CHILDREN'S COMMISSIONER

Children's mental health services 2022-23

March 2024

Contents

Foreword from Dame Rachel de Souza

Since I came into post in 2021, I have spoken to over a million children and young people across the country. The vast majority of children are happy, and feel supported by their family, school and wider community.

However, there is a growing group of children who are struggling with their mental health. This generation of children has experienced uniquely uncertain and challenging times. Some have spent some of their most formative years isolated and indoors, fearful they or their loved ones may catch a deadly virus. They have felt the squeeze of a cost-of-living crisis, and are keenly aware of the pressure their parents are under. They are constantly bombarded by negative news, of wars and climate catastrophe. An increasing number are exposed to the harmful impact of social media, cyber bullying, and online exploitation. Crucially - not all children have the support system and protective factors they need to thrive in these difficult circumstances.

Against this backdrop, it is not surprising that we continue to see the number of children experiencing poor mental health at persistently high levels. The NHS estimates that 1 in 5 children and young people aged 8 to 25 in England have a probable mental health condition. This is in line with what children told me in my *The Big Ask* survey back in 2021, with higher levels of poor mental health among particular groups of children – such as older teenage girls and children in care.

I do not think it is an overstatement to speak of a crisis in children's mental health and the services needed to support them. For this reason, every year I have been in office I have published figures tracking the gap between need and spending – as seen in waiting times and other key metrics – to keep the spotlight on this issue.

This report shows how much further we need to go to effectively support children to lead healthy, happy lives. Children are still waiting far too long to access the help they need – with over 270,000 children still waiting for support, and in the last year nearly 40,000 children experiencing a wait of over 2 years.

We should be ambitious about seeing demand for these services go right down. With the right early support, many children would not need to access mental health services. It is shocking to see so many children being referred to mental health services because they have reached crisis.

As my previous reports have shown, the level of care that children receive is very much still down to the luck of where they live. Waiting times vary hugely across the country, from an average of 147 days in Sunderland to just 4 days in Southend.

Many of the problems we see in children's mental health services stem from a lack of prioritisation, at both a national and local level. Despite children being disproportionately likely to experience a mental health condition, inflation-adjusted growth in investment by ICBs in children's mental health services is stagnating.

We need fresh, long-term thinking when it comes to children's mental and emotional health and wellbeing. Much of this work must be done upstream, creating an environment and a world – both online and offline - where children grow up feeling happy, safe and supported. This means every child feels loved and nurtured, lives free from poverty, and is able to focus on learning. With enough focus on prevention, children should never come close to crisis.

For children who need it, support should be put in place quickly and locally: no child should be left on a waiting list for months or years.

I hope that these latest figures will contribute to the considerable body of evidence that the sticking plaster approach to children's mental health is not working. There is clearly a persuasive economic case

to increase investment in children's mental health services – which are the springboard so many children and young people need for happy and fulfilling adult lives. However, in my view there is a far more compelling moral imperative to take more ambitious action now. We would never knowingly allow a child's physical health to deteriorate to the point of lasting or even irreversible damage.

Whenever I speak with children and young people, I am always amazed by their immense resilience and hopefulness that things can and will get better. This resilience should not be taken for granted. As we approach a general election this year, I want to see a culture shift – with leaders acknowledging that the health and wellbeing of our children is paramount for future prosperity. I want this generation of children to be the healthiest yet.

"To raise a generation that is equipped for life, that is ambitious, that can change the country for the generations after us too, the government needs to deal with the appalling mental health crisis in the UK." – Girl, 16

Executive Summary

This report contains findings on children's access to mental health services in England during the 2022-23 financial year, based on new analysis of NHS England data. This data underlines that demand for children's mental health services continues to outstrip the availability of support. Despite welcome increases in investment in Children and Young People's Mental Health Services (CYPMHS, commonly known as CAMHS)[i] – the inflation adjusted growth of investment has slowed.

The NHS England data analysed in this report has a number of shortcomings. The new ICB footprints do not map directly onto the previous Clinical Commissioning Groups (CCGs), limiting the comparability of this report with previous Children's Commissioner's office (CCo) mental health briefings. How long children wait to access mental health support must be estimated through the proxy of contacts with CYPMHS. To avoid underestimating how long children wait, CCo uses 2-contacts (not the 1-contact measure used by the Government and NHS England). This report calls for the development of a single and comparable way of measuring the most meaningful wait a child is subject to. Rather than number of contacts, this should focus on how long children wait for assessment of their needs, and for support or treatment to begin. Greater insight is also needed into the journeys of children who have their referrals closed before treatment in CYPMHS, and/or who may have been re-referred onto services not included in the Mental Health Services Data Set.

Key findings:

Access

- **There were 949,200 children and young people who had active referrals to Children and Young People's Mental Health Services (CYPMHS) at any point within the 2022-23 financial year.** This is 8% of the 11.9 million children in England. Of these children and young people:

[i] NHS England refers to children's mental health services as 'CYPMHS', however many children, young people and professionals still refer to 'CAMHS' (Child and Adolescent Mental Health Services). Sometimes CYPMHS is used as an umbrella term which includes CAMHS as well as other mental health services that may be available to children.

  - Almost **305,000** (32%) entered treatment;
  - **270,300** (28%) were still waiting at the end of the year;
  - **372,800** (39%) had their referrals closed before accessing CYPMHS.
- **Of the 1.4 million children estimated to have a probable mental health condition[1], less than half received at least 1 contact with CYPMHS during the year (49%)**, broadly the same as last year (48%).
  - This access rate falls to **21.7% when measuring entering treatment as having had a 2nd contact with services – down slightly from 22.2% last year.**

Waiting times

- For the 305,000 children and young people (32% of those referred) **who entered treatment within the year, they waited an average of 35 days (median) or 108 days (mean).** *Note that this figure is not comparable with previous CCo reports (see methodology for details).*
  - Some children experience particularly long wait times before they entered treatment. In 2022-23, there were **6,300 children and young people who waited over 2 years** (104 weeks) before entering treatment, for whom the average wait was over three years (median 1,128 days, mean 1,399 days).
- New CCo analysis shows that for the 270,300 children and young people recorded as **still waiting at the end of the year for their 2nd contact, they waited on average 142 days (median) or 359 days (mean).**
  - Of this group, **32,200 children had been waiting for over 2 years.** These children had been waiting on average 1,361 days (median) or 1,704 days (mean).

Reasons for referrals

- In 2022-23, the most common primary reason for referral was 'unknown', making up 34% of those entering treatment within the year. This is followed by **anxiety, 'in crisis', neurodevelopmental conditions (excluding autism), depression, and self-harm** behaviours. These top six reasons add up to the large majority (81%) of all children entering treatment.

Access and waiting times for different groups of children

- **Boys, younger children, and white children all wait longer periods of time for mental health support on average.** These groups of children may be less likely to present with or be

identified as having acute needs (children referred because they are in crisis or self-harming wait for the shortest length of time).

  - **Boys wait longer on average to enter treatment** – a median of 46 days compared to 29 days for girls. Waiting times for those who are non-binary were notably shorter than any other group, with a median wait of 7 days.
  - **Younger children wait longer to access treatment compared to older children and young people** – a median wait of 98 days for under 5s, compared to a median wait of 17 days for those age 16 to 17.
  - **Children of unknown ethnicity waited the longest (median 42 days), followed by white children (median 35 days)**. Asian and black children waited the shortest length of time (median 19 days and 25 days, respectively).

- **Children with suspected autism wait the longest time for support on average** (median wait of 216 days), **followed by children with other neurodevelopmental conditions** (median wait of 111 days). This likely corresponds with the longest waits for 'Autism Service' (median wait of 481 days) and 'Neurodevelopment Team' (median wait of 194 days).

Spending

- Spending on children's mental health services (excluding spending on mental health services for children with learning disabilities and eating disorder services**) has increased in both real and nominal terms since 2018-19.** Of the total NHS budget for England, Integrated Care Boards (ICBs) spent £997 million on CYPMHS in 2022-23, equal to 1% of total ICB spend. This compares to £922 million in 2021-22 – an increase of 8% in nominal terms. However, when adjusted for inflation, **growth has slowed from 7% between 2020-21 and 2021-22 to 1% between 2021-22 and 2022-23.**
- Bearing in mind the 950,000 children referred to CYPMHS in 2022-23, this £997 million averages out to **£1,050 per child with an active referral** (in nominal terms). When considering the estimated 1.4 million children and young people with a probable mental health disorder,[2] this figure becomes **£710 per child or young person in need.**

Content warning

This report makes reference to mental health conditions, including suicidal thoughts and self-harm. The CCo acknowledges that this content may be difficult to read. However, it is important to provide frank insight into the level of need among children, to ensure services are set up to support them. We encourage you to take care of your own wellbeing when reading this report.

If you are affected by the issues discussed, the following organisations can provide you with expert information, advice and support:

childline
ONLINE, ON THE PHONE, ANYTIME
childline.org.uk | 0800 1111

Childline is a free and confidential service for under-19s living in the UK: www.childline.org.uk | Call 0800 1111

NHS England

NHS Urgent Mental Health Helpline (England only)
Offers mental health support and advice, help to speak to a mental health professional, and can arrange an assessment to help decide on the best course of care.
www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

SAMARITANS

Samaritans is a free listening service that offers 24/7 support.
www.samaritans.org | Call 116 123

shout 85258
here for you 24/7

Shout provides 24/7 for urgent mental health support via text:
www.giveusashout.org | text SHOUT to 85258

Introduction

Recent figures from the NHS and other organisations have shown a large increase in the number of children suffering with mental health issues. The NHS estimates that in 2023 approximately 1 in 5 children (20%) had a probable mental health condition, a stark increase from 1 in 8 (12.5%) in 2017. Concerningly, some groups of children suffer from especially poor mental health. Though rates were similar for boys and girls from age 8 to 16, the rates for young women spiked at age 17, to the point where they were almost twice as likely as young men to suffer from probable mental health conditions.[3]

With new figures sourced from NHS England using the Children's Commissioner's legislative powers to request data, **this report examines spending on children's mental health, numbers of children referred to and accessing Children and Young People's Mental Health Services (CYPMHS), commonly known as CAMHS, and waiting times between referral and treatment (having a 2nd contact with CYPMHS).** Mental health services in this report refer to advice and support from a range of professionals, including for problems like stress, low mood and depression, anxiety, self-harm, eating disorders or difficulty managing behaviours.

The CCo has calculated a summary score for each local area based on four key indicators of CYPMHS performance. This score shows how each Integrated Care Board (ICB) compares to the rest of England in terms of children's access to mental health services. The best possible score is 20. The four key indicators are:[ii]

1. **Mental health spend per child referred** – calculated using NHS Mental Health Dashboard spending figures and referrals data provided in the data collection (where higher spend per child referred means a higher score).
2. **ICB spending on children's mental health** as a percentage of a ICB's total expenditure (where a higher percentage means a higher score).

[ii] This year, the metrics used to calculate overall area scores have changed. Instead of spend per child aged 0 to 17 in the ICB (previously CCG), this report uses spend per referral (using England totals provided by NHS England) to CYPMHS. This aims to capture more directly the link between mental health spend and need, as most children and young people in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated by the percentage of the child population (aged 0 to 17) receiving two contacts with CYPMHS, has been dropped from the list of metrics.

3. Average waiting time for children who receive a 2nd contact with services (where lower average waiting times means a higher score).
4. The percentage of referrals that are closed before treatment (where a lower percentage of referrals closed means a higher score).

For the first time, CCo is also able to provide findings on:[iii]

- The number and detailed waiting times for children who **waited more than 12 weeks to access treatment** as well as the **number of children who were *still waiting*** (having not received two contacts by the end of the year) for mental health support and how they long they had been waiting for.[iv]
- **Waiting times between referral and 1st contact, and between 1st and 2nd contact,** on top of the usual data on waiting times between referral and second contact.
- Children and young people's **primary referral reasons**, and waiting times by referral reason.
- **The services** children and young people are waiting for, and waiting times by service type.
- Breakdowns on waiting times by **gender, age, ethnicity, disability and geography.**

All quotes from children and young people in this report are drawn from the CCo's *The Big Ambition* survey, which ran from September 2023 to January 2024. The full findings of this survey and methodology will be published at the end of March 2024. The survey included one open text question which was answered by 174,131 children: *"What do you think the government should do to make children's lives better?"*

[iii] Data on spend and eating disorders is publicly available on the NHS Mental Health Dashboard and data provided to the CCo on referrals and waiting times has now been published on the NHS website (see Methodology). Any findings not presented in this report will be explored in subsequent analysis.

[iv] Previous CCo reports were based on data that only included children who were referred during the year. As a result, the analysis excluded children who were referred before the financial year and did not capture children waiting more than a year to enter treatment.

About this report

Many frontline NHS practitioners work tirelessly to improve children's health outcomes. Children are proud of the NHS, and all the people who make it possible. The purpose of this research is to keep a sustained focus on the issue of children and young people's mental health and wellbeing, and highlight the need for sustainably resourced services to support them. The performance indicators have enabled CCo to look into good and promising practice happening in local areas that perform well across several key metrics.

This report captures data on waiting times, spending and referrals closed before treatment – but there are several caveats to keep in mind when interpreting the data. These figures alone do not provide insight into:

Exactly how long children wait for assessment and treatment to begin
Pathways to support vary hugely from area to area. A 1st or 2nd contact may mean very different things in terms of the support a child receives – depending on how the referral pathway is designed. Some children may continue to wait for long periods after their 2nd contact for treatment to begin.

How well supported children are during their wait
This data does not capture whether and how well children are supported during their wait.

