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A LOT OF MENTAL ILLNESS STARTS IN ADOLESCENCE. THEREFORE SHOULD WE SHIFT SOME OF THE SPENDING FROM ADULT TO ADOLESCENT MENTAL HEALTH SERVICES?

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SUMMARY

In May 2015 the UK elected a new government. In election campaigns, health is one of the most important areas of debate and over the preceding 12 months, the state of child and adolescent mental health services (CAMHS) had held a particularly high profile in the media and in political debate. Many had suggested that the rate of mental illness starting in adolescence is increasing and that service provision is not of sufficient quality or scale to meet this need. A brief review of the sources for these statistics reveals that whilst this may be true, there is a dearth of accurate and up to date data on the scale of the need for CAMHS or the extent to which it is being met.

Nonetheless, members of all parties claimed to support improvements in mental health service provision for children and adolescents through increases in funding. A key question for policy makers has therefore become, from where any additional funding might be derived. One suggestion has been that funding be transferred from spending on adult mental health services. The exact practical nature of such a policy is yet to be explored in detail by government or stakeholders. The primary purpose of the present discussion is therefore to consider the possible ethical implications of such a policy in principle. The discussion forms part of a wider and evolving political and professional discourse on society's and government's attitude towards mental illness, towards the balance of individual and societal needs and towards the balance between preventative and supportive interventions to improve health.

Key words: *child & adolescent – health services – policy – ethics*

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INTRODUCTION

The approach taken to make this discussion tractable identifies and evaluates three distinct elements. First, the claim that "a lot of mental illness starts in adolescence" is evaluated on the basis of epidemiological data. Adolescence is defined and the burden of mental illnesses presenting in adolescence is considered. Additionally, consideration is given to the extent to which mental illness in adolescents goes on to negatively impact on mental health in later life. Assessment of the quantity and quality of the data is used to qualify the certainty of conclusions with regard to this claim. The second element of the discussion is to evaluate the claim, "adolescent mental health services should receive more funding". An argument in favour of this claim would need to demonstrate that the level of service provision achieved with the current level of funding is insufficient and that if funding is increased, there is an evidence base to support the way in which additional money would be spent to be most effective in improving outcomes. Thirdly and finally, the moral and ethical question of whether funds should be taken away from adult services in order to finance such interventions in adolescence is evaluated. The likely impacts of a transfer of funds on individuals using adult and adolescent mental health services is described by applying the "four principles" approach (Beauchamp 1979). Based on this description and the above evaluation of adolescent service provision and potential for improvement, the impact of such a funding shift on the current service user population in both adult and adolescent services is evaluated from utilitarian and Universalist egalitarian perspectives. The conflicting conclusions drawn by applying each of these moral philosophies to the question highlight the difficulty in determining a broadly acceptable course of action in choosing between the two options of either not increasing funding to adolescent services or doing so at the expense of funding for adult services. Finally, then, the validity of this dichotomy is called into question.

EVALUATING THE DEGREE TO WHICH, "A LOT OF MENTAL ILLNESS STARTS IN ADOLESCENCE" MIGHT BE TRUE

The nature of the claim "a lot of mental illness starts in adolescence" lends itself to quantitative evaluation, taking account of the burden of disease attributable to mental illness in general, and to specific mental illnesses. In order to thoroughly evaluate the strength of this claim, several phenomena will be considered, namely: the prevalence and incidence of mental illness in adolescents, including specific examples of the most prevalent illnesses; the morbidity and mortality attributable to mental illness; and the extent to which mental illness in adolescence continues into or recurs in adulthood. If none of these factors supports the claim, we can reject it and if some are supportive, it may be held to be a weak claim. If all of these factors seem to broadly support the claim, we can consider it to be a strong claim.

The World Health Organization defines adolescence as the period of human growth and development between childhood and adulthood, from age 10-19 years. It is described as a "critical transition", through which a rapid pace of change is experienced (WHO 2015). Experiencing a critical transition at a rapid pace seems to strongly imply a level of stress, which one might well think could contribute to a burden of mental illness in adolescence. In addition to investigating the prevalence and incidence of different mental disorders within this important period, in evaluating how much mental illness starts in adolescence, it is important to appreciate the extent to which mental illness beginning in adolescence continues into adult life.

