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An Exploratory Study of Children's Mental Health Providers' Perspectives on the Transition to Adult Care for Young Adolescents in the Canadian Context

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ABSTRACT

Purpose: Many youth who receive specialized children's mental health treatment might require additional treatment as young adults. Little is known about how to prepare these youth for transitions to adult care.
Design and methods: This study gained perspectives from children's mental health providers (n = 10) about the process of caring for younger adolescents (aged 12–15) with mental health problems (e.g., depression, anxiety), who might require mental health services after age 18. Providers were asked about their clients' future mental health needs and the possibility of transition to adult care.
Results: Using Grounded Theory analysis, an over-arching theme was providers' reluctance to consider the transition process for their younger clients (<16 years old). This stemmed from uncertainty among providers about: (1) *who* [which youth] will need adult mental health services; (2) *when* this discussion would be appropriate; and (3) what adult services would be available.
Conclusions and practice implications: Findings indicate a lack of treatment capacity within children's mental health to routinely monitor youth as they approach the age of transfer (18 years old). In the absence of routine monitoring (post-treatment), it may be difficult to predict who will need adult care. A comprehensive evaluation of existing follow-up practices, in children's mental health and beyond, is needed to identify strategies for ensuring adolescents with recurring conditions receive optimal transition care.

Introduction

The global prevalence of mental illness among children and adolescents is 10–20%, and incidence rates are expected to increase by 50% over the next 10 years (Canadia Pediatric Society, 2006; World Health Organization, 2015). About 15–18% of children have a diagnosable mental health disorder, and many of these disorders last into adulthood (Georgiades, Duncan, Wang, Comeau, & Boyle, 2019; Kessler et al., 2005; Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Though mental health problems should be treated early and effectively, some youth will require additional treatment as young adults. Some youth who receive Children's Mental Health (CMH) treatment will experience a recurrence, with rates of recurrence as high as 47% for youth following treatment for depression (Curry, Silva, Rohde, Ginsburg, & Kratochvil, 2011; Kennard et al., 2009). Anxiety disorders also tend to recur and last into young adulthood (Essau, Conradt, & Petermann, 2002; Pine, Cohen, Gurley, Brook, & Ma, 2013). As well, about 14% of youth diagnosed with a disruptive behavioural disorder, such as Attention Deficit-Hyperactivity Disorder (ADHD) or oppositional defiant disorder, do not fully recover 15 years after onset (Biederman, Petty, Evans, Small, & Faraone, 2010; Bussing, Mason, Bell, Porter, & Garvan, 2010; Keller et al., 1992). Unremitting or persistent mental health conditions, including some cases of severe depression, can also onset during childhood and adolescence. It is unclear how CMH providers manage the *possibility*

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of transition to adult care with youth and their parents. At what age do these providers anticipate the need for adult care for their clients? How is the topic of transition discussed? The current study addresses these questions.

Caring for youth with chronic mental health conditions

Almost two decades ago, Kazdin (1987) suggested that children's behavioural problems might be viewed as "chronic" problems requiring ongoing care (Kazdin, 1987). Unfortunately, very few longitudinal treatment studies have followed youth with mental health problems after receiving an evidence-based treatment (EBT). This limits our understanding of the potential need for ongoing care among treated youth with mental health problems (i.e., recurring or persistent) (Curry, 2014; Manassis, Avery, Butalia, & Mendlowitz, 2004; Nevo & Manassis, 2009). There is also very little evidence or policy on managing youth with *recurring* or *persistent* mental health problems, such as anxiety or depression, within community mental health settings.

One solution is to provide follow-up care or further intervention. Research on "booster sessions", for example, suggests these sessions can be effective for maintaining or improving outcomes post-treatment in childhood (Bry & Krinsley, 1992; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Eyberg, Edwards, Boggs, & Foote, 1998; Gearing, Schwalbe, Lee, & Hoagwood, 2013; Kolko & Lindhiem, 2014). Substantial variation in how these sessions are operationalized across studies, however, limits what we know about the optimal number or timing of "booster sessions" for maintaining, or improving, youth outcomes (Eyberg et al., 1998; Eyberg, Boggs, & Jaccard, 2014; Kolko, Lindhiem, Hart, & Bukstein, 2014). No data exists on "booster" sessions in routine clinical services. In "real-world" community mental health settings, some youth do not complete a full course of treatment (McKay, McCadam, & Gonzales, 1996; O'Brien, Fahmy, & Singh, 2009). For those who complete mental health treatment, it is unlikely one or two booster sessions would be sufficient to circumvent the need for further treatment (Clarke et al., 1999), based on what we know from the natural history of many childhood-onset mental health disorders (Tsybina et al., 2012; Woodward & Fergusson, 2001). Understanding how youth treated for mental health problems use services over time is important for improving their longterm care. CMH provider input on this topic is critical because they can offer unique 'on-the-ground' insights about how youth and families navigate the mental health system (Dimitropoulos, Tran, Agarwal, Sheffield, & Woodside, 2012; Marcer, Finlay, & Baverstock, 2008; Reale & Bonati, 2015). It is also important that CMH provider perspectives are considered in developing or refining treatment approaches. To date, no studies have specifically asked CMH providers about their views on caring for youth with recurring and/or persistent mental health problems in community-based settings.