What happens to referrals closed before treatment
While generally lower numbers of referrals closed before treatment suggests a higher quality of referral and more children accessing support, there are some instances where a referral closed before treatment represents a positive outcome for a child. This may be the case, for example, when a child is effectively signposted to a service that better meets their needs. Currently, data is not recorded on what, if any, services children who have their referral closed are referred onto.

Children and young people's experiences of mental health services, effectiveness of support, and outcomes

While children's access to mental health services alone is an important metric, further research is needed to understand children's experiences of accessing mental health support, and what kind of support is most effective for meeting the child's needs. As well as speaking to children and young people about their experiences, joined up data between health, education and social care is needed to gain this full picture - for example measuring whether children receiving mental health support are less likely to miss school than those who are still waiting or who have had their referral closed before treatment.

Further challenges are highlighted in the section *'Limitations and data challenges'* at the end of this report.

"CAMHS don't get nearly enough money to support all the children that have been referred to them and as a result, staff are overworked and overlooked." – Girl 16

"NHS mental health services are dire: severely underfunded and understaffed with clinicians who mostly genuinely care but physically cannot give everyone everything they need." – Girl, 16

1) Trends in children and young people's mental health and access to NHS Children and Young People's Mental Health Services (CYPMHS)

"I'm part of the COVID lockdown generation [...] We expected some sort of response from the government/ health service but were let down - and continue to be, as still the majority of those people haven't seen a professional. Please fix the healthcare crisis." – Girl, 17

Overall rates of children and young people with probable mental health conditions have increased substantially in recent years, from about 1 in 8 (12.5%) children and young people in 2017 to 1 in 5 (20.3%) in 2023.[4] There could be a range of reasons for this, with research suggesting that it could include the impact of the Covid-19 pandemic and the increased cost of living.[5]

Applying the 2023 NHS mental health prevalence rates to Office for National Statistics (ONS) mid-year 2022 population estimates for those age 8 to 17 (the latest available figures) suggests that there is a pool of approximately **1.4 million children and young people with a probable mental health condition in England, a slight increase from 1.3 million in 2022[v].**

In recent years, the NHS updated their primary metric for indicating whether a child has accessed treatment from whether the child had at least 2 contacts with CYPMHS (a 2-contact measure) to whether the child had at least 1 contact with CYPMHS (a 1-contact measure).

NHS England's mental health dashboard (formerly called the Five year forward view for mental health dashboard), shows that 678,400 children and young people had at least 1 contact with CYPMHS and

[v] Prevalence rates for probable mental disorders is an estimate of how children may have a mental health concern. Some children in the estimated pool of 1.4 million children and young people may already be known to services and in treatment, be newly referred or have yet to be referred.

NHS funded services[vi] in 2022-23, up from 661,000 in 2021-22. From this we can estimate that the 1 contact based CYPMHS access rate (based on the pool of children with a probable mental health disorder in England) **is 48% in 2022-23 - still less than half and about the same as 49% in 2021-22.**

However, as it is unclear whether a child or young person's treatment for their mental health condition begins after 1 contact, **the Children's Commissioner's office (CCo) prefers to retain the 2-contact measure as a proxy for treatment beginning.** Measured in this way, NHS figures for England show that just over 300,000 entered treatment within the 2022-23 financial year. Applying this number to the approximate pool of children with a mental health need in 2022-23, **the two-contact access rate is 21.7% - down slightly from 22.2% in 2021-22.**

"I have struggled with my mental health for most of my life, and the time I have spent on the waiting lists is outrageous. I have even been dismissed without actually being seen." – Child, 14

[vi] Includes NHS funded community services and school or college based Mental Health Support Teams. This 678,400 figure for children and young people accessing treatment (1+ contacts) is calculated by adding up the total children receiving at least 1 contact with CYPMHS across all ICBs. This figure does not include children and young people with unknown ICBs and, as a result, is an undercount. The total figure (including those in unknown ICBs) is available in the NHS mental health bulletin annual report for 2022/23. These figures show that 709,559 0 to 17s had at least 1 contact with CYPMHS in 2022/23, up from 674,485 in 2021/22.

2) Overall numbers and waiting times

Latest CCo analysis shows that there were 949,200 children and young people who had active referrals to CYPMHS in the 2022-23 financial year. Of these children and young people:

- Almost **305,000** (32%) children and young people entered treatment (had 2 contacts with CYPMHS);
- **270,300** (28%) children were still waiting at the end of the year (were yet to receive their 2nd contact with CYPMHS);
- **373,000** (39%) had their referrals closed before accessing CYPMHS (referral closed before 2nd contact).

In last year's report CCo reported that 734,000 children had been referred to CYPMHS in 2021-22. This (and other figures calculated using NHS England referral and waiting times data) is not directly comparable with this year's figure due to a methodology change. To investigate children waiting longer than a year to enter treatment, the group of children included in the data has been expanded, from those with referrals that started during 2022-23, to all children with active referrals in 2022-23 (some of whom may have been referred years before).

For the 305,000 children and young people who entered treatment within the year (received their 2nd contact with CYPMHS), they waited an average of 35 days (median) or 108 days (mean). Some children and young people waited a short time before their second contact. About 15% of children (47,200) entered treatment within four weeks, who waited on average 10 days (median) or 11 days (mean). Others waited for particularly long periods of time before they received their 2nd contact, as reflected in the large disparity between the median and mean waiting times. In 2022-23, there were **6,300 children and young people who waited over 2 years (104 weeks) before entering treatment**, for whom the average wait was 1,128 days (median) or 1,399 days (mean).

For the 270,300 children and young people still waiting at the end of the year for their second contact with CYPMHS, they waited on average 142 days (median) or 359 days (mean). Last year CCo reported the average (median) was 40 days[6], but as mentioned above, this figure only relates to children with referrals that started in 2021-22, not every child with an active referral within the year. Of the 270,300 children and young people still waiting at the end of the year, **32,200 had been waiting over 2 years (104 weeks).** These children had been waiting on average 1,361 days (median) or 1,704 days (mean).

Other research citing a lower number of children waiting for mental health support is likely an underestimate, due to being based on the NHS's 1-contact measure to indicate a person entering treatment.

"I've waited a year for my [autism] assessment, and I waited two years before that for my admission to CAMHS." – Girl, 16

As with previous years, the average waiting time for children to enter treatment (receive 2 contacts with CYPMHS) varies widely by ICB, from as quick as 5 days in NHS Mid and South Essex to as long as 79 days in NHS Hampshire and Isle of Wight (see table below). The disparity between areas with the shortest and longest waiting times becomes more prominent when looking at sub-ICB level data. As with last year, NHS Sunderland had the longest median waiting times, where children wait 147 days to access treatment. This compares to just 4 days in NHS Southend (see annex table A1 for full list).

"Access to mental health services is rubbish. Youth workers and youth clubs just don't exist in my area. My council is bankrupt and they are going to cut even more." – Girl, 14

Table 1: CYPMHS average waiting times by ICB

Integrated Care Board	Children referred	Median wait in days	Mean wait in days
NHS Hampshire And Isle of Wight ICB	8,910	79	145
NHS Gloucestershire ICB	3,320	78	116
NHS Norfolk And Waveney ICB	4,645	77	180
NHS Devon ICB	5,940	77	205
NHS Derby And Derbyshire ICB	4,585	73	172
NHS Black Country ICB	5,985	72	123
NHS Nottingham And Nottinghamshire ICB	6,615	69	251
NHS Herefordshire And Worcestershire ICB	2,550	67	108
NHS Surrey Heartlands ICB	5,720	65	136

NHS Coventry And Warwickshire ICB	2,385	64	189
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	6,295	63	152
NHS Sussex ICB	6,640	61	136
NHS Frimley ICB	3,785	60	140
NHS Dorset ICB	2,565	59	94
NHS North Central London ICB	7,210	58	133
NHS Lincolnshire ICB	3,970	56	70
NHS North West London ICB	7,955	49	88
NHS Bath And North East Somerset, Swindon And Wiltshire ICB	4,900	48	116
NHS Cambridgeshire And Peterborough ICB	4,545	47	124
NHS Kent And Medway ICB	9,830	41	215
NHS Northamptonshire ICB	5,015	36	63
NHS South West London ICB	8,315	34	76
NHS North East And North Cumbria ICB	22,270	34	85
NHS Staffordshire And Stoke-On-Trent ICB	6,055	33	101
NHS Birmingham And Solihull ICB	4,325	32	89
NHS Humber And North Yorkshire ICB	7,050	32	94
NHS Cornwall And The Isles Of Scilly ICB	2,990	29	61
NHS Hertfordshire And West Essex ICB	7,090	29	66
NHS Cheshire And Merseyside ICB	14,380	29	128
NHS Bristol, North Somerset snd South Gloucestershire ICB	3,460	28	74
NHS Somerset ICB	2,235	28	58
NHS West Yorkshire ICB	17,195	28	100
NHS South East London ICB	7,375	26	114
NHS Shropshire, Telford and Wrekin ICB	2,160	24	92
NHS South Yorkshire ICB	5,925	23	88
NHS Greater Manchester ICB	26,400	21	94
NHS North East London ICB	10,545	21	59

NHS Suffolk And North East Essex ICB	6,090	19	78
NHS Lancashire And South Cumbria ICB	11,170	19	82
NHS Bedfordshire, Luton and Milton Keynes ICB	7,460	10	39
NHS Leicester, Leicestershire and Rutland ICB	8,435	6	46
NHS Mid And South Essex ICB	6,520	5	36

3) Waiting times by demographic characteristics

Certain groups of children wait longer than others to access CYPMHS. This report will examine each demographic characteristic in turn.

3a) Age

Children and young people aged 13 to 15 were by far the largest group of children accessing CYPMHS treatment, making up 37% of all entering treatment despite making up only 17% of all children in England (see table 2 below). The large majority (78%) of all children and young people entering treatment were aged 10 or above.

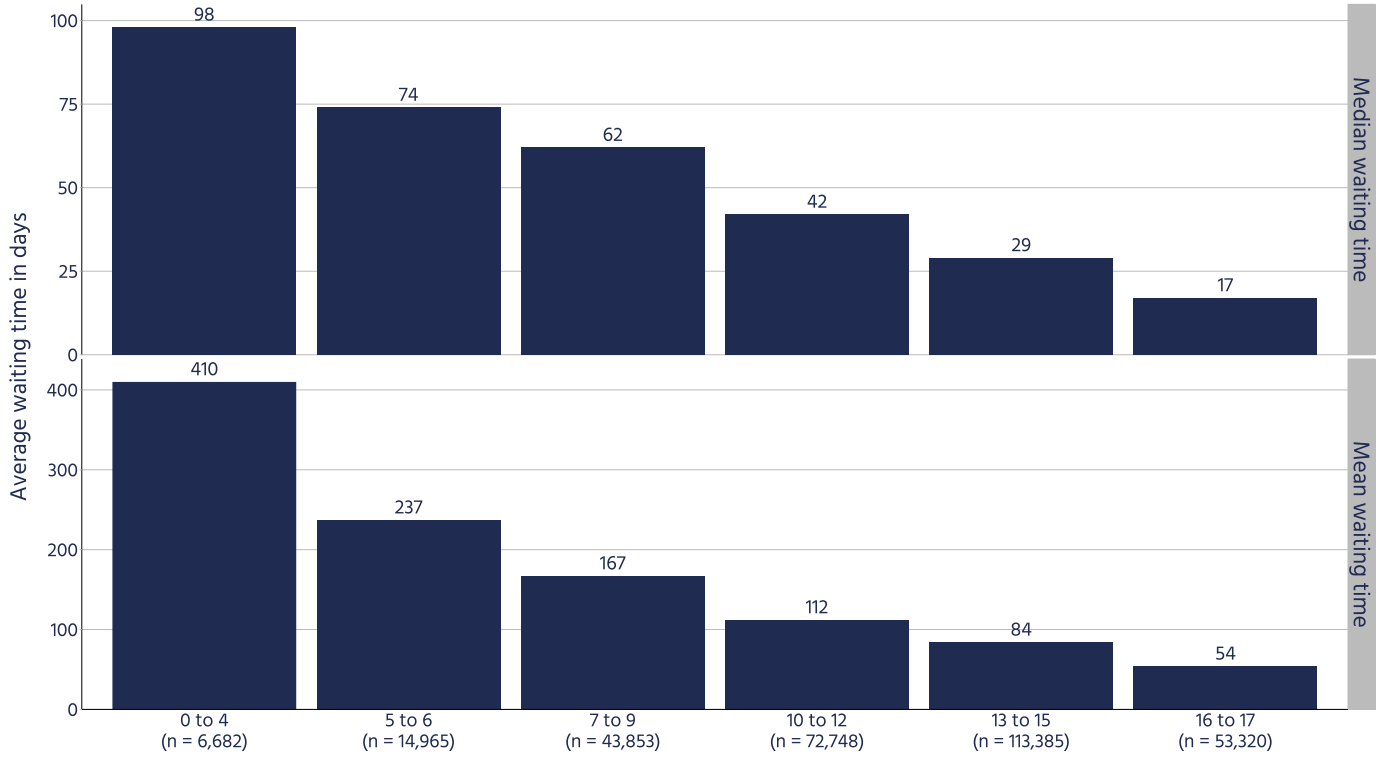
Waiting times are longest for the youngest children and shorten as they age. For example, children aged under 5 wait a median of 98 days, compared to 29 days for those aged 13 to 15, and 17 days for those aged 16 to 17 - the shortest wait of all age groups.

