CHILDREN'S COMMISSIONER

# Children's Mental Health Services 2021-22

March 2023

CHILDREN'S COMMISSIONER

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## Foreword from Dame Rachel de Souza

When I became Children's Commissioner, one of my first actions was to carry out The Big Ask survey. I wanted to understand, as we were emerging from the shadow of the pandemic, what children wanted for their futures, and what worries were holding them back. It was clear from the responses to that survey, as well as from the conversations I have had with children, that good mental wellbeing is of paramount importance to England's children. Children and young people were speaking about their feelings and struggles with a level of eloquence and confidence that escapes many adults.

While I was delighted to find that most children were happy with their lives, there were far too many who were unhappy. 1 in 5 children were unhappy with their mental health. And it is older teenage girls who I worry most about - nearly 2 in 5 of 16–17-year-old girls were unhappy with their mental health.

This is why I have made children's health and wellbeing a key pillar of my work as Children's Commissioner. When I think about children's mental health it is clear to me that we need to think holistically about a child. So much of a child's wellbeing will be down to things such as their relationships with family and friends, their participation in education, or their experiences of the online world. That is why a preventative approach is essential, and why mental health cuts across all areas of my work – to place family at the heart of policy making in my independent Family Review, to drive 100% attendance in schools, or to make the Online Safety Bill the best it can be.

But there is also, of course, a need for the right treatment to be in place. That is why in this report I dig into the data to understand what is happening in children's mental health provision. The data shows mental health provision across CCG areas for children and young people. This data is the first available since services were widely re-opened after the pandemic, and shows a surging demand for help. The welcome progress that has been made in recent years on improving children's access to the right support is struggling to keep up with this demand – with waiting times increasing in the first time in years. It is vital that this support is made available because to allow children the chance to recover, and go on to achieve all that they want to, but also because without support things can end up in

crisis.

Alongside the data, my team have spoken to children living in mental health inpatient settings who say time and again that if only the right help had been there earlier on, they wouldn't have ended up in hospital. But too many children still are ending up in hospital, and again there seems to be a particular issue for older teenage girls. 71% of detentions of children under the Mental Health Act are of girls[1].

It is my aim for no child to live in an institution. These settings struggle to provide the kind of caring, familial environment that children desperately need. And in the last year we have seen that in some cases they can be dangerously unsafe – as the tragic deaths Nadia Sharif, Christie Hartnett, and Emily Moore while they were in inpatient mental health care show. And I am if anything even more worried about the rapidly growing number of children being deprived of liberty in other types of settings – where no official data tells us where they are living, or how long for.

That is why I want to see every child getting the right support in their community, as soon as they need it. Because as one girl in a hospital we visited so rightly put it '*The best place to get better is at home*'.

# Introduction

The mental health of children has deteriorated markedly in recent years. As of 2022, the NHS estimates that 18% of children aged 7 to 16 years and 26% of those aged 17 to 19 have a probable mental health disorder, up from 17% in 2021.[2] Some groups of children have particularly poor levels of mental health. Among girls and young women the problem is particularly widespread, with 31% of girls and young women aged 17 to 24 estimated as having a probable disorder.[3] Half of looked after children (49%) had 'borderline' or 'cause for concern' scores in 2020-21 based on their answers to the Strengths and Difficulties Questionnaire, a measure of mental health and wellbeing.[4]

To truly tackle this crisis, both preventative action and appropriate treatment are required. This report aims to assess children's ability to access timely treatment, and to understand how that has changed in recent years.

In 2019 the NHS set out its Long-Term Plan, which included several goals for children and young people's mental health services (CYPMHS). These included: testing approaches that could deliver four week waiting times; rolling out Mental Health Support Teams in schools and colleges; for children's mental health spend to increase as a share of overall spend, and an ambition for 100% of children to get the specialist care they need.[5] This report allows us to understand progress towards those goals, and where challenges are emerging.

Using new figures sourced from NHS England and NHS Digital under Section 2F of the Children Act 2004, this report examines spending on children's mental health, numbers of children referred to and accessing CYPMHS and waiting times between referral and treatment (having a second contact with CYPMHS). Mental health services in this report refer to advice and support from a range of professionals, including Mental Health Support Teams, for problems like stress, low mood and depression, anxiety, self-harm, eating disorders or difficulty managing behaviours.

The report provides a summary score for each local area based on five key indicators of CYPMHS performance. This score aims to show how each Clinical Commissioning Group (CCG) compares to the rest of England in terms of children's access to mental health services. The best possible score is 25. The five key indicators are:

1. Mental health spend per child - calculated using NHS Five Year Forward View for Mental Health spending figures[6] and Office for National Statistics population estimates for CCG areas (where higher spend per child corresponds with a higher score)
2. CCG spending on children's mental health as a percentage of a CCGs total allocation (where a higher percentage corresponds with a higher score)
3. Average waiting time for children who receive a second contact with services (where lower average waiting times corresponds with a higher score)
4. Total number of children referred to children's mental health services as a proportion of the local under-18 population (where higher shares of children referred corresponds with a higher score)
5. The percentage of referrals that are closed before treatment[a] (where a lower percentage of referrals closed corresponds with a higher score).

Access to timely treatment is vital. Without the right care at the right time, children can end up in crisis. This report also includes the findings from visits to two in-patient mental health settings, and interviews with children in those settings.

[a] This report defines a child as not receiving treatment if they were referred but did not subsequently receive at least two contacts with CYMPHS. There may be some instances where in the first contact it may be clear that the cause of distress is not a mental health difficulty

The children and staff in each hospital were clear that with more help, when problems first emerged, many of these children could have avoided an in-patient admission. Currently the Mental Health Act is being reformed, with proposals in place to make it harder to detain people under the Act. This is very welcome, as the children spoken to for this report were clear that an in-patient ward was not a place they wanted to be. They can be frightening places for children, who are separated from friends and family, taken out of their usual education, and often see and experience high levels of restraint. In some tragic instances, children experience abuse and maltreatment – which is why the Government is currently carrying out a rapid review into in-mental health inpatient settings.

To achieve the goal of fewer children being detained under the Mental Health Act, and without simply moving children into other institutions under other legislation, it is essential that the right level of community support is available.

This report therefore considers the whole of a child's journey through mental health services, to understand how we can improve access to CYMPHS support in the community, which will be of benefit to children today, but also help to prevent children being hospitalised in the future.

It will also explore how those inpatient mental health settings can be improved for the children who are living in them, to make them feel more familial and loving, and to ensure that the appropriate safeguards are in place. It is the Children's Commissioner's ambition that no child should live in an institution, but on the road to achieving that goal things can be done to improve them for the children living in them today.

# Executive summary

This report outlines our main findings in understanding children's access to mental health services in England in financial year 2021-22.

- Of the 1.4 million children estimated to have a mental health disorder, less than half (48%) received at least 1 contact with CYPMHS and 34% received at least 2 contacts with CYPMHS.
- The percentage of children who had their referrals closed before treatment has increased for the first time in years. In 2021-22, 32% of children who were referred did not receive treatment compared to lower numbers in 2020-21 (24%), 2019-20 (27%) and 2018-19 (36%). There remains wide variation across the country in how many children's referrals were closed without treatment, from as low as 5% of referrals in NHS East Sussex to 50% in NHS North Cumbria.
- The average waiting time between a child being referred to CYPMHS and starting treatment increased from 32 days in 2020-21 to 40 days in 2021-22. The average waiting time for children to enter treatment (defined as having two contacts with CYPMHS) varies widely by CCG from as quick as 13 days in NHS Leicester City to as long as 80 days in NHS Sunderland.
- Spending on children's mental health services has increased every year, after adjusting for inflation, since 2017-18. CCGs spent £927 million on CYPMHS in 2021-22, equal to 1% of the total budget allocated to them. This compares to £869 million in 2020-21 – an increase of 7% in real terms. The share of CCGs spending over 1% of their total budget increased from 30% in 2020-21 to 45% in 2021-22.
- The number of children admitted to inpatient mental health wards continues to fall, as does the number of detentions of children under the Mental Health Act each year. Of the 869 detentions of children under the Mental Health Act in 2021-22, 71% were of girls.

- An increasing number of children, many of whom have mental health difficulties but are not admitted to hospital, are being deprived of their liberty in other settings. These children are hidden from view as they do not appear in any official statistics, but research suggests that over ten times as many children are being deprived of liberty in this way in 2023 as in 2017-18.

- Children in inpatient mental health settings who we spoke to wanted more, earlier intervention to prevent crisis admissions – sometimes children are presenting multiple times at A&E before an inpatient admission is considered.

- Much more can be done to make inpatient mental health wards feel safe and familial. Children reported a huge variation in the quality of relationships they had with staff. For example, while some children felt they knew staff genuinely cared about them, one child described how staff would only refer to children by their initials, rather than their name. There appears to be a particularly acute issue with the quality of night staff.

- Education was viewed very positively by most of the children spoken to for this report, and highlights the importance of high-quality education in these settings for children's recovery as well as their learning.

- The data collected on children in inpatient settings, including demographic information and information about key safeguards for children, is patchy and makes it harder to improve quality.

# 1. Trends in children's access to CYPMHS

## 1.1 Overall access to CYPMHS

Given the rising numbers of children experiencing mental disorders, and the importance of accessing early treatment, the NHS committed in 2019 that at least 345,000 more children and young people would be able to access community support by 2023-24, with a long-term goal for 100% of children needing specialist support to receive it.[7]

Applying the mental health prevalence rates to Census 2021 population estimates for those aged 7 to 17 suggests there is a pool of 1.4 million children and young people with a probable mental health disorder.[8] The NHS recently updated the measure used for indicating whether a child has accessed treatment from a two-contact measure (whether the child had at least two contacts with CYPMHS) to a one-contact measure (whether the child had at least one contact with CYPMHS). The NHS Five Year Forward View dashboard shows that there were 661,000 young people who received at least one contact with CYPMHS in 2021-22. From this we can calculate that the rate for children and young people in need who were able to access mental health services was 48% in 2021-22.

