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Comparison of child and adult clinicians' perceptions of barriers and facilitators to effective care transition

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ABSTRACT

Among individuals with mental illness, transition-age youth (TAY; age 16–25) have the lowest rate of treatment-seeking and the highest rate of premature exiting from treatment, at the exact time when their needs for mental health supports are greatest. This qualitative study provides insight into the perspectives of adult and child service clinicians regarding their perceived barriers and facilitators to reducing disengagement during the transition from child to adult mental health care. While child and adult clinicians agreed on many key barriers, they often disagreed on influencing factors. Child and adult clinicians had greater agreement among facilitators, particularly the need to provide greater service array flexibility during this transition.

Introduction

Up to 75% of the adults with psychiatric disorders report that symptoms emerge during the transition to adulthood (16–25 years old), and rates of major psychiatric disorders dramatically increase during this time (i.e. major depression, schizophrenia, and bipolar disorder; Kessler et al., 2005). Further, the co-occurrence of substance use disorders also peaks in young adulthood (Merikangeas et al., 2010). Unfortunately, this rise in behavioral health needs corresponds with weak or non-existent handoffs between child- and adult-serving mental health systems. Among individuals with mental illness, TAY have the lowest rate of treatment-seeking and the highest rate of premature exiting from treatment. This lack of clinical engagement starkly contrasts the fact that, given their developmental stage, the need for mental health supports is greatest for TAY (Huey, Tilley, Jones, & Smith, 2014; McGorry, Bates, & Birchwood, 2013; Singh & Tuomainen, 2015). The challenges surrounding transitions from child to adult health care systems result in disengagement from care, increased crisis care utilization, and overall poor health outcomes

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(Huey et al., 2014; Paul et al., 2013). Studies consistently find that both child and adult mental health systems often fail to address the unique developmental needs of emerging adults and restrict access to adult mental health services (Cohen, Klodnick, Kramer, Strakowski, & Baker, 2020; Davis & Butler, 2002; Davis, Koroloff, & Ellison, 2012).

In addition to not meeting the unique needs of TAY, adult and child systems are often siloed, leading to uncoordinated transitions between systems of care (Broad et al., 2017; Davis & Koroloff, 2006; Skehan & Davis, 2017). Historically, adult and child mental health services evolved independently, with vast differences in treatment goals and methods, assumptions of underlying causes of distress, funding sources, diagnostic approaches, outcome measures, and clinician training (Cohen et al., 2020; Dixon, Goldman, Srihari, & Kane, 2018; Goldman & Morrissey, 2020; Grob & Goldman, 2006). The transition in mental health programming from adolescence to young adulthood is therefore rife with fragmented, fractured, and often, absent handoffs for effective clinical and social supports (Broad et al., 2017; Davis & Koroloff, 2006; Skehan & Davis, 2010). Resulting from this system disconnect, emerging adults find that their preferences and goals are not met by either adult or child treatment systems, ultimately leading to limited engagement in care (Davis et al., 2012; Davis & Vander Stoep, 1997; McMillen & Raghavan, 2009; Miller, Southam-Gerow, & Allin, 2008; Moore, 2018; Munson et al., 2012; Paul et al., 2013).

In the last 15 years, more attention has been paid to the specific vulnerabilities of the transition-to-adulthood population. Through SAMHSA Healthy Transitions Initiative demonstration grants, a number of states designed and implemented promising bridge or multidisciplinary models for 16 to 25 year olds with serious mental health conditions (SMHC). Despite the need to better understand change mechanisms, identify beneficial practices, capture outcomes, and further test efficacy, these approaches have neither been thoroughly operationalized nor evaluated. In contrast, the National Institute of Mental Health RA1SE initiative produced substantial knowledge about the design and benefits of Coordinated Specialty Care (CSC) (Dixon et al., 2015; Drake et al., 2020). CSC is a recovery-oriented treatment program for individuals with a first episode psychosis (FEP), which typically occurs between the ages of 16 to 25. However, to date, there has been limited FEP research or practice focusing on care transitions for TAY and limited, rigorous research on models for mood disorders (Jones et al., 2020; Klodnick et al., 2020).

