JOURNAL
OF THE CANADIAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY / DE L'ACADÉMIE CANADIENNE DE PSYCHIATRIE DE L'ENFANT ET DE L'ADOLESCENT

DEBATE

Arguments for Keeping Child & Adolescent Psychiatry Focused on Persons Under 18 Years of Age

Peter Braunberger MD, PhD, FRCPC[1]; John D. McLennan MD, PhD, FRCPC[2]

Abstract

Child and adolescent psychiatrists and their associations are grappling with the idea of restructuring their subspecialty to including transitional age youth (TAY), sometimes operationalized as persons 18-25 years of age. This consideration is currently before the Canadian Academy of Child and Adolescent Psychiatry (CACAP). This essay identifies several concerning and potentially harmful consequences of widening the age range of child and adolescent psychiatry. A key concern is the consequential and substantial increase in the population mandate which will significantly dilute already strained and limited child and adolescent psychiatry resources. Furthermore, the nature of some of the needs of TAY may preferentially divert resources away from younger patients. The change in age range will also disrupt existing partnerships which facilitate multidisciplinary care and needed efficiencies for the child and adolescent population, such as close working ties with pediatrics and schools. This is not to say that there may not be merit in child and adolescent psychiatrists contributing to the care of TAY, just as our members already contribute to other areas of mental health outside our immediate mandate. However, to advance such a mandate change, a threshold of evidence of a net beneficial impact including a systematic evaluation of potential harms and opportunity costs is needed. Unfortunately, such an assessment has not yet occurred and therefore a mandate and name change is premature. We recommend a much more deliberate evaluation of the role child and adolescent psychiatrists and their associations might play in contributing to the needs of TAY.

Résumé

Les psychiatres pour enfants et adolescents et leurs associations sont aux prises avec l'idée de restructurer leur surspécialité en y incluant des jeunes d'âge transitionnel (JAT), parfois concrétisés comme étant des personnes de 18 à 25 ans. L'idée est présentement prise en considération par l'Académie canadienne de psychiatrie de l'enfant et de l'adolescent (ACPEA). Le présent essai identifie plusieurs conséquences préoccupantes et éventuellement nuisibles d'élargir le groupe d'âge de la psychiatrie de l'enfant et de l'adolescent. Une préoccupation essentielle est l'augmentation conséquente et substantielle du mandat dans la population, qui diluera significativement les ressources déjà grevées et limitées de la psychiatrie de l'enfant et de l'adolescent. En outre, la nature de certains besoins des JAT peut détourner préférentiellement des ressources des patients plus jeunes. Le changement de groupe d'âge dérangera aussi les partenariats existants qui facilitent les soins multidisciplinaires et les efficacités nécessaires pour la population des enfants et adolescents, comme des liens de travail étroits avec des pédiatres et des écoles. Cela ne veut pas dire qu'il ne puisse pas y avoir de mérite à ce que des psychiatres pour enfants et adolescents contribuent aux soins des JAT, tout comme

[1]St Joseph's Care Group Thunder Bay, Northern Ontario School of Medicine, and Telemental Health, The Hospital for Sick Children, Toronto, Ontario

[2]Departments of Psychiatry & Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Alberta

Corresponding E-Mail: pbraunberger@nosm.ca

nos membres contribuent déjà à d'autres domaines de la santé mentale, hors de notre mandat immédiat. Cependant, pour mettre de l'avant un tel changement de mandat, il faut un niveau de preuve d'un effet bénéfique net, notamment une évaluation systématique des dommages potentiels et des coûts de renonciation. Malheureusement, cette évaluation n'a pas encore eu lieu et par conséquent, un changement de mandat et de nom est prématuré. Nous recommandons une évaluation beaucoup plus consciente du rôle que peuvent jouer les psychiatres pour enfants et adolescents et leurs associations dans la contribution aux besoins des JAT.

