

Key Issues Paper by the DGKJP and DGPPN
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Transition from adolescence to adulthood: The challenges to establish “transition psychiatry”

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The transition from adolescence to adulthood is a major developmental challenge for everyone. While it is often successful, it sometimes fails or threatens to fail – particularly in young people with mental illness. In a comprehensive key issues paper, the DGKJP and DGPPN (the German scientific associations of child and adolescent psychiatry and psychotherapy, and adult psychiatry and psychotherapy) now draw attention to these challenges and offer solutions to optimise the process of a planned transition from adolescent-centred to adult-oriented mental health care and thus to support adolescents in solving related problems.

The main demands of the DGKJP and DGPPN at a glance:

- Interdisciplinary outpatient, day-patient, inpatient and complementary services are to be created in patient care that take into account the specific features of the transition from adolescence to adulthood and consider the additional need for therapeutic services aimed at development-specific problems.
- These approaches are to be transferred to the complementary care system, or separate approaches to the provision of services are to be developed and promoted for this system.
- Programmes on transition psychiatry are to be established in medical education, especially training, and continuing medical education in order to provide the professional groups involved with specific, previously missing expertise.
- The transition phase should be given greater consideration in the revision of the professional training regulations for both child and adolescent psychiatry and general adult psychiatry. Innovative, interdisciplinary, cross-specialization continuing education opportunities and rotations are to be promoted.
- There is a special need for basic neurobiological research, care research and intervention research. So far, systematic research funding programmes that focus on transition processes are lacking.
- Political action is required in the areas "care structures", "cross-sector care models", "complementary care offerings" and "specific research funding".

Background

The transition from adolescence to adulthood represents a major developmental challenge for everyone; while it often succeeds, it sometimes fails or threatens to fail. As adolescence and young adulthood represent a particularly vulnerable period for the development and chronification of mental disorders, the best possible care needs to be ensured for these age groups. The necessary transition from adolescent-centred to adult-oriented care represents an additional challenge as regards development-related aspects. During this period, the specific needs of mentally ill adolescents aged between 16 and 24, all of whom have different maturational processes and developmental conditions, need to be considered. The psychiatric help system is faced with the challenge of organising this transition in an optimal manner and supporting the adolescents in solving related problems. At present, however, in many areas there are still considerable problems at the interface between the different segments of care in childhood, adolescence and adulthood, resulting in higher treatment discontinuation rates, treatment disruptions and other factors that have a negative impact on the course and prognosis.

Although the transitions between developmental stages differ greatly between individuals, sharp boundaries or transition periods are formally defined for the transition from adolescence to adulthood. Young people reach the age of majority on their 18th birthday. In the night before their 18th birthday, issues of self-determination and treatment consent change fundamentally. Nevertheless, in various contexts, the legislator provides criteria for individual maturity. Thus, in Germany, adolescents aged 14 or 15 may be able to give consent if they can fully grasp the consequences of respective decisions. In German criminal law, a specific category exists for juveniles (18-21 years) which allows juvenile law to be applied to young adults if certain immaturity criteria are fulfilled. Youth welfare social law provides assistance with the education and integration of psychiatrically disabled young people or young people at risk of psychiatric disability until age 21, in exceptional cases even up to age 27. If adolescents are considerably behind in maturity, after the age of 18, legal care can be arranged and is often further delegated to parents.

As a result of the reform of participation support and integration assistance and the upcoming participation legislation for adults as well as children and adolescents, this age limit – which is relevant for the complementary care of many young people with mental health problems – has to be redefined and redesigned in the respective service areas.

Maturation processes are rarely linear. Rather, particularly in young people with mental illness, one can sometimes observe developmental setbacks or strong efforts at independence. As regards developmental psychology, international data (see Seiffge-Krenke 2015) show an increasing prolongation of the transition period between adolescence and adulthood. In southern Europe, the economic situation has significantly contributed to the fact that young people often live with their parents until the age of 30. In Germany too, the living situation often derisively referred to as "Hotel Mama" is becoming increasingly common. Although young people often live with different partners during the transition phase to work or study, they frequently no longer necessarily move out of the parental home.

To date, the psychiatric help system is not sufficiently attuned to the particular circumstances of the transition from adolescence to adulthood, and the problems associated with the prolongation of ado-

lescence into the third decade of life, i.e. of "emerging adulthood" as an independent development phase. Emerging adulthood has established itself since the late 1990s as a result of sociological and cultural changes in almost all Western industrial nations and is associated with temporal shifts in objective sociological and psychological markers of adulthood (cf. Seiffge-Krenke 2015).