Table 2: Waiting times for children and young people entering treatment by age group

Age group	Number of children	% entering treatment	Median wait in days	Mean wait in days
0 to 4	6,682	2%	98	410
5 to 6	14,965	5%	74	237
7 to 9	43,853	14%	62	167
10 to 12	72,748	24%	42	112
13 to 15	11,3385	37%	29	84
16 to 17	53,320	17%	17	54
Total	304,953	100%	35	108

Note: due to rounding, the percentages of children do not add up to 100%.

Figure 1: Waiting times for children and young people entering treatment by age group



Older adolescents are more likely to self-harm, attempt suicide and experience acute mental health problems as a consequence of alcohol and substance misuse than younger children.[7] Similarly psychosis and eating disorders requiring acute intervention are more likely to present in late adolescence. This increased prevalence of mental health presentations requiring urgent assessment or treatment among older children could explain the shorter waiting list for this cohort. Younger children are more likely to present to mental health services with behavioural problems, for which the waiting time for assessment is longer (see table 7).

3b) Gender

More than half (56%) of all children and young people entering treatment were girls. In comparison, 40% of this group were boys and 1% were non-binary[vii]. Gender was recorded as unknown or indeterminate for the remaining 3% of children.

This finding reflects wider research, which shows that teenage girls and LGBTQ+ young people and adults on average have higher rates of mental health conditions.[8] In the Children's Commissioner's 2021 *The Big Ask* survey, 1 in 5 children (20%) reported they were not happy with their mental health, rising to 2 in 5 (40%) among older teenage girls.[9]

On average, boys wait longer than girls for their 2nd contact with the NHS, a median waiting time of 46 days compared to 29 days for girls, or over 50% longer. Waiting times for those who are non-binary were strikingly shorter than any other group, with a median wait of 7 days. As with the difference between older and young children, the shorter waiting time for girls and non-binary children may reflect that these groups of children are presenting to mental health services with greater severity of need, though further research is needed to better understand this finding.

"I see too many people being bullied for their ethnicity, sexuality, or gender identity and it needs to stop…There also needs to be larger investments into children's mental healthcare… It took me two years to be seen by CAMHS, and a further two years to receive my autism diagnosis." – Young person, 18

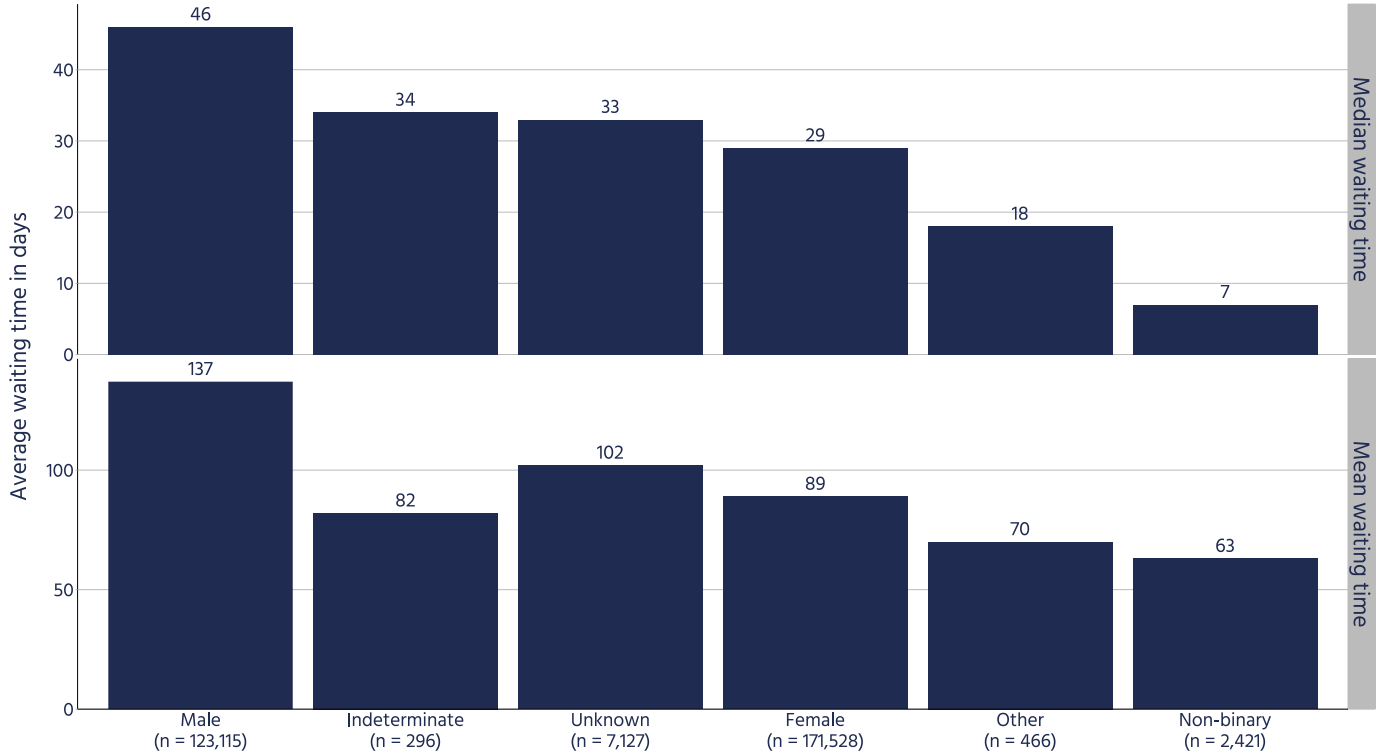
"I also think [violence against women and girls] prevention should be taught in schools and that mental health services should be made better available in schools." – Girl, 13

[vii] Note that gender identity information was only introduced as part of MHSDS version 5, which went live in October 2021. There are still a number of providers who do not submit data on non-binary genders. As a result, the numbers quoted for non-binary are almost certainly an undercount.

Table 3: Waiting times for children and young people entering treatment by gender

Gender	Number of children	% referred	Median wait in days	Mean wait in days
Male	123,115	40.4%	46	137
Female	171,528	56.2%	29	89
Non-binary	2,421	0.8%	7	63
Indeterminate	296	0.1%	34	82
Other	466	0.2%	18	70
Unknown	7127	2.3%	33	102
Total	304,953	100%	35	108

Figure 2: Waiting times for children and young people entering treatment by gender



3c) Ethnicity

Children and young people from a white ethnic group comprised 62% of all entering treatment in 2022-23, followed by children of unknown ethnicity (22%).[viii] The remaining 16% of children were made up of those from mixed (6%), Asian (4%), black (3%) and other ethnicities.

Excluding those of unknown ethnicity, children and young people of white ethnic groups comprise 80% of those accessing treatment – a notable overrepresentation compared to the benchmark provided by the ONS 2021 Census figures (73% of the population of England aged 0 to 17). This is compared to the underrepresentation of those Asian children (6% accessing CYPMHS vs 12% of the 0 to 17 population) and black children (4% accessing CYPMHS vs 6% of the 0 to 17 population).[10]

Children of unknown ethnicity waited the longest (median 42 days), followed by white children (median 35 days). Asian and black children, despite only making up 4% and 3% (respectively) of all children entering treatment, had notably shorter waiting times than any other ethnic group (see table 4 below). Compared to the national median of 35 days, Asian children waited on average 19 days, and black children waited on average 25 days.

Similarly to how waiting times are shorter for older children, girls and non-binary children, Asian children and black children's shorter waits may be a result of a greater severity of need at the point they present to mental health services. This may reflect the additional barriers Asian and black children face in accessing early, appropriate mental health support that meet their needs. Data on adults detained under the Mental Health Act show that in the year to March 2022, black adults were almost 5 times as likely to be detained as white adults.[11] Further research is needed to understand this trend among children and young people.

"Improve the mental health services and help minorities feel safer at school. I have experienced racism and homophobia as a gay person of colour."
– Boy, 17

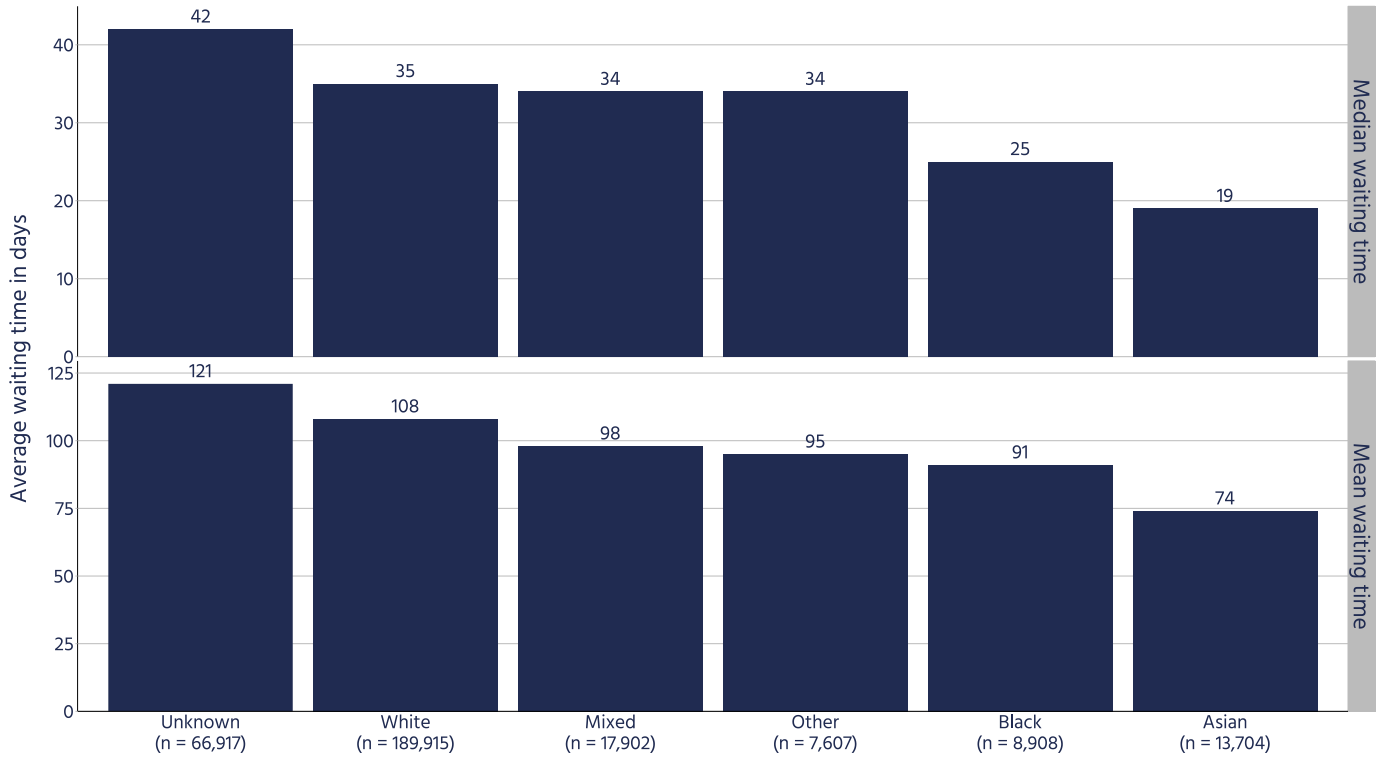
[viii] CCo recognises that these may not be the terms that children and young people use themselves or identify with, and broad ethnicity categories can fail to recognise differences between the different cultures and communities within them.

Table 4: Waiting times for children and young people entering treatment by ethnicity

Ethnic group	Number of children	% entering treatment	Median wait in days	Mean wait in days
Asian	13,704	4%	19	74
Black	8,908	3%	25	91
Mixed	17,902	6%	34	98
Other	7,607	2%	34	95
Unknown	66,917	22%	42	121
White	189,915	62%	35	108
Total	304,953	100%	35	108

Note: due to rounding, the percentages of children do not add up to 100%.

Figure 3: Waiting times for children and young people entering treatment by ethnicity



4) Waiting times by primary referral reason

There are many reasons why a child or young person is referred to specialist mental health services. In 2022-23, due to shortcomings in NHS England data, the most common primary reason was 'unknown', making up 34% of those entering treatment within the year. NHS England told us reasons for this include that the data field is not mandatory, and the reason for a child or young person accessing support may not become apparent until their first appointment.

Of the known primary referral reasons (see table 5), anxiety was the most common (20%), and children 'in crisis' was the second most common referral reason (10%). This reflects a wider trend, with the number of children referred to emergency mental healthcare increasing by 53% in the last three years (from 21,242 referrals in 2019-20, to 32,521 referrals in 2022-23).[12] These children are often suicidal or seriously ill, with many not getting the support they needed early enough.

"In my case, I was at crisis point before I was even able to speak to anyone. I waited nearly a year." – Boy, 17

"Currently I am out of school and have been waiting for emergency mental health services for six months." – Girl, 16

"I have been a danger to myself and in excruciating mental pain, not being able to do basic self care or go out and not receiving any help." – Young woman, 18

Jamie's* story

In 2024 Jamie's mum contacted *Help at Hand,* the Children's Commissioner's advice and representation line. Jamie suffers with serious mental health issues including psychosis.

Jamie had been sectioned a year ago and did not receive the help he needed when he was discharged, which led to him being readmitted to hospital. He was then promised much better community care when he was discharged for a second time.

Jamie's mum got in touch to say this had not happened, and she was worried they were heading back into crisis. *Help at Hand* have made representations for Jamie and helped him access an advocate who can ensure he gets the support he needs.

**not his real name*

"By failing children now, parents have to give up work to support that vulnerable child...Have you ever begged for help for your child's mental health, and been told 'once your child is cutting themselves or attempting suicide, then CAMHS will be able to support them'?"

