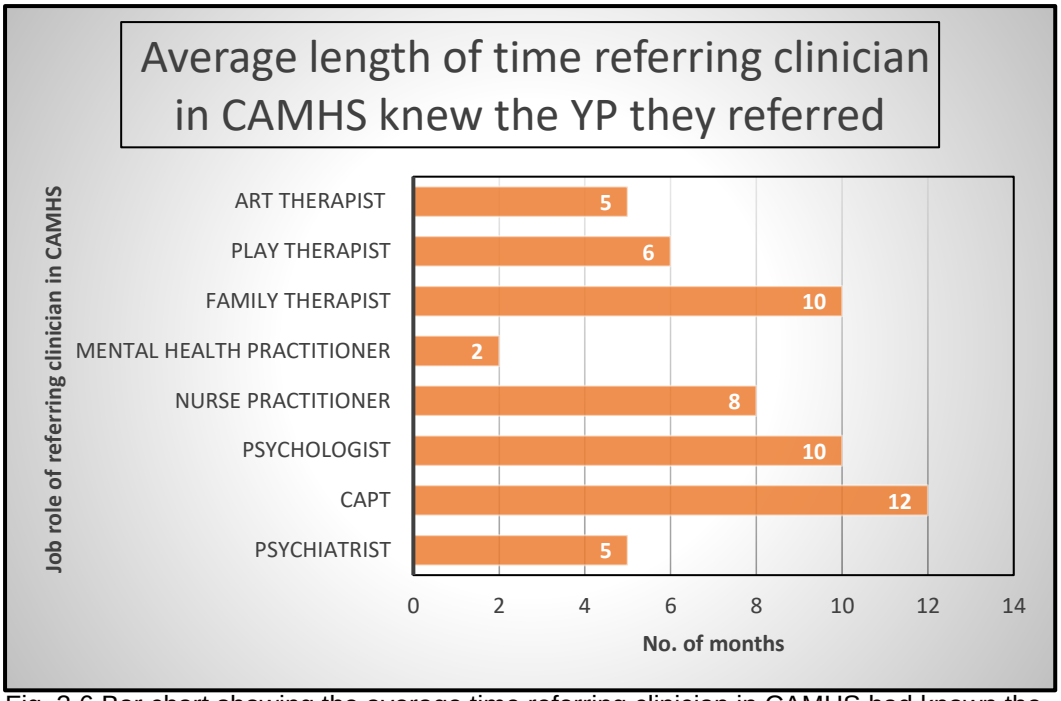

Fig. 3.6 Bar chart showing the average time referring clinician in CAMHS had known the YP they were referring and what their job roles were.

<u>Component 3:</u> Is there evidence that NICE Guidance (2016) on transition was followed and to what extent?

3i) Is there evidence that NICE Guidance (2016) was followed?

Table of the no. of YP for who the four main principles of NICE Guidance (2016) on transition were adhered to

NICE Guidance (2016) principles	1)Adequate time	2)Involve the YP	3)Transition Plan	4)Identify a Key Worker
No. of YP transitioned that meet the Guidance	15	11	4	6

Table 4.1: The no. of YP for whom NICE Guidance (2016) on transition was adhered to.

3ii) To what extent was NICE Guidance (2016) followed?

The data shows that only 2 out of 15 (13.3%) YP referred to AMHS and third-sector equivalent met all four overarching principles for transition as stated by the NICE Guidance (2016). However, there was evidence in all 15 cases that transition had been discussed in a timely way, where the young person was given adequate time for transition to take place, this being from no later than 17.3 years in line with Trust policy, so differs from the guidance. 11 out of 15 (73.3%) records showed that these YP had been involved with conversations about transition however, only 4 out of 15 (26.6%) records showed evidence of transition planning and only 6 out of 15 (40%) had an identified key worker. Furthermore, YP referred to AMHS, as opposed to the third-sector equivalent, were more likely to meet two or more of the NICE Guidance (2016) standards for transition.

Discussion of findings:

Historically, AMHS has provided services to people who have severe and enduring mental health difficulties with a focus on diagnosis-led treatment (Singh & Tuomainen, 2015). This contrasts with CAMHS, where a more developmental approach is adopted. In CAMHS, children and YP presenting with emotional, behavioural, and emerging mental health problems, as well as those with more

complex mental health difficulties, are cared for with consideration to the role of the family (Arnett, 2007; Singh et al., 2005; Singh et al., 2010; Tantum, 2005). This approach is central to CAMHS, where YP are seen as existing within part of a wider support structure, such as the family/school, whose involvement in the young person's care is not only helpful but essential (Hovish et al, 2012; Tantum, 2005). In contrast, AMHS intervention is usually only offered when a clinical diagnosis has been made (Hovish et al, 2012). Tantum (2005) suggests that cultural variations between CAMHS and AMHS, such as different conceptual ideas of diagnostic treatments, may create challenges in navigating the transition between the two services.

Despite this, Singh et al. (2010) revealed that, in their study, over 88% of referrals made to AMHS were accepted. This was also supported in the audit, as all 15 (100%) YP referred to AMHS and third-sector equivalents were accepted. These findings may infer that positive aspects of transitional care exist, as YPs with the highest risk appear to be making the transition successfully. For example, all 15 (100%) YP referred for transition presented with a comorbidity of presenting conditions, including suicidal ideation, depression, and eating disorders, compared to those not referred, who presented with 52.4% comorbidity. Simultaneously, this does raises concerns regarding those who do not make the transition at all, given that over half of the YP in the study had two or more presenting mental health conditions

and/or diagnoses. There was a higher percentage of YP who had been diagnosed with depression who did not transition (19%) than those with the same diagnosis who did transition (13.3%). However, to preserve anonymity, it is not possible to state what other comorbidities may have affected the decisions to refer or not to refer to AMHS between these two groups of the YP with a diagnosis of depression.

Component 1) How many YP require transition, who gets referred (presenting difficulties and characteristics) and who does not, and why?

Firstly, the audit identified that a significant population of CAMHS patients are in late adolescence, 17.3 years and older) (n=73). This is supported by the literature, which notes that CAMHS services nationally have a large number of adolescents that make up the overall population of service users (Singh et al., 2005; Singh et al., 2010; Tantum, 2005). And yet, mental health transitions from child-oriented to adult services, despite a wealth of literature, remain a largely unexplored area of research interest (Singh, 2009).

The researcher wondered whether one of the reasons for this supposed lack of ongoing interest in the study of mental health transition in academia was related to the paucity of the need for transitional mental health care beyond CAMHS. However, this audit found that almost half of the YP (36 out of 73) in the sample who were due

to leave CAMHS at 18 did potentially require a transition to AMHS. For the remaining 58.3% YP, transition was not cited as having even been a consideration. Yet, what happened to these YP was unclear, and the study did not investigate further reasons for mental health care ending in CAMHS, as this was felt to be beyond the scope of this study.

For those YP classified as potentially eligible for transition, only 15 (41.7%) out of 36 were actually referred. The audit found that out of these 15 YP that were referred, they had agreed/consented to a referral, unlike the remaining 21 (58.3%) that, from what can be gathered from the medical notes, expressed a wish not to be referred or declined to engage in the process. This is an interesting finding and an area of study that, to date, has not been represented in the literature.

The audit found that the nature of the diagnosis in CAMHS was a factor in determining the need for transition. For example, YPs with comorbidities of severe and enduring mental health were more likely to be considered as potential referrals for transition. This was also seen in the literature. McNicholas et al. (2015) reported that in Ireland, YP with psychosis or a mood disorder were more likely to be referred to AMHS. Furthermore, Singh et al. (2010) found that having a diagnosis of severe and enduring mental illness, being prescribed medication at the time of transition, or having been admitted to hospital while receiving care from CAMHS were predictive factors for transition.

However, these findings in the literature were not strongly supported by the audit. For example, only 33.3% of the 15 YP who went on to be referred were on medication or had been previously while receiving treatment in CAMHS. These YP did, however, have several different presentations ranging from depression to eating disorders, and all 15 had at least two presenting conditions. Yet, it is to be noted that this study had a very small sample size, and therefore its results need to be considered proportionately against the larger-scale studies outlined in the literature considered.

Nonetheless, this study found that out of the 21 (58.3%) YP who were not referred, they had similar diagnoses and presentations to those who were then referred for transition. The audit also found this group of YP who were not referred, despite potentially being eligible, were more likely (than those referred) to have difficulties such as neurodevelopmental disorders, including ASD (28.6%) and ADHD (38%). This finding was also cited in the literature. Studies by McLaren et al. (2013) and Singh et al. (2010) found that emotional difficulties, neurodevelopmental trauma, and/or emerging personality disorders were not routinely referred to as AMHS in the studies they conducted. This is despite mental health difficulties associated with disorders such as ASD/ADHD persisting into adulthood (Swift et al, 2013). In follow-up studies post-discharge from CAMHS, the literature found that for this group of YP,

their ongoing needs remain unmet following discharge from CAMHS (King et al, 2020; Swift et al, 2013).

Component 2) Of these YP, who are they referred to, where are they referred to, and by whom?

The audit found that, alongside the importance of the characteristics and mental health difficulties of the YP transitioning, a pattern emerged regarding the role and specialisation of the referring clinician. The CAMHS clinicians in the audit can come from a multitude of disciplines, each with different training and perspectives.

This was despite different disciplines having different levels of competence and understanding in the assessment and formulation of presentations and diagnoses. However, those from the professional groupings and disciplines of psychiatry, psychotherapy and psychology did, in the main, refer to AMHS over third-sector equivalents. Ford (2013) suggests that for other professionals who do not refer to AMHS, they are more likely to have antipathy towards ‘the medical model’, with a focus on ‘disease’ and concepts of psychopathology. Yet, the clinicians in this study came from a variety of professional groupings, both with and without medical backgrounds, and this did not seem to be an over-determining factor in the service to which the young person was referred.

In addition to this, an important factor in the referral process seemed to be related to the length of time the young person had been known to the clinician. For example, of the 5 YP referred to AMHS, all had known their CAMHS clinician for over 1.5 years. Those referred to third-sector services were, on average, 6 months old. This could indicate that the relationship between clinician and young person, as well as the professional identity of the clinician in CAMHS, has an impact on whether a young person is referred for transition. This is in addition to the nature and seriousness of the presenting mental health difficulty and diagnosis of the young person.

Component 3) Is there evidence that NICE Guidance (2016) on Transition was followed, and to what extent?

Despite the recommendation in the NICE guidance (2016) and the trust's commitment to adhering to these principles, only 2 out of the 15 YP referred for transitional care met all four overarching principles for a good transition. However, the audit showed that all YPs referred for transition did so in a timely manner, in line with the guidance. On closer inspection, the trust policy states sufficient timing to not be beyond 17.3 years and is backed by the guidance, which in fact leaves little or no time for the following criteria of the guidance to be adhered to. Co-planning and

establishing links between services to provide consistency of care can only be achieved over time and is a complex process involving multiple moving parts. Therefore, leaving consideration for transition, let alone planning or discussion, until 9 months before the YP's 18th birthday, especially when there is a strict age boundary for when CAMHS input ceases, may be problematic.

For those YP who did receive transition in line with the NICE Guidance (2016), the clinical records assessed showed that only 4 YP had a 'transition plan' that involved collaborative joint working between both services, CAMHS and AMHS, as well as the young person themselves. Furthermore, the literature also suggests that when YP are given information regarding what to expect and are themselves fully involved in the process and preparation for transition, they are found to have more successful transitions (Sigh, 2010). To add to this, only just over half of the YP in the audit had been assigned to, or had met, a key worker in the new adult service. This is despite the guidance stating the importance of identifying a key worker. The literature also discussed the disadvantage YP were put at when they were given little opportunity to be introduced to the new adult services, which included meeting a named worker in advance of the transfer of their care (Singh, 2008). Over time, this was seen as a contributing factor in determining the level of engagement with the adult service (Paul et al, 2014). Similarly, Singh et al. (2010), drawing upon the findings of the TRACK research, found that evidence of co-working between services and

collaborating on shared tasks such as joint assessments was also an indicative factor of successful transition.

In this study, the inconsistency as to whether the guidance was followed or not and to what extent it is perhaps important to consider, but as part of a bigger picture considering other factors. Despite providing a baseline for what constitutes good transitional care and what does not, the guidance does not take into account more fully the individual differences of YP, including personal and external influencing factors. The researcher wondered whether this was one contributing aspect of the inconsistencies seen in the audit, where there was no clear pattern between cases as to how they were transitioned. This was also noted in the research conducted by Singh (2010), which seems to support this idea of focusing on the developmental needs and states of mind of YP rather than on prescriptive guidance.

Summary of Study 1 and its relation to Study 2:

This chapter presents the study design of the service audit, detailing sampling and ethical considerations. The results from this quantitative analysis of the data in Study One1 and the emergent findings from this methodology pose further questions and are a precursor for Study Two and its qualitative research method. In particular, the quantitative data in this study suggests that transitional mental health care does not

follow rigid and prescribed ‘conditions’ for transition for the cohort studied. Instead, the quantitative data suggests multiple factors at play, such as the presenting characteristics of the YP themselves as well as the relationship/length of time the YP haves been in CAMHS/known the referring clinician in CAMHS.

Although informative in terms of capturing the number of YP requiring mental health transitional care and the characteristics and presentations of these individuals, Study One did not seek to explore the individual experiences of the transition process. In order to investigate YP’s nuanced sense-making and understanding of their individual transition experiences, a small-scale qualitative study will now be presented, and its data explored.

Study 2) Research Methodology

This chapter outlines the study design of the service evaluation and a rationale for using the chosen qualitative method of analysis: interpretative phenomenological analysis (IPA). The process of recruitment and the inclusion and exclusion criteria in relation to ethical considerations will be explained in detail. Consideration is given to issues of subjectivity in research, and a description of the data collection and analysis procedures will also be presented. The chapter ends with an outline of the final three superordinate and six subordinate themes that emerged after a close and careful qualitative data analysis.

Study Design:

Study 2 of this project focuses on understanding individuals' experiences, so a qualitative methodological design was chosen. In contrast, Study 1 explored the number of YP transitioning from CAMHS through a service audit, where quantitative data was collected. Each of the two study designs offers complementary data measures, with Study 1 providing data on the number of transition effects among YP and Study 2 providing rich qualitative data on the experiences of these individuals.

In Study 2, semi-structured interviews were conducted with YP who were in the process of transition or who had transitioned from CAMHS to AMHS or a comparable

third-sector transition service, such as Turning Point. The purpose of the interviews was twofold: first, to explore YP's experiences of transition between different services. The second purpose was to capture something of the participants' emotional or internal world experiences of the transition process at this developmental stage of their lives.

Study 2 focused specifically on the following:

-how the YP experienced and made sense of the transition process,

-the YP's thoughts and feelings as they approached the end of their participation in CAMHS and as they entered AMHS, and

-the YP's abilities to think about and reflect on the transition process and what the experience meant to them personally.

Qualitative Methodology:

The purpose of using qualitative research methods is to describe and understand experiences, not to predict them (Willig, 2013). Researchers using qualitative methods are interested in learning how individuals make sense of their experiences in the world. This includes allowing participants to raise and contribute themes to a study that the research did not anticipate. Qualitative research methods construct meanings from individual experiences by drawing on information about how individuals experience them (Willig, 2013; Flowers & Larkin, 2012). Thus, qualitative

methods facilitate a deeper understanding of the phenomenon than quantitative methods would have achieved (Smith et al., 2012).

