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Delivering better outcomes for children and young adults – new service models and better transitions across mental health

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POSITION STATEMENT

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Introduction

The Royal College of Psychiatrists (RCPsych) welcomes the focus of the NHS Long Term Plan on children and young people's mental health, including the commitment to "extend current service models to create a comprehensive offer for 0 to 25-year-olds that reaches across mental health services for children, young people and adults" (NHS, 2019). Infants, children, young people and young adults (0–25s) have diverse needs. To create better services for them we need to strengthen the workforce, system and culture that understand the developmental needs of each age group (infants, children, adolescents, young adults), their unique history and context, how this relates to the mental health problems they present with, as well as understanding the impact of developmental disorders. While the NHS Long Term Plan is specific to England, these age groups face challenges accessing care across the UK, making this paper relevant to all four nations (also Scottish Government 2017, Welsh Government 2020, NI Department of Health 2021).

The College welcomes the move to more seamless service provision for young adults and recognises the need for flexibility for local areas to take account of differences in services already available, resources and the variances in populations. There is clearly an urgent need to shift away from age-based transitions to transitions that are built around individual patient's needs, to ensure a cohesive therapeutic journey. It is also clear from experiences to date that where accessible and developmentally appropriate services are offered, there is a significant increase in demand for services. It is therefore vital that services are adequately resourced for them to become established and sustainable in this context (O'Shea and McHayle, 2021). Additionally, there are some substantive challenges in developing better services for young adults that need to be considered and addressed, both by local areas working to determine what 'menu of services' best meets the needs of their local population and broader challenges that will need to be addressed at regional or national levels.

The purpose of this statement is to identify these challenges with a view to working with stakeholders, including NHS England and the devolved nations' counterparts, to address them. It has been informed by members of the College's Child and Adolescent and General Adult faculties, as well as consultation with other faculties, and with patients and carers. In considering how the services could work, this statement sets out key principles, identifies challenges and discusses five general and non-mutually exclusive models to inform opportunities to improve transitions for young adults.

Additional considerations since COVID-19

Young people are one of the most vulnerable groups to be adversely affected by the economic and educational impacts of the pandemic. These young people are likely to have significant additional mental health needs in years to come and, in response, it is important for our services to develop an improved offer for this group. Parents with young children have also been identified as a group whose mental health has been particularly adversely affected by the pandemic. The Covid crisis has demonstrated how quickly services can adapt in challenging times and this impetus must now be harnessed to speed up the development of appropriate services and fulfil the aspirations of the NHS Long Term Plan, including the urgent development of appropriate workforce plans.

Background

Creating a comprehensive service offer for children and young people aged 0–25 will require considerable effort. While the strengthening of existing specialist Child and Adolescent Mental Health Services (CAMHS) will be key to this agenda (and subject to a forthcoming report by the RCPsych), the delivery of the 0–25 commitment will hinge on the expansion and improvement of services for age groups who currently often fall through the cracks of specialist provision, namely infants and children under the age of five and children and young adults between the ages of 18 and 25. Throughout this document we will use the term children and young people (CYP) to denote infants, children and young people up to the age of 18 years and young adults for those aged 18–25 years.

The importance of the early years, including pregnancy, as a foundation for the future mental and physical health of older children, adolescents and adults means that special consideration should be given to 0 to 5-year-olds in particular. The spotlight on adverse childhood experiences (ACEs) and intergenerational trauma in the UK and across the world, though not without complexity, has highlighted the importance of preventative therapeutic interventions which both target underlying risk factors and support family strengths and resilience early enough in a child's life to have maximal positive impact (Early Intervention Foundation, 2020). While not discussed in detail in this paper, the College intends to publish a position paper focused on specialist mental health provision for infants and children under the age of five years and their parents/carers, recognising the importance of collaboration across different mental health specialties as well as services across health, social care, education and the third sector. Challenges that may arise when teenagers and young adults with complex mental health problems become parents will also be covered in this forthcoming college early years' report.