– Parent of a 10 year old boy

Table 5: Primary referral reasons to CYPMHS in 2022-23

Primary referral reason	Children referred	Percentage (%)
Unknown	104,820	34.4%
Anxiety	59,730	19.6%
In crisis	30,666	10.1%
Neurodevelopmental Conditions, excluding Autism	19,983	6.6%
Depression	17,539	5.8%
Self harm behaviours	14,193	4.7%
Conduct disorders	9,624	3.2%
Adjustment to health issues	8,775	2.9%
Eating disorders	8,685	2.9%
Suspected Autism	8,178	2.7%
Relationship difficulties	4,279	1.4%

Unexplained physical symptoms	2,996	1.0%
Diagnosed Autism	2,622	0.9%
Post-traumatic stress disorder	2,171	0.7%
Self - care issues	2,075	0.7%
Attachment difficulties	1,909	0.6%
Obsessive compulsive disorder	1,476	0.5%
(Suspected) First Episode Psychosis	1,081	0.4%
Behaviours that challenge due to a Learning Disability	615	0.2%
Drug and alcohol difficulties	610	0.2%
Organic brain disorder	520	0.2%
Gender Discomfort issues	459	0.2%
Perinatal mental health issues	384	0.1%
Phobias	327	0.1%
Personality disorders	293	0.1%
Ongoing or Recurrent Psychosis	215	0.1%
Bi polar disorder	114	<0.1%
Gambling disorder	58	<0.1%

**Note that not all referral reasons are shown due to disclosure control.*

The next most common primary referral reasons (table 5) are neurodevelopmental conditions (excluding autism) (7%), depression (6%), and self-harm behaviours (5%). These top six reasons add up to the vast majority (81%) of all children entering treatment (table 5). Autism and other neurodevelopmental conditions are not mental health conditions. However, diagnostic assessments for these conditions can take place in CYPMHS, and some children may be in contact with CYPMHS because of the overlap that can exist between neurodiversity, neurodevelopmental conditions and mental ill-

health. Identifying children's primary need, and whether mental health services are appropriate, is challenging due to shortcomings in the way data is currently collected by NHS England.[ix]

Of all the primary reasons for referral (excluding unknown), the longest wait times were for suspected autism, neurodevelopmental conditions (excluding autism)[x] and obsessive compulsive disorder, with medians of 216 days, 111 days and 86 days respectively.

Research shows that mental health problems are common and poorly treated among people with autism and other neurodevelopmental conditions, with services often disjointed.[13] [14] Conversely, children with mental health problems may also be neurodiverse, have delayed development, or be disabled. The CCo will be publishing further analysis to understand the experiences of children with suspected and diagnosed neurodevelopmental conditions accessing support in community health services.

[ix] The NHS England data on service type splits children into two types: mental health, learning disability/autism (LDA) and one combining the two for all services. First, a child is assigned to a service based on any inpatient stay they may have had then again based on the information in the referral. In most cases the groupings are distinct, however, if a child has an inpatient stay on a children's ward and then a referral to the Autism Service team type, then it is possible for them to appear in both the mental health only and the LDA only datasets. If the child being referred to the Autism Service only had a referral and no inpatient stay then they would be flagged as LDA only. Though rare, a young person could also be referred to more than one team as part of the same referral. For example, if a child had a referral to both Autism Services and Community Mental Health Team. It is also possible that some children will have multiple referrals across the year which could be to different services. In those scenarios, that child in the count would likely fall into both cohorts.

[x] Later in 2024, CCo will be publishing a separate report focusing on children who are primarily referred to and access LDA services in CYPMHS. This data will largely consist of children who only access LDA services but as mentioned in a previous footnote, a small pool of children will be flagged as having accessed both LDA and mental health services. As many autism assessments of children also take place in community paediatric services, this report will also draw on data from the Community Services Dataset (CSDS). CCo is aware of some of the limitations of the CSDS data, including the lack of *"autism"* and *"suspected autism"* as primary referral reason codes (unlike MHSDS). CCo will instead be looking at how long children waited for an autism diagnosis in a CSDS service.

Table 6: Top 20 primary referral reasons with the longest median waiting times

Primary referral reason	Number of children	Median wait in days	Mean wait in days
Suspected autism	8,178	216	389
Neurodevelopmental conditions, excluding autism	19,983	111	239
Obsessive compulsive disorder	1,476	86	145
Gambling disorder	58	76	126
Behaviours that challenge due to a learning disability	615	73	167
Gender discomfort issues	459	70	189
Diagnosed autism	2,622	69	178
Post-traumatic stress disorder	2,171	67	122
Attachment difficulties	1,909	63	123
Phobias	327	63	103
Anxiety	59,730	44	86
Organic brain disorder	520	42	94
Depression	17,539	41	81
Conduct disorders	9,624	41	94
Unexplained physical symptoms	2,996	39	111
Personality disorders	293	39	64
Relationship difficulties	4,279	35	79
Adjustment to health issues	8,775	34	77
Self - care issues	2,075	32	77
Bi-polar disorder	114	31	75

Some referral reasons had relatively short waiting times (see table below). This year, the referral reasons with the shortest waiting times were "in crisis" (median 5 days), self-harming behaviours (median 7 days), drug and alcohol difficulties (median 9 days), suspected first episode psychosis (median 13 days) and eating disorders (median 21 days). While it is encouraging that children and young people with such serious conditions are seen within a month, 5 days is a long time for those in crisis to wait.

Table 7: Top 20 primary referral reasons with the shortest median waiting times

Primary referral reason	Number of children	Median wait in days	Mean wait in days
In crisis	30,666	5	32
Self-harm behaviours	14,193	7	51
Drug and alcohol difficulties	610	9	36
(Suspected) first episode psychosis	1,081	13	35
Eating disorders	8,685	21	62
Ongoing or recurrent psychosis	215	26	99
Perinatal mental health issues	384	27	43
Bi-polar disorder	114	31	75
Self - care issues	2,075	32	77
Adjustment to health issues	8,775	34	77
Relationship difficulties	4,279	35	79
Unexplained physical symptoms	2,996	39	111
Personality disorders	293	39	64
Depression	17,539	41	81
Conduct disorders	9,624	41	94
Organic brain disorder	520	42	94
Anxiety	59,730	44	86
Attachment difficulties	1,909	63	123
Phobias	327	63	103
Post-traumatic stress disorder	2,171	67	122

5) Waiting times by service and team type

Of the 45 service and team types provided in NHS England's data return (excluding unknown), children and young people who entered treatment were most commonly referred to other mental health services – out of scope of the **National Tariff Payment System (18%), Community Mental Health Teams (17%) and Mental Health Support teams (13%).** The service type referred to was unknown for 14% of those accessing CYPMHS.

The service and team types with the longest waits in 2022-23 were **Autism service (median 481 days), Mental health services for deaf people (median 249 days) and Neurodevelopment team (median 194 days).**

Conversely, the service and team types with the shortest waits (all with a median of 0 days) were the **Psychiatric Liaison Service**[xi] **and Health Based Place of Safety Service**.[xii] There was also a median waiting time of 0 days for the **24/7 Crisis Response Line**, which given the nature of the service is to be expected.

Table 8: Service and team types by waiting time to 2nd contact, ordered by longest to shortest median wait in days

Service or team type	Number of children	Median wait in days	Mean wait in days
Autism Service	213	481	647
Mental Health Services for Deaf people	31	249	330
Neurodevelopment Team	11,979	194	346

[xi] Liaison psychiatry is designed to bridge the gap between physical and mental healthcare. Their services provide mental healthcare to children being treated for physical illness in general hospitals, whether they attend out-patient clinics, are admitted to inpatient wards or present to the A&E department.

[xii] A Health Based Place of Safety is provided for children detained under Section 136 of the Mental Health Act. These service users are typically brought to the mental health trust by the police for an assessment of their mental health needs.

Psychotherapy Service	1,583	141	249
Acquired Brain Injury Service	30	120	250
Asylum Service	29	96	124
Community Mental Health Team – Organic	273	82	127
General Psychiatry Service	7,861	77	177
Primary Care Mental Health Service	5,206	68	128
Community Mental Health Team – Functional[xiii15]	51,187	67	130
Psychological Therapy Service (non IAPT)	7,629	66	107
Looked After Children Service	2,338	56	116
Mental Health and Wellbeing Hubs	1,033	53	100
Mental Health In Education Service	4,276	51	62
Community Team for Learning Disabilities	133	42	147
Specialist Perinatal Mental Health Community Service	521	41	96
Specialist Parenting Service	100	40	96
Individual Placement and Support Service	313	37	48
Other Mental Health Service – in scope of National Tariff Payment System	23,167	35	110
Substance Misuse Team	158	34	67
Mental Health Support Team	38,824	30	46
Forensic Mental Health Service	897	27	51
Community Eating Disorder Service	7,261	21	60
Single Point of Access Service	17,137	20	73
Other Mental Health Service – out of scope of National Tariff Payment System	53,706	19	85

[xiii] Organic disorders are caused by structural defects or physiological dysfunction of the brain. The causes of functional disorders have not yet been identified. For example, delirium and dementia are considered organic mental health problems as they are often explained by a physiological cause. Functional mental health problems traditionally refer to psychiatric disorders.

Youth Offending Service	923	19	56
Personality Disorder Service	359	15	34
Early Intervention Team for Psychosis	790	13	26
Walk-in Crisis Assessment Unit Service	39	11	21
Paediatric Liaison Service	7,365	7	53
Assertive Outreach Team	346	7	23
Day Care Service	47	7	19
Crisis Caf/Safe Haven/Sanctuary Service	272	5	11
Crisis Resolution Team/Home Treatment Service	12,091	2	6
Criminal Justice Liaison and Diversion Service	933	1	13
Psychiatric Liaison Service	3,272	0	3
Health Based Place Of Safety Service	16	0	1
24/7 Crisis Response Line	418	0	1

** IAPT: Improving Access to Psychological Therapies*

*** Some service/team types not shown for reasons of statistical disclosure control (counts of 10 children or fewer).*

6) ICB spending on children's mental health services

Overall, spending on children's mental health services (excluding spending on mental health services for children with learning disabilities) increased every year from 2018-19[xiv] to 2022-23 (see table 9 below).[16] Nationally, ICBs spent £997 million on CYPMHS in 2022-23, equal to 1.02% of the total spent by ICBs. This compares to £922 million in 2021-22 – an increase of 8% in nominal terms (see table below). However, when adjusted for inflation, growth has slowed from 7% between 2020-21 and 2021-22 to 1% between 2021-22 and 2022-23.

Bearing in mind the 950,000 children with an active referral in 2022-23, this £997 million averages out to £1,050 per child with an active referral (in nominal terms). Considering the pool of 1.4 million children and young people with a probable mental health disorder, this figure becomes £710 per child or young person.

Table 9: Real and nominal spend on children's mental health services, 2018-19 to 2022-23

Year	Nominal spend (millions)	Nominal growth rate (%)	Real spend (millions)	Real growth rate (%)
2018-19	£724m		£742m	
2019-20	£799m	10.3%	£799m	7.7%
2020-21	£868m	8.7%	£824m	3.1%
2021-22	£922m	6.2%	£882m	7.0%
2022-23	£997m	8.1%	£893m	1.3%

Note: Reference year of 2019-20, for consistency with previous year's reports.

As with other indicators, spending on CYPMHS varies widely by area (see table 10 below). Total spending on CYPMHS ranges from as much as £65 million in NHS North East and North Cumbria (spend per child

[xiv] NHS Mental Health Investment Standard categories were updated in 2021 and CCGs were required to review their historical spending to 2018-19. This analysis uses reviewed spend figures and does not include figures from before 2018-19 for consistency.

referred: £1,035, 1.16% of ICB total spend) to £8 million in NHS Shropshire, Telford and Wrekin (spend per child referred: £1,000, 0.95% of ICB total spend).

Spend per child with an active referral ranges from £2,236 in NHS North Central London (total spend on CYPMHS: £43 million, 1.58% of ICB total spend) to £573 in NHS Buckinghamshire, Oxfordshire and Berkshire West (total spend on CYPMHS: £19 million, 0.72% of ICB total spend).

Spending on CYPMHS as a percentage of ICB's total expenditure ranges from 1.68% in NHS Norfolk and Waveney to 0.72% in NHS Lincolnshire and NHS Buckinghamshire, Oxfordshire and Berkshire West.

