Care Quality Commission

Children and young people

Key points

- The increasing need for children and young people's mental health services means they continue to face long waits for a bed to become available, risk being placed in inappropriate environments or being sent to a hospital miles away from home.
- Research commissioned from the Strategy Unit on the use of the MHA for children and young people shows variation across integrated care board areas in the use of the act, lengths of stay and the distance of beds from home.
- Many services have specialist staff who are trained to care for children and young people. However, access to specialist staff is being affected by low staffing levels leading to patients' needs not being met.
- The quality of physical environments for children and young people varied, with access to food and drink, and food preparation facilities key issues for many children and young people.
- We continue to hear about challenges in transitions of care between children and young people's mental health services and adult mental health services, with many young people still falling through the gaps and not getting the care and support they need.

As we raised in this year's State of Care report, demand for children and young people's mental health services continues to grow. Data from the Mental Health Services Data Set (MHSDS) shows that in 2023/24, on average each month nearly 560,000 children and young people under 18 were in contact with mental health services. At the same time referrals also rose, with the average number of referrals each month for children and young people increasing by 4% from the previous year.

However, the increasing need for mental health care is not always being met. A recent report published by Mind warns that children and young people continue to face challenges with their mental health but the NHS and schools cannot cope with the level of need. MHSDS data shows that while the number of children and young people in contact with mental health services increased by 16% from 2022/23 to 2023/24, the number of interactions they had with mental health services only increased by 10%. Evidence from the 2023 Community mental health survey also showed that children and young people continued to face long waiting times at all stages of care from initial assessments, to diagnoses, medicines, and therapies.

Florence's story

Florence first started struggling with food at the end of 2020. She didn't recognise it as an issue at first, just viewing what she was doing as normal dieting to lose weight. Florence's dieting became gradually more extreme and then escalated in the summer of 2021.

Florence was rapidly losing weight and, when her periods stopped and some of her hair started to fall out, she decided to speak to her mum about what she was going through. Florence visited the GP in October 2021 who made a referral to children and young people's mental health services.

Anticipating a long wait for help from the children and young people's mental health services, Florence accessed support from an eating disorder therapist privately, which she found very helpful. However, Florence and her family still wanted to access family-based therapy and support from a nutritionist through children and young people's mental health services.

Florence waited 7 months for initial contact from children and young people's mental health services. While nutritionist support was put in place quickly, the wait for therapy was another 6 months.

In late 2022, Florence started therapy with an eating disorder specialist from children and young people's mental health services. However, she didn't develop a good relationship with the therapist and felt patronised and misunderstood by a therapist who she believed spoke to her like she was younger and less intelligent than she was. She found these sessions so frustrating that she would regress with her eating because of them, so she decided to discontinue the therapy.

> "This was really upsetting because we've been on a ... wait list for a year to receive therapy and now that therapy was doing me more harm than good."

