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Factors Affecting Transition from Child to Adult Mental Health Services. Considering the role of Client and Therapist Attachment Styles on the Therapeutic Relationship.

by

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Abstract

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Chapter one of this thesis is a systematic review consisting of 13 studies, aiming to explore the evidence regarding association between attachment styles and the therapeutic relationship. Findings demonstrated that complementary attachment styles (e.g anxious client x avoidant therapist, therapist secure x client insecure or highly anxious therapist x less anxious client) do help the therapeutic relationship, in terms of working alliance, greater session depth and smoothness. Clinical and theoretical implications are discussed and recommendations for future research outlined.

Chapter two is a research paper exploring factors which predict transition satisfaction when moving from child to adult mental health services (AMHS). The role of attachment to one's therapist is also explored. A series of regression analyses found that young people who had an individualised care plan, involvement of transition services and ensuring that treatment in AMHS constitutes a continuation of treatment in CAMHS, were more likely to successfully transition. Involving young people during the transition, supportive relationships young people had with their CAMHS clinician, alongside positive parent involvement in AMHS predicted transition satisfaction. The results suggest clients' transition process might be significantly improved by focusing on transition structure and the young person's involvement during their transition, as well as young people having a choice with regards to the level of parent involvement post transition. Working on a secure attachment may be a way to improve transition satisfaction on the AMHS side. Implications for theory and clinical practice are identified and discussed.

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Research Thesis: Declaration of Authorship

Print name: PARIS WILLIAMS

Title of thesis: Factors effecting transition from Child to Adult Mental Health Services. Considering the role of Client and Therapist Attachment Styles on the Therapeutic Relationship.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University.
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated.
3. Where I have consulted the published work of others, this is always clearly attributed.
4. Where I have quoted from the work of others, the source is always given. Except for such quotations, this thesis is entirely my own work.
5. I have acknowledged all main sources of help.
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself.
7. None of this work has been published before submission

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Chapter 1 Systematic Review: Client and Therapist Attachment Style and the Therapeutic Relationship.

1.1 Abstract

The purpose of this literature review was to explore the hypothesis that complementary attachment between therapists and clients facilitate a secure base in psychotherapy, leading to favourable alliances. A total of 13 studies that met inclusion and explored the association between clients and therapists' attachment styles on the therapeutic relationship were identified through a systematic search. There is some indication that complementary attachment styles (e.g. anxious clients x avoidant therapist, therapist secure x client insecure or highly anxious therapist x less anxious client) do help the therapeutic relationship, in terms of working alliance, greater session depth and smoothness. The variation in methodology and quality of the studies used across the review means that the findings should be interpreted with caution. This review highlights preliminary evidence, suggesting attachment style is an important factor to consider in the context of the therapeutic relationship. Research would benefit from further exploration of this interaction, particularly assessing how combinations of attachment styles impact the relationship throughout the course of therapy.

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1.2 Introduction

The relationship between client and therapist is typically considered a helping one and therefore therapeutic in nature. The therapeutic relationship is an important aspect of psychotherapy and can be a vehicle to develop insight and other therapeutic effects (Levy et al., 2006). This can include the ability to deal with therapeutic ruptures (Safran & Muran, 2000) and increase clients' self – exploration within therapy (Berretta et al., 2004).

There are many theories which have provided a framework to understand the processes that occur in the therapeutic relationship, which differ regarding the positioning of the therapeutic relationship as a mechanism of change (Hill & Knox, 2009). For example, relational theory (Levenson, 1995; Safron & Muran, 2000) argues that relational work is central to change whereby therapist and clients are coparticipants in developing and resolving problems within the therapy relationship. In contrast, behaviourists are motivated to address interpersonal conflict when they interfere with the therapy (Hill & Knox, 2009). Furthermore, the extent to which the therapist and client interactions play a role in providing relational conditions also differ across theories. Person centred theories place emphasis on the therapist being responsible for providing relational conditions. However, the clients' response to the therapist and the degree of collaboration between them lacks detailed discussion in the client – centred literature (Horvath, 2000). In contrast, psychoanalytic theories (e.g Greenson, 1967) promote the exploration and development of transference, as well as therapists monitoring their own countertransference reactions (Hill & Know, 2009). Nevertheless, most theories exploring the therapeutic relationship acknowledge the role of both therapist and client as important drivers for understanding the interpersonal process which occur (Carson, 1969).

The features which define the therapeutic relationship are less clear. Gelso (2014) criticized previous studies which failed to capture the full understanding of what constitutes the therapeutic relationship, often relying on the definition of the working alliance. The working alliance is defined as the "*alignment of the reasonable self or ego of the client and the therapist's analysing or 'therapizing' side for the purpose of the work"* (Gelso & Carter, 1994, p. 297). The concept of alliance is rooted in early psychoanalytical theories, linking back to Freud's (1958) work. The quality of the working alliance has consistently shown to be a moderate and reliable predictor for treatment outcome in adult (Horvath & Symmonds, 1991; Martin, Garske & Davis, 2000) and emerging youth populations (Mcleod, 2011).

However, research suggests that the nature of the therapist and client relationship involves factors that extend beyond that of the working alliance (Mallinckrodt, 2001). To address this and

allow for empirical study of additional components of the therapeutic relationship, Gelso & Carter (1994) introduced the Tripartite Model.

1.2.1 The Tripartite Model

The three concepts involved in the model consist of the real relationship, working alliance and transference and countertransference. All three concepts are argued to exist regardless of the therapeutic orientations and contribute to the process of therapy (Ain & Gelso, 2011; Smith et al., 2010). The real relationship is defined as "*the personal relationship between therapist and patient marked by the extent to which each is genuine with the other and perceives the other in ways that befit the other"* (Gelso & Carter, 2014,p. 119). Findings have shown positive associations between real relationship and process and outcome (Ain & Gelso, 2011; LoCoco et al., 2011).

Developing Gelso and Carter's (1994) earlier definition, Bordin (1979) outlined three core features of working alliance, including the therapist and client agreement on goals, tasks to achieve such goals and the development of a bond between therapist and client. The alliance can be strengthened by nursing any ruptures and offering repairs in the context of the above core features (Smith, Msetfi & Golding, 2010).

The concepts of transference and countertransference can be defined as "*the patient's experience and perceptions of the therapist that are shaped by the patient's own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviours belonging rightfully to and in earlier significant relationship" (*Gelso & Cater, 2014,p.121) . The literature on countertransference and attachment produces mixed evidence (Steel, 2018). Some studies with strong methodology yielded no significant associations (Ligiero & Gelso, 2002), whilst others have found even early interactions can activate the attachment patterns of therapists enough to result in countertransference (Mohr, Gelso & Hill, 2005).

The three components of the tripartite model are also considered to overlap and influence each other. For example, ratings of the working alliance and real relationship have found to be moderately correlated using therapists ratings (Bhatia & Gelso, 2013; Marmarosh et al., 2009) and highly correlated when rated by clients (Kelley et al., 2010; Marmarosh et al., 2009).

Despite research supporting the idea that all three aspects contribute to the therapeutic process (Gelso, 2014), there is an absence of longitudinal research testing out the constructs of the model over the course of therapy. Given the evolving nature of therapy, this does limit the validity of the model in terms of understanding how the components unfold and impact the therapeutic relationship over time (Bhatia & Gelso, 2017).

Nevertheless, this review will use the tripartite model as a basis for understanding and conceptualising the therapeutic relationship. Viewing the therapeutic relationship through this lens aims to yield further information about additional factors outside of the alliance, and its association with attachment styles.

1.2.2 Attachment theory

The term attachment was first defined by Bowlby (1969), who proposed we are all born with an innate need to seek proximity, comfort, and safety in relationships. Initially, primary caregivers are the source of security and guidance, developing confidence in the child's ability to explore their physical and social environments, whilst also trusting the caregiver to respond to their needs upon return. The varying degree to which caregivers are available and responsive can result in different attachment patters being developed, as evidenced by Ainsworths' pioneering studies (Ainsworth, Blehar, Waters & Wall, 1978). Bowlby argued that these attachment experiences become internalised which influence the development of a child's concept of self *(Am I worth caring for?)* and others *(Can I rely on others to keep me safe?).* Bowlby called these internal working models (IWM). These are different (but related to) attachment styles, whereby we internalise IWM from our early relationships and this results in patterns of responding (i.e. attachment style).

Measuring attachment patterns in research have favoured dimensional approaches, with studies showing it accounts for a larger proportion of variance and predictive power, in comparison to categorical approaches (Shi et al., 2014). One of the two main dimensions is *attachment anxiety.* An individual with this pattern of relating fears they will be rejected by others and therefore need significant amount of reassurance and approval. If the significant other is not readily available, this may create distressing and overwhelming feelings. Individuals on the anxious scale, tend to use hyperactivating strategies such as being overly dependent on others, to seek security.

The other dimension is *attachment avoidance.* Here, individuals tend to focus their efforts in seeking emotional distance from significant others, and struggle with intimacy and closeness. They tend to be disinclined to share their feelings or trust other people's intentions. These individuals use deactivating strategies, such as heavy self-reliance or cancelling therapy appointments, to distance themselves from potentially rejecting others (Yoskowitz, 2018).

1.2.3 Research into attachment styles and the therapeutic relationship

Based on Bowlby's theory, the therapist and client relationship are comparable to primary caregivers providing a secure base in childhood. This is understood as therapists acting as a secure base from which clients can explore distressing psychological experiences (Petrowski et al., 2011).

Much research into attachment and the therapeutic relationship has looked at client attachment styles and working alliance, with evidence suggesting more securely attached clients form stronger working alliances with their therapists (Bernecker et al., 2014). However, as this research found small correlations, it is possible that other factors may account for the variance such as therapists' attachment style, which has received mixed results in research to date. A recent review by Degnan et al., 2016 found preliminary evidence for therapists' attachment style influencing the working alliance. They concluded that therapeutic process and outcome could be improved by increasing therapists' insight into their own patterns of relating. They hypothesized that therapists' awareness of how their attachment style can interact with clients can facilitate a better understanding of attachment related behaviours within therapy. This in turn can help with managing and repairing ruptures and guide interventions (Degnan et al., 2016).

However, there is continued debate in the literature about whether therapist attachment styles become activated during therapy, due to perceptions that clients do not resemble attachment figures (Ligiero & Gelso, 2002).

1.2.4 Purpose of the review

Whilst there is preliminary evidence for the role of both therapist and client's attachment styles on the therapeutic process, there is less research synthesising the two separate bodies of literature, to inform understanding of how they may interact. The aim of this paper is to review empirical studies that explore the evidence, regarding associations between attachment and the therapeutic relationships, in the context of individual therapy. A review of the literature identified three systematic reviews which have examined attachment styles and working alliance. The reviews either primarily focussed on client's attachment patterns (Smith et al., 2010), or the role of the therapist's attachment style (Degnan et al., 2016; Steel et al., 2018). The recent reviews may reflect the developing interest of the role of therapist factors in the therapeutic relationship and outcome literature. However less than a quarter explored both client and therapist attachment and only included published literature and therefore may have been subjected to publication bias. To address these issues, this review included unpublished literature and placed more emphasis on exploring the interactional effects with the aim of answering the following questions:

1) Are attachment styles of the client and therapist important when considering the development of the therapeutic relationship?

2) Is the therapeutic relationship influenced by an interaction between the attachment styles of the therapist and client?

1.3 Methods

1.3.1 Search strategy

The protocol for this systematic review was published on Prospero (Prospero ID: CRD 42020193266). Three electronic databases relevant to psychological research were used. These included PsycINFO, MEDLINE and Web of Science. The following search terms used for attachment included "*attachment behaviour*" OR "attachment disorder*" OR "attachment theor*" OR "attachment style*" OR "object attachment".*

The terms used to capture the therapeutic relationship consisted of *"therapeutic alliance" OR "therapeutic process" OR "psychotherapeutic resistance" OR "working alliance" OR "professional-patient relations".*

Search terms used for individual therapy included the *"Psychological therapy" OR "individual psychotherapy" OR "psychotherapeutic counselling" OR "psychotherapy" OR "psychotherapy brief" OR "psychotherapy psychodynamic" OR "interpersonal psychotherapy" OR "person centred therapy".*

Results were screened for relevance, with titles and abstract assessed against the exclusion criteria by two independent reviewers. As illustrated in Figure 1, n=13 studies were included in the final review.