Limited research, including a review of ten studies with TAY, indicates that the most effective treatment engagement facilitators for TAY include: 1) practical, system-level practices such as building an early, positive relationship through assessment; 2) using psychoeducation with clients regarding their mental illness and; 3) addressing practical and

psychological barriers to treatment (Moore, 2018). Additional research indicates a need for child and adult service clinician training to foster attitudinal changes toward cross-sector services while enhancing the capacity to empower TAY to become partners in their transition (Viner, 2007). A clearer understanding of the approaches to care for TAY and the perceived barriers in both child and adult service systems could identify misalignment. Additionally, efforts can be further advanced by improving developmentally appropriate care and creating seamless transitions as youth shift from one setting to the other.

The current study explored the beliefs of child and adult mental health clinicians about the transition process, and their experiences and roles supporting individuals transitioning from child to adult mental health service systems. Our study aim was two-fold: 1) to understand and describe clinicians' perceptions of facilitators and barriers in the transition process, and 2) to explore if there were similarities and differences in perceptions of facilitators and barriers between child and adult clinicians. While this study sought the views of clinician and not youth (e.g. Broad et al., 2017), a related study by Cohen and colleagues (under review) explores the youth and young adults' views on the transition process.

Primary Research Questions

1) What are the perspectives of a child- and adult-serving clinicians about the role of the clinician, barriers, and facilitators to service transitions, and how to improve the transition from child to adult mental health services?
2) How are the perceptions of a child- and adult-serving clinicians similar or different about the role of the clinician, barriers and facilitators to service transitions, or how to improve the transition from child to adult mental health services?

Method

Focus groups were conducted to explore clinician views on the transition from child to adult mental health services. Data were collected from clinicians based on the assumption that clinicians would be willing to share their viewpoints within a group setting of their peers. The study team determined the goals of the project and developed the plan for data collection. The interview guide was informed by two TAY with lived experience of mental health treatment. These youths provided feedback on question language. Prior to data collection, Institutional Review Board approval was obtained from the University of Texas at Austin, and recruitment of clinicians was achieved through collaboration between a member of the research team and clinical leaders at the mental health services agency.

Setting

The study occurred within one large urban public mental health provider in Texas. This agency has about 900 employees, 45 locations, and is primarily funded through Medicaid, state and federal grants, and foundations. This agency was recruited because it provides both child and adult mental health services, and was interested in improving the transition process between child to adult mental health services. The agency serves approximately 29,000 individuals each year – approximately 6,500 of those are children and families and 22,500 are adults. Approximately 250 individuals age out of child services every year. The client demographic make-up is 60% White, 18% Black, 2% Asian, 16% other race or unknown, and 33% Hispanic. Texas uses a managed care structure in which individuals are assessed regularly (every 90 days as a child; every 6 months as an adult) to prescribe a "level of care" (LOC). The LOC determines a minimum and a maximum number of specific services (e.g., case management, psychiatry, therapy). A majority of children age out of child services at their 18th birthday, however, a very small number are allowed to stay in child services until the age of 19. This is only the case for youth who are served under the Medicaid 1915c waiver. Previous analysis indicated that children who qualify for the highest level of care at age 17 tend to only qualify for the lowest level of care at age 18 (Cohen, Lopez, Klodnick, & Stevens, 2016).

Recruitment

Clinicians who serve clients aged 16–25, either in child- or adult-serving clinics within a local public mental health center were invited to participate in two focus groups. Groups were facilitated by the first and third authors. Clinicians were placed into separate focus groups based on whether they served children or adults, due to differences in child and adult mental health service array. Twenty-two clinicians participated in two groups lasting 1.5 hours each. Focus groups were held during the work day and clinicians were provided with food during their participation. Focus groups were recorded and transcribed for coding. All participants agreed to being recorded. The interview guide included questions related to barriers faced by individuals regarding engagement and receipt of care during the transition from child to adult mental health services. Questions were arranged into four main domains: access to care, assessment, treatment, and outcomes. See Table 1 for focus group questions.

Participants

Twenty-two clinicians working with individuals aged 16–25 participated in the focus groups. Clinicians held a variety of degrees and specialties, including Licensed Professional Counselors (LPC), Clinical Psychologists, Art Therapists,

Table 1. Focus group questions used with TAY mental health clinicians.