As it is unclear whether a child or young person's mental health condition can be successfully treated in one contact, the CCo prefers to retain the two-contacts measure as a proxy for treatment. Under the two-contact measure, 471,000 children (34%) would have been considered to have accessed treatment in 2021-22.

Using both of these measures, this analysis finds that over half of the children with a mental health disorder did not receive treatment in 2021-22.

## 1.2 Number of children referred to CYPMHS

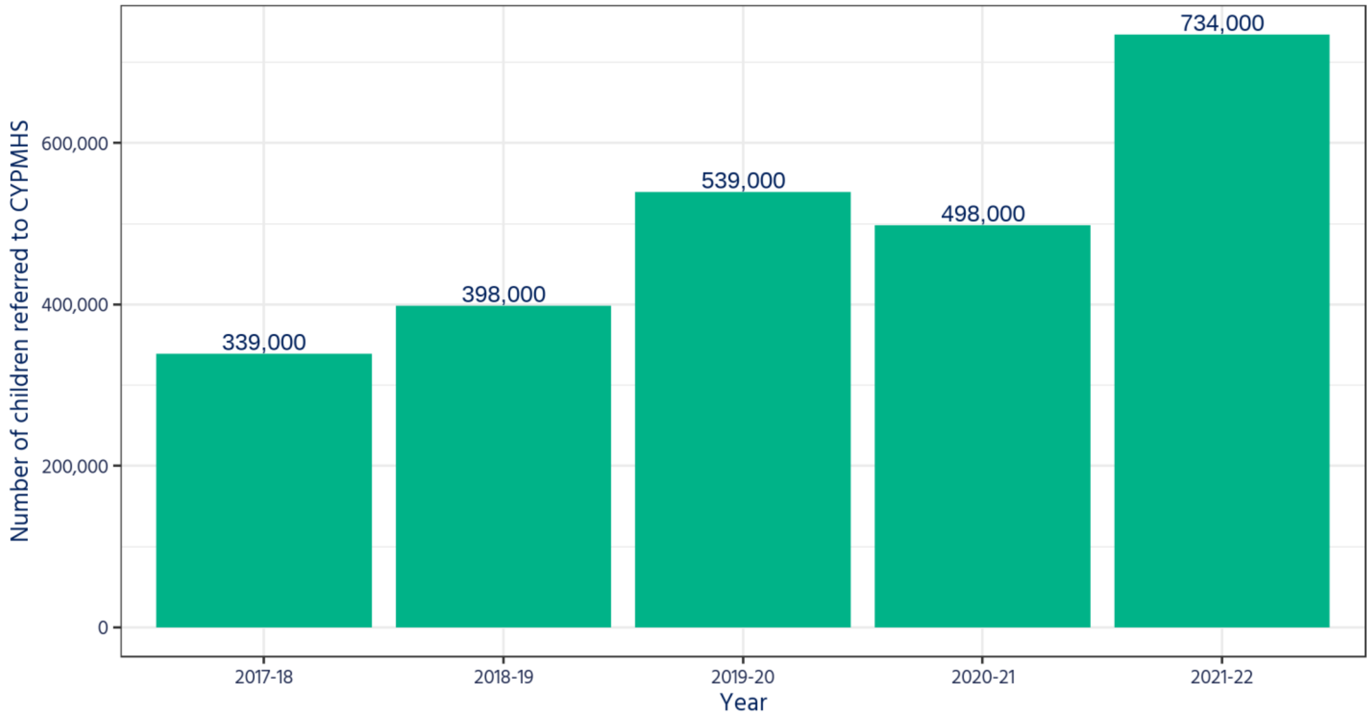
Essential to ensuring that all children who could benefit from it and get the help they need is the initial step of referring children to appropriate CYPMH services. In almost every year since 2017-18, there have

been steady increases in the number and rate of children being referred to CYPMHS. The only year in which this was not the case was in 2020-21, when the number of children referred dipped to 498,000 children from 539,000 in 2019-20 (see Figure 1). It is highly likely that this is the result of fewer children being in contact with professionals who could identify need and make onward referrals.

Latest figures for 2021-22 show that there has been an increase in the number of children referred to CYPMHS – 734,000 in 2021-22, a 47% increase from the previous year and an 84% increase from 2018-19, the last year before covid. This increase in the number of children referred likely reflects a methodological change.[b]

**Figure 1. Number of children referred to CYPMHS, 2017-18 to 2021-22**

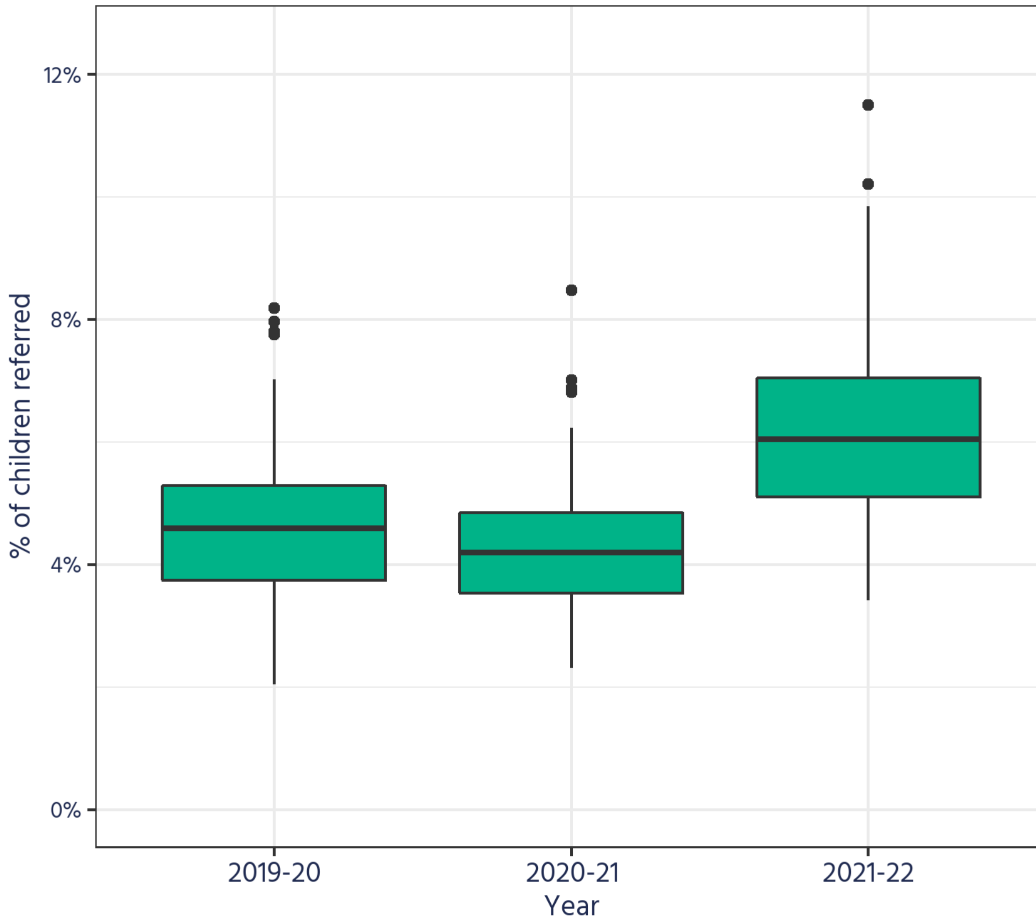
[b] Note there was also a methodology change in 2021-22: the data includes referrals for children and young people which, during the reporting period, stopped being submitted by providers as part of their monthly Mental Health Services Dataset submissions.




New data published in the 2022 update to the NHS Mental Health of Children and Young People report show that the rates of children with probable mental disorders have increased since 2017. For 7 to 16-year-olds, the rate has increased from 12.1% in 2017 to 16.7% in 2020 and 18.0% in 2022 and for 17 to 19 year-olds, the rate has increased from 10.1% in 2017 to 17.7% in 2020 and 25.7% in 2022.[9]

At a national level, the percentage of children referred was 6% in 2021-22, up from 4% in the previous two years. Most CCGs saw an increase in referral rates to CAMHS from 2020-21 to 2021-22, as shown in Figure 2.

**Figure 2. Distribution of CCG referral rates to CYPMHS, 2019-20 to 2021-22**




Note: In the figure above, the median CCG is shown by the line in the middle of the box. The upper and lower quartiles are the ends of the box. Vertical lines represent 1.5 times the interquartile range and the dots outside the box and whiskers are outliers.

In 2021-22, NHS South Tyneside, an outlier in Figure 2, had the highest rate of children referred at 12%. NHS South Tyneside also had the highest rates of referrals in 2020-21, at 8%. (see table A1) NHS North West London had the lowest rate of children referred at 3%, an increase from 2% in the previous year (see table A2).

A number of factors will influence differences in referral rates between areas. Estimates of mental health disorder prevalence are not available by local CCG area. It is therefore possible that different areas, perhaps due to a particular focus on prevention, for example, have lower rates of children with disorders, and therefore would need fewer referrals.