In qualitative studies, semi-structured interviews are a common method of data collection. Smith and Osborn (2003) suggested that semi-structured interviews were perhaps the best method for data collection in studies using IPA. Semi-structured interviews were therefore used for this study, as they produce rich, authentic and credible data in a way that gives participants some choice (Smith & Osborn, 2003; Coolican, 2009). For this study, the qualitative data was collected and analysed in accordance with IPA. The interpretative process within IPA allowed the data to be organised into emergent themes to capture the YP's emotional experiences as described in their interviews. The philosophical underpinnings and rationale for using IPA are briefly outlined below.

Interpretative Phenomenological Analysis:

Interpretative phenomenological analysis (IPA) is a qualitative research method that explores how people make sense of their life experiences. It has a theoretical grounding in phenomenological, idiographic and interpretative perspectives. The idiographic nature of IPA is concerned with the particular rather than the general (Larkin & Thompson, 2012). It has developed to examine 'in detail what the

experience for this person is like [and] what sense this particular person is making of what is happening to them' (Smith et al., 2012, 3). Phenomenology is the philosophical study of being and is concerned with how the world is perceived through human experience (Smith, 2008). An individual's account of a particular experience thus becomes a phenomenon (Willig, 2013).

According to Smith et al. (2012), IPA research can be used to explore individuals' perspectives by beginning with a comprehensive examination of each case before exploring the points of unification or divergence across cases. IPA also has an interpretative (or hermeneutic) phenomenological epistemology that focuses on understanding an individual's relationship to the world through making sense of experiences (Larkin & Thompson, 2012). Interpretation within IPA occurs at two levels, referred to as a 'double hermeneutic' (Smith & Osborn, 2003, 35). First, there is the participant's understanding of their experience, followed by the researcher's interpretation of the participant's experience. In this way, the researcher can engage fully with the experience while recognising the implications of their own opinions and values.

In this study, following the three interviews with YP who had attended CAMHS for more than three months before the age of 17 years and 3 months, IPA was used to analyse the data to ensure that they had not simply passed through the service before transitioning to AMHS or a comparable third-sector institution.

IPA and its relationship to psychoanalytic thinking and countertransference:

In addition to using IPA rooted in psychology and sociology, this study has drawn on the phenomenon of unconscious mental life, which is at the core of psychoanalytic enquiry. Although not aligned with psychoanalytic thinking, there are some parallels in how IPA can be used to explore the specifics of experience and personal interactions (Rustin & Rustin, 2019). Both IPA and psychoanalytic enquiry recognise that subjective experiences contribute to complex layers of meaning and need to be investigated with depth and rigour. Both methods of enquiry seek to immerse themselves in the experience under investigation through in-depth and close observation. Therefore, the additional dimension of using unconscious thinking could be seen as an extension of the already thorough and robust IPA process.

As the researcher becomes immersed in the field of study, different kinds of relationships develop with the research participants and the experiences they bring with them. The close relationships that develop in response to closeness to the participants' experiences are conducive to transference (Hunt, 1989). Both the researcher and the participant are thus consciously and unconsciously in a relationship with each other, which can be experienced, for example, as a sense of developing a good rapport. In clinical settings, unconscious transference relationships can be examined, held and reflected upon, which is not the primary

task in the research setting. Nevertheless, the countertransference experience, or the researcher's unconscious reaction to the participants' transference, can be illuminating. The analysis of the countertransference reactions elicited in the research process served to facilitate understanding of the individual experiences brought by the participant and the rich world of unconscious meaning.

Subjectivity and the researcher's personal experiences:

According to the IPA method, researchers need to acknowledge the potential influence of their identities and personal experiences throughout the research process. This includes one's initial interest in the subject through selecting the participants, conducting the interviews, and analysing and discussing the data. There are personal, academic and professional reasons for this researcher's interest in the research topic. These motivations are relevant to the choice of study. Still, the values, assumptions, and perspectives she brings to the research will inevitably be reflected in the knowledge produced from the data.

For this reason, the researcher has attempted to make the research process reflexive by being aware of her potential biases and blind spots. Throughout data selection, collection and analysis, the researcher repeatedly asked herself if she had experienced something that she was now projecting. Regular supervision also served as a fundamental means of mitigating her subjectivity, for example, by

avoiding over-identification with participants' positions or views. One way the IPA research method helps to address the effect of subjectivity directly is through the free-coding stage of analysis after the data has been collected. In free coding, the researcher attempts to consciously acknowledge their feelings about the research area and record their emotional responses as data before analysing the interviews in more depth and before the more formal process of creating themes is undertaken. While setting up and conducting the interviews, the researcher was preoccupied by her concerns about departure and time constraints. This manifested itself either in a concern that there would not be enough time (that the participant would no longer be available to CAMHS, and therefore there was a race against time) or that it would be very difficult to find a young person who would be willing to give up their own time to discuss what could be an emotional subject. Once the interviews began and the data was analysed, this sense of time was evident in all three interviews in different ways and degrees. These various senses of temporality were likely also related to the researcher's subjective experience of being on the threshold of a time of transition and change.

Ethical considerations:

Ethical approval for the project was sought and granted by the Tavistock Research Ethics Committee (TREC) and from the Research and Development Department of

the Trust, where the data collection took place. Initially, participants were given a copy of the ‘Participant Information Sheet’ and ‘Consent Form’ (see Appendix 2) detailing the aims of the research project when they expressed interest following a conversation with their case managers or key workers in CAMHS who had suggested them as potential candidates for the study.

Limits to confidentiality were acknowledged, for example, if the researcher was concerned about the safety of the participant or others and anonymity could not be maintained in that case. Otherwise, it was stated that every effort would be made to ensure confidentiality before, during and after participation. If a safety issue arises, a procedure is in place to address concerns. In such a case, the young person would be informed that the trust’s safeguarding policy would be followed. In addition, should a young person become distressed during the interview, the participant would be given the option to take a break or stop the interview altogether. If participants became distressed after taking part, they were advised to seek the support of their case managers at CAMHS or AMHS. This information was explicitly stated on the information sheet, again on the consent form and then before and after the interviews began.

Each participant was assigned a pseudonym that was used throughout the research process. Only the researcher and the case manager who assisted in recruiting the YP knew the participants’ real names. Any contact information or other identifiable

information, such as completed consent forms, was stored separately from the data in a secure online document. The digital recordings of the interview and the one online chat interview were also stored securely on a password-protected online system.

Inclusion Criteria:

Participants were considered eligible for the study if they met the following criteria:

- were aged 17.3 years and months and older,
- had been informed of and consented to the transition from CAMHS to AMHS (and this was recorded on their medical files);
- were considered by their CAMHS case managers to be able to participate in an interview of approximately 60 minutes, and
- were not displaying any level of significant risks such as suicidal ideation, active self-harm or injury.

Recruitment:

Following university ethical approval (TREC), case notes were accessed via the NHS Trust's electronic system to determine the number of YP aged 17.3 years and over who accessed the CAMHS service between August and November 2020. At this point, this number was 73. In line with the inclusion criteria, the researcher identified which of these 73 YP had been informed of and consented to referral to AMHS (including third-sector equivalents) and were at some stage in the transition

process, which was recorded in their medical files. This process resulted in eight potential participants for the interview after excluding those YP displaying any level of significant risk, such as suicidal ideation, active self-harm, or injury.

From here, the researcher approached colleagues who were (or had been in the last six months) case managers of YP who were undergoing or had transitioned from CAMHS to AMHS. It was then discussed with the individual case managers whether the potential participants were suitable to take part in the project. This discussion allowed verification that, in the case manager's clinical opinion, the potential participants met all the inclusion criteria and were therefore suitable for participation based on their current or prior knowledge of the YP in the service. The information given by the case managers and access to the online medical records served as a source of information about the participants before the interviews (see a later synopsis of participants derived from the information obtained).

Next, the case managers were given a copy of the participant information sheets and consent forms to read through and disseminate to the potential participants identified in the preliminary discussion with the researcher. However, after the onset of the COVID-19 pandemic, the case managers obtained consent from the YP for the researcher to contact them directly regarding the study. Those YP who responded to the researcher's invitation to participate were then sent electronic versions of the

information sheet and consent form, which all participants emailed back in various forms, such as written consent. Once potential participants agreed to take part in the study, a convenient date, time for the interview and platform (telephone or video) were arranged.

Sample:

In line with the aims of IPA, which are to describe in detail the experiences and understandings of a specific group rather than make more general statements, the sample for this study was selected accordingly. Due to its strong idiographic focus, IPA requires that cases be examined individually in detail before conducting a cross-case analysis (Smith et al., 2012). To enable comprehensive case analysis, IPA typically involves a small, focused sample, as noted by Larkin and Thompson (2012), where the quality rather than the quantity of data is analysed. Therefore, the current study's sample of three YP was considered sufficient to yield meaningful results. However, the original study design envisaged recruiting between three and six YP to participate and recruited a minimum of three participants due to the difficulties in recruiting participants during the pandemic.

Selection and description of participants:

The three participants in the study were all between 17 and 18 years old and met the inclusion criteria for the study. Each participant was given information about the project from their case manager or directly from the researcher after discussing eligibility for participation with their current or previous case manager in CAMHS. Two of the young people were still in CAMHS at the time of the interviews, and one had been discharged and had some contact with a third-sector adult service. Two of the young people who took part opted to be interviewed over the phone. One participant asked to be interviewed online via Zoom's chat function.

Interview schedule:

The interview schedule was designed to explore the YP's experiences transitioning from CAMHS to AMHS or other similar services and whether they felt they had reached emotional readiness for such a change. The interview schedule was developed using guidance from the literature studies (see the Literature Review section). The researcher should consider a wide range of issues that might be covered during the interview and then arrange them into an appropriate structure.

The topics covered in the interview were as follows (see Appendix 3 for the interview schedule):

- the experiences of CAMHS and what they understood about the reasons for requiring mental health services,
- the transition process and planning for transition once they understood that this step was necessary for them,
- whether the young person could reflect on other transitions in life and how these transitions were experienced,
- the impact of this and other transition experiences and their meaning for this particular individual and
- what the young person thought about life after CAMHS.

In addition to these overarching discussion points, the interview included open-ended questions and appropriate prompts to encourage participants to elaborate on statements or words they used (Smith & Eatough, 2007).

Interview procedure:

Participants each took part in a semi-structured interview that lasted approximately one hour. At the outset, the participants were reminded of the study's aims and asked again if they had consented to participate. The researcher carefully reminded participants of confidentiality, and that participation in the study was voluntary. The researcher spent some time speaking with each participant before introducing the interview questions at the beginning of the interview to build rapport with them (Smith

et al., 2012). The interviews were conducted flexibly, with open-ended questions and prompts as needed to help put participants at ease while obtaining rich data.

After the interview, the researcher thanked the participants for their contributions and allowed them to comment on the process and ask further questions. Finally, all participants were debriefed and reminded who to contact if they a) had questions about what they were asked or wanted to know how the information they had given would be used, or b) if they were emotionally distressed by discussing topics that were potentially anxiety-inducing (see Appendix 4).

Two of the three interviews conducted by telephone were recorded using a digital recorder to allow for later transcription and analysis. One interview conducted online via Zoom's chat function was saved as an electronic file. All the data from the digital recorder or online chat was transferred to a password-protected file. The two telephone interviews were then securely sent to Transcription UK for transcription. The recordings were deleted after transcription.

Data analysis:

As stated above, the interview data from the two telephone interviews was transcribed by a transcription service and transmitted electronically to the researcher

via secure means. The online chat interview was already available in text format and stored securely on the researcher's hard drive.

After a transcription agency had transcribed the interviews, the researcher immersed herself in the raw interview data. The researcher was aware of countertransference feeling while analysing the participants' statements for meaning and content. The researcher read through the three interviews twice while taking notes, starting with the first and ending with the last. The associations were gathered by writing down thoughts next to the transcript. Thinking about any associations while following the transcript line by line helped the researcher begin to sense the data. This process was conducted for every transcript viewed from the beginning of the interview. The interview data was then analysed using IPA in the following three stages: The transcript was annotated (including free-coding themes); the annotations were examined for emergent themes; and the emergent themes were transposed and examined for relationships. Then, the final superordinate themes were identified across the whole data set. The step-by-step process will now be outlined.

- **1) Reading, re-reading and note-taking:**

In line with the idiographic commitment of the IPA, each interview was first analysed in depth individually (Smith et al., 2012). Then, the researcher listened to each

recording and read the transcripts several times to delve into the narratives. These steps ensured the researcher could develop a sense of meaning. Finally, initial annotations were noted in the right margin of the transcripts (see Appendix 5). These annotations included notes about the use of language and descriptions of what the researcher found interesting or important in the transcript (e.g. the quality with which something was expressed).

- **2) Developing emerging themes:**

Having focused on the transcript across the entire document, the researcher moved on to a deeper level of investigation. This involved developing and documenting emerging themes in the left margin of the transcripts (see Appendix 5). This was to further refine what had originally been noted in the right margin. The emerging themes were close to what the participants said but were expressed at a theoretical level, taking into account possible unconscious meanings.

-3) Searching for connections across emergent themes:

The emerging themes were listed so they could be examined, and relationships between them were sought. To this end, the listed themes were cut out by hand to group all the common meanings. At this stage, the researcher repeatedly switched

between the whole transcript and the individual emerging themes. Some emerging themes were discarded at this stage.

- **4) Moving on to the next case:**

The same process was repeated for the other two transcripts. Smith and colleagues (2012) argued here for treating each case on its own merits. Where possible, while working on the next case, the researcher noted the ideas from the analysis of the previous case using the reflective diary. In this way, the whole data analysis process could continue with the IPA's idiographic approach.

- **5) Identifying patterns across cases:**

The next step was to reread the themes and arrange them into groups on the page. After this, they were regrouped and regrouped again. The themes were further studied, and similar themes were clustered. Part of this process involved printing and physically cutting out each theme to create a tangible, large-scale layout where all emergent themes could be viewed together. When the themes were cut up and compared, associations and connections could be drawn between all the data. Some sense of the themes emerged, and some unexpected directions developed. The

step-by-step nature of the IPA process helped the researcher focus on one data set at a time and then across cases.

This process enabled the researcher to look for patterns across the data, such as areas of similarity or difference. Following this process, a list of recurrent emerging themes was created. Emergent themes were then grouped further to create subordinate themes. Although the frequency with which a theme was supported across cases acted as an indicator of the importance of a theme, other themes that occurred only once in one interview were also considered important and included in the final list of themes. To ensure quality throughout the analytic process, the researcher met with the research supervisors to check the credibility of the emerging themes that formed the initial and final subordinate themes.

- **6) Developing superordinate and subordinate themes**

Subordinate themes were developed from all three interviews, as outlined by repeatedly putting together and separating emergent themes. Slowly, several subordinate themes started to fit the developing range of final superordinate themes, which fell broadly into three categories.

First, the superordinate theme: 1) ‘I went when I was, like, quite young, me’ – Relationship to the CAMHS in childhood, incorporating two subordinate themes: 1i)

‘Always just sort of been there’ and 1ii) ‘The last goodbye’ as participants spoke of attending CAMHS as being synonymous with childhood. Here, the experience of moving from CAMHS to AMHS also involved a process of letting go of the familiarities of childhood and its associated dependencies and of entering adulthood and new adult services.

Second, the superordinate theme: 2) ‘I’ve got to work them out, and they’ve got to work me out’ – Different states of mind in transition, incorporating the two subordinate themes: 2i) ‘Who is this person we have here?’ and 2ii) ‘I really don’t feel 18. I’ve never felt my age’ captures the participants’ fluctuating states of mind related to transition challenges. This included the service transfer process and the emotional meaning they attached to such experiences. Feelings of instability and not belonging between leaving one context, experience or identity and entering the next made participants reflect on their worldview and place amid such changes.