1.3.2 Eligibility criteria

Studies were excluded if they met the following criteria:

- Participants were under 18 years or over 65 years
- Intervention was based on couple or group therapy
- Recruited on other factors other than mental health difficulties
- Did not measure both client and therapist attachment styles
- Did not measure the therapeutic relationship
- Qualitative designs

Studies were included if they met the following criteria:

- Participants were adults
- Recruited from a context based on their experience of mental health difficulties (of any kind) which they received treatment (individual therapy of any description)
- Quantitative designs
- Measures of attachment (client and therapist) were primary or secondary outcomes
- Measures of the therapeutic relationship as defined by the tripartite model were included as primary or secondary outcomes
- Studies looked at the association between attachment and the therapeutic relationship
- Published and unpublished empirical studies were included, and no restrictions placed upon language or year of publication.

1.3.3 Quality assessment

To critically appraise the quality of the included studies, the QualSyst tool (Kmet et al., 2004) was used to ensure that studies met a minimum quality standard (score of 75% or above). The two raters (authors one and three) scored these independently, with only two of the studies demonstrating a greater than five % discrepancy. Discrepancies between the two raters were discussed and resolved together with a third rater (author four).

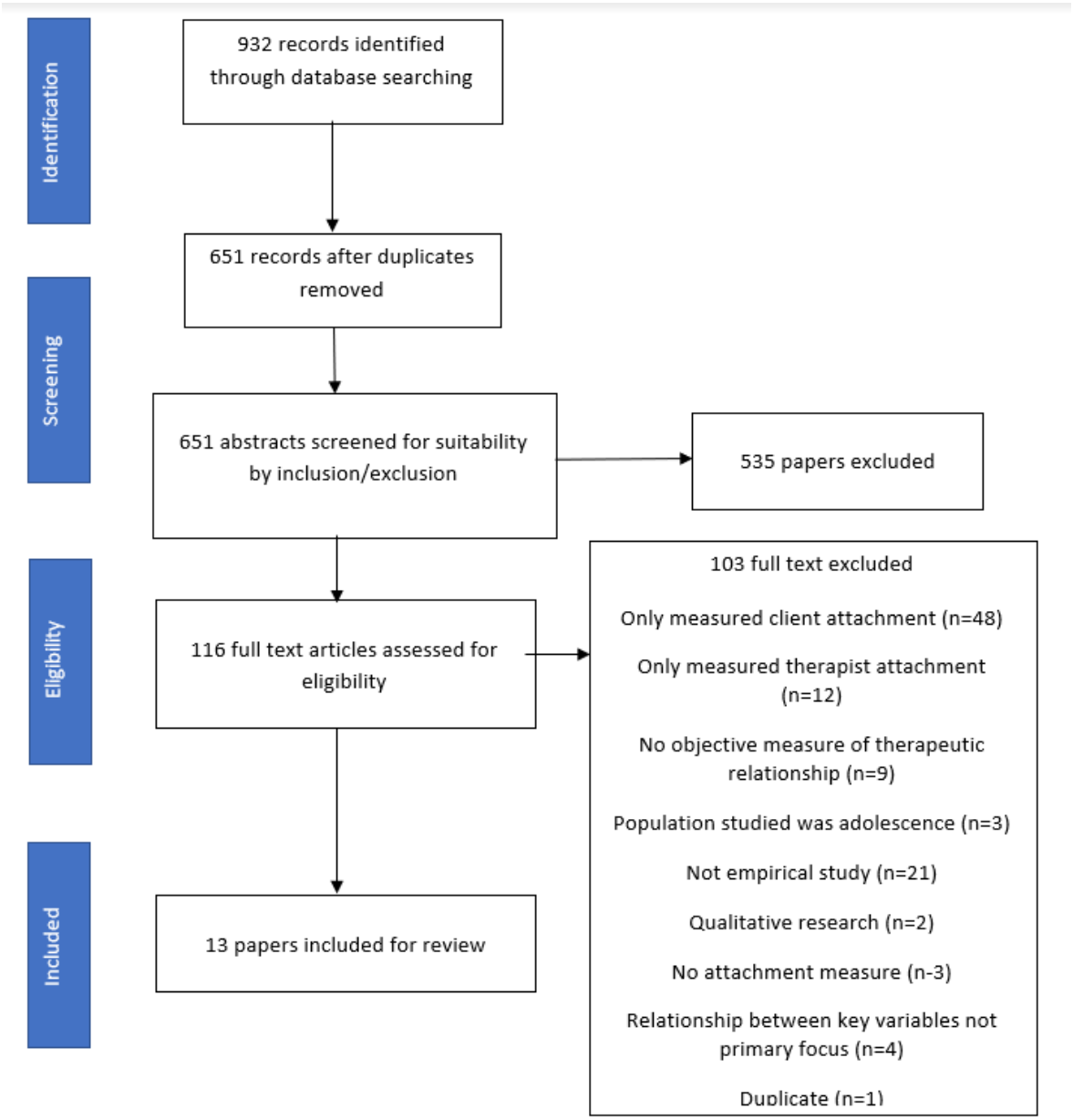

Figure 1 PRISMA flow diagram

1.4 Results

1.4.1 Key characteristics

The present review identified eleven studies exploring associations between client and therapist attachment and the therapeutic relationships. Table 1 summarises the extracted data which includes quality assessment rating, outcome measures, analyses, and key statistical findings.

Table 1 Interaction between Client and Therapist Attachment Styles on the Therapeutic Relationship

Study	Attachment Measure	Therapeutic Relationship Measure	Analysis	Interaction Effect	Effect Size	Quality Rating
Biscoglio, 2005	RSQ	WAI, SEQ	Bivariate correlational	Greater difference between patient and therapist in secure attachment related to higher intensity of therapist rated rupture	.38	79%
				Great differences between patient and therapists in fearful attachment were less likely to experience the resolution of reported ruptures	.-66 (PR) .-36 (TR)	
				Great differences between patient and therapists in preoccupied attachment predicted less session depth, reported by therapist.	-.44	
				Great differences between patient and therapists in dismissing attachment predicted sessions as less smooth, as rated by therapist.	-.40	

Britton 2006	Parental Bonding Inventory ECRS	WAI 12	Cross sectional	No significant correlations between client and therapist attachment and alliance.	Not reported	82%
Bruck et al., 2006	RSQ	WAI 12, SEQ	Bivariate correlational	Greater differences in secure attachment style predicted stronger therapist rated alliances	.30	83%
				Greater difference in fearful attachment was associated with patient rated session depth and smoothness	.32 & .38	
Bucci et al., 2016	RSQ	WAI -C WAI -T	Bivariate correlational	Preoccupied match coefficient predicted better therapist rated alliance	.43	86%
				Dismissive match coefficient predicted better client rated working alliance	.041	
Frehling 2005	ECSR	WAI	Quasi experiential	No significant relationship between attachment style and working alliance.	No reported	82%
Marmorosh et al., 2014	ECRS	WAI-C WAI-T short form	Actor-partner model dyads	Interaction: higher alliance with anxiously attached therapist with decreasingly anxiously attached clients; less anxiously attached therapist with increasingly anxious clients.	-.046	81%
Petrowski et al., 2011	AAI	HAQ clients only	Regression analysis	Preoccupied and disorganised clients rated alliances with dismissing, rather than pre-occupied therapists as more helpful	0.37	81%

Romano et al., 2008	ECRS (T) CATS (C)	WAI-C	Hierarchical linear regression	High levels of client global anxiety attachment, together with high levels of therapist attachment avoidance, predicted lower levels of clients perceived session depth	-.72	86%
Sauer, 2000	AAI & RQ	WAI-C WAI-T	Correlational, ANOVA, multiple regression	Secure therapist x insecure clients dyads received lower client-rated working alliance scores than did insecure therapist x insecure client's dyads at time 1. By time 3, secure therapist x insecure clients received higher therapist rated alliance.	Not reported	77%
Sibrava 2009	AAI Perceptions of adult attachment	WAI	Hierarchical Linear Modeling	Interaction between therapist and client attachment was not significantly related to client-rated WAI scores early in treatment or ratings of the alliance over time	Not reported	79%
Yoskowitz 2018	ECRS	WAI-SF	Hierarchical Regression Analysis, Correlational	Therapist attachment security was not found to be significantly correlated with the client-rated alliance when client attachment was secure or insecure.	Not reported	86%

Note. Rsq = relationship scale questionnaire; wai -c = working alliance inventory-client; wai-t = working alliance inventory therapist; wai-sf = working alliance inventory shot form; seq = session evaluation questionnaire; ecrs = experience in close relationship scale; aai = adult attachment interview; haq = helping alliance questionnaire; cats = client attachment to therapist scale; rq = relationship questionnaire; PR = patient rated; TR = therapist rated.

1.4.2 Measures

Most of the research (n=10) used dimensional measures of attachment. This is in line with recommendations from the literature which consider dimensional, rather than categorical measures of attachment, more methodologically sound (Shi et al., 2014). The measures used in this review which are components of the Tripartite model (Gelso & Carter, 2014) include the Working Alliance Inventory (WAI) and the Real Relationship Inventory (RRI; Gelso et al., 2005). The WAI was most frequently employed across the studies (n=10) and is regarded as the most widely used measure of this construct, receiving more empirical support in the adult literature across different populations, than other measures (Doran, 2016). The RRI questionnaire consisted of two elements 'genuineness' and 'realism' (the greater and more positive ratings of genuineness and realism, the stronger the real relationship).

Other measures of the therapeutic relationship included the Session Evaluation Questionnaire (Stiles et al., 1994). This uses the session depth subscale, which assess client's explorations within sessions, specifically the session power and value, aspects which Bowlby (1969) linked to secure base exploration (Romano, Fitzpatrick & Janzen, 2008). Session smoothness is also assessed and refers to the in-session experience of relating to the client/therapist as comfortable versus distressing. Lower levels of session smoothness and depth are characterised as having a weaker therapeutic relationship.

1.4.3 Quality assessment

Overall, the quality of the studies was considered acceptable as rated by the QualSyst tool (Kmet et al., 2004) The ratings ranged from 77 – 86% (see Appendix A). In particular, Yoskowitz, 2018, Bucci et al., 2016, Romano et al., 2008 & Fuertes, 2007, reflected high quality studies.

1.4.4 Therapist attachment style and the therapeutic relationship

Five studies reported no evidence of an association between therapist attachment style and the therapeutic relationship (Britton, 2005; Bucci et al., 2016; Frehling, 2005; Petrowski et al., 2011 & Yoskowitz, 2018).

Three cross sectional studies found that less secure therapists, as measured by the Experience of Close Relationship Scale (ECRS; Brennan et al., 1998) formed weaker therapeutic relationships with clients, as rated by the therapist ratings of the WAI and RRI (Fuertes et al., 2007; Fuertes et al., 2019 & Marmarosh et al., 2014). Using a different measure, similar findings were reported by Bruck and colleagues (2006) study. They utilised the Relationship Scale Questionnaire (RSQ; Griffin

& Bartholomew, 1994), and found that therapist attachment style was associated with alliance and session depth. Securely attached therapists reported stronger alliance and session depth, whereas therapist insecure attachment style negatively correlated with session smoothness, as rated by the SEQ and RR. In these studies, lower session smoothness and depth were characterised as negative alliance processes and higher levels of these factors associated with positive alliances.

Only two cross sectional studies found an association between therapist attachment and client rated alliance and these were lower quality studies. Fearful attachment negatively predicted session smoothness when using the SEQ (Bosglio,2005) and WAI; however only when clients symptoms were more severe (Bucci et al., 2016).

Similar results were found in both longitudinal studies. Insecurely attached therapists received higher rated client alliance, than their securely attached colleagues at the beginning of therapy, however the trajectory changed over time. By the end of therapy, therapists who were more securely attached, scored higher on the client rated working alliance, than did the insecure therapists (Sauer, 2000; Sibravo, 2009).

1.4.5 Client attachment style and the therapeutic relationship

Three studies (Romano et al., 2008; Fuertes, 2007; Sauer, 2000) which measured secure attachment dimensions using the Relational Questionnaire (RQ; Bartholomew & Horowitz, 1991), and Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995) all found a significant result in the expected direction; clients who were securely attached to their therapist, formed better relationships as assessed by the WAI and RRI. All studies were of strong quality. The results showed large effect sizes, which is greater than previous findings which have reported medium effect sizes (Smith et al., 2010).

There was evidence showing clients who had insecure attachment to their therapists formed less positive therapeutic relationships as assessed by SEQ, WAI and RR (Romano et al., 2008; Fuertes et al., 2007; Biscoglio; 2005 Sauer, 2000). This was more evident with the avoidant attachment subgroup.