This position paper, arguing to retain the focus of child & adolescent psychiatrists on children & adolescents, arises in response to discussions within the Canadian Academy of Child & Adolescent Psychiatry (CACAP), including a preceding paper in this issue of the Journal and a town hall, proposing what we believe to be a problematic widening of our mandate. We argue to maintain the current age range of our subspecialty, i.e., under 18 years, and the name of the Canadian Academy of Child & Adolescent Psychiatry (CACAP), in contrast to the proposal to extend the Academy's mandate to include transitional age youth (TAY) (e.g., 18-24 years) and to change the name to the Canadian Academy of Child and Youth Psychiatry or a similar variation.

The significant mental health needs of TAY, and current service shortcomings for this population, are not disputed, rather they are acknowledged. That the response to these needs should be an increase in the age range and name change of the CACAP is, however, contested.

There should indeed be space in the CACAP to propose and debate new ideas and directions, however, acting on these ideas should be informed by a systematic consideration of the strengths and weaknesses of any proposition, with a clear threshold of meaningful evidence to move forward. Regarding the proposed age and name changes, we raise questions about the rationale, the risks, and the absence of evidence of potential benefits.

No moral high ground to expanding the CACAP mandate

Changing the CACAP's age range and name has sometimes been framed as a moral imperative. And we too, as psychiatrists, acknowledge a share of the wider societal and medical community responsibility for the mental health needs of TAY. It is not, however, obvious that child & adolescent psychiatrists have added moral responsibility, neither should advocating for the mental health needs of children & adolescents be seen to be an ethical shortfall. In contrast, that we are well placed to advocate for the needs of our *current* underserved population might be understood as a priority responsibility.

An increase in the age range for child & adolescent psychiatrists will result in increased demands on already limited psychiatric resources for children & adolescents

Severe shortfalls in child & adolescent psychiatry human resources are well-established (AACAP, 2018; Findling & Stepanova, 2018; Parker et al., 2002; Thabrew et al., 2017; Thomas & Holzer, 2006). It would be expected, then, that an extension of the age range of CACAP's mandate, and those of its members, would further decrease per capita child & adolescent psychiatry resources in Canada. According to the 2016 Canadian Census, adding 18-23-year-olds (inclusive) to our current mandate of under 18 would represent a 37% increase in base population (Statistics Canada, 2019). As 18-23-year-olds have twice the reported rates of annual psychiatry "presentations" versus younger persons, as per Ontario data (MHASEF 2017), expansion would further dilute the per capita availability of child & adolescent psychiatrists. These estimates do not take into account the already rising demand within child & adolescent mental health services even without an age change (Gardner et al., 2019).

Although proponents of a change in age range suggested, in a CACAP town hall debate, that partnerships with general psychiatrists already providing care for TAY will obviate the need for expansion of direct clinical care by child & adolescent psychiatrists, we find this reassurance lacking specificity and credibility. An anticipation that our general psychiatry colleagues, and other mental health stakeholders working with TAY, might only need and ask for occasional indirect developmental consultation is indeed hopeful and not reflective of the shortage of mental health and psychiatry services not only for TAY, but across all age ranges. We propose that it is more realistic to expect a substantial increase in both direct and indirect service demands on already strained child & adolescent psychiatric services.

With an increase in the age range and responsibilities of members of the CACAP, young adult crisis presentations will be in direct competition with the needs of younger children. It is foreseeable that the child & adolescent

psychiatrist, now child & youth psychiatrist, will consistently be expected to address the acute suicidal, psychotic, and forensic needs of young adults before, and if ever, being able to address the serious, but sometimes less immediately lethal, mental health needs of children & adolescents.

In the face of exposure to the acute mental health needs of young adults, mental health resources and care for younger groups may be further eroded in rural and other underserved settings. In contrast to the various restrictive admission criteria of some urban and academic programs which may effectively protect services for children & adolescents, as well as subspecialty program viability, age may be one of the only operationalized criteria to protect child & adolescent services in rural contexts.

Although proponents of an increase in age range speak hopefully of new partnerships and a widening of supports, overlapping roles of providers and lack of clarity of referral pathways may have serious medico-legal consequences.