Various attempts have been made to measure the prevalence of specific mental disorders in adolescents, globally and in the UK. In the UK, the contribution of mental illness to the adolescent burden of disease is significant with up to 1 in 10 children and young people suffering from a mental health problem (UK Department of Health 2013). According to data from the Office of National Statistics (ONS 2004), approximately half of cases are conduct disorders, with the majority of the rest being emotional disorders and ADHD. The onset of ADHD and conduct disorder is more often earlier in childhood, whilst emotional disorders increase in incidence in mid to late adolescence. Globally, a 2006 meta-analysis estimated the prevalence of major depressive disorder (MDD) in the adolescent population to be around 5.7%, making it one of the most prevalent disorders of adolescent onset (Costello 2006). In addition to those meeting diagnostic criteria for MDD, there may also be a sizeable population with sub-threshold symptoms and people in this group may be more likely to go on to suffer from MDD and to attempt suicide in the future (Fergusson 2005). Bipolar affective disorder and drug and alcohol dependence may also be important disease of adolescent onset (Burke 1990).

The prevalence and incidence of mental health disorders amongst adolescents seems to indicate a large scale problem and confirm that "a lot of mental illness starts in adolescence". However, it should be noted that the latest UK data of a high quality comes from an ONS survey in 2004, making it more than 10 years out of date. Over the course of a decade, changes in the prevalence and incidence of different diseases in the adolescent population may have changed considerably. It is therefore difficult to state with any great confidence what the level of need for child and adolescent mental health services is in 2015.

The mental disorders identified as affecting adolescents and having their onset in adolescence are amongst the biggest contributors to morbidity and mortality in this age group, and perhaps into adulthood. Amongst adolescents, in 2012 suicide was the third leading cause of mortality globally (WHO 2014). As for morbidity, unipolar depression was responsible for the largest disease burden measured by Disability-Adjusted Life Years (DALYs) and anxiety disorders were the 5th biggest contributor to global total DALYs among adolescents. In addition to morbidity and mortality related directly to a mental health condition, there is evidence for indirect effects. For, example, although it would be difficult to establish causal relationships, associations between mental disorders and physical health outcomes such as acute infection have been demonstrated (Lien 2007). Therefore it seems that not only is mental illness common in adolescents but that this is a serious problem with significant impacts on individuals and society.

Mental illness having its onset in adolescence can continue throughout adulthood. MDD may be one of the biggest contributors to morbidity and mortality in later life. MDD has a high rate of recurrence, with up to 50% of patients going on to experience a chronic relapsing course of the disease (Crown 2002). MDD in adolescence is associated not only with further episodes of MDD in later life but also with a potentially 5-fold elevated risk of a first suicide attempt (Weissman 1999). In addition to diseases diagnosed in adolescents continuing into adulthood, there is evidence that mental illness diagnosed in adults may begin in adolescence. According to the Dunedin Multidisciplinary Health and Research Unit, more than 3 of every 4 adults accessing adult mental health services had a diagnosable condition before the age of 18 (DMHDRU 2015). There are also examples of diseases which may begin with more insidious development in adolescence, including personality disorders. The traditional view is that personality continues to develop fluidly throughout adolescence, however it has more recently been claimed that research suggesting Borderline Personality Disorder can be reliably diagnosed in adolescence supports routine diagnosis and treatment at this early stage (Kaess 2014). In addition to major impacts on social functioning, Borderline Personality Disorder is associated with high rates of suicide and self-harm. The implication of a change in classification systems to recognize Borderline Personality Disorder as a disorder of adolescence would surely be an increasing number of patients requiring treatment through child and adolescent mental health services. Looking to the future, then, it seems that demand for adolescent mental health services may continue to grow, either because of increasing numbers of adolescents being recognised to meet existing diagnostic criteria, or because of changes to diagnostic criteria to cover a greater number of adolescents.