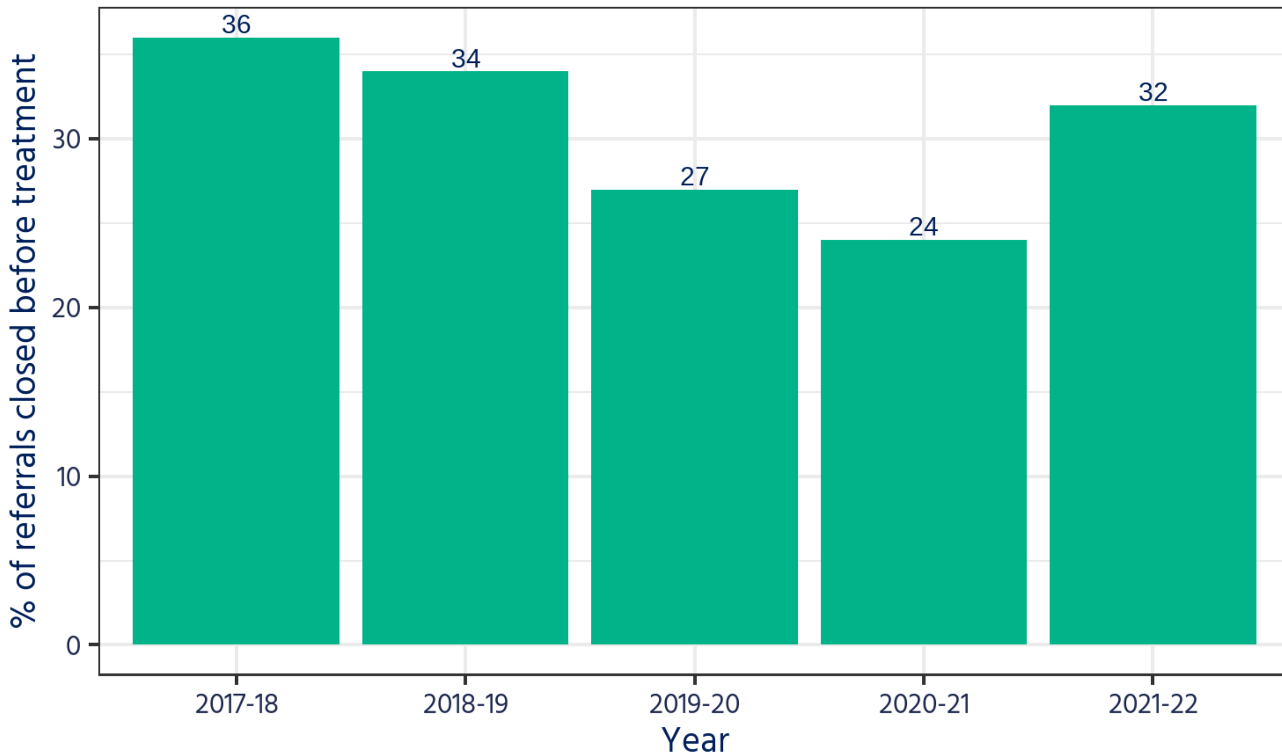
## 1.3 Referrals closed before treatment

As the number of children in need of mental health services surges, there is concern that existing NHS service capacity and infrastructure may not be able to cope with the additional pressure. For the first time since 2017-18, the percentage of children who had their mental health referrals closed without accessing treatment has increased, back up to nearly a third.[c]

Previous reductions in the closure rate of children's CYPMHS referrals were lost in 2021-22. Before now, the NHS had been making steady progress in reducing the proportion of referrals closed before treatment, successfully lowering it from 36% in 2017-18 to 24% in 2020-21. In 2021-22, this figure rose to 32%, equivalent to 238,000 children in England who were referred to mental health services but did not receive treatment.

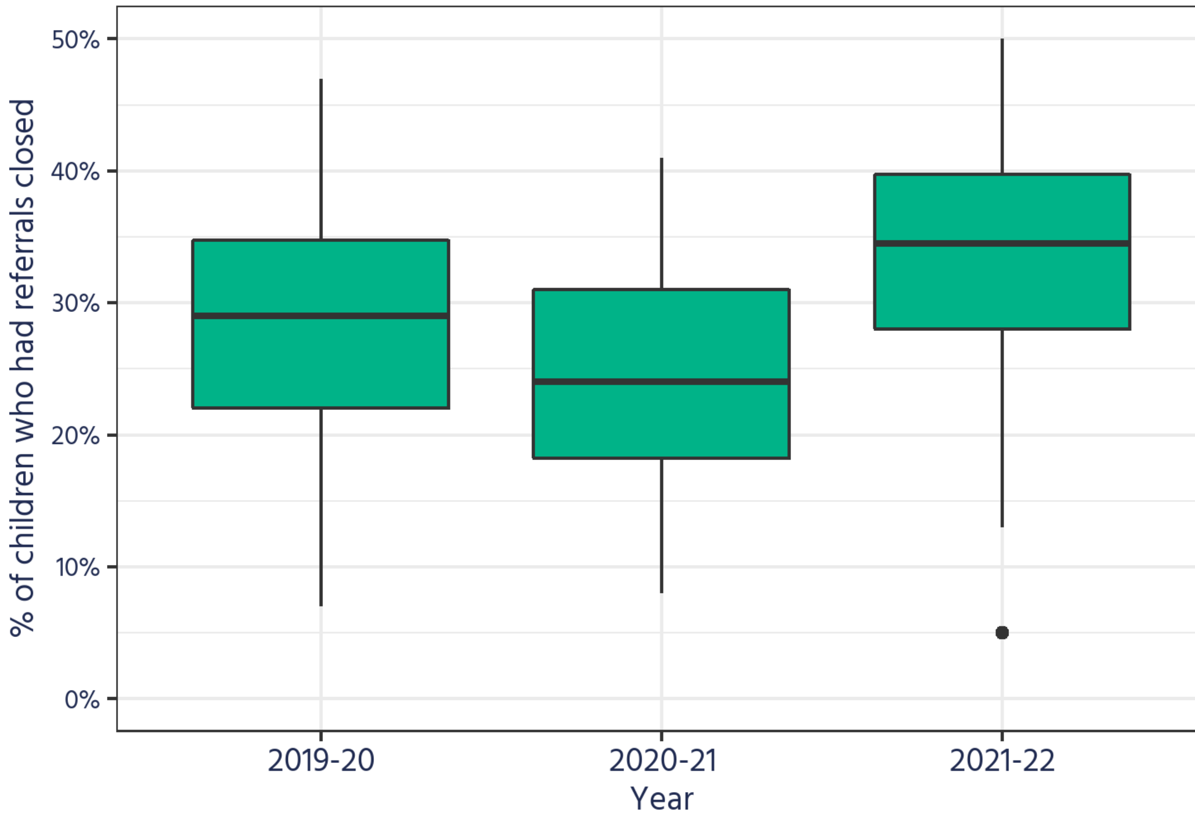
**Figure 3. Percentage of referrals closed before treatment**

[c] This section of the report refers to children and young people who do not receive two contacts after being referred to CYPMHS because their referral was subsequently closed. This measure will include some children whose referrals was closed because they may not have required specialist treatment, chose not to pursue further intervention, or were referred to other services and support, such as through a Mental Health Support Team in a school or college.




Since 2020-21, almost all CCGs (91%) had an increase in the proportion of referrals closed before accessing CYPMHS (see boxplot below). Of these, NHS Blackburn with Darwen, NHS Bristol, North Somerset and South Gloucestershire CCG and NHS Wirral CCG had the largest increases in the proportion of children whose referrals were closed – a 25 percentage point increase in all three CCGs (see table A5).

**Figure 4. CCG distribution of the percentage of children with referrals closed before treatment in 2021-22**




Note: In the figure above, the median CCG is shown by the line in the middle of the box. The upper and lower quartiles are the ends of the box. Vertical lines represent 1.5 times the interquartile range and the dots outside the box and whiskers are outliers.

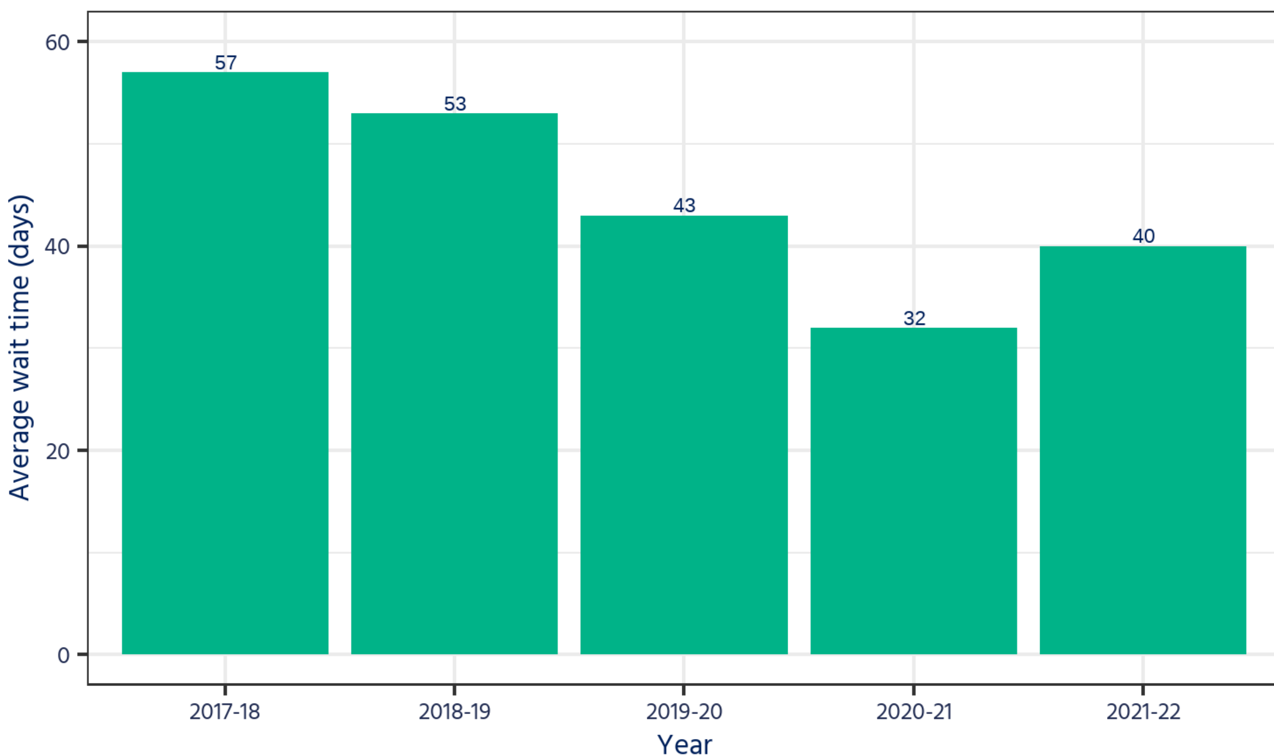
There remains notable variation across the country in the numbers of children whose referral was closed before treatment, from as low as 5% of referrals in NHS East Sussex to 50% in NHS North Cumbria (Figure 4; see tables A3 and A4 for further detail). However, this is still a large improvement from 2017-18 when, in some CCGs, more than 80% of children had their referrals closed.[10]

## 1.5 Waiting times

As previously noted in CCo's 2022 report 'A Head Start'[11] and in systematic literature reviews[12], early intervention is a powerful tool that can help children build strong foundations for good mental health

and develop the skills needed to live happy and healthy lives. This is why it is concerning that the average waiting time in England between referral and the start of CYPMHS treatment has increased for the first time in years (see Figure 5). Between 2017-18 and 2020-21, the NHS cut average waiting times almost in half from 2 months (57 days) in 2017-18 to about a month (32 days) in 2020-21. In 2021-22, the average wait time increased to 40 days.