The focus of this paper is the transition from CAMHS to adult mental health services (AMHS). It is well documented and researched that this transition is seldom smooth and can be a very difficult time for service users and their families. There is little difference in the values or aims of AMHS and CAMHS, both are based around the provision of holistic care that meets all of the patient's needs with a focus on ensuring that there is multi-agency working where required. However, the developmental focus and different legal aspects of some care with children and young people can make the services appear different.

Transitions to AMHS generally occur when young people are most vulnerable, at a time of major physiological, emotional and social change in young people's lives (Jones, 2013). There are also CYP with difficulties that do not transition to AMHS but who continue to need help and therefore fall though the gaps as thresholds for CAMHS and AMH vary (e.g. a young adult with ADHD on medication may not be accepted by adult services). These difficulties may be further exacerbated by differences in transition age ranges for social care services and education provision. There are also young people who need developmentally appropriate and easily accessible services across all levels of mental health need de novo who are currently poorly served (e.g. 17- or 18-year-olds with eating disorders and requiring physical treatment but who are too old to access paediatric services)

The NHS Long Term Plan committed to address this problem with a new approach to young adult mental health services for people aged 18–25 which will support the transition to adulthood and bridge this traditional gap in services, as well as better provision for those who may not have attended specialist CAMHS but need mental health provision at this age. Its Implementation Plan for 2019/20 to 2023/24 further stipulated that there will be a 'menu' of models which local systems can draw from to provide services for 0–25s. It also includes a commitment to student mental health which is welcome, particularly since this population's mental health was adversely affected by the Covid pandemic and associated lockdowns. NICE (2016) guidelines and the Commissioning for Quality and Innovation (CQUIN) scheme (NHS, 2017) have provided further information.

As part of efforts to implement the Long Term Plan, local areas are already advancing efforts to provide better and more aligned care for young adults, leveraging baseline and transformation funding announced by NHSE and drawing on different service models and lessons learned from across the country to develop local solutions. Likewise, in other parts of the UK, there has been the development of policy and funding released to improve the experience of young adults accessing mental health services. For example, in Scotland funding has been made available to support the transition between mental health services of particularly vulnerable young people, like those who are looked after and accommodated or have an intellectual disability. In Wales the ALN reforms which include 0–25 years are providing an opportunity for health and education to work together to support young people with mental health needs and address some of the mental health challenges faced by students in further education settings who often get lost to services after leaving school.

In considering how the services could work, this document sets out key principles, identifies key challenges and includes discussion about five general, and non-mutually exclusive, models to improve transitions for young adults.

Key principles

There are a number of key principles which should underpin all young adult mental health services regardless of the model they use. These are:

- integrated across systems
- young adult centred; values driven with shared decision making
- quality, evidence and outcomes driven
- flexible and accessible service design with fewer barriers
- planned in collaboration with families (where appropriate) and future proofed, rather than reactive service reconfiguration
- workforce with the appropriate training, with access to high-quality continuing professional development and protected reflective supervision
- flexibility around service transition age cut offs
- streamlining the system for easier access for young adults and their families
- joined-up approach across agencies, to avoid gaps in service provision
- use of local data to help guide the nature of service provision
- commissioning for impact, wherein services are commissioned with a view to reducing existing health inequalities.

Summary NCCMH principles

- Co-produced with young adults
- Age-appropriate care
- Need and complexity-based care
- Youth-friendly and non-stigmatising
- Early identification
- Early access, flexibility and choice
- Partnerships and integrated working
- Effective management transitions

Involvement of young people and their families and carers

It is important that service users and families are involved throughout the planning and implementation phases of any new service, as their input to decision makers on what they need, what works and what doesn't is crucial. This ensures services are fit for purpose and that there is greater buy-in from the groups they are aiming to serve.

For example, young people played a significant role in the development of JIGSAW Ireland and continue to play a role in day-to-day decision making and strategic planning (Jigsaw, 2020). Young people also contribute content to JIGSAW's website, ensuring that the information available is age appropriate and accessible.