It seems that mental illnesses in adolescents, particularly depression and anxiety, are responsible not only for a significant burden of disease in this age group, but that the beginnings of mental illness in this age group can lead to further problems throughout adult life. We can therefore take, "a lot of mental illness starts in adolescence", to be a strong claim.

EVALUATING WHETHER ADOLESCENT MENTAL HEALTH SERVICES SHOULD RECEIVE ADDITIONAL FUNDING

Substantiation of the claim that "a lot of mental illness starts in adolescents" is not sufficient to conclude that adolescent mental health services should receive more funding. An effective argument in favour of additional funding would need to demonstrate two points. First, that current levels of funding are not adequate to meet demand and second, that there are ways of spending any additional money that could lead to improved clinical outcomes. For example, money can be spent on hiring more psychiatrists, more psychiatric nurses or more psychologists, depending on which group is currently a "limiting factor" in expanding services. Alternatively, additional training and skilling up of existing staff could be funded. Additional costs for physical infrastructure such as premises to house additional services would need to be taken into account. If current funding levels are inadequate in light of the scale of the need that has been established, the question is whether there is any evidence to support the scaling up of any particular intervention or specific service. This evidence should pertain not only to clinical effectiveness but to effectiveness and cost-effectiveness at the large scale of the health system and the population.

The state of funding for adolescent mental health services is fluctuant. In 2014, the government announced in a report on improving access to mental health services, that NHS England would be immediately investing an additional £7 million for the provision of inpatient beds for children and young people (UK Department of Health 2014). However, according to NHS England data, this is set against the background of a real terms cut in funding for children's mental health services of 6% since 2010, equivalent to £50 million (The Rt Hon Norman Lamb MP 2015, Buchanan 2015). According to information collected by the charity YoungMinds, of those who responded to requests for information,55% of local authorities have cut or frozen child and adolescent mental health budgets since 2010/11 and 77% of Clinical Commissioning Groups have cut or frozen their child and adolescent mental health budget from 2013/14 to 2014/15 (YoungMinds 2014).

As for the level of service provision that current funding allows relative to the level of need, there seems to be limited evidence on either side of the equation. According to an NHS England report in summer 2014, although waiting times are not comprehensively monitored, amongst service providers reporting voluntarily the median waiting time for urgent assessment in the community by child and adolescent mental health services was 3 weeks in 2012/13 (NHS England 2014). Non-urgent referrals took on average 15 weeks to be seen, compared with 14 weeks in 2011/12. Inpatient capacity had increased from 1128 to 1264 available beds between 2006 and 2012 but bed occupancy was also much higher: over 85% in October 2013, almost 10% higher than in October 2012. Over 250 children and adolescents were treated on adult wards in the first half of 2013/2014 compared to only 219 in the whole of 2012/13 (Briggs 2014).

In addition to the waiting times and capacity to treat those children and adolescents engaged with services, it has also been estimated that only 1 in 4 children in need of mental health services actually receives treatment (YoungMinds 2014). If that figure is accurate it would imply that access to services needs to be drastically scaled up. However that scaling up would happen, it will almost certainly require additional funding, to meet costs such as employing additional staff. The data on which this estimate is based are not immediately apparent and it is therefore difficult to evaluate the accuracy in quantitative terms. However, this is one important indicator that current funding for child and adolescent mental health services may be inadequate to provide treatment for all adolescents in need. Despite the limited evidence, the overall picture seems to be of increasing demand and limited supply. Scaling up of both community and inpatient child and adolescent mental health services may be necessary.

The implication of all of these data is that community waiting times are long and demand for inpatient beds is increasing. It seems that the level of service provision being achieved at the present level of funding, across the whole system of adolescent mental health care, is insufficient. Whilst there may be no causal relationship between long waiting times in the community and increasing demand for inpatient services, it would be rather short-sighted to invest money solely in inpatient beds without considering whether investing more money in community adolescent mental health services would be more effective and cost-effective in the long-term. The government's current pledge of a one-off release of funds targeted at increasing inpatient capacity therefore may be a necessary measure but seems unlikely to be sufficient to address the scale of need for adolescent mental health services. Additional solutions need to be considered for potential funding.