Results from Bruck and colleagues (2006) and Biscoglio (2005) found different results not predicted by the models. They found that both fearful and dismissing attachment styles were positively correlated to session depth and smoothness. Furthermore, Biscoglio (2005) found that preoccupied (anxious) attachment was related to less intense patient reported ruptures.

1.4.6 Interaction between client and therapist attachment styles and the impact on the therapeutic relationship

Eleven studies explored the combined effects of client and therapist attachment styles. Table 1 highlights the seven studies showing optimum combinations of client/therapist attachment which can influence the therapeutic relationship. Four studies, which were all unpublished theses found no significant findings (Britton, 2006; Frehling, 2005; Sibravo, 2009; Yoskowitz, 2018).

There was evidence from five studies to suggest that complementary attachment styles lead to more favourable therapeutic relationships. Marmarosh et al. (2014) found that less anxiously attached clients formed better alliances with more anxiously attached therapists, however this was only related to the dimension of attachment anxiety and from the perspective of the client. Similarly, Bucci et al. (2016) found that a greater difference in preoccupied (anxious) attachment, was associated with more favourable ratings of the working alliance from the therapist's perspective, whilst the greater the difference in dismissing (avoidant) attachment, the more favourable the alliance from the client's perspective.

Using the RSQ and WAI, Bruck et al. (2006) found that more securely attached therapists may form more favourable alliances with less securely attached clients, with this finding being consistent with relationships over time (Sauer, 2000). However, this was not the case when exploring the influence of dissimilarity in insecure attachments on the WAI. Biscoglio (2005) used the same measures as Bruck's (2006) study, however failed to find any significant association using the WAI, only the SEQ. They found that greater differences in secure attachment styles related to higher intensity of ruptures. Furthermore, differences between insecure dimensions (fearful, preoccupied & dismissive) between client and therapist were associated with a less favourable therapeutic relationship, as measured by SEQ. This is the opposite to Bruck et al. (2006) findings in that the greater difference in fearful attachment was associated with better patient rated depth and smoothness (thus more favourable relationship processes).

Using the Adult Attachment Interview (AAI) (George et al., 1985), a strong validated measure of attachment, findings from Petrowski et al. (2011) suggested that clients with a more preoccupied attachment style (highly anxious) rated positive helping alliances with more avoidant as opposed to preoccupied therapists. This was not found on the opposite interaction effect; those therapists that were more securely attached did not form stronger alliances with neither dismissing nor preoccupied clients (Petrowski et al., 2011). However, this was not a consistent finding across all studies with Romano et al. (2008) reporting that anxiously attached clients perceived lower levels of session depth (negative alliance processes) with avoidant therapists.

Investigating these effects over time, Sauer (2000) reported that early in therapy, the pairing of secure therapist and insecure clients received lower client rated working alliances, compared with dyads involving both insecure therapists and clients. By the end of therapy, secure therapist and insecure client pairing received better alliance scores.

1.5 Discussion

1.5.1 Overview of findings

This study aimed to review empirical studies that explore the evidence regarding associations between attachment and the therapeutic relationships, in the context of individual therapy.

The results suggest that client and therapist attachment style can have an influence on the quality of the therapeutic relationship, supporting findings from previous reviews (Dinger et al., 2009; Steel 2018). The two unexpected findings from Bruck et al. (2006) and Biscoglio (2005), which found insecure attachment styles of clients were positively related to the therapeutic relationship, were taken at a single timepoint. Therefore, we cannot generalise these findings across the whole duration of therapy. Eath & Roth (2000) found that early in therapy, anxious attachment was associated with lower alliance ratings, which improved over time. They hypothesised that anxious individuals have a strong need for intimacy which may facilitate stronger alliance over time.

Regarding therapist attachment styles, half of the studies showing less secure therapists formed weaker relationships with clients, were only significant in the therapist rated alliance samples. Given that the literature shows stronger support for client, rather than therapist predicted alliance, the results of these studies needs to be considered when drawing conclusions.

When exploring the influence of dissimilarity in insecure and secure attachment on the WAI, Bruck et al. (2006) found only the latter formed favourable alliances. This suggests that the benefit of different attachment styles on the WAI measure, was based solely on the therapists having more secure attachment styles compared to the clients. Another interesting finding came from Petrowski et al. (2011) study which found anxious patients formed better alliances with avoidant therapists. However, securely attached therapists did not form better alliances with either dismissing or preoccupied clients. One explanation put forward by Petrowski and colleagues (2011) was that avoidant therapists may provide a corrective experience, by dialling down attachment issues allowing space to facilitate a more helpful alliance.

The extent to which relational patterns of therapists and clients should be considered separate or combined remains unclear. The findings suggest partial evidence supporting the benefit of

complementary attachment styles. These came from studies with strong methodological rigour, with three out of the five studies choosing high quality designs and data analyses. A particular combination of client/therapist attachment style as being the most effective is less clear, as there were differences within the studies with regards to specific combinations of therapist and client's attachment styles, differences in client and therapists' perspectives and whether studies measured change over time.

In relation to attachment theory, we would expect attachment security to be related to a more favourable therapeutic relationship (Bowlby, 1988). Those studies which found a significant relationship supported this hypothesis. One interesting, yet seemingly contradictory finding emerged in Biscoglio (2005) study. They reported greater ratings in ruptures in the securely attached sample of therapists. However, this may be a consequence of secure therapists being more attuned to act on subtle changes in the therapy relationship; feeling confident in facilitating opportunities for repair, therefore may not necessarily reflect weak alliances (Safran & Muran, 2000).

Likewise, we would expect more insecure clients to perceive the relationship as less positive due to them either avoiding forming closeness or feeling anxious in the therapeutic relationship. This was partially supported, with most studies finding avoidant dimensions (as opposed to anxious dimensions) led to less favourable alliances. This is in line the literature which have found clients attachment anxiety is not consistently related to alliance (Kivlighan & Marmarosh, 2018). Furthermore, theory suggests that clients who tend to have avoidant attachments are arguably less driven to build an alliance with a therapist, therefore scoring it as low (Bartholomew, 1990).

1.5.2 Clinical and Theoretical implications

There were five studies whereby the specific attachment style of either the therapist or client did not affect the therapeutic relationship when used in isolation. Only when explored in the context of the therapist-client interaction, do we see the influence attachment has on the therapeutic relationship. This supports both relational and psychodynamic theories which implicate client and therapist as active agents in the therapeutic relationship and highlight the importance of not only being aware of clients' attachment styles, but for therapists to recognise their own relational patterns and how this may influence the therapeutic relationship. Furthermore, it can be argued that the relational processes that occur are shaped and influenced by both the therapist and clients' ways of relating and considering both these positions, in turn, may facilitate a better understanding of the therapeutic relationship.

Additionally, findings offer support for attachment theory, suggesting that attachment patterns shaped in our early life, continues into adulthood, and may influence the psychotherapy relationship. Mallinckrodt (2000) describes a model whereby the therapist accommodates the level of emotional distance and intensity in the context of the therapeutic relationship. This allows the opportunity for a corrective emotional experience helpful to the clients' attachment pattern. For those clients with an avoidant type of attachment, the therapist may aim to create a closer relationship than the client initially would favour, whilst simultaneously monitoring the client's level of anxiety. The other end of the continuum (highly anxiously clients) the therapist may wish to maintain emotional distance, despite clients' initial desire to seek out proximity, whilst at the same time monitoring client's level of frustration. Therefore, attachment theory can be a useful framework to inform how therapists work with clients, negotiating the level of closeness and dependency within the therapeutic relationship, beneficial to the clients' needs (Mallinckrodt, 2000)

As this review does indicate possible interactional effects of client and therapist's attachment style, it may be worth therapists considering their own attachment responses and those of their clients when understanding the relational aspects of therapy. For example, considering what might facilitate meaningful engagement with a client who have similar or dissimilar ways of relating. A focus on identifying and responding to different clients' attachment styles could therefore be an important area to explore, especially given how a client's interpersonal experience of therapy can be a complex process (Zilcha-Mano et al., 2017). In particular, developing sills in engagement, collaboration and perceptions of alliance and repairing ruptures within the therapy relationship, may be helpful additions to clinical training programmes (Crits-Christopher et al., 2006).

Findings from this review does provide support for understanding the therapeutic relationship in the context of attachment. In particular, therapists may act as a secure base promoting the self-exploration of the client. This was illustrated in Romana et al., 2008 findings whereby secure attachment between client and therapist enabled a deeper exploration of problems during the sessions. This may have implications when considering the supervisory context between trainee therapists and their supervisors. For example, the importance of trainee's having a containing space which encourages safe exploration of their own attachment patters and interpersonal processes in therapy. This in turn may lead to trainee's feeling more ready to offer a secure base to their clients.

The findings support some features of the Tripartite model, mainly working alliance and the real relationship concepts. Furthermore, Bruck et al., 2006 study found a significant association only

when measuring session depth and not working alliance. This supports the model which suggests that understanding the interpersonal context of therapy goes beyond the agreement of goals, tasks, and the development of bonds, which is often termed the working alliance.

1.5.3 Strengths

This review exercised strong validity with two independent raters completing the screening process and quality assessing the final studies. The quality assessment reflected all studies met the minimum quality standard which adds more certainty to the findings and conclusions drawn. Five studies were unpublished research which is likely to have reduced the risk of publication bias. This also provides a more balanced picture of the existing literature in this area. Additionally, the eligibility criteria allowed for more opportunity for studies to be included, without compromising its validity. For example, studies written in any language and published in any year. Lastly, drawing on the dual perspectives of both client and therapist attachment styles is another strength of this review. There is growing evidence of therapists' contributions to the therapeutic relationship (Biscoglio, 2005), therefore understanding how therapist and client attachment styles enhance or impede the therapeutic relationship is of value to clinical and theoretical understanding.

1.5.4 Limitations

The differences in findings, including those studies which produced non-significant results may be due to small samples sizes and low power for the number of variables that were measured. Furthermore, methodological, and theoretical explanations should also be considered, such as the different measures used. For example, Biscoglio (2005) used the WAI and SEQ, and only found significant results when using the latter measure. This may reflect the varying aspects of the therapeutic relationship that different measures tap into. Therefore, it is important for future research to explore the therapy relationship as a construct that is understood beyond that of just the working alliance. Due to the studies in this review mainly using the WAI, the findings may not have captured a full picture of the therapeutic process that occurs between therapists and clients. Furthermore, measures used to capture the therapeutic relationship are self-report and thus from a subjective perspective. i.e from the client or therapist. Whilst this yields some information, there is no simple way to capture the whole psychological experience between therapist and client in the context of the therapeutic relationship (Rozmarin et al., 2008), as most concepts are often rooted in psychoanalytic theory, which can be abstract and difficult to unpick.

Another limitation of this review was the search terms used, which on reflection, were not as inclusive or relevant to the Tripartite Model as they could have been. For example, 'transference

and countertransference'; a core element of the Tripartite model, were not included as search terms. This may have resulted in studies which did explore transference and countertransference were missed. Furthermore, capturing these studies would have provided a more detailed evaluation of the concepts defined by the Tripartite model.

Another consideration was the diverse sample of therapists, which included student therapists from a range of backgrounds and experiences. One possible consequence of these variances may include differences in the therapist abilities to manage interpersonal conflicts within therapy sessions – something which may be unrelated to attachment style.

Given that Bucci et al. (2016) only found an interactional effect when the severity of client's symptoms was considered, does indicate the possible role of in session anxiety. However, no study in this review examined the role of therapist levels of anxiety. Given a large proportion of the sample were student therapists, it may be the case that even if a student/trainee therapist is measured as having a secure attachment style, their anxiety levels during the sessions may be having a greater influence in how the client responds, and in turn how the therapeutic alliance is perceived. Therefore, it may be worthwhile for future studies to take distress/anxiety levels of both client and therapist into account.

The reliance on self-report measures across all the studies means that there is a risk of social desirability bias. Furthermore, one study relied on client's memory about early bonding with their primary caregivers, which may have been impacted by recall bias. In addition, three studies relied on therapists self-selecting the client sample which carries risk of bias in terms of only choosing clients who they perceive as having a 'better' relationship with.

Lastly, only two studies measured the therapeutic relationship over time. Given the nature of therapy, it would be helpful for research to use longitudinal designs. This would further add to our understand of the relationship between attachment styles and the therapeutic relationship, due to there being mixed results in the literature with two opposing results having been reported (Goldman & Anderson , 2007; Kanninen, Salo, & Punamaki, 2000).