The participation group, consisting of young adults and carers, who contributed to this document developed the following recommendations for the development of 0–25 services/youth services:

1. Any transition between services is difficult but the move to adult services at 18 comes at a time in a young person's life when they are dealing with many different transitions at once and can be made more vulnerable due to a change in their mental health service provision. With this in mind, the participation group broadly welcomes the idea of 0–25 services.

2. At 25 there will still be a transition; this should be managed with clear transition protocols and procedures to avoid 'another cliff edge'.

3. Any future service design(s) should be co-produced with young adults and carers.

4. These services should retain an ethos of co-production and participation involving young adults and carers in continuing service development including staff training and recruitment.

5. New service(s) should be person centred and work with young adults as individuals; this is particularly important given the age ranges involved and the differing requirements of individuals at different ages. Some young adults would benefit from a more CAMHS style nurturing approach but others of the same age might feel this to be infantilising.

6. It will be important for staff to have training across each age range and have an understanding of age-appropriate options and flexibility.

7. A 'menu' of service models must not result in a 'postcode lottery' in service provision. Different language and terminology being used to describe similar services should be avoided as this is a barrier for young adults and carers to understand service provision.

8. Clear funding arrangements to ensure young adults do not get stuck when there is a lack of clarity. Access to appropriate treatment being stymied or delayed due to funding delay can have a serious impact on recovery.

Reflection piece by a participation consultant and member of the participation group

"I recently had the opportunity to contribute to the workshop on transition and the possibility of a 0–25 service, at the Child and Adolescent Royal College of Psychiatry Annual Conference. It was very interesting to hear about ongoing research and arguments for and against a 0–25 service. During the workshop, I discussed that, fortunately, I had never had to go through the transition from CAMHS to adult services as I was discharged from CAMHS before I turned eighteen. However, I have known friends who have gone through the transition and I have seen young people transitioning through my placements as a student mental health nurse. I have seen young people going through a very smooth and positive transition from CAMHS to adult services but I have also seen young people who have described the transition to be very unsettling and worrying.

At the conference, I spoke about how I think that I, personally, would have found transiting from CAMHS services to adult services to be extremely difficult and anxiety provoking. Having been a patient in CAMHS for a number of years, I had built a strong therapeutic relationship with my nurse. I felt that I could really trust her and could be totally honest with her about how I was feeling. I also felt that she understood me and she was always able to tell when I wasn't myself or if I was struggling. I feel that it would have been such a shame to have developed such a good relationship with my nurse, to then be discharged at the age of eighteen and put into the care of someone new, only for the process of getting to know each other to start again. I imagine that this process would have been extremely anxiety provoking for me and perhaps have even caused a deterioration in my mental state.
I also feel that eighteen is often not the best age to introduce such a big change to young people. While transition will be hard at any age, at eighteen young people are undertaking stressful examinations; moving away from home to university; starting their first job; building relationships and friendships etc. Perhaps, waiting until the young person is slightly older before transitioning would be a positive change."

Key challenges

Within CAMHS there is a developmental focus with the work informed by a child protection framework and the need to review and revise their developing capacity and ability to give fully informed consent. Adolescence is a time of significant brain development and can be a time of psychological turmoil and extreme emotional dysregulation which can create acute risk to the young people when combined with mental illness. At best this can result in intensive multi-agency input with health, education, social services and the third sector potentially involved to keep the young person safe. However, from the age of 16 years, the legal frameworks and the level of support from services can change dramatically with the young person given more autonomy over how they live their life and access to services. Within adult mental health services, unless the young adult meets the threshold for use of the Mental Health Acts, there is no remit to provide assessment, diagnosis or treatment if they do not request it and attend appointments offered. This is in keeping with the model for adults with the capacity to accept or refuse treatment but in the case of young adults it requires a significant shift in their organisational abilities and assertiveness in seeking treatment at a time when there may also be major changes in their life circumstances, e.g. leaving full-time education, moving home for education or employment purposes and possibly leaving the care system. There are also young adults with neurodevelopmental conditions who may not have received a formal assessment and diagnosis of their difficulties who struggle to access support within the adult model of care.

