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Good mental health services for young people

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Why now?

There is increasing awareness of the importance of good mental health in young people (Department of Health, 2015) and long-standing concerns that current service configurations do not adequately meet the needs of young people with mental health problems (Lamb *et al.*, 2008; Birchwood & Singh, 2013). In response, a number of new service models have emerged.

Across the UK there are examples of innovative practice that attempt to address the gaps between child and adolescent services and adult services. These include disorder-specific services, transition workers, and age-specific youth mental health services. In England, clinical commissioning groups are now beginning to commission mental health services across the 0–25 age range.

Good Mental Health Services for Young People aims to outline the principles that underpin effective services for young people, summarise the evidence base, provide information about a range of service models and offer some comparison of the different models. It also highlights the key training concerns in providing services for young people (defined in this report as 14–25 years of age) and offers suggestions for the roles that psychiatrists can play in the effective implementation of good mental health services for young people.

Good Mental Health Services for Young People can be used by clinicians, service managers, commissioners, young people and carers to help refine existing services and develop new services.

Background

Most mental disorders have their origins in the teenage years (Jones, 2013) and many have precursors in childhood. The years 16–18 are a particularly critical period of vulnerability to mental illness, as well as a period of major physiological, emotional and social change in young people's life (Jones, 2013).

The traditional age split between child and adolescent mental health services (CAMHS) and adult mental health services (AMHS) has resulted in services being described as 'weakest at the point of highest need' (McGorry, 2007). This weakness is substantiated by research findings (Singh *et al*, 2010). Across the jurisdictions of the UK, there have been efforts to address this problem by improving the process of transition and transfer of care. In addition, in England and Wales there is government and commissioner interest in supporting new models of care for youth that bridge the traditional age gap between CAMHS and AMHS (e.g. services that cover people 14–24 years, 16–25 years, or 0–25 years of age).

Problems of the CAMHS/AMHS divide:

- Lack of continuity of care for young people/families who are experiencing transition.
- Different thresholds and concepts of what constitutes a mental disorder.
- Different models of care and expectations for young people, their families and service providers (e.g. psychosocial interventions v. psychopharmacology).
- Different intensity of care provided for young people by AMHS.
- Different bureaucratic, administrative and commissioning structures and arrangements (e.g. disorder v. clusters in England).

- Different potential pathways from children's to adult services, with different destinations (e.g. AMHS, Improving Access to Psychological Therapies (IAPT), primary care, college counsellor, third sector).
- Lack of training and expertise in AMHS regarding working with young people

There are long-standing concerns about the experiences of young people when they transition from CAMHS to AMHS, and many papers outlining the problems and possible solutions (Children's Commissioner for England, 2007; Lamb *et al*, 2008; Singh *et al*, 2010; Parker *et al*, 2011; Social Care Institute for Excellence, 2011; Birchwood & Singh, 2013; NICE, 2016).

A number of risk factors for poor outcomes have been identified for young people in transition to adult services, such as becoming 'lost in the system' and having nobody to support engagement with adult services. Protective factors that promote an effective transition have also been identified, including the importance of having a trusted adult who takes on the key role of transition or link worker and is the sole point of contact for the young person during transition (Department for Education, 2003; Lamb *et al*, 2008; NICE, 2016;).

Young people and families report that they value flexible, non-stigmatising, community-based services appropriate to their age. They find the change in service philosophy between CAMHS and AMHS confusing and express concern regarding the lack of services for specific groups (e.g. attention-deficit hyperactivity (ADHD), autism spectrum disorder, emerging personality disorders).

Who needs the service?

Young people

Who are the young people transitioning from CAMHS to adult services?

- Those with severe or enduring mental disorder who clearly meet AMHS eligibility criteria (e.g. psychosis, major mood disorders, severe eating disorders).
- Those with severe or enduring mental disorder who do not meet the eligibility criteria for most AMHS (e.g. neurodevelopmental disorders such as ADHD, autism spectrum disorder with comorbid anxiety).
- Vulnerable young people attending CAMHS with pronounced and multiple needs not clearly expressed as mental disorder but who have risk factors for poor outcome (e.g. a history of severe trauma, severe repetitive self-harm and/or emerging personality disorder; those in the care or youth justice systems).
- Young people with chronic physical illnesses who have secondary mental illnesses.

Children's services focus on the early detection of and intervention for a range of emotional and behavioural difficulties from the early years of childhood. Some of these difficulties are precursors to mental disorders in adult life. It is well known that intervening early, when individuals are

first developing a mental disorder, improves the prognosis, quality of life, future prospects and outcomes for patients, families and carers. This in turn reduces future demand on mental health services, which in times of austerity is important for healthcare providers.

Early intervention has economic benefits, as demonstrated by studies of the economic impact of early intervention in psychosis services (Knapp *et al*, 2014; Perez *et al*, 2015). Not only does it improve outcomes for the individual and family concerned, it also reduces the burden of disease at a population level by preventing the development of lifelong mental illness. This can lead to increased productivity and financial savings for organisations, by reducing demand on in-patient beds and reducing referrals to secondary mental health services; this would improve referral-to-treatment times and reduce the demands on social services, local authorities and other support and welfare services.

Young people with neurodevelopmental disorders are significantly over-represented in the secure estate (prisons, secure accommodation and young offender institutions) (Table 1). Early identification and intervention is likely to help divert young people from prison and so lead to significant cost savings across the wider health system (Hughes *et al*, 2012).

Table 1 Young people with neurodevelopmental disorders in the secure estate^a

Condition	Prevalence in secure estate	Prevalence in the general population
Intellectual disability	23–32%	2–4%
Specific intellectual difficulties	43–57%	10%
Communication disorders	60–90%	5–7%
Attention-deficit hyperactivity disorder	12%	1.7–9%
Autism spectrum disorder	15%	~1%

a. Source: Hughes *et al* (2012)

Vulnerable groups

The majority of young people who develop mental health problems do not have additional vulnerabilities. However, there are particular groups of young people who are at a much higher risk of developing a mental disorder and therefore should be prioritized when developing mental health services for young people.