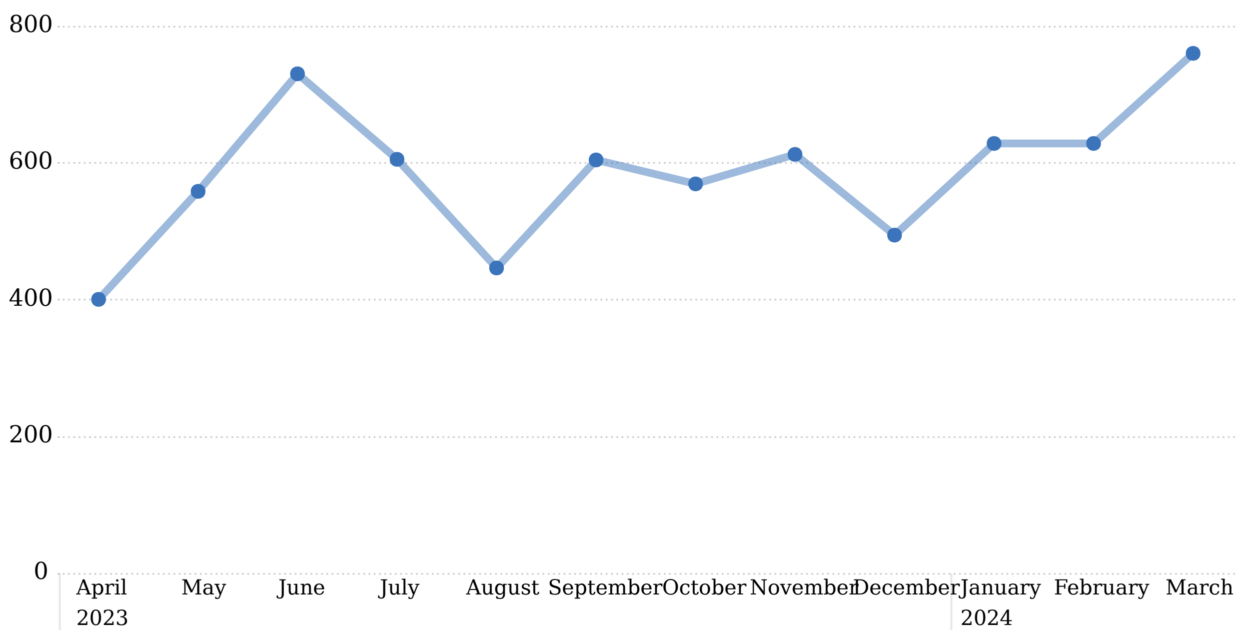
Florence was still receiving support from her private therapist throughout this time. The therapist advised her to seek some additional support from children and young people's mental health services for underlying depression so a referral to a psychiatrist was made in the summer of 2022.

After 8 months of waiting, Florence was given an appointment with a psychiatrist to support with the underlying depression. By this point Florence wasn't struggling with depression anymore so it was decided no further support was required.

Not getting help when they need it can increase the risk of children and young people reaching crisis point. According to MHSDS, in 2023/24, there were over 7,000 very urgent referrals to crisis teams for children and young people under 18. While numbers of referrals vary across the year, we are concerned that services are falling below the expected standard in providing people with care

Best practice guidelines from the Royal College of Psychiatrists state that crisis teams should see very urgent referrals within 4 hours, and urgent referrals within 24 hours. In April 2023, 47% of the very urgent referrals of very urgent referrals of children and young people or people under 18 met the time standard of 4 hours. This varied across the year (figure 2), with a low of 33% in March 2024.

Figure 2: New very urgent referrals of children and young people under 18 to crisis care teams, April 2023 to March 2024



Source: NHS England, Mental Health Services Data Set

As we described in detail in last year's Monitoring the Mental Health Act report, not getting the right support in the community at the right time can lead to children and young people ending up in inappropriate environments, including urgent and emergency care. This is a particular risk for young people aged 16 to 18 as support from children and young people's mental health services typically ends at 18 years old.

Research from the Strategy Unit found that people aged 18 to 21 consistently have the highest rates of presentation for mental health issues at both emergency departments and urgent care centres. In addition, the research shows that children and young people aged 0 to 17 were the only age group to have an increase in attendance rates at type 1 urgent and emergency services (A&Es) since 2019/20.

In 2023/24, there were around 5 million attendances to emergency departments by children and young people, of which 64,000 had a primary diagnosis of a mental health condition. More than 85% of those children and young people attending emergency departments for a mental health condition were known to mental health services. Data from MHSDS shows the rate of attendance in younger females was substantially higher than for younger males in every year since 2019/20. For example, in 2023/24, the rate in younger females was 515 per 100,000, whereas in younger males it was 263 per 100,000.

The lack of specialist beds for children and young people can then lead to them facing long waits in urgent and emergency care while they wait for a bed to become available, being placed in inappropriate environments such as adult wards, or being sent to a hospital miles away from home. This can be hugely detrimental to their recovery.

This year, we have continued our work to identify how we can improve our regulation of children who are placed in unsuitable settings. As described in last year's report, as part of this, we are working with internal and external stakeholders to design and implement solutions so that all children will be cared for in placements where they are cared for by staff who can understand, and meet, their needs.