1.6 Conclusion

This systematic review examined 13 studies that empirically explored the relationship between attachment styles and therapeutic relationship. There is partial evidence to suggest that attachment styles of both therapist and clients are important to the development of the therapeutic relationship. Whilst the research demonstrates the importance of considering attachment styles in the context of the therapeutic relationship, more research is needed to

understand how this process evolves over time and whether addressing the interpersonal aspects of the therapeutic relationship is more appropriate at certain stages of therapy. Furthermore, more empirical research is needed exploring all the specific elements of the Tripartite model to better understand the process for different types of therapists and clients. Nevertheless, given that the therapeutic relationship is associated with treatment outcome, exploring factors such as attachment styles, which attempt to aid understanding about what makes these relationship work, is valid area for future research. This review suggests ways in which training programmes can play a role in developing trainee's awareness of self and clients' attachment styles and skills to support future attachment-based interactions with clients.

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Chapter 2 Factors Affecting Transition Satisfaction from Child to Adult Mental Health Services.

2.1 Abstract

The transition from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) typically occurs between 16-18 years. This is a period often associated with an increase in psychological comorbidity and increasing severity of existing difficulties, yet many clients drop out of the healthcare system at this point. While potential disengagement from mental health service use can be problematic, it is not well understood which factors may lead to young people disengaging from or continuing service use. This study is looking at 12 pre-transition, 16 peri-transition, and 11 post-transition variables, previously outlined in qualitative research, to quantitatively identify which key themes may play a role in the transition process. In total, n= 274 participants (Mean = 20 +/- 2.31) years, n = 219 females) completed an online survey relating to transition experience and attachment. Participants were aged 16 or above, having had some experience with the British healthcare system. The result show that whether a client successfully transitioned from CAMHS to AMHS was significantly predicted by individualised care planning, involving transition services, and ensuring that treatment in AMHS constitutes a continuation of treatment in CAMHS. Involving young people during the transition, supportive relationships young people had with their CAMHS clinician, alongside positive parent involvement in AMHS, predicted transition satisfaction. Those who felt less emotionally and practically supported by their GP when transitioning from CAMHS to AMHS were less happy with their transition. Less secure attachment to AMHS clinician was associated with transition unhappiness. The results suggest clients' transition process might be significantly improved by focusing on transition structure and the young person's involvement during their transition, as well as young people having a choice with regards to the level of parent involvement post transition. Working on a secure attachment may be a way to improve transition satisfaction on the AMHS side.

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2.2 Introduction

In the UK, mental health services are organised by age. Young people up to age 18 years are seen by child and adolescent mental health services (CAMHS), and service users over 18 years are seen by adult mental health services (AMHS). For some service users, for whom difficulties continue from childhood to adulthood, a transition from CAMHS to AMHS is necessary. Transitions typically occur between age 16-18 years. At the same time, this adolescent period is often associated with increased psychological comorbidity (Murphy & Fonoagy, 2012), and an increase in severity of pre-existing difficulties (Kessler et al., 2005). Furthermore, young people are often negotiating a developmental transition which can be accompanied by further needs, outside of those which are illness specific (Aldiss et al., 2015). Therefore, having an individualised approach to care planning for young people who are transitioning might help ensure that these developmental needs are not missed.

Ideally, any young person who required continued support for their mental health post 18 years, would experience a smooth transition to adult services. However, research suggests that navigating between child and adult mental health services can pose as quite a challenge, particularly for the young person and their families (Nguyen et al., 2017). Additionally, Kennedy (2010) reported that young people often end up falling through the gap, particularly if they don't meet criteria for adult services. This can leave many young people and their families without the necessary mental health input needed.

Research suggests that transitions for young people lack a process which they feel involved in and appropriately prepared for (Fegran et al., 2014). In the UK, the Quality Care Commission (CQC, 2014) reported only 54% of young people felt involved in their transition journey and 80% of pre-transition notes had no transition plan. Given the disruption of care young people experience during transition and the impact this has on their health, wellbeing and future health outcomes (Lamb et al., 2008, White et al., 2004), you would expect individualised transition care plans to be a central part of a young persons transition.

The process of transitioning from child to adult mental health services has been an area of need for clients and their families for some time (Department of Health, 2006; 2008). As a result, the transition process has been a central feature in government policy and initiatives. NICE guidelines (2016) highlighted the need for early planning, strength based and person-centred approaches and ensuring joint working to enable better transition experiences. Furthermore, NHS England (2017) welcomed a new CQUIN (Commissioning for Quality and Innovation), aiming to encourage

improvements to the experiences and outcomes of young people transitioning. Nevertheless, despite such transition guidance being in place, there are considerable differences between services across the UK (Broad et al., 2017).

There has been increasing interest to develop mental health services for 0-25-year olds, where there is much debate about the future of CAMHS services. The DoH "Future in mind strategy" (2015) suggest a better transition age from CAMHS to AMHS would be 25. Green et al., 2005 recommends age boundaries should be considered flexible, with individual needs given more emphasis rather than a defining age gap, due to research suggesting that transitions at 18 is not appropriate and services are starting to move towards a more flexible needs based model (Green et al., 2005). In addition to the adolescent period being an increased risk of mental health problems, further rationale for establishing mental health services for people aged 0-25, include the profound maturational brain development which occur up until the mid-20s (Poli, 2019). Early Intervention Services for young people aged 12-25 years experiencing psychosis is one example of how youth mental health services have developed. Evidence suggests that young people who access these services not only demonstrate improvement in symptoms and quality of life, but also report greater satisfaction with services (Poli, 2019).

2.2.1 Defining transition

In the literature, developmental and situational transitions are the most cited definitions of transitions (McGrandles & McMahon, 2012). The former refers to the developmental context, for example adolescent to adulthood. This transition typically is associated with increased independence including moving away from home, and encompasses a range of emotional, social, and personal development.

Situational transitions on the other hand can be used to understand the process of moving from CAMHS to AMHS, often triggered by reaching a certain age milestone (Singh et al., 2010). Ensuring transition support and service provision is developmentally appropriate is considered of value. The benefit of placing young people in age appropriate facilities is widely accepted, however this vision does not always translate into practise (Osgood et al., 2010).

There are various factors at the policy, organisation, service, and individual level that shape the complexities surrounding continuation of care. In a recent review, Hendrick (2020) outlined some of the challenges that CAMHS and AMHS face when ensuring policy is implemented into practise. These complexities largely stem from cultural and systemic differences that exist between CAMHS and

AMHS, including eligibility thresholds and waiting lists, which may increase the risk of young people being left without interim support.

Once referred from CAMHS to AMHS, the care trajectory is not always predictable, with many young people choosing not to access support from adult services. There may be many reasons for this, including young people seeking more autonomy in wanting to solve their problems on their own (Rickwood et al., 2007) in addition to the stigma attached to having a mental health problem surpassing adolescence into adulthood (Haywood-Bell et al., 2016).

2.2.2 Theoretical framework of transition

Meleis et al., (2000) developed a transition theory model, which considers the nature of transitions, transition conditions, and response patterns to transitions. This could be used as a framework to understand the journey involved in transitioning from CAMHS to AMHS. Regarding the nature of transition, these can vary depending on the developmental and situational contexts, with multiple transitions occurring at once. For instance, the age of the young person transitioning to adult services typically occurs within a developmental transition context, i.e. moving from adolescence to adulthood.

'Properties of transition' are best understood not in isolation but as "interrelated properties of a complex process" (Meleis et al., 2000 p.18). For example, a person's knowledge of the transition process (awareness) can influence the extent to which they engage with the process, for example seeking out information, and actively preparing.

Successful transitions are not always achieved. The model proposes that there are 'transition conditions' that can facilitate or hinder the achievement of a successful transition. For instance, an individuals' preparation for the transition, their knowledge about the process, and how much support is accessible to them.

Patterns of response signal whether the transition process is being managed and experienced at an optimal level. These may include feeling connected, interaction, developing confidence, agency, and resilience. Lastly, assessing the readiness and preparation needed for transition (supportive and therapeutic interventions) requires acknowledgement of the above four components.

This study explores the pre, peri and post transition phases of moving from CAMHS to AMHS, as well as clients' attachment to their therapists. Even though the study was developed based on the qualitative research that had been conducted in this area (Broad et al., 2017), this theoretical model will aid the integration of the results into a larger theoretical framework.

2.2.3 Attachment

Attachment can be defined as an emotional bond between two people in which each seeks closeness and security. The term 'attachment 'derives from the work of Bowlby (1969) who proposed that humans evolved to regulate distress interpersonally, which he termed the attachment system. One of the two main dimensions are *attachment anxiety (*beliefs include others may reject them, therefore illicit a significant amount of reassurance and approval). The other is classified as *attachment avoidance (*individuals tend to focus their efforts in seeking emotional distance from significant others, and struggle with intimacy and closeness). A *secure attachment* consists of feeling confident in others response to own distress, whereby soothing and containment and the ability to regulate one's own emotions occurs.

Rich (2017) used a qualitative approach to explore the experiences of young people who were transitioning out of CAMHS. Findings highlighted the need for emotional containment from clinicians throughout the transition process to reduce the distress young people experienced. This suggests that relational safety may play an important role in facilitating a smoother transition. Relational safety can be understood through the lens of attachment theory. Currently, there is little research using attachment to explore transition (Rich, 2017). Most studies relate to other life transitions, such as moving to university (Car et al., 2013) and adolescent to adulthood (O'Connor et al., 2012). Findings from these studies suggest individuals with secure attachments cope better with developmental and situational changes.

2.2.4 Overview of Research

Transitioning between CAMHS and AMHS is a challenging experience universally. Both Canada and United States identify a lack of continuity of care and a process which appears disjointed for many young people (Embrett et al., 2015). In the UK, 61% of young people stop receiving care once they turn 18 (Embrett, et al., 2015). Although not all young people in CAMHS require further support, it is largely unclear why such a high number of people who were receiving support leave the mental healthcare system when they become ineligible for CAMHS.

The literature appears to refer to the transition process being very challenging for many young people, with a lack of joint working and poorly defined procedures (Paul, 2013; Leavey, 2019). Across studies, diagnosis was a strong predictor in whether someone was referred or not. Typically, those young people with severe mental health disorders were more likely than neurodevelopment disorders, such as autism, to be referred to adult services (Paul et al., 2013). Research suggests that

there are also significant variations between services regarding transition procedures, despite there being guidelines in place. Singh and colleagues (2010) conducted a cohort study of young people who were crossing the CAMHS to AMHS boundary over 1 year. They found variations existed across services with regards to which professionals would be involved and the age and duration of transfer. Most services were operating from local protocols which emphasised practical and procedural aspects of the process, and neglected recommendations surrounding preparing young people for their transition.

Furthermore, results indicated less than 5% of people experienced 'optimal levels' of transition, characterised by a minimum of one transition planning meeting involving the service user/carer, a period of joint working and optimal transition information (referral letter, summary of CAMHS contact and CAMHS notes). However, the findings reflect perspectives from clinicians and not young people, and therefore, the study was subject to considerable biases.

Broad et al. (2017) conducted a qualitative thematic synthesis of eighteen qualitative studies that reflected the experiences of 253 young people. Participants were receiving support during the CAMHS and AMHS transition. There were no limitations on diagnosis or age of youth. Studies which explored transition in the context of youth with chronic physical health conditions were excluded.

Broad et al. (2017) summarised several themes across the transition phases that patients described as key for their transition experience and success across services (Table 2).