**Figure 5. Average wait time between referral and treatment (in days)**



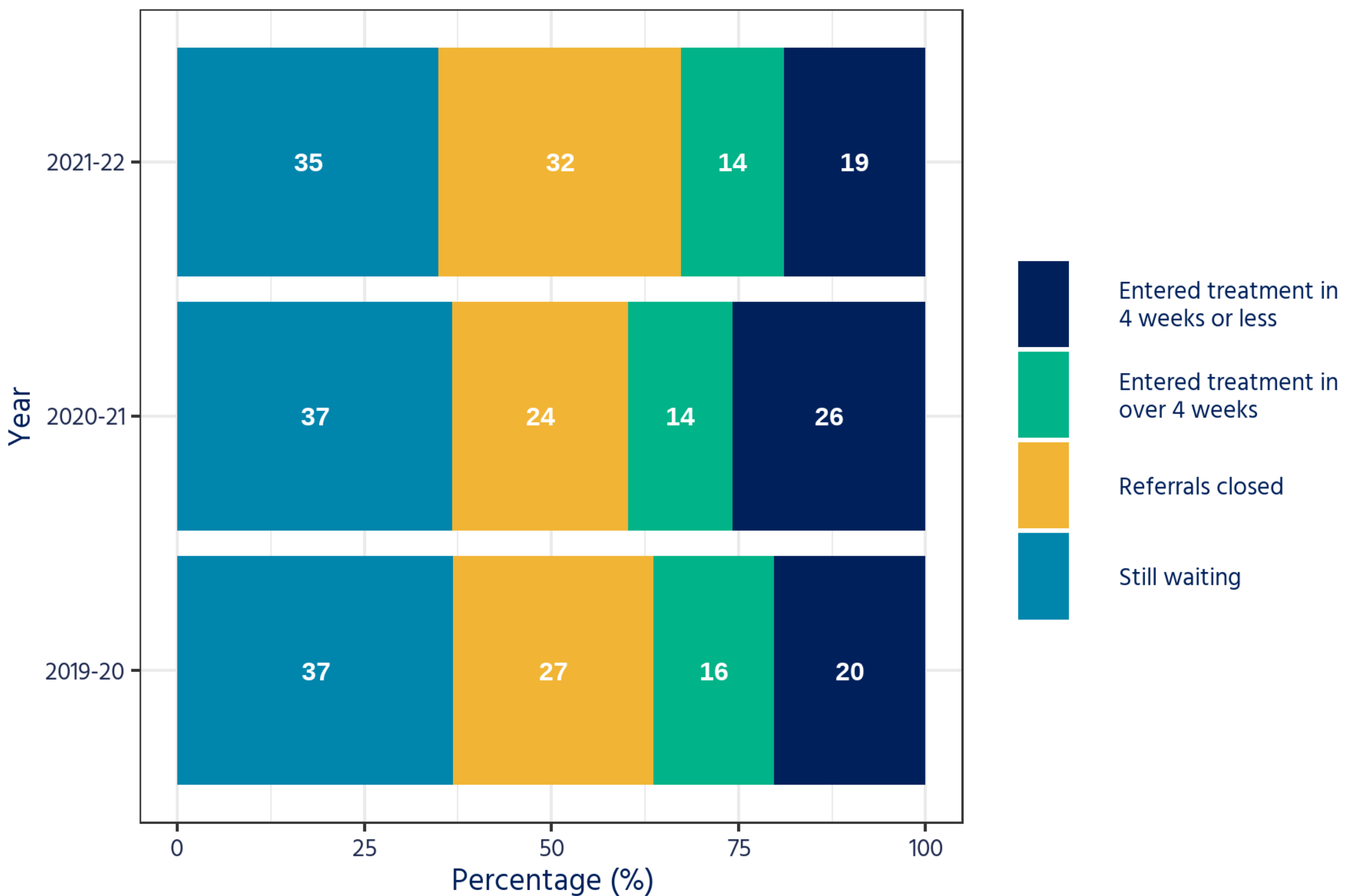

As with other indicators, the average waiting time for children to enter treatment (defined as two contacts with CYPMHS) varies widely by CCG, from as quick as 13 days in NHS Leicester City to as long as 80 days in NHS Sunderland (see tables A6 and A7).

Three-quarters of CCGs (75%) increased their average waiting times in 2021-22. Three CCGs saw waiting times increase by 30 days or above. In particular, NHS Basildon and Brentwood was one of the

CCGs with the lowest average waiting times in 2020-21 at 7 days. In 2021-22, this had increased to 37 days (see table A8).

A fifth of children referred to CYPMHS (19%) entered treatment within four weeks – a decrease from 26% of children referred in 2020-21 (Figure 6). Considering the surge in mental health need and referrals to CYPMHS outlined in earlier chapters, this drop in percentage shows services have not been able to expand quickly enough to keep pace.

**Figure 6. Percentage of children referred to CYPMHS in 2019-20 to 2021-22 by outcome**



## 1.6 CCG spending on children's mental health services

Overall, spending on children's mental health services (adjusted for inflation and excluding spending on mental health services for children with learning disabilities) has increased every year since 2017-18 (table 1).[13] Of the total NHS budget for England, CCGs spent £927 million on CYPMHS in 2021-22, equal to 1.0% of total allocations to CCGs. This compares to £869 million in 2020-21 – an increase of 7% in real terms (see Table 1).[d]

For reference, CCGs spent 13% of the total budget on adult mental health services – equivalent to £11.8 billion.

**Table 1. Real and nominal spend on children's mental health services, 2017-18 to 2021-22**

| Year | Nominal spend (millions) | Nominal growth rate (%) | Spend in 2019-20 £ (millions)[e] | Real growth rate (%) |
|---|---|---|---|---|
| 2017-18 | £640.5 | | £668.9 | |
| 2018-19 | £726.1 | 13% | £745.0 | 11% |
| 2019-20 | £799.0 | 10% | £799.0 | 7% |
| 2020-21 | £868.7 | 9% | £816.4 | 2% |
| 2021-22 | £927.1 | 7% | £875.4 | 7% |

Spend per child has also increased by 7%, adjusted for inflation, up from £72 in 2020-21 to £77 in 2021-22 (see Table 2).

[d] As a result of independent reviews on CCG spend reporting, NHS England identified areas where spend categorisation was not treated consistently across the country. This led to a new set of categories and guidance for CCGs, and NHS England commissioned all CCGs to review and revise their historical spending. The data reported in this briefing are from the updated reports and as a result, these spend figures will not match those reporting in CCo's previous mental health briefings.

[e] Inflation adjusted spend calculated using ONS GDP deflators.

**Table 2. Real and nominal spend per child, 2019-20 to 2021-22**

| Year | Nominal spend per child to the nearest £ | Nominal growth rate (%) | Spend per child in 2019-20 to the nearest £[f] | Real growth rate (%) |
| --- | --- | --- | --- | --- |
| 2019-20 | £66 | | £66 | |
| 2020-21 | £72 | 9% | £68 | 3% |
| 2021-22 | £77 | 7% | £73 | 7% |

The share of CCGs spending over 1% of their total budget on CAMHS increased from 30% in 2020-21 to 45% in 2021-22. As with other indicators in this briefing, there is notable variation in mental health spending across CCGs. Spend per child in the population varies from a low of £34 in NHS Doncaster to a high of £141 in NHS Norfolk (see tables A9 and A10).

In 75% of CCGs, spend per child increased in 2021-22 compared to 2020-21. However, in a few areas, spend per child decreased by large amounts in 2021-22. For example, NHS Cannock Chase CCG spend per child decreased from £121 to £71 (see tables A11 and A12).

## 1.7 CCG overall scores

As with last year's report, to provide an overall indication of how each CCG compares to the rest of England in terms of children's access to mental health services, we created a summary score for each CCG based on five key indicators of CYPMHS performance. These indicators are:

1. Mental health spend per child - calculated using NHS Five Year Forward View for Mental Health spending figures and Office for National Statistics population estimates for Clinical Commissioning Group areas (where higher spend per child corresponds with a higher score)

[f] Inflation adjusted spend calculated using ONS GDP deflators.

2. CCG spending on children's mental health as a percentage of a CCG's total allocation (where higher spending corresponds with a higher score)

3. Average waiting time for children who receive a second contact with services (where lower average waiting times corresponds with a higher score)

4. Total number of children referred to children's mental health services as a proportion of the under-18 population (where higher shares of children referred corresponds with a higher score)

5. The percentage of referrals that are closed before treatment[g] (where a lower percentage of referrals closed corresponds with a higher score)

For each indicator, CCGs are ranked from best to worst (e.g. shortest waiting time to longest) and assigned to 5 quintiles. Scores are then given to each CCG based on their quintile group. The best performing 20% of CCGs are given a score of 5 while the worst performers are given a score of 1. We then add these quintile scores together to form an overall score ranging from a minimum of 5 (worst) to a maximum of 25 (best) for each CCG. An overall score of 5 would indicate being in the bottom quintile across all 5 measures while a score of 25 would indicate being in the top quintile across all measures.

The CCo has given a greater weight to spending in the overall measure by using two spending indicators to compensate for the fact that some CCGs will have invested in lower-level MH services that will not necessarily be reflected in the number of children referred, average waiting times or percentage of referrals closed.