The value of existing age-related service alignments, partnerships & expertise should be protected

Proponents of a change in age range have suggested that a cut-off at 18 years of age is biologically arbitrary and that important maturation and development continue beyond 18 (Maughan & Collishaw, 2015; Toronto Central Local Health Integrated Network: Transitional Aged Youth Mental Health and Addictions (TAYMHA) Advisory Committee, 2015) and hence service cutoffs at this age do not make sense. Service cut-offs at 23, 24, or 25 years of age should, however, also be recognized as similarly arbitrary. One could argue that there is no clear age cut that adequately aligns with the diffuse concept of development, nor the heterogeneity of any specific measure thereof. It should also be understood that developmental aspects of mental health, assessment and intervention, are relevant across the life span, and not the sole purview of child & adolescent specialists. The reality that age is a poor proxy for development might then suggest value in aligning the age-range of our Academy with other services and institutions.

Training and then working in the specialty field of child & adolescent psychiatry fosters advanced skills in collaborative work with other professionals and organizations serving children & adolescents, including the child welfare system, primary and secondary educational systems, the juvenile justice system, and pediatric services. Maintaining coordinated and synchronized alignments with other professionals and organizations focused on similar age ranges facilitates important efficiencies for multidisciplinary care.

The proposed change in age range may also impact the quality of education and advocacy roles of the recently attained child & adolescent psychiatry subspecialty status of the Royal College of Physicians and Surgeons of Canada. And, if CACAP members are now to identify as having advanced expertise for TAY up to 24 years of age, should and how and when will this impact training? Increased training time with TAY, would mean reduced time with other populations and age groups. Should trainees then spend less time studying neurodevelopmental disorders or less time with elementary aged or preschool patients, or should the duration of subspecialty training be extended with this new proposed mandate? Although proponents of a change in age range speak of existing and relevant developmental knowledge and skills, additional TAY-related training needs of already practicing child & adolescent psychiatrists, whose work has been exclusively with patients under 18, will yet warrant meaningful consideration.

Opportunities already exist for child & adolescent psychiatrists to reach out to other populations to provide support and expertise

It is important to highlight precedence and ongoing partnerships of CACAP members providing consultation and care outside of our specialty age range without the CACAP needing to change its name or mandate. For example, CACAP members with expertise in eating disorders are already involved in the consultation and care of adults with eating disorders given their specialized expertise, which, parenthetically, are not truncated at the arbitrary age of 24 or 25. Similarly, CACAP members working in the field of developmental disabilities are often involved with adult services for those with developmental problems, including up to geriatric ages. It is therefore not clear why CACAP members, with interest and expertise in TAY, would not also proceed with sharing their expertise without a name and age change. Indeed, we see no reason why CACAP should not encourage and support its members with interest and expertise in TAY from contributing where they can, just as they can encourage CACAP members to contribute to other aspects of the broad field of mental health and not be bound by age or labels. Additionally, there should be no restriction within the CACAP for general psychiatrists, with interest in care of children, adolescents or TAY, from joining CACAP.

Is a lack of developmental expertise really a primary limitation to psychiatric care of TAY, and could this limitation be addressed without the proposed age and name change?

That unaddressed developmental needs of TAY constitute a critical service problem (Toronto Central Local Health Integrated Network: Transitional Aged Youth Mental Health and Addictions (TAYMHA) Advisory Committee, 2015) is a prominent premise of the argument for an age and name change for the CACAP**.** It is then implied that the involvement of child & adolescent psychiatrists would address this deficit. There are, however, several problems with this line of argument.

First, the proponents of a change in age range do not operationalize the nature of the developmental deficit in existing services. This would be important to better gauge whether these deficits might be significantly addressed through proposed child & adolescent psychiatry developmental consultation.

Second, assuming that there is a developmental related deficit to services, that this is a leading contributor to shortcomings in the mental health care of TAY warrants additional scrutiny. Sheer resource limitations might very reasonably be argued as a more substantial contributor to gaps in care. And generic system issues, not specific to but including TAY services, including prolonged waitlists, poor communication between agencies, repeated opening and closing of files even within existing age mandates of services, etc., may also be more prominent barriers to care. A comprehensive determination of barriers and gaps in care is essential to determine where developmental deficits fit in and consequently what degree of change may arise with addressing that particular deficit.