Transitioning to adult mental health care: when does this begin?

Much of the emphasis in the literature on transitions in mental health has focused on older adolescents (>16 years old; Reale & Bonati, 2015), and those transferring to specialized adult mental health programs (Cappelli et al., 2014; Singh et al., 2010). This work is important for understanding barriers and/or facilitators at the age of transfer (age 18 in most jurisdictions). However, this research is not generalizable to all youth who receive CMH treatment since most will not be eligible for specialized adult mental health programs, and will therefore be transferred back to their primary care physician (Islam et al., 2016; Schraeder, Brown, & Reid, 2018). Adequate preparation for transfer to adult care, whether it is to primary care or adult mental health services, is recommended. Very little research has examined *how* and *when* youth should be prepared for this process (Dunn, 2017). For youth with chronic physical health conditions (e.g., diabetes, cystic fibrosis), or pervasive developmental disorders or intellectual disabilities, the recommended age to begin the transition process is 12 years old (Ally et al., 2018; American Academy of Pediatrics, 2002; Reiss & Gibson, 2002; Sable et al., 2011). In contrast, for youth with recurring mental health conditions (e.g., depression, behavioural problems), the age for starting the transition process is much less clear. Does the CMH provider of a 12-year old client, who recently completed treatment for anxiety, consider the possibility them requiring adult care? Recent work suggests *parents* of younger adolescents (ages 12–15) with mental health problems anticipate their child's problems will persist (or recur), and future mental services will be needed (Schraeder, Reid, & Brown, 2018). No studies to date have examined the possibility of transition for these youth from the perspective of CMH providers who directly care for them. If transfer to adult mental health is needed, preparation for this transition should occur well before age 18. The current study sought to understand the perspective of CMH providers in relation to preparing their younger clients for the possibility of adult care.

The current study

This qualitative study focused on describing CMH provider perspectives on the challenges of caring for youth with ongoing and recurring mental health problems. This study was a secondary analysis of a subset of data from a larger project, which involved two other groups of participants (i.e., youth and their parents); findings from this larger project have been published elsewhere (Schraeder et al., 2018; Schraeder et al., 2018). For the purposes of this study, we focused our analysis on three questions asked of CMH providers related to the process of transition to adult care: 1) Do providers perceive their younger clients' problems as chronic and, if so, how does this influence services they anticipate them to need? 2) How are services delivered to youth who require longer-term CMH care? (3) How is transition to adult care considered by providers for younger adolescents (ages 12–15)?

Methods

Constructivist Grounded Theory was selected as the optimal qualitative methodology because it tends to be more abstract and has the potential for improving understanding or offering explanation when compared with descriptive methods (Charmaz, 2006). The purpose of constructivist grounded theory is to build an explanatory theory by examining how participants construct meanings and actions for specific circumstances. The constructivist approach assumes the resulting theory is an interpretation of the data which *depends* on the researchers' views and their relevant experience (Charmaz, 2014).

Recruitment procedures

CMH providers were recruited from two publicly-funded community CMH agencies located in London, Ontario, Canada. Agencies were accredited members of a provincial association representing Ontario's publicly funded Child and Youth Mental Health agencies (i.e., Children's Mental Health Ontario), and were the main agencies serving a catchment size of about 500,000 individuals. Both agencies offered a full range of services, including assessment and diagnosis of CMH problems, individual/group/family counselling, day treatment, residential treatment) to children (0–18 years) who have serious emotional or behavioural problems and their families. As is typical in community-based CMH agencies in Ontario, some EBTs are offered (e.g., Triple-P parenting), but in most cases it is unlikely that families receive an EBT (Barwick et al., 2019; Eichstedt, Collins, Phoenix, Haensel, & Dozois, 2014). Providers were eligible if they: a) had provided care to the youth for at least 3 face-to-face visits (Reid et al., 2015) within a service/program within the agency (e.g., day treatment, residential treatment); (b) had authority to make decisions about the youth's treatment planning; and (c) could be interviewed in English (Schraeder et al., 2018; Schraeder et al., 2018). Participating families, part of the larger study, allowed a member of the research team to invite

their CMH provider to participate in an interview for this study. Providers were therefore purposefully recruited based on their direct involvement with a client who: (a) was 12 to 15 years old; (b) was currently residing with a parent/guardian; (c) had been receiving care for 1 year or longer at the agency, or for at least 9 months with a prior episode of care (i.e., 3 face-to-face visits) within the previous 5 years; (d) could be interviewed in English; (e) did not have a developmental disorder (e.g., Autism) or intellectual disability. Criteria around length of service involvement allowed for questions about youth's ongoing mental health needs. Notably, youth (n = 10) who participated in an interview reported extensive CMH involvement ($M = 2.4$ years at the agency, Range = 1–5; $M = 4.4$ years within the CMH system, Range = 1–8; see Table 2; Schraeder et al., 2018; Schraeder et al., 2018).