According to these scoring criteria, the best performers this year were NHS Wakefield, NHS Heywood, Middleton and Rochdale and NHS Tees Valley, with overall scores of 24, 23 and 22 respectively.

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

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**Table 3. Top 20 best performing CCGs in 2021-22 by overall score**

| Clinical Commissioning Group | Spend per child (to nearest £) | % of budget spent on CYPMHS | Average wait in days | % referred to CYPMHS | % referrals closed before treatment | CCG overall score |
|---|---|---|---|---|---|---|
| NHS Wakefield CCG | £135 | 1.2% | 24 | 9.0% | 21% | 24 |
| NHS Heywood, Middleton and Rochdale CCG | £104 | 1.5% | 33 | 8.0% | 31% | 23 |
| NHS Tees Valley CCG | £113 | 1.4% | 30 | 8.3% | 36% | 22 |
| NHS South Tyneside CCG | £136 | 1.4% | 54 | 11.5% | 22% | 21 |
| NHS Stoke On Trent CCG | £123 | 1.6% | 25 | 7.0% | 37% | 21 |
| NHS Wirral CCG | £96 | 1.1% | 30 | 7.4% | 36% | 21 |
| NHS Bedfordshire, Luton and Milton Keynes CCG | £75 | 1.2% | 26 | 6.4% | 22% | 21 |
| NHS North Staffordshire CCG | £135 | 1.6% | 31 | 6.6% | 37% | 20 |
| NHS Bury CCG | £106 | 1.5% | 33 | 8.2% | 49% | 20 |
| NHS Salford CCG | £135 | 2.2% | 29 | 6.1% | 35% | 20 |
| NHS North East Lincolnshire CCG | £96 | 1.3% | 36 | 7.8% | 41% | 20 |
| NHS Norfolk and Waveney CCG | £141 | 1.6% | 50 | 7.7% | 36% | 20 |
| NHS County Durham CCG | £97 | 1.0% | 37 | 9.7% | 29% | 20 |
| NHS West Lancashire CCG | £81 | 1.1% | 37 | 6.9% | 28% | 19 |
| NHS Barnsley CCG | £87 | 1.1% | 23 | 4.7% | 24% | 19 |
| NHS Northumberland CCG | £91 | 1.0% | 34 | 7.0% | 36% | 19 |
| NHS Sunderland CCG | £114 | 1.3% | 80 | 9.9% | 31% | 19 |
| NHS Leicester City CCG | £84 | 1.1% | 13 | 4.8% | 21% | 19 |
| NHS Brighton and Hove CCG | £123 | 1.6% | 72 | 5.7% | 23% | 19 |
| NHS Tameside and Glossop CCG | £80 | 1.2% | 40 | 6.6% | 26% | 19 |

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Conversely, there were six CCGs tied at the bottom with an overall score of 9. These were: NHS Stockport, NHS Oxfordshire, NHS Bristol, North Somerset and South Gloucestershire, NHS Dorset, NHS Lincolnshire and NHS Kent and Medway.

**Table 4. Top 20 worst performing CCGs in 2021-22 by overall score**

| Clinical Commissioning Group | Spend per child (to nearest £) | % of budget spent on CYPMHS | Average wait in days | % referred to CYPMHS | % referrals closed before treatment | CCG overall score |
|---|---|---|---|---|---|---|
| NHS Stockport CCG | £58 | 0.8% | 25 | 4.8% | 44% | 9 |
| NHS Oxfordshire CCG | £50 | 0.7% | 57 | 5.2% | 30% | 9 |
| NHS Bristol, North Somerset and South Gloucestershire CCG | £62 | 0.8% | 36 | 4.1% | 45% | 9 |
| NHS Dorset CCG | £76 | 0.8% | 48 | 4.3% | 44% | 9 |
| NHS Lincolnshire CCG | £51 | 0.6% | 37 | 5.5% | 40% | 9 |
| NHS Kent and Medway CCG | £57 | 0.8% | 43 | 6.6% | 46% | 9 |
| NHS Bassetlaw CCG | £63 | 0.9% | 44 | 5.7% | 42% | 10 |
| NHS Castle Point and Rochford CCG | £60 | 0.8% | 18 | 4.5% | 41% | 10 |
| NHS Mid Essex CCG | £44 | 0.5% | 14 | 4.5% | 36% | 10 |
| NHS Portsmouth CCG | £61 | 0.8% | 65 | 6.6% | 42% | 10 |
| NHS Herefordshire and Worcestershire CCG | £66 | 0.8% | 66 | 4.9% | 34% | 10 |
| NHS North Yorkshire CCG | £55 | 0.6% | 38 | 5.3% | 32% | 10 |
| NHS Greater Preston CCG | £63 | 1.0% | 39 | 4.8% | 37% | 11 |
| NHS Doncaster CCG | £34 | 0.5% | 20 | 4.5% | 35% | 11 |
| NHS Sheffield CCG | £76 | 0.9% | 40 | 4.8% | 45% | 11 |
| NHS West Suffolk CCG | £59 | 0.8% | 55 | 7.1% | 35% | 11 |
| NHS Cannock Chase CCG | £71 | 1.0% | 65 | 6.5% | 44% | 11 |

| NHS East Staffordshire CCG | £66 | 1.0% | 50 | 4.9% | 38% | 11 |
|---|---|---|---|---|---|---|
| NHS South East Staffordshire and Seisdon Peninsula CCG | £72 | 1.1% | 57 | 5.2% | 47% | 11 |
| NHS East Riding Of Yorkshire CCG | £63 | 0.8% | 28 | 5.7% | 43% | 11 |

# 2. Inpatient provision

## 2.1 Types of inpatient provision

When children with mental ill-health become severely unwell, they may be admitted to inpatient mental health settings. They can be detained under the Mental Health Act – for a shorter period of assessment or a longer period of treatment – which is commonly referred to as being 'sectioned'. This power can only be used when a child has a mental disorder, and is a risk to themselves or others. They can also be admitted 'informally', where either the child themselves, or a parent, consents to admission.

There are a range of inpatient wards for children – including general adolescent wards, but also those that specialise in children with eating disorders, learning disabilities and autism, and deaf children. Children can either be 'sectioned' or admitted 'informally' to these wards. In addition, there are designated secure units in hospitals, which are only for children detained under the Mental Health Act. These are:

- Medium Secure Units for those who pose the highest risk to themselves and others, and who may have committed serious crimes
- Low Secure Units for those who pose a lower, but still significant, risk to their own or others' safety

In addition, some hospitals have Psychiatric Intensive Care Units which are wards with additional levels of security. They should be used for no more than 8 weeks at a time for those experiencing short term behavioural disturbance or for those being assessed before moving to a long-term unit or returning home.

Alongside the wards designed for children with mental disorders, children can also be detained both in general paediatric wards, and on adult mental health wards.

## 2.2 Numbers of children in inpatient settings

The information available on children in inpatient mental health settings is far from comprehensive. The most recent performance data, from the NHS Mental Health Services Monthly Statistics, shows that 348 children were detained at the end of July 2022 (data since July has been affected by a cyber incident, making the figures unreliable).[14] However, research by the Children's Commissioner has previously shown that nearly a third of children on inpatient mental health wards are there informally, so this figure only provides part of the picture.[15] In addition, the Mental Health Services Monthly Statistics only record information about the number of children in mental health settings – children who are detained on paediatric wards will not appear in these figures. The annual figures show that over the course of 2021-22 there were 869 detentions of children under the Mental Health Act. It is notable that 71% of these detentions were of girls, while among adult detentions, 48% were of women.[16]

There are a number of known data quality issues with these figures, and they are limited in that they do not cover children who are not in a mental health hospital, but are detained under the Mental Health Act. That means it is challenging to accurately track this population of children over time, to understand where they are, and the legal basis for them being there.

The data suggests that over time fewer children are being detained under the Mental Health Act, and that fewer children are being admitted to hospital for mental health treatment. In 2021/22, children spent 312,000 bed days in Tier 4 wards, a 33% decrease from 465,000 in 2017/18.

Any reduction in the number of children living in a mental health institution is to be welcomed. It is the Children's Commissioner's goal for no child to be living in an institution, but receive the timely early support they need to stay living with family.

However, it is possible that this apparent fall in admissions to inpatient settings is not the whole picture, as the data leave out a group of children who are admitted to hospital, but no appropriate bed is found, so they remain on paediatric or other wards.

Another group of children who currently fall between the gaps in in the data are children for whom it is deemed that a mental health admission would not be appropriate, but where no children's home that can provide the necessary high level of both security and therapeutic intervention can be found.

These children end up being deprived of their liberty under the 'inherent jurisdiction' powers of the High Court. This is used when no existing piece of legislation allows for a child to be deprived of liberty, but it is judged necessary to keep them safe. If a child cannot be admitted to a mental health ward under the Mental Health Act because it is not judged appropriate, but they also cannot be admitted to a Secure Children's Home under s25 of the Children Act (either because it is not appropriate or none are available) the High Court can authorise their deprivation of liberty elsewhere. In some of these cases, a child may be judged detainable under the Mental Health Act, but an NHS Access Assessment finds that admission is not in fact appropriate, in effect over-ruling a Mental Health Act assessment[17].

No official data is recorded on how many of these children there are, where they are living, or how long they are there for. However, the evidence suggests that the number of children in this position is rising. The Children's Commissioner first requested data on these children from 2017-18, and found that there were 103 children on applications before the High Court[18]. The latest figures collected by the Nuffield Family justice Observatory shows that there were 125 applications in the month of January 2023 alone[19].

## 2.3 Life in inpatient settings

For this report the Children's Commissioner's team visited two inpatient mental health hospitals and spoke to 14 children about their experiences there, as well as members of staff.