Third, we do not believe the proponents have provided evidence as to the positive impact of child & adolescent psychiatrists, or developmental expertise, on TAY services. Our proposition is that the main mechanism will be brute human resources to see more patients in the TAY range. What other outcomes are to be anticipated from this expanded mandate with the associated age and name change? And what is the evidence that the changes will result in such outcomes? At a surface level bringing "developmental expertise" sounds attractive, but it is unclear what this would entail, and to what effect. What empirical evidence is there that developmental consultation at, for example, a program level has resulted in improved services and reduced morbidity and mortality? In the absence of empirical data, at least a strong logic model would be informative but neither has this been presented.

Some might assume that hopeful narratives of new models of care for TAY may be reason enough to move forward. However, concerns as to the lack of evidence of positive impacts of popular but possibly premature TAY models of care, such as Australia's headspace, warrant additional caution (Jorm, 2018; Jorm & Kitchener, 2020; Looi et al., 2021).

Are there better ways to manage transitions?

Service challenges will occur at any age-based transition whether it occurs at 18 or 25. And youth have indeed reported anxiety about such transitions (Dunn, 2017). However, the same youth in a participatory discussion highlighted a number of potentially helpful strategies that might decrease anxiety without necessarily continuing in the same program (Dunn, 2017). And a number of other studies helpfully widen the discussion about effective transitions (Calheiros et al., 2013; Cappelli et al., 2016; Cleverley et al., 2020; Rosenberg, 2016). Before changing the age range of child & adolescent psychiatry, the potential of alternative strategies to facilitate effective transitions should be considered.

What's in a name?

An understanding of continuing development into early adulthood is not new, nor is the recognition of evolution over time of the language and naming of ages of development and their association with professional practice (Fabrega & Miller, 1995; Maughan & Collishaw, 2015; Oswell, 2013; Sherwood, 2014). More contemporary is client participation in service development (Levac et al., 2019) as well as a democratization of self-identification, which are increasingly articulated as both ethical and pragmatic**.** Despite the evolution of these societal values, the roles and contribution of children, teenagers, adolescents, and young adults (in addition to parents and other caregivers and stakeholders linked with this population) are not evident in the proposition for a name change.

For example, even though we do not doubt the suggestion that at least some young persons dislike the term "adolescent", neither do we understand support for the word "youth". And in contrast to the use of the word "youth", we might also understand at the age of 18 a common valuation of, and identification with, the title of "adult". If indeed there is a need for additional clarity around how CACAP should proceed, with both name and age range, we at the very least hope for a robust client-informed process.

Conclusion

Like our colleagues proposing a wider mandate, we aim to have the best interests of children & adolescents and youth in mind. However, we argue that we must first protect and advocate for care for underserviced children and adolescents who comprise our current mandate, and who already face a profound shortage of evidence-based mental health care. And to this end, we argue for a wider consideration and deliberation on psychiatry and mental health needs of TAY. A more diverse participatory process is also recommended before final decisions are made. We look forward to ongoing dialogue as to how child & adolescent psychiatrists can best contribute to improving mental health for the youngest in our societies.

References

AACAP. (2018). *Workforce fact sheet*. https://www.aacap.org/App_Themes/AACAP/docs/resources_for_primary_care/workforce_issues/workforce_factsheet_updated_2018.pdf

Calheiros, M. M., Patrício, J. N., & Graça, J. (2013). Staff and youth views on autonomy and emancipation from residential care: A participatory research study. *Evaluation and Program Planning*, *39*, 57-66. https://doi.org/10.1016/j.evalprogplan.2013.04.003

Cappelli, M., Davidson, S., Racek, J., Leon, S., Vloet, M., Tataryn, K.,… Lowe, J. (2016). Transitioning youth into adult mental health and addiction services: An outcomes evaluation of the youth transition project. *Journal of Behavioral Health Services and Research*, *43*(4), 597-610. https://doi.org/10.1007/s11414-014-9440-9

Cleverley, K., Rowland, E., Bennett, K., Jeffs, L., & Gore, D. (2020). Identifying core components and indicators of successful transitions from child to adult mental health services: A scoping review. *European Child and Adolescent Psychiatry*, *29*(2), 107-121. https://doi.org/10.1007/s00787-018-1213-1

