Are we listening?

Review of children and young people's mental health services

Phase Two supporting documentation

Quantitative analysis

March 2018

Contents

Introduction

This report presents a summary of national data for the Care Quality Commission's (CQC) thematic review of mental health care for children and young people

It provides a summary of relevant, nationally available data that covers all of England and is available publically.

It was developed to support the report authors for the phase two report to use evidence in this document alongside other supporting evidence (summary of evidence from CQC fieldwork and summary of bespoke CQC engagement work with children and young people) as well as supporting documents from the phase one report for the review (specifically, the review of literature).

Summary

Variable numbers, circumstances and characteristics of children and young people

This section focuses on national levels and geographic variation in the number of children and young people in different circumstances and with different characteristics. It was drafted to support writing sections of the phase two report that focus on the experiences of children and young people in these circumstances and with these characteristics.

The list of circumstances and characteristics is based on those known to put children and young people at increased risk of needing mental health care or having different needs when or experiences of receiving mental health care.

This section highlights that there is quite a lot of variation across local authorities. For example:

- The Black and ethnic minority population in local authorities across England range from 1% to 71%. Children's reporting of their own depressive symptoms varied by ethnicity[1] and the phase one report noted that stigma can be a major barrier to accessing mental health services for children and young people from Black and minority ethnic communities.[2]

- The percentage of children and young people looked after by the local authority ranged from 0.4% to 1.2%. Looked after children are more likely to have social, emotional and mental health problems identified in their special educational needs (SEN) statement than their peers who are not looked after but do have a SEN statement. Their peers are more likely to experience problems associated with autism and speech and language.[3]
- The percentage of juveniles (10 to 17-year-olds) who received their first conviction or youth caution in local authorities across England ranged from 0.2% to 0.7%. Children entering the youth justice system are commonly from disadvantaged and deprived communities who have experienced abuse and neglect which can lead to emotional distress and mental health problems. Children and young people in the youth justice system have higher than normal levels of depression, anxiety disorders and psychotic like symptoms.[4]

These are just three examples and all circumstances and characteristics showed some degree of variability across England.

Local authorities may not be consistently high or low on all of these indicators and so each local authority has to consider individually what the specific needs are for their local area.

Data gaps and data quality issues

- Data on gender identity in England is limited, with no national data on the number of children and young people who identify themselves as transgender.
- Data regarding children identifying as lesbian, gay or bisexual is restricted to young people aged 16 to 24 and is only available for the UK and not for smaller geographies, such as England or local authorities.

- Available data tends to be suppressed when the values are so low that it could lead to deductive disclosure of individuals. High levels of suppression for indicators about children and young people who are Gypsy or Roma or those seeking asylum meant we could only examine these two indicators at a regional level (the four or nine government office regions).
- Young carers data was only available at a regional level as local authority data groups the youngest age group into those under 24 years old.
- A number of circumstances and/or characteristics reported are often hidden for different reasons (for example, individuals not wanting to disclose or not being fully aware of the circumstances). Therefore it is difficult to get accurate prevalence estimates regarding, for example, child sexual exploitation, young carers and children and young adults identifying as lesbian, gay or bisexual.

Variable prevalence of mental health needs in children and young people

This section focuses on measures of the estimated prevalence of mental health needs.

Across England in 2015, the data estimates that 9% or over 700,000 five to 16-year-olds had mental health conditions. The difference between the local authorities with the lowest (7%) and the highest (11%) estimated prevalence is not particularly large and is fairly evenly spread either side of the England value.

The map (figure 19) of estimated prevalence shows the local authorities with higher percentages of children and young people with mental health conditions (darker shading) seem to be in the (1) North of England and (2) areas of London, such as, East and North East London, and (3) around Birmingham. The 2015 estimates are based on the 2004 prevalence survey[5] results and the age, sex and socio-economic make-up of a local population to estimate the prevalence in that local area. This survey groups together mental health conditions. Therefore, the national variation in estimated prevalence looks fairly similar to the national variation of deprivation (see appendix 1).