Table 10: Spending on CYPMHS by ICB in 2022-23, ordered from highest to lowest spend per child referred

ICB name	Total spend on CYPMHS	Spend per child referred	% of total expenditure spent on CYPMHS
NHS North Central London ICB	£43m	£2,236	1.58%
NHS North West London ICB	£42m	£2,104	1.08%
NHS Birmingham And Solihull ICB	£33m	£1,648	1.37%
NHS North East London ICB	£42m	£1,631	1.21%
NHS Norfolk And Waveney ICB	£30m	£1,555	1.68%
NHS Dorset ICB	£13m	£1,544	0.92%
NHS Cornwall And The Isles Of Scilly ICB	£11m	£1,480	1.10%
NHS Somerset ICB	£10m	£1,474	1.06%
NHS Staffordshire And Stoke-On-Trent ICB	£25m	£1,458	1.29%
NHS South East London ICB	£34m	£1,437	1.02%
NHS Sussex ICB	£31m	£1,401	1.03%
NHS Bristol, North Somerset And South Gloucestershire ICB	£14m	£1,350	0.86%
NHS Bath And North East Somerset, Swindon And Wiltshire ICB	£17m	£1,336	1.18%
NHS Bedfordshire, Luton And Milton Keynes ICB	£19m	£1,332	1.24%
NHS Mid And South Essex ICB	£15m	£1,198	0.78%

NHS Hertfordshire And West Essex ICB	£25m	£1,129	1.02%
NHS Black Country ICB	£26m	£1,129	1.26%
NHS Derby And Derbyshire ICB	£18m	£1,110	0.98%
NHS Frimley ICB	£16m	£1,101	1.40%
NHS South West London ICB	£23m	£1,099	0.94%
NHS Herefordshire And Worcestershire ICB	£11m	£1,088	0.83%
NHS Gloucestershire ICB	£10m	£1,074	0.97%
NHS Northamptonshire ICB	£10m	£1,058	0.84%
NHS Hampshire And Isle Of Wight ICB	£33m	£1,041	1.09%
NHS North East And North Cumbria ICB	£65m	£1,035	1.16%
NHS Devon ICB	£18m	£1,028	0.86%
NHS Leicester, Leicestershire And Rutland ICB	£16m	£1,015	0.94%
NHS Shropshire, Telford And Wrekin ICB	£8m	£1,000	0.95%
NHS Lincolnshire ICB	£10m	£977	0.72%
NHS Suffolk And North East Essex ICB	£15m	£959	0.87%
NHS Cheshire And Merseyside ICB	£46m	£938	0.94%
NHS Humber And North Yorkshire ICB	£23m	£903	0.82%
NHS Surrey Heartlands ICB	£18m	£883	1.08%
NHS Greater Manchester ICB	£56m	£875	1.06%
NHS Lancashire And South Cumbria ICB	£27m	£856	0.82%
NHS South Yorkshire ICB	£20m	£850	0.80%
NHS West Yorkshire ICB	£38m	£802	0.93%
NHS Cambridgeshire And Peterborough ICB	£14m	£778	0.97%
NHS Kent And Medway ICB	£22m	£627	0.73%
NHS Nottingham And Nottinghamshire ICB	£15m	£606	0.75%
NHS Coventry And Warwickshire ICB	£15m	£586	0.95%
NHS Buckinghamshire, Oxfordshire And Berkshire West ICB	£19m	£573	0.72%

7) Overall Integrated Care Board (ICB) level scores

As in previous years, to provide an overall indication of how children's access to mental health services compares across ICBs, CCo has created a summary score for each ICB based on four key indicators of CYPMHS performance. These indicators are:

1. **Mental health spend per referral** - calculated using NHS Mental Health Dashboard spending figures and NHS England counts of children with active referrals for each ICB area (where higher spend per referral means a higher score).

2. **ICB expenditure on children's mental health** as a percentage of an ICB's total spending (where higher spending means a higher score).

3. **Average waiting time (in days) for children** who receive a 2nd contact with services (where lower average waiting times means a higher score).

4. **The percentage of referrals that are closed before treatment** (where a lower percentage of referrals closed means a higher score).[xv]

For each indicator, ICBs were ranked from best to worst (e.g. shortest waiting time to longest) and assigned to 5 groups. Scores were then given to each ICB based on their group. The best performing 20% of ICBs received a score of 5 while the worst performers received a score of 1. CCo then added these scores together into an overall score ranging from a minimum of 4 (worst) to a maximum of 20 (best) for each ICB. An overall score of 4 would mean being in the bottom group across all 4 measures while a score of 20 would mean being in the top (best) group across all measures.

Some ICBs will have invested in lower-level mental health services that will not necessarily be reflected in the number of children referred, average waiting times or percentage of referrals closed. This should, however, be captured in the two spending measures.

[xv] This report defines a child as not receiving treatment if they were referred but did not subsequently receive at least two contacts with CYPMHS.

This year, the metrics used to calculate overall area scores have changed. Instead of spend per child aged 0 to 17 in the ICB (previously CCG), this report uses spend per referral. This aims to capture more directly the link between mental health spend and need, as most children and young people in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated as the percentage of the child population receiving two contacts with CYPMHS, has been dropped from the list of metrics this year.

Given these changes, the scores are not comparable with the scores in previous CCo mental health briefings in which the maximum overall score was 25. Furthermore, in 2021, 106 CCGs merged to form 42 combined ICBs. Many top performing CCGs in last year's report have been merged with CCGs that do not perform as well by CCo metrics (and vice versa when worse performing CCGs merged with better performing CCGs). As a result, the top and bottom performing areas this year are not the same as those in previous years.

According to these scoring criteria, the best performing ICBs in 2022-23 were NHS Bedfordshire, Luton and Milton Keynes (7th last year), NHS North East London and NHS North Central London, with overall scores of 19, 17 and 16 respectively out of 20 (table 11). It should be noted that no London CCGs appeared in the top 20 CCGs in 2021-22 when ranked by overall score. This year, 5 of the top 20 ICBs are in London.

Worst performing was NHS Devon with an overall score of 6. Slightly outperforming NHS Devon with overall scores of 7 were NHS Kent and Medway, NHS Lincolnshire, and NHS Nottingham and Nottinghamshire.

Figure 4: ICBs by overall score

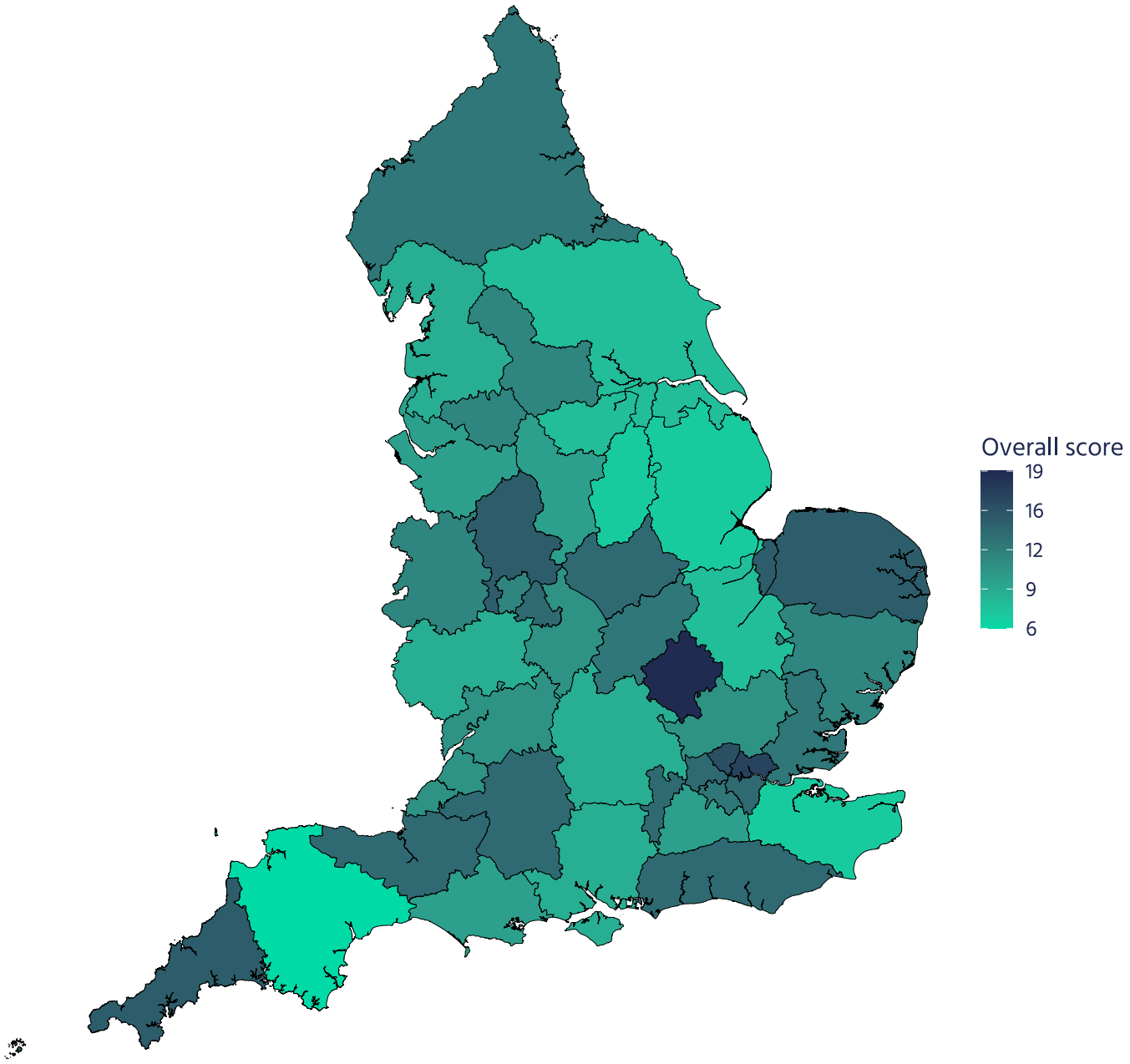


Table 11: 2022-23 ICBs by overall score, best performance to worst performance

ICB name	Spend per child referred	% total expenditure spent on CYPMHS	Median wait in days	% referrals closed before treatment	Overall score
NHS Bedfordshire, Luton and Milton Keynes ICB	£1,332	1.24%	10	30%	19
NHS North East London ICB	£1,631	1.21%	21	42%	17
NHS North Central London ICB	£2,236	1.58%	58	36%	16
NHS Cornwall and The Isles Of Scilly ICB	£1,480	1.1%	29	40%	15
NHS Norfolk and Waveney ICB	£1,555	1.68%	77	36%	15
NHS Staffordshire and Stoke-On-Trent ICB	£1,458	1.29%	33	39%	15
NHS Bath and North East Somerset, Swindon And Wiltshire ICB	£1,336	1.18%	48	36%	14
NHS Birmingham and Solihull ICB	£1,648	1.37%	32	59%	14
NHS Frimley ICB	£1,101	1.4%	60	35%	14
NHS Leicester, Leicestershire and Rutland ICB	£1,015	0.94%	6	26%	14
NHS North West London ICB	£2,104	1.08%	49	40%	14
NHS South East London ICB	£1,437	1.02%	26	38%	14
NHS Somerset ICB	£1,474	1.06%	28	59%	14
NHS Sussex ICB	£1,401	1.03%	61	21%	14
NHS North East And North Cumbria ICB	£1,035	1.16%	34	36%	13
NHS Mid and South Essex ICB	£1,198	0.78%	5	38%	13
NHS Northamptonshire ICB	£1,058	0.84%	36	29%	13
NHS South West London ICB	£1,099	0.94%	34	33%	13
NHS Greater Manchester ICB	£875	1.06%	21	42%	12

NHS Shropshire, Telford and Wrekin ICB	£1,000	0.95%	24	40%	12
NHS Suffolk and North East Essex ICB	£959	0.87%	19	39%	12
NHS Black Country ICB	£1,129	1.26%	72	42%	12
NHS West Yorkshire ICB	£802	0.93%	28	31%	12
NHS Bristol, North Somerset and South Gloucestershire ICB	£1,350	0.86%	28	51%	11
NHS Coventry and Warwickshire ICB	£586	0.95%	64	18%	11
NHS Gloucestershire ICB	£1,074	0.97%	78	33%	11
NHS Hertfordshire and West Essex ICB	£1,129	1.02%	29	45%	11
NHS Cheshire and Merseyside ICB	£938	0.94%	29	43%	10
NHS Dorset ICB	£1,544	0.92%	59	50%	10
NHS Derby and Derbyshire ICB	£1,110	0.98%	73	38%	10
NHS Surrey Heartlands ICB	£883	1.08%	65	38%	10
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£573	0.72%	63	28%	9
NHS Hampshire and Isle Of Wight ICB	£1,041	1.09%	79	44%	9
NHS Lancashire and South Cumbria ICB	£856	0.82%	19	43%	9
NHS Herefordshire and Worcestershire ICB	£1,088	0.83%	67	33%	9
NHS Cambridgeshire and Peterborough ICB	£778	0.97%	47	51%	8
NHS Humber And North Yorkshire ICB	£903	0.82%	32	40%	8
NHS South Yorkshire ICB	£850	0.8%	23	50%	8
NHS Kent and Medway ICB	£627	0.73%	41	41%	7

NHS Lincolnshire ICB	£977	0.72%	56	43%	7
NHS Nottingham and Nottinghamshire ICB	£606	0.75%	69	34%	7
NHS Devon ICB	£1,028	0.86%	77	45%	6

8) The way forward

Children's brain development, mental health and wellbeing are influenced by many factors as they grow up – from their relationships with parents, carers and other children, to whether they feel safe and supported in their school and local community. For children to have good mental health and wellbeing, much of the critical prevention work must happen upstream – ensuring no child grows up in poverty, and every child has a safe home, receives a brilliant education, and is nurtured by parents and carers who are well-supported themselves.

When a child does show signs that something may not be right, health and wellbeing services provide a critical safety net to support children to get well. The recommendations in this report focus on what change is needed in these services - as part of an integrated system of care which prioritises prevention and centres the needs of children and young people.

1) A bold, strategic long-term vision for children and young people's mental health and wellbeing

- **A 10-year plan for children and young people's mental health, to ensure fewer children experience mental ill-health, and all who do receive excellent care.** This strategy should have a strong focus on addressing the determinants of poor mental health and wellbeing - including poverty, inequality and insecurity. It should put children's mental health services on a sustainable footing, and pool funding in a way that enables health, education and social care to work in a much more aligned way.

"Make reforms to mental health services so that they are more effective and efficient in helping young people, and make reforms to tackle more structural issues affecting young people's lives (poverty, social inequality, etc.)" – Young woman, 18.

2) Understanding and responding to prevalence of need

- **As well as continuing with further waves of the NHS England prevalence survey of children and young people's mental health,** the national picture of need should be informed by Integrated Care Board's (ICBs) *Joint Strategic Needs Assessments* (JSNAs). This will allow for detailed insight into the distinct needs of children by geography and demographic, and a central government funding formula which more adequately and sustainably meets demand for children's mental health services.