### 2.3.1. Family connections

Being apart from family and friends was of course a source of great distress for many children. While many of the children had complicated family relationships, with several having been formally looked after or in informal kinship arrangements before coming into hospital, they still very much wanted to see family members and be supported to maintain and improve their relationships. Children had some practical concerns about the way visits ran, with one child saying:

*'The visiting stuff here isn't the best, the room is like a meeting room'* – Girl, 16

Although some children were also allowed to have community leave with family members, which was seen as a more positive experience. Different wards across the country have different rules about whether family members are able to come onto the wards, or to help their children settle in. One child felt this was something that they would value:

*'It would be nice if [someone] could come and help you unpack'* – Girl, 16

The NHS has recently introduced a 'Family Ambassador' role, which is to support parents to understand their child's admission and what will happen to them during their stay, so that they can be involved in decision making. This has the potential to be a positive model for ensuring that the role of family in a child's stay and recovery is supported.

### 2.3.2. Earlier Intervention

A theme that emerged from conversations with children was that they felt if there had been more appropriate help at the right time, they would have been less likely to have needed an admission to hospital. Children spoke about how they had demonstrated their need for help frequently – either by directly asking for help, or going to A&E while in a mental health crisis, or being admitted to hospital as a result of self-harm - but it had not been forthcoming.

*'I really thinks CAMHS needs more money so children can get the therapy they need without going into hospital – with the right help I wouldn't be here.'* – Girl, 17

*'I was in A&E lots of times but was just sent home. In the end it was her headteacher who kept calling for help until finally I was admitted to hospital'* – Girl, 16.

### 2.3.3. Relationships with staff

Many of the children in the wards we visited were subject to a high level of observation – some children were accompanied by several members of staff, who would note down their 'obs' (as the children refer to the observation notes) at regular intervals. While these precautions are taken for children's safety, it unsurprisingly leads to an often uncomfortable environment. On one visit the team observed large groups of adults sitting and not interacting with children. In conversations with staff, it was clear that there were very different attitudes to their roles and responsibilities towards children. Some staff talked about the importance of sitting down with the children, getting to know them and building relationships, whereas others were more focused on the need to restrain children and impose boundaries.

The difference in these attitudes were keenly felt by children. One child explained that some members of staff would only refer to them by their initials, and said that *'they don't treat us like people'* whereas *'the better ones engage and talk to you'* -Girl, 16.

Most children felt that the quality of relationships they had with daytime staff was more positive, while staff at night were more likely to be agency staff who they knew less well and felt less comfortable with.

### 2.3.4. Restraint

Restraint was a concerningly common occurrence in the settings we visited and was clearly deeply frightening both for children who experienced it themselves, and who witnessed the restraint of other children. Children described being held down on the floor by several members of staff, and the fear

they felt while this was happening. Talking to staff about restraint showed a range of different attitudes – some spoke about how important it was to avoid restraint, and that building better relationships with children could help to minimise how often restraint was needed. However, other members of staff were more focused on the impact on staff – and how tiring restraints could be – rather than the impact on the child.

It was not only the direct experience of restraint that frightened children, but also directly or indirectly being aware of it happening to other children. Some children described walking in on other children being restrained as a common occurrence, and several children spoke about the invasive nature of alarms on the wards. Alarms that sounded throughout the wards would let them know that something was happening, and they would imagine the worst.

Children on eating disorder wards also spoke about feeding through nasogastric tubes, with some children saying that they were aware of which children were "compliant" and "non-compliant" (the words they used) and therefore who would be fed in this way. This was clearly deeply distressing for children.

### 2.3.5. Advocacy and wider support

Children in inpatient mental health settings are entitled to a range of support. For example, all children who are detained under the Mental Health Act have a statutory right to an Independent Mental Health Advocate (IMHA). However, on the wards we visited all children, whatever their status, were offered access to an advocate – however this was with a general children's advocacy service, and there were significant delays in accessing designated IMHAs. Children had different experiences of the advocacy offer – with some having made use of an advocate to make a complaint about their care, while others knew the advocate was there but was unsure why they would speak to them.

All children should also be visited by a social worker from their local authority, if they are there for more than three months, while looked after children and those on Child in Need plan or Child Protection Plan should be visited in accordance with those plans.

Professionals spoke about the very different levels of involvement from children's social care teams around the country, with some visiting regularly and in person, while others had to be chased. One senior leader said that she felt all children in inpatient settings should have involvement from children's social care, at the level of a Child in Need plan[h] at the very least, but that often because the child was seen to be in a place of safety they would struggle to get local authorities to place them on a plan. This could lead to significant difficulties when it came to planning for their discharge and reintegration into the community.

### 2.3.6. Education and enrichment

Boredom was a common theme to emerge in the conversations with children. As one child described it: *'There are not many activities on site, that is a shame, especially on weekends, you can only really watch TV…the weekends drag on and on'* – Girl, 16.

Children did describe some types of group activity that took place on the ward, but a desire for more activities and more opportunities to have community leave were common issues. The management in both hospitals discussed the issues with staffing they were having, and children felt the impact of this – explaining that leave and activities were often cancelled due to lack of available staff.

For the majority of children school was seen as one of the main positives of life on the ward. One child said: *'Education is brilliant, and the headteacher is very motivating and brilliant'* – Girl, 16.

Another child who had a largely negative experience of the ward overall saw school as a bright spot: *'School Is one of the only good things about this place'* – Girl, 14.

[h] Children can be supported by their Local Authority on a Child in Need plan under s17 of the Children Act 1989 if they need services to hep them achieve a reasonable standard of health or development.

However, children also described wanting more education, as they only received a few hours a day, and more access to computers to be able to keep up with work from their home school – especially in the run-up to exams.

In discussion with school and hospital leaders, the importance of education for children's recovery was keenly felt, and improvements were being made to ensure that the school and wards were aligned in how they worked with children. There were significant concerns raised about the challenges they had in securing Education, Health and Care plans for children, even though it seemed clear to them that all the children in the setting would meet the criteria for having one.

# 3. The way forward

Every child should be supported to have good mental health, from the earliest years of their life through to adulthood. To achieve this will need the right combination of preventative efforts to address the determinants of poor mental health, alongside early and appropriate intervention.

It is the ambition of the Children's Commissioner that no child should end up needing to live in an inpatient hospital setting, or any other institution, but until that goal is achieved all settings must be as safe, caring, and familial as possible.

**Recommendation 1**

The Government's recently announced Major Conditions Strategy, which is to replace the previous plans for a Mental Health Strategy, must have a core focus on the needs of children. Children's mental health needs must not be overshadowed by the other conditions included in the strategy. It is essential that this strategy covers the whole spectrum of mental health support, from prevention to inpatient provision, and is delivered across Government. It must join up closely with the DfE's 'Stable Homes, Built on Love' strategy, and its SEND and alternative provision improvement plan. This strategy should set out clear ambitions for children's mental health, including how to ensure that no child needs admission to an inpatient setting.

**Recommendation 2**

As Integrated Care Partnerships are established, accountability mechanisms should be put in place to ensure that they are prioritising the needs of children, including mental health needs, with key metrics available for scrutiny of how far their strategies go in meeting these needs.

**Recommendation 3**

Given the vital role that schools play in shaping, identifying and addressing children's mental health, there must be a mechanism for them to contribute to Integrated Care Partnerships. Schools should

become the fourth statutory safeguarding partner (alongside police, local authorities, and health). Being a statutory member of safeguarding partnerships would then enable them to feed into Integrated Care Partnerships.

**Recommendation 4**

In order to drive more effective collaboration in tackling both the determinants of children's mental health, and the most effective community-based support, Recommendations 10 to 14 of the Children's Commissioner's Family Review on improving local integration should be adopted by the Department for Education, the Department of Health and Social Care, the Department for Levelling Up, Housing and Communities, the Home Office, and the Ministry of Justice.[20]

**Recommendation 5**

Given the surging demand for mental health support, and the increased waiting times, it is vital that the Department for Health and Social care rolls out Mental Health Support Teams to every school by the end of 2025.

**Recommendation 6**

The Department for Education, the Department for Health and Social Care and the Ministry of Justice should develop a joint commissioning strategy for integrated, secure therapeutic care for children with mental health and welfare needs, who may also have offended.

**Recommendation 7**

The Department for Education and the Department for Health and Social Care must urgently establish a resolution process for children falling between the gaps between Mental Health Act detention and secure welfare accommodation. Currently these debates are being held in the High Court. Instead the respective Secretaries of State should appoint senior officials who are able to determine a jointly

funded package of support for these children, or to direct their placement in either a Secure Children's Home or an inpatient mental health bed.

In addition the Ministry of Justice should work with the Department for Education to ensure that data is collected and published on the number of children subject to Deprivation of Liberty authorisations, and for that data to be included in the Department for Education's Children Looked After return.

**Recommendation 8**

NHS England should conduct a review of family visiting to inpatient settings, to understand how physical spaces could be made more welcoming, how visits could include more activities for children who are not entitled to community leave, and to review policies about families having access to wards.

They should continue to fund the role of Family Ambassadors for a further year, to gain a fuller evidence base.

**Recommendation 9**

The Department for Education, the Department for Health and Social Care and NHS England should work together to establish an improvement network for inpatient school settings, so that leaders of these schools can share best practice and learning. The Education Endowment Foundation and What Works Wellbeing should carry out research into effective provision of education in inpatient settings in order to support this network.

**Recommendation 10**

NHS England must publish sufficient data on children in hospital with mental health disorders to allow improved understanding of the quality of care provided, and the sufficiency of provision. This should include:

- The total number of children detained under the Mental Health Act, including those on paediatric and non-mental health wards.

- A database of all children's inpatient mental health settings, their bed capacity, ward types and the number of children living in them, including information about their, age, gender and ethnicity. It should include information on a child's length of stay, the legal basis for their admission, and their distance from home.
- Information about how many children have seen an advocate, and how many have seen an IMHAs, and complaints that have been made.
- Information about how many children in inpatient settings are also Looked After, have a Child in Need or Child Protection Plan, and how many have an Education, Health and Care plan.
- Information on how many safeguarding referrals are made to Local Authority Designated Officers regarding inpatient mental health settings.
- Improved information about children placed in adult wards.