Consent to participate included the agreement to be audio-recorded. CMH providers were contacted about study participation and scheduling an interview by telephone and/or email. Prior to starting the interview, providers reviewed the letter of information and signed consent. CMH providers participated in the study during staff time and were given a $10 store gift card in appreciation for completing the interview (N.B., the dollar value of compensation received by CMH providers was suggested and agreed upon in collaboration with managers at the agencies). The study was approved by the Research Ethics Board at both CMH agencies and at The University of Western Ontario.

Data collection

Data were collected through in-depth interviews by one investigator (KS). Interviews with CMH providers were in-person at the CMH agency, and were on average about one hour in length. Providers provided demographic and training information (e.g., educational attainment, professional training). A semi-structured interview guide included open-ended questions about involvement with the youth's treatment and their views on this youth's current and future service needs. CMH providers were asked about whether they had discussed the possibility of transfer to adult care with their youth or their family. Providers were also asked about caring for youth with ongoing and recurring problems more generally. Across all interviews, questions focused on participants' suggestions for change, consistent with critical research approaches supporting empowerment and social change (Carroll, 2004).

Interviews were open, flexible and, where appropriate, deviated from the interview guide to enhance the richness of data collected. All interviews were audiotaped, transcribed verbatim, and checked for accuracy by the interviewer. Field notes were recorded to capture specific details, such as interviewer perceptions and nuances of communication. Transcripts were de-identified and assigned numeric codes to preserve anonymity.

Data analyses

Data collection and analysis occurred simultaneously and iteratively. Data were analyzed using the constant comparison methods of CGT, building the emergent theory and returning to particular instances to analyze discrepancies and refine understanding of relationships between categories (Charmaz, 2014). CGT requires three sequential phases of coding: open coding, focused coding, and theoretical coding. The *first phase* of the analysis focused on developing initial codes that emerged from the data. A line-by-line analysis of transcripts involved constructing an initial coding template. Coding was entered into NVivo10 (NVivo, 2012), a qualitative research software program used to organize and manage data.

The *second phase* of analysis involved 'focused' coding or making decisions about which initial codes best represented the data (Charmaz, 2006; Miles & Huberman, 1994). This process attended to the "most useful" codes to synthesize and analyze larger amounts of data. This iterative process allowed new questions about emerging themes to be added to the interview guide and facilitated theoretical sampling. Focused coding involved saturating categories and generating explanations from the descriptions within the data. Data collection ceased upon "theoretical saturation" or when gathering new data did not provide new theoretical insights.

The *third phase* involved theoretical coding, which conceptualized relationships between categories to move the 'analytic story' in a theoretical direction. To facilitate this process, a data matrix was created to represent a visual summary of common emerging themes among participants with exemplar quotes. Matrices were created to analyze categories and make comparisons between participants (Lingard & Mcdougall, 2013). At each analytic phase, memo-writing and diagramming bridged the gap between coding and conceptual development, providing a logic for organizing the analysis.

Credibility and trustworthiness

Credibility and trustworthiness of the data were enhanced through the use of verbatim transcripts and independent and team analysis (Charmaz, 2006; O'Brien, Harris, Beckman, Reed, & Cook, 2014). Theory and investigator triangulation (Guion, Diehl, & Mcdonald, 2002) were achieved through (a) having a team of researchers from different disciplines (i.e., psychology, social work, family medicine) who provided multiple perspectives on the data; and (b) authors (K.E.S., J.B.B.) who independently analyzed the data but synthesized the results of the whole team (K.E.S., J.B.B., G.J.R.) in the final analysis. Reflexivity processes, which account for the researchers' influence on the analytic process, included reflective memo-writing and referring back to the literature to explore whether the analysis provided new conceptual insights (Charmaz, 2006; Malterud, 2001).

Final sample

One CMH provider was identified for each family (n = 10) from the larger project (Schraeder et al., 2018; Schraeder et al., 2018), for a total of 10 CMH providers. All providers were eligible; none declined participation. Interviews were conducted between April and December 2015. Table 1 summarizes demographic characteristics for participating CMH providers. Professional roles included child and youth counsellors, family therapists, and social workers; no physicians or psychologists were interviewed. Demographic characteristics of the youth clients, who were the focus of interviews with providers, are also provided (Table 2). Notably, most CMH provider participants were interviewed

Table 1
Children's mental health (CMH) provider characteristics.

Demographic characteristics	Proportion of sample (n = 10)
Sex	
Female	60%
Age	
<30 years old	10%
30–50 years old	60%
>50 years old	30%
Training qualifications	
University – Master's degree	50%
University – Bachelor's degree	10%
College (e.g., child and youth counsellor)	40%
Program/setting working in	
Community services (e.g., individual/group counselling, family therapy)	80%
Day treatment or residential treatment	20%
Length of time working in current position (*M*, range)	15 years (0.67–30 years)
Length of time working in profession (*M*, range)	11.8 years (0.67–30 years)
Length of time working with patient (*M*, range)	1.2 years (0.25–2.5 years)

Table 2
Youth demographic characteristics.