Unfortunately, a dearth of high quality evidence seems to be a continuing theme when considering how additional funds might be spent most effectively if it is agreed that adolescent mental health services require additional funding. The Department of Health and NHS England seem to agree that service provision indeed needs to be scaled up, having set up a specific working group to investigate possibilities for how to do this most effectively. Some specific suggestions for where to direct additional funds have already been made by other groups. In the run-up to the 2015 general election, The Mental Health Policy Group has made specific recommendations for key areas to address with respect to child and adolescent mental health (YoungMinds 2014). They would like to see implemented in the next parliament, measures to address four priorities: better maternal and post-natal care; training for schools to

support mental health services and education; timely access to Child and Adolescent Mental Health Services; and greater investment in evidence-based parenting programmes. There is not sufficient space here to comprehensively evaluate the strength of the evidence in support of each of these specific services. Furthermore, as fairly high-level policy objectives, such an evaluation might be very difficult without an idea of how concepts such as timely access to services might be operationalised. There are many routes that could be taken in pursuit of that goal and it is this level of detail that still needs to be presented for consideration.

The Children and Young People's Mental Health and Well-Being Taskforce should report in 2015 on options that they deem likely to be most effective and cost-effective for system-level change. The implication of this process is that, as far as the Department of Health and NHS England are concerned, there are not currently any ways of improving service provision that stand out as being more strongly supported by sufficient evidence of clinical and cost-effectiveness. Provision of services should be evidence-based and it does not seem unreasonable to evaluate how to increase funding for maximal benefit before embarking on any large-scale spending projects. On the other hand, given the possible scale of the inadequacy of the reach of services in their current state, it is difficult to suppress a sense of urgency.

It seems that the level of services provision for adolescent mental illness achieved at current levels of funding is insufficient to meet a seemingly increasing need. Whilst this recommends additional funding in principle, there seems to be relatively little evidence currently of how to spend any additional funding most effectively to improve outcomes. Hopefully this will change later this year as expert working groups report. On the whole, it seems that with the continued caveat that the evidence is generally limited in both quantity and quality, in order to provide a sufficient level of services, adolescent mental health services should receive additional funding.

DESCRIBING THE MORAL IMPLICATIONS OF A POTENTIAL SHIFT IN FUNDING

Whether the increased funding for adolescent mental health services is provided by taking funding away from adult mental health services is primarily an ethical question. Two complementary approaches to this ethical question can be taken. As a starting point, a comprehensive description of the potential impacts on individual members of different groups can be structured around the 'four principles' approach of Beauchamp and Childress. The four principles referred to are at opposite ends of two axes: justice and autonomy on one axis; beneficence and non-maleficence on the other. The consequences of a particular action, in this case shifting spending from adult mental health services to adolescent mental health services, are discussed with regard to each party involved. In the present discussion those parties are taken to be: current and potential adult mental health service users; and current and potential adolescent mental health service users. This structured description of potential impacts can then be used to evaluate the proposition from the point of view of different moral philosophies. In this case, a utilitarian perspective contrasted with a more Universalist egalitarian perspective highlight potential conflicts in trying to reach a morally acceptable conclusion.

There is not sufficient space here to discuss any specific plans for precisely where cuts in funding to adult services might fall in order to create the overall pot of money shifted across to fund adolescent services. The proposition discussed here assumes in general terms that reducing funding for adult services will result in a decrease in either the quality of service provided to adults, or to the scale at which services are provided. The logical basis for this conclusion would be along the following lines: if the current services provided to adults necessarily incur a defined cost and the funds currently available to provide these services are calculated to meet and not exceed that defined cost, then a reduction in funding would not prevent the current services being provided. It is quite possible that an in-depth quantitative analysis might reveal some of these premises to be invalid. For example, funds currently provided might exceed what is necessary to provide current services, either because of inaccuracies in calculation or because more efficient operating models have been discovered by providers. This level of analysis is important and should take place elsewhere as there is not sufficient space to fully address it here. For present purposes, the conclusion that there would be some reduction in the quality or scale of services for adults if funding was shifted to adolescent services will be taken as valid and the four principles will be applied accordingly.