3) Identify and close the gaps in support

- **The Care Quality Commission** should carry out a thematic review of children's mental health services, identifying where the most common gaps in thresholds lie between statutory provision. Through speaking to children and young people, it seems there is often little support for children whose needs are deemed too complex for Mental Health Support Teams, and not serious or urgent enough to be referred to CAMHS. This review should also highlight good practice in addressing this gap.

"There isn't much support for those who are not mentally ill, but have poor mental health and is struggling with more than anxiety and low mood."
– Girl, 17

"My own brother was suicidal and he was declined help by CAMHS."
– Girl, 17

4) Early support for children with their emotional health and wellbeing

- **An Early Support Hub** to deliver early mental health and wellbeing support for children and young people in every local area, working closely with Family Hubs so that children, young people and their parents are supported through a whole family approach.

- **National roll-out of Mental Health Support Teams (MHSTs)** so that every child can be supported in school, as part of a Whole School Approach to good mental health. In 2022-23, only 28% of schools and colleges and 35% of pupils had access to a mental health support teams.[17] MHSTs can provide earlier support for children, without the need for them to be referred to a separate service.
    - **The MHST model should be expanded to make a qualified school counsellor available to every school**. Counsellors can help to bridge the gap for children who fall between the thresholds for MHST and CAMHS support.
- **Where a child is on a CAMHS waiting list or in receipt of CAMHS support and starting to disengage from school, these children should be automatically referred to multi-agency attendance forums and assigned a key worker –** who can work together to address any underlying issues which may be causing the child's poor mental health.

"Early diagnosis and treatment can overall take pressure off of the NHS instead of giving psychiatric treatment to children which may not be necessary."
– Young woman, 18

"We also need more of an emphasis on mental health, an assembly a week or once a few months from a CAMHS therapist, we need people to be taught they can be open with their feelings and talk to others." – Young man, 18

Learning from Rochdale *– health, education and social care working together to tackle mental health-related non-attendance*

Rochdale is now part of the Greater Manchester Integrated Care Partnership, and was the CCo's second highest scoring area last year as part of the Heywood, Middleton and Rochdale CCG. As a sub-ICB area, this year it remains in the top 20 for shortest median waiting times out of the 106 areas across England (see annex).

This year the CCo visited Rochdale to understand what has been working well in the area to address children's mental health needs early and reduce waiting times. Leaders in Rochdale told us they are proud of fostering a culture of collaboration, which means professionals working across health, education and social care avoid siloed working – and many are even co-located in the council's headquarters.

One example of this collaboration in action is the work that health, education and social care professionals have done to support children who are struggling to attend school because of their mental health. For children's needs who have become too high to be addressed by Mental Health Support Teams, **Rochdale has created *an Emotional-Based Non-Attendance (EBNA) Panel.***

The role of the EBNA panel is for a range of professionals to consider the factors contributing to the poor mental health of the child, and develop a joint support plan for children who need additional help to be able to attend school.

One case study raised was that of Tom (not his real name). Tom was a Year 8 student who struggled with anxiety that could become overwhelming. Tom stopped attending school after personalised support in the school's internal alternative provision was withdrawn. This had a huge impact on Tom, and also on his siblings and mother – who had to stop working to support him.

Health, education and social care came together through the EBNA panel to agree that Tom needed a keyworker, who supported Tom to begin to leave his house and access positive activities in the community. The keyworker also advocated for Tom and attended the EBNA panel and meetings to share his views and wishes on his behalf. The EBNA panel also arranged for the local authority to fund short-term Alternative

Provision linked to a local football club. As Tom's confidence and resilience increased, the EBNA panel coordinated his school to use their funding to provide more 1 to 1 support so he could begin to attend lessons again, which he did on a reduced timetable.

His mother gave feedback which was shown to the CCo: *"I cannot actually believe I am writing this...[Tom] has done his first full week in school since September 2022!!...Thank you for listening to [Tom] and making him smile again."*

5) Reducing waiting times for mental health services

- **No child should be turned away from mental health support, or wait more than four weeks for an initial assessment of their mental health needs,** and four weeks for treatment to begin in Children and Young People Mental Health Services (CYPMHS).

"Waiting lists...can often invalidate young people's problems and makes us lose faith in our healthcare system."- Girl, 16

What is needed to get there:

- **NHS England should develop a single and comparable way of measuring the most meaningful wait a child is subject to.** Rather than number of contacts, this should focus on how long children wait for assessment of their needs, and for support/treatment to begin.

- **Where a referral is closed before treatment**, data should be collected by NHSE on why the referral was closed, and whether and what service children were referred onto to support their mental health and wellbeing, and whether there was a separate waiting list for this service. Local areas should be incentivised and supported to pioneer linked data systems between the NHS and voluntary, community and social enterprises (VCSE), so that children's outcomes in other wellbeing services can be measured. **NHS leaders should continue work with partner agencies and the public to increase the quality of referrals to CAMHS**, so that as few as possible are closed before treatment.

- **The Department for Health and Social Care should be clear in guidance to commissioners that triaging of referrals should never be commissioned out to organisations without clinical expertise**.

- **The government should introduce a consistent unique identifier for all children,** based on the existing NHS number. This unique identifier would better enable services to share information on a child and make an assessment of the support they need, for example triaging referrals to CAMHS with up-to-date information about a child's school attendance and social care needs.

"Fund NHS Mental Health services more so more issues are caught earlier instead of being put on a waiting list and so they don't escalate."
– Young person, 16

- **Central government to provide additional, annual ring-fenced funding to Integrated Care Systems** to ensure that every local area is able to meet the mental health needs of the children in its area. Data in this report on how much high performing ICBs are spending per child with an active referral should be used as a benchmark of the additional investment required, with funding appropriately weighted by child population, levels of deprivation and other key indicators of need. Even the highest performing ICB in 2022-23 only invests 1.24% of its budget on children and young people's mental health services, which demonstrates the importance of ring-fencing this additional funding so that it is not absorbed into spending on adult and other services.

"I have spent 10 years on waiting lists or not receiving the right help I deserve while I have been battling EXTREME mental illnesses and autism."
– Young woman, 18

- **Improve pathways of support from 0-25 for children and young people with autism, ADHD and neurodiversity** who have suspected co-current mental health, emotional and behavioural support needs. This research shows that too many autistic children wait the longest for the

support they need. CCo will soon be publishing further research into neurodiverse children's experiences of support in health services.

Learning from Leicester, Leicestershire and Rutland (LLR) Integrated Care Board

– improving the quality of referrals and tracking children's journeys outside of the NHS

Over the past few years Leicester, Leicestershire and Rutland (LLR) have consistently had one of the shortest waiting times for children's mental health services, with a median waiting time of just 6 days in 2022-23. This wasn't always the case – but CCo heard that local leaders have worked together to bring these waiting times down.

As well as investment in prevention and early intervention services, LLR took the decision to allow children and young people to self-refer into their Triage and Navigation Service - which is the single point of access for all mental health support. Rather than overwhelming their CAMHS team, CCo heard that the result has been that the quality of referrals and speed with which they can be processed has significantly increased - with fewer referrals being rejected on the basis that more detailed information is needed. Before children and young people can complete the self-referral form, the website signposts them to tools and resources to begin to self-assess their mental health and wellbeing needs, and information about the pathways to support that may best meet their needs. LLR believe this makes children feel reassured and in control, and has resulted in fewer children seeking CAMHS support and shorter waiting lists.

LLR hosted a co-production event with children and young people (both those who had accessed their services and those who hadn't) to design their website so that is easy to find and navigate. Children fed back that they wanted to be able to scan a QR

code that led them straight to a directory of mental health and wellbeing services, which the ICB is now commissioning.

With CAMHS not always the right source of help for every child, LLR has invested in an online platform with the aim of better joining up health services and community-based services. GPs' case management system is integrated with a social prescribing case management system, which functions as a 'shop window' directory of services for GPs, and allows them to track their referrals, and better measure outcomes for children and young people. This platform is live in Rutland, and will be launched in the rest of Leicester and Leicestershire in April 2024.

6) Loving, caring support for children with the most acute needs

- **Reform the Mental Health Act 1983** so that it is fit for the 21st century, and accelerates the decrease in the number of children being inappropriately detained and restrained in mental health hospitals - and the shift towards supporting children at home or in the community. The opt-out model of advocacy provision should also be extended to children who are informally detained under the Mental Health Act.
- **The Department for Education, NHS England and the Ministry of Justice must establish a model of care for all children at risk of needing secure care**. This includes a model for joint ways of working so that services can co-commission services, to provide intensive community support to avoid a secure placement, and to co-commission integrated, therapeutic secure placements. This should be funded jointly by NHS, local authorities and the Ministry of Justice, through pooled budgets. This should include step-down services for when children are ready to move on from secure provision, into gradually more open settings.

"More Psychiatric Intensive Care Units and Low Secure Mental Health Units further down the country as otherwise young people from [rural areas] are sent hundreds of miles away from home and their families...which contributes to loneliness and therefore escalating mental illnesses further." – Child, 16

"I met several patients who had been waiting in the paediatric ward for 6 months following suicide attempts because there was no space in the mental health ward."
– Girl, 17

Leaning from Wakefield – *ensuring CAMHS is the right pathway for children, and preventing children from being hospitalised.*

Wakefield, part of the West Yorkshire Integrated Care Partnership, has been among the strongest performing areas across the metrics in CCo annual mental health briefings. Last year it was CCG with the highest overall score.

Leaders in Wakefield told the CCo that they have made improvements to their referral pathway in recent years following increased investment in CYPMHS in 2020-21, which is helping to keep CAMHS waiting times short. CCo was informed that previously children had to wait fairly long periods after an assessment of their needs to receive any help. Wakefield now operates a "2plus1" model for referrals to CAMHS, meaning all children receive a brief initial assessment of their needs as soon as they are referred to the Primary Prevention team, followed by two intervention sessions. These two intervention sessions provide tools and strategies for the child and family to manage the child's difficulties and meet their goals, and are useful for practitioners to better understand whether an alternative pathway is right for the child. Some children will need to go on to access support from CAMHS, but others may be offered a group session or signposted to other services, such as non-clinical, community-based support.

For children with the most acute needs (including suicidal ideation, self-harm and a noticeable change in their condition), Wakefield operates ReACH, which provides intensive treatment in the home to prevent children from requiring admission to inpatient mental health services. Most of the referrals come from Accident & Emergency departments. The ReACH team aims to visit children in their homes, schools or other appropriate settings and assess their needs within 4 hours of the referral coming in, or within 24 hours for those who are based in the surrounding areas outside of Wakefield.

To prevent children's needs from re-escalating, the ReACH team provides intensive home therapy responsive to their level of need, ranging from a minimum of two contacts a week to three visits a day. Wakefield reported that there are currently 2 young people in inpatient settings which it reports is the area's average over a year.