Demographic characteristics	Proportion of youth sample (n = 10) % or *M*, range
Sex	
Female	20%
Age	
12 years old	50%
13 years old	20%
15 years old	30%
Presenting problem(s)[a]	
Attention deficit hyperactivity disorder	60%
Anxiety	50%
Behavioural problems	70%
Depression	30%
Sleep problems	20%
Trauma-related problems	50%
Other providers involved in youth's mental health care	
Child welfare provider	30%
Family physician	80%
Pediatrician	40%
Psychiatrist	90%
School provider (e.g., social worker)	20%
Duration of service involvement with CMH agency	*M* = 2.4 years (1–5 years)
Duration of service involvement with CMH system	*M* = 4.4 years (1–8 years)

[a] Most youth (70%) had multiple problems that were the focus of treatment; thus, percentage of cases for type of problem sum to >100%.

about a client who was male with externalizing problems (e.g., oppositional behaviour, aggression); problems were highly comorbid with other disorders (Schraeder et al., 2018; Schraeder et al., 2018). The perspective of the youth clients and their parents were analyzed separately. Families reported receiving care from specialist physicians, namely a child psychiatrist and/or pediatrician, and some youth had previous emergency department visits and/or inpatient admissions; most were involved with multiple sectors of care (e.g., child welfare).

Findings

Our analysis generated three main themes from the data on CMH provider perspectives: (1) beliefs about the chronic course of common CMH problems, (2) perceived challenges of caring for youth with ongoing mental health concerns in community mental health settings, and (3) reluctance to discuss transitions to adult care.

Theme one: viewing youth's problems as chronic

Providers did not anticipate their clients' problems would resolve completely, even after receiving treatment: *"I think he's always going to be an anxious kid. I don't think there will be a day when [youth] is not an anxious kid"* (CMH5). CMH providers generally felt their clients' mental health problems were chronic, regardless of whether problems were described as recurring (remitting) or persistent (un-remitting). Certain factors contributed to this perception. First, providers' understanding of psychopathology reinforced their perception that both internalizing (e.g., anxiety) and externalizing problems (e.g., aggression) could be long-lasting: *"The impact of the PTSD really colours everything, it affects all kinds of relationships. It affects [youth]'s daily life continuously"* (CMH10). Second, CMH providers were more likely to view problems as chronic when they were severe and comorbid with other disorders: "*She's only got the ADHD, but if [youth] had a further assessment, chances are we'd probably find out more about her. Do I think she'll need mental health services in the future? Yes"* (CMH2). Finally, providers' viewed the impact of environmental stressors and family psychopathology on a chronic disorder course: *"This would be your classic multi-problem family: mom's mental health, history of abuse, ongoing dubious relationship with [step-father]"* (CMH10).

Most CMH providers described their youth clients' disorder course as *recurring* over time. If youth's problems had not recurred, providers described their clients as "*at-risk*" of problems coming back in the future. For example, one provider believed her client was "at-risk" due to known ongoing family stressors (e.g., client's father might leave family) and parental psychopathology (e.g., client's mother was recently hospitalized for a mental health-related issue): "*Right now, at the end of [treatment], he is not complex. But he has a potential to be very complex"* (CMH5). Another CMH provider believed their client's problems would recur in spite of a treatment *"success story"*: *"I still think he's got that fragility"* (CMH6). This provider viewed his client as potentially 'at-risk' based ontheir adjustment and transition to high school: "*A lot depends on how the next couple of years go… I know sometimes high school is very tough on kids and that's where his anxiety could really start to overwhelm him"* (CMH6). Only one CMH provider viewed her clients' problems as *persistently* chronic, and based that on a lack of response to several different types of CMH treatments at the agency, comorbidity of problems, and extensive service involvement.

The following sections illustrate how CMH providers' perceptions about problems, as either persistent or recurring, influenced their beliefs about needed future services. First, the ways in which CMH providers cared for youth with chronic problems within the CMH system are described. Second, perspectives on the issue of transition to adult care are examined.

Theme Two: Caring for youth with ongoing mental health problems in community mental health

Providing care to youth with ongoing mental health problems was articulated as a major challenge within our current CMH system. CMH providers anticipated youth with chronic problems would require services again: "*[Youth, age 13] will need further services. There's no question in my mind"* (CMH1). Many providers reported their clients had returned for additional CMH treatment when problems recurred. One provider described providing care to his client intermittently, as needed, over time: "*I felt the family was ready to take a break… I think we kind of consider ourselves a brief intermittent model. The family would come, get some services, and go off for a period of time. We knew she was coming back"* (CMH1). Comparatively, youth perceived to have chronic and persistent problems did not have "breaks" in treatment. As stated by one provider, more complex problems required longer-term services:

> *If you look at 75% of the kids that come through our doors, they have on average 3-5 different diagnoses. They're not simple diagnoses… they're psychosis or extreme anxiety or depression. Those don't just go away after somebody gets services... We know that. The fact that kids are lasting longer in our program is a good indicator they need the services.* – CMH7