Evidently, the beneficence of the shift in funding could be highly significant. A recent government report, *Achieving Better Access to Mental Health Services by 2020*, asserts, "Prevention and early intervention to support children and young people with mental illness can dramatically improve the quality of their lives and future" (UK Department of Health 2014). As discussed above, there are multiple possibilities and evidence is currently being collected on how best to improve service provision for adolescents. However, it might broadly be the case that for those already engaged with services, increased funding might allow improved quality; more frequent contact and shorter waiting lists, for example. It might also be more likely for those becoming ill to engage with services, where they currently either are not seen as adolescents or are seen comparatively late on in the course of a disease, facilitating earlier diagnosis and treatment, which might improve outcomes, not just in the short-term, but into adult life as well. With regard to future and potential adult mental health service users, it is plausible that the

shift of funding to adolescents might lead to some indirect beneficence to one particular sub-group. For people who are adult mental health service users and are also parents of adolescents with mental illness, better service provision for adolescents might reduce or remove a significant stressor, which in turn might improve their own mental health. As this only represents a subgroup of adult service-users, however, the scope of this potential beneficence is limited.

With regard to non-maleficence, it would be difficult not to conclude there is maleficence to the group of adult service users as a whole if funding is taken away and shifted to adolescent services. It might initially be difficult to see how a shift in funding to adolescent services could harm current any potential adolescent service users. However, for a subset of adolescent mental health service users – those whose parents are currently engaged with adult mental health services – there may some indirect harm. A shift in funds away from adult mental health services may impair their parents' access to adequate treatment for their mental illness. In turn, this may impair the parents' ability to effectively function, with negative consequences for those adolescents. This consideration only applies to a sub-group of service users, perhaps limiting its scope. Dependent on the nature of the increase in service provision, a further consideration with regard to non-maleficence might be whether there would be a general lowering of the threshold to diagnose and treat mental illness. It would not be implausible to suspect that if a referral to specialist services from primary care were faster and easier, more adolescents might be referred, investigated and treated, some of whom might not have a mental illness. Under the current circumstances they might not have been referred. This could present harms in the form of inappropriate labelling and unnecessary stress.

Autonomy is often thought of as an individual's liberty to make decisions. Although having a mental illness is not a decision that is made by an individual, engagement with services requires actions on the part of the patient. For example, a person suffering from depression may go to see their GP, where they might be diagnosed. If they are referred for a talking therapy, attending the appointment and working on any homework both require actions on the part of the patient. If the funding shift increased access to these services it might be argued to be increasing the options open to adolescents, strengthening their autonomy in the sense of their ability to engage with services. If we take this as a valid argument, the converse must be equally true: cutting funds to adult services over-rides the autonomy of current and potential adult service users.

In considering justice, the wider impact on society of increasing funding to provide mental health services for adolescents might be difficult to quantify. Perhaps the most significant potential impact of improved services following a shift in funding would be a future reduction in the prevalence of adult mental illness, or in the incidence in related complications, such as deliberate self-harm and suicide. If it were the case that adequate intervention in adolescence could significantly reduce the morbidity and mortality from mental illness not only in the short term but throughout the adult life of this cohort and future adolescents subject to improved services, the benefits to society would be huge. A reduction in the demand for adult mental health services would allow funding to be reduced and improved mental health would reduce the productivity lost due to time off work related to mental illness. The impact of this would not be measurable for a number of years – until the current adolescent mental health service users had been through several years of adult life. Other societal impacts might relate to how the funding shift impacted on specific sub-groups of current and potential adolescent service users. In some it has been found that specific mental illnesses in adolescence are associated with early termination of secondary school education lower levels of education (Lee 2009). That being the case, better identification and management of mental illness might improve educational outcomes, increasing the pool of skilled labour when these adolescents become employed as adults, which might be better for the economy. Any current adolescent service-users who are also young carers might also be better able to care for dependent relatives, easing social care burdens and improving outcomes for their dependents.