We continue to consider what actions we can take as the regulator to improve the quality of care being provided to children. This has included a number of actions to improve our oversight of where children are being cared for, and to help the public and providers to understand how we work together with other stakeholders and regulators to provide quality regulation of children's services within evolving models of care. In addition, we are continuing to ensure that our regulation, including the assessment framework and any accompanying guidance or training, are inclusive of children and young people. This includes strengthening our assessment approach for those children and young people who are admitted to unsuitable settings.

Spotlight on use of the MHA for children and young people

It is vital that when children and young people are admitted to hospital for treatment of their mental health condition it is for the shortest time possible. NHS England has recognised that some children and young people may remain in hospital for longer periods than ideal. The reasons for this are varied and may be due to complexities and pressures across the system, increased mental health needs, or a breakdown in a social care placement.

Length of detentions may also be affected by how far away from home children and young people are placed. As we have highlighted in previous Monitoring the Mental Health Act reports, being placed out of area can present challenges when patients are ready to be discharged, such as securing appropriate community support back in the person's local area.

To understand more about the detention of children and young people under the MHA, we commissioned the Strategy Unit (hosted by NHS Midlands and Lancashire) to look at how detentions under the MHA for children and young people (covering ages 0 to 24) has varied over the last 5 years.

As part of its research, the Strategy Unit looked at the nature of 'conversions' between different sections of the act; lengths of stay; and how far from home patients were admitted to beds. The research found:

- The types of section used to detain children and young people, and how often they were used, varied greatly between integrated care board (ICB) area.
- Between 2019/20 and 2023/24, around 45% of children and young people detained, for a single episode or more than one episode, started off with short-term detentions (sections 136, 4, 5(2) and 5(4)) – the equivalent for adults over the same period is 30%.
- The median length of stay varied by ICB area and has increased over time from 15.3 days in 2019/20 to 21.5 days in 2023/24.
- Of the 11,854 MHA detention spells in 2023/24, 1.65% were longer than 365 days.
- Almost half of all instances where children and young people are detained have at least one period of re-detention within 12 months. Some children and young people may have multiple periods of detention within these numbers.
- There has been a small increase in the mean distance children and young people are admitted from their home.

Staffing and quality of care

Children and young people who are admitted to hospital often have complex and changing needs. The MHA Code of Practice is clear that they should be cared for by staff with the right training, skills and knowledge to understand and address their specific needs.

Through our monitoring activity we have found that children and young people's mental health services have some specialist staff who are trained to care for children and young people. We found that many services had multidisciplinary teams in place, including occupational therapy, psychiatry, speech and language therapy, dietetics, teaching/education, and social work.

We have also found evidence of multidisciplinary teams and care teams working together to understand the needs of the patients and ensure the least restrictive methods were used. This was supported by feedback from children and young people, and their carers, who were generally positive about staff and described them as attentive, kind and caring, and that they felt supported day-to-day.

However, as described in our section on workforce, concerns around staffing have been raised in some services. This included staff on some wards, particularly agency staff, lacking the knowledge and skills required for the specialist services they were working in. Most staff were trained in verbal de-escalation, physical restraint, chemical restraint and the prevention and management of aggression. However, we heard how some staff members were observed to be using inappropriate language towards already distressed patients. We heard how this could have a negative effect on the recovery of patients.

> "One patient told us that permanent members of staff were always caring and that they would provide reassurance during periods of distress. However, feedback regarding agency staff was not so positive, with patients feeling that they sometimes could not always support them in a person-centred way."

In some cases, access to specialist staff was affected by low staffing levels which, MHA reviewers identified, led to patients' needs not being met. For example, at one service we heard there were not enough doctors available to cover the unit, which meant that patients were not always seeing doctors often enough. The service had also reduced the number of patients it was able to accept as it was not able to open all its beds due to the lack of staff.

> “[The ward] is a 10-bed [children and young people’s mental health ward] for male and female patients. At the time of our visit only 6 beds were open due to staffing issues.”

As highlighted in previous Monitoring the Mental Health Act reports, access to activities, for example arts and crafts, playing board games, watching TV, and trips out into the community, is important as they give children and young people a sense of purpose, structure to the day and aid their recovery.