This results in real challenges for developing effective, seamless services for young people and young adults as they transition between specialist CAMHS and adult provision, both in terms of ensuring developmentally appropriate and holistic care is offered to individual patients and enabling staff with different expertise, approaches and terminology to support them. Below, we set out a number of specific challenges that local areas must consider when strengthening their offer for young adults.

Workforce and demand issues

The proportion of children aged five to 16 struggling with poor mental health has increased substantially since 2017, with a survey conducted in early 2021 finding one in six children (17.4%) having a probable mental disorder, compared to just one in nine (10.8%) in 2017 (NHS Digital, 2021). This has translated into unprecedented pressure on CAMHS services. Between April and June 2021, 190,271 0 to 18-year-olds were referred to children and young people's mental health services, up 134% on the same period in 2020 and 96% compared to 2019. As a result, long waiting lists and unaccepted referrals are still a real challenge for CAMHS services (Lennon, 2021).

While teenagers and young adults are at higher risk of developing mental health problems, they are also often less likely to seek out support (Centre for Mental Health, 2016). Pre-pandemic, it was estimated that around 20% of young people aged 16–25 experience a diagnosable mental illness during early adulthood (McManus, 2007). We also know that young adults often struggle to access services, with some studies suggesting an average of 10 years between the first onset of symptoms and patients accessing support (Kessler et al, 2005).

In order to deliver better outcomes for this group, there will be a significant impact and demand on workforce. Workforce issues require careful consideration, particularly in light of current workforce shortages. The most recent fill rates for higher training posts in child and adolescent psychiatry and general adult psychiatry are only 81% and 80% respectively (HEE, 2021). This issue will need to be addressed to ensure an adequate workforce in future years.

Wide variation in transition points

There is significant variation in transition points for different mental health services, which varies across the country, by service type and in line with various legislation. This creates a very complex care environment.

In some areas, CAMHS services end at aged 18, whereas for others it is 16, 17 or 19. Specialist services can have even wider variation – for example, Forward Thinking Birmingham provides early intervention in psychosis services up to age 35 while their eating disorder services work with young people until age 25 (Forward Thinking Birmingham, 2020).

This is compounded by varying provisions of the Mental Health Act across the UK, where different sections apply to young people under the age of 16 or 18. Similarly, the Children's Act makes provisions for local authority services for under 18s, under 19s or under 25s. There are also service-specific NICE guidelines for transitions where this is the case.

It is important that these differences are mapped and recognised in how services are developed.

Leadership needed to deliver change

Leaders play a crucial role in enabling and encouraging closer working between child and adult services – good leadership is needed to bind them together. No matter what models an area selects from the 'menu', good leadership will ensure that there is buy-in and that implementation is a success.

Available reviews of already implemented youth mental health services reinforce this with leadership cited as a key driver of success.

Birchwood et al (2018) state that informants on their evaluation of Forward Thinking Birmingham believed that strong leadership was important in the face of inertia and collaborative problems. This was particularly important in the case of Forward Thinking Birmingham which implemented radical changes to young adult services.

Leadership was also instrumental in the development and successful implementation of the JIGSAW services for young people in Ireland, with Illback and Bates (2011) citing leadership as the most important ingredient for change.

NHSE and the NHS in the devolved nations must therefore work with leaders at both a strategic and operational level. Clinical leaders need to have capacity, both in terms of protected time and appropriate training and management support, to enable them to lead by example and work across teams to deliver any necessary change.

Service alignment across CAMHS and AMHS

There are a number of key differences in the way services are delivered in CAMHS and AMHS and the types of services provided. This is one of the key issues for service users transitioning from CAMHS or AMHS, in addition to the resources needed to provide services.

Attention deficit hyperactivity disorder (ADHD) services are an example of this as evidence shows that some young people with ADHD who still need support and help from services do not successfully transition from CAMHS to AMHS (Buitelaar, 2017). Part of the reason for this is the different thresholds for admission between CAMHS and AMHS but resources are also key. Adult ADHD has now been identified as a long-standing unmet need and funding and expertise are needed to address this (Crimslick, 2011). These young adults may present via another route, often the criminal justice system.