In 2015/16, 2% (over 180,000) of school pupils had a SEN statement where the primary needs were identified as social, emotional and mental health needs. Local authorities ranged from 1% to 5% of school pupils.

The national picture of school pupils with social, emotional and mental health needs looked a little different to estimated prevalence:

- There were still areas in the north of England that were showing high SEN prevalence but there were also many local authorities in this area that were low.
- There were also local authorities in the South West and London that seemed to have higher percentages of school pupils with social, emotional and mental health needs.
- The national variation could reflect that real differences existed due to known national variation in socio-economic factors known to be related to increased risk of mental health conditions. Alternatively, it could also reflect unmet needs of children and young people in areas that have low numbers of social, emotional and mental health needs identified through SEN statements. However, variation may also reflect differences in the way that

the special educational needs of children and young people are assessed, identified and recorded by the local authority.

- The difference between the estimated prevalence of mental health conditions and the numbers of children and young people with social, emotional and mental health needs could reflect the differences in conditions captured by these two measures. Alternatively, the differences could reflect differences in how the indicators were measured. The estimated prevalence is standardised based on the age, sex and socio-economic characteristics of individual local authorities. In comparison, the social, emotional and mental health needs is based on primary needs raised in SEN statements and therefore only includes children and young people with a SEN statement.

Data gaps and data quality issues

- Caution should be exercised when using the estimated prevalence of mental health needs in children and young people. There are known data quality issues.
- The data is based on a baseline survey from 2004 and local prevalence is estimated each year based on the age, sex and socio-economic make-up of the local population at that time.
- The estimates are based on grouping all mental health into one category rather than the range of conditions that come under the umbrella of mental ill-health.
- The results from the 2016 Office for National Statistics survey, due in 2018, will allow for an update of all of these prevalence rates.[6]

Variable access to mental health care for children and young people

This section provides some basic analysis of the number and source of referrals of children and young people (0-18 years) to mental health (either children and young people's or adult) services, as well as the numbers in contact with these services. This section also reviews the findings of other key stakeholders. This section is based on papers that have been recommended to us and is not meant to be taken as a review of the literature. This section should be considered alongside the review of literature from phase one.

Of the over 41,000 referrals to mental health services in England, almost four in 10 were from primary health care.

The number of children and young people in contact with mental health services appears to have dropped from August 2016 to July 2017. We are not sure whether this is true drop or a reflection of known data quality issues with under-reporting in the Mental Health Services Dataset (MHSDS).

Data gaps and data quality issues

- There are a number of gaps and quality issues with data about access to mental health care. Data regarding access to mental health care does not currently provide clear and reliable measures across the whole system (including non-NHS services) of:
  - the number and source of referrals
  - the number of children and young people meeting eligibility criteria following referral, or the number of contacts with services.

- MHSDS is trying to fill this data gap and can provide data on some of these areas. However, MHSDS is classed as experimental and so some caution should be exercised.

- Within the Care Quality Commission (CQC) we are still assessing the coverage of the data and it is clear that not all providers that should be supplying data are currently doing so. We do plan to use this data to monitor the availability and outcome of mental health and learning disability care provided to children and young people.

- Data is missing around unmet needs. For example, we do not have data that tracks vulnerable groups and indicates whether they are accessing services, for example, looked after children or children from Black and minority ethnic populations.

- Data is not available regarding transition between services and whether these transitions are monitored nationally.

Variable experiences of mental health care and outcomes for children and young people

This section covers a variety of measures aimed to understand experiences of mental health care and outcomes for children and young people. We present CQC's ratings of inpatient and community child and adolescent mental health services (CAMHS). We present the current picture of ratings and review changes in ratings from the first time they were inspected to their current rating. This section also reviews others' findings. This section is based on papers that have been recommended to us and is not meant to be taken as a review of the literature. This section should be considered alongside the review of literature from phase one.