While most patients MHA reviewers spoke with said that they had access to a range of activities as a part of their daily routine, we were concerned that low staffing levels were also affecting the availability of activities in some services. This view was shared by some carers we spoke with who told us their relatives did not have enough to do on the ward and that they would like to see more activities available.

Feedback from MHA reviewers also highlighted the significance of access to educational opportunities. They described how these opportunities provided children and young people with structure, specialist support (such as speech and language therapy and trained teachers) and gave them a space to develop life skills.

We found that patients generally had access to schooling and learning, with most services able to provide access to classroom-based learning facilitated by an education professional. However, not all children and young people had equal access to educational opportunities, with some patients saying they had not received any education or had only been offered online modules and non-teacher led sessions (see section on transition).

Quality of environments

Section 131A of the Mental Health Act is clear that children and young people admitted to hospital for the treatment of mental disorder should be cared for in an environment that is suitable for their age (subject to their needs). This includes having appropriate physical facilities. Getting the right care in a therapeutic environment supports people to get better more quickly and reduces avoidable time spent in hospital. However, we found that the quality of physical environments for children and young people varied.

The MHA Code of Practice highlights Article 8 of the European Convention on Human Rights (ECHR) as particularly important for people detained under the Act. This requires public authorities to respect a person's right to a private life. Through our MHA monitoring visits we found positive examples of services providing children and young people with their own ensuite bedrooms and supporting them to have some privacy. However, we also found examples of patients having to share washing and toileting facilities. We heard how this could have an impact on admissions.

> "Only 2 bedrooms had an ensuite shower room. This meant the majority of patients had to share communal bathing and toileting facilities. Staff told us that admissions were impacted by this as considerations had to be made for the ratio of male to female patients but also the use of the assisted bathroom."

When children and young people cannot be admitted to a children's specialist ward, there is an increased risk of them ending up in inappropriate environments, including adult wards. In 2023/24, we were notified of 120 instances where children and young people under 18 years old were admitted to adult wards. While most of these were emergency detentions, 12% were planned admissions and 20% were informal admissions. In addition, we found that admissions of children and young people to adult wards varied across the country. The areas that reported the most notifications were the central and north regions, which accounted for 44% and 33% of total notifications.

We found that some of these admissions were directly supported by children and young people's mental health teams. This would happen when an adult seclusion room was being used due to lack of seclusion space for children on the children's units. In a small but notable number of admissions, the children affected were autistic, had ADHD or were children with a learning disability, but it wasn't clear what considerations were being made for their care. A number of the admissions were due to preference, whether that be clinical, social or legal (for example, if the young person couldn't be placed with other children due to ongoing criminal prosecution), and a small number were due to the child approaching their 18th birthday.

The design of ward environments can also have an impact on patient recovery. We found that wards for children and young people were not always age appropriate. MHA monitoring reports sometimes described wards as *"too clinical"*, and that they did not offer patients a relaxed and comfortable environment. However, MHA Reviewers were often positive about patients' access to services that would support their ongoing recovery and development. These included access to sensory rooms, occupational therapy rooms, classroom environments, and bedrooms fitted with hoists and profiling beds.

Access to food and drink, and food preparation facilities were key issues for many patients. While most services provided patients with access to food and drink preparation facilities and food storage, some patients told MHA reviewers that the food they were provided with was unpleasant and that there was limited choice.

> "Two patients told us the food was not very nice and there was a limited choice. However, they both said there were alternatives to the menu. Patients told us snacks were available, although a patient was unhappy with the limited choice of these."

In other cases, patients described needing to get staff permission and/or supervision to access to these facilities.

Restrictive practices

Restrictive practice is defined as "making someone do something they don't want to do or stopping someone doing something they want to do" (see also our section on environment). Most people recognise restraint, seclusion, and segregation as the more extreme forms of restrictive practice. But there are more subtle forms of restrictive practice that easily become day-to-day normal responses to perceived risk or lack of time. This includes, for example, denying people access to visitors, friends, or food due to a lack of staff or time.