Access
    1. What do you think the experience is like for 16–25-year old's trying to access services?
    2. Is this experience different for child and adult clients?
    3. Can you explain the process of accessing services at your agency?
    4. How convenient do you think is it to access help?
Assessment
    1. What do you think the assessment process is like for transition-age youth?
    2. How easy is it to get an appointment for the assessment?
    3. How can the assessment process be changed to be more helpful?
    4. What are some of the barriers during the assessment process?
    5. Are there challenges to the diagnostic process for this age group?
    6. Are you ever uncomfortable asking specific required questions?
    7. What sort of feedback have you received from clients about the access process?
Treatment
    1. What approaches do you think work with this age group?
    2. What do you find the most difficult about this age group?
    3. Where do you meet with them?
    4. What do you do if a youth does not show up for services?
    5. How can services be changed to better serve this age group?
    6. What is the role of education, employment, and housing goals in services for this age group?
Outcomes
    1. How do you set goals?
    2. How do you assess clinical improvement?
    3. What do your AYA clients to get out of treatment?
    4. How do you know the youth has met their treatment goals?
    5. How do you plan for discharge or transition?

TAY stands for transition-age youth.

Licensed Master Social Workers (LMSW), Case Managers, Nurses (BSN, LVN, PMHNP), and Qualified Mental Health Professionals (QMHP). Five clinicians identifying as female and one clinician identifying as male participated in the child clinician focus group. The child clinician group was comprised of 83.3% White, 16.7% Black or African American, and 16.7% Hispanic or Latino participants. The second focus group was comprised of clinicians working primarily with adults. The adult clinician group was made up of eleven individuals identifying as females and five who identified as male. This group was 31.3% White and 43.8% Hispanic/ Latino; 25% of the group did not identify their race/ethnicity. See Table 2 for demographics.

Data analysis

Two coauthors who did not participate in the interviews independently coded focus group transcripts and developed codes that categorized the

Table 2. Child and adult clinician demographics.

	Child Clinicians	Adult Clinicians
Gender		
Male	1 (16.7%)	5 (31.3%)
Female	5 (83.3%)	11 (68.7%)
Race/Ethnicity		
White	5 (83.3%)	5 (31.3%)
Black/African American	1 (16.7%)	0 (0%)
Hispanic/Latino	1 (16.7%)	7 (43.8%)
Did Not Identify	0 (0%)	4 (25%)
Age Range	23–59	28–60

discussion into three themes: Barriers to Care (n = 13), Facilitators for Successful Transition (n = 14), and Suggested Engagement Opportunities (n = 7).

The analysis was based on a grounded theory and template approach to qualitative data; codes were developed based on content and were not predetermined (Miller & Crabtree, 1999; Walker & Myrick, 2006). In grounded theory, the researchers create thematic categories of data for the purpose of relating said categories amongst and between one another, and thus understanding the experiences and perceptions of clinicians through the conceptualization of these relationships (Glaser & Straus, 1967). The relationships between categories are then used to develop theory. Coding in grounded theory is described as the "pivotal link between collecting data and developing an emergent theory to explain these data" (Charmaz, 2014, p. 46). First, one of the coders (C1) independently reviewed the focus group transcript and identified three main themes: Barriers to Care (n = 13), Facilitators for Successful Transition (n = 14), and Suggested Engagement Opportunities (n = 7). After multiple reviews of the transcript, themes were broken into several levels of subcategories or codes. After C1's thorough review of each transcript, a second coder (C2) independently reviewed each transcript and confirmed C1's codes, developing new codes where previously uncharacterized themes were identified.

A comprehensive coding form was developed to outline code definitions based on C1 and C2's extraction of focus group content. After independent review from each coder, the research team collaborated to discuss coding discrepancies, merge subcategories, and confirm final coding. After three rounds of discussion between C1, C2, and the research team, a final hierarchy of codes was established, separated into 3 main themes, 21 parent codes, and 13 subcodes. The final coding form included 34 total codes. See Table 3.

After determining a final codebook, both coders utilized a template approach to tag text passages of the focus group transcripts with codes. In order to do so, the qualitative data analysis software, NVivo, was used. This process allowed the research team to more systematically separate text into categories and draw final conclusions regarding the frequency of themes.

Rigor

Several procedures were utilized to monitor and enhance the quality of the collected data, including a systematic review of focus group transcripts and frequent, recurrent debriefing meetings with research members. A team-based approach was used to limit the potential for bias and promote alternative explanations. Triangulation methods (e.g., corroborating data and member checking) were used to increase the credibility of our findings.

Table 3. Focus group coding references.