Lastly, 3) ‘Things seem to be coming together a bit’ – Integration in transition) had two subordinate themes: 3i) ‘I do need someone here to help me’ and 3ii) ‘Not as bad as I used to be’, where participants’ demonstrated, in fluctuating degrees, a capacity to take responsibility for their minds and actions as part of the assimilation of their new adult identities within an adult mental health service.

These themes reflect the overall sense-making of the data in relation to the topic of the emotional experience of transition. However, they do not attempt to outline or

summarise everything that the YP brought to the interviews. Furthermore, not every theme presented was equally prevalent in every interview. While many of the themes were common to all three participants, there were also areas of divergence and difference, which will be addressed in the findings and discussion in the next chapter. For example, the richest data from the interview with Sonja meant that the themes discussed were more explicitly raised, whereas the interview with Tony had more implicit references. Instead, the themes were chosen for their symbolic relevance to the task of transition, both in terms of service transition and developmental transition in adolescence.

- **7) Summarising themes into a table:**

The researcher constructed a summary table (see Appendix 6 and below) to present the final three superordinate themes and six subordinate themes.

Superordinate themes	**Subordinate themes**	
1)'*I went when I was, like, quite young, me'* – Relationship to CAMHS in childhood	1i) '*CAMHS has always just sort of been there'*	1ii) '*The last goodbye'*
2)'*I've got to work them out, and they've got to work me out'* – Different states of mind in transition	2i) '*Who is this person we have here?'*	2ii) '*I really don't feel 18. I've never felt my age'*
3) '*Things seem to be coming together a bit'* – Integration in transition	3i) *'I do need someone here to help me'*	3ii) *'Not as bad as I used to be'*

Summary of the qualitative method:

This chapter presented the study design for the service evaluation of Study 2, including a description of the recruitment process, ethical considerations and a detailed description of the data collection and analysis procedures. From here, the rationale for using the chosen qualitative research method of analysis, IPA, and the implications of the researcher's subjectivity were outlined. The aims of Study 2 were explained in the context of the use of the qualitative method of analysis, which enabled the researcher to go beyond the descriptive accounts of Study 1 to explore the meaning of the data at a deeper level of interpretation. The themes that emerged from the data were distilled until three superordinate themes and six subordinate themes emerged. Each of the three superordinate themes and the two subordinate themes are presented, with excerpts from the data to illustrate the analytic propositions. The framework in the table above provides a structure for presenting the data and will be discussed in the next chapter.

Study 2: Findings and Discussion

This chapter presents the themes that emerged following an IPA of the data collected from interviews with three YP who were in the process of or had recently transitioned from CAMHS to AMHS. The intention of the interviews was twofold: firstly, to explore the lived experiences of the participants' transition from the CAMHS to the AMHS, and secondly, to capture their internal worlds and how these related to their thoughts about transition and their ability to manage it. The data revealed the complexity of transitioning between CAMHS and AMHS regarding transitional care provision and the developmental task of transitioning between adolescence and adulthood. In addition, connections are made to existing literature describing adolescent states of mind, their capacity to manage adult-related tasks and service transitions between mental health care providers. Quotations from the data were taken verbatim from the transcription service or the online chat.

Synopsis of participants:

‘Sonja’

Sonja first came to CAMHS as a latency child after being referred from her primary school for her behaviour. Following this initial referral, Sonja received some low-level interventions and was discharged from CAMHS a few months later.

A few years later, Sonja was referred to CAMHS, this time by her general practitioner (GP). Again, she was offered low-level intervention strategies before receiving once-weekly psychotherapy at the age of 16, which she continued until she was 18. In the earlier phase of psychotherapy, Sonja was also seen by a psychiatrist and prescribed medication.

Sonja was the first participant to be interviewed by telephone. Sonja had started having transitional meetings with the new adult services (NHS AMHS) and met with her named worker three times before the interview.

‘Tony’

Tony first attended CAMHS as a latency child when the GP referred him for concerns about obsessive behaviours. Only later, when Tony was in early adolescence and following a significant death in the family, he was referred again to CAMHS, this time by social services.

At age 16, Tony began receiving regular support from a clinical psychologist at CAMHS, which continued until he was 18.

At the time of the interview, Tony wanted to be transferred to adult services, but it was not yet clear whether this would be statutory services or a third-sector organisation. There had been conversations in the network about his transition for some time, including with his social worker and GP. However, despite frequent discussions about transitional care, no clear plan had been arranged during the interview.

Tony was the second participant to be interviewed. He asked to do so via the chat function of an online video platform.

‘Erin’

Unlike the other two participants, Erin had left CAMHS by the time the interview occurred. In addition, the CAMHS clinician who had been her last care coordinator had known her for a shorter time (just over three months before her discharge from CAMHS) than the other two participants.

CAMHS had first seen Erin following an overdose she had taken in early adolescence, for which she had received brief intervention from the crisis team. Some years later, after another overdose, Erin was put on a waiting list for a

specialist intervention, but this work did not occur. Instead, she received telephone appointments over three months, focusing on low-level CBT-type support. At age 18, Erin was encouraged by her CAMHS case manager to self-refer to a third-sector organisation, which she did. However, from what she revealed in the interview, she did not meet the threshold for support from this organisation. Erin was the last participant to be interviewed, and she was interviewed by phone.

COVID-19 Pandemic:

While not the focus of this study, it is critical to acknowledge that the thinking, data collection and, to some extent, data analysis of this project were influenced by the COVID-19 pandemic. Given the impact of the pandemic, it is impossible to isolate the participants' experiences without pointing out that the pandemic came at a critical time in the development of these YP who were transitioning from CAMHS to AMHS and from adolescence to adulthood.

In terms of service provision, the advent of the pandemic brought with it, more than ever, a hierarchy of risks. In some statutory mental health services (including the one in which this study was conducted), there was a rapid move to online consultation, with only the YP with the most severe mental health difficulties being seen at all. With the emphasis on crisis and risk, and only those in the most urgent situations

being seen and rarely face-to-face, mental health difficulties could arguably be viewed as a lower priority as the country battled the urgent and rapidly spreading virus. However, during this pandemic, anxiety, depression and self-harm increased across the population (Holmes et al., 2020; Royal College of Paediatrics and Child Health, 2020).

The YP in this study were already facing unprecedented changes at a time of transition, arguably more than at any other time than early childhood. During the pandemic, the usual rhythms of time and place were disrupted, but so was the world of the transitioning YP, who were adapting to new realities about themselves and others. The pandemic, especially during periods of lockdown, gave the impression that time was suspended, but the development of YP's adolescent progress cannot be stopped (Catty, 2021). How the pandemic intersected with the individual trajectories of this study's participants is unknown. Furthermore, it is beyond this study's scope and aims to explore the pandemic's implications. However, a confused sense of time and what the future held compared to what had passed was likely to be magnified in a time of change and uncertainty on such a global scale, especially among adolescents.

Findings of Study 2:

Adolescence is, in many ways, a time of transition, but most markedly, it signifies a passage from childhood to adulthood. Physical, psychological and external life changes characterise this transformative development period. As understood in psychoanalysis, the young person in adolescence is caught between a present shaped by the past and an unknown future that contains this past in the present (Catty, 2021). The holding function of the earlier latency years now gives way to the dispersion and fragmentation of the self when faced with new emotional and physical realities (Waddell, 2018). This study addresses this period of change at the transitional boundary between childhood and adulthood and the psychological mechanisms that come into play.

This chapter will explore the participants' capacity to manage the transition between CAMHS and AMHS at a time when 'development runs unevenly' (Waddell, 2018, 177). Psychoanalytical thinking seeks to understand each individual's particular life situation and experiences. This study will consider the data from this psychoanalytically informed lens using IPA as the method of analysis. Smith et al. (2009) provided helpful guidance for conducting an IPA study.

Superordinate Theme 1) *'I went when I was, like, quite young, me'* – Relationship to CAMHS in childhood

In all three interviews, ideas about childhood ran parallel to thoughts and discussions about their time at CAMHS. At some moments, the participants, all now in later adolescence, faced the reality of losing their childhood and tried to engage with the adult world, as shown in the data.

This theme of a relationship with CAMHS in childhood ran throughout all the interviews and developed into the superordinate theme, reflecting the frequency with which CAMHS was mentioned by participants as synonymous with growing up and being a younger child.

The overarching superordinate theme developed from the first subordinate theme: 1i) '*CAMHS has always just sort of been there'*. In different ways, participants conveyed that leaving CAMHS meant losing something known and certain. They pointed out that CAMHS, perhaps like childhood itself, was the known world, though not without its limitations and difficulties at times.

Subordinate theme 1i): – '*CAMHS has always just sort of been there'*

This first subordinate theme came directly from Tony's account of his experience with CAMHS; it had 'always just sort of been there'.

'I've been going to CAMHS on and off most of my childhood. CAMHS has always just sort of been there' (Tony, p5).

Tony seemed to say attending CAMHS had become part of his childhood experience. He spoke about CAMHS with a nostalgic quality, as if the institution had become a kind of 'parental figure' with whom he had closer contact than with others at specific points in his childhood but who was still available to him when he needed it. Similarly, Sonja expressed having experienced a kind of yo-yo effect between attending and not attending CAMHS throughout her childhood.

'I went to CAMHS [___ 0:00:08]. I went when I was, like, quite young. I went when I was, like, really young, and then I stopped going for a while, and I came back when I was, like, I think I was 14 or 15, but I don't really remember (Sonja, p1).

Sonja stated that she could not 'really remember' the exact timing of her involvement with CAMHS, but, like Tony, she was able to talk in detail about what she did remember: that CAMHS had been a service that was not new to her at the time of her departure. The service audit in Study 1 found that all YP referred for transition, including the three interviewed here in Study 2, had been known by CAMHS for an average of eight years. Perhaps the phrase 'don't really remember' also indicates the difficulty of understanding the 'edges', implying that, for a while, it may have felt as if time stood still and CAMHS would always just 'be there'.

Tony even talked about his memories of the former CAMHS clinic building. He was a veteran of the service and perhaps imagined that his relationship with the service was longer than that of the researcher.

'I don't really know. I can't really remember, so I can't comment on that. It were (sic) probably when I were (sic) 9 and 10, back at the old (previous clinic) CAMHS. I'm not sure if you'd know it' (Tony, p4).

Erin, on the other hand, who also had contact with CAMHS throughout her childhood, did not speak directly about her memories of attending CAMHS. Instead, her experiences seemed embedded in the family alliances and identifications of the time:

'I was the caregiver, and in 2018, I tried to take my own life. My dad would be manipulative, like lying about his health and stuff. Then, in 2019, I think it was at the beginning of that year, I admitted myself to the hospital with my auntie because I didn't feel safe at home because my uncle and my dad had stopped me from seeing my grandad. I used to live with my grandpa when I was little, and then I left when I was about eight. After that, I can't really remember' (Erin, p2/3).

By speaking about the change in living arrangements between family members, Erin seemed to highlight that family relationships were seen as a central issue in CAMHS, in contrast to adult services, where the focus is on the adult individual. Thoughts of being a child from her family of origin also seemed prevalent for Sonja, who described attending CAMHS with her family and being supported by CAMHS through family:

'My mom and dad came with me (to CAMHS) when I was younger, so I think they told my mom and dad what the best things were [___ 0:02:23], do you know what I mean? and how to help me and that' (Sonja, p4).

She later went on to add:

'They (the AMHS) just spoke to me now. My family haven't got a clue what's going on, and it's very different now that I'm expected to manage it on my own, which is a bit scary. I don't know what's happening now' (Sonja, p15).

Part of the task of becoming an adult is to find an identity as an adult separate from family. Likewise, part of the transition from CAMHS involves giving up familiar structures and taking on a more autonomous role in AMHS. However, as noted in the literature review, this change in service culture can feel like a different language as AMHS becomes more focused on medication and diagnosis (TRACK, 2008). This is also linked to Mulvane's (2015) finding that, unlike in family-oriented CAMHS services, YP at AMHS need to play a more autonomous role in their health care.

Similarly, the literature on psychoanalytic perspectives on adolescence argues that the adolescent's main task is to find an identity, not only as the child of their parents but as a separate individual (Brenman-Pick, 1988). This identity search involves 'all too real relinquishments and losses, for example, of the known childhood-self with its known family structures' (Waddell, 2018, 157). The participants in this study touched on these issues in different ways. The loss was twofold: leaving behind childhood and losing the familiar CAMHS service that had 'always been there'. Sonja was

explicit about her anxieties that being seen in AMHS meant taking responsibility for her own care, which felt like a frightening ‘shit scary’ prospect without her family's involvement, as had been the case with CAMHS.

Subordinate theme 1ii): ‘*The last goodbye’*

In order to move forward, there is inevitably a process of parting that must also be endured. However, how these goodbyes were managed pragmatically by the services and within the psychic constellations of the participants provided insight into how the transition experience was handled overall.

During data analysis, the researcher discovered how often the participants referred to their relationships with significant others that had ended or had clearly changed as they moved through their adolescence into adulthood. This included relationships with clinicians in CAMHS who had become important and meaningful to them. Although patient-clinician relationships in CAMHS were not a central research question, nor did the interviewer specifically ask about personal relationships, all three participants clarified how the loss of known relationships shaped their transition experiences. Juxtaposed with the idea of a relationship with an ever-present service (as discussed in the ‘always just been there’ theme), there was also the reality of an ending in CAMHS and the finality of that end.

Sonja stated:

'Before I just went (to CAMHS) because I had to go, but now I do genuinely want to go because I feel better after[wards], and then knowing I've got to that point where it's got to stop and say goodbye, it's a bit gutting' (Sonja, p16/17).

The end of CAMHS appeared to be very painful for Sonja and her therapist, with whom she had once-weekly appointments for nearly two years (a long-term intervention within CAMHS NHS), as she indicated in her interview. The researcher was also quite moved when she heard about Sonja's relationship with her therapist and her profound disappointment at its ending. Despite her ability to think about her experience, there was also evidence in the interview that Sonja was vulnerable to lapsing into more defensive states of mind. The researcher felt that Sonja required continued help and understanding in the adult service.

'I know it's got to happen.' It is a bit gutting because, obviously, once you get to know someone, and you start to trust them, and you feel that they're genuinely helping you, I'll miss it. I don't trust easy' (Sonja, p16).

The researcher wondered if thinking about what was being given up (CAMHS and the relationship with the therapist) when participating in the interview process acted as a painful reminder of the good experiences, which at moments felt too painful to accept, causing Sonja instead to be sceptical and critical of anything new: 'I don't trust easy'.

Though fleeting, Tony acknowledged that there was a passage of time over which he had no control. Consequently, his last contact with CAMHS, specifically with the clinical psychologist who had supported him in CAMHS over the previous three years, was imminent. The clinician described the intervention he received as a type of 'holding', given the turmoil Tony was facing in his family life and owing to his familiarity with this clinician, which she felt was important to maintain, considering his ASD diagnosis.

> *'[I'm] not sure how I'll feel at our last goodbye (with his long-standing CAMHS worker). We're speaking later today' (Tony, p9).*

Unlike Sonja, Tony found it difficult to 'speak to' his feelings about this 'last goodbye' and spoke instead more formally and less conversationally. This, of course, is also likely to reflect the method by which the interview was conducted via the chat function of an online video platform. In doing so, both researcher and participant were denied the opportunity to learn more about each other through the nuances of the inflexion or rhythm of speech. The researcher wondered if this 'last goodbye', due to its emotional impact on Tony, was defensively reduced to something more akin to a business transition in Tony's mind to keep at bay the recognition of the loss involved.