- Looked after children, who have a fivefold increased risk of any childhood mental disorder and a four-to-fivefold increased risk of a suicide attempt as an adult (Ford *et al*, 2007).
- Young people with an intellectual disability, who have a 6.5-fold increased risk of mental health problems (Bax & Gillberg, 2010).
- Young people with special educational needs, who have an increased risk of conduct disorder (Meltzer *et al*, 2009).
- Young people with physical illness, who have an increased risk of emotional and conduct disorder (Hysing *et al*, 2007).
- Homeless young people, who have an eight-fold increased risk of mental health problems if living in hostels or bed and breakfast accommodation (Vostanis *et al*, 1998).
- Young offenders (Hughes *et al*, 2012):
 - Males in custody who are 15–17 years of age have an 18-fold increased risk of suicide.
 - Females in custody who are <25 years of age have a 40-fold increased risk of suicide.
 - Both genders have a fourfold increased risk of anxiety or depression and a three-fold increased risk of any mental disorder.
- Young people who self-harm (Madge *et al*, 2008).
- Teenage parents.
- Young carers.
- Young people with a family history of psychosis or a major mood disorder, or prodromal symptoms.

What do young people need?

Good transition

Qualitative research carried out across the UK has identified elements that are important for successful transition of care, including preparation for transition, case management, strong therapeutic relationships, joint management of care, and flexibility regarding point of transfer (NICE, 2016). Key policies and guidance relating to adolescent mental health specify the need for the full participation of the young person in these processes (United Nations, 1989; Department of Health, 2000; Department for Education, 2003; Lamb *et al*, 2008; Birchwood & Singh, 2013; Paul *et al*, 2013; NICE, 2016). The MindEd website (www.minded.org.uk) was created with a parent co-author and outlines how a parent or carer can support a young person in achieving a good transition from CAMHS to AMHS.

The key principles outlined in these documents are supported by recent NICE guidance on transitioning from child to adult services (NICE, 2016). These include involving young people, parents and carers, ensuring that transition occurs at a developmentally appropriate time, providing continuity of support before and after transition, using a person-centred approach, and ensuring that different agencies and the managers of different agencies work together.

NICE (2016) recommends that good transition planning include the designation of a named worker that the young person trusts, who will act as a link between child and adult services and provide continuity of support for a minimum of 6 months before and after transfer. It also recommends that transition planning focus on building independence, make use of peer-support groups and mentoring,

and build in support for employment, community inclusion and health and well-being.

In addition, NICE recommends that attention is paid to the supporting infrastructure: ensuring there is a senior executive accountable for transition strategies and an operational-level champion supporting the process and reviewing effectiveness of the local strategy.

The NICE (2016) guidance notes the particular importance of good transition in special groups, including looked after young people and young people in young offender institutions. More research is required into the most effective ways of supporting care leavers in the transition from CAMHS to AMHS. NICE guidance highlights that it is essential that birth parents have a role in the management of childhood-onset, long-term physical and mental health conditions and that their role continues throughout transition. For young people in local authority care, even if they have had a stable placement or social worker during their time in children's services, transition is a period when their social care support is likely to change. The status of the health service user often changes when they turn 18, and the primary receiver of information becomes the young person, not their social worker or foster carer. There is a need for research on how health and social care services can better collaborate with the young person during transition, respecting their need for privacy but also enabling inter-agency communication when this is agreed by the young person.

Young offenders tend to be highly vulnerable, with multiple problems. There is a concern that they tend to undergo particularly poor transitions into adult services. There is a lack of evidence for this group, despite documented high need and poor outcomes.

Models of service

The concern is not just about achieving good transition between services, but also the quality of mental health services provided to young people.

There are now integrated lifespan mental health NHS strategies for each jurisdiction of the UK, with an emphasis on improving services at the CAMHS/AMHS interface:

- *No Health Without Mental Health* (Department of Health, 2011)
- *Together for Mental Health* (Welsh Government, 2012)
- *Mental Health Strategy for Scotland* (Scottish Government, 2012)
- *Service Framework for Mental Health and Wellbeing* (Department of Health, Social Services and Public Safety, 2011)

There has been considerable impetus, over recent years, for the development of innovative services across the UK that promote better working between CAMHS and AMHS (Birchwood & Singh, 2013). However, the range and quality of services for young people is variable.

This has been addressed in England through service transformation, via Children and Young People's Improving Access to Psychological Therapies and Future in Mind (Department of Health, 2015). In Wales, the key driver is the Together for Children and Young People CAMHS improvement programme (National Assembly for Wales, 2015). Both strategies include improving the experience of transition as an important objective. NICE has produced guidance on the transition from child to adult services (NICE, 2016).

There is little high-quality research on models of service for young people, but key good-practice points have been identified by various authors (Lamb *et al*, 2008; Singh *et al*, 2010; Parker *et al*, 2011; Joint Commissioning Panel for Mental Health, 2012).

- Developmental and family-oriented approach.

- Emphasis on meaningful engagement.
- Joint working and close liaison with other agencies – statutory and non-statutory.
- Range of psychological, psychiatric and psychosocial interventions.
- Mix of expertise from CAMHS and AMHS.
- Availability of appropriate crisis, intensive community treatment and in-patient care.
- An emphasis on supporting young people in getting on with their lives.
- Involvement of young people in service development.

To combat gaps in service and inequity of provision, an increasing number of mental health services have developed clinical liaison or link posts to facilitate joint working between CAMHS and AMHS. Other areas, for example Nottingham, have set up transition clinics. There are also age-specific teams for older young people, some generic and others disorder specific (e.g. early intervention in psychosis services). Many of these teams work across the conventional age of transition (18 years). There are, additionally, multi-agency 'one-stop shops' for youth (e.g. The Zone in Plymouth; www.thezoneplymouth.co.uk) and general practitioner (GP)-led, multi-agency, primary care youth clinics with an embedded mental health specialist or robust links to local specialist teams (e.g. www.thewellcentre.org).