Code	Total Number of Coding References	Adult Provider Coding References	Youth Provider Coding References
Barriers to Care	**93**	**42**	**51**
1. Developmental Factors	10	5	5
1.1 Service Entry at the Cusp of Transition	2	1	1
1.2 Inexperience Navigating the System	9	4	5
2. Insufficient access to Peer Specialists	5	4	1
3. Insufficient Family Support	4	0	4
4. Parental Over Involvement	10	4	6
4.1 Loss of Care When Parental Involvement Ends	4	1	3
5 System Disconnect	16	8	8
5.1 Disrupted Access to Supports	13	9	4
5.1.1. Shifting Relationship Between Provider and Family	2	2	0
5.2 Increased Rigidity in Service Array	10	2	8
5.3 Shift of Clinical Focus	4	1	3
5.3.1. Lack of Counseling Services	4	1	3
Best Practices for Successful Transition	**75**	**25**	**50**
1. Continuity of Community Supports	7	2	5
2. Creating Opportunities for Peer Support	4	3	1
3. Cross System Provider Collaboration	5	2	3
4. Flexibility in Youth Service Provision	11	3	8
5. Independent Life Skill Training	4	1	3
6. Person-Centered Care	10	6	4
6.1. Fostering Youth Self Determination	10	1	9
7. Supporting Families Through Transition	1	0	1
7.1. Linking Families to Resources	3	2	1
7.2. Modeling New Boundaries	6	2	4
7.3. Psychoeducation	6	3	3
8. Supporting Clinicians with Resources	1	0	1
9. Transition Specific Care	3	0	3
10. Utilizing Existing Technology	4	0	4
Future Engagement Opportunities	**14**	**6**	**7**
1. Continuity of Care with Peer Specialists	4	2	2
2. Discretionary Extent to Transitional Care	2	1	1
3. Increased Access to Counseling	2	2	0
3.1. Increased Transition Specific Therapy	1	0	1
4. Integrating Technology	3	0	3
11. Transition Age Assessment Tools	1	1	0

Results

Final coding frequency and inter-rater reliability between coders were determined using NVivo. After multiple meetings and discussions, coders ran

a comparison query and found, using the kappa coefficient, a 96.5% alignment in their coding of focus group content.

Barriers to care

With 93 context references, *Barriers to Care* was established as the main theme among both adult and child clinician focus groups. *Barriers to Care* was defined as any micro-, mezzo-, or macro-level barrier to transitions from the child to adult mental health care. As highlighted in Table 3, *Barriers to Care* served as an umbrella to five subthemes, including: 1) developmental factors; 2) insufficient access to peer specialists; 3) insufficient family support; 4) parental over involvement; and 5) system disconnect. Throughout both focus groups, clinicians agreed on many of the barriers to care. However, as barriers were broken down to more granular subthemes, discrepancies arose.

Both child and adult clinician groups agreed that the two main barriers to a successful transition in care were developmental factors and a general system disconnect. Through continued discussions, developmental factors were broken down further to describe TAY who struggled with the autonomous nature of the transition. Clinicians focused on this aspect, citing that the developmental stage of TAY informed an inexperience navigating mental health systems. The adult clinician focus group believed that developmentally, TAY had trouble conceptualizing their needs and the responsibilities associated with being an adult seeking services:

> I think what they [TAY] find overwhelming is navigating the [adult mental health] system. When they are brought into services, it [the system] is like, "here's a case manager, here's a psychiatrist, here's a nurse, here's a PCP." All of this is thrown at them at once. And they're just trying to figure out, "well what does this person do? How are they working together?" It's a lot to take in at once.

When addressing the commonly stated barrier of system disconnect, both clinician groups felt that the abrupt shift in services, supports, and infrastructure upon entering the adult system left many individuals feeling unprepared for the transition. One adult clinician explained this disconnect by stating, "there's a drop in the level of intensity of service package automatically. It's just sort of like dropping off a cliff." However, child and adult clinicians disagreed when breaking down the cause for system disconnect. Adult clinicians attributed this disconnect to a disrupted access to supports and the shifting – and ultimately, less involved – the relationship between clinicians and families. One clinician asked rhetorically, "Are they ready to transition from having a case worker that meets with them once a week to having a case worker that meets with them once every three months?" Child clinicians, on the other hand, were more likely to attribute the disconnect to an increased rigidity in services and a shift in clinical

focus. For example, they pointed out that the "adult side" of care focused more on medication and case management, with fewer opportunities for counseling. Child clinicians referenced how disrupted access occurs when individuals move from mental health services provided in the school setting, where they can easily access counseling as part of routine child services, to the adult system, where they have less access to consistent counseling. One adult clinician commented:

> So, on the adult side, we kind of have a conversation about the difference in the focus and I know that there's a lot of case management, there's a lot of the medication piece, but the therapy part we usually refer out, and I think that having kind of that transition or that change is challenging for a lot of the clients I work with that are turning eighteen.