Table 2. Broad et al.'s summary of what youths recommended for a positive transition from CAMHS to AMHS using qualitative thematic synthesis

Transition period	**Themes identified by Broad et al. (2017)**	**Items developed for this survey**
Pre-transition (CAMHS)	• CAMHS clinician qualities (tenacity, flexibility, instilling hope, providing support and reassurance, non-judgemental, good listener)	• I felt I had a good relationship with my CAMHS clinicians • I felt my CAMHS clinicians were tenacious (reliable) • I felt my CAMHS clinicians were flexible • I felt my CAMHS clinicians instilled hope in me • I felt emotionally supported by my CAMHS clinicians

		• I felt practically supported by my CAMHS clinicians • I felt reassured by my CAMHS clinicians • I didn't feel judged by my CAMHS clinicians • I felt listened to by my CAMHS clinicians
	• Preparation (e.g. early notification of transition to AMHS)	• I felt prepared for my transition from CAMHS to AMHS • I felt that my transition from CAMHS to AMHS was sudden (*reverse coded)*
	• Youth involvement in transition planning	• I felt involved in the transition planning process
Peri-transition (CAMHS – AMHS)	• Individualised care plans geared towards youth goals of functioning	• An individualised care plan (transfer CPA) based on my own unique needs was designed to help with my transition from CAMHS to AMHS • My individualise care plan was used during my transition from CAMHS to AMHS • My individualised care plan was helpful during my transition from CAMHS to AMHS • I felt my opinion was taken into account when decisions were made about my transition from CAMHS to AMHS
	• Increase autonomy in decision-making	• I felt my concerns were taken into account when decisions were made about my transition from CAMHS to AMHS
	• Community supports and primary care physicians who provide scaffolding across the transition	• I felt emotionally supported by my GP when transitioning from CAMHS to AMHS • I felt practically supported by my GP when transitioning from CAMHS to AMHS • I engaged in a transition service to help with my transition from CAMHS to AMHS

		• I felt fully informed about what was happening regarding my transition from CAMHS to AMHS
	• Gradual and flexible timing of transition	• I felt my transition from CAMHS to AMHS was undertaken gradually • my transition from CAMHS to AMHS was flexible in terms of timing
	• Care continuity including relational care continuity (to reduce fear of losing relationships with pre-transition staff and to promote comfort with AMHS) and system level continuity to reduce gaps)	• I felt I had formed a close relationship with my CAMHS clinicians • I felt I was able to contact my CAMHS clinicians when needed during my transition from CAMHS to AMHS • Treatment in AMHS aimed to continue what I had previously been working in with CAMHS • I felt I saw my CAMHS clinician regularly during my transition • I felt I saw my AMHS clinician regularly during my transition
Post-transition (AMHS)	• Staff support and practical structure	• I felt supported by staff at the AMHS after my transition from CAMHS to AMHS • I was offered practical support (i.e. life skills, help getting back into education, etc.) by my AMHS clinicians
	• Autonomy in treatment decisions	• I felt I had a say regarding my treatment choices in AMHS

• Choice about parental involvement	• I felt I has a choice as to whether or not my parents could be involved in my care at AMHS • I felt there was an abrupt reduction in parental involvement when I joined AMHS (*reverse coded*) • I felt comfortable with the reduction in parental involvement in my care when I moved from CAMHS to AMHS
• Physical care environments geared towards young adults	• I felt supported by AMHS staff as an individual who had just transferred from CAMHS
• Informational continuity (sharing of clinical information between CAMHS and AMHS)	• I felt my information was transferred effectively from CAMHS to AMHS • I felt I had to keep repeating myself when I met with AMHS clinicians after my transition from CAMHS to AMHS • My AMHS clinician(s) were informed about my diagnoses and treatments during my time in CAMHS • My experiences with AMHS have been positive

Note. Camhs = Child and adolescent mental health services; Amhs = Adult mental health services. Taken from Broad, K. L., Sandhu, V. K., Sunderji, N., & Charach, A. (2017). Youth experiences of transition from child mental health services to adult mental health services: a qualitative thematic synthesis.

While this qualitative research identified key themes that play a role in the transition process, it remains unclear which of these themes determines a successful and satisfactory transition. For this purpose, a survey was designed, turning the themes identified by Broad and colleagues (2017) into items that could be measured quantitatively. A theory building approach with inductive reasoning (De Vaus, 2001) was used to generate the questionnaires from previous findings. Moreover, standardised questionnaires were used to assed the quality of the attachment between clinicians and clients because one important theme concerns the client-therapist relationship.

2.2.5 Aims and Hypotheses

The first aim of this study was to determine how much the specific themes identified in Broad and colleagues (2017) research, influence the extent to which young people feel satisfied in their experience of moving from CAMHS to AMHS. The analyses will aim to determine the most important specific factors that can be addressed that will make transition more satisfactory for future clients.

The second aim of this project is to ascertain if there are differences between those participants that went on to adult mental health services and those that did not, in order to determine which factors need to be addressed to increase the likelihood of a successful transition. Transition success was defined as those participants who reported they had attempted to transfer from CAMHS to AMHS and had been accepted int AMHS.

Thirdly, the survey explores how attachment to one's therapist can influence the extent to which young people feel satisfied in their experience of transitioning between services. For analysing the data, the themes identified in Broad and colleagues (2017) study will be summarised into several factors. This analysis is exploratory as there is no prior quantitative research to draw from.

Hypothesis 1 Irrespective of the themes that may emerge from the factor analysis, it can be hypothesised that clients who were more engaged in the transition process prior to the transition are more likely to successfully transition to AMHS.

Hypothesis 2 Clients who receive more support during their transition from CAMHS to AMHS are more likely to be satisfied with their transition.

Hypothesis 3 Clients with a secure attachment style to their CAMHS clinician are more likely to experience a satisfying transition.

2.3 Method

In this study, n = 274 (n =219 females) completed an online survey consisting of two main sections: one related to transition satisfaction (see Appendix B) and one relating to attachment (see Appendix C). Approval to recruit from Non-NHS settings was approved (see Appendix D), but approval to recruit directly from CAMHS was not approved by NHS ethics. To meet the inclusion criteria, participants were aged 16 or above, and had some experience with the British healthcare system (e.g. patient, past patient, parent, carer). Due to the wealth of information, only participants who indicated they had wanted or tried to transition from CAMHS to AMHS or had successfully

transitioned were included in the analyses in this paper. Transition success was defined as those participants who reported they had attempted to transfer from CAMHS to AMHS and had been accepted into AMHS. This reduced the number of participants considerably, due to many either having had experience in only one of the systems (i.e CAMHS or AMHS), which would not fully capture the transition process. This resulted in a final sample of N = 98 (N = 75 female) participants (mean age = 19.8, SD = 2.63, range = 16-19). The number of participants met the requirements of the sample size needed (N = 89) to achieve adequate power, calculated by G*Power.

2.3.1 Measures

Transition satisfaction was measured by a transition survey, constructed based on the themes that were identified by Broad and colleagues (2017). Each theme was turned into an item, following standard scale construction guidelines (Chiang et al., 2015). The transition survey consisted of three sections. These included pre-transition themes, i.e. themes that influenced clients' transition experience before the transition process started (N^{items}= 12, α =.79, acceptable), peri-transition themes, i.e. themes that influenced clients' transition experience during the transition (N^{items}= 16, α = .85, good) and post-transition themes (N^{items}= 11, α = .81, good), i.e. themes that influenced clients' transition experience after they had transitioned. Each item was presented on a 5-point Likert Scale. The responses were labelled: strongly agree (4), agree (3), neither agree nor disagree (2), disagree (1), strongly disagree (0). There was also a 'not applicable' option.

Pre-transition themes included items such as 'I felt I had a good relationship with my CAMHS clinicians', 'I felt prepared for my transition from CAMHS to AMHS' and 'I felt involved in the transition planning process'. Peri-transition themes consisted of items such as 'my individualised care plan was helpful during my transition from CAMHS to AMHS', ' I felt emotionally and practically supported by my GP when transitioning from CAMHS to AMHS' and 'I felt my transition from CAMHS to AMHS was undertaken gradually'. Post -transition themes contained items such as 'I felt I had a say regarding my treatment choices in AMHS', I felt comfortable with the reduction in parental involvement in my care when I moved from CAMHS to AMHS' and 'I felt my information was transferred effectively from CAMHS to AMHS' (for a full list of items, see Appendix E - G).

Transition satisfaction was assessed using 5 items presented on a 5-point Likert scale. The satisfaction items were developed based on the concept of transition satisfaction and were based on optimal item development criteria. To increase reliability, researchers asked the "same" concept in multiple different ways. The inclusion of unhappiness items was guided by research which suggested that mental ill-ness and wellbeing are not opposites, i.e. the presence of one does not mean the

absence of the other (Parsley & Fitzsimons, 2016). Both satisfaction (N^{items}= 3, α =.845) and unhappiness factors (N^{items}= 2, α =.837) demonstrated good internal consistency. Examples of items included 'I was happy with my transition from CAMHS to AMHS', 'I was happy with the support I received with regards to my transition from CAMHS to AMHS', and 'My mental health took a turn for the worse during my transition from CAMHS to AHMS because of the transition'.

The Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995) was used to measure client attachment to their therapist. This is a 36-item measure, asking clients to respond using a 6-point scale ranging from *strongly agree* to *strongly disagree.* The measure is intended to assess client's perceptions of the client-therapist relationship within an attachment theory framework. The CATS consist of three subscales including pre-occupied (*I would like my therapist to feel closer to me),* avoidant (*It's hard for me to trust my therapist)* and secure attachment (*my therapist is dependable).* The scale has good psychometrics properties with internal consistency alphas ranging from .73 to .94 for CATS secure, .73 to .91 for CATS avoidant, and .73 to .89 for CATS preoccupied subscale (Mallinckrodt et al., 2017).

In our sample, the scale demonstrated good psychometric properties with internal consistency alphas of .88 for the CAMHS secure, .93 for the CAMHS avoidant, and .92 for the CAMHS preoccupied subscales. Similar alphas were found for the AMHS subscales of .77 for the secure, .90 for the avoidant, and .91 for the preoccupied subscales.

2.3.2 Procedure

Participants were recruited via volunteer sampling. Adverts were displayed on social media sites, the University of Southampton (UK) efolio system and through charities, inviting participants to complete the survey in exchange for study credit and a chance of winning one of ten £40 amazon vouchers (see Appendix H). Adverts contained a link to the survey which participants accessed and were presented with an information sheet (see Appendix I). They were asked to complete the survey and to then fill out the CATS questionnaires relating to clinicians situated in both CAMHS and AMHS if appropriate. Upon completion of the survey, participants were then presented with a debriefing form which included an optional mood repair task (see Appendix J).

2.3.3 Statistical analyses

Several factor analyses with Varimax rotation were conducted to reduce the number of outcome variables (transition satisfaction items), and the number of predictors. Individual factor analyses

were conducted on the pre, peri and post transition items. Means were calculated across all items in each factor to build a limited number of predictors.

A binary logistic regression, with transition success (yes /no) as the dependent variable, and the pre, peri and post transition factors as independent variables were used. This was to determine if there were differences between those who successfully transferred (only participants who completed the transfer) and those that did not (participants who wanted or tried to transfer but did not).

A series of linear analyses were then used to investigate which of these factors significantly predicted transition satisfaction and unhappiness respectively. To run these regressions, assumptions of normality, linearity, homoscedasticity, and absence of multicollinearity are required. Upon visual inspection, the data followed the normality line, with little deviation hence the data is normally distributed. The scatterplot showed values equally distributed above and below on the X and Y axis. Lastly, all variance inflation factors (VIF) were < 10, indicating that the assumptions were met.

To meet the secondary objective, a correlation analyses was used to explore the relationship between transition satisfaction / unhappiness and clients' attachment to their clinician.

2.4 Results

Table 3 shows the study demographics. Mood and anxiety disorders were combined and compared with the remainder of the diagnoses due to a limited n. These were no more likely than the other disorders to attempt to transfer (χ (1) = 0.017, p = .896 or successfully transfer (Table 3).

Table 3. Demographic Characteristics of Participants

	Transfer attempted (*n*=98)	**Transferred successfully (*n*=59)**	**Difference between attempted and transferred**
Age	M=19.8, SD=2.63	M=19.8, SD=1.68	$t(95) = -.021$, $p = .835$

Gender			$\chi^2(2) = 4.33$, $p = .115$
Male	14 (14.6%)	5 (8.6%)	
Female	75 (78.1)	48 (82.8%)	
Other	7 (7.3%)	5 (8.6%)	
Ethnicity			$\chi^2(3) =, 3.32$ $p = .343$
White	81 (89%)	48 (88.9%)	
Mixed*	10 (11%)	6 (11.1%)	
Diagnosis			
Mood Disorders	35 (35.7%)	18 (30.5%)	$\chi^2(1) = 0.08$,
Anxiety disorders	22 (22.4%)	14 (23.7%)	$p = .780$
Behavioural Syndromes with Physiological Disturbances	9 (9.2%)	5 (8.5%)	
Personality Disorders	11 (11.2%)	11 (18.6%)	
Intellectual Disability	4 (4.1%)	2 (3.4%)	
Pervasive and specified developmental disorders	3 (3.1%)	3 (5.1%)	
Behavioural and Emotional Disorders with Childhood Onset			

Mental Disorder NOS	3 (3.1%)	1 (1.7%)
	8 (8.2%)	4 (6.8%)
Who diagnosed you		
G. P	37 (37.8%)	28 (47.5%)
Psychologist	25 (25.5%)	9 (15.3%)
Psychiatrist	28(28.6%)	17 (28.8%)
Neurologist	1 (1%)	1 (1.7%)
Paediatrician	1 (1%)	1 (1.7%)
Other*	6 (6.1%)	3 (5.1%)
Currently being assessed by AMHS	23 (23.5%)	21 (35.6%)
Currently being treated by AMHS	27 (27.6%)	21 (35.6%)

Note. Mixed = white and asian, white and black Caribbean, white and black African, Other = mental health nurse, counsellor, parent, and teacher

The factor analysis on the transition satisfaction items, identified two factors: 1) 'transition satisfaction' and 2) 'transition unhappiness' (see Appendix K). The factor analysis on the pre-transition items revealed 2 factors: 1) 'Quality of CAMHS clinician support (e.g. having a reliable, flexible and emotionally supportive clinician) and 2) 'transition planning' (i.e. perceived level of involvement and preparation) (see Appendix L). On the peri-transition items, factor analysis revealed 3 factors: 1) 'involvement in transition' (e.g young person's views considered, gradual transition and regular contact with CAMHS and AMHS clinicians), 2) 'transition structure' (e.g individualised care plans and continuity of treatment) and 3) ' Quality of G.P. support' (e.g having offered practical and emotional support from their GPs) (see Appendix M). The factor analysis on the post-transition items revealed 4 factors: 1) 'positive AMH experience' (e.g clinician support offered in context of young

people having recently transferred and autonomy regarding treatment decisions), 2) 'positive parent involvement' (perceived level of choice regarding parental involvement), 3) 'transition efficiency' (e.g AMHS clinicians holding knowledge of the young person's history in mind and providing practical support such as like skills and getting back into education) and 4) 'reduction in parental involvement' (e.g perceived sudden ending of parental involvement) (see Appendix N).