Designated liaison/link posts

Some NHS trusts and health boards have funded transition or liaison posts, which comprise one or two clinicians, often community psychiatric nurses with expertise in working with young people. These individuals carry out assessments and some face-to-face work, in addition to working jointly across both CAMHS and AMHS teams to facilitate work with older young people.

Transition clinics

In some areas, there are regular joint clinics where young people approaching transition are seen by both CAMHS and AMHS in the transition clinic to jointly plan the care pathway from child to adult services.

Age-specific generic youth mental health services

Youth mental health services are predicated on three observations. First, that the majority of adult mental disorders, setting aside dementia, appear between 14 and 25 years of age. Second, that transitions from CAMHS to AMHS are often poor. Third, that young people often experience difficulties in accessing traditional services.

In the main, services are based on strong participatory principles, with young people centrally involved in the planning, development and delivery of the service. These services tend to be provided in non-stigmatising, community settings, some in multi-agency 'one-stop shops'. Most youth mental health services use an early intervention model, promoting a youth-centred and flexible approach, with an emphasis on effective engagement with young people who are showing functional impairment and signs of distress. They treat the range of mental disorders presenting in this age group and often include a multidisciplinary team drawn from both CAMHS and AMHS. They use a recovery model with a range of psychological and psychosocial interventions, in collaboration with third-sector and other agencies, to promote positive psychosocial functioning.

In England, where these transition or youth mental health (YMH) teams exist, they frequently link with or are part of an early intervention in psychosis service, and have good working relationships with their local home-treatment and crisis-resolution teams, as well as Social Services, education, local youth offending teams and substance misuse services (e.g. Wirral 16–19 team, Norfolk Youth Mental Health Service (14–25 years) Birmingham (0–25 years)).

Colleagues in Scotland have expressed concerns about the YMH model. They are uneasy about staff not having the appropriate qualifications and skills to see younger people, which could affect their ability to undertake key tasks, such as risk assessment. They are worried about young people using the same facilities as adults, with attendant safeguarding risks. However, they recognise that some of the recommendations made about training could ameliorate some of these risks.

Disorder-specific services

A number of disorder-specific services have been set up to span the traditional age range of transition across CAMHS and AMHS.

In England, early intervention services for first-episode psychosis in 14- to 35-year-olds were introduced in 1999. They were widely implemented and, in some areas, have acted as a catalyst for the development of generic youth mental health services that bridge the transition age range. There are also eating-disorder services and ADHD services that bridge the age gap.

ADHD services

A significant proportion of young people with ADHD have service needs at the point of discharge from children's services (Taylor *et al*, 2010). Specialist nurses are common in children's services to support these needs, but are unusual in adult services. In England services are increasingly organised around the principal of providing 'care packages' (Mental Health Clustering and Payment by Results), with people moving in and out of services for interventions as required. The concept of ADHD does not fit well into the structure of the current clustering arrangements. In primary care in England, IAPT services concentrate on treating depression and anxiety and do not currently have specialised skills around ADHD.

Some specialists suggest that all young people with ADHD should eventually transition to AMHS (Young *et al*, 2011; Hall *et al* 2015). Others are of the view that not all adults with ADHD require

adult mental health input (Taylor *et al* 2010; Marcer *et al*, 2008; Crimlisk 2014; Reale *et al* 2014), as long as monitoring arrangements are in place in primary care and arrangements are available for review in AMHS.

Young people with ADHD who have benefited from a stable medication regimen might wish to continue this for many years into adulthood, and are supported in doing this by NICE guidelines (Kendall *et al*, 2008; NICE, 2008). The responsibility for long-term monitoring is passed on to primary care. This is also common when diagnosis has been undertaken by regional centres or private clinics. Shared-care protocols for ADHD with GPs are common in CAMHS, but less so in AMHS. In some areas, stabilized ADHD patients are discharged to primary care for monitoring, under a shared-care principle with guidance and easy access for advice or reassessment.

When young people with ADHD have not yet been stabilised, experience significant side-effects, or need further psychoeducational or psychological intervention for ADHD, they should be able to transition to appropriate adult ADHD services. Reale *et al* (2014) discuss an example of a decision tool that helps inform this process.

Transition mental health team for looked after children

Some NHS trusts have joined with other agencies and implemented multi-agency commissioning to provide transition mental health teams for the sole use of looked after children (i.e. young people 16–18 years of age who are in care or in the process of leaving care).

Virtual team

Another example of a model linking CAMHS and AMHS is the ‘virtual team’, where designated members from separate multidisciplinary teams work together, calling on their range of skills and

expertise to help meet the developmental and mental health needs of older young people presenting to either service.

Multi-agency ‘one-stop shops’ for youth

These ‘one-stop shops’ tend to be based in youth services, alongside a number of other services for young people. Mental health expertise is provided by inreach clinicians alongside a range of multi-agency workers who provide other services, including housing and financial advice, substance misuse services and activity programmes (e.g. The Zone in Plymouth; www.thezoneplymouth.co.uk).

GP-led multi-agency primary care youth clinics

The emphasis of these clinics is on engaging with youth, early detection and intervention. The youth-only setting provides walk-in appointments in a non-stigmatising setting and a range of medical assessments and interventions. Physical health problems are addressed (e.g. sexual health, skin complaints, substance misuse) alongside mental health problems. There is an on-site youth worker and help and advice for housing and finance. These clinics have an embedded mental health specialist and/or robust links to local specialist mental health teams (e.g. the Well Centre in London; www.thewellcentre.org).

Summary

Most of the models cited above have improved the mental health service offered by forging strong working links or formal partnership agreements with other agencies involved with young people. Successful partnerships have been formed with non-statutory and voluntary organisations, as well as with those from the statutory sector.

How can we do it?