Many clinicians commented on the newly assumed responsibilities placed on TAY, such as navigating their own treatment planning, and the logistics surrounding appointment scheduling and securing transportation once turning eighteen.

Clinicians in both adult and child focus groups expressed concern about insufficient access to peer specialists in their systems, indicating that TAY could benefit from this type of navigation support during adolescence, and as they enter adult services. Specifically, the adult-serving clinicians more frequently referenced the function of current adult peer specialist within the agency to provide relational support to middle-aged adults and their services do not meet the needs of the adolescent and young adults. One adult system clinician explained, "I've had several kiddos within the early teenage range, who've asked for something like a mentorship program. And at least as far as I know, we don't offer anything like that." Both child and adult clinicians noted the potential benefit of pairing individuals transitioning from child to adult services with peers who could assist them in navigating the process.

Both child and adult clinicians' groups discussed the nuanced relationship between parental involvement and TAY engagement with services. However, child clinicians more frequently expressed concern over the lack of parental involvement or support that they attribute to youth dropping out of services as they transition into adult care. One explained this problem:

> ...when they have that not-good support at home and there's more chaos or the parent has their own struggles financially, or with relationships, substances, or their own mental health issues; those are the kids that are impacted the most and are probably the ones that aren't going to continue after they're eighteen.

However, both focus groups reflected that parental *over*involvement can similarly lead to loss of care. In instances where caregivers have forced their children into services, their child may consequently drop out of services upon reaching adulthood. Adult clinicians discussed parental pushback to the restrictions preventing clinicians from offering client-specific information to

TAY parents. These clinicians noted their need to establish boundaries for parents once their child turns eighteen, such as educating them on their child's newfound autonomy.

> Yeah, I think by the time they reach adulthood, if you've got a twenty-year-old and you've got a parent that's calling you ten times a day, it's more therapeutically appropriate to be setting boundaries with the parent that we're kind of past that point. And so, it's more appropriate for the case managers to, at that point, be setting a very clear message across the board about their child [being an adult].

Child clinicians noted the challenges with confidentiality and parental *over*involvement.

> Legally there's no, in terms of confidentiality, when they're younger, talking to the parent is exactly the same thing as talking to the kid. Our therapists always walk this tightrope because how much do we involve the parent, how much do we share in terms of . . . really, if it's not a safety concern [we do not share]. But that parent, I could tell, was perplexed because they wanted to be able to have more control over, more say so.

This challenge was more present when preparing parents for the shift to the adult mental health system. Clinicians mentioned that "letting that control go and letting the children move on to transitioning into adults is a really tough time [for parents]."

Facilitators for successful transitions

To combat the identified barriers to access, clinicians offered insight into facilitators when working with TAY. The *Facilitators* theme was defined as any micro-, mezzo-, and macro-level practice that clinicians believed would improve the transition from child mental health services to adult mental health services for transition-age youth. *Facilitators* made up for 75 context references throughout both focus groups. The most referenced subthemes for *Facilitators* were: 1) continuity of community supports; 2) flexibility in child service provision; and 3) person-centered care. Both focus groups found it beneficial to support families through the transition through psychoeducation, modeling new boundaries, and linking them to resources as best practices. For example, adult clinicians mentioned finding ways within their capacity to support the needs of their clients' parents.

> We can do parent skills training. We can do all of these things that involve the parent and help them get connected to resources . . . We can give them like all these family groups that are awesome. CoDA groups, Al-Anon groups, tons of print outs and explain to them what these are and how it could relate to you and be beneficial as a parent.

Both child and adult clinicians also suggested that TAY can benefit from the continuation of care until a child is ready to age out. During the continuation of care, clinicians focus on individuals' goals and needs as they transition into

adulthood. For example, clinicians from the child focus group mentioned how they often extend services through the summer, and accompany the child to adult services, to help with the transition process.