Similarly, when asked about her experiences and thoughts about leaving CAMHS, Erin's answers were short but imbued with meaning:

'It happened (the transfer between services) just like that, hello and goodbye' (Erin, p16).

Unlike Tony, for whom there may have been a desire to strip the ending of any personal meaning, Erin, in her non-verbal communication and the feelings of countertransference she evoked in the researcher, communicated her anger and frustration at what she perceived as a rushed overlap of services. In addition, the researcher drew on the reflective diary she kept throughout the interview process to continue the idiosyncratic nature of the IPA while also considering thoughts and feelings of countertransference.

When thinking about the impact of these different experiences of goodbyes, the researcher came to understand that not only were participants negotiating separation and loss in this most current transition between services, but they were doing so in the context of previous losses and separations that they may have been emotionally ill-equipped to manage or understand as younger children. Due to the very nature of their involvement with CAMHS and the need for transitional mental health care, it could be argued that all three participants were more vulnerable. Disturbed early lives, broadly described as attachment difficulties, were part of the picture for all three participants. In addition, at some point in the CAMHS, all three had received a diagnosis, which is a statement of developmental difficulties or disturbances. However, as Kraemer (1999) argued, the most powerful influence on one's capacity

to manage life's changes and challenges is the care received in childhood, especially early childhood. The participants in this study had all endured difficulties in their childhoods, where, at times, it appeared that psychic containment in the family was limited.

For example, as discussed in the synopsis of the participants' backgrounds, Tony tragically experienced the suicide of a close family relative during his early adolescent years. This then caused a breakdown in relationships in the family, resulting in the severance of contact. Likewise, as Erin had, Sonja had to negotiate several different living arrangements throughout her childhood, often without a fixed abode.

One aspect of these losses that seemed particularly difficult for the participants was the way the experiences felt abruptly thrust upon them. This was captured most succinctly in Erin's statement when she stated, in the same breath, 'hello and goodbye'. This could be thought of as mirroring something in the transition process when it happened suddenly, without much preparation or consideration of the young person's experience or preparation for such a change.

Some studies in the literature found that YP often spoke of feeling 'abandoned' following discharge from CAMHS, especially when the transition was sudden (Lindgren et al., 2014; Swift et al., 2013). In addition, some young people feel unsafe and ignored after transferring to AMHS (Lindgren et al., 2015). The literature

suggests these feelings are related to the expectation YP now face – that they should be prepared to take responsibility for their own care needs – leaving some feeling alone and confused about autonomous decision-making (Lindgren et al., 2015; Swift et al., 2013).

This sudden transfer of care can become problematic, not only in terms of continuity of service provision but also because the young person does not have the opportunity to mourn what they are losing in the process and therefore what they can gain from the new service. The sense of loss was most discernible in the interview with Sonja, who spoke candidly of how ‘gutted’ she felt when she had to leave CAMHS or, more specifically, the important relationship with her therapist. Arguably, leaving and loss are closely linked. However, the literature on CAMHS provision for those in need of transition neglects the impact and capacity of the young person to process the loss as an essential and central issue in the process.

The literature also seems to neglect the adolescent’s central task of developing a stable identity of their own and how this developmental task permeates the transition process that throws the young person back into early, even infantile, states about belonging and existence in the world. This may not be consciously perceived by the young person or the services involved in the transition. Leaving one service to join another seemed to generate, to varying degrees, an awareness of the reality of the

loss of unquestioned belonging to CAMHS and the relative safety of that service in the face of the unknown and unfamiliar.

Superordinate theme 2) *'I've got to work them out, and they've got to work me out'* – Different states of mind in transition

Participants talked about the transition process, their thoughts and feelings about the loss and separation involved, and the challenges of change, which can feel like a threat from the unknown and unfamiliar. These thoughts and feelings could be considered either developmental or anti-developmental. There were also points of oscillation between the two. The first of these will be explored within the superordinate theme: 2) *'I've got to work them out, and they've got to work me out'* – Different states of mind in transition, capturing the fluctuations in participants' internal worlds. The data revealed that, for participants, the state of transition was perceived as an unstable or 'not belonging' experience as they negotiated leaving one service and identity to join the next: the adult service and adult self.

Subordinate theme 2i) *'Who is this person we have here?'*

The first subordinate theme emerging from this second superordinate theme encapsulates some participants' reflections on the shift from a child to an adult

identity and how this impacted their sense of self and how they felt perceived by others. 2i) '*Who is this person we have* here?' illuminates changes that co-occurred within the move to the AMHS, both with regards to how participants felt they were viewed by the new service and how they felt about themselves, including conscious and unconscious phantasy, amidst such changes. These changes included making decisions for themselves and feeling that they were becoming more independent, along with ambivalence and confusion in the process of the move to adult services.

Of the three participants, Sonja spoke most clearly about the expectation she felt to adapt quickly and compliantly to a completely different cultural shift between CAMHS and AMHS. In her reflections, she raised the fundamental issue of feeling that the staff at the new AMHS were not taking enough time to get to know her as an individual:

'At CAMHS, they treat you like you're a person, not a number, and I just feel like I'm just a number to them. They're just like, "Well, we've got this person here." They don't say, "Who is this person we have here?" They don't understand me. They just see me as some random person' (Sonja, p41).

Sonja's experience of feeling depersonalised was echoed in the literature. For example, Singh et al. (2008) observed that YP felt 'known' only through diagnostic criteria and labels in AMHS service. This echoes Paul's (2013) argument that transitional mental health care is often viewed in medical terms rather than as a human experience that needs to be considered individually. By being referred to as

‘just a number’ rather than an individual with needs and wants, Sonja seemed to suggest that this perhaps reinforced an internal phantasy that she was not being cared for or understood for who she was.

When faced with the imminent separation from the CAMHS and childhood itself, the researcher noted that the participants sometimes presented with defensive, even potentially destructive, states of mind alongside healthier parts of their personalities. Klein (1935, 1940, 1945) characterised these different states of mind or positions that influence the axis on which one sees and feels seen by the world as being present regardless of chronological age. These positions can be understood as regressions to more infantile states of mind, the paranoid-schizoid (Klein, 1946) and the alternative depressive position (Klein, 1945). As the literature described, the latter involves love and concern for others. Instead, the paranoid-schizoid person has a primarily narcissistic attitude in which the world is viewed from a position of self-interest and tends to see things from extreme and polarised perspectives.

From the data, it appears that one way Sonja deals with anxieties related to the task of transition is by splitting, which is typical of Klein’s paranoid-schizoid position. This split is between the perhaps now idealised CAMHS and, on the other hand, the denigrated AMHS. Faced with losing the relationship in CAMHS, the researcher wondered if this splitting of services into good and bad was one way Sonja unconsciously defended herself against the anxieties of change. Nonetheless, Sonja

was then able to reflect on how she'd initially had similar reservations about attending CAMHS:

'It didn't used (sic) to work at all for me (psychotherapy), but I think once someone works me out and they know how to approach me, and they know how to speak to me, once they've got my trust, then I'm completely fine." My psychotherapist has my trust now. [___ 0:20:05]. Obviously, I didn't trust her at first, ___, so I didn't even used (sic) to really speak, but obviously, I feel comfortable now, and I feel fine, but it's just going through that again. I've got to work them out, and they've got to work me out. Do you know what I mean? (Sonja, p26-27)

Sonja, however, was able to reflect on her ambivalence. The researcher speculated that in Sonja's psychotherapy, she had explored the unconscious mechanisms and defences she turned to in times of pressure and change. She could put this into words in the interview. In contrast to psychotherapy, an individualised intervention in CAMHS, Sonja reflected on how she felt rushed and then hostile about AMHS:

*'They (AMHS) want to do it too fast. It feels like they want to get you in, find out sh*t about you, and then just get rid of you as fast as possible. They don't even care. It makes me just not want to do it' (Sonja, p47).*

Here, Sonja's feelings of hopelessness and dissatisfaction are clear. Such feelings have also been highlighted in the literature. Dimitropolous et al. (2014) discovered that several of the participants in their study had negative views about the new AMHS. They had not participated in conversations about why they were being transitioned to the AMHS or what would be offered when they arrived (Dimitropolous et al., 2014). This is despite current guidance from NICE (2016), which recommends

that ‘person-centred approaches should be used to ensure that young people are supported to make decisions about their own care’. Support with decision-making in CAMHS may empower young people to develop autonomous decision-making, which will inevitably be required in AMHS (Dimitropolous et al., 2014). The service audit also showed that only 26.6% of YP who transitioned had a transition plan. However, despite poor evidence of transition planning, 73.3% of these YP were involved in discussions about their transitional care and had a say in what would happen to them.

Sonja spoke of turning away from the AMHS clinician, whom she perceived as uncaring and unsupportive, to mitigate feelings of disempowerment and exclusion. However, through her own process of rejection, Sonja was also able to recognise the potential negative impact this would have on negotiating a new therapeutic relationship in AMHS:

> *‘I’m not trying to push them away. It’s just I can’t let myself trust them right away. It takes quite a long time, and people don’t get that, and they think I’m just doing it to be a bit of a dick. You know what I mean? (Sonja, p27).*

This sense of rejection experienced by YP transitioning between services has been widely reported in the literature (Singh, 2010; McNamara, 2017) and, again, is often seen as the result of poor planning, which would help the young person prepare for leaving one service and all that is familiar there for another. However, for YPs with a propensity for feeling rejected and excluded, the external transition experience could

activate more paranoid states of mind. The more persecutory states of mind are awoken by an unconscious fear of separation that stems from an earlier phase of life, namely infancy. This is not raised in the literature in relation to the specific transition experience between the CAMHS and the AMHS and is a significant finding of the study, which will be discussed later in this section.

The researcher felt that Sonja's ability to describe her thoughts and feelings, including her ambivalence, demonstrated fluctuations in her internal psychic world. Another adolescent might not be capable of this degree of reflection in the way Sonja was able to consider her contribution to the relationship with the new adult service and how she came across to others, even with her strong reservations about their intentions towards her.

Unlike Sonja, Tony conveyed a strong sense that his internal world would be at risk of collapse without the ongoing support of external structures:

'To minimise my potential stress and risk of falling into a negative cycle, I think I would need structure and to know what's happening' (Tony, p8).

Tony spoke again about needing 'structure' in more concrete terms:

'Having a good structure of what was happening and support with a safety net through social workers and CAMHS is what I needed' (Tony, p8).

The researcher was reminded that Tony had no supportive family network around him and was under the care of the local authorities. Although he was not literally

homeless, as he had once been threatened to be, the researcher had the impression that Tony felt he was psychologically ‘unhoused’. Without robust internal resources to support him, Tony expressed his need for a safety net in the form of external services. However, Tony also spoke of his deep mistrust of others and relationships, distancing himself from those on whom he might depend.

‘The original assessment (in CAMHS) was heavily backed, to my knowledge, by my family. I’ve been independent from my family for a long time’ (Tony, p4).

He added:

‘I have had bad relationships, and I feel I have privacy concerns. For a while, now I can (sic) manage most things on my own’ (Tony, p6).

Levinson (1986) claimed that between each life stage, a transitional period exists in which existing life structures, such as the sense of self, are reappraised and rebuilt. Positioned in the ‘in-between’ place, Tony appears to quickly lose touch with any internal figures of support in his mind. Instead, Tony reflected on his need for an external network to support him through this transitional period. However, Tony also reported that he feels and has experienced relationships as problematic.

At points in the interview, the researcher experienced these difficulties with the relationships Tony referred to in the countertransference feelings evoked, especially because his interview was conducted online via a chat function. The researcher further considered that being at a distance from the interviewer provided Tony with a

place of safety when discussing potentially evocative issues around the subject of transition. However, the absence of sensory contact, visuals and audio (which had been present in the other two interviews conducted on the phone) left the researcher considering the motives for rejecting this more personal sort of contact, perhaps because it was linked to persecutory anxieties that the qualities of potentially helpful and supportive external figures could be undermined. The researcher wondered if this had led to a distorted internal version of relationships with others, similar to how Sonja spoke about her suspicion of the new AMHS, based on her experience of the cultural change between services but also founded on her own internalised expectations and assumptions that prevailed when faced with the challenges of transition.

The confusion between fantasy and reality can become problematic when the young person is left unaware of the reality of the relationship (Waddell, 2018). The researcher wondered if this tendency to distort what help had been and was available resulted from being unable to imagine the paternal qualities of ordinary concern. The statement made, ‘I can manage most things on my own’, suggests that one way Tony managed to struggle with changing identity was to become what in the literature Winnicott (1965), Miller (1995) and Diem-Wille (2021) refer to as a ‘pseudo-adult’, thereby, in moments, denying needs and dependencies. Erin similarly presented some pseudo-adult qualities that were, on the surface, convincing.

Similarly, with the other two participants, the researcher at times felt Erin wished to convey that she didn't need any more help from the mental health services:

'I phoned and had a meeting with a lady over the phone to see what I needed help with, and then, I think it was a month or so, I got an appointment with somebody (in the adult service). They only [___ 00:10:59] because the lady didn't think I needed it anymore. I don't think I need any more help' (Erin, p20).

However, on closer inspection during the data analysis, the researcher noted that Erin's assertion that she did not need further help came about after she had been turned away from the third-sector adult service to which she had self-referred. As discussed above, the feelings of rejection likely contributed to Erin's shift to a more omnipotent mindset where a denial of help prevails. The researcher also wondered if Erin expected and deeply feared rejection due to her separation anxiety and therefore behaved in ways that provoked rejection by the new adult service. This conflict between the dependent ('I phoned … to see what I needed help with') and the rejectionist ('I don't need any more help') evident in this one statement by Erin but is largely absent from the literature. These opposing forces may explain why some YP referred to adult services declined the support offered, as did the 19 YP who declined further support in Study 1.

In addition, Erin spoke about the feeling of not being seen. In relation to talking about going to college, another transition she had undergone, Erin expressed her outrage at the disinterest and oblivion of her existence during online seminars by tutors. The

researcher sensed that Erin's anger about how she felt the college treated her was related to more than just the incident to which she referred:

'She (the college tutor) can't and doesn't want to see our faces. She doesn't know if we're listening or asleep!' (Erin, p54).

In what could be viewed as a narcissistic preoccupation, present more notably in adolescence but not limited to it, Erin seemed to be raising the anxiety-provoking issue of being seen as an adolescent caught in transition emerging into the external adult world. As Steiner (2006) pointed out, 'seeing and being seen are important aspects of narcissism, where self-consciousness is always a feature' (p1). Erin seemed to simultaneously want to be seen, be outraged by not being seen and feel anxious about what would be seen as she negotiated a new adult identity. Furthermore, Erin's complaint about not being seen seemed to relate to issues identified in the literature about adolescents' sensitivity to separation and the search for individuation. As Brady (2015) observed, Erin described her baby self, which needs care and nurture, and demonstrated defences against infantile impulses, such as a manic insistence on wanting to be left alone and the fact that one can manage independently. Defences against a painful awareness of separateness and loss can tempt a young person to reach for a false sense of independence and to assert that further support is not needed despite the reality, as in Erin's case.