Principles

When commissioning and developing services for young people, it is essential that young people, families and carers are actively involved in the process. The services should be designed to ensure ease of access and achieve multi-agency integration to reflect the multiple agencies that young people use. The service models should provide for the range of mental health problems that are common in those 14–25 years of age. Staff capacity, as well as the breadth and depth of staff skills, should reflect the challenges of engaging with young people across a broad age range and with a wide range of needs (Lamb *et al*, 2008; Royal College of Psychiatrists, 2013).

Service design should allow access to peer support, social support and evidence-based interventions and focus on a recovery model. Finally, services should be designed to target the needs of particularly vulnerable groups, including young people with neurodevelopmental problems, young people with first-episode psychosis, young offenders, care leavers, those not accessing education or training, and survivors of sexual exploitation.

Co-commissioning

Informed commissioning will be at the heart of ensuring local services meet the needs of young people with mental health disorders, their families and carers. Local areas will need to ensure there are age-appropriate, accessible, universal and targeted mental health services available to young people, to ensure early detection and provide evidence-based interventions.

Services' goals should include prevention, improved health outcomes and fostering of optimal physical, psychological, and social and educational development. No single commissioning body can achieve this ambitious balance, especially when current service models need to change or adapt

and where there may be resistance to change from professional groups. Co-production in commissioning decisions is a realistic and effective way of achieving change. Co-commissioning may present greater challenges. However, *Future in Mind* and the new Special Educational Needs reforms in England actively promote collaboration between commissioners and the effect of both of these may act together to lower the barriers to co-commissioning. Arrangements for the commissioning and provision of NHS services in the other jurisdictions is different, but similar issues are relevant when considering co-commissioning across different statutory agencies or in partnership with the third sector.

The New Economics Foundation defines co-production as 'a relationship in which professionals and citizens share power to design, plan and deliver support together, recognising that all parties have vital contributions to make to improve quality' (Slay & Penny, 2014). Young people have been crucial in achieving change. For instance, service commissioners in Islington reviewed their youth strategy in 2011 and focused on quality assurance standards, to be used in unannounced and other assessment visits to youth services. They redesigned and co-produced these quality assessments with young people to make sure that the needs, aspirations and expectations of young people were being met in the borough. Commissioners also rewrote the quality assurance framework and trained a group of young quality assessors to lead site visits. The co-produced framework sets out nine areas that young people, providers and commissioners felt were important to youth services. This radical step would not have occurred without a commitment to co-production.

Within the rapidly changing commissioning environment in health and social care affecting services for young people, co-production ensures the fundamental aims and values of these services remain in the foreground, shaping local decisions against a background of national policy frameworks.

For transformational change and effective co-commissioning, services need to talk to each other and meet regularly. It is proposed that commissioners can ensure that this happens even when services are being commissioned from different financial sources.

Psychiatric expertise and training

The developmental needs of young people with severe mental disorder must be balanced with the needs for appropriate expertise in the professionals caring for them. Hence individuals presenting with early onset of a psychotic illness should have access to the local specialist service for that diagnostic group (e.g. early intervention in psychosis services) alongside access to CAMHS. Expertise in working with children and young people must be present in any mental health team treating young people under 18 years. It is recommended that no consultant psychiatrist should have sole clinical responsibility for a patient aged under 18 years unless that psychiatrist has specialist training in child and adolescent psychiatry. Similarly, no psychiatrist should have sole clinical responsibility for a patient aged 18 years or over unless they have specialist training in adult psychiatry.

The changes introduced by the General Medical Council and Health Education England with respect to the postgraduate training of psychiatrists has had an impact on the training experiences available across the age range and on the relative expertise obtained in developmental issues. It is recommended that all psychiatrists have a training in developmental psychiatry so that they may understand and manage the clinical issues arising out of transitions from child to adult services.

It is currently the case that, in many circumstances, agreement is reached for CAMHS and AMHS psychiatrists to combine their expertise and that of other members of CAMHS and AMHS multidisciplinary teams, and other key agencies, to meet the mental health needs of transition-aged young people.

In the longer term, two structural changes to training will help to create more formal structures

for psychiatrists working in YMH services. First, the development of schemes to allow consultant psychiatrists to develop additional skills and competencies (after Certificate of Completion of Training credentialing) will help consultants develop competencies that reflect their changing roles within the new service structures. Second, for trainees wishing to work specifically within YMH services, the Child and Adolescent Psychiatry Further Education Curriculum Committee (CAPFECC) and the General Adult Psychiatry Further Education and Curriculum Committee (GAPFECC) are developing dual training in child and adolescent and general adult psychiatry.

What can psychiatrists do to improve mental health services for young people?

What can psychiatrists directly affect?

- Highlight the available evidence on the epidemiology of mental disorders in youth.
- Highlight the available evidence on the need for good transition and how to achieve it (NICE, 2016).
- Ensure services are family/carer-friendly (e.g. Triangle of Care).
- Ensure constructive relationships with colleagues in both CAMHS and AMHS.
- Support and facilitate access to a range of interventions, including psychological, psychosocial and pharmacological interventions.
- Organise care around need (context, severity and risk), as well as diagnosis.
- Make sure that transitions are managed according to individual need and support a flexible approach with respect to the age at which transfer of care begins.
- Support good communication with young people and families and between services.
- Act as an advocate for young people, as well as an expert.

- Support public engagement with respect to young people's mental health needs (informally, formally and via trusts and health boards).
- Be open and transparent about expectations.

What can psychiatrists influence?

- Influence commissioning processes and service delivery.
- Promote awareness of young people's mental health needs.
- Influence the development of service models and delivery of care, ensuring access to evidence-based interventions.
- Influence policy development (e.g. in development and implementation of local transformation plans).
- Influence the attitudes and behaviour of colleagues.
- Influence other agencies and services.
- Ensure adequate time for transition work and effective flexible work with young people in job plans.

What is more difficult for psychiatrists to influence?

- Structural context of commissioning.
- Resistance to change.
- Resource and capacity.