Annex

Annex A1: CYPMHS waiting times by Sub-ICB, from longest to shortest median wait

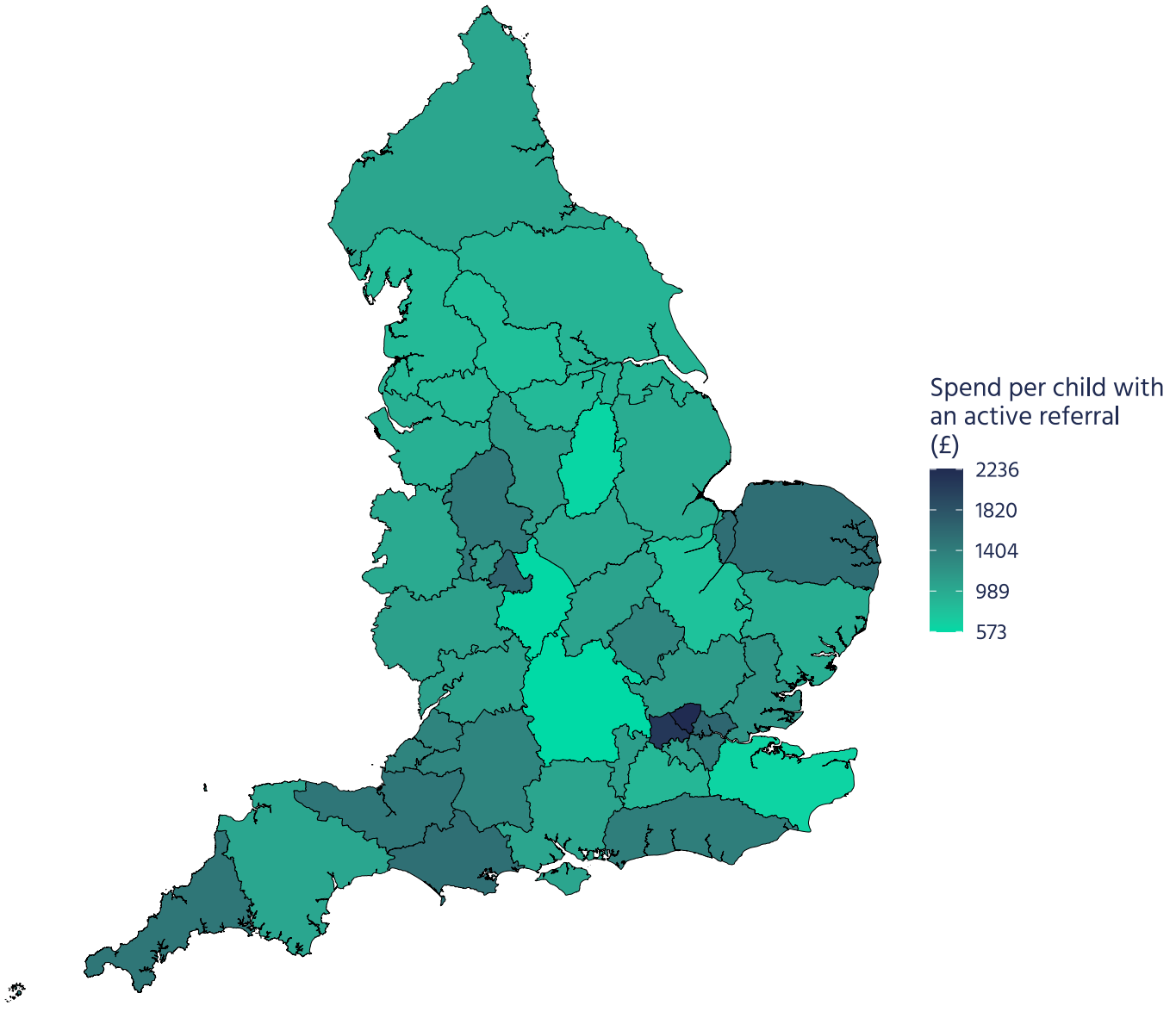
Sub-ICB name	Children referred	Median wait in days	Mean wait in days
NHS Sunderland Sub-ICB	2,355	147	159
NHS Portsmouth Sub-ICB	800	133	179
NHS Brighton and Hove Sub-ICB	1,525	97	156
NHS Cheshire Sub-ICB	2,650	96	291
NHS South Tyneside Sub-ICB	1,635	88	128
NHS Newcastle Gateshead Sub-ICB	2,600	83	160
NHS Oxfordshire Sub-ICB	1,455	82	164
NHS Gloucestershire Sub-ICB	3,320	78	116
NHS Norfolk & Waveney Sub-ICB	4,645	77	180
NHS Devon Sub-ICB	5,940	77	205
NHS Hampshire, Southampton and Isle of Wight Sub-ICB	8,110	76	142
NHS Derby and Derbyshire Sub-ICB	4,585	73	172
NHS Black Country and West Birmingham Sub-ICB	5,985	72	123
NHS Leeds Sub-ICB	3,655	71	176
NHS Nottingham and Nottinghamshire Sub-ICB	6,090	71	263
NHS Herefordshire and Worcestershire Sub-ICB	2,550	67	108
NHS Surrey Heartlands Sub-ICB	5,720	65	136
NHS Coventry and Warwickshire Sub-ICB	2,385	64	189
NHS Fylde & Wyre Sub-ICB	845	61	130
NHS Frimley Sub-ICB	3,785	60	140
NHS Berkshire West Sub-ICB	3,055	59	170
NHS Dorset Sub-ICB	2,565	59	94
NHS North Central London Sub-ICB	7,210	58	133
NHS Lincolnshire Sub-ICB	3,970	56	70
NHS Hull Sub-ICB	1,335	56	182

NHS East Sussex Sub-ICB	1,860	56	139
NHS Cannock Chase Sub-ICB	665	56	79
NHS Bassetlaw Sub-ICB	525	56	100
NHS Buckinghamshire Sub-ICB	1,785	55	111
NHS Stafford and Surrounds Sub-ICB	615	54	86
NHS South Sefton Sub-ICB	930	51	103
NHS West Sussex Sub-ICB	3,255	50	127
NHS Greater Preston Sub-ICB	660	50	131
NHS Chorley and South Ribble Sub-ICB	730	49	219
NHS North West London Sub-ICB	7,955	49	88
NHS North Tyneside Sub-ICB	1,155	49	107
NHS Bath and North East Somerset, Swindon and Wiltshire Sub-ICB	4,900	48	116
NHS Blackpool Sub-ICB	1,390	47	89
NHS Cambridgeshire and Peterborough Sub-ICB	4,545	47	124
NHS South East Staffordshire and Seisdon Peninsula Sub-ICB	855	46	71
NHS Morecambe Bay Sub-ICB	1,685	42	115
NHS East Staffordshire Sub-ICB	635	41	60
NHS Kent and Medway Sub-ICB	9830	41	215
NHS Vale of York Sub-ICB	1,875	38	83
NHS Tameside and Glossop Sub-ICB	2.030	37	117
NHS Wigan Borough Sub-ICB	1.985	37	129
NHS Herts Valleys Sub-ICB	2,735	37	85
NHS Northamptonshire Sub-ICB	5.015	36	63
NHS West Suffolk Sub-ICB	1,460	36	94
NHS Sheffield Sub-ICB	1,500	36	101
NHS Northumberland Sub-ICB	1,970	35	55
NHS Southport and Formby Sub-ICB	530	35	88
NHS South West London Sub-ICB	8,315	34	76
NHS Wirral Sub-ICB	1,805	34	252

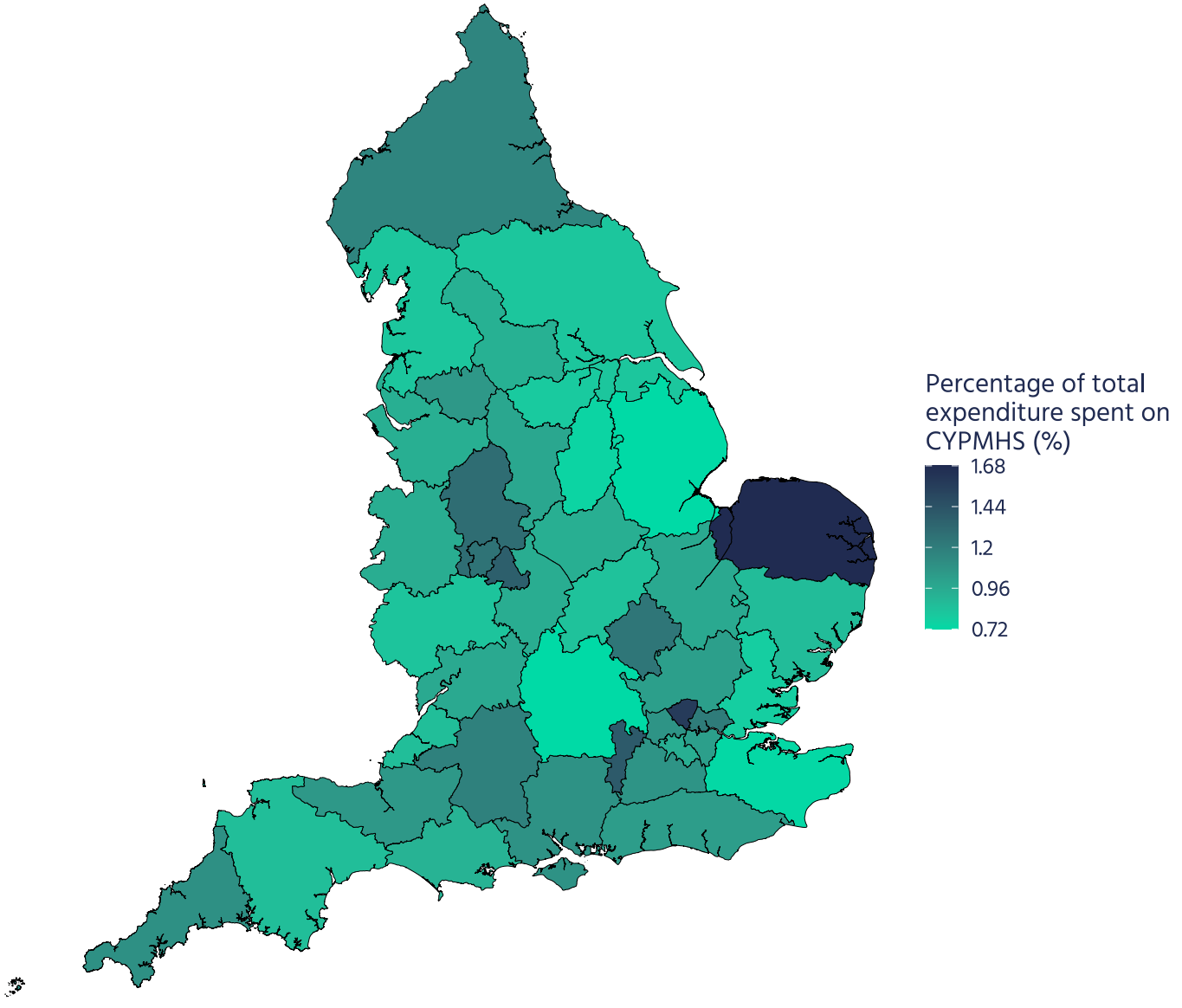
NHS Bradford District and Craven Sub-ICB	5,180	33	93
NHS Rotherham Sub-ICB	1,850	33	130
NHS Bury Sub-ICB	1,495	33	125
NHS Birmingham and Solihull Sub-ICB	4,325	32	89
NHS North Lincolnshire Sub-ICB	890	30	97
NHS Oldham Sub-ICB	1,680	30	59
NHS Kernow Sub-ICB	2,990	29	61
NHS East and North Hertfordshire Sub-ICB	2,810	29	53
NHS East Riding of Yorkshire Sub-ICB	950	28	96
NHS Trafford Sub-ICB	2,175	28	164
NHS Bristol, North Somerset and South Gloucestershire Sub-ICB	3,460	28	74
NHS Calderdale Sub-ICB	1,625	28	80
NHS Liverpool Sub-ICB	3,625	28	70
NHS Somerset Sub-ICB	2,235	28	58
NHS Knowsley Sub-ICB	1,400	28	52
NHS North East Lincolnshire Sub-ICB	370	27	57
NHS County Durham Sub-ICB	4,830	27	64
NHS South East London Sub-ICB	7,375	26	114
NHS Ipswich and East Suffolk Sub-ICB	2,330	26	105
NHS West Lancashire Sub-ICB	800	25	75
NHS Bolton Sub-ICB	1,970	25	60
NHS Shropshire, Telford and Wrekin Sub-ICB	2,160	24	92
NHS North Cumbria Sub-ICB	1,290	23	79
NHS Salford Sub-ICB	3,090	21	90
NHS Stockport Sub-ICB	1,660	21	92
NHS North East London Sub-ICB	10,545	21	59
NHS North Staffordshire Sub-ICB	1,300	20	117
NHS Stoke on Trent Sub-ICB	1,985	19	117
NHS Tees Valley Sub-ICB	6,435	19	44
NHS Warrington Sub-ICB	1,425	17	35

NHS Doncaster Sub-ICB	1,555	16	54
NHS North Yorkshire Sub-ICB	1,635	15	48
NHS Barnsley Sub-ICB	1,020	14	48
NHS Manchester Sub-ICB	7,780	14	84
NHS St Helens Sub-ICB	1,185	14	38
NHS Heywood, Middleton and Rochdale Sub-ICB	2,535	14	55
NHS Kirklees Sub-ICB	3,695	13	77
NHS Wakefield Sub-ICB	3,040	12	34
NHS West Essex Sub-ICB	1,545	11	53
NHS Bedfordshire, Luton and Milton Keynes Sub-ICB	7,460	10	39
NHS Thurrock Sub-ICB	985	8	48
NHS North East Essex Sub-ICB	2,300	8	36
NHS Halton Sub-ICB	825	8	45
NHS Blackburn with Darwen Sub-ICB	1,780	6	20
NHS West Leicestershire Sub-ICB	2,490	6	58
NHS East Leicestershire and Rutland Sub-ICB	1,715	6	73
NHS East Lancashire Sub-ICB	3,285	6	20
NHS Leicester City Sub-ICB	4,230	6	27
NHS Mid Essex Sub-ICB	1,980	5	36
NHS Basildon and Brentwood Sub-ICB	1,450	5	36
NHS Castle Point and Rochford Sub-ICB	985	5	32
NHS Southend Sub-ICB	1,120	4	32

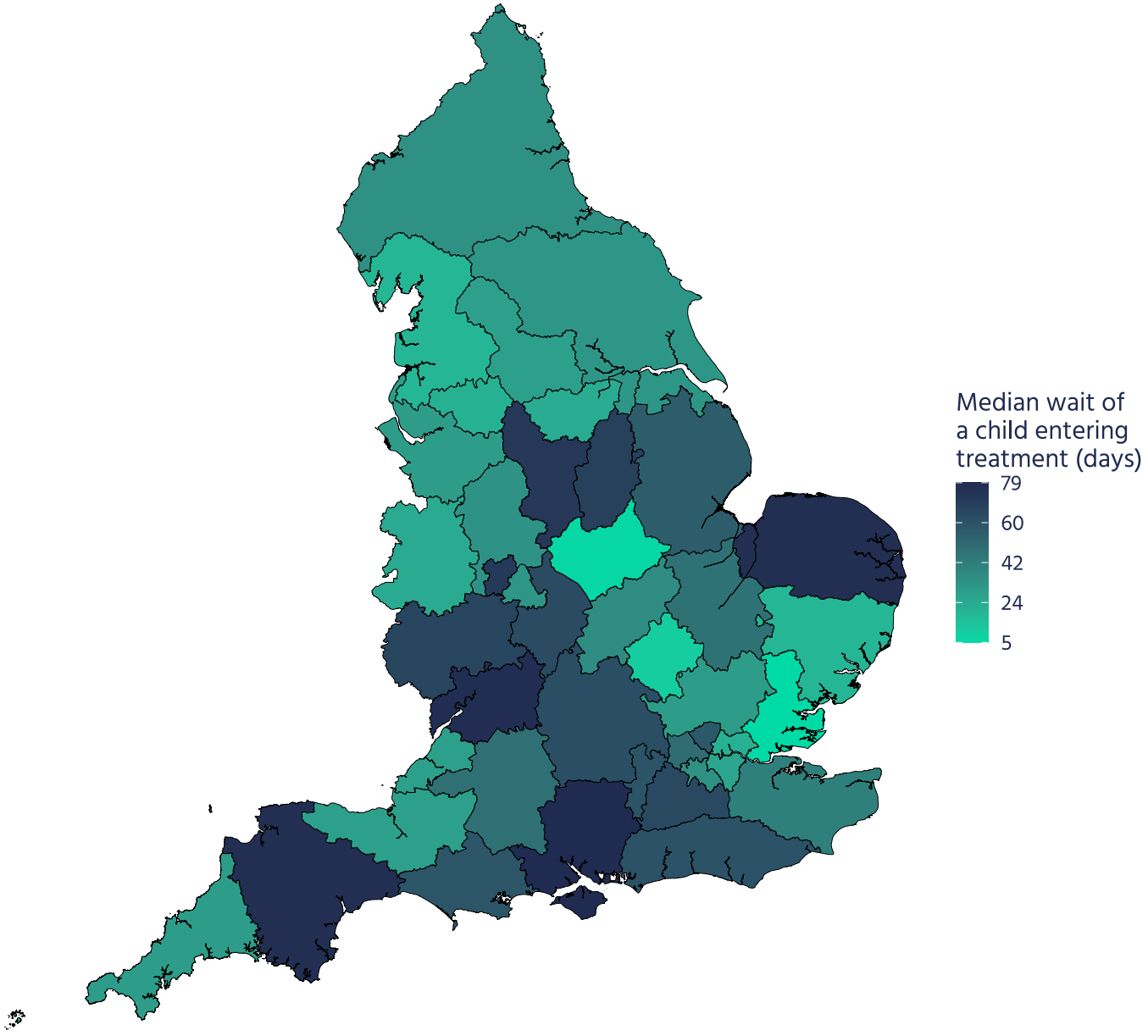
Annex A2: ICBs by the spend per child with an active referral, the first component of their overall score