> . . .The therapist went with her to the adult place to get an intake, and was there for hours and [the youth] just expressed it was a much different process and it's [adult clinic] a totally different environment.

Members of the adult clinician focus group supported continuity by encouraging community staff to attend the TAY's first clinical appointment with their new case manager on the "adult side." Child and adult clinicians agreed that successful transition hinges on the employment of person-centered care and clinicians collaborating across adult and child systems. However, child clinicians more frequently noted their orientation toward person-centered care and discussed their focus on fostering youth self-determination as a tool to prepare youth for the autonomy associated with adult systems.

> Empowerment or advocacy because it's more about handing somebody a resource and encouraging them . . . helping them to actually connect . . . I encourage people to make calls in the office.

Child clinicians reflected on the flexibility in the child service array that affords them the ability to incorporate in-vivo learning in a variety of settings, as deemed therapeutic, beneficial, or convenient for any given client.

> Yes, one of my clients I used to work with, she was really big into art. And so, one thing that we would actually do is, we would go to Graffiti Park. And we would go to the Cathedral of Junk and actually, like go to places and talk about like how those are helpful for her when it comes to expressing her emotions. Emotion regulation. We talked about how that's a healthy coping skill. How to be able to use that healthy coping skill. So, actually doing those things.

Akin to this concept of greater flexibility in the youth service array, child clinicians reported their willingness to utilize phone apps and technology that appealed to TAY clients.

> I think for kids that have phones, I use a lot of phone reminders with them . . . We have another therapist that uses a lot of apps. So, like, she found like thought tracking logs and will help the kids download the app and practice the app in session and then ask them to track it out of session and discuss it.

These examples of innovation stemmed from a flexibility inherent to the child system that was not described by adult clinicians. Both adult and child clinicians agreed that child clinicians had more freedom to offer flexible service provision. Specifically, the Youth Empowerment Services Y.E.S. 1915c Medicaid waiver allowed child clinicians to provide non-traditional supports and services that were non-existent in the adult system. This

flexibility directly opposed the identified barrier- "increased rigidity in service array" – associated with the adult system.

Future engagement opportunities

As child and adult clinicians reflected on barriers and facilitators, they also discussed activities they would like to see implemented to improve the engagement of adolescents and young adults. The theme *Future Engagement Opportunities* was defined as any micro-, mezzo-, or macro-level practice suggested by a clinician to engage transition-age youth in continuing mental health services. This theme included several subthemes highlighted in Table 3: continuity of care with peer specialists, discretionary extent to transitional care, increased access to counseling, integrating technology to practice, and transition-age specific assessment tools. Many of the subthemes of *Future Engagement Opportunities* were concepts expanded from *Facilitators* in which clinicians identified things they would like to see changed.

Clinicians from the child focus group suggested integrating technology and other transition-specific components into the therapeutic process. "Integrating technology, too. It's hard. People won't answer the phone. It's the agency policy where we can't text so being able to use some kind of app, like you were saying, that can be used to communicate … ".

Adult focus group clinicians noted opportunities during the discussion of system disconnectedness. They recognize the increased rigidity in adult services, and subsequent need to emphasize more access to general counseling for TAY entering adult services. One adult clinician explained,

> And for the counseling thing … Again, I've spent the majority of my career in crisis counseling, I just recently moved over to adult behavioral health side. From what I can tell there's a lot less access to counseling, regular counseling services than there are to [other] obviously really beneficial services like case management, prescriber, but just the opportunity to process things. We could use more of it.

During discussions about how the unique developmental stages of TAY contribute to challenges experienced when transitioning into adult care, adult clinicians commented on the limitations of relying on assessment tools that pigeonhole clients into either adult or child categories. Clinicians suggested the need for the state to change the required assessment tools to capture their unique developmental stage.

> I think it would be nice if there was a better assessment tool because I think … the Adult Needs and Strengths Assessments (ANSA) are so adult heavy and the Child and Adolescent Needs and Strengths Assessments (CANS) are so youth oriented that there's really something that's not … I mean there's … Part of the piece that's missing is being able to assess where they are in terms of their independence. And then, being able to bring that into treatment.