Conclusions

A range of models have been developed to meet the mental health needs of young people, each of which have relative strengths and weaknesses. The way these models play out in individual localities will depend in part on the configuration of local mental health services (CAMHS and AMHS), and also on local education, social care, physical healthcare and voluntary sector provision. Different solutions will be appropriate for different settings. The relative strengths of the different solutions are laid out in Appendix 1 and we hope that commissioners, providers, young people and their families will find this a helpful guide to deciding which solution will work best for their local conditions.

Consultant psychiatrists will continue to have an essential role in service improvement and service delivery and we hope this report will help them to decide what will work best for their local area and what part they can play in improving services for young people.

Finally, we look forward to working closely with CAPFECC, GAPFECC, the General Medical Council and Health Education England to ensure that psychiatrists are trained (both within specialist training schemes and via post-CCT credentialing) in the right skills to ensure high-quality clinical work with young people.

Appendix 1

Table A1 Advantages and disadvantages of various types of services: more general services			
Type of service	Multi-agency 'one stop shop': third sector	Multi-agency 'one stop shop': primary care	Youth mental health service: virtual team Youth mental health service: commissioned team (14-25 years)
Family's and carers' experience	<ul style="list-style-type: none"> • Might or might not have knowledge and skills to deal with moderate and severe problems. 	<ul style="list-style-type: none"> • Good range of services available. • Good access. • Might be a gap if onward referral to specialist services is required. 	<ul style="list-style-type: none"> • A service meeting a range of needs delivered by various professionals and disciplines. • Transition to adult mental health services if needed, or back to GP if mental health needs have been met during the treatment period.
Young person's experience	<ul style="list-style-type: none"> • Relaxed, informal and puts young person at ease. 	<ul style="list-style-type: none"> • Can deliver many NICE guideline therapies in non-threatening, local environment (e.g. group therapy for depressive disorders). 	<ul style="list-style-type: none"> • A service designed to make the young person feel at ease, with workers experienced in dealing with adolescents and young adults. Some will need to transition to AMHS at 26 years of age.
Training and workforce	<ul style="list-style-type: none"> • Can be trained in targeted approaches for specific conditions. • Will lack specialist skills to deal with moderate to severe disorders. • Might miss potentially important conditions with implications for optimal management (e.g. autism spectrum disorder). 	<ul style="list-style-type: none"> • Can be trained to recognise those conditions requiring referral to specialist services. • Will lack specialist skills to deal with moderate to severe disorder. • Might miss potentially important conditions with implications for optimal management (e.g. autism spectrum disorder). 	<ul style="list-style-type: none"> • Might be drawn from a variety of disciplines and backgrounds, hand-picked and recruited for the age range of the service, and could include doctors, nurses, social workers, youth workers, etc. • Those with little mental health training will need specific training in mental illness.

Table A1 *Continued*

Type of service	Multi-agency 'one stop shop': third sector	Multi-agency 'one stop shop': primary care	Youth mental health service: virtual team	Youth mental health service: commissioned team (14–25 years)
Developmentally appropriate setting	<ul style="list-style-type: none"> • Non-stigmatising location. • Youth-friendly facilities. 	<ul style="list-style-type: none"> • Non-stigmatising location. • Local to patient. 	<ul style="list-style-type: none"> • No identified setting. • Dependent on individual tailoring to needs. 	<ul style="list-style-type: none"> • Commissioning for the service allows settings to be designed with young people in mind.
Range of provision	<ul style="list-style-type: none"> • Will vary according to resourcing and local agreements, but unlikely to deliver specialised treatments for complex or serious conditions – will remain at primary care level. 	<ul style="list-style-type: none"> • Will have access to GPs and other primary care professionals. • Unlikely to have access to specialist opinion or treatments and will require referrals to be made. 	<ul style="list-style-type: none"> • Will vary according to local provision and what is currently available. 	<ul style="list-style-type: none"> • Primary and secondary healthcare for physical and mental issues. • Social Services' contact and input. • Employment and educational support, benefits advice. • Working with youth justice. • Each service might have a different configuration depending on commissioning arrangements, resources and leadership.
System-wide	<ul style="list-style-type: none"> • Limited to third sector with access to statutory agencies regulated by referral criteria, etc. 	<ul style="list-style-type: none"> • Limited to primary care with access to secondary care and social care regulated by availability, resourcing and referral criteria. 	<ul style="list-style-type: none"> • Might depend on networks that are individually constructed. 	<ul style="list-style-type: none"> • This depends on commissioning arrangements and local links and structures.
Unmet need and exclusions	<ul style="list-style-type: none"> • Potentially inclusive of all. 	<ul style="list-style-type: none"> • Potentially inclusive of all. 	<ul style="list-style-type: none"> • Unmet need of those who require support in the transition to AMHS. • Young people with needs that encompass social and emotional issues (employment and educational issues will be excluded). 	<ul style="list-style-type: none"> • Should be inclusive and able to meet the needs of young people or facilitate those needs being met (e.g. contraception, advocacy).
Commissioning	<ul style="list-style-type: none"> • CCGs might request 'redesign' to ensure secondary specialist input to such services. 	<ul style="list-style-type: none"> • CCGs might request 'redesign' to ensure secondary specialist input to such services. 	<ul style="list-style-type: none"> • Will be expected to be funded from existing funding envelope in secondary services. 	<ul style="list-style-type: none"> • Will be more effective if jointly commissioned between local authority and CCG, but it might depend on locality – recognition is needed that this requires increased resource, which is unlikely to be obtained.