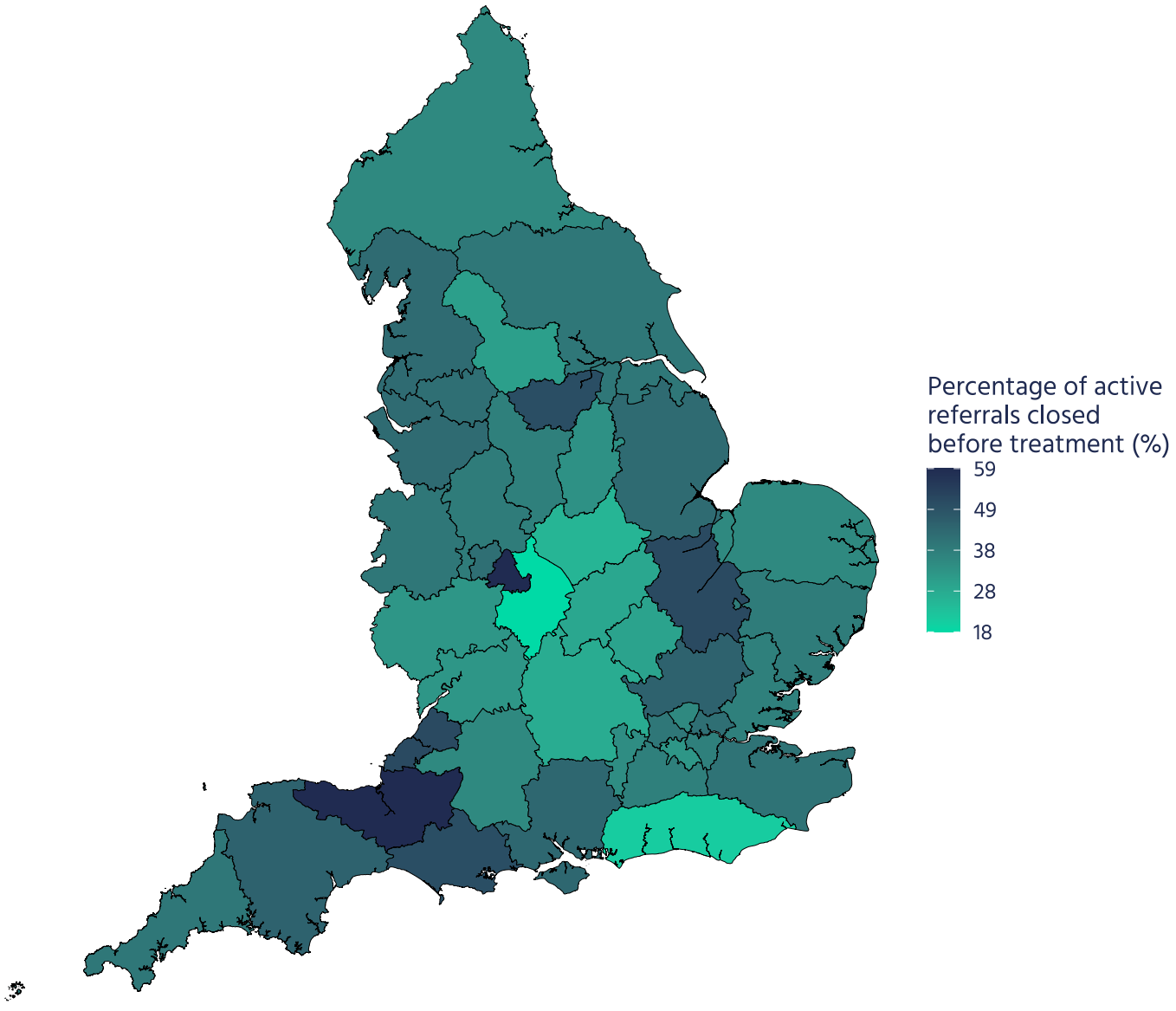
Annex A3: ICBs by the percentage of total expenditure spent on CYPMHS, the second component of their overall score



Annex A4: ICBs by the median wait of a child entering treatment, the third component of their overall score



Annex A5: ICBs by the percentage of active referrals closed before treatment, the fourth component of their overall score



Methodology

This report is based on analysis of NHS England data for 2022-23, visits to and a meeting with ICBs in February 2024, and comments written by children and young people in response to *The Big Ambition* survey, which ran from September 2023 to January 2024.

All quantitative data used in this analysis, except where specified, was sourced from the two datasets described below. Both are extracts provided to the CCo by NHS Digital and NHS England (now NHS England, following the two organisations' merger in February 2023). Data on spend is publicly available on the NHS Mental Health Dashboard (see below) while the data provided to the CCo on referrals and waiting times has now been published on the NHS website.[18]

The CCo also visited NHS Wakefield and NHS Rochdale in February 2024, and had the opportunity to meet with children and young people accessing mental health services in these areas. CCo also met with leaders from Leicester, Leicestershire and Rutland ICB online.

All quotes from children and young people in this report are drawn from *The Big Ambition* survey, which ran from September 2023 to January 2024. The full findings of this survey and methodology will be published shortly. The survey included one open text question which was answered by 174,131 children: *"What do you think the government should do to make children's lives better?"*

NHS Mental Health Dashboard

The NHS Mental Health Dashboard, formerly known as the Five year forward view for mental health (FYFVMH) dashboard, aggregates key data across mental health services to monitor performance against targets set in their five-year plan. In 2022-23, the underlying data aggregated in the dashboard was collected via the NHS Mental Health Services Dataset (MHSDS). The dashboard data provides information on:

- The percentage of young people accessing mental health services during the year estimated as a percentage of children and young people with a diagnosable mental health condition.
- Levels of spending on children and young people's mental health services and how this compares to overall ICB budgets.

- The percentage of children and young people able to access eating disorder treatment within a 1 week or 4 week time frame.
- Total number of bed days and admissions for CYP under 18 in Children and Young people's Mental Health Inpatient wards.

NHS Mental Health Services Data Set

The Mental Health Services Data Set (MHSDS) contains pseudonymised record-level data from all ICBs in England about the care of young people and adults who are in contact with mental health, learning disabilities or autism spectrum conditions services.

The dataset provided to the CCo contained information on all children with active referrals to CYPMHS for treatment during 2022-23 including:

- Average waiting time between referral and second contact.
- The number and percentage of children who had referrals that were closed before receiving treatment.
- The number and percentage of children still awaiting their second contact at the end of the year.
- The number and detailed waiting times for children who waited more than 12 weeks to access treatment as well as the number of children who were still waiting (having not received two contacts by the end of the year) for mental health support and how they long they had been waiting for.
- Waiting times between referral and 1st contact, and between 1st and 2nd contact, on top of the usual data on waiting times between referral and second contact.
- Children and young people's primary referral reasons, and waiting times by referral reason.
- The services children and young people are waiting for, and waiting times by service type.
- Breakdowns on waiting times by gender, age, ethnicity, disability and geography

Limitations of data and analysis

1. **Comparability of this report with previous CCo mental health briefings is limited.** This is because from July 2022, multiple smaller CCGs merged to form new combined ICBs. This gives

the impression that performance in some areas has worsened over the past year when this may not be the case (and vice versa when worse performing CCGs are merged with better performing CCGs).

2. **The metrics used to calculate overall area scores have changed.** Instead of spend per child in the ICB (previously CCG), this report uses spend per child with an active referral (using totals previously provided by NHS Digital and now provided by NHS England) to CYPMHS. This aims to capture more directly the link between mental health spend and need, as most children and young people in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated by the percentage of the child population receiving two contacts with CYPMHS, has been dropped from the list of metrics this year. Given these changes, the scores are not comparable with the scores in previous CCo mental health briefings.

3. **Previous iterations of the referrals and waiting times data looked only at referrals which started within the financial year**. To examine children waiting over a year, the CCo requested 2022-23 data that included any referrals which were active within the financial year. This means that the referrals have potential to have been open much longer and, as a result, the CCo is able to look at children waiting over 2 years before entering treatment.

4. **NHS England data only includes children's mental health services funded by the NHS**. As such, this report does not examine figures on mental health provision financed by organisations outside the NHS such as school-based counselling or services provided by local authorities (services which may be supported by the NHS but not considered NHS-funded). ICBs that spend more on external or preventative services at the expense of NHS funded CYPMHS will underperform on indicator scores based solely on CYPMHS.

5. **A child is counted as accessing treatment if they have two contacts with CYPMHS.** In some cases, a child may have more than 1 contact before treatment begins, while others may be referred or not need further support from CYPMHS after 1 contact. Therefore, we cannot

confidently state in all cases that a child with fewer than two contacts did not have their needs met or that every child with two contacts has entered treatment. However, this remains the best proxy measure available due to a lack of other reliable data sources estimating the number of young people receiving treatment at a single contact. It is also in line with the measures used to monitor progress in the Five year forward view for mental health.

6. **Children whose referrals were closed may not have required specialist treatment or may have been referred to services funded by, for example, local authorities and non-NHS funded charities.** Some children may also have chosen not to enter treatment. However, the data provided does not specify why a referral was closed. This is a key gap in evidence about the outcomes and circumstances of those referred.

7. **A small number of ICBs show reduced spend on Children and Young People Mental Health or Children and Young People Eating Disorders services in 2022-23 compared to 2021-22.** These are primarily due to mapping of CCGs to ICBs where parts of CCGs joined ICBs or due to re-categorisation of spend following ICB formation. NHS England told us they believed no areas had in fact decreased spend between last year and this year.

References

[1] NHSE. *Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey*. 2022. Link.

[2] Ibid.

[3] Ibid.

[4] CCo calculation based on population counts for children aged 7-17 from ONS. *Estimates of the population for the UK, England, Wales, Scotland and Northern Ireland*. 2022. Date accessed: 05/03/2024. Link. and mental health disorder prevalence rates for children aged 8-16 and young people aged 17-19 from NHSE. *Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey*. 2022. Link.

[5] Newlove-Delgado, T., McManus, S., Sadler, K., Thandi, S., Vizard, T., Cartwright, C. and Ford, T., *Child mental health in England before and during the COVID-19 lockdown*. 2021. The Lancet Psychiatry, 8(5), pp.353-35. Link.

[6] The Children's Commissioner's office. *Children's mental health services 2021-2022.* 2023. Link.

[7] WHO, *Mental Health of Adolescents*. 2021. Link.

[8] Pitman et al. *The mental health of lesbian, gay, and bisexual adults compared with heterosexual adults: results of two nationally representative English household probability samples*. Journal of Psychological Medicine. Cambridge University Press. 2021. Link.

[9] The Children's Commissioner's office, *The Big Answer*. 2021. Link.

[10] ONS. *Ethnic group, England and Wales: Census 2021*. 2022. Date accessed: 11/03/2023. Link.

[11] NHS Digital. *Detentions under the Mental Health Act*. 2023. Link.

[12] Royal College of Psychiatrists, *We cannot allow childhood mental illness to become the new norm*". 2024. Link.

[13] Ogundele MO, Morton M. Classification, prevalence and integrated care for neurodevelopmental and child mental health disorders: A brief overview for paediatricians. World Journal of Clinical Paediatrics. 2022. Link.

[14] Crane, L., Adams, F., Harper, G., Welch, J., & Pellicano, E. 'Something needs to change': Mental health experiences of young autistic adults in England. 2019. Link.

[15] Dilsaver SC. *Differentiating organic from functional psychosis*. Am Fam Physician. 1992. Link.

[16] Office for National Statistics. *GDP deflators at market prices and money GDP.* March 2023. Date accessed: 27/02/2024. Link.

[17] Department for Education, *Transforming Children and Young People's Mental Health Implementation Programme*, 2023. Link.

[18] NHS England, 2024. *Waiting times for children and young people's mental health services, 2022-23.* Link.

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