In addition, there are issues with transition for young people with emotional instability who may or may not have been given a diagnosis of emerging personality disorder. Improving access to psychological therapies (IAPT) is rarely a separate service in CAMHS and comprehensive dialectical behaviour therapy (DBT) services are currently the exception rather than the rule for the under 18s. CAMHS community teams are rarely linked to a social care team; there is limited access to therapeutic or supported accommodation outside of an inpatient admission and there may be no access to specialist learning disability services.

These variances between CAMHS and AMHS need to be identified and the needs of young people considered when models are developed and implemented to ensure that service users have seamless care, no matter the speciality or disorder. Transitions between services are guaranteed to fail if there is no appropriate service into which young people can transition.

Consideration of student mental health has already been included in the NHS Long Term Plan, which commits “to build the capability and capacity of universities to improve student welfare services and improve access to mental health services for the student population, including focusing on suicide reduction, improving access to psychological therapies and groups of students with particular vulnerabilities”. This is particularly welcome given the negative impact of the Covid-19 pandemic on students’ mental health.

Common language to deliver services

Currently some CAMHS and AMHS operate very separately with different professional terminology. This causes confusion for staff and patients alike. There is concern that the introduction of a menu of service models will create further confusion due to a lack of common language.

Much of the language which underpins CAMHS does not translate to AMHS. Anecdotally we have heard from AMHS clinicians that i-Thrive (Wolpert et al, 2019), which is central to the 0–25 ambitions in the Long Term Plan, does not resonate and that currently there is little understanding of its meaning. This is something that needs to be considered and addressed with urgency if the concept of i-Thrive is going to underpin the ambitions in the Long Term Plan.

A common language developed by all mental health specialities should be used when creating new models for services.

Key training considerations

There is a wide variation as to how much psychiatry teaching occurs in medical schools but there will be lectures mainly in adult psychiatry (18 onwards) with a limited number of lectures for CAMHS (0–18). The situation is similar in the paramedical training programmes.

In core psychiatric training, all doctors focus mainly on adult psychiatry with usually all of the three years in training spent in adult services except for just six months in developmental psychiatry with a placement based in CAMHS or intellectual disability services and sessions in the other. It is not until higher specialist training that a significant amount of time is spent in CAMHS for those who choose to specialise in child and adolescent psychiatry. From this stage onwards there is little crossover in training. This means that, for 0–25 services at the present time, doctors will need to keep to their specialist area of 0–18 or 18–65/70.

However, with the credentialing process now being piloted by the General Medical Council (GMC), a good solution would be the development of a youth services credential, training CAMHS specialists to work up to 25 and AMHS specialists to work down to 14/16. This will require development and funding to be made available.

Regardless of the model, development would need to ensure that the workforce can have the training time and resources to adapt and provide effective and safe services. This would have implications for employers (providers of services). Similarly, there would need to be an explicit acknowledgment and investment in resources to ensure trainees can access training pathways and appropriately trained clinical supervisors so that they may be employed in such services.

Commissioning

Delivering seamless, integrated services for children and young people has been a recurring issue in mental health policy. Despite the complexity of this, the combined skills, capacity and capability across clinical commissioning groups/integrated care systems (CCGs/ICSs), local authorities, primary care networks, provider collaboratives and NHS England should be harnessed to drive a family mental health approach that supports the delivery of the NHS Long Term Plan. Multi-agency approaches are critical to meeting the needs of young adult patients. A further discussion of commissioning services for children and young people aged 0–25 years, including services linked to higher education institutions, is included in the appendix.

Different models for a comprehensive 0–25 offer underpinned by principles

- **CAMHS extending to 25 years**
- **AMHS continue treating young adults (16/18–25s)**
- **A new service for 18–25s**
- **Staff who manage transitions between CAMHS and AMHS**
- **A flexible boundary between services at around age 18**

Young adults are at a uniquely exciting and challenging time in their lives. The adolescent brain develops unevenly but they are primed to learn, develop friendships and sexual relationships and make sense of their place in the world. Opportunities to develop in these areas have been affected by the Covid-19 pandemic which highlights the need for services to assess and offer support for young adults according to their needs and abilities, rather than strictly according to a chronological age. Their increased acceptance of mental health difficulties, which they often see as important as physical health problems, provides an opportunity to work with them to co-produce services which are accessible and meet their needs.