After its early beginnings in the period between the two World Wars, child and adolescent psychiatry established itself as an independent entity from adult psychiatry with its own specialist qualification (Specialist for Child and Adolescent Psychiatry and Psychotherapy) and achieved nationwide recognition after the 1975 report on the situation of psychiatry in Germany ("Psychiatrie-Enquête"). In the staffing of hospitals, the regulation on staff in psychiatry takes into consideration the fact that young people always require education in addition to medical treatment. So-called "care and education services" comprise mixed teams of nurses, social care workers, educators and social pedagogues. Hospital schooling and the associated guarantee that students will have access to subsequent education elsewhere, in accordance with the UN Convention on the Rights of the Child, is a standard feature of inpatient and day-patient treatment in child and adolescent psychiatry. However, this proven increased staffing need ends abruptly at age 18. At this time, the regulation on staff in adult psychiatry takes effect, even though mental problems related to developmental tasks still require specific types of personnel and a higher number of staff.

Child and adolescent psychiatric treatment is almost always a treatment for the whole family. Parents and possibly siblings are also strongly involved in treatment approaches and offerings. The guardians, usually the parents, are key decision makers in child and adolescent psychiatric treatment and can, if necessary and after judicial approval by the Family Court, themselves arrange for their child to be admitted to a closed ward. The young patients are seen and treated as part of a family system. The developmental aspect and certain developmental tasks and educational objectives play a central role in the treatment.

In contrast, adult psychiatry focuses on individualized diagnosis and treatment and has to consider the autonomy of adults from their biological families. Issues of developmental psychology become less important than the treatment and management of specific diseases, and disorder-oriented psychotherapeutic and sociotherapeutic interventions and the accompanying psychopharmacological therapy assume greater significance. Adult psychiatry treats ages ranging from young adults to senior citizens and has to consider – by means of necessary specialisations – disease-specific characteristics (keyword: special departments for disorder groups) on the one hand and special age-related processes (keyword: geriatric psychiatry) on the other.

The cross-linking of these two areas of the psychiatric help system should be improved in order to deal with the particular problems associated with the transition from adolescence to adulthood and the recently emerged developmental phase "emerging adulthood." To date, age transitions are regulated differently by social law. Twenty-one is the established age limit for outpatient treatment by office-based specialists in child and adolescent psychiatry and psychotherapy and for child and adolescent psychotherapy, meaning that a necessary transition phase is largely guaranteed in outpatient settings. However, outpatient care by clinics at institutions of child and adolescent psychiatry and psychotherapy ends at age 18 and may be continued only in special types of care (IV contracts, model

projects according to § 64b SGB V) or at special request. Again, appropriate transition services should be created.

Key issues of the DGPPN and DGKJP for transition psychiatry in adolescence and young adulthood

In compliance with international definitions in the health care sector (see Mayr et al. 2015), both professional associations understand transition as the targeted support of the transition process in the sense of coordinating suppliers and ensuring supply continuity on the path from youth-centred to adult-oriented care. These transitions are being discussed and researched throughout Europe (see EU Milestones Project, grant number HEALTH-F3-2013-602442).

Improve transition medicine for people with mental illness

Transition medicine arranges the transition, especially for chronically ill children and adolescents, from a usually very caring paediatric health care to adult care, with its greater degree of patient self-determination (cf. Fegert et al. 2015).

In particular, early-onset chronic diseases such as infantile autism and other pervasive developmental disorders result in a close binding of the parents of affected children to the child and adolescent mental health care system. Consequently, the transition to adult psychiatry, which so far has focused less on childhood-specific illnesses, is often avoided for as long as possible.

Conversely, it was primarily adult psychiatry that examined the long-term course of psychotic disorders that start in childhood and adolescence and that thus stimulated a broad debate in both fields about the importance of early detection and early treatment, e.g. of schizophrenic disorders (Bechdolf et al. 2012). For too long, index illnesses were trivialized in child and adolescent psychiatry as crises of adolescence, meaning that the opportunity for prevention and early intervention was not adequately exploited. As a consequence, in Germany, the first interdisciplinary early detection and early treatment centres have been created in these fields (e.g. Resch & Herpertz 2015).

Intensify research in developmental neurobiology

The transition phase is also characterized by considerable neurobiological changes. In adolescence, a restructuring takes place that is associated with the demise of redundant synaptic connections from the earlier childhood development, resulting in a complex maturation of neuronal structures. This process has a substantial effect on central elements of psychopathology and behaviour, such as risk-taking behaviour (see Crone et al. 2016). Both professional scientific associations emphasize the need for joint and interdisciplinary research on neurobiological development in adolescence and young adulthood.