On the other hand, reducing the funding and level of provision for current adult service-users could have equally far-reaching consequences for society. Adults of working age are the main contributors to the workforce and economy. If fewer current and future adult services users were able to continue to access treatment, there could well be an increase in the number of days of productivity lost to illness and the incidence of deliberate self-harm and suicide might increase, with associated costs. Adults with inadequately managed mental illness may find it increasingly difficult to look after dependents (either, elderly parents or young children) which could negatively impact upon those individuals and also increase social care pressures. The economic cost to society might be very high.

INTERPRETING THE MORAL IMPLICATIONS OF A POTENTIAL SHIFT OF FUNDING

Interpretation of the four principles analysis of a potential shift in funding from adult to adolescent mental health services could take place from one of several moral philosophical perspectives. Without more specific proposals for how to cut funding for adult services and how to spend additional funding for adolescent services, and considerably more and higher quality evidence of the potential impact, a pure utilitarian approach, measuring net overall benefit, is difficult. Ideally, a quantitative analysis of DALYs

avoided by increasing funding for adolescent mental health services would be undertaken and weighed against any increase by shifting funding away from adult mental health services. In general, assuming that evidence-based interventions to improve adolescent mental health services are available and would have both short and long-term benefits to the health of those adolescents, the greater good in the long-term would be achieved by shifting funding from adult to adolescent services. This is because the adolescents currently using services would benefit now, and continue to benefit throughout their adult lives. They will live more years, more healthily than the adults affected by a cut in funding will live, less healthily. This is in keeping with a common bias of the utilitarian approach, toward providing services for younger people at the expense of older people, largely on the basis of life-expectancy.

Attaching more weight to the negative consequences for current user of adult mental health services would probably lead one coming from a perspective of universal egalitarianism to conclude against a shift in funding. Any harm coming to the population of adult service-users due to funding cuts would be unfair on the basis that they did not have the chance to access services as adolescents. This is true of those whose illness had already begun in adolescence, many years ago, and of those who only became ill, or continue to become ill, as adults. The only circumstances under which we might conclude in favour of shifting funding taking this approach would be if adolescents were currently receiving less or lower quality care than adults. The shift would therefore be necessary to achieve egalitarian access to services across the whole population. There is some evidence to suggest that the state of provision of services for adult mental illness is currently also barely adequate. It has been estimated that only 1 in 3 people with depression receives treatment (Mental Health Policy Group 2014) and 1 out of every 10 adults referred for a talking therapy has been waiting for more than a year for treatment to begin (We Need to Talk Coalition 2013). There is also evidence that demand for services has grown in recent years (Health & Social Care Information Centre 2012). This is comparable to the situation of adolescent service provision since, as described above, 1 in 4 young people in need is receiving treatment.

An egalitarian perspective might take into account access relative to need; indeed, in this context, it would make little sense in practical terms to consider access in any other terms since access to services for managing mental health problems is primarily of benefit to those suffering from a mental illness. This might be the most reasonable egalitarian approach but in practical terms is likely to lead to the original conclusion, that funds should not be shifted. This is because adult mental health services do not seem currently to be provided at a level that is superfluous to need. Therefore any reduction in funding that reduces access to services would create a higher relative need, likely to offset any lower relative need achieved by increasing access to services for adolescent mental health service users.

As members of the medical profession, our two principle motivations are to alleviate suffering and do no harm. It is therefore unsurprising that whilst drawn to the quantitative evaluative framework offered by a utilitarian approach, I find it difficult to argue in favour of taking funding away from adult mental health services, in the knowledge that this is likely to negatively impact on the lives of the people using those services who, by definition, are already suffering. Equally natural in following the premise that the alleviation of suffering should be a prime motivation, is the question of the extent to which funds spent outside mental health, and indeed outside health altogether, are spent, and what these funds contribute to the alleviation of suffering. It may be that the question of whether or not to shift money from adult to adolescent mental health services is a false dichotomy. Would it not be possible to maintain current levels of funding for adult mental health services whilst increasing funding for adolescent mental health services from another source?