We have considered how these 0–25 services could work by examining four general models, which may be adapted and applied in different arrangements based on local area populations and services. Given the significant increase in referrals to service for under 18s over the past few years, it is untenable to consider that specialist CAMHS could just "see up to 25-year-olds" without a huge increase in funding and expansion of the workforce. These models are not mutually exclusive and can be combined in different ways, across different services, to meet local population needs. The precise design of local pathways should also incorporate a multi-agency approach to meeting the needs of young adult patients. Each model comes with its own benefits and challenges which need to be properly considered. Some of these considerations are highlighted below.

CAMHS extending to 25 years

Extending CAMHS to service young adults up to the age of 25 would solve the problem of transition occurring at 18 when services users are often going through a number of other changes. However, as mentioned previously, the increased prevalence of mental health disorders and increased demand for services which has been seen over the past few years among the 5 to 18-year-olds is already overwhelming specialist CAMHS.

AMHS continue treating young adults (16/18–25s)

This is the very much the status quo of what is currently available to young adults but improvements and resources are needed to ensure that services are better aligned so patients do not fall through the gap. Staff must be properly trained and feel confident to deal with disorders (such as ADHD) and able to provide family-based approaches where indicated. CAMHS and AMHS need better alignment and protocols that should be closely followed (such as the NICE (2016) guidelines for transition).

However, this model does not address the longstanding issue of transition at aged 18 (or 16 in some areas) when young people are vulnerable. In addition, an increased workforce is required with additional training and supervision needs if we are to meet the needs of young people who currently do not meet the threshold for AMHS.

A new service for 18–25s

A new service for 18–25s would provide specialist developmental and age-appropriate treatment. There would be opportunity for new services to be developed in conjunction with young people ensuring that they are accessible and suitable. This will however be very costly and will likely require significant capital investment.

A specialist 18–25 service would mean that young people would potentially go through twice as many transitions, one when they are 18 and then again when they are 25. This is a considerable risk when transitions as they currently stand do not always go smoothly.

Staff who manage transitions between CAMHS and AMHS

A specialist group of staff who manage transitions is another way a comprehensive offer for 0–25s could be implemented, e.g. transition navigators. These staff members would work across both CAMHS and AMHS, guiding young people and their families. They would take away the administrative burden of managing transitions from clinicians and allow them to focus on patients' mental health needs.

For these staff members to work seamlessly across both CAMHS and AMHS better information services are needed so that there is access to appropriate patient information when and where patients need it. On its own, however, this model does not address the significant level of unmet need due to threshold differences between services and the additional resources required to meet this need.

A flexible boundary between services at around age 18

This model works well for the boundary between general adult and older adults services. This could support a more person-centred approach which reflects the needs of the young adult and not just their chronological age. This model offers the best opportunity to develop collaborative practices and care pathways between CAMHS and AMHS with minimal disruption to young adults. Training and additional staffing would need to be provided to support a more developmental focus within AMHS and to allow CAMHS

clinicians to provide a gradual transition past the age of 18 years, where this better meets the needs of the young adult. This work would also need to join up with education, social care and voluntary, community and social enterprise (VCSE) organisations but, if properly implemented, could offer the best option to improve the experience of transition for young adults.

Mental health support in higher education

Achieving better outcomes in transitions for young adults entering higher education has gained much attention with media coverage of several student suicides over recent years. This group are at risk of falling through the gaps when they leave home at a time of significant transition and experience challenges in accessing care. As with many other transitions between services, collaboration across health specialities, education and third sector is just as important as the involvement of the student voice, teaching unions and parents or carers. Special consideration will need to be given to communication and consent to information sharing in this group and to developing appropriate protocols for the sharing of confidential and sensitive information.