Table A1 <i>Continued</i>			
Type of service	Multi-agency 'one stop shop': third sector	Multi-agency 'one stop shop': primary care	Youth mental health service: commissioned team (14–25 years)
Links to other services	<ul style="list-style-type: none"> • Could have good links to statutory services and be able to take on an advocacy role for the young person. • Good links to other community resources and youth services. 	<ul style="list-style-type: none"> • Good links to other statutory and third-sector services. 	<ul style="list-style-type: none"> • Links to other services catering for young people in the same age range will be facilitated.
Links to primary care	<ul style="list-style-type: none"> • Easy access to primary care services if integrated care systems including the voluntary sector are in place. 	<ul style="list-style-type: none"> • Easy access to other primary care services. 	<ul style="list-style-type: none"> • Workers will make links to primary care based on individual need, and should have ample time to both inform professionals in primary care and advocate for the young person.
Access and length of stay	<ul style="list-style-type: none"> • Access should be easy, depending on availability and community information systems, including school provision. • Length of stay could be time-limited or variable, depending on provision. 	<ul style="list-style-type: none"> • Access should be easy and via primary care and GP surgeries. 	<ul style="list-style-type: none"> • Ideally, self-referral with information about the service disseminated in primary care and community settings. • Resourcing and capacity issues may affect referral criteria. • Length of stay could be lengthy, depending on needs but should be based on condition; needs and ability of other services to meet on-going needs.
Access to evidence-based interventions	<ul style="list-style-type: none"> • Access to appropriate interventions limited for complex presentations. 	<ul style="list-style-type: none"> • Access variable dependent on funding streams, resources and particular knowledge and skills of individual members of the team. 	<ul style="list-style-type: none"> • Depends on the degree of expertise and professional disciplines employed within the service. If it has a full range of health professionals, including psychiatrists, then it should have full access to evidence-based interventions.
		<ul style="list-style-type: none"> • May be problematic as relies on professionals making contact electronically or by phone. 	
		<ul style="list-style-type: none"> • Poor links to primary care as unlikely to have resources to visit and contact GPs and other professionals in primary care. 	
		<ul style="list-style-type: none"> • Access may be problematic and dependent upon referral systems, individual knowledge and networks. • Length of stay variable because of capacity/demand and efficiencies of individual professionals and disciplines. 	
		<ul style="list-style-type: none"> • Depends on the individual configuration of the team, and services available in the local secondary specialist services. 	

Table A1 *Continued*

Type of service	Multi-agency 'one stop shop': third sector	Multi-agency 'one stop shop': primary care	Youth mental health service: virtual team	Youth mental health service: commissioned team (14–25 years)
Payments system	<ul style="list-style-type: none"> • Funding from central government/local authority grants. Subject to uncertainty with public sector cutbacks. • Could be subject to repeated bid-writing for funds, less likely to get recurrent funding. Possibly funding for specific projects. 	<ul style="list-style-type: none"> • From CCGs and individual GP practices. 	<ul style="list-style-type: none"> • No extra funding expected for this service. Will be required to be found out of current mental health funding by CCGs. 	<ul style="list-style-type: none"> • Investment needed via business case and support from CCG and local authority. • Contracts likely to be between trust and CCG or partnership arrangements with pooled funding.
Unintended consequences	<ul style="list-style-type: none"> • Resources diverted from specialist services to universal and community services. 	<ul style="list-style-type: none"> • Resources diverted from specialist services to primary care. • Increasing the tendering of services by commissioners. • Might miss moderate and severe conditions requiring specialist input. 	<ul style="list-style-type: none"> • Worse therapeutic experience for families and patients. 	<ul style="list-style-type: none"> • Difficulty recruiting professionals with sufficient expertise, leading to dependence upon locums and fragmentation of team.

AMHS, adult mental health services; CAMHS, child and adolescent mental health services; CCG, clinical commissioning group; GP, general practitioner; NICE, National Institute for Health and Care Excellence.

Table A2 Advantages and disadvantages of various types of services: more specific services

Type of service	Transition multidisciplinary team/clinic	Transition worker	Disorder-specific services	Population-specific services
Family's and carers' experience	<ul style="list-style-type: none"> A range of professionals and disciplines bringing different skills and perspectives, easing the transition by joint meetings between CAMHS clinicians and AMHS. 	<ul style="list-style-type: none"> Individual management of case. Less risk of 'falling through the gap'. Only one worker to relate to. 	<ul style="list-style-type: none"> Expert assessment. Tailored treatment packages allowing for expert tailoring if medication indicated. Outcome measures built in to assess treatment efficacy. 	<ul style="list-style-type: none"> High-intensity work might be easier to accomplish. Tailored treatment. Good knowledge and skills of workers.
Young person's experience	<ul style="list-style-type: none"> Ease of transition. No 'falling through the gap'. 	<ul style="list-style-type: none"> Depends on relationship between young person and clinician and the service to which they are moving. 	<ul style="list-style-type: none"> Continuity of care with named care coordinator and doctor Person-centred transition protocols between early intervention services and CAMHS, including joint working for 3–6 months. 	<ul style="list-style-type: none"> Continuity of care with named care coordinator and doctor.
Training and workforce	<ul style="list-style-type: none"> Can innovate and try new service models and methodology. Might not have resources to employ and maintain workforce. Might be a knowledge and skills gap although with good joint working skills will be enhanced. Might face organisational difficulties if CAMHS and AMHS are in different trusts. 	<ul style="list-style-type: none"> With appropriate knowledge and experience can bridge the gap between primary/secondary care and CAMHS/AMHS interface. 	<ul style="list-style-type: none"> Some teams are resourced because of government mandates and targets. Some have developed special skills. Potential problem with many adult services without knowledge and skills in specific neurodevelopmental disorders, which would need curriculum-based resourcing. 	<ul style="list-style-type: none"> Need specialist workers who might be in short supply.
Developmentally appropriate setting	<ul style="list-style-type: none"> Depends on estate provision: can be designed to specific requirements and more appropriate than AMHS out-patient clinics. 	<ul style="list-style-type: none"> Worker is mobile and travels with the young person to the appropriate location. 	<ul style="list-style-type: none"> Depends on provision of services and estates strategy of trust providing the service; can be variable. Might not be local and might not be youth-friendly. 	<ul style="list-style-type: none"> Depends on who is hosting (providing) the service – local authority, healthcare or third sector – and whether there is co-location.