CMH providers expressed frustration with a short-term treatment model: *"With the amount of diagnoses that some of the kids come in with, it's really hard to take them from one step, to the next step in a short period of time"* (CMH7). CMH providers foresaw an increase in service demands for ongoing mental health care for youth. One provider reported few cases in her experience seemed to "*fit the bill*" for brief CMH treatment:

> *I think in the 11 years we have run this program I have had maybe a handful of appropriate cases that would fit that bill; those cases that you open, you build a rapport, you get them set, and they're done, you close, and life is all good for everybody. But more often than not, we get 'these' cases. When someone like this comes through, it's a bit of a muddy situation and there isn't clear direction from the top [CMH*

agency managers]… that's why we bend the rules a little bit. – CMH2

When youth did not "*fit the bill*" for short-term CMH treatment, providers responded by "*bending the rules*". For some, this meant "*informally*" checking-in or monitoring youth post-treatment or in-between sessions.

"Bending the rules" to provide ongoing mental health care for youth and families

In general, a theme of 'stretching the boundaries' emerged. "Bending the rules" captured multiple instances when CMH providers altered their usual practice to be responsive to their client's ongoing mental health needs. To illustrate, consider the following statement by a CMH provider who explicitly contrasted his usual care to what he actually provided his client: *"We're usually 12 to 14 sessions. And I have on file 23 sessions... That would not include ongoing or booster-type of sessions"* (CMH1). Extending a youth's CMH involvement was particularly common for youth with ongoing stressors (e.g., high family conflict, self-medication through substance abuse). One provider described their efforts to extend the standard number of sessions when youth were not *"ready to leave"* CMH: "*I'm going to push to keep [youth] here, and it'll be 2 years. That'll be a first [within the program]. But he is not the only one that I would push past this semester [typically the program provided services by academic semesters]"* (CMH7).

Many providers described following up with youth well past their agency's standard *"6-month window"* post-treatment. Some providers anticipated their youth clients to check-in post-discharge: "*[Youth] is somebody I could see coming to meet with me or talking to me on the phone over the years to come"* (CMH10); this was also the case for parents of youth: *"I think [parent] will use me as a resource or just check-in and update [me] on how youth is doing"* (CMH4). Many CMH providers described "*leaving it open"* for youth and families to re-engage: *"I sort of left it open for [youth's parent], like even though we're closed, it doesn't mean you can no longer call me or exchange emails"* (CMH4). A strong therapeutic relationship reinforced providers' expectations about seeing their clients again post-treatment: "*If you build a good relationship with the family and they trust you, and you've helped the family, they will contact you again. I'm quite certain [family] will be in touch with me again*" (CMH1).

Identifying a need for "formalized", ongoing monitoring

"Sometimes it just means working a longer day or bumping clients, current clients too" (CMH1). For some CMH providers, follow-up care felt like *"a whole caseload on its own"* (CMH4). One provider described treatment programs operating more like *"a revolving door service"* for families. Providers also perceived a *"limited amount of time"* to follow youth post-discharge due to a lack of treatment capacity: *"I can't keep seeing people from outside discharge because I haven't got the hours to provide that kind of follow-up with the caseload here"* (CMH8). This was exacerbated by a lack of resources and CMH professionals: *"It can get crazy. We really need another social worker"* (CMH8).

Providers viewed formalizing monitoring processes as not being the "norm" or expectation: *"It could be just a phone call, checking in. The way it works now… when the case is closed, you're done"* (CMH9). CMH providers identified a need for providing more formalized monitoring: *"[Youth] made good progress but I think without support, it's easy [for youth] to fall back to old patterns"* (CMH8). Monitoring was also viewed as an important part of assessing a client's risk of harm: *"I think the older [youth] gets, the bigger he gets… that's going to make him potentially more out of mom's control, and violence is always just over the horizon with this family"* (CMH10).

CMH providers viewed several benefits to monitoring, including cost-savings for the system by off-setting crises: *"I think it would save Emergency Room visits where the kid is really at their wit's end, or it might bypass some very costly crisis"* (CMH5). One CMH provider viewed monitoring as important for improving continuity of care: "*[Youth] don't feel like they have to start over telling their story all the time and the therapist is up to speed as to where they actually are. I think it truly makes a seamless transition"* (CMH8). However, CMH providers were unsure about how monitoring would be implemented. Some providers felt this care would be less *intense"* or frequent: *"It doesn't need to be continuous. The timing may need to be thoughtfully considered"* (CMH9). Overall, provider expressed uncertainty about how youth would be monitored beyond the age of transfer. The following section explores this issue by covering CMH providers' views on discussing transition to adult care.

Theme three: reluctance to discuss transitions to adult care

CMH providers anticipated youth who had received CMH services over a long period of time to likely require transfer to adult care: *"I've been in this business for 36 years. You get a client that starts at a young age, if they're still continuing into teenage-hood, you can guarantee they're going to be needing services in adulthood*" (CMH7). Yet, the topic of transition was not discussed by providers: *"What would it look like? [laugh] I don't know because I don't often do it"* (CMH1). CMH repeatedly expressed they *"don't look that far into the future"* and tended to focus on the short-term: *"I don't look at 10 years from now. I look at maybe six months from now, maybe a year from now"* (CMH3). Three main questions seemed to be asked: (1) Will this youth client require transfer to adult care? (2) When would I have this discussion? (3) What adult services will be available?