# Annex

## CCG Tables

**Table A1. The 10 CCGs with the largest percentage of children referred to CYPMHS in 2021-22**

| Clinical Commissioning Group | % referred to CYPMHS in 2020-21 | % referred to CYPMHS in 2021-22 | Change (percentage points) |
|---|---|---|---|
| NHS South Tyneside CCG | 8 | 12 | 3 |
| NHS Sunderland CCG | 7 | 10 | 3 |
| NHS Liverpool CCG | 6 | 10 | 4 |
| NHS County Durham CCG | 6 | 10 | 4 |
| NHS Blackpool CCG | 7 | 9 | 3 |
| NHS Manchester CCG | 7 | 9 | 3 |
| NHS Wakefield CCG | 6 | 9 | 3 |
| NHS St Helens CCG | 5 | 9 | 3 |
| NHS Blackburn with Darwen CCG | 4 | 8 | 4 |
| NHS Rotherham CCG | 5 | 8 | 3 |

**Table A2. The 10 CCGs with the lowest percentage of children referred to CYPMHS**

| Clinical Commissioning Group | % referred to CYPMHS in 2020-21 | % referred to CYPMHS in 2021-22 | Change (percentage points) |
|---|---|---|---|
| NHS North West London CCG | 2 | 3 | 1 |
| NHS Castle Point and Rochford CCG | 3 | 4 | 1 |
| NHS Mid Essex CCG | 3 | 4 | 1 |
| NHS West Essex CCG | 3 | 4 | 1 |

| | | | |
|---|---|---|---|
| NHS Bristol, North Somerset and South Gloucestershire CCG | 3 | 4 | 2 |
| NHS Dorset CCG | 3 | 4 | 1 |
| NHS Southport and Formby CCG | 2 | 4 | 2 |
| NHS South East London CCG | 3 | 4 | 1 |
| NHS Northamptonshire CCG | 3 | 4 | 1 |
| NHS North Central London CCG | 3 | 4 | 1 |

**Table A3. The 10 CCGs with the lowest percentage of referrals closed before treatment in 2021-22**

| Clinical Commissioning Group | % closed before treatment in 2020-21 | % closed before treatment in 202-22 | Change (percentage points) |
|---|---|---|---|
| NHS East Sussex CCG | 8 | 5 | -3 |
| NHS Northamptonshire CCG | 12 | 13 | 1 |
| NHS Kirklees CCG | 11 | 14 | 3 |
| NHS Southport and Formby CCG | 16 | 19 | 3 |
| NHS Fylde and Wyre CCG | 22 | 21 | -1 |
| NHS Leicester City CCG | 19 | 21 | 2 |
| NHS West Leicestershire CCG | 15 | 21 | 6 |
| NHS Leeds CCG | 8 | 21 | 13 |
| NHS Wakefield CCG | 17 | 21 | 4 |
| NHS South Tyneside CCG | 18 | 22 | 4 |

**Table A4. CCGs with the highest percentage of referrals closed before treatment in 2021-22**

| Clinical Commissioning Group | % closed before treatment in 2020-21 | % closed before treatment in 2021-22 | Change (percentage points) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| NHS North Cumbria CCG | 32 | 50 | 18 |
| NHS Bury CCG | 36 | 49 | 13 |
| NHS St Helens CCG | 39 | 48 | 9 |
| NHS South East Staffordshire and Seisdon Peninsula CCG | 34 | 47 | 13 |
| NHS Blackburn with Darwen CCG | 21 | 46 | 25 |
| NHS East and North Hertfordshire CCG | 41 | 46 | 5 |
| NHS Wigan Borough CCG | 32 | 46 | 14 |
| NHS Halton CCG | 25 | 46 | 21 |
| NHS Warrington CCG | 26 | 46 | 20 |
| NHS Kent and Medway CCG | 39 | 46 | 7 |

**Table A5. The 10 CCGs with the highest increase in proportion of children with their referrals closed**

| Clinical Commissioning Group | % closed before treatment in 2020-21 | % closed before treatment in 2021-22 | Change (percentage points) |
|---|---|---|---|
| NHS Blackburn with Darwen CCG | 21 | 46 | 25 |
| NHS Bristol, North Somerset and South Gloucestershire CCG | 20 | 45 | 25 |
| NHS Wirral CCG | 11 | 36 | 25 |
| NHS Oldham CCG | 23 | 45 | 22 |
| NHS Buckinghamshire CCG | 10 | 31 | 21 |
| NHS Halton CCG | 25 | 46 | 21 |
| NHS Warrington CCG | 26 | 46 | 20 |
| NHS North East Lincolnshire CCG | 22 | 41 | 19 |
| NHS Chorley and South Ribble CCG | 21 | 39 | 18 |
| NHS North Cumbria CCG | 32 | 50 | 18 |

**Table A6. The 10 CCGs with the shortest waiting time in 2021-22**

| Clinical Commissioning Group | Average wait time (days) in 2020-21 | Average wait time (days) in 2021-22 | Change (days) |
|---|---|---|---|
| NHS Leicester City CCG | 13 | 13 | 0 |
| NHS West Leicestershire CCG | 10 | 13 | 3 |
| NHS Mid Essex CCG | 9 | 14 | 5 |
| NHS East Leicestershire and Rutland CCG | 9 | 15 | 6 |
| NHS East Lancashire CCG | 19 | 17 | -2 |
| NHS Thurrock CCG | 14 | 17 | 3 |
| NHS Blackburn with Darwen CCG | 18 | 18 | 0 |
| NHS Castle Point and Rochford CCG | 6 | 18 | 12 |
| NHS Doncaster CCG | 17 | 20 | 3 |
| NHS Southend CCG | 10 | 20 | 10 |

**Table A7. The 10 CCGs with the longest waiting time in 2021-22**

| Clinical Commissioning Group | Average wait time (days) in 2020-21 | Average wait time (days) in 2021-22 | Change (days) |
|---|---|---|---|
| NHS Sunderland CCG | 55 | 80 | 25 |
| NHS Brighton and Hove CCG | 40 | 72 | 32 |
| NHS Gloucestershire CCG | 41 | 70 | 29 |
| NHS Herefordshire and Worcestershire CCG | 46 | 66 | 20 |
| NHS Cannock Chase CCG | 81 | 65 | -16 |
| NHS Portsmouth CCG | 55 | 65 | 10 |
| NHS Stafford and Surrounds CCG | 64 | 64 | 0 |
| NHS Bolton CCG | 26 | 60 | 34 |
| NHS Leeds CCG | 52 | 59 | 7 |

| NHS Newcastle Gateshead CCG | 40 | 57 | 17 |
|---|---|---|---|

**Table A8. The 10 CCGs in which the average waiting time increased the most from 2020-21 to 2021-22**

| Clinical Commissioning Group | Average wait time (days) in 2020-21 | Average wait time (days) in 2021-22 | Change (days) |
|---|---|---|---|
| NHS Bolton CCG | 26 | 60 | 34 |
| NHS Brighton and Hove CCG | 40 | 72 | 32 |
| NHS Basildon and Brentwood CCG | 7 | 37 | 30 |
| NHS Ipswich and East Suffolk CCG | 24 | 53 | 29 |
| NHS West Suffolk CCG | 26 | 55 | 29 |
| NHS Gloucestershire CCG | 41 | 70 | 29 |
| NHS Sunderland CCG | 55 | 80 | 25 |
| NHS North Cumbria CCG | 35 | 55 | 20 |
| NHS South Sefton CCG | 28 | 48 | 20 |
| NHS Herefordshire and Worcestershire CCG | 46 | 66 | 20 |

**Table A9: The 10 CCGs with the highest mental health spend per child in 2021-22 (cash terms)**

| Clinical Commissioning Group | Spend per child (£) in 2020-21 | Spend per child (£) in 2021-22 | Change (days) |
|---|---|---|---|
| NHS Norfolk and Waveney CCG | £133 | £141 | 8 |
| NHS South Tyneside CCG | £136 | £136 | 0 |
| NHS North Staffordshire CCG | £54 | £135 | 81 |
| NHS Salford CCG | £113 | £135 | 22 |
| NHS Wakefield CCG | £130 | £135 | 5 |
| NHS Stoke On Trent CCG | £51 | £123 | 72 |

| NHS Brighton and Hove CCG | £116 | £123 | 7 |
|---|---|---|---|
| NHS North Central London CCG | £113 | £120 | 7 |
| NHS Sunderland CCG | £108 | £114 | 6 |
| NHS Tees Valley CCG | £114 | £113 | -1 |

**Table A10: The 10 CCGs with the lowest mental health spend per child in 2021-22 (cash terms)**

| Clinical Commissioning Group | Spend per child (£) in 2020-21 | Spend per child (£) in 2021-22 | Change (£) |
|---|---|---|---|
| NHS Doncaster CCG | £42 | £34 | -£8 |
| NHS Mid Essex CCG | £50 | £44 | -£6 |
| NHS Buckinghamshire CCG | £50 | £46 | -£4 |
| NHS Kirklees CCG | £45 | £46 | +£1 |
| NHS Rotherham CCG | £45 | £47 | +£2 |
| NHS Berkshire West CCG | £43 | £47 | +£4 |
| NHS Calderdale CCG | £51 | £48 | -£3 |
| NHS East Leicestershire and Rutland CCG | £50 | £50 | £0 |
| NHS West Leicestershire CCG | £50 | £50 | £0 |
| NHS Oxfordshire CCG | £48 | £50 | +£2 |

**Table A11. The 10 CCGs in which spend per child decreased the most from 2020-21 to 2021-22 (cash terms)**

| Clinical Commissioning Group | Spend per child (£) in 2020-21 | Spend per child (£) in 2021-22 | Change (£) |
|---|---|---|---|
| NHS Cannock Chase CCG | £121 | £71 | -£50 |
| NHS East Staffordshire CCG | £110 | £66 | -£44 |
| NHS South East Staffordshire and Seisdon Peninsula CCG | £116 | £72 | -£44 |
| NHS Stafford and Surrounds CCG | £123 | £103 | -£20 |

| | | | |
|---|---|---|---|
| NHS Kernow CCG | £100 | £90 | -£10 |
| NHS Doncaster CCG | £42 | £34 | -£8 |
| NHS Castle Point and Rochford CCG | £68 | £60 | -£8 |
| NHS Vale Of York CCG | £67 | £60 | -£7 |
| NHS Mid Essex CCG | £50 | £44 | -£6 |
| NHS North Tyneside CCG | £78 | £72 | -£6 |