Subordinate theme 2ii) *'I really don't feel 18. I've never felt my age'*

The researcher felt that even in late adolescence, there was a disparity between the physiological, emotional and chronological ages of the interview participants. Indeed, participants commented on this, as did the literature that explored links between adolescence and infancy, infantile states in adolescence where 'in the second decennium of life, the development he passed through in the first five years' (Jones, 1992, 39-40, in Waddell, 2018, 165). This subordinate theme also encompasses how the adolescent must now rework infantile conflicts in a new and fluctuating adolescent mind and body. This came to the fore, particularly when the participants were asked to consider other transitions they had undergone and how these experiences had been managed. For example, in the interview, one participant, Sonja, spoke most vividly about her experiences, describing how her development has not been a linear process and how her perspective is captured in the subordinate theme: 2ii) 'I really don't feel 18. I've never felt my age':

> *'I don't think the adult mental health people intentionally do it, but they do it, like, a little bit, quite a bit." I don't think it's intentional, but they do a little bit. They're like, "You're 18 now, so you should be doing this." It's like expectations are just way too high. I don't feel 18 at all. I really don't feel 18. I've never felt my age' (Sonja, p43).*

Drawing on her experience of transitioning from primary to high school, Sonja again spoke of a gap between her actual age, the associated expectations, and her felt age:

'Everyone expects, like, a lot from you just because you've left school. Just because you've hit that certain age, everyone expects so much from you, and it's like, you can't expect me to change that much just because I've left school. I'm still the same person. Do you know what I mean?' (Sonja, p21)

Sonja addressed the issue of the transition from CAMHS to AMHS, adding,

'I think it's stupid, really, because if you're not, like, an adult the day before your birthday, people expect you to suddenly change overnight. "Well, you're 18 now, you should be doing this, and you should be doing that." It just annoys me because then you feel pressured into doing it, and you constantly feel like you're not good enough because you're not hitting this mark, and it's, well, annoying' (Sonja, p22/23).

She continued:

'You know, just with some stuff people say, and as soon as you're 18, all people say to you is, "You're 18 now, you're 18 now." It's, like, "Do you not think I know my own age?" "You don't have to continuously tell me how old I am." Do you know what I mean? That's what everybody does to me now. It makes a massive difference. It's just a number, isn't it, really?' (Sonja, p23).

There is widespread agreement in Western culture that the 18th birthday signifies the beginning of adulthood. It is also usually the dividing point between services for 'children' and those for 'adults'. The importance of the 18th birthday may even seem to imply that something magical happens overnight, where a transformation from child to adult occurs. This notion is at odds with the reality of a protracted transition to adulthood. Furthermore, Catty (2021) described the 18th birthday as a 'crisis point' for the young person, both in terms of service provision and on a symbolic level. As shown in the service audit, the strict age-based threshold used to determine the timing of transition rather than individual need reinforces this illusion of increased

capacity and readiness for overnight change. In the literature reviewed (Heinz, 2009), some participants felt pressured to meet others' expectations of tasks they should have mastered by the time of transition. These findings seem to be further illustrated in the data from Sonja's interview and thus in the subordinate theme.

Nonetheless, given that she had received weekly psychotherapy in CAMHS (and that this was a particular experience in which Sonja's internal worldview would have been explored in the patient-therapist relationship), the researcher wondered whether Sonja could speak with some force and eloquence about the perceived pressures of maturity and of growing up. The researcher considered that Sonja conveyed that she had to some extent, experienced and internalised the notion of someone who 'waits with the patient, perhaps rather than for them' (Catty, 2021). On this basis, Sonja's outrage at being expected to be more adult could be understood, in part, as a reaction to the loss of this kind of relationship, in which Sonja felt that she was being received and understood in terms of all the facets of her more childlike state of mind alongside the mature parts of her personality.

Erin also spoke of the significance of her 18th birthday, feeling this had been the cut-off point for when she felt she no longer legitimately 'belonged' to CAMHS:

'It felt like, because I'm 18, I shouldn't be allowed in there (CAMHS) if that makes sense' (Erin, p25).

The literature frequently reported that participants were in an ‘in-between’ place, feeling they were no longer children but not yet fully adults (Burnham Riosa et al., 2015; Lindgren et al., 2015). This state of being ‘in-between’ raised concerns for the YP, particularly about the withdrawal of parental involvement and an increased level of responsibility for themselves (Swift et al., 2013). For example, Erin spoke of having to be responsible for a chronic health condition that suddenly erupted once she turned 18.

‘I got diagnosed with (a severe medical condition) just after turning 18’ (Erin, p11).

The researcher felt it was too painful for Erin to reflect on her time at CAMHS and her transition to adulthood like Sonja did. Instead, Erin’s preoccupation was much more about her physical health care concerns that had developed, as she put it, ‘overnight’ once she turned 18.

‘I’m on pain patches, so I dose up on morphine all day, and I’m on anti-sickness tablets, and I’ve had the camera down, and I’ve had MRCP ultrasounds. I’d never been to the hospital in my entire life until I turned 18. Then suddenly, overnight, it all changed’ (Erin, p12).

During and after her interview, the researcher wondered if Erin’s physical, chronic and acutely painful health conditions were exacerbated by her transition into adulthood and moving away from CAMHS.

As the interview progressed, Erin’s pain was palpable:

'It's the point when the pain comes. You can't walk. I'll just be sick because of the pain' (Erin, p14).

Here, Erin seems to be saying that the speed at which things can change unpredictably, despite outwardly growing up over the adolescent years, collides with the stark reality of her impending adulthood.

'I don't like the feeling of being drunk anyway, so drinking I'm not really bothered about. The only thing I really can't do is go out on my own or walk the dogs because it could come at any split second' (Erin, p14/15).

Erin described this life-threatening and debilitating medical condition as requiring constant care and medical intervention. From a psychoanalytic perspective, the massive personality changes in the adolescent years can be seen in the context of the deepest and earliest layers of the personality and can aid in understanding why the CAMHS and, in parallel, childhood can feel frightening and full of risks.

The researcher also thought Erin spoke with some satisfaction about how horrendous the next attack on her bowels would be as if she could already anticipate it. But on the other hand, the researcher wondered about Erin having to wait for the inevitable next attack. One way Erin seemed to manage this anxiety-provoking tension was to speak as if she had fast-forwarded to the time after the attack when life-saving measures and treatments were being administered.

'I'm on anti-sickness tablets, I've had the camera down, and I've had MRCP ultrasounds. I know when the next attack is coming. I can feel it and have to be rushed to the hospital, and then the next thing I know, it's over' (Erin, p12).

As Erin talked about her physical health condition, conscious thoughts about transition seemed to be put aside. The researcher wondered if Erin was more able to describe her physical health difficulties, even if they were very painful, as physical or bodily sensations that could be successfully controlled or treated to some degree and then passed, at least for a time. In contrast, different and protracted states of mind might not be so quickly calmed and contained.

Furthermore, Erin spoke of requiring specialist care, and the researcher wondered if this was one way she felt she could bypass the more ordinary support she would inevitably still need from those around her. It seemed that, for Erin, her physical condition obscured her fluctuating emotional states, and, in turn, she might receive further support from AMHS.

Similarly, Tony spoke of somatic responses to difficulties brought about by the transition process:

'For me, I would find the unknown and not knowing who to go to quite stressful and unnerving. This is when my ASD symptoms get worse, and I get bad headaches, and then I need to see my GP' (Tony, p10).

Tony, like Erin, spoke about his body becoming the site of painful feelings and sensations, perhaps more so when under pressure and in a stressful and unnerving situation, such as undergoing the transition process, both between services and the transition into adulthood.

For both Erin and Tony, physical symptoms seemed to elicit the need for care responses of a particular kind, particularly for Erin, who reported having frequently visited the hospital for treatment since turning 18. However, for this age group, this wish for nurturing care is also at odds with urges to become more adult and move away from the mother or care provider towards others and, ultimately, a partner of one's choosing (Diem-Wille, 2021). However, this requires a balance between opposing impulses. How a personality is structured depends on the particular balance between these two functions. The theme ‘movement in transition’ captures this oscillation between infantile and more adult-developing aspects of the participants’ personalities.

The psychoanalytic lens through which the particularity of the participants’ experiences is viewed within this theme helps to open up an understanding of their transitional states of mind, where there is both a thrust forward into the future, imbued with unconscious phantasy and simultaneously a pull to the past (Catty, 2021). For Sonja, the researcher felt there was evidence of a depressive position (Klein, 1945) alongside a more primitive disintegration towards splitting. This splitting could be seen as an expulsion or an attempt to solve this conflict by not facing loving and hostile impulses towards the same person or service. This would be more in the area of the paranoid-schizoid position, as discussed above.

Superordinate theme 3) '*Things seem to be coming together a bit'* – Integration in transition

The final superordinate theme captures not only the participants' struggle but also their capacity to integrate the emotional elements of their experiences within their personalities. Alongside feelings of disintegration in the process of movement in transition (as discussed in the previous themes), participants spoke of feeling they could take more responsibility for their minds and actions as part of the beginning of the assimilation of their new adult identities. In such states, feelings of coherence and togetherness related to transition were evident, yet their impact was neither linear nor permanent.

Subordinate theme 3i): *'I do need someone here to help me'*

Alongside moments in the interviews indicative of the presence of persecutory anxieties, participants could also draw upon internal supportive capacities while acknowledging a need for further support from the adult service, as Sonja put it:

'I do need someone here to help me because I can't deal with things on my own, and that's why I go off the rails because I can't deal with stuff. The way I deal with stuff is I go get pissed or off my head, which is not ideal' (Sonja, p51).

For Sonja, self-concern seemed to be a source of motivation for seeking further help from AMHS. Sonja showed an interest in her inner world and could, albeit fleetingly,

take responsibility for her own mind at points in the interview. By occupying an observational stance in relation to herself, Sonja could think about her need for ongoing support in AMHS. She had discovered something about her capacity to identify her needs rather than being solely a victim of circumstances. The researcher felt that Sonja began to understand the value and importance of relationships by enduring painful self-examination and self-exploration.

'I think now I can see that maybe if I had started seeing the adult people a bit earlier, that would have helped me personally. Maybe I could have asked to see them sooner' (Sonja, p45).

In addition, Sonja's self-recognition and acknowledgement of her tendency to turn away from help when she felt misunderstood indicated that she was developing the capacity to tolerate both her positive and negative states of mind concerning herself and others. In reflecting on her involvement with AMHS, she spoke of feelings of guilt and remorse at how she'd spoken with the new adult worker. The researcher felt Sonja was more in touch with depressive anxiety (Klein, 1946), as reflected in how she talked about how she had treated the worker trying to support her in the new adult service.

'It makes me feel a bit bad, though, because she's only trying to do her job and that, but I can't help how I feel. She is trying to help me, and I don't make it easy' (Sonja, p48).

Here, Sonja could imagine the adult worker as a person. She was not engaged in just a process but said that the transition process depended on developing trust-based relationships. The researcher felt Sonja could express the painful process of beginning to reclaim some projections of disappointments and inadequacies, an intrinsic aspect of a personality in the making (Waddell, 2018). Perhaps out of the three participants in the study, Sonja had the burgeoning capacity to set aside her grievances and omnipotence and be more in touch with her dependency and fear of loss. Sonja's psychotherapy and commitment to therapeutic work – an experience of reciprocal relationship – are likely to have contributed to her ability to turn towards truthfulness, alongside moments of slippage back into defensive splitting and projection.

To some extent, Erin could also acknowledge that if she needed help, she could seek out services to provide it.

> *'I referred myself to Turning Point. A turning point will always help. I couldn't cope with my pain and everything else, but [I] knew I could go to them' (Erin, p18).*

However, unlike Sonja, Erin was not engaged with the new adult service but spoke of knowing they were there to 'go to' if needed. Her comments were different from denying the potential for any further or future help altogether in a more manic, omnipotent or pseudo-independent state of mind, which was also evident at points in her interview.

On the other hand, Tony found it difficult to think about what help he needed. He could, however, acknowledge that the services had helped him:

'The social worker and CAMHS have helped a lot' (Tony, p9).

When asked more directly what sort of help he thought he might need going forward, Tony responded:

'I tend to speak with (the clinical psychologist) a lot about decisions after I'm 18 and what would be best, but I'm unsure. If I were doing it myself, I would know what would be practical' (Tony, p9).

Tony seems able to recognise that he requires further support but feels dependent on someone else to tell him what this support might look like. The researcher wondered if this could be problematic for Tony in a new adult service with an expectation of autonomy around decision-making. As already discussed, the literature found that when young people felt they had increased agency in their transitional care, they had improved engagement with the services (Coyne et al., 2015; McNicholas et al., 2015). However, like many participants in studies considered in the literature, Tony expressed feeling disempowered or unable to make judgments and decisions regarding transitional mental health care (Coyne et al., 2015; Davis. 2003).

Successful transitions have been noted, such as when young people have been given a chance to meet with the new AMHS, including an opportunity to meet with a

designated worker, before the final transfer (Paul et al., 2018). Furthermore, when young people were given information regarding what to expect during the transition, this was advantageous, resulting in a successful transition (Singh et al., 2010; Broad et al., 2017). Singh and colleagues (2010) suggested successful transitions involve the young person being fully informed about their care and understanding why they require a transition. As highlighted in several studies (Singh, 2010; McLaren, 2013; Hovish, 2012), where transfers of care were successful, there was joint working between the services and open communication.

However, nothing in the literature specifically addresses the impact of what YP themselves bring to the transition process and outcome. For example, Sonja's ability to self-reflect and acknowledge or anticipate her ongoing needs is an important area of research into why some YP transition more successfully than others and needs to be studied alongside considering what the services themselves bring to the process and how policy and practice can support YP in using their own resources.

Subordinate theme 3ii): *'Not as bad as I used to be'*

In addition to having doubts and resistance to all that the transition encompasses, the data revealed that participants also wanted to and felt, in part, ready to transition. The subordinate theme of 3ii) 'Not as bad as I used to be' captures the sense of

growing maturity and increased tolerance and capacity to meet difficulties and challenges. It appeared that, for some of the participants, ‘underneath the losses and separation pain remains a striving towards independence, growth and development towards intimacy and the potential satisfactions of maturity’ (Waddell, 157, 2018).

Erin spoke of feeling that, within her development towards adulthood, she had become better able to manage her problems.

‘I’m not as bad as I used to be. I can handle it better now’ (Erin, p39).

Perhaps, at times, Erin did feel that she was now better able to manage her difficulties with the benefit of the passage of time. Yet Erin was locating all her difficulties in her physical health problems, perhaps neglecting the impact of her ongoing emotional needs. The researcher also wondered if Erin was instead trying to convince both herself and the researcher of this statement, which could be understood rather as a manic defence against the reality of now being without the support of CAMHS, which she was now too old to access again.

Erin spoke of having been taken in and could remember that she had been helped in CAMHS in the best way the service could at this point in her life:

‘CAMHS helped me quite a lot, and there was not much more they could do. I do remember that’ (Erin, p33).

The researcher wondered if Erin was expressing some gratitude in this statement and acknowledging the support she'd received. But, on the other hand, Erin's comment had a flatness to it that was suggestive of a passive acceptance that 'there was not much more they could do'.

In contrast to Erin, Sonja spoke with conviction of feeling she had become someone with 'a voice' who could make a valuable contribution:

'I speak up now. I do have a voice' (Sonja, p42).

In the interview, Sonja revealed that while she did not feel she was always autonomously involved in the transition process, she had developed an increased capacity to manage difficulties rather than being overwhelmed by them.

'I understand why, but, obviously, like, there's nothing you can do about it, is there? It's just life, and I'm learning to get better at managing things' (Sonja, p14).

Tony also tentatively acknowledged that he felt he was better able to cope with difficulties:

'I know, for me, I'd need to know what the long-term support would be, as I feel if I went low again, I may find myself falling into a bad cycle again, although maybe I could manage it a bit better now' (Tony, p6).

Tony quickly added:

'I do feel that I would struggle to refer myself for support later if I would need it' (Tony, p7).