The Royal College of Psychiatrists' Report (Mental health of higher education students; CR231, May 2021) highlights these issues and barriers to smooth transition of care and integrated provision. There are various pathways to care that may be accessed when a student is experiencing psychological distress. Some students will access specialist psychiatric care through referral by their GP, while others will seek help through counselling and services provided by the third sector and higher education institutions. There is often a lack of coordination and integration between these services. The report outlines eight solution-based recommendations which should inform the work with commissioners, service providers and partner agencies to improve the mental health support available and encourage interprofessional working to improve outcomes for students in higher education.

Some higher education institutions are already advancing efforts to provide better mental health support and transitions. Policies have been proposed by bodies such as Universities UK, which promotes mental health as a strategic priority and takes a whole university approach. That is for universities to be places that promote mental health and wellbeing, enabling all students and all staff to thrive and succeed to their best potential. Stepchange: mentally healthy universities provides a co-produced shared framework for change and a self-assessment tool produced with the Child Outcomes Research Consortium (CORC) for leaders of schools, colleges, universities and community organisations to take a whole organisation approach to the mental health of their students, young people and staff.

Recommendations for services

The RCPsych supports local services in working out how best to meet the needs of young people who need to transition into adult services or access them de novo in the context of their existing services and funding arrangements which will vary across the country. One size does not fit all but current services are not meeting the needs of young people and change is required. It is essential that any development is joined up with improvements to services for infants and children. Increased investment in mental health services will be critical to delivering on the ambitions of the NHS Long Term Plan and system leaders will need to keep a close watch to respond to changes in demand as services are adapted and expanded.

1 Strategic, operational and clinical leaders need to be given protected time to undertake the work required to expand and harmonise services to better meet the needs of young adults, which must include proactive efforts to develop a common language to describe services and bridge cultural differences across CYP and adult services.

2 Young people and their parents/carers should be at the centre of their individual transition planning between specialist mental health services and have a role in the wider service development and delivery. Clinical information from specialist CAMHS should be shared with the young adult and AMHS and different IT systems should not be a barrier to good information sharing.

3 National and local commissioners should support joint working between leaders of CAMHS, AMHS, local authority services and third sector organisations to improve the experience for young people of transition between mental health services. Additional funding is likely to be required to meet increased demand and for additional staff to support carefully planned transitions which should feel virtually seamless for the young person themselves.

4 Training needs should be identified for staff working within CAMHS and AMHS to support developmentally appropriate clinical care with an emphasis on equality, diversity and inclusion. The RCPsych should develop training programmes for psychiatrists to work with 0–5s, under 18s and 18–25s when this is not part of their specialist training.

5 People of all ages need safe, comfortable and confidential mental health facilities. These should be developmentally appropriate and children, young people and vulnerable young adults need consideration particularly regarding access to a safe and calm environment.

6 Access to advocacy should be made available to all young people. High-quality information about AMHS which has been co-produced with young adults should be provided in different media/languages for young people who are moving from CAMHS to AMHS.

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Appendix – Commissioning

Commissioning the mental health system for children and young people 0–25 years – A family mental health approach

A key recurring issue that comes up in children and young people's mental health policy is the need for a seamless, integrated service. This has proved difficult for 5 to 18-year-olds, so a seamless service for 0–25s is likely to be even more challenging but some models do exist. Whilst they will have their issues, they at least demonstrate that it can be done.

Despite the complexity of this, the NHS Long Term Plan should be utilised to reorient services that will allow commissioners and providers of public services to focus on a preventative approach harnessing the combined skills, capacity and capability across local authorities, primary care networks (PCNs), integrated care boards (ICBs), integrated care partnerships (ICPs,) place-based systems, provider collaboratives and NHS England.

The planning and commissioning of services needs to be guided by data and population health management to ensure that services meet local needs, rather than being based on historical arrangements.

Challenges

Fragmentation

Mental health provision for 0–25, especially for 16–25s, has been an ongoing issue and, despite being cited in numerous mental health policy documents, it remains a challenge.