Table A2 Continued

Type of service	Transition multidisciplinary team/clinic	Transition worker	Disorder-specific services	Population-specific services
Range of provision	<ul style="list-style-type: none"> Secondary care dealing with young people already in CAMHS and deemed necessary to graduate into AMHS. 	<ul style="list-style-type: none"> Worker will be constrained to working within existing structures and unable to change or innovate. Can work with all young people transitioning from CAMHS – those going into specialist AMHS, those transitioning back to primary care, and those who can benefit from accessing local social care and voluntary sector provision. 	<ul style="list-style-type: none"> Limited to condition-specific, and usually applying to those who have come to the attention of CAMHS or Early Intervention in Psychosis services, although might enter a condition-specific service via paediatrics (e.g. self-harm) or youth justice system. 	<ul style="list-style-type: none"> Will be limited to the defined population. Might not be able to deal with comorbidity or other problems.
System-wide	<ul style="list-style-type: none"> Secondary care, limited to commissioned health and social care professionals for secondary mental healthcare. 	<ul style="list-style-type: none"> Secondary healthcare, with transfer to primary and secondary care. 	<ul style="list-style-type: none"> Secondary care commissioned by health commissioners. 	<ul style="list-style-type: none"> Can include primary care, statutory agencies and third sector.
Unmet need and exclusions	<ul style="list-style-type: none"> Young people with social and emotional needs (employment and educational issues will be excluded). Those who do not need to be in secondary mental health services will have to transition out of services with unknown level of support then available to them. 	<ul style="list-style-type: none"> Young people with needs that encompass social and emotional issues; employment and educational issues. Those that do not need to be in secondary mental health services. Employment and educational issues will be excluded. 	<ul style="list-style-type: none"> All those young people who do not have the specified condition, but who have social/emotional and health-related needs requiring support from agencies other than their families. Employment and educational issues will be excluded. 	<ul style="list-style-type: none"> All those young people who do not fall within the specified inclusion criteria but have social/emotional and health-related needs requiring support from agencies other than their families. Employment and educational issues will be excluded.
Commissioning	<ul style="list-style-type: none"> Less likely to support increased investment and request realignment of existing services because inconsistent with key legislative changes (e.g. Children and Families Act 2014). 	<ul style="list-style-type: none"> Might fund additional transitional worker as part of investment in mental health services, but in competition with all other pressures on mental health budget. 	<ul style="list-style-type: none"> Some specific services are commissioned; depends on local need and CCG priorities. If there is national funding and guidelines, more likely to receive funding and have associated key performance indicators. With decreasing resources, commissioners more likely to look at redesign than investment. 	<ul style="list-style-type: none"> Joint commissioning of services from CCG/local authority or via public health and health and wellbeing boards.

Table A2 Continued

Type of service	Transition multidisciplinary team/clinic	Transition worker	Disorder-specific services	Population-specific services
Links to other services	<ul style="list-style-type: none"> • Good links to CAMHS, AMHS and (in some areas) paediatrics. • Might have poor links to primary care, social care and the third sector. 	<ul style="list-style-type: none"> • Adaptable and mobile. • Able to forge links with other services on a case-by-case basis. 	<ul style="list-style-type: none"> • Will have good links to 'parent' service (e.g. CAMHS or AMHS or both). • Will be able to forge good condition-specific links with the voluntary sector, employment and education services, if sufficiently resourced. 	<ul style="list-style-type: none"> • Will have good links to parent service. • Might have poor links to other statutory agencies and will be dependent on service-specific referral criteria.
Links to primary care	<ul style="list-style-type: none"> • Capacity to make good links might be limited by time and workload, but should be good when done on a case-by-case basis 	<ul style="list-style-type: none"> • Capacity to make good links might be limited by time and workload, but should be good when done on a case-by-case basis. 	<ul style="list-style-type: none"> • Will make links with primary care when necessary on an individual basis but could risk becoming a 'messenger' from the CAMHS team rather than an advocate for the patient. 	<ul style="list-style-type: none"> • Should have capacity and ability to form links with primary care on an individual basis and act as an advocate for patient and the service, in the process educating the service about the condition.
Access and length of stay	<ul style="list-style-type: none"> • Access facilitated by system, should be easy. • Length of time in clinic variable and dependent on individual needs, could be accessing adult services while remaining with some services more available in CAMHS (e.g. family therapy). 	<ul style="list-style-type: none"> • Depends on demand and the capacity of one worker. However, with good links, many of the services can be tailored to individual needs and received from a combination of AMHS and CAMHS. 	<ul style="list-style-type: none"> • Condition-dependent and should be individually tailored. 	<ul style="list-style-type: none"> • Dependent on entry criteria, and might be able to access various services provided by AMHS and CAMHS according to need. Length of stay also according to need.
Access to evidence-based interventions	<ul style="list-style-type: none"> • Would have access to health-related interventions (e.g. family therapy). • Would be expected to use standard assessment and outcome measures, NICE guidance and other best-practice guidelines. 	<ul style="list-style-type: none"> • Less likely to have access to full range of interventions. • Will be dependent on liaison and referral criteria. 	<ul style="list-style-type: none"> • Good access to evidence-based interventions in the specific specialist condition. 	<ul style="list-style-type: none"> • Good access to evidence-based interventions for the particular population group served, if team adequately staffed and funding is recurring.

Table A2 Continued

Type of service	Transition multidisciplinary team/clinic	Transition worker	Disorder-specific services	Population-specific services
Payments system	<ul style="list-style-type: none"> • CCG commissioning. • Redesign of existing resources, with potential extra funding with a successful business case. 	<ul style="list-style-type: none"> • Likely to be CCG funding, but might be redesign of existing services to allow one clinician to develop this portfolio. 	<ul style="list-style-type: none"> • Possible development of 'special interest' sessions by medical staff responding to local needs. • Possible funding by local CCG, although trusts might develop a marketing and business plan as part of a growth. • CCG funding for early intervention services. 	<ul style="list-style-type: none"> • Local authority/public health funding for some services (e.g. for looked after children). • Might have some funding from education to expand services into schools, counselling, etc.
Unintended consequences	<ul style="list-style-type: none"> • Two transitions instead of one. 	<ul style="list-style-type: none"> • Delays due to capacity issues with one worker. 	<ul style="list-style-type: none"> • Highly specialist service starves generic services of clinicians. 	<ul style="list-style-type: none"> • Resources diverted from universal and targeted services to specialist services.