**Table A12. The 10 CCGs in which spend per child increased the most from 2020-21 to 2021-22 (cash terms)**

| Clinical Commissioning Group | Spend per child (£) in 2020-21 | Spend per child (£) in 2021-22 | Change |
|---|---|---|---|
| NHS North Staffordshire CCG | 54 | 135 | 81 |
| NHS Stoke On Trent CCG | 51 | 123 | 72 |
| NHS Oldham CCG | 63 | 87 | 24 |
| NHS Salford CCG | 113 | 135 | 22 |
| NHS Tameside and Glossop CCG | 61 | 80 | 19 |
| NHS Trafford CCG | 41 | 60 | 19 |
| NHS North Cumbria CCG | 88 | 103 | 15 |
| NHS Northumberland CCG | 76 | 91 | 15 |
| NHS Bolton CCG | 63 | 78 | 15 |
| NHS Bath and North East Somerset, Swindon And Wiltshire CCG | 70 | 85 | 15 |

## Data sources

All data used in this analysis, except where specified, is sourced from the two datasets described below. Both are extracts provided by NHS Digital and NHS England (now NHS England, following the two organisations' merger in February 2023) to the CCo and made publicly available.

**NHS Five-Year Forward View for Mental Health Dashboard**

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 2021-22, 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 proportion 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 CCG 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 CCGs in England about the care of young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services.

The dataset provided to the CCo[21] compiles information on all children referred to CYPMHS for treatment during 2021-22 and contains the following information:

- 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.

## Limitations of data and analysis

1. The Five Year Forward View for Mental Health dashboard and Mental Health Service dataset only presents data for 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). CCGs that spend more on external or prevention-based services at the expense of NHS provided CYPMHS may underperform on indicator scores based solely on CYPMHS datasets.

2. As with data used for national monitoring, a child is counted as accessing treatment if they have two contacts with CYPMH services. This is the best proxy measure currently available until wider measures are routinely collected via the MHSDS. In some cases, a child may have more than one contact before treatment begins, while others may be referred or not need further support from CYPMHS after one contact. Therefore, we cannot confidently state in all cases that a child with less 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.

3. Children whose referrals were closed may not have required specialist treatment or may have been referred to services funded by other routes and organisations (e.g. local authorities and non-NHS funded charities). Some children may also have chosen not to enter treatment even when offered or advised. However, the data provided does not specify why a referral was closed. Until such data is provided, this will be a key gap in establishing the outcomes and circumstances of those referred.

4. There was also a methodology change affecting the number of referrals in 2021-22: the data includes referrals for children and young people which, during the reporting period, stopped being submitted by providers as part of their monthly Mental Health Services Dataset submissions.

5. Since last year's report was published, multiple smaller CCGs merged to form new combined CCGs (see table A13 for further details). Where this report compares rates over time, the average rate of the smaller CCGs in previous years is taken to represent the past rate of the combined CCG. Some of the best performing CCGs last year have been merged with lower scoring CCGs which has thus pulled down their score. This could give the impression that the CCG's performance 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).

6. The NHS's 2022 update to the Mental of Children and Young People report estimates that the prevalence of children with a probable mental disorder has increased substantially during the pandemic (from 1 in 9 to 1 in 6 children aged 7 to 16). For young people aged 17 to 19, it is estimated that 1 in 4 have a probable mental health disorder – up from 1 in 6 last year. This combined with the negative pressure of covid on the NHS's capacity to deliver services has reduced the number of children in need of mental health support successfully accessing treatment (when new prevalence rates are taken into account).

7. In some cases, children referred near the end of a financial year may enter treatment early in the following year. These children would be shown in 2020-21 data as "still awaiting treatment" despite a relatively short wait. As a result, we cannot assume that all children still waiting for treatment have waited long periods for their second contact.

8. In its Mental Health Services Data Set data quality report, the NHS noted that each year there are some mental health service providers that do not submit data to the Mental Health Services Data Set.[22] Though the number of providers submitting data has improved over the past few years, the data presented here is still incomplete due to underreporting.

9. This briefing uses the total of CCG figures as the figure for England. Some patients who have accessed or have been referred to CYPMHS were not assigned to an English CCG. As a result, the sum of the regional totals may not equal the England total.

**Table A13. CCG Mergers[23]**

| 2020-21 CCG name | 2021-22 CCG name |
|---|---|
| NHS Bedfordshire CCG | NHS Bedfordshire, Luton and Milton Keynes CCG |
| NHS Luton CCG | NHS Bedfordshire, Luton and Milton Keynes CCG |
| NHS Milton Keynes CCG | NHS Bedfordshire, Luton and Milton Keynes CCG |
| NHS Fareham and Gosport CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS Isle of Wight CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS North Hampshire CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS South Eastern Hampshire CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS Southampton CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS West Hampshire CCG | NHS Hampshire, Southampton and Isle of Wight CCG |
| NHS East Berkshire CCG | NHS Frimley CCG |
| NHS North East Hampshire and Farnham CCG | NHS Frimley CCG |
| NHS Surrey Heath CCG | NHS Frimley CCG |
| NHS Barking and Dagenham CCG | NHS North East London CCG |
| NHS City and Hackney CCG | NHS North East London CCG |
| NHS Havering CCG | NHS North East London CCG |
| NHS Newham CCG | NHS North East London CCG |
| NHS Redbridge CCG | NHS North East London CCG |
| NHS Tower Hamlets CCG | NHS North East London CCG |
| NHS Waltham Forest CCG | NHS North East London CCG |
| NHS Brent CCG | NHS North West London CCG |
| NHS Central London (Westminster) CCG | NHS North West London CCG |
| NHS Ealing CCG | NHS North West London CCG |
| NHS Hammersmith and Fulham CCG | NHS North West London CCG |
| NHS Harrow CCG | NHS North West London CCG |
| NHS Hillingdon CCG | NHS North West London CCG |
| NHS Hounslow CCG | NHS North West London CCG |

| | |
|---|---|
| NHS West London CCG | NHS North West London CCG |
| NHS Shropshire CCG | NHS Shropshire, Telford and Wrekin CCG |
| NHS Telford and Wrekin CCG | NHS Shropshire, Telford and Wrekin CCG |
| NHS Dudley CCG | NHS Black Country and West Birmingham CCG |
| NHS Sandwell and West Birmingham CCG | NHS Black Country and West Birmingham CCG |
| NHS Walsall CCG | NHS Black Country and West Birmingham CCG |
| NHS Wolverhampton CCG | NHS Black Country and West Birmingham CCG |
| NHS Coventry and Rugby CCG | NHS Coventry and Warwickshire CCG |
| NHS South Warwickshire CCG | NHS Coventry and Warwickshire CCG |
| NHS Warwickshire North CCG | NHS Coventry and Warwickshire CCG |
| NHS Greater Huddersfield CCG | NHS Kirklees CCG |
| NHS North Kirklees CCG | NHS Kirklees CCG |

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[1] CCo calculation based on NHS England, Table 1e of Mental Health Act Statistics, Annual Figures, 2021-22, Date accessed 27/02/2023 Link
2 NHS England. *Mental Health of Children and Young People in England*. 2022. Date accessed: 05/02/2023. Link.
[3] NHS England. *Mental Health of Children and Young People in England*. 2022. Table 1.1: Mental health of child or young person by age and sex, 2022. Link.
[4] Department for Education. Children looked after in England including adoptions. 2022. Date access: 23/02/2023. Link.
[5] NHS England. NHS Long Term Plan. 2019. NHS. Link
6 NHS England. *NHS Five Year Forward View for Mental Health Dashboard*. 2022. Date access: 20/02/2023. Link.
[7] NHS England (2019). NHS Long Term Plan. Link
8 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*. 2021. Date accessed: 05/02/2023. Link and mental health disorder prevalence rates for children aged 7-16 and young people aged 17-19 from NHS England. *Mental Health of Children and Young People in England*. 2022. Date accessed: 05/02/2023. Link.
9 NHS England, Mental Health of Children and Young People in England 2022. Date accessed 21/02/23. Link
[10] Office of the Children's Commissioner. *Mental Health Briefing 2018.* Link
[11] Office of the Children's Commissioner. *A Head Start: Early support for children's mental health*. 2022. Date accessed:14/02/2023. Link.
[12] Early Intervention Foundation. *Adolescent mental health: A systematic review on the effectiveness of school-based interventions*. 2021. Date accessed: 14/02/2023. Link.
[13] Office for National Statistics. *GDP deflators at market prices and money GDP.* March 2022. Date accessed: 15/02/2023. Link.

[14] NHS England, Monthly Mental Health Services Monthly Statistics, Performance July 2022, Date accessed 27/02/2023 Link

[15] Children's Commissioner, *Who are they, Where are they? 2020*, Date accessed 27/02/2023 Link

[16] CCo calculation based on NHS England, Table 1e of Mental Health Act Statistics, Annual Figures, 2021-22, Date accessed 27/02/2023 Link

[17] Blackpool Borough Council v HT (A Minor) & Ors [2022] EWHC 1480 (Fam) (17 June 2022), Date accessed 27/02/2023 Link

[18] Children's Commissioner, Who are they, Where are they? 2019, Date accessed 27/02/2023 Link

[19] Nuffield Family Justice Observatory, National Deprivation of Liberty Court, Latest Data trends – January 2023, Date accessed 27/02/2023 Link

[20] Children's Commissioner, Part 2 of the Independent Family Review. Link.
[21] Download the data here: 2019-20, 2020-21, 2021-22.
[22] NHS Digital. Waiting times for children and young people's mental health services 2021 – 2022. Link.
[23] NHS Digital. Change summary, 2021 CCG mergers. Link