Adult and child clinicians agreed that, depending on client need, service plans should also include a discretionary extent of youth care for TAY, until they feel prepared to enter into adult services. Clinicians agreed that TAY are not always ready to enter into an adult system so abruptly, but should take time transitioning, learning skills related to adulthood, to ease the transition. However, child and adult clinicians disagree on how to solve this issue. One child clinician stated:

> I think I'd rather they stay in our services longer than transition to adult services. Just 'cause the environment is just so different. That's just my wish list. And continue to see the adolescent psychiatrist. I know a lot of people don't agree with that, but I just think, for a lot of our kids, the maturity level is very different.

However, other clinicians felt that a bridge should be built to reduce treatment disengagement.

Both child and adult clinicians discussed the benefit of TAY receiving continuity of care through informal supports such as peer or mentor engagement. Clinicians discussed how it is developmentally appropriate for TAY to seek peer-directed supports who can normalize their experience, provide informed insight, and serve as a mentor.

> I think if they're starting from the children and family services side, having someone who can basically follow them straight through into the adult side. Maybe, not necessarily the therapist they were working with, but we do get something like a peer or a mentor. Have that person be able to follow them from children into adult and then stay with them there.

Discussion

This qualitative study provides insight into the perspectives of adult and child clinicians regarding the barriers, facilitators, and opportunities for change as it relates to the mental health needs of TAY transitioning from child to adult care. The most common barriers identified were described as 1) a "disconnect across service systems" wherein systems do not align or communicate with each other; and 2) a "disrupted access to supports" when moving from the child service system to the adult service system. The three most commonly reported facilitators reported by clinicians with TAY were "flexibility in youth service provision", "person-centered care", and "practices that foster youth self-determination". The two most commonly suggested future engagement opportunities (practices that clinicians felt would benefit TAY's transition if implemented) were "continuity of care with peer specialists" across systems and the "integration of technology" into engagement practices.

While child and adult clinicians agreed on many key barriers, they often disagreed on influencing factors. For example, the most widely reported barrier, "system disconnect", was equally referenced by each group. However, adult

clinicians attributed much of this disconnect to a disrupted access to supports (such as family, teachers, clinicians, etc.), whereas the child clinicians felt the increased rigidity in adult services was to blame. Overall, both groups agree that the child system offers more flexibility and person-centered care treatment options. The different types of care offered across systems contribute to an abrupt shift for TAY. In addition, the lack of clinician collaboration across the service systems contributes to a general system disconnect as service plans do not transition easily from child to adult systems. These different views held by clinicians illuminate how a disconnect between systems is maintained, resulting in ongoing barriers to a successful transition. However, youth and adult clinicians agree on certain influencing factors, such as acknowledging that shifting from child to adult level care results in a loss of supports. This agreement offers a basis for building recognition among all clinicians that despite challenges, there is an opportunity to improving supports during the transition that can be addressed by clinicians in both service systems.

The results of this study indicate clinicians perceive multiple factors impacting TAY participation in mental health services. While this study is qualitative, its findings may be helpful to clinicians in similar systems, as they align with prior research that has outlined the philosophical divide between child and adult mental health services that causes problems during care transitions (Broad et al., 2017; Mulvale et al., 2016). Child mental health philosophy is described as nurturing and, in many ways, a family-centered environment, while adult mental health has a more impersonal atmosphere (Broad et al., 2017; Mulvale et al., 2016). The adult system's expectation of autonomy can result in less follow-up when youth do not show for appointments, and may lead to young adults dropping out of care.

Alternatively, individuals who have a long history of multi-system involvement (i.e. mental health, child welfare, and juvenile justice) may have never been afforded the opportunity for autonomous decision-making (Bruns et al., 2010; Haight, Bidwell, Marshall, & Khatiwoda, 2014; Rosenblatt, 1996). This lack of support to learn to make autonomous decisions puts them at a greater disadvantage to obtain proper care during young adulthood. Further, the discontinuity of family involvement that can happen during the transition may lead to TAY's need not being met and thus leave TAY vulnerable to greater risks (Gitelson & McDermott, 2006; Heinz, 2009; Kraemer & Blacher, 2001; Singh et al., 2010). Previous research has shown the importance of relationships with clinicians for positive experiences in mental health care (Gilburt et al., 2008). Difficulty forming new relationships with adult clinicians may also lead to a poorer therapeutic alliance and a higher risk of disengagement (O'Brien, Fahmy, & Singh, 2009). Finally, the poor developmental timing of the transition can cause the greatest difficulties. With mental illness frequently emerging during the transition to adulthood (Kessler, 2005), some youth are early in their service use and may have had less comfort and

investment with accepting mental health care. Having gaps or suboptimal care during this time put these already at-risk individuals at the greatest risk for disengagement and decompensation.