The role of local authorities and public health commissioners is less widely understood. They commission services such as youth services, health visiting services, school nursing and services for children in care. Public Health England has to date commissioned the healthy child programme, which includes mental health and is aimed at 0 to 19-year-olds.

Educational settings, including further education colleges and universities, can also provide their own services and these are often independent of the services commissioned by the NHS or local authority. Students with pre-existing mental health problems can often face difficulties accessing services in the university as there is often no join up between the university services and external mental health services.

In summary, fragmentation in commissioning can be unhelpful and result in duplication and gaps in service provision. From a service provider perspective, they will potentially have to work across different commissioners and have to satisfy different indicators for contract fulfilment. Similarly, commissioners will need to work with a number of different providers and commissioners in order to commission an integrated service. This is

avoidable when providers and commissioners work together on a shared strategic plan and in some instances a single contract. The development of integrated care systems (ICSs) and provider collaboratives will help to streamline some of these processes.

Funding

From an NHS perspective funding has increased but historically there has been under investment in children and young people's mental health, especially in preventative approaches. A key issue is that the NHS has a number of competing priorities and physical health has in the past been more of a priority than mental health.

Local authorities generally commission preventative services such as youth services, children centres and public mental health services. Cuts to their budgets have meant that they have decided to cut back and, in some instances, close services for children and young people. This has resulted in a corresponding increase in children identified as being in need as well as in care[1]. Whilst we welcome additional funding to the NHS, we also need preventative approaches that reduce the number of children and young people needing specialist mental health services in the first place.

Whilst the government is increasing the support and education around mental health in schools; funding for the early years before school age needs to be increased, to implement preventative measures. These services are often commissioned by local authorities and are often very cost effective.

Funding for any 0–25 service would have to focus on a preventative/early intervention approach that is tied to impact rather than throughput. With increasing recognition of the lifelong impact of adverse childhood experiences (ACEs) and its link with poor mental health and physical morbidity, funding will need to move from an age-segregated approach to a family-focused approach. Providers would need to consider pooling resources such that families with intergenerational mental health problems are not disadvantaged.

Governance

Children and young people are often reported to prefer mental health services provided by voluntary and community sector (VCS) services. Often because they are more child or young person centred, easier to access, can provide a range of services under one roof and generally offer good value for money. However, we do hear from VCS services that they aren't always being commissioned, even when they have a good track record of working with children and young people in various settings, or they become another bottleneck for accessing specialist CAMHS.

A way forward would be for all NHS Trust contracts to include support, supervision and seamless working across the NHS and VCS. This will enable ICSs or provider collaboratives to support smaller VCS within a commissioning for quality paradigm.

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Family-centred approach

Children and young people's mental health services have a family-centred approach and often work with parents/carers and families. If we want to help the child, we need to work with parents/carers and families as well and this goes beyond a 0–25 approach and into a broader family mental health approach. To improve outcomes for children and young people, we need to consider how to commission and provide a system that supports the parent/carers and family as well.

Commissioning aims

Services for 0–25s, especially for the 18–25 age group, is not a new issue and has been on the policy radar for a number of years. It was included in Future in Mind and more recently in the NHS Long Term Plan. We largely know what the issues are but we now need to move forward and implement the policy we have all been involved in forming over the years.

- Seamless service or system for 0–25s, which is jointly planned and commissioned across a system to meet local needs.
- There won't be one model that fits everywhere but we need to learn from existing models and take account of VCS services (such as youth information, advice and counselling (YIAC) services or youth hubs).
- More up-stream interventions – A family mental health service approach to prevent mental health problems developing in the first place.
- Address the unmet social needs and risk factors that children and young people face.
- Build resilience.
- Improve equality of access for any child or young person with a mental health problem, regardless of whether they have a learning disability, neurodevelopmental problem or conduct disorder.
- Commission for impact rather than activity.
- Continue to make information about mental health investment more transparent.
- Continue to improve data on children and young people's mental health; to help commissioners/ICSs take a population health management approach and commission based on local need; and to help monitor contracts for good outcomes and value for money.