Mental health services for young people: matching the service to the need

Max Birchwood and Swaran P. Singh

Summary
It is now known that the onset of severe and recurring mental health problems begins for the most part before the age of 25: this provides a clear focus for preventive strategies and public mental health that are a feature of many health policy frameworks. The present distinction between child and adolescent mental health services and adult services at 16 or 18 does not fit easily with these data and the now well-documented problems of transition suggest that a fundamental review of services for young people is overdue. This supplement provides an overview of the epidemiological, conceptual and service structures for young people with emergent and existing mental health problems, and asks the question, ‘How should we design services for young people to promote prevention and service engagement, and to improve outcomes?’

Declaration of interest
None.

Matching service to need
How best should we provide mental health support to our young people? For many years the international care model has distinguished the child and adolescent mental health service (CAMHS) pathway for those aged up to 18 years (or 16 years in some settings) from adult mental health services (AMHS). The developmental dimension described above broadly supports such a distinction, particularly if opportunities for prevention are realised. Singh et al, however, reported that the transition from CAMHS to AMHS is problematic for many adolescents, with a large proportion dropping through a care gap between the two services and losing much-needed continuity of care. Adolescents with a serious mental illness such as psychosis or bipolar affective disorder under CAMHS care do get referred to adult care, especially if in receipt of medication or admitted to hospital. However, young people with conditions such as attention-deficit hyperactivity disorder (ADHD), autism spectrum disorders, mild intellectual disability, emotional and neurotic disorders and emerging personality disorder are either not referred to adult care or if referred are not accepted. Those who do make the journey across services feel unprepared for the transition and the abrupt cultural shift from a child-centred developmental approach to the adult care model. It is perhaps for this reason that many disengage from adult services. For the majority, transition is poorly planned, poorly executed and poorly experienced. Singh et al reported that many felt overburdened and others felt...
abandoned by services.\textsuperscript{10,11} Clearly this lamentable state of affairs needs to be corrected.

The question then arises whether the problems with the CAMHS–AMHS distinction at age 16 or 18 years can be remedied, or whether we should consider it as fundamentally flawed and a structural impediment to care and treatment. Jones describes a steep rise in age incidence at this time,\textsuperscript{2} and McGorry\textit{ et al} argue therefore that ‘the current system is weakest where it needs to be strongest’.\textsuperscript{1} McGorry\textit{ et al} challenge us to consider whether, if we were to design services now, we would propose the present structure or argue instead that a care pathway from age 12 years to 25 years best fits epidemiological data and clinical need.\textsuperscript{12} According to McGorry\textit{ et al} this would fit with international definitions of youth, and incidentally in the UK would align with local authority definitions.\textsuperscript{12} 

Lamb\textit{ & Murphy} present a considered analysis of the current position and options from a CAMHS perspective.\textsuperscript{13} They argue that separate commissioning frameworks for CAMHS and AMHS potentiate discontinuities and are inimical to good care and effective use of resources. They raise critical questions about the potential for future service redesign. McGorry\textit{ et al} describe alternative service models from the different settings of Australia, Ireland and England.\textsuperscript{12} Neither the status quo nor these alternative models have clear evidence of efficacy; McGorry\textit{ et al} argue that the issue here is to agree on the criteria that need to be followed in designing such services, for example that they are aligned to evidence on epidemiology and age at onset and meet opportunities for prevention.\textsuperscript{12} These two papers, by Lamb\textit{ & Murphy} and McGorry\textit{ et al}, together lay out the critical issues in reforming mental health services for our young people.\textsuperscript{12,13}

### Concluding remarks

In the UK a zeitgeist has emerged in government policy encouraging more systematic attention to public mental health and prevention, one that the Royal College of Psychiatrists has strongly endorsed.\textsuperscript{14} A consistent theme of the papers in this supplement is that we can realise this aspiration by a fundamental review and reform of mental health services for young people so as to give them (and us) the best opportunity to prevent lifelong recurrence. We hope that this supplement will trigger a much-needed debate about the future of services for our young people so that, unlike Socrates, we will no longer look upon them as a lost cause.

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### References

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