Tony's uncertainty about being able to seek help without the support of the CAMHS clinician was evident in the interview, indicating his struggle to trust himself and his own judgment. Tony's rapid shift between independence and dependency seemed to reflect infantile longings and to show how individuals, particularly in this age group, can have a fragile grip on burgeoning adulthood and collapse back into infantile states of mind.

Summary of Findings of Study 2:

The researcher's experience conducting the interviews:

The researcher thought all three participants engaged in the interview process with openness and willingness to discuss the given topic. Even Tony, who had requested that his interview be conducted online via the 'chat' function, demonstrated a commitment to the interview process. The researcher felt this resulted in three fruitful interviews that yielded rich data. However, despite the vast amounts of data collected from the interviews, the researcher could only benefit from the surface, overt content of what was said by participants, including potential unconscious communications and inferences, at the level of psychoanalytically informed analysis. For example, during the interview process, the researcher found that while participants could speak about what had happened to them and when (e.g. what treatment they had received and when), reflecting on how they felt about what they had experienced, particularly emotionally, proved much more challenging. This led to the study's finding that participants were not necessarily aware or knowledgeable about what their transition experiences meant to them as individuals.

This finding could have significant implications when considering policy guidance that YP should be asked directly about their transition experiences and that this should feed directly into the policies that apply to YP at the point of service delivery. In the interviews, the researcher found that statements from YP who were asked

explicitly about their transition experiences may not reflect the individual's lived experience. For example, all three participants in this study found it difficult to speak directly about what they understood of their own lived emotional experience of transition. This led the researcher to reflect on her predetermined expectations that participants would 'know' what their own emotional experience was like and would therefore speak to this in the interview. This reflection will be explored further when considering the strengths and limitations of the project.

Key Findings of Study 2:

Study 2 aimed to explore the emotional and lived experiences of YP transitioning between mental health services from a psychoanalytically informed perspective. This study considered YP's external world experiences, how they related to the transition task, and what this might suggest about their inner emotional states of mind. In addition, the emotional impact of the transition could be explored by using a qualitative method based on semi-structured interviews with three YP moving from CAMHS to AMHS.

However, a key finding of Study 2 was that participants did not necessarily know the emotional impact of the transition process on them as individuals beyond an awareness of the transition being an external event. Although each participant could

speak to the experience of moving from one service to another, the findings of this study suggest that the emotional meaning of such an experience is much harder to put into words. Phrases such as '*dunno*' and '*I don't really remember'* in all the interviews could indicate that the transition experience remained, at some level, undigested and not yet fully available for thought and emotional expression. This finding suggests that, despite participants giving voice to their experiences, there was less awareness of the emotional significance of the transitional experience.

To access the deeper, emotional aspects of the data, the researcher drew upon her own feelings of countertransference to interpret and analyse what was being communicated beyond the actual words used by the participants in the interviews. This unconscious receptivity to the emotionality of the data was a critical source of information about what was occurring in the participants' minds. Before the interview was conducted, the researcher assumed that each young person interviewed would 'know' what their experiences were. However, upon reflection, it may have been the researcher's desire (and the service's) to assume that an experience had been worked through and comprehended before the YP left the children's service.

Study 2's other key finding concerns the significance of the individual's internal worldview in adolescence and how this affects the transition process and includes, for example, whether the participant was (unconsciously and consciously) open to transition despite some complaints, as in the case of Sonja, or whether the

participant was more hostile and ambivalent about the transition, as seen with Erin. The data indicated that no one participant seemed to experience transition in the same way as another, corresponding to differences between YP in this developmental phase of adolescence, where ‘development runs unevenly’ (Waddell, 2018, 177).

The impact of the individual on the transition process is a significant finding, as it demonstrates that, even with the best service planning and preparation, those involved in the transition process also need to take account of YP’s emotional life and mental and psychological development.

This finding was not considered in the previous trust audit in 2017 following the CQC inspection. The prior audit looked at whether the four overarching principles of the NICE Guidance on Transition (2016) had been adhered to and found that they had in more than 80% of cases. However, the audit also revealed that post-transition, only 11% of the YP said they had had a good transition, and almost none of those who had transitioned were still engaged with the new adult services. This seems to support the finding of this study that, even with optimal service preparation and planning, what the individual brings to the process has significant implications for transition success.

The findings of Study 2 will now be discussed in more detail, with consideration given to the relevant literature, along with a discussion of the strengths and limitations of both studies in this project and recommendations for future research.

Discussion of findings:

The results of Study 2 were illuminating in terms of what they revealed about the adolescent developmental task, which permeates the transition process. As indicated in the literature, adolescence is a time that throws the young person back into early, even infantile, states of mind (Catty, 2021; Diem-Wille, 2021; Waddell, 2018). The data suggested that infantile states of mind, such as persecutory anxieties, were awoken in the context of the loss and separation of leaving CAMHS in the context of the adolescent's emotional life more broadly.

Thoughts about loss and separation seemed to permeate the data. For example, participants spoke of the double meaning of transition: saying goodbye to CAMHS was also linked to saying goodbye to childhood and, hitherto, even earlier transitions, such as infancy. This idea developed into the first superordinate theme: 'I went when I was, like, quite young, me' – Relationship to CAMHS in childhood captures the transitional angst of giving up one service for another and its association with leaving childhood. The difficulties that arose from this loss appeared consistent with the literature when comparing the developmental tasks of adolescents and infants. The infant, who once had sole possession of an idealised mother or caregiver, at least in phantasy, must now relinquish and mourn this loss, leading to feelings of rage, confusion and sometimes despair. However, participants in the study approached and reacted differently to their need for transitional care.

Tony, and more notably Erin, described developing somatic responses after turning 18, perhaps indicating their need to be physically cared for and contained, much like infants. For Erin, the retreat to physical health care seemed to eclipse her awareness of the need for ongoing mental health care. In addition, Erin and Tony's interviews revealed that their transition experiences had been less than optimal regarding meeting recommendations (see Appendix 1) given by NICE Guidance (2016), but also from an emotionally informed and containing position. Erin described her transition as being rushed, and for Tony, it was prolonged to the point of leaving little to no time for an ending in CAMHS to be sufficiently held and thought about.

On the other hand, Sonja's transition had been more carefully and successfully planned and implemented as a joint endeavour by both services, notwithstanding her ambivalence and complaints about the new adult team. This finding about coordinated service planning may be one reason why Sonja, out of all three participants, had a greater capacity to speak and reflect on her experience, including this meaningful ending in psychotherapy, in an in-depth and emotional way.

On this matter, the literature distinguishes between transition viewed as a service transfer, as an event in the process of transferring from one care provider to another and transition as a process (Singh, 2008). 'Transfer', with a more medicalised way of viewing transitional care as a transaction from one care provider to another, does not consider the dynamic transition process in which the YP's personal needs and

wishes are part of the picture. Some of the literature studied reflected this growing understanding that other life transitions were powerful influences on the transitional mental health care experience, particularly at this point in later adolescence (Singh et al., 2010), as are previous life experiences and events and how these have been thought about and managed by the YP.

In addition to Singh's (2010) finding, this study found that the idiosyncratic experiences of YP transition cannot, therefore, be understood in terms of diagnostic labels; the individual's unique inner worldview and disposition play a critical role in the transition process. Thus, despite the importance of good service planning and preparation, the interviews also revealed that this was insufficient to ensure transition success. Nor did it account for how participants came to think about and understand their emerging adult identity within the context of past losses and separations, some of which had occurred tragically and traumatically for these YP. This finding of a need to consider the impact of a capacity to mourn the transition process, and indeed childhood itself, demonstrates that the YP at the centre of transition will approach and manage the task differently.

Another important discovery from the data was that the opportunity to develop a relationship between a clinician and a patient in CAMHS positively contributed to the transition process. However, scant literature explores the impact of the relationship with the referring clinician in the CAMHS and the loss of such a relationship during

the transition process. In this study, all participants spoke of the support and commitment of the CAMHS worker and how these relationships provided a secure base from which to transition.

Part of growing up is finding an adult identity separate from the family. Similarly, part of the transition from CAMHS involves relinquishing known structures and relationships to take on a more autonomous role in AMHS. All three participants spoke favourably about their current key worker or referring clinician. Still, losing this important relationship also seemed to lead to resistance to change and getting to know someone new. Despite her ability to reflect on her experiences, Sonja was prone to lapse into a defensive state when asked to reflect on leaving CAMHS. Nevertheless, she acknowledged that the opportunity to get to know and be known by her therapist in CAMHS had supported her transition, even with all her anxieties about the process. However, recognising the importance of this sustaining relationship in CAMHS is only one element influencing transition success.

The results of this study have repeatedly shown that participants' personal dispositions, the way they appeared to use their minds, and their capacity for emotional engagement are important factors influencing how individuals manage and relate to the transition task. This finding is a significant and new contribution to this area of study. The second superordinate theme captures this finding: 'I've got to work them out, and they've got to work me out' – Different states of mind in transition

summarise the importance of each participant's prevailing states of mind and how this interacts with their experiences of transition. For example, Sonja was sometimes able to take ownership of her contribution to the process, albeit fleetingly. Part of the complexity of an adolescent’s task is to turn away from known dependencies and forge a separate identity of their own. However, turning away angrily and defensively, even if there is an interface with developmentally appropriate development, can result from disturbed object relations and lead to falling back into paranoid-schizoid defences.

Furthermore, the results indicated that when service-level coordination and planning around transition were poor at the service level (as discussed above with Erin and Tony, to some extent), this seemed to increase and even collude with the psychological defences that all three participants fluctuated between at points in the interviews. If these defensive structures become dominant states of mind, they could impede further personal development, including engagement in the transition. This finding is supported by the literature on psychoanalytical perspectives, in which it is suggested that infantile impulses and defences from the beginning of life are reworked in times of change, such as during transitions. Arguably, this is particularly true for the adolescent age group, among whom paranoid-schizoid modes of functioning and projective processes may dominate, and acting rather than thinking often occurs (Waddell, 2018).

All three participants exhibited forms of paranoia or hostility deriving from defensive projective systems bound up in the transition process that was likely to have been serving an adaptive form of functioning from early in life. In its more extreme form, the individual may feel in danger and full of persecutory anxiety when psychological equilibrium is disturbed. This may explain why Tony, fearing internal collapse on the hinge of transition, projects his internal feelings of vulnerability outward and declares that if only he had an actual safety net in the form of external service support, his mental health would not suffer. Nevertheless, there was fragility yet rigidity in Tony's interview and the countertransference feelings evoked. His use of splitting, although also essential for development from the beginning, as documented by Klein (1946), seemed to prevent him from fully engaging and moving on to a new adult service. Instead, his views of them were imbued with his own hostilities. Therefore, his internal perceptions arguably became external, negative expectations of how he would be treated.

On the other hand, for Sonja, there seemed to have been some emotional integration of her experiences, as she could tentatively reflect, with anger, pain and sadness, on her transition. Although a less prominent theme emerged from the data, the final superordinate theme, ‘Things seem to be coming together a bit’ – Integration in Transition – acknowledges that states of mind akin to paranoid-schizoid functioning could also be moved through by participants, albeit temporarily.

Sonja, for example, spoke in detail about knowing she still needed help. Perhaps through repeated experiences of having her thoughts and feelings responded to in her psychotherapy with sensitivity, she had been able to introject a feeling of being cared for, while her therapist also could contain her projections in the same way that Bion described what the mother does for her infant through 'reverie' (1962b). Sonja and her therapist had the time and space to think together about this, which may explain why Sonja, perhaps more so than the other participants, could be reflective of this experience. Of note, Sonja was also the only participant who had engaged with the new adult service beyond the first meeting, although begrudgingly at times.

In contrast to Sonja, Erin was much more ambivalent and clearly expressed something of her conflict about the dependent part of her personality (*'I phoned … to see what I needed help with'*) along with the more rejecting side ('*I don't need any more help'*). Here, Erin seemed to describe the duality of wanting and not wanting to accept further help as part of the transition process. As discussed, dependence on a new service can be challenging for adolescents transitioning to young adulthood. This requires relinquishing dependency on others and reconstructing them as stable internal objects or images in the inner world that can support autonomous development. Yet, as well as wanting one's own independence, renouncing what is on offer can propel the YP back into more persecuted, infantile states of mind (Diem-Willie, 2021; Waddell, 2018).

When persecuted states of mind are present, projective defence mechanisms, such as denial and splitting, can prevail. For example, although Tony felt he had matured in some respects, he still spoke in a way that suggested that there was a clear division in his mind between the ‘good’ CAMH service and the ‘bad’ AMHS.

Integrating more realistic aspects of the world and these services may have been too much of a burden for Tony at this point. Without the split, Tony might discover that what is idealised and denigrated is not purely external but internal to the self. Yet Tony is not alone in trying to free himself of complicated and conflicting mental content. All individuals are prone to projecting their hostilities or fears onto others and the world, particularly during times of change and actual or perceived uncertainty, such as the transitional years of adolescence. This kind of recognition of one’s own distortion of reality is shocking to the self and brings with it feelings of guilt and responsibility, which is how Klein (1940, 1946) viewed the depressive position. However, when these most primitive parts of the mind cannot be borne out, as seen in this study, YP’s capacity to fully and authentically engage with the transition process is compromised. This area of study is absent from the literature. It may contribute to explaining why some YP approach and engage with the transition process more successfully than others, despite challenges on all sides.

The researcher's own subjectivity:

The researcher's identity as a child and adolescent psychotherapist brought a psychoanalytically oriented approach to the study, including understanding the unconscious processes that facilitate or impede the relationship between researcher and subject. This personal subjectivity has positive and potentially negative implications for the research. For example, the researcher's capacity to engage with the participants in the interviews in a therapeutic way mobilised feelings of transference and countertransference, which affected the participants' narratives and how the researcher listened, reacted and responded. At times, considering the impact of the researcher's subjectivity was a valuable way to explore some of the unconscious dynamics of the subject-object relationship. In other instances, however, the researcher's own position may have led to splitting and projection, particularly because the researcher has gone through a series of personal and professional transitions in parallel with conducting and documenting this research.

The researcher's own transitions included completing her clinical training, beginning work as a qualified clinician, and, at the intersection of this important professional transition, the sudden death of a parent and what then felt like the end of dependence on an external parent-child relationship. As a result, the researcher could not help but be acutely and, at times, painfully aware of her own vivid, raw transition experience and the likely impact of her subjective experiences on the

project, particularly on the analysis of interviews and the feelings of countertransference evoked. The conception of this study had begun almost six years ago, and perhaps it had been naïve to imagine that the researcher would not encounter her own experiences of transitional changes and challenges over time. However, without these subjective experiences, the study might not have been conducted with sustained commitment and interest.

Strengths and Limitations:

Initially, the researcher began the project with a particular interest in understanding the extent to which NICE Guidance on Transition (2016) had been followed for YP in transition. However, when designing Study 2, the focus shifted to understanding more about the characteristics of the YP themselves and the treatments or interventions they had received in CAMHS before the transition. The focus of the project thus changed as the study evolved. This shift could be seen as a limitation, as it would have been beneficial to return to Study 1 to understand more about the group of YP who did not go on to transition, despite their potential eligibility. In hindsight, as part of the service audit process, it would have been interesting to explore further the reasons for not referring potential cases as part of the audit of services, as more than half of the YP in the sample, who were 17.3 years old at the time of the audit, were not considered for transition despite having moderate to

severe and enduring mental health difficulties. Understanding more about this group would be essential to inform clinical outcomes, especially given the findings of Study 2 that primitive and defensive mental mechanisms are stirred up and reworked both in adolescence and during times of transition. In addition, this may contribute to the understanding of non-consent or engagement.