In some services, we found that children and young people had opportunities to exercise independence by having a key to their room and being able to personalise their room the way they wished. However, in others we found that some patients had to ask for permission to access services and facilities, such as toilets, food storage, and outdoor spaces, which had an impact on their personal development and access to independence.

Blanket restrictions and measures were in place in some services, which prevented children and young people from engaging in what may be considered standard day-to-day tasks, such as going to the toilet, going outside and making a hot drink.

Access to fresh air and outdoor spaces was a key area of concern for MHA reviewers. While outdoor spaces and fresh air were available to patients most of the time, in many services children and young people had to seek permission or supervision to access otherwise locked outdoor spaces. Some outdoor spaces were also deemed unsafe and therefore access was restricted.

> "Both parents of [the patient] were concerned that their relative was not having access to fresh air. They had been told by their relative that they were not able to access the courtyard because of "trip hazards." They would like their relative to be able to access fresh air."

We also found evidence of blanket restrictions in relation to the use of electronic devices. Not all services allowed the use of electronic devices, resulting in some patients having limited access to the internet and social media. The MHA Code of Practice states that although a policy around mobile phone possession and usage should exist, they should be proportionate to risk and should not seek to impose blanket restrictions on patients.

In many services, restrictions on device use were proportionate and based on individual need. We found that children and young people had access to their own mobile phones or had access to a phone of some sort. Some patients also had access to laptops and tablets. Most services had Wi-Fi or internet access for young people to use. This is in line with the MHA Code of Practice to support patients in making and maintaining contact with family and friends by telephone, mobile, e-mail or social media.

Challenges in transitions in care

In last year's MHA annual report, we raised concerns about transitions in care between children and young people's mental health services and adult mental health services. We reported the negative impact transitions can have, with young people being moved onto adult wards as soon as they turn 18, or because they are soon to turn 18, and feeling like they are suddenly being expected to act as an adult.

In December 2024, the Healthcare Services Safety Investigation Branch (HSSIB) published its investigation report 'Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services.' The findings of this report echo our concerns around the quality of care and support for young people during transition. Key findings from the report include:

- Young people may be discharged from inpatient children and young people's mental health services because they have reached 'transition age' and not because their mental health care needs have changed.

- The criteria of adult mental health services for ongoing care as an 'adult' inpatient may mean young people are discharged from inpatient children and young people's mental health services to an alternative setting that is not suitable to meet their ongoing needs, for example bed and breakfast hostels, with community services providing more limited mental health care and support.
- Health, social care, local authorities and education do not always work together in a consistent and integrated way to support positive outcomes for young people who are transitioning from inpatient children and young people's mental health services to adult mental health services.
- In many children and young people's mental health services, 'blanket' safeguarding measures are implemented overnight for people reaching 18. These measures are not based on a change in individual behaviours or risks. Perceived safeguarding challenges are a driver for rigid aged-based transitions.

But it is not just about transfer of clinical care. Access to educational opportunities is a particular concern for young people when transitioning from children and young people's mental health services to adult mental health services. In its report, HSSIB found that the education needs of young people approaching 18 who are transitioning from inpatient children and young people's mental health services are not always being met. Investigators heard about the challenges some young people faced after moving between services, such as not being able to sit exams. This, they heard, could have lifelong impacts on young people and have a negative effect on their outcomes.

Concerns around transition between children and young people's mental health services and adult mental health services are not new. In our 2014 report 'From the pond into the sea', we highlighted how poor transitions can lead to disastrous health outcomes and deterioration in people's physical and mental health.

Guidance from the National Institute for Health and Care Excellence (NICE) is clear that transition planning should start from year 9 (age 13 or 14). But this needs to be person-centred. As highlighted in our 2014 report, what works for one 14-year-old may not work for another because of developmental maturity and their resulting needs. What matters most is that services must be integrated, and care co-ordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life – whatever their age. However, the recent HSSIB report found that current NHS England service specifications and commissioning guidance for inpatient children and young people's mental health services do not support needs-based flexible transitions.