Consider age- and maturity-related features in treatment

Various important and severe mental illnesses of adulthood such as dependence disorders, psychotic disorders or self-harming and suicidal behaviour have a peak age in adolescence or young adulthood and, in contrast to the psychopathology of childhood, are characterised by their emergence in adolescence (Kaess & Herpertz 2015). However, various longitudinal studies such as the New Zealand Dunedin longitudinal study show that half of all mental disorders in 25-year-old adults start in puberty or even childhood, i.e. before the age of 15 years (Kim-Cohen et al. 2003).

These typical courses give rise to corresponding areas of cooperation, but when designing therapeutic offerings, the specific needs at each age and level of maturity have to be considered.

Promote transition psychiatry in continuing education and care

In recent years, the courses of development-related disorders of childhood such as autism and specific learning disabilities have been more strongly addressed in regard to their effects in adolescence and the transition to adulthood. This topic requires more research and improvement of psychosocial care.

The training for both medical specialties needs to build stronger skills in the treatment and understanding of patients in the transition age. E-learning and new teaching methods that facilitate interdisciplinary training modules need to be conceptualized in an interdisciplinary manner.

In outpatient, day-patient and inpatient care, coordinated transition and treatment pathways need to be developed that require flexible case management. New cross-sector care models need to be developed specifically in this area.

Consider knowledge from transition psychiatry in forensic psychiatry

Adolescence and young adulthood are also high-risk phases for delinquency and multiple social difficulties. Forensic psychiatry services and the corresponding expert opinion practice have to take this into account. Attention must be paid to the fact that a relatively large number of child and adolescent psychiatric patients with so-called "social behaviour disorders" are cared for in residential youth welfare institutions and, in young adulthood, such patients at first rarely use adult psychiatric services on their own initiative. More specific offerings for so-called "care leavers" need to be developed because these young people often have a significant history of exposure to trauma.

Promote educational qualifications, facilitate entry into working life and enable participation

When starting their career, a substantial proportion of young people with mental disorders fail or have significant problems in the transition to the adult world (see Kölch et al. 2011). Specialized health care services and complementary support from employment agencies or age-specific organisations for integration support are urgently needed for this group.

Improve coordination of complementary care systems

Complementary care systems, e.g. in integration support, have to be coordinated in order to support transitions and participation in society more systematically than hitherto. In the upcoming participation reform, the responsible ministries (BMFSFJ for childhood and adolescence and BMAS for adulthood) have to coordinate concepts and transitions without thereby neglecting the specific needs of the respective age groups. Flexible transition possibilities and forms of support for adolescents must be maintained.

Develop new cooperative services

Whereas in outpatient child and adolescent psychiatry and child and adolescent psychotherapy, treatment transitions and follow-up treatment are possible up to the age of 21, day-patient and inpatient treatment is clearly separated from adult psychiatry on the basis of age. This separation is also reflected in German states' planning of psychiatric services.

As regards developmental psychopathology, specific day-patient and inpatient services would be appropriate that support the transition and are adequate for the patient's maturity level; some models of such offerings have already been developed in an interdisciplinary approach. It is of central importance that medical treatment in the transition phase from adolescence to adulthood should take into account fluctuating, indeed sometimes oscillating maturation processes. Moreover, it should combine core elements of treatment expertise and settings in adolescent psychiatry with core elements of treatment competence in adult psychiatry in a setting that is suited to young people and staffed appropriately. Work with parents, psychoeducation of afflicted young people and their relatives (partners and parents), the inclusion of development-specific issues in psycho- and socio-therapeutic services, the involvement of peer groups, support in starting a job or support of training objectives are core characteristics of integrated mental health care that must be designed specifically for the target group.

Conclusion

Transition psychiatry is facing great challenges and major developmental requirements in the following areas:

- Interdisciplinary outpatient, day-patient, inpatient and complementary services are to be created in patient care that take into account the specific features of the transition from adolescence to adulthood and consider the additional need for therapeutic services aimed at development-specific problems.
- These approaches are to be transferred to the complementary care system, or separate approaches to the provision of services are to be developed and promoted for this system.
- Programmes on transition psychiatry are to be established in medical education, especially training, and continuous medical education in order to provide the professional groups involved with specific, previously missing expertise.

- The transition phase should be given greater consideration in the revision of the professional training regulations for both child and adolescent psychiatry and general adult psychiatry. Innovative, interdisciplinary, cross-specialization continuing education opportunities and rotations are to be promoted.
- There is a special need for basic neurobiological research, care research and intervention research. So far, systematic research funding programmes that focus on transition processes are lacking.
- Political action is required in the areas "care structures", "cross-sector care models", "complementary care offerings" and "specific research funding".

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