One might argue against this approach on moral or practical grounds. On practical grounds a response might simply be that public funds are not sufficiently large to fund every service imaginable and that it is not possible to make perfect decisions about how exactly to spend the money. From a moral perspective, one might argue that public funds spent on services other than mental health are necessary to prevent and alleviate different kinds of suffering in different groups of people. For example other health services may reduce suffering of some groups within the population in relation to cardiovascular disease, infections and cancer. The arguments along this line with regard to defence, for example, might be somewhat more tenuous but are still difficult to completely rebuff. If taking funding away from these services would reduce their capacity to alleviate suffering, two moral arguments counter the suggestion. First, from a utilitarian perspective there could only be marginal returns when decreasing suffering in one part of the population, with regard to one problem, at the expense of increasing the suffering of another part of the population, with regard to another problem. Second, from an egalitarian perspective, it is no fairer to fund adolescent mental health service-users by taking funding and services away from people in need of cardiovascular treatments, for example, than it is to take money away from adults with mental illness. However, given the level of need that seems to exist, the potential harm that may come to individuals and wider society if nothing is done and the potential gains if increased funding is successful in improving outcomes, it seems unlikely that funding for adolescent mental health services should not be more highly prioritised than some other areas of public spending. It would therefore probably be more appropriate to increase funding for adolescent mental health services by transferring funding from other public services.

CONCLUSIONS

A great number of adolescents are affected by mental illness and this number may be increasing. Conduct and affective disorders such as depression and anxiety seem to be particularly prevalent and morbidity and mortality due to suicide and self-harm is significant. In many cases, it seems that illness carries on into adulthood. Although evidence of the scale of need for adolescent mental health services is lacking in quantity and quality, it seems reasonable to state that a lot of mental illness starts in adolescence.

Over recent years, adolescent mental health services have had budgets cut and frozen, despite the apparently rising demand for services. It does seem that waiting times for community services are long and increasing and that inpatient services have also been affected as despite increases in bed numbers, bed occupancy has increased. There is a need for scaling up access to services. However, there is currently insufficient evidence to assess how any additional funding might most effectively be spent to improve adolescent mental health and access to services in the long term. Suggestions are emerging and hopefully the recommendations of a government coordinated network of experts will reach some firm conclusions later in 2015. However the evidence suggests access might be scaled up, it is almost certain to involve increasing funding for adolescent mental health services and this seems entirely appropriate and necessary with some urgency.

Whether the additional funding deemed necessary for improving access to adolescent mental health services should be derived through a shift of funding from adult mental health services presents a significant moral and ethical challenge, regardless of the moral philosophy with which one approaches the question. When one's primary motivation is to relieve suffering in general, the opportunity to relieve some degree of suffering in one group of people at the expense of a possible increase in suffering of another group of people is highly unpalatable. When so many individual people are likely to be affected by a decision it is tempting to take a utilitarian approach and in this case, it would seem that a shift in funding from adult services might be justifiable as a better option than not increasing funding for adolescent mental health services.

However, since there seems to be a great need for both adolescent and adult mental health services, a more attractive solution would be to increase funding froman alternative source, rather than artificially restricting the decision to the dichotomy of "fund transfer from adult services" against "no additional funding". Possible alternative sources include public funds currently available or increased through taxation. Superficially, this might seems to be equally morally imperfect since mental health services only benefit the minority of the population using them. However, within this group there is a sufficiently great need and because of this a sufficiently great potential impact on society, that additional funding would likely be justified when weighed against other uses of public or private funds. This third way could therefore prove to be a more morally justifiable solution than either failing to increase funding to adolescent mental health services or shifting funds from adult to adolescent mental health services.

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