In 2019, NHS England outlined plans to redesign the structure of children and young people's mental health services to create a comprehensive offer for 0 to 25-year-olds that reaches across mental health services for children, young people and adults. This included delivering an integrated approach across health, social care, education and the voluntary sector.

This was supported by the publication of the NHS Mental Health Implementation Plan 2019/20 to 2023/24, which stated how "NHS England and NHS Improvement will document and share learning from areas ...so local systems can adapt their models of care. These models will include stretch arrangements and changes in commissioning and service approaches for both children and young people's mental health services and adult mental health services to ensure young adults receive appropriate support regardless of their age or diagnostic profile."

Summer's story

Summer first started experiencing extreme stress and suicidal thoughts when she was at school and starting her GCSEs. She didn't speak to anyone about how she was feeling, but significant changes to her behaviour in school resulted in an admission to hospital, where she stayed under observation for a few days. This was when Summer first had contact with children and young people's mental health services, with support planned to remain in place once she was discharged. However, after discharge, Summer recalls the support from community children and young people's mental health services being withdrawn prematurely and the impact this had on her:

> "I think at the time I was not engaging very well just because of my state at the time and so basically, because I wasn't really talking about things, they just sort of dropped me … I felt a bit forgotten about and a bit confused because I sort of thought like if they said I needed help, why did they just drop me?"

Summer looks back on this time as a crucial turning point in her life:

> "And I think if I hadn't been dropped by them and they just gave me a bit of time to get to know them, would I have got into crisis? Would I have come back to hospital? (the second time)"

Around 18 months later, Summer was in crisis again and was referred to the school nurse, who made a GP appointment for her. The GP referred her to the crisis team and she was admitted to hospital under inpatient children and young people's mental health services initially for 2 weeks. Although Summer agreed to the initial admission, after 2 weeks, healthcare professionals didn't feel she was ready to leave hospital. At this point she was detained under section 2 of the Mental Health Act.

> “I felt like I didn't deserve it and at the time, I felt like I wasn't ill and I didn't need to be sectioned. So, it was really confusing for me. I felt bad because I thought I'm taking up someone else's place in the hospital. And I felt really guilty about that.... it was quite a hard time because nothing was really working for me in terms of treatments, and I ended up staying there for about 2 years. I was only discharged because I was 18, not because I was better.”

Summer describes the impact the 2-year stay in hospital had on her life:

> “I didn't do many GCSEs. When I left, I didn't know what to do because I didn't have any GCSEs and I thought no one's gonna want to give me a job and I'm not gonna be able to go to college...I felt like I wasn't a normal person of my age because I was in hospital and I missed out on all the things I thought were normal of people of my age.”

When Summer was admitted to hospital for the second time, she was referred to the Early Intervention Service (EIS). This service will see patients for a maximum of 3 years. Therefore, by the time she was discharged from hospital she only had 6 to 7 months of support left. Summer describes how the withdrawal of that support felt:

> “I felt quite helpless to be honest, I felt uncertain about what was happening... I felt like because I was in hospital I wasn't getting the support from them so I was a bit confused as to why that was included (in the 3 years)... It takes me a while to get to know people and to really want to talk to them. So, it’s quite frustrating because I'd only just left hospital. I'd started therapy and then it's just suddenly stopped.”

After being discharged from the EIS, Summer was referred to various adult mental health services. She describes being “passed on” from service to service for approximately 1 year before being accepted by an adult mental health team and offered ongoing support. The only support available to Summer during this time was emergency crisis support.

> “I just wanted to feel reassured in terms of, yeah, you're in the right place, we can help here, and like just feel hopeful and encouraged. So, it was quite difficult because I wasn't getting that feeling.”

Summer is now under an adult mental health team and is generally happy with the support she is receiving. She feels like she can request an appointment if she needs one, but also feels that the service isn’t always as proactive with contacting her as they should be, and the changeover of staff is high. Since leaving hospital, with support from her family, Summer completed her English GCSE and enrolled in a college course.

> “If I hadn't been to hospital my life would be a lot different now. I probably wouldn't have chosen the degree I've done ... If I hadn’t been in hospital some things that are important to me now wouldn't be.”

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