Dunn, V. (2017). Young people, mental health practitioners and researchers co-produce a Transition Preparation Programme to improve outcomes and experience for young people leaving Child and Adolescent Mental Health Services (CAMHS). *BMC Health Services Research*, *17*(1), 1-12. https://doi.org/10.1186/s12913-017-2221-4

Fabrega, H., & Miller, B. (1995). Adolescent Psychiatry as a product of contemporary Anglo-American society. *Social Science and Medicine*, *40*(7), 881-894. https://doi.org/10.1016/0277-9536(94)00166-Q

Findling, R. L., & Stepanova, E. (2018). The workforce shortage of child and adolescent psychiatrists: Is it time for a different approach? *Journal of the American Academy of Child and Adolescent Psychiatry*, *57*(5), 300-301. https://doi.org/10.1016/j.jaac.2018.02.008

Gardner, W., Pajer, K., Cloutier, P., Zemek, R., Currie, L., Hatcher, S.,… Lima, I. (2019). Changing rates of self-harm and mental disorders by sex in youths presenting to Ontario emergency departments: Repeated cross-sectional study. *Canadian Journal of Psychiatry*, *64*(11), 789-797. https://doi.org/10.1177/0706743719854070

Jorm, A. F. (2018). Concerns about the headspace model of youth mental health services. *Psychiatric Services*, *69*(7), 838-839.

Jorm, A. F., & Kitchener, B. A. (2020). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? *Australian and New Zealand Journal of Psychiatry*. https://doi.org/10.1177/0004867420976861

Levac, L., Ronis, S., Cowper-Smith, Y., & Vaccarino, O. (2019). A scoping review: The utility of participatory research approaches in psychology. *Journal of Community Psychology*, *47*(8), 1865-1892. https://doi.org/10.1002/jcop.22231

Looi, J., Allison, S., Bastiampillai, T., & Kisely, S. (2021). Headspace, an Australian youth mental health network: Lessons for Canadian mental healthcare. *Journal of the Canadian Academy of Child & Adolescent Psychiatry*, *30*(2), 116-122.

Maughan, B., & Collishaw, S. (2015). Development and psychopathology: A life course perspective. In A. Thapar, D. S. Pine, F. Leckman, S. Scott, M. Snowling, & E. Taylor (Eds.), *Rutter's Child and Adolescent Psychiatry* (6th ed., pp. 1–16). John Wiley & Sons, Ltd.

Oswell, D. (2013). *The Agency of Children: From Family to Global Human Rights*. Cambridge University Press.

Parker, Z., Steele, M., Junek, W., Morin, L., Davidson, S., Fleisher, W.,… Yates, T. (2002). *Child psychiatry in Canada: Physician resources. Position Paper*. Ottawa: Canadian Psychiatric Assocation.

Rosenberg, L. (2016). Bridging the gap between adolescence and adulthood: The challenges of emerging adults. *Journal of Behavioral Health Services and Research*, *43*(4), 518-520. https://doi.org/10.1007/s11414-016-9535-6

Sherwood, J. (2014, August). Is 'Emerging Adulthood' really a thing? The secret history of words for young people. *Slate*. https://slate.com/human-interest/2014/08/emerging-adults-teenagers-adolescents-and-other-words-for-young-people-are-older-than-they-seem.html

Statistics Canada. (2019). *Census Profile, 2016 Census*. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=01&Geo2=&Code2=&SearchText=Canada&SearchType=Begins&SearchPR=01&B1=All&TABID=1&type=0

Thabrew, H., Henderson, S., Hazell, P., Moor, S., Kowalenko, N., & Kenn, F. (2017). Is it time for child psychiatry to grow up? *Australian and New Zealand Journal of Psychiatry*, *51*(10), 971-973. https://doi.org/10.1177/0004867417718946

Thomas, C. R., & Holzer, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*(9), 1023-1031. https://doi.org/10.1097/01.chi.0000225353.16831.5d

Toronto Central Local Health Integrated Network: Transitional Aged Youth Mental Health and Addictions (TAYMHA) Advisory Committee. (2015). *Final Report*.