Will this youth require transfer?

Conversations with youth about adult care were described to be *"hit or miss"* and *"very situational"*. This stemmed from providers' uncertainty about whether youth would require adult services: *"I'm rather hesitant to go predicting or recommending service for the future"* (CMH8). Another provider indicated he would discuss transition "*if it seemed relevant… if it looked like the family needed extensive long-term services*" (CMH2). The majority of CMH providers believed their clients would benefit from "*periodic counselling*". However, providers could not identify clear criteria about who would require transfer to adult care. Providers hoped their clients would continue to use their coping strategies and, in spite of "*not having a crystal ball*", hoped this could offset the need for additional treatment.

When would I have this discussion?

Providers were unsure *when* a discussion about transition to adult care would be appropriate. Some CMH providers felt their client might be too young for this discussion: *"Most of the kids that I deal with are, like, seven to eleven. He's what, 12? We didn't go there."* (CMH3). CMH providers did not know if it was "appropriate" for them to have this discussion with youth, especially with other more present issues: "*I guess I didn't know if that was really appropriate for me to bring up. Because this is a family that's on the day-by-day. Looking down the road 4 years is probably not overly realistic*" (CMH5). Providers also frequently described being in "*the thick of it*" or still trying to make treatment progress: *"I guess I haven't shifted to closure in my mind yet. I'm still sort of trying to make [treatment] make a difference"* (CMH9).

Providers perceived parents to struggle with navigating CMH, and this seemed to delay any conversation about the adult system. Related to this, another reason for not discussing transition was inadequate time to plan in CMH: "*We don't often get a lot of notice when somebody's going to be discharged. If I had my way, we'd have time to make the referral a couple of months ahead so that when they walk out the door, they've got an appointment next week*" (CMH8). Some providers worked less with older youth clients, and assumed this discussion would occur at the age of transfer. As noted by one provider: "*most of the families stop working with us long before the youth turns 18*", so, "*if he ages out, then that would provide the opportunity to look at transition into adult service*" (CMH8).

What adult services will be available to this youth?

A perceived gap in available transition services between CMH and adult care contributed to providers' reluctance to discuss transition: *"Services that bridge between 16 and 20 is terrible. There's nothing there. The gap is ridiculous"* (CMH7). Providers acknowledged their lack of awareness about available adult mental health services: "*[Youth] needs trauma work. Who's going to do that? Who's going to pay for it? I don't know where to refer them for that*" (CMH9). Frequent change in adult services made this challenging: *"The toughest part is things change so much. Agencies change. Phone numbers change. Mandates change. Giving [families] information now… in 4 years when they go to access it, it may not be what it was"* (CMH6). According to CMH providers, discussing transition to adult care was not part of their routine practice: "*I've never really looked at the long-term or the big picture, but it wouldn't surprise me if I were to continue to hear from [youth]"* (CMH8). As stated by one provider, *"we're not used to thinking beyond… into the gap that your study is looking at"* (CMH6).

Discussion

There is little research evidence to guide appropriate long-term care for youth with recurring (e.g., depression, anxiety) or persistent (un-remitting) mental health conditions. This is particularly true when considering the possible need for adult care when working young adolescents. This study explored perspectives from CMH providers about delivering services to these youth (ages 12–15) and their families. Providers were specifically asked about their views on the long-term course of their clients' problems and about the possibility of their clients needing future services or transfer to adult care. Below, our main themes are compared with the current literature, including our previous work which focused on the youth and parents' perspectives on this topic.

Providers' beliefs about common childhood mental health problems

CMH providers were invited to participate if they had a youth client receiving CMH services for at least one year, as the aim was to recruit providers of families who might need ongoing CMH care and who *might* require transfer to adult care. Notably, *all* participants believed their clients were at-risk of recurring mental health problems at some point in the future, which appeared to stem from knowledge of their clients' individual risk factors (e.g., family history of mental illness) and situational factors (e.g., family conflict). This belief was also held by most parents and youth interviewed as part of the larger study (Schraeder et al., 2018; Schraeder et al., 2018). Providers also believed their agency's standard treatment protocols did not match their clients' ongoing and recurring mental health needs. Youth were generally perceived to "not fit the bill" for short-term treatment and this influenced how providers delivered services. Even though CMH providers anticipated their clients would need services as young adults, they were reluctant to discuss the possibility of transition to adult care with them. Potential reasons for this are discussed below, and data from the larger project are also considered.

Longer-term monitoring in children's mental health may be beneficial

A theme of "bending the rules" involved CMH providers working beyond the agency's standard number of treatment sessions and "*leaving it open*" for families to re-engage with them post-discharge. This may influence some youth and parents who think their provider will not "shut the door" on them, even after they age-out of CMH services. Previous work has shown that CMH providers frequently continue to work with older youth clients (e.g., 17–19 years) beyond the age of transfer into young adulthood, especially when a strong therapeutic relationship has been established (Belling et al., 2014; McNamara et al., 2013). Our study found similar findings for CMH providers of younger adolescents (12–15 years) with ongoing problems, and are not yet 18 years old.