Another limitation of Study 1 is the potential for misinterpretation of the results. Practitioners and clinicians in CAMHS identify or name the presenting characteristics in different ways based on their own professional training or identity. For example, a psychiatrist is more likely to use medically informed language, whereas a non-medical practitioner might refer to a presenting difficulty in other terms. In addition, some conditions, such as depression and anxiety, seemed to be discussed as though they were interchangeable. Therefore, a standardised understanding of characteristics is problematic, particularly as the service audit was based on a narrow snapshot of time. As a result, the results cannot be generalised to the population as a whole. However, it can be seen from the collected data that this area of study, namely the transition from CAMHS to AMHS, is worth exploring, given the prevalence of YP requiring transitional mental health care.

An inherent methodological limitation of Study 2 was the small sample size. In addition, the participants were purposefully rather than randomly selected by their case managers, who knew the YP and their willingness to take part. Had participants

been recruited by other means, the data may have produced different themes and areas of study. Nevertheless, enough thematic data was produced to explore meaningful and illuminating areas of study. It is also worth noting that the CAMHS in which the research was conducted was located in an urban setting. The results might have reflected this diversity in a more diverse setting, for example, by including multiple racial groups or rural communities.

Another limitation of Study 2 was the extent to which the researcher knew the background information of each participant, as this may have influenced the expectations and therefore the findings of this study. The researcher knew a considerable amount about the participants' family histories and their presenting mental health difficulties while in CAMHS. Furthermore, at the preliminary pre-recruitment stage of the project, potential participants had not given permission specifically for their notes to be accessed for potential recruitment for the study. (Since this study was conducted, access to online medical records has changed). At the time of data collection for this study, permission to access notes was a blanket agreement, or disagreement, for notes to be accessed by all NHS professionals.

In contrast, patients now have more autonomy over who can access what information about them and when. The researcher also knew the intervention each participant had received in CAMHS and the quality of their engagement with such

treatments. Access to such in-depth and personal information may have led to a bias in what the researcher expected to find in the interviews.

A strength of the study was that the three YP interviewed were at different stages of the transition process, which facilitated a varied and rich discussion of their experiences. However, this strength could be viewed as a limitation in the context of cross-case examination because the results are more difficult to compare, although this was not the aim of the study. In recent years, the CQC (2020) has become interested in learning more about people with personal experience using mental health services. These insider views of service users, known as ‘Experts by Experience’, inform practice and policy development for regulated services. As Study 2 was informed by service users, its findings could further support service delivery and training similarly to Experts by Experience.

Recommendations:

The following ideas emerged from this study and could form the basis for future research. First, based on the findings of this study, the researcher recommends that future studies seek to better understand the developmental needs and states of mind of YP undergoing the transition process rather than simply describing or explaining what services are already doing on a prescriptive basis. In addition, considering the

experiences of YP would allow for a better understanding of how their inner world manifests itself in an external setting. For example, further research should consider what happens to YP who reject transition altogether and are not transitioned, despite the potential for relapse or severe and enduring mental health difficulties. This could well be the many YP who 'fall through the cracks' of services (Singh & Tuomainen, 2015; Singh, 2009) and whose ongoing mental health needs are unmet by services that quickly discharge them. Similarly, the new adult service may be reluctant to take on referrals unless they are deemed psychiatrically and clinically indicative, as organisational constraints of depleted and overstretched services are all too familiar.

Linked to the demands on services, a further recommendation from this study would be that additional considerations are needed on the impact of organisational defences on the services and teams involved in transitional care. Further exploration of how psychological phenomena can be acted out at the level of the organisation, where workers and teams may re-enact disturbing emotional processes of the patient group who require transitional care, could further our understanding of why the crossover between children's and adult mental health services remains so complex and difficult to navigate for all involved. This, in turn, would support the YP at the centre of the transition process to have an experience in which services and agencies involved in their transitional care can better contain, rather than act upon, unconscious processes and projections. Additional research in this area would have

important implications for future policy development, implementation and service delivery. Further understanding of these unconscious dynamics could aid the continued learning of how to use multi-disciplinary teams best and transfer between services and teams.

Conclusion:

The aim of this project was to explore the process and emotional lived experiences of YP who were transitioning from CAMHS to AMHS. The quantitative service audit of Study 1 considered which types of YP require mental health transitional care, who they were referred by, and to which service. Study 2 explored the qualitative elements that enable a smoother transition for YP. Study 2 aimed to understand what makes YP feel prepared for the transition or not. Interviews were used to gather the data, from which themes emerged that enabled the researcher to determine what YP themselves bring to the transition process, which could support service-level delivery.

Overall, the findings highlight the complex transition process between CAMHS and AMHS and its relationship to the simultaneous experience of a developmental transition in later adolescence. This is a developmental period in which YP are developing adult identities, managing separations, including forming new relationships and losing others, and developing greater autonomy and independence.

The results have shown that an individual's personal disposition, how they use their mind and their capacity for emotional development are important factors that influence the success of the transition. Therefore, a key finding from this study is that an individual's psychological defences, which have roots in infancy, greatly impact

how a young person approaches and manages the transition between mental health services. Furthermore, as suggested in the NICE Guidance (2016), previous studies focusing on service-level improvements do not consider what the YP themselves bring emotionally to the transition process. Thus, the findings from this study add to the existing body of literature, where previous studies addressing the transition between mental health services have largely neglected to centrally consider individuals' developmental and emotional needs (Singh, 2009).

Overall, the discoveries of this study are significant in several respects. First, this study considers who transitions (as seen in Study 1) and how adolescents manage the transition as part of coping with adult-related tasks more broadly in this developmental period. Second, the findings of Study 2 demonstrated that the impact of the adolescent task, with its association with loss and separation, is also closely linked with the task of transition. Finally, the study found that the individual dispositions of the YP in transition and their capacity to emotionally engage with the task are fundamental. These findings are significant for both practice and policy as they help to consider how individuals can be supported in transition by looking beyond the surface and the apparent difficulties or assertions. For example, the study found that statements such as '*I don't need help anymore*' can be powerful defences against primitive thoughts and feelings evoked by the transition process that the YP may need help understanding.

Study 1, with its quantitative method, found that only 15 of the 36 YP in the sample were referred for transition, despite potential eligibility. The literature argues that YP are often not referred because CAMHS clinicians involved in their care doubt whether AMHS would accept referrals due to perceived strict thresholds and criteria (Paul, 2013; Singh, 2008). However, the audit revealed that of the 21 YP (58.3%) who were not referred (despite being eligible for transition), in all 21 cases, the YP had made a specific request not to be referred or had declined to engage in the transition process. This is another important finding because it suggests that YP may not want to transition despite an ongoing need for mental health care, which relates to the results of Study 2. It also indicates that even when a YP has a specific diagnosis (11 of the 21 YP had comorbidities of two or more mental health conditions or diagnoses, including depression, self-harm and anxiety), if the young person indicates that they do not wish to transition, this is usually heeded by services.

As discussed in the literature, when defence mechanisms such as avoidance, neglect of personal responsibility and denial of needs are presented, the defensive use of splitting or rejection against the transition changes comes to the fore. This can lead to omnipotent assertions of no longer needing help. So convincing are these statements that they could be taken at face value by those engaging with the YP when, in fact, further enquiry is required. Furthermore, there may be an interface between the emotional experience of transition and what happens at the service

level, which could lead to an increase in denial of need, such as the omnipotent assertion that further help is not needed, which services do not pursue. The cycle becomes that this plays into the often-limited resources of impoverished services that can appear to decline referrals anyway. In this context, reasons for non-engagement or consent to refer were not explored in Study 1, as they were beyond the scope of the study and its quantitative method. Yet, Study 2 found that, for all three participants, there was a continual oscillation between states of mind that could be viewed as facilitating or hampering the transition process and that defences have a major impact on how the YP manages the transition between services.

Additionally, it is crucial to revisit the significance of the researcher's subjective position and how this relates to the research process. As a child and adolescent psychotherapist, conducting this project within the service in which the researcher both trained and continues to work has been a fascinating and, at times, demanding experience. Conducting research in this way, using a combination of methodological approaches, has been a great learning experience, both personally and professionally. For the researcher, it has been a privilege to see this project through, which was threatened by external events in its earlier stages and made the researcher feel apprehensive about the feasibility of this study. Therefore, the conception of this study, arising before the COVID-19 pandemic, had to undergo

modification and delayed reworking. Yet, the most fundamental change involved being creative with how interviews with YP would be conducted.

Initially, the researcher assumed and planned that all interviews would occur in person. When, for safety reasons, this option was taken away, the researcher feared that the nuances and subtleties of interaction, notably the non-verbal, would be lost. Given that child and adolescent psychotherapists are trained to pay careful attention to the less immediate and apparent communications, including the ineffable, the absence of physicality between researcher and participant felt, at first, to be a significant disadvantage. However, psychological phenomena can be observed and explored on the phone and online. For example, Sonja's liveliness and chattiness, which were gripping to engage with, could and did seem to tell the researcher as much about Sonja's states of mind in relation to her transition as the content of her words. Similarly, Tony's request to be interviewed online seems to speak volumes.

Despite the move to remote encounters, what emerged from the data was rich, revealing the nature of the YP's relationship to their transition experiences, arising from their distinctive, complex inner subjectivities. The researcher hopes to have captured and presented these transition processes and emotional experiences with the interest and enquiry they deserve.

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Appendices

-**Appendix 1**: NICE Guidance (2016) Transition from children's to adults' services for young people using health or social care services

- **Appendix 2**: Participant information sheet, opt in form and consent form
- **Appendix 3**: Interview Schedule
- **Appendix 4**: Sample of data analysis process
- **Appendix 5**: Thematic table

- **Appendix 1:**

NICE Guidance (2016) Transition from children's to adults' services for young people using health or social care services

https://www.nice.org.uk/guidance/ng43

1)Adequate time given for transition to take place:

Begin to have the conversation about transition in healthcare from age 13 /14 years (year 9). NICE Guidance Transition states that timing of transition should be developmentally appropriate, taking into account the person's:

• maturity
• cognitive abilities
• psychological status
• needs in respect of long-term conditions
• social and personal circumstances
• caring responsibilities
• communication needs.

2)Involve the young person:

Ensure that the young person has opportunity to ask questions and met with prospective service to prepare for transition. Where possible,
involve young people and their carers in service design, delivery and evaluation related to transition by co-producing transition policies and strategies with them and feeding back to them about the effect their involvement has had. Person-centred approach to be taken that:
• treats the young person as an equal partner in the process and takes full account of their views and needs
• involves the young person and their family or carers, primary care practitioners and colleagues in education, as appropriate
• supports the young person to make decisions and builds their confidence to direct their own care and support over time

• fully involves the young person in terms of the way it is planned, implemented, and reviewed.

3) Transition action plan and planned point of transfer:

Ensure the transition planning is developmentally appropriate and takes into account each young person's capabilities, needs and hopes for the future. The point of transfer should:
• not be based on a rigid age threshold
• take place at a time of relative stability for the young person.

For young people entering the service close to the point of transfer, planning should start immediately.

Hold a meeting to review transition planning and share the outcome with all those involved in delivering care to the young person. This meeting should:
• involve all practitioners providing support to the young person and their family or carers, including the GP (this could be either in person or via teleconferencing or video)
• involve the young person and their family or carers
• inform a transition plan that is linked to other plans the young person has in respect of their care and support.

4) Identified named worker to 'oversee' transition:

The named worker should:
• oversee, coordinate or deliver transition support, depending on the nature of their role
• be the link between the young person and the various practitioners involved in their support, including the named GP
• arrange appointments with the GP where needed as part of transition
• help the young person navigate services, bearing in mind that many may be using a complex mix of care and support
• support the young person's family, if appropriate
• ensure that young people who are also carers can access support

• act as a representative for the young person, if needed (that is to say, someone who can provide support or advocate for them)
• proactively engage primary care in transition planning
• direct the young person to other sources of support and advice, for example peer advocacy support groups provided by voluntary and community sector services
• think about ways to help the young person to get to appointments, if needed
• provide advice and information.

- **Appendix 2:**

Participant information sheet and details regarding informed consent

Moving on from Child and Adolescent Mental Health Services (CAMHS): Young people's experiences of transition.

What is the research about?

Hi, my name is Emily and I am a child and adolescent psychotherapist in clinical training working at Wakefield CAMHS.

I am running a project as I am interested in hearing from you and other young people about your experience of transitioning between children and adolescent mental health service (CAMHS) and adult mental health services (AMHS) or similar, and what you think about this change.

Why have I been invited to take part?

You have been invited to participate in this project because you have been identified as a young person (aged nearly 18 or that is 18) who has used CAMHS and is preparing to move on from the service. You will be invited to talk about your experiences in a one-off interview.

Why is this research important?

I'd really like to get to know more of your experience of preparing for transition on from CAMHS and/or between services and what this means to you. In doing so, your views can help to contribute towards improving what services can offer young people like you when going through similar situations.

What if I want to take part?

If after reading this information sheet you decide that you would like to take part in this project, you will be asked to complete the consent form. Once I have received the consent form I will contact you to arrange a suitable date to speak and answer any questions you may have.

What will happen if I agree to take part?

Participating in the project will mean taking part in an interview that will last approximately 45 minutes and will be on a video call, the phone or similar. You will be asked about your experiences of transition. The interview will be sound, but not visually recorded. Your name and any other personal information will not be disclosed, so your views will remain anonymous and no identifiable information given.

Before the interview begins, I will talk to you about consent and go through a consent form with you. The consent form is a way of making sure that you know what you have agreed to and you will be asked to sign it if you are still happy to continue with an interview. I will then ask you questions about your experience of moving on from CAMHS. There are no right or wrong answers, you will have full control over what is said and can take a break or stop the interview whenever you need to.

If you require a translator service or the information in an additional format, such as the consent form in an audible version, please tick the box on the opt- in form and I would be more than happy to discuss this with you.

What will happen after the interview?

After the interview, you are free to ask me any questions you might have, even after the interview has ended. If you want to talk to someone other than myself, you can also contact your case coordinator. These contact details will be made available to you after the interview and before you leave the clinic.

Thank you for considering taking part in this study and for taking the time to read this information sheet.

Opt in form:

Moving from Child to Adult Mental Health Services: Young people's experience of transition.

Thank you for reading the Participant Information Sheet. Please let me know if you are interested in taking part in the project and are happy for me to contact you by ticking one of the following options:

You are reminded that it is entirely up to you whether you wish to take part in this study. A decision to not take part will not affect any care or support that you receive, now or in the future.

☐ **Yes**, I am interested in the study and would like to know more. I agree for the researcher to contact me. **Please enter your contact details below**.

☐ **No**, I would not like to know more about the study and do not wish to be contacted by the researcher. You do not need to provide any contact details.

Please place this form in the envelope provided and hand back to your case coordinator.

With thanks,

Emily Morgan, Child and adolescent Psychotherapist in Clinical Training

- -

If you have answered **'Yes'** above, please provide the following:

Your name: _____

Address: _____

Telephone number: _____

E-mail address: _____

☐ Please tick this box if you require a translator or would like any information in a different format and I would be more than happy to discuss this with you.

The best way to contact me is by (please circle):

Letter Telephone E-mail

Consent form:

Moving on from Child to Adult Mental Health Services: Young people's experience of transition.

Please carefully read the following statements and if you are happy with each statement please sign and print your name at the bottom of the sheet, thank you.

1. I confirm that I have read and understood the information sheet for this study. I have been given the opportunity to consider the information, ask questions and understand why the research is being done.

2. I understand that taking part in this study is entirely voluntary.

3. I understand that I can withdraw from the study at any point before, during or up to four weeks after the interview has taken place without needing to give an explanation.