2.4.1 Transition success

A binary logistic regression was performed to determine the effect of the pre and peri transition factors on the likelihood that participants successfully transitioned or not. The logistic regression model explained 15% of the variation in the outcome. Peri structure factors (having an individualised care plan based on young people's own needs, engaging in the transition process and treatment continuity from CAMHS to AMHS) predicted transition success (Table 4).

Table 4. Transition factors (pre/peri transition) predicting whether participants successfully transitioned or not

	B	**S.E.**	***P***	**Exp (B)**	**CI lower**	**CI upper**
Pre-transition factors						
Clinician	.20	.30	.512	1.22	.68	2.20
Planning	.23	.42	.580	1.26	.55	2.89
Peri-transition factors						
Involvement	-.88	.59	.138	.42	.13	1.32
Structure	1.13	.49	**.020**	3.09	1.19	8.00
GP support	.03	.27	.908	1.03	.61	1.76

2.4.2 Transition satisfaction

The linear regression model predicting transition satisfaction from all transition factors was overall significant (F (9,41)=*2.08*, $p<0.05$). Involvement during transition and positive parent involvement in AMHS were significantly associated with transition satisfaction (Table 5).

Table 5. Regression models predicting transition satisfaction

	B	**SE**	***ß***	***T***	***p***	**CI lower**	**CI upper**
(constant)	1.10	.81		1.36	.184	-.55	2.75
Pre-transition factors							
Clinician	-.01	.11	-.01	-.09	.929	-.24	.22
Planning	.06	.15	.07	.40	.689	-.25	.37
Peri-transition factors							
Involvement	.39	.15	.42	2.54	**.016**	.08	.70
Structure	.18	.18	.17	1.01	.321	-.18	.54
GP support	.09	.087	.12	.98	.336	-.09	.26
Post-transition factors							
Positive AMHS experience	.07	.130	.07	.54	.596	-.20	.34
Positive Parent Involvement	.54	.222	.70	2.44	**.021**	.09	.99
Reduction in Parent Involvement	-.11	.084	-.15	-1.29	.207	-.28	.06
Transition efficiency	-.59	.344	-.52	-1.70	.098	-1.27	.12

2.4.3 Transition unhappiness

The linear regression model predicting transition unhappiness from all transition factors was overall significant ($F(9,53) = 4.92$, $p<0.05$). People who felt less emotionally and practically supported by their GP when transitioning from CAMHS to AMHS had a less satisfying transition experience (Table 6).

Table 6. Regression models predicting transition unhappiness

	B	**S.E.**	***ß***	***T***	***P***	**CI lower**	**CI upper**
(constant)	3.61	.69		5.23	<.000	2.22	5.00
Pre-transition factors							
Clinician	.05	.12	.05	.41	.686	-.19	.29
Planning	-.08	.18	-.09	-.46	.651	-.45	.28
Peri-transition factors							
Involvement	.05	.20	.05	.23	.823	-.37	.46
Structure	-.38	.20	-.35	-1.91	.063	-.78	.02
GP support	-.23	.11	-.31	-2.14	**.038**	-.44	-.01
Post-transition factors							
Positive AMHS experience	-.23	.16	-.25	-1.43	.159	-.54	.09
Positive Parent Involvement	.07	.20	.09	.35	.726	-.34	.48
Reduction in Parent Involvement	.14	.09	.19	1.65	.106	-.03	.31
Transition efficiency	-.10	.34	-.08	-.31	.758	-.78	.57

2.4.4 Relationship between transition unhappiness and attachment to therapist

The linear regression model predicting transition unhappiness from client attachment to therapist factors was overall significant ($F(6,48) = 5.041$, $p<0.05$) (Table 7). Participants who had a less secure attachment with their AMHS clinician were less happy with their transition.

Table 7. Regression models predicting transition unhappiness and attachment to therapist

	B	**S.E.**	***ß***	***T***	***P***	**CI lower**	**CI upper**
Model 1							
(constant)	4.47	1.08		4.16	<.000	2.30	6.64
CAMHS Clinician							
Secure attachment to therapist	-.13	.20	-.15	-.63	.532	-.53	.28
Avoidant attachment to therapist	.13	.18	.16	.75	.459	-.23	.49
Preoccupied attachment to therapist	-.03	.16	-.04	-.19	.849	-.35	.29
AMHS Clinician							
Secure attachment to therapist	-.45	.17	-.52	-2.71	**.010**	-.79	-.12
Avoidant attachment to therapist	-.09	.16	-.11	-.59	.559	-.41	.22
Preoccupied attachment to therapist	-.21	.16	-.24	-1.38	.176	-.52	.10

2.4.5 Relationship between transition satisfaction and attachment to therapist

The linear regression model predicting transition satisfaction from client attachment to therapist factors was overall significant ($F(6,37) = 3.205$, $p<0.05$) (Table 8). There was no significant correlation found between satisfaction and attachment to either CAMHS or AMHS.

Table 8. Regression models predicting transition satisfaction from attachment to therapist

	B	**S.E.**	***ß***	***T***	***P***	**CI lower**	**CI upper**

(constant)	-.44	1.15		-.38	.705	-2.79	1.91
CAMHS Clinician							
Secure attachment to therapist	.25	.20	.34	1.23	.227	-.16	.67
Avoidant attachment to therapist	.11	.19	.15	.59	.559	-.27	.50
Preoccupied attachment to therapist	.17	.17	.25	1.00	.326	-.17	.50
AMHS Clinician							
Secure attachment to therapist	.31	.23	.39	1.32	.196	-.17	.78
Avoidant attachment to therapist	.06	.22	.08	.26	.800	-.39	.50
Preoccupied attachment to therapist	.10	.17	.13	.58	.566	-.24	.43

2.5 Discussion

Table 9 summarises the key findings from the results.

Table 9. Key predictors influencing young people's transition experience

Factors predicting transition success
• Transition structure • Young people who had an individualised care plan based on their needs • Young people who engaged in a transition service • Continuity of treatment from CAMHS to AMHS

Factors predicting transition satisfaction	
• Involvement during the transition process	• Young people's opinions and concerns were considered
	• Fully informed about the process
	• Transition was undertaken gradually and was flexible in terms of timing
	• Close relationship with CAMHS clinician and was available to contact during the process
	• Both CAMHS and AMHS clinician were regularly available during the transition
• Positive parental involvement	• Young people had a choice regarding parental involvement, and they were comfortable with reduction
Factors predicting transition unhappiness	
• G.P support	• Young people were less unhappy if they were less emotionally and practically supported by their G.P
Attachment to therapist and transition	• Young people were less happy with their transition if they had a less secure attachment to AMHS clinician

Regarding the first hypothesis, pre-transition factors did not predict transition success. The results suggest that the transition structure during the transition from CAMHS to AMHS plays a significant role in whether the transition is successful or not. Young people who had an individualised care plan based on their needs which was utilised during their transition, those who engaged in a transition service to help with their transition, and those people who felt their treatment in CAMHS continued to AMHS, were more likely to successfully transition. This highlights the importance of having a

transition service, which can focus on the specific needs of those transitioning. This is in line with research that has found transition workers were key in enabling a smoother and successful transition process, leading to better engagement rates (Singh at al., 2010). In a qualitative study, Haywood – Bell (2016) findings demonstrated the importance of transition services at both the emotional and practical level. Young people reported benefit of having a transition worker involved in supporting them to develop a support plan which was collaborative, empowering and individualised to their needs. Furthermore, young people felt reassured and contained knowing that their transition worker would remain involved during the process. This may reflect the need of the transition process having an element of continuity, during a time of many potential changes. The current study shows that amongst the other factors contributing to a successful transition, this might be the most important one. Therefore, using individualised care plans, involving transition services, ensuring clients feel they are actively engaged in the transition process, and ensuring that treatment in AMHS constitutes a continuation of treatment in CAMHS, may help more young people transition successfully. However, whether there is a causal link between improving the transition process on a structural level and fewer clients dropping out, would have to be tested in an experimental design.

Similarly, treatment in AMHS aiming to continue what the young person had previously been working on in CAMHS was important. Whilst this may reflect the need for continuity, it may also be understood in the context of young people needing a more gradual approach to adapting to adult services. This may be important, given the cultural differences between child and adult mental health services, generated through treatment options as well as different attitudes, beliefs, and language (Mclaren, 2013). The former tends to consider family and social context such as education and social services, whose engagement and input is encouraged and perceived as important (Hovish et al., 2012). Whereas a narrower range of services are utilised in AMHS. The focus tends to be treatment of mental health difficulties at the individual level, with services viewing young people as adults taking responsibility and having autonomy (Lindgren et al., 2013).

Ensuring treatment consistency across CAMHS and AMHS, suggest the important of not only developmentally appropriate but also person-centred approaches. This is highlighted in other studies which found the loss of person-centred care was of significant concern for young people (Betz et al., 2018; Fegran et al., 2014). This is particularly relevant given the significant variations in culture between CAMHS and AMHS as previously mentioned. This could be achieved through closer, joined up working between CAMHS and AMHS. Singh and colleagues (2010) found that getting to know the service user and working in line with their best interests and treatment goals was facilitated by joint working.

Results provided partial support for hypothesis 2, which predicted that those clients who received more support during their transition from CAMHS to AMHS, were more likely to be satisfied with their transition. Involvement in the transition process during the transition and positive parental involvement following transition was significantly associated with transition satisfaction. It is not surprising that considering young people's opinions and concerns about transition decisions enables people to feel more satisfied with their transition. Young people often feel in a powerless position when accessing services (Coyne at al., 2015). This appears to be precipitated by a lack of involvement in decision making regarding their care, with better service experiences arising from young people having more control and autonomy in making decisions (Dimitropolou et al., 2015).

The literature on client involvement in health processes and outcomes have been well documented, with studies showing better therapeutic relationships (Omeni et al., 2014), reduction in anxiety and increase self-esteem and confidence (Vahdat et al., 2014). Henderson and colleagues (2004) found that client involvement led to not only co-producing joint crisis plans, but better engagement with their treatment plans, which significantly reduced the use of compulsory admission during crisis. Although Henderson et al., (2004) study does not specifically relate to transition, as previously mentioned the age in which this typically occurs coincides with increase in severity of difficulties, which may lead to a crisis.

If young people were given a choice as to whether parents were involved and were comfortable with a reduction in their involvement, led to a more satisfying transition. This supports Broad and colleagues (2017) research which found young people struggle with the sudden and abrupt shift in parental involvement when transitioning to AMHS. Research has also found that parents report being less involved post transition, and this was associated with feelings of loss and powerlessness (Lindgren et al., 2016). Young people having a choice as to the degree of involvement from their parents, as well as considering the experiences of parents in the transition process may be important to hold in mind. These findings highlight the possible benefits of a later transition age (age 25 instead of 18), as parental involvement would likely remain throughout this additional time period. Furthermore, remaining in CAMHS until age 25 would also encourage a more holistic approach and the benefits of considering a young persons' mental health in the context of their developmental needs and life experiences are referenced in the literature (Haywood-Bell et al., 2016).