Proposed system changes for improved engagement

According to clinicians, in order to improve lifelong outcomes for young adults with serious mental health conditions, systemic and organizational changes must occur to reduce mental health service disengagement. First, results indicate a need for greater service delivery flexibility for this age-group. Young adulthood is a time of immense instability for individuals' living situations, schedules, supports, and interests (Arnett, 2005) coupled with emerging mental health illness symptoms (Kessler et al., 2007). Clinicians also suggested that public mental health systems should allow flexibility around diagnosis, determining the best time for transition, and exploring ways to improve warm handoffs and gradual transitions. While some clinicians advocated for extending child services, others recommended that unique, bridging services would be more appropriate for the unique needs of TAY. At the same time, clinicians highlighted the importance of introducing comprehensive, developmentally appropriate services for young adults. While recent federal funding has paved the way for emerging research on Coordinated Specialty Care (CSC) for recent onset of psychosis in young adults (Bello et al., 2017; Dixon et al., 2018; SAMHSA, 2018), results suggest a need for applying emerging research beyond the recent onset of psychosis and inclusive of young people with a variety of SMHCs.

Previous research shows that TAY want to participate in normalizing activities such as work and school (Cohen et al., 2020; Klodnick et al., 2015). Exploring life beyond mental health has previously been used as an initial engagement strategy. Clinicians suggest that it should additionally be used as a treatment strategy. For example, clinical services can focus on meeting developmentally appropriate goals (e.g., managing anxiety at work, coping with anger within relationships) instead of solely focusing on symptom management or medication adherence. Clinical language can also be balanced with developmentally appropriate language (Davis et al., 2012). Finally, adult mental health services can become more family friendly. Traditionally, family involvement has played a small role in adult mental health, while it has been a primary focus in child mental health (Kraemer & Blacher, 2001; Singh et al., 2010). The present study emphasizes the importance of helping TAY decide who they want to be involved in their treatment and their level of involvement. Additionally, it highlights the value of providing continued support to the family in an individualized and dynamic way as the TAY ages, becomes more independent, and experiences changes in their need for family involvement.

Limitations

This study had a number of limitations. First, the agency and the clinicians participated on a voluntary basis and participation reflects possible selection bias. Second, the sample was small and only included one group of child clinicians and one group of adult clinicians. Third, this study solely focused on the perspectives of clinicians. It did not include the views of individuals or family members who might think differently about facilitators and barriers to successful care transitions. Based on other research related to TAY, it is quite possible that the child or adult clinicians' views are not fully in line with the preferences and service needs of TAY. It is also possible that the limited TAY best practice research does not support all of their views. Future research will be more impactful if clinicians, TAY, and their supportive family members and/or friends are all included to understand their perspectives and preferences related to improvement system engagement before, during, and after the transition from youth to adult mental health care. Finally, there are a variety of reasons for disengagement from mental healthcare during adolescent and young adulthood, and this study only focused on care transitions from child to adult services. It is just as important for future research to examine barriers and facilitators to care for individuals who are new to mental health services in early adulthood.

Conclusion

This article undergirds findings from prior research on TAY transition by emphasizing the need for greater collaboration and coordination across child and adult mental health services. A primary practice commonly cited is the use of collaborative clinical meetings (Cobb & Alwell, 2009; Mulvale et al., 2015; Singh et al., 2010; Stans, Stevens, & Beurskens, 2013) and joint care coordination while youth transition between services (McGrandles & McMahon, 2012; Paul et al., 2013; Singh et al., 2010). Further, others have stated the importance of clinicians explicitly acknowledging their care policies, and then developing protocols and guidelines that support a gradual transition between one approach to another (Munoz-Solomando et al., 2010; Singh, Evans, Sireling, & Stuart, 2005). For example, the state of Texas is in the process of rolling out a specific TAY level of care plan that will allow clinicians to combine child and adult service delivery options across ages 16 to 20 (Children's Mental Health Transition-Age Youth Services, 2019). Such periods of overlap could provide an opportunity for greater collaboration between child and adult mental health service teams. Additionally, specialized transition

professionals or navigators who can bridge child and adult mental health programs can be funded to work across services and support coordination of care (Singh et al., 2005, 2010; Walker, Koroloff, & Mehess, 2015).

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