"Bending the rules" with respect to service delivery occured in spite of not having the resources or infrastructure to provide longterm care. Some providers described working longer hours or *"bumping"* other clients to provide additional treatment to youth with ongoing and recurring mental health problems. There are some potential issues with this. First, increasing caseloads and demands on front-line staff have the potential to lead to burn-out and high staff turnover (Hovish, Weaver, Islam, Paul, & Singh, 2012; Reid & Brown, 2008). Second, if post-treatment monitoring is provided for some clients, this might reduce time and resources for new referrals. For example, wait-listed youth might experience longer delays for treatment; this was acknowledged by participating CMH providers as a barrier to "*bending the rules*".

Reluctance to discuss transition to adult care with younger clients and families

CMH providers acknowledged a need for longer-term services for their clients. However, they were reluctant to discuss the possibility of adult care with their youth clients or their parents. This stemmed from uncertainty about: (1) *who* should transfer; (2) *when* this discussion would be appropriate; and (3) *what* adult services would be available.

Who should transfer?

In some cases, transfer is not a controversial issue. Youth who have a mental health disorder with onset in late adolescence and an established severe and chronic course (e.g., schizophrenia) (Jones, 2013; Rapoport & Gogtay, 2011) will almost invariably require adult care. For older youth clients at the age of transfer who are still receiving treatment (e.g., therapies, medication), CMH providers might be more likely to consider transfer (McNamara et al., 2013). For younger adolescents with recurring problems, determining transfer is much less clear. This was exemplified in the current study as all participating providers expressed uncertainty about their clients' longterm care needs.

Criteria for identifying youth at-risk of disorder recurrence or persistence have recently been proposed for depressed and anxious youth (Schraeder & Reid, 2017). Researchers have also begun to explore the utility of applying clinical staging models to determine a youth's future mental health needs by establishing markers of illness progression (Hickie et al., 2013; Purcell et al., 2015). Very large sample longitudinal studies are required, however, before long-term predictive value of such staging classifications can be determined. Research is desperately needed to support the development of criteria for screening youth with a wide range of mental health problems for transfer.

When to discuss transition

Having adequate time to prepare youth and families for transition to adult care and not "leaving it too late" has been emphasized in prior work involving youth who have transferred (Hovish et al., 2012; McNamara et al., 2013). However, from the perspective of youth and families *approaching* age 18, many already feel "out of options" and do not having a clear plan about where, or how, to re-access mental health care after age 18 (Schraeder et al., 2018). Understanding this perspective from youth and families, or their beliefs about needing (or not needing) long-term mental health care, can begin at the outset of treatment. Strategies for supporting youth and families approaching transfer have been widely discussed within the context of chronic physical health conditions and youth who have developmental disorders (e.g., Autism) and comorbid mental health conditions (Colver et al., 2018), for example, supporting them to develop knowledge of their mental health condition and possibly its recurring nature. Future studies are needed to help understand how best to help youth with other mental health conditions, in terms of maintaining their functioning and reducing the likelihood of relapse following treatment.

Unfortunately, there is very little research to inform when the topic of transition should be discussed for youth with a primary recurring mental health conditions (e.g., depression). In a review of existing transition protocols in the UK, none specified *when* the transition process should start or exactly *how* youth should be prepared (Singh, Paul, Ford, Kramer, & Weaver, 2008). The current findings suggest that, for younger adolescent clients (ages 12–15), determining *when* to discuss transition should consider additional factors. For instance, some youth and their parents may not have considered the possibility of adult care (Schraeder et al., 2018). Discussing transition with younger adolescents and labelling their CMH problems as "chronic", especially if they are only at risk for recurrence, might be potentially stigmatizing and distressing. The guiding principle of "do no harm" might therefore deter many CMH providers from discussing transfer to adult care with younger adolescent clients and their families. However, if clinicians review ideas of *risk*, not certainty, of recurrence along with ways of maintaining mental health and when and how to re-engage with services, risk of harm should be minimized.

What adult services would be available?

For most youth with chronic disorders, the need for treatment as an adult, and where to receive treatment in the adult system, is clear. For example, in the case of diabetes, there is often one specialty clinic at a children's hospital and a parallel clinic at an adult hospital. In the case of mental health conditions, most child-focused clinics do not have a clear 'match' service/clinic in the adult system. Further, many individuals with recurring problems (e.g., anxiety, depression) do not meet criteria for specialized AMHS. A lack of appropriate services in adult care has been emphasized (Singh et al., 2010); specific concerns have been raised by CMH providers for youth with ADHD and learning disorders (Belling et al., 2014; Gilmer, Ojeda, Fawley-King, Larson, & Garcia, 2012). CMH providers consequently "bend the rules" to fill a gap in service provision during the transition period. Any instances of "bending the rules" should be systematically documented so mental health agencies can advocate and allocate needed resources for their clients.