AMHS, adult mental health services; CAMHS, child and adolescent mental health services; CCG, clinical commissioning group; NICE, National Institute for Health and Care Excellence.

Appendix 2

Youth mental health services: brief literature review

Traditional services for young people 0–25 years of age are divided into Child and Adolescent Mental Health Services (CAMHS, 0–18 years) and Adult Mental Health Services (AMHS, >18 years). The discontinuity between these service streams falls right at the age at which the incidence of new-onset mental health problems peak. Thus, the system is weakest where it should be strongest (McGorry *et al*, 2013).

Paul *et al* (2013) conducted a systematic review of transition services for young people. Nineteen studies of variable quality were identified. None were randomised or case–controlled. Studies incorporating patient/carer perspectives highlighted the need to tackle stigma and provide accessible, age-appropriate services. Parents/carers wanted more involvement with AMHS. Transitional care provision was considered patchy and often not prioritised within mental health services. There was no clear evidence of the superior effectiveness of any particular model.

The review included three US intervention studies. Styron *et al* (2006) evaluated Young Adult Services, a comprehensive service including clinical, residential, case-management, and planned step-up/step-down care. Young Adult Services aimed to help young people develop viable and durable social support systems, achieve educational or vocational success and learn prosocial adaptive behaviours and independent living skills. A randomly selected sample of 60 young people with moderate to severe problems was studied. Strength-focused treatment planning contributed to significant improvements in quality of life and community-focused treatment planning contributed to fewer arrests.

Haber *et al* (2008) studied 193 young people 14–21 years of age enrolled in five Partnership for Youth Transition services. The Partnership for Youth Transition was an initiative to develop programmes offering comprehensive transition support for adolescents with serious mental health conditions. Programme tenure was significantly associated with increased educational advancement, employment and productivity and decreased criminal justice involvement, mental health symptom interference and substance misuse interference. Young people aged 19 years or over tended to do better. Those with mood or intellectual disorders did better than those with disruptive behaviours.

Gilmer *et al* (2012) evaluated an out-patient programme within AMHS, tailored for young people at the transition age (18–24 years of age;

$n=931$), and compared it with standard AMHS care ($n=1574$). Mean out-patient visits were 12.2% (significantly) greater within the tailored out-patient programme.

The clinical efficacy and cost-effectiveness of early intervention in psychosis services for young people in improving outcomes and engagement has led to call for an early intervention model to be applied for all disorders common in young people (Vyas *et al*, 2015). On the basis of demonstrated need, innovation and model efficacy, the Australian government has invested heavily in early intervention services for young people through deployment of community based 'headspace' centres throughout the country (McGorry *et al*, 2013). As of April 2016, there were 85 such centres across Australia.

In 2006, Headstrong – The National Centre for Youth Mental Health was founded in Ireland based on the work in Australia (O'Keeffe *et al*, 2015). Headstrong is a registered charity that takes part in service delivery, research and engagement related to the mental health needs of young people 12–25 years of age. Headstrong developed Jigsaw, an early-intervention mental health service that provides support to young people in association with statutory, voluntary and community mental health and related services. Jigsaw is now established in ten communities across Ireland. Jigsaw gives young people access to youth-friendly, integrated mental health support in the community and promotes community awareness of mental health. O'Keeffe *et al* (2015) studied 2420 young people accessing this service. The two most common referral pathways to Jigsaw were the self and parent, indicating the accessibility of the Jigsaw service. Healthcare services, educational services and community organisations also referred young people to Jigsaw. Some young people were referred to existing CAMHS or AMHS services. Others were signposted to support organisations. The majority only needed a brief intervention and were not referred to another service. Jigsaw provided a much-needed service for young people with mild and emerging mental health difficulties. Overall, there was a significantly lower level of post-intervention psychological distress in this group of young people (as assessed by Clinical Outcomes in Routine Evaluation questionnaires). However, a control group was not studied.

Birmingham and Solihull Mental Health NHS Foundation Trust piloted a dedicated youth mental health service, with a target age group of up to 25 years, from July 2011 to January 2012. The service aimed to be rapidly responsive, youth-friendly and intervene early using a broad range of interventions. The youth mental health service completed an assessment and provided diagnostic formulation to a GP within 1 week of referral. Individuals were screened for psychosis, bipolar disorder, eating disorders and personality disorders. This was followed by a brief cognitive-behavioural therapy intervention and symptomatic treatment by a GP with advice from the consultation team. The clinical team offered a quick response, flexibility and choice of venue (with an emphasis on non-stigmatising, youth-friendly environments), active signposting of young people to activity aimed at reducing NEET (Not

in Education, Employment or Training) status via community partnerships, personalised plans of support, access to online support and information, and support and intervention from a named youth mental health practitioner. The emphasis was on quick assessment, quick discharge after intervention and quick re-access if required. The pilot phase, evaluated by Health Innovation and Education Cluster, looked at 247 referrals and compared this group with a similar group of referrals to community mental health teams. Youthspace was able to offer a faster first contact after referral (2 days v. 12 days), quicker first assessment (16 days v. 45 days) and a markedly reduced 'did not attend' proportion (5% v. 28%). Approximately 65% of those referred to support organisations to reduce NEET status showed a positive response. There was high level of user satisfaction, with 67% reporting continued use of maintenance techniques taught by Youthspace 12 months later. On the basis of these results, the Birmingham commissioners are now radically recommissioning services to develop integrated pathways for the 0–25 year age group, to begin in October 2015. This will be the first major service reform for young people's mental health in the UK in over 30 years (Vyas *et al*, 2015; www.forwardthinkingbirmingham.org.uk).

The success of these reforms can only be determined after careful evaluation and further health services and economic research with feedback from all stakeholders.

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