4. I agree to take part in a one-off interview and understand that if I agree to the interview, it will be audio-recorded. I understand that all audio recordings will be deleted after they have been typed up (transcribed).

5. I understand that the interview transcripts will be anonymised by using a code-name and only anonymised information will be shared with the supervisor on the project and included when writing up the results of the study.

6. I understand that all information I provide during the interview will be held in a confidential form by the researcher (with the exception of any information relating to concerns to mine or others' safety, in which case the researcher will need to contact other people and I will be informed of this).

7. I understand that anonymised information collected during this study may be made publicly available (e.g. as a summary report for young people), and I give my permission for this.

Signed……. Printed name……..
Date…….

Thank you for taking this time to read through this information.

- **Appendix 3:**

Interview schedule

Semi- structured interview schedule

Introduction (not read verbatim)

Thank you for agreeing to meet with me today. As you know, my name is Emily and I am a child and adolescent psychotherapist in clinical training. I am conducting a research study exploring the experiences of young people who are moving on from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). As you are someone that is undergoing this transition, I would like to spend some time talking to you about your experience of preparing for this move. There are no right or wrong answers; it is your personal experiences and feelings that I am interested to hear.

Firstly, I will ask about your experience of CAMHS, how you first came to CAMHS and what sort of help you received. Following on from this, I'm interested to hear how you are preparing for the move from CAMHS to AMHS and your experiences of any other transitions you've undergone in the past. After this, there will be some time for you to ask me any questions you might have.

If you would rather not answer a question, or would like a break at any point, just let me know.

Before we start, I would like to talk through the consent form with you to ensure that you understand what taking part in this study will involve and that you are happy to continue with our interview today (each item on the consent form will be discussed with the participant).

I would like to remind you that our conversation will remain confidential. The only time where this would not apply is if you told me something that made me concerned that there was a risk of serious harm to either yourself or to another person. If this happened, I would be required to tell others involved in your care. However, I will always let you know when and why I was doing this.

During our interview it is important that I listen to you very carefully, so I am planning on recording the interview (point to the digital recorder). Only I will hear the recording, and I will keep them safely locked in a filing cabinet.

Are you happy for me to record our conversation?

Thank you- I will now switch on the recorder and we'll begin the interview …

Topic Guides: (prompts in brackets)

CAMHS experience:

- Could you tell me the story about how you first came to see someone in CAMHS? (How old were you when you were first seen? Whose decision was it for you to be seen there? Who did you see?)

- How would you describe your experiences of CAMHS? (What were the best things, what were the worst things? were your family involved?)

Transition process –planning for transition:

- Thinking about the time when the move to AMHS was first mentioned.... How did you come to know that your time in CAMHS would be ending? (what were you told and by whom? how far in advance did you know, what was your understanding of the reasons for the move to adult services?)

- To what extent were you/are you involved in setting up the on-going support you might require? (How do you feel about that?)

- How are you (and others) preparing for the move? Who else has been involved in this transition? (any important/therapeutic relationships that have changed/ended? - Has there been anything that's been particularly helpful/unhelpful? E.g. have you had any initial meeting with someone from the adult service? Is there anything that could have been done differently to help you to prepare for the move?)

- How do you feel about leaving CAMHS? (how did you feel about the prospect/timing of transition? What do you expect to happen when you leave CAMHS?)

Thinking back- other transitions in life:

- Can you tell me about another time in your life when you feel you had to manage a different sort of transition … maybe like moving from primary – high school, moving house/placements, new area/country … How was that for you? What sort of support, if any, did you receive to help with that? (Family/friends/services?)
- Looking back at that (those) experience(s), how do you feel it has helped or not helped you now when facing this new sort of transition? (helped with - confidence/with life skills/ with strengthening relationships/ hindered –

confidence/ trusting/ feeling unsettled? Does it make a difference that you are now older than before?)

- Is there anything similar about your previous experience of managing change and this current moving on from CAMHS and Turning Point? (increased/decreased capacity to tolerate change? Dealing with feelings of dependency/ uncertainty?)

Impact of transition (change):

- Do you feel that in thinking about and preparing for the move from CAMHS to AMHS it has affected or changed your understanding about yourself? (Do you feel it has had any effect on your independence; changed the way you engage in services; changed the understanding of your problems?)

- How has is felt for you knowing that you are soon to leave behind what is known and familiar in order to face something new? (How has it made you feel? -empowered, like an adult, being left to get on with it, in at the deep end?)

- In what ways have you tried your best to prepare yourself for this change? (Connecting with other young people who are/have undergone similar change; engaging with online resources; trying to be more pro-active in self-care; accepting that it is happening, even if you'd prefer to stay in CAMHS?)

Looking forward:

- Thinking about the whole experience of transition between CAMHS and AMHS, how would you describe this experience? (What have been your expectations/hope/fears?)

- In your experience, which parts of being in CAMHS have helped you the most? (who and in what way? Which aspects have helped less? In what way?)

- Is there anything else you would like to say about your experience of preparing for the move on from CAMHS to AMHS that we haven't talked about today?

- How could it be improved?

Thank you for telling me about your experiences and reflecting on preparing for leaving CAMHS, and what this has meant to you. We can now finish.

Additional probing question examples:

Can you tell me more about that?

Can you give me an example?

What did you think about that?

How did you feel about that?

What did that mean for you?

-Appendix 4:

Debrief

Debrief

Thank you for participating in this project. It is hoped that the findings of this study will lead to a better understanding of the experiences of young people that are undergoing the transition between CAMHS and AMHS.

If following your participation, you would like to ask any further questions about your involvement in this study, you are able to contact myself:

Emily Morgan, Child and Adolescent Psychotherapist in Clinical Training

Emily.morgan@swyt.nhs.uk

Or my clinical supervisor at CAMHS:

Selina Perocevic

Selina.perocevic@swyt.nhs.uk

If you feel you would like to contact someone for emotional support, you can contact your case coordinator. They are aware of your involvement with this study.

Name: ……

Contact number: ……

If you have any concerns about the conduct of the researcher, or any other aspect of this research project, you can contact Simon Carrington, Head of Academic Governance and Quality Assurance at the Tavistock and Portman NHS clinic: (academicquality@tavi-port.nhs.uk)

You can also contact the following organisations for support and advice:

Kooth:

https://www.kooth.com/

Mind:

0300 123 3393

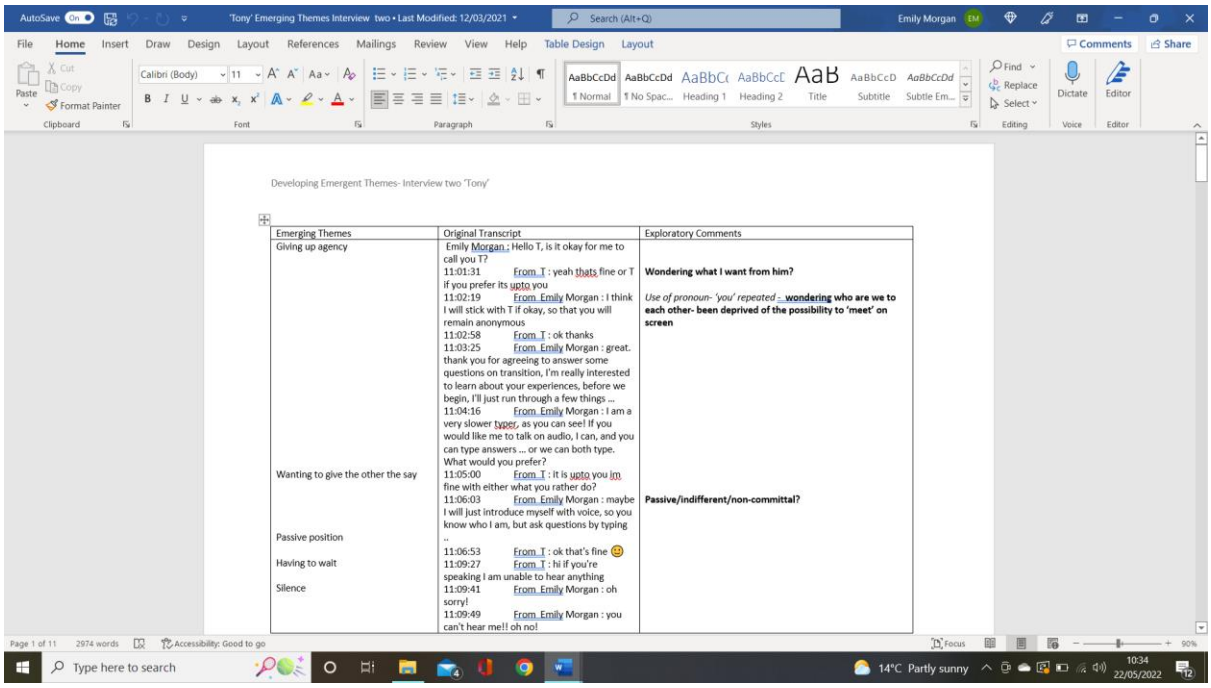
https://www.mind.org.uk/

Rethink:

https://www.rethink.org/

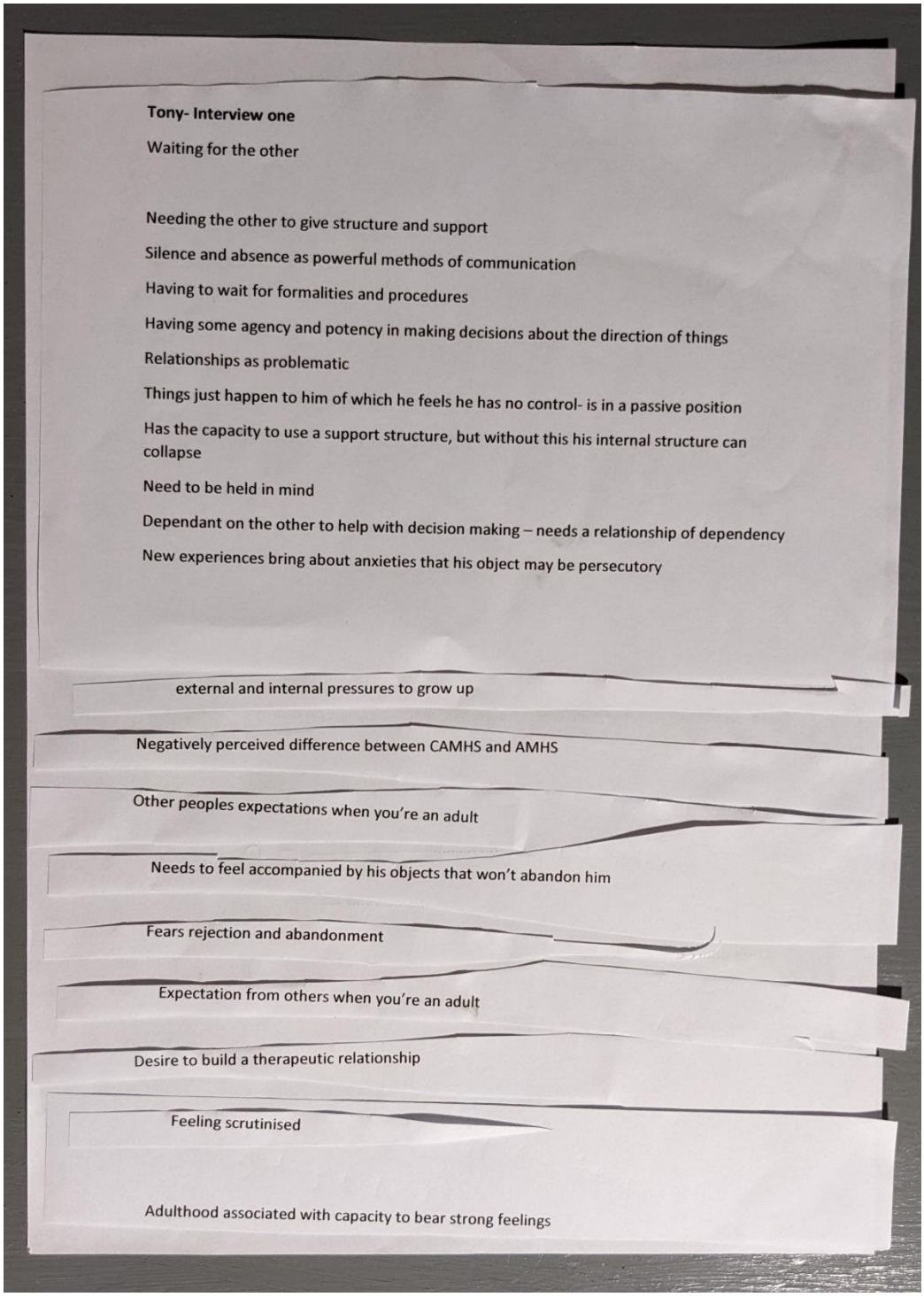
-Appendix 5:

Sample of data analysis process



Developing Emergent Themes- Interview two 'Tony'

Emerging Themes	Original Transcript	Exploratory Comments
Giving up agency	Emily Morgan : Hello T, is it okay for me to call you T? 11:01:31 From T : yeah thats fine or T if you prefer its upto you 11:02:19 From Emily Morgan : I think I will stick with T if okay, so that you will remain anonymous 11:02:58 From T : ok thanks 11:03:25 From Emily Morgan : great. thank you for agreeing to answer some questions on transition, I'm really interested to learn about your experiences, before we begin, I'll just run through a few things ... 11:04:16 From Emily Morgan : I am a very slower typer, as you can see! If you would like me to talk on audio, I can, and you can type answers ... or we can both type. What would you prefer?	**Wondering what I want from him?** *Use of pronoun- 'you' repeated -* **wondering who are we to each other- been deprived of the possibility to 'meet' on screen**
Wanting to give the other the say	11:05:00 From T : it is upto you im fine with either what you rather do? 11:06:03 From Emily Morgan : maybe I will just introduce myself with voice, so you know who I am, but ask questions by typing ..	**Passive/indifferent/non-committal?**
Passive position	11:06:53 From T : ok that's fine 😀	
Having to wait	11:09:27 From T : hi if you're speaking I am unable to hear anything	
Silence	11:09:41 From Emily Morgan : oh sorry! 11:09:49 From Emily Morgan : you can't hear me!! oh no!	



Tony- Interview one

Waiting for the other

Needing the other to give structure and support

Silence and absence as powerful methods of communication

Having to wait for formalities and procedures

Having some agency and potency in making decisions about the direction of things

Relationships as problematic

Things just happen to him of which he feels he has no control- is in a passive position

Has the capacity to use a support structure, but without this his internal structure can collapse

Need to be held in mind

Dependant on the other to help with decision making – needs a relationship of dependency

New experiences bring about anxieties that his object may be persecutory

external and internal pressures to grow up

Negatively perceived difference between CAMHS and AMHS

Other peoples expectations when you're an adult

Needs to feel accompanied by his objects that won't abandon him

Fears rejection and abandonment

Expectation from others when you're an adult

Desire to build a therapeutic relationship

Feeling scrutinised

Adulthood associated with capacity to bear strong feelings

-Appendix 6:

Thematic table

The final three superordinate themes and six subordinate themes.

Superordinate themes	Subordinate themes	
1)*'I went when I was, like, quite young, me'* – Relationship to CAMHS in childhood	1i) *'CAMHS has always just sort of been there'*	1ii) *'The last goodbye'*
2)*'I've got to work them out and they've got to work me out'* – Different states of mind in transition	2i) *'Who is this person we have here?'*	2ii) *'I really don't feel 18. I've never felt my age'*
3) *'Things seem to be coming together a bit'* – Integration in transition	3i) *'I do need someone here to help me'*	3ii) *'Not as bad as I used to be'*