Current short-term treatment approaches not a "good fit" for all

Current treatment approaches in publicly-funded CMH systems appear to be based on an acute-illness model (Weisz & Kazdin, 2003). CMH services are provided only in times of extreme need and EBTs are brief (about 6-months or less) (Barrett, Dadds, & Rapee, 1991; Kendall & Hedtke, 2006; Lochman & Wells, 2003). The current findings highlight how such a model of care is not appropriate for youth with ongoing and recurring CMH problems. New models of care that incorporate routine monitoring need to be considered.

Monitoring youth at-risk of recurring problems might offset the need for more intensive and costly services (e.g., hospitalization) in the future; for example, a youth who experiences a significant decrease in functioning could be managed by their CMH provider during a scheduled follow-up appointment, rather waiting for a relapse or crisis to occur. Without follow-up, families likely rely on tertiary care services (e.g., emergency department, crisis lines) to manage their child's recurring problems (Gandhi et al., 2016). The current findings suggest monitoring *all* youth post-discharge is not feasible within CMH. A serious lack of treatment capacity and funding within CMH contributes to this problem (Mental Health Commission of Canada, 2010; Schraeder & Reid, 2014; Waddell et al., 2002). Cost-effective and feasible solutions to monitoring should continue to be explored (Forchuk et al., 2013; Kazdin & Rabbitt, 2013).

It has been recommended that, following treatment, youth should be monitored in primary care by their family physician (Kutcher, 2011; Schraeder & Reid, 2016; Singh, Anderson, Liabo, & Ganeshamoorthy, 2016; Taylor, Fauset, & Harpin, 2010). For youth who are not appropriate for AMHS, over half (56%) are discharged to their family physician (Islam et al., 2016). In the current study, the majority (80%) of youth reported having a family physician. Family physicians are in a unique position to monitor youth who have received CMH treatment, as they are the only health professionals who routinely follow individuals across the lifespan. However, recent work shows families and CMH providers express uncertainty about family physicians in this role (Schraeder, Brown, & Reid, 2017). Perspectives of primary care providers are important and may highlight potential training needs for optimal follow-up care for young adolescents (e.g., promoting adolescent's self-efficacy, teaching self-management skills, helping adolescents understand the relapsing-remitting course of their condition, etc.). Ultimately, barriers for integrating CMH and primary care need to be overcome, as primary care offers valuable opportunities to improve continuity of care (Collins, Hewson, Munger, & Wade, 2010; Durbin, Durbin, Hensel, & Deber, 2013; Kates et al., 2011).

Study strengths, limitations, and future directions

The current study has several strengths. It is the first to examine issues related to transition for younger adolescents (12 to 15 years) from the perspective of their CMH providers. Providers varied in terms of sex, training background, and years of work experience, and also represented different programs (e.g., day treatment, residential care, intensive family therapy). Other studies have reported barriers to recruiting CMH providers (e.g., high staff turnover, lack of consent from youth/families to contact providers) (Hovish et al., 2012); we did not encounter these in this study.

A limitation of this work is that our sample reflected providers from two CMH agencies in the province of Ontario in Canada, which were publicly-funded. Our findings may not be relevant to providers working in other systems of care in other countries (e.g., privatized). Perspectives from CMH providers might also differ from providers in other sectors of care (e.g., education, child welfare). This work would benefit from the additional perspectives of professionals working in community CMH agencies, and in other sectors of care. In terms of future directions, improving transition preparation within CMH and testing out new models of CMH care (e.g., routine monitoring post-treatment, involvement of family physicians) will require input from CMH providers, such as in this study, as well as the perspectives of youth and families (Schraeder et al., 2018). There may also be opportunities for using novel 'co-design' type strategies within mental health settings (e.g., experience-based co-design), where providers and services users (e.g., youth, families) work together to improve or re-design service delivery models or co-develop transition policies; research on the effectiveness of these methodologies is underway (Chisholm, Holttum, & Springham, 2018). In addition, our study would suggest that more work is needed to develop transition policies within community CMH agencies. Existing transition policies and guidelines (e.g., (Trainor, Morningstar, & Murray, 2014; Walker, Pullmann, Moser, & Burns, 2012), which focus on older youth (e.g., entering post-secondary school, independent living) or populations known to need ongoing care (e.g., Autism, intellectual disabilities), could be revised for younger adolescents (ages 12–15) and for populations where the need for future mental health services is unknown. Future research is also needed to support when and how to effectively discuss transitions with younger populations. A comprehensive evaluation of existing follow-up care or monitoring practices during adolescence would be beneficial in order to identify best practices for ensuring youth with ongoing mental health issues receive optimal transition care.

Compliance with ethical standards

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/

or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

Declaration of competing interest

All authors declare they have no conflicts of interest.

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CRediT authorship contribution statement

Kyleigh E. Schraeder: Conceptualization, Methodology, Formal analysis, Writing - original draft, Writing - review & editing, Investigation, Funding acquisition.**Graham J. Reid:**Conceptualization, Formal analysis, Writing - original draft, Writing - review & editing, Funding acquisition, Resources, Supervision.**Judith Belle Brown:**Conceptualization, Methodology, Formal analysis, Writing - original draft, Writing - review & editing, Funding acquisition, Supervision.

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