Lastly, people who felt less emotionally and practically supported by their GP were less happy. This may reflect the need for additional support, outside of community mental health teams to negotiate the move between CAMHS and AMHS (Lindgren et al., 2013).

The results suggest that the transition process could be improved by promoting and encouraging young person's involvement in the process, ensuring individualised care plans and continuity of care across services and giving young people a choice regarding the degree of parental involvement. One way to facilitate this would be through the involvement of transition services.

Given that we based our study on Broad and colleagues (2017) research that identified themes pertinent to the transition process, we expected to find more of the previously identified variables would be significant in the transition process. However, Broad et al., 2017 summarised qualitative research, which is not driven as much by the number of people reporting a certain issue. Our study identified those themes that played the largest role across clients in this sample. On the one hand, this is a suitable approach to identify those themes that should be prioritised. However, a larger sample may have led to more themes being identified as having significance in the transition process, for a greater number of people.

The results did not support the hypothesis 3 that '*Individuals with a secure attachment to their CAMHS clinician will have a more satisfying transition"*. Findings did suggest that individuals with a less secure attachment to their AMHS clinician said they were less happy with their transition. This provides partial support to the literature suggesting that the relationship young people have with their clinician, plays a role in experiencing a better transition (Wheatley et al., 2014 & Linegran, 2013). Transitioning between services is often accompanied with a loss of familiar and safe relationships to the formation of new ones. This may add to the anxieties young people already feel about moving on. Drawing on Bowlby's theory of attachment, building safe and trusting relationships with professionals may facilitate positive attachments to not only clinicians, but more broadly to the service. This in turn may increase the likelihood of engaging with adult mental health services.

2.5.1 Theoretical and Clinical implications

Although this study was developed based on the qualitative research that had been conducted in that area, Meleis and colleagues (2000) theoretical model was used to aid the integration of the results into a larger theoretical framework. The findings partially supported some aspects of the model, particularly related to transition conditions. Meleis et al. (2000) suggested community resources and social support can facilitate successful transitions. In our study, those people who engaged with a transition service were more likely to successfully transition. It is unclear whether these transition services were standalone services (such as third sector voluntary) or embedded within existing CAMHS or AMHS. If the former, then this may need reflect the need for additional

support outside of community mental health teams. If the transition services were embedded within existing NHS services, then it suggests the benefit of investing into services to support the transition process, including specific training for staff to support young people with their transition. This also may be an opportunity for young people to become involved in co-producing peer support services, to help manage anxieties and increase motivation to engage with services.

The importance of being sensitive to the attachment needs of young people was also demonstrated in this study. Whilst, the transition model refers to disruptions in relationships as being a factor to consider, this description does not capture the complexities of ending and forming new relationships. There is some potential for the model to be considered in a young person's transition planning, however the extent to which the whole model can be applied is less clear and needs further exploring.

Nevertheless, the findings suggest individuals with a less secure attachment to their AMHS clinician said they were less happy with their transition. Therefore, ensuring staff are sensitive to the attachment needs of the young person is important and in line with providing person centred planning. Staff training on attachment and skills in developing and maintaining positive attachments, whilst also managing the endings of therapeutic relationships may also be of benefit. Preparatory sessions could be one way to facilitate relational and emotional safety, with young people having focussed time to meet with their new clinician to start developing new attachments, whilst gradually ending attachments with their CAMHS clinician.

2.5.2 Limitations

The recruitment method might be considered a limitation, given that the survey required internet access. This may have excluded participants from disadvantaged backgrounds, therefore limiting the generalisability of the results. There may have also been some recall bias, due to the reliance of participant's ability to recall their experiences. For example, those participants who were going through the transition process may have been able to recall more accurately their experiences, in comparison to participants who were older. Furthermore, participants who had just recently transferred to AMHS, may have not been in the position to reflect on their experiences. However, the mean age in the study was 19 years, which is in line with other research exploring service users crossing the CAMHS/ AMHS boundary over 1 year (Singh et al., 2010).

Furthermore, the inclusion criteria was too broad which meant that the study included participants who had experience in only one of the systems (i.e CAMHS or AMHS), which would not fully capture the transition process. Given that the research question was focusing on the transition process

between CAMHS to AMHS, the inclusion criteria would have benefitted from making this more explicit i.e. participants *must have* transferred from CAMHS and accepted into AMHS.

Lastly, there was an underrepresentation of males and individuals from diverse ethnic backgrounds, with most of the sample identifying as white and female. There needs to be a focus on making research more accessible for males and different ethnic groups, to explore if there are gender and cultural differences regarding the support needed during transition process.

2.6 Conclusion

Clients' transition process was significantly improved when the transition process had structure. This was characterised by using individualised care plans, involving transition services, and ensuring that treatment in AMHS constitutes a continuation of treatment in CAMHS. Furthermore, involving young people during the transition was important, characterised by responding to their opinions and concerns, as well as maintaining a close relationship with their CAMHS clinician and giving young people a choice regarding the degree of parental involvement. Involving GPs in the context of providing practical and emotional support during the transition process, as well as fostering secure attachments with AMHS clinicians, may determine transition happiness. Improving these factors could lead to lower drop-out rates, however, this would need to be researched specifically with a longitudinal design.

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Appendix A Quality assessment ratings

References:	Q1. Question/objective sufficiently described	Q2. Study Design	Q3. Method of subject comparison	Q4. Subject Characteristics	Q5. Random allocation	Q6. Blinding of investigators	Q7. Blinding of subjects	Q8. Outcome and exposure measures	Q9. Sample Size	Q10. Analytic Method	Q11. Estimate of Variance	Q12. Confounding	Q13. Results reported in detail	Q14. Conclusion supported by results	%
Biscoglio (2005)	2	2	2	2	1	n/a	n/a	2	1	2 1	2	0 1	2	1	79
Britton (2006)	2	2	2 1	2	n/a	n/a	n/a	2 1	1	2 1	2	0 1	2	1	82 86
Bruck et al (2006)	2	2	2	2	1	n/a	n/a	2	2 1	1	1	1	2	2	83 79
Bucci et al (2016)	2	2	1	2	n/a	n/a	n/a	2	2	2 1	2	0 2	2	2	86
Feurtes (2007)	2	2	2	2	n/a	n/a	n/a	2	1	2	1	1	2	2	86
Feurtes et al. (2019)	2	2	2 1	2	1 n/a	n/a	n/a	2	1	2	1 2	1	2	2	83 86
Frehling (2005)	2	2	2 1	2	n/a	n/a	n/a	2	0	2	2	1	2	1 2	82 73
Marmarosh et al (2014)	2	2	2 1	2	n/a	n/a	n/a	2	1	2	2 1	0 1	2	1 2	81

Appendix B Transition satisfaction survey

Rate the extent to which you agree with the following statements using the scale provided.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly disagree	Not Applicable
I was happy with my transition from CAMHS to AHMS	○	○	○	○	○	○
I was happy with the support I received with regards to my transition from CAMHS to AMHS.	○	○	○	○	○	○
I am satisfied with my transition from CAMHS to AHMS	○	○	○	○	○	○
I suffered during my transition from CAMHS to AHMS	○	○	○	○	○	○
My mental health took a turn for the worse during my transition from CAMHS to AHMS because of the transition	○	○	○	○	○	○
The transition process was difficult because I was not able to see a clinician for a while because I was transitioning	○	○	○	○	○	○
The transition process was difficult because the relationship with my new clinician in AHMS was not as good as the previous one in CAMHS	○	○	○	○	○	○
The transition process was difficult because I did not feel sufficiently informed	○	○	○	○	○	○
I never fully transitioned from CAMHS to AMHS.	○	○	○	○	○	○
I did not see a clinician in AMHS.	○	○	○	○	○	○
I tried to see a clinician in AHMS.	○	○	○	○	○	○
I stopped trying to see a clinician in AHMS during my transition.	○	○	○	○	○	○
I stopped trying to see a clinician in AHMS before my transition started.	○	○	○	○	○	○
I stopped trying to see a clinician in AHMS after my transition.	○	○	○	○	○	○

Appendix C Client Attachment to Therapist Scale

I don't know how to expect my therapist to react from session to session.	○	○	○	○	○	○	○
I can tell that my therapist enjoys working with me.	○	○	○	○	○	○	○
I resent having to handle problems on my own when my therapist could be more helpful.	○	○	○	○	○	○	○
My therapist helps me to look closely at the frightening or troubling things that have happened to me.	○	○	○	○	○	○	○
My therapist is a comforting presence to me when I am upset.	○	○	○	○	○	○	○
I know my therapist will understand the things that bother me.	○	○	○	○	○	○	○
I feel sure that my therapist will be there if I really need her him.	○	○	○	○	○	○	○

When I'm with my therapist, I feel I am his/her highest priority.	○	○	○	○	○	○	○
I think my therapist disapproves of me.	○	○	○	○	○	○	○
Talking over my problems with my therapist makes me feel ashamed or foolish.	○	○	○	○	○	○	○
I know I could tell my therapist anything and s/he would not reject me.	○	○	○	○	○	○	○
I don't like to share my feelings with my therapist.	○	○	○	○	○	○	○
I feel humiliated in my therapy sessions.	○	○	○	○	○	○	○
Sometimes I'm afraid that if I don't please my therapist, s/he will reject me.	○	○	○	○	○	○	○
I suspect my therapist probably isn't honest with me.	○	○	○	○	○	○	○
My therapist wants to know more about me than I am comfortable talking about.	○	○	○	○	○	○	○
I feel safe with my therapist.	○	○	○	○	○	○	○

My therapist treats me more like a child than an adult.	○	○	○	○	○	○	○
It's hard for me to trust my therapist.	○	○	○	○	○	○	○
I'm not certain that my therapist is all that concerned about me	○	○	○	○	○	○	○
I yearn to be "at one" with my therapist.	○	○	○	○	○	○	○

I wish my therapist could be with me on a daily basis.	○	○	○	○	○	○	○
I would like my therapist to feel closer to me.	○	○	○	○	○	○	○
I'd like to know more about my therapist as a person.	○	○	○	○	○	○	○
I think about calling my therapist at home.	○	○	○	○	○	○	○
I think about being my therapist's favourite client.	○	○	○	○	○	○	○

I wish there were a way I could spend more time with my therapist.	○	○	○	○	○	○	○
I wish I could do something for my therapist too.	○	○	○	○	○	○	○
I wish my counsellor were not my therapist so that we could be friends.	○	○	○	○	○	○	○
I often wonder about my therapist's other clients.	○	○	○	○	○	○	○

Appendix D University Ethics Approval

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 46759.A4
Submission Title: Factors affecting transition from Child to Adult Mental Health Services: A Quantitative Approach (Amendment 3)
Submitter Name: Paris Williams

The Research Integrity and Governance team have reviewed and approved your submission.

Appendix E Pre-Transition Items

Rate the extent to which you agree with the following statements using the scale provided.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Applicable
I felt I had a good relationship with my CAMHS clinicians.	○	○	○	○	○	○
I felt my CAMHS clinicians were tenacious (reliable)	○	○	○	○	○	○
I felt my CAMHS clinicians were flexible.	○	○	○	○	○	○
I felt my CAMHS clinicians instilled hope into me.	○	○	○	○	○	○
I felt emotionally supported by my CAMHS clinicians.	○	○	○	○	○	○
I felt practically supported by my CAMHS clinicians.	○	○	○	○	○	○
I felt reassured by my CAMHS clinicians.	○	○	○	○	○	○
I didn't feel judged by my CAMHS clinicians.	○	○	○	○	○	○
I felt listened to by my CAMHS clinicians.	○	○	○	○	○	○
I felt prepared for my transition from CAMHS to AMHS.	○	○	○	○	○	○
I felt that my transition from CAMHS to AMHS was sudden.	○	○	○	○	○	○
I felt involved in the transition planning process.	○	○	○	○	○	○

Appendix F Peri-Transition Items

Rate the extent to which you agree with the following statements using the scale provided.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Applicable
An Individualised care plan (transfer CPA) based on my own unique needs was designed to help with my transition from CAMHS to AMHS.	○	○	○	○	○	○
My individualised care plan was used during my transition from CAMHS to AMHS.	○	○	○	○	○	○
My individualised care plan was helpful during my transition from CAMHS to AMHS.	○	○	○	○	○	○

I felt my opinion was taken into account when decisions were made about my transition from CAMHS to AMHS.	○	○	○	○	○	○
I felt my concerns were taken into account when decisions were made about my transition from CAMHS to AMHS.	○	○	○	○	○	○
I felt emotionally supported by my GP when transitioning from CAMHS to AMHS.	○	○	○	○	○	○
I felt practically supported by my GP when transitioning from CAMHS to AMHS.	○	○	○	○	○	○
I engaged in a transition service to help with my transition from CAMHS to AMHS.	○	○	○	○	○	○
I felt fully informed about what was happening regarding my transition from CAMHS to AMHS.	○	○	○	○	○	○
I felt my transition from CAMHS to AMHS was undertaken gradually.	○	○	○	○	○	○
I felt my transition from CAMHS to AMHS was flexible in terms of timing.	○	○	○	○	○	○
I felt I had formed a close relationship with my CAMHS clinicians.	○	○	○	○	○	○
I felt I was able to contact my CAMHS clinicians when needed during my transition from CAMHS to AMHS.	○	○	○	○	○	○
Treatment in AMHS aimed to continue what I had previously been working on with CAMHS.	○	○	○	○	○	○
I felt I saw my CAMHS clinician regularly during my transition.	○	○	○	○	○	○
I felt I saw my AMHS clinician regularly during my transition.	○	○	○	○	○	○

Appendix G Post-Transition Items

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Applicable
I felt supported by staff at AMHS after my transition from CAMHS to AMHS.	○	○	○	○	○	○
I was offered practical support (i.e. life skills, help getting back into education, etc.) by AMHS clinicians.	○	○	○	○	○	○
I felt I had a say regarding my treatment choices in AMHS.	○	○	○	○	○	○
I felt I had a choice as to whether or not my parents could be involved in my care at AMHS.	○	○	○	○	○	○
I felt there was an abrupt reduction in parental involvement when I joined AMHS.	○	○	○	○	○	○
I felt comfortable with the reduction in parental involvement in my care when I moved from CAMHS to AMHS.	○	○	○	○	○	○
I felt supported by AMHS staff as an individual who had just transferred from CAMHS.	○	○	○	○	○	○
I felt my information was transferred effectively from CAMHS to AMHS.	○	○	○	○	○	○
I felt I had to keep repeating myself when I met with AMHS clinicians after my transition from CAMHS to AMHS.	○	○	○	○	○	○
My AHMS clinician(s) were informed about my diagnoses and treatments during my time in CAHMS	○	○	○	○	○	○
My experiences with AMHS have been positive	○	○	○	○	○	○

Appendix H Advert

Factors affecting the transition from child to adult mental health services.

Participate and get the chance to win 1 of 10 £40 amazon gift vouchers

What is the study about? This study explores experiences with young people's mental health care and adult mental health care and the possible transition period between them. This study aims to further understand the factors that need to be taken into consideration in the future, to help create better conditions for individuals transitioning from child to adult services.

What will I be asked to do? You will be asked to participate based on your experiences of accessing services. It will involve completing an online survey, which should take approximately 15-20 mins. If interested, please click on the link below.

https://www.isurvey.soton.ac.uk/32542

Contacts: This study is part of the Doctorate in Clinical Psychology (DClinPsych) training programme at the University of Southampton

If you have questions, please e-mail: Paris Williams (pw1u18@soton.ac.uk)

Appendix I Participant Information Sheet

Study Title: Factors affecting the transition from child to adult mental health services: A Quantitative Approach.

Researcher: Paris Williams, Dr Valerie Brandt, Dr Alison Bennetts

ERGO number: 46759

You are being invited to take part in the above research study because you are16 years old or over and you live in the UK. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether to take part. If you are happy to participate you will be asked to tick a box to indicate your consent.

What is the research about?

My name is Paris Williams and I'm currently studying the Doctorate of Clinical Psychology course at the University of Southampton. For my thesis I am looking into the factors that affect an individual's transition from child to adult mental health services. Specifically, I will be looking at pre-, peri- and post-transition factors as well as the effect of a client's attachment to their therapist on how the individual perceived the transition process.

What will happen to me if I take part?

Once you have clicked on the survey you will be directed to a series of questions about your experiences with child and adult mental health services in the UK. Once you have completed the survey you will be directed to a debrief form.

Are there any benefits in my taking part?

By taking part in this study you will also be helping us to identify factors that need to be taken into consideration in the future to help create better conditions for individuals

transitioning from child to adult mental health services. If you agree to take part, you will be entered into a prize draw for the chance of winning 1 of 10 £40 amazon vouchers in order to thank you for your participation.

If you are a Psychology student at the University of Southampton, you will receive 4 credits for taking part.

Are there any risks involved?

As this project is looking at experiences related to the topic of mental health, there may be a possibility that you could experience some emotional discomfort as a result of reflecting on your transitioning experience and personal struggles with mental health.

If you experience any emotional distress during or following the completion of the survey, please seek support from your clinician or you can contact Mind.org (Monday – Friday, 9am – 6pm) on 0300 123 3393 or the Samaritans (free 24-hour helpline) on 116 123.

Furthermore, the below websites may also be helpful:

- Mood Gym: https://moodgym.com.au
- Bite Back: https://www.biteback.org.au
- Beating the Blues: http://www.beatingtheblues.co.uk/

Lastly, at the end of the survey you have the option to complete a mood repair task.

Will my participation be confidential?

Your participation and the information we collect about you during the research will be kept strictly confidential. We will be collecting email-addresses, via a separate survey at the end of the main one, to give out the vouchers. Emails will be stored in a separate database to the main survey and drawn randomly for prize draw, after which the emails will be deleted.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All these people have a duty to keep your information, as a research participant, strictly confidential.

Following completion of the study, the anonymised data will be deposited at the university's institutional repository, therefore available for others to access (e.g. public or wider academic community). All research data will be stored in accordance with the University of Southampton's policy and should be held for a minimum of 10 years. The university's research data management policy can be found on its website http://www.calendar.soton.ac.uk/sectionIV/research-data-management.html.

Do I have to take part?

No, it is entirely up to you to decide whether to take part. If you decide you want to take part, you will need to indicate your consent by ticking the consent box provided to show you have agreed to take part. You can withdraw from the study up to the point of submission by closing your browser window. Once you have submitted your data, it cannot be withdrawn because it is anonymous.

What happens if I change my mind?

You have the right to change your mind without giving a reason and withdraw up to the point of submission by closing the window.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Where can I get more information?

If you wish to gain more information about this research project, please don't hesitate to contact a member of the research team: Paris Williams (pw1u18@soton.ac.uk) , Dr Valerie Brandt; V.C.Brandt@soton.ac.uk, Dr Alison Bennetts; a.bennetts@soton.ac.uk.

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions.

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University must ensure that it is in the public interest when we use personally identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and can identify a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you.

Appendix J Participant Debrief Form

The aim of this research was to explore the factors affecting the transition quality individuals experience, when transitioning from child to adult mental health services in the UK.

Pre-, peri- and post-transition factors were explored, in addition to the effect of individuals attachment to their therapist. It is expected that the factors measured in this study (i.e. clinician qualities, timings of the transition and support received) would significantly predict how well an individual perceived their transition. It is also expected that the type of attachment an individual had to their therapist; will significantly predict how well they perceived their transition.

Your data will help expand our understanding of the factors that affect transition and will provide the basis for suggestions on how to improve this process. Once again, the results of this study will not include your name or any other identifying characteristics.

If you experience any emotional distress during or following the completion of the survey, please seek support from your clinician or you can contact Mind (Monday – Friday, 9am – 6pm) on 0300 123 3393 or the Samaritans (free 24 hour helpline) on 116 123. Furthermore, you may find the following websites helpful:

- Mood Gym: https://moodgym.com.au
- Bite Back: https://www.biteback.org.au
- Beating the Blues: http://www.beatingtheblues.co.uk/

If you have any further questions, please contact me Paris Williams on pw1u18@soton.ac.uk, Dr Valerie Brandt on V.C.Brandt@soton.ac.uk or Dr Alison Bennetts on a.bennetts@soton.ac.uk.

Thank you again for your participation in this research project.

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

This is an optional task which can be completed at any time after taking part in the research study. Please read each of the jokes below and rate how funny you found each one on the scale provided.

1= Not at all funny, 4= very funny.

1	2	3	4
○	○	○	○

1	2	3	4
○	○	○	○

Appendix K Factor loadings: Transition Satisfaction

Factor loadings for transition satisfaction factors

	Transition satisfaction	Transition unhappiness
I was happy with my transition from CAMHS to AHMS	**.885**	-.201
I was happy with the support I received with regards to my transition from CAMHS to AMHS.	**.877**	-.062
I am satisfied with my transition from CAMHS to AHMS	**.816**	-.291
I suffered during my transition from CAMHS to AHMS	-.150	.845
My mental health took a turn for the worse during my transition from CAMHS to AHMS because of the transition	-.181	.838

Appendix L Factor loadings: Pre-Transition

Factor loadings for Pre-Transition Factors

	Clinician Factors	Transition Planning
Good Relational with clinician	**.872**	.033
My clinician was reliable	**.843**	-.028
My clinician was flexible	**.716**	-.042
My clinician Instilled hope in me	**.869**	.102
I felt emotionally supported by my CAMHS clinician	**.912**	.150
I felt practically supported by my CAMHS clinician	**.829**	.102
I felt reassured by my CAMHS clinician	**.915**	.118
I didn't feel judged by my CAMHS clinician	**.718**	.210
I felt listened to by my CAMHS clinicians.	**.832**	.237
I felt prepared for my transition from CAMHS to AMHS.	.100	**.893**
I felt that my transition from CAMHS to AMHS was sudden.	**.301**	-.194
I felt involved in the transition planning process	.133	**.907**

Appendix M Factor loadings: Peri-Transition

Factor loadings for Peri-Transition Factors

	Involvement in transition	Transition Structure	GP Support
An Individualised care plan (transfer CPA) based on my own unique needs was designed to help with my transition from CAMHS to AMHS	.554	**.582**	.211
My individualised care plan was used during my transition from CAMHS to AMHS.	.513	**.711**	.039
My individualised care plan was helpful during my transition from CAMHS to AMHS.	.362	**.799**	.132
I felt my opinion was taken into account when decisions were made about my transition from CAMHS to AMHS.	**.783**	.385	.197
I felt my concerns were taken into account when decisions were made about my transition from CAMHS to AMHS.	**.793**	.311	.313
I felt emotionally supported by my GP when transitioning from CAMHS to AMHS.	.222	.145	**.953**
I felt practically supported by my GP when transitioning from CAMHS to AMHS.	.239	.138	**.945**
I engaged in a transition service to help with my transition from CAMHS to AMHS.	.006	**.829**	.114
I felt fully informed about what was happening regarding my transition from CAMHS to AMHS	**.742**	.368	.344
I felt my transition from CAMHS to AMHS was undertaken gradually.	**.798**	.020	.156
I felt my transition from CAMHS to AMHS was flexible in terms of timing.	**.855**	.087	.159
I felt I had formed a close relationship with my CAMHS clinicians.	**.537**	.235	.025
I felt I was able to contact my CAMHS clinicians when needed during my transition from CAMHS to AMHS.	**.772**	.367	.082
Treatment in AMHS aimed to continue what I had previously been working on with CAMHS.	.472	**.478**	.197
I felt I saw my CAMHS clinician regularly during my transition.	**.808**	.332	.207
I felt I saw my AMHS clinician regularly during my transition	**.701**	.254	.287

Appendix N Factor loadings: Post-Transition

Factor loadings for Post-Transition Factors

	Positive AMH Experience	Positive Parent Involvement	Transition efficiency	Reduction in parental involvement
I felt supported by staff at AMHS after my transition from CAMHS to AMHS	**.836**	.015	.227	.189
I was offered practical support (i.e. life skills, help getting back into education, etc.) by AMHS clinicians	.140	.409	**.616**	.349
I felt I had a say regarding my treatment choices in AMHS.	**.837**	.256	.151	.040
I felt I had a choice as to whether or not my parents could be involved in my care at AMHS	.339	**.811**	.123	-1.07
I felt there was an abrupt reduction in parental involvement when I joined AMHS.	.133	.139	.115	**.928**
I felt comfortable with the reduction in parental involvement in my care when I moved from CAMHS to AMHS	.064	**.830**	-.143	.375
I felt supported by AMHS staff as an individual who had just transferred from CAMHS	**.840**	-0.020	-154	.181
I felt my information was transferred effectively from CAMHS to AMHS.	**.849**	.109	-.008	-.073
I felt I had to keep repeating myself when I met with AMHS clinicians after my transition from CAMHS to AMHS.	.130	-.168	**-.866**	.082
My AHMS clinician(s) were informed about my diagnoses and treatments during my time in CAHMS	.486	-.143	**.581**	.285
My experiences with AMHS have been positive	**.861**	.221	.003	.164