NHS England's Improvement and Assessment Framework scores for CAMHS transformation shows a wide variety from very low compliance to very high compliance (some quarters show a range of 0% to 100% compliance). Therefore, there is a lot of variability in the process of transformation of CAMHS across clinical commissioning groups.

Fewer children and young people are being taken to a police cell following a section 136 detention under the mental health act; declining from 143 in 2014/15 to 20 in 2016/17. However, 20 children and young people being taken to a police cell in 2016/17 does mean that *Future in Mind's* aspiration to have no under-18s taken to a police cell is not achieved yet.

The number of children and young people staying in adult wards declined from August 2016 to July 2017. Seventeen-year-olds were the most likely to spend time on an adult ward.

The number of ward stays at least 50km away from the home of children and young people seemed to increase from August 2016 to July 2017.

Although the children and young people's survey focuses on children and young people's experiences of receiving care in an acute hospital, the findings highlight that children and young people with mental health conditions also have poorer experiences of receiving care for their physical health needs than their peers without mental health conditions. Differences included:

- Children and young people and their parents reported poorer involvement in their care.
- Children and young people were less likely to understand what was happening during and following their hospital stay
- Parents were more likely to report that staff did not understand their or their child's individual needs and histories.

Data gaps and data quality issues

- Data is generally lacking about children and young people's experience of mental health care, for example, through patient surveys.
- Data is available from CQC's children and young people's survey about the experiences of children and young people with mental health diagnoses when accessing care for their physical health needs. However, we do not have a national survey about children and young people's, or their parent's or carer's, experiences of receiving care for their mental health needs.

Summary of data gaps and data quality issues

This section covers data gaps and data quality issues that were found through: compiling the supporting information for fieldwork; creating this summary of nationally available data; and discussions with internal stakeholders. This section was completed before a meeting of the External Advisory Group that discussed data gaps and quality issues. Therefore, this section should be considered with notes from that meeting.

These data gaps and data quality issues include:

- Data quality issues with the existing prevalence data (see section about prevalence above)
- The lack of data about access to mental health services, especially those that are not provided by the NHS (see section about access above)
- The lack of data about experiences of children and young people when accessing mental health care (see section on experiences above)
- There is not good national data available to understand all the different circumstances and characteristics of children and young people in different local authorities (see section on children and young people above)

Details of evidence

Variable numbers, circumstances and characteristics of children and young people

There are a number of different characteristics and circumstances that are known to put children and young people at increased risk of needing mental health care or having different needs or experiences of receiving mental health care. For example, children and young people who identify as lesbian, gay or bisexual, those from Black or minority ethnicities, or those who are caring for a family member. The following section provides summary data of the number of children and young people in different circumstances and with different characteristics. The final list of circumstances and characteristics reflects those included in supporting information for the review fieldwork and those identified in the analysis of evidence summaries from the fieldwork.

We report on the national levels as well as on variation seen within England and within the 10 health and wellbeing boards we visited for the phase two fieldwork.[a] Many of these circumstances and characteristics vary across England. Therefore, areas will differ in terms of the specific needs for the children living in their area. For example, London has higher levels of unaccompanied asylum seeking children (UASC) and children and young people from Black and minority ethnicities, while local authorities in the North of England tend to have higher levels of deprivation. One of our fieldwork sites had the lowest number of fixed period exclusions per 100 pupils at state-funded schools and the highest number juvenile first time entrants to the justice system in England. Therefore, each area should be considering the particular needs of the children and young people in their area, for example, through Joint Strategic Needs Assessments (JSNAs).

Fieldwork teams did review available JSNAs and local transformation plans (LTPs) when preparing for their visits. Many of the indicators we use in this section are included in the Children and Young People's Mental Health and Wellbeing Profiling Tool by Public Health England.[b] On their website ('Fingertips'), you can download an area profile for any local authority that provides a summary of where the area is in comparison to England and their region for the most recent data.

Appendix 2 shows the national numbers and proportion of children and young people with different characteristics and in different circumstances. We present the three most recent years of data available (if possible). More information is contained below, including more years of data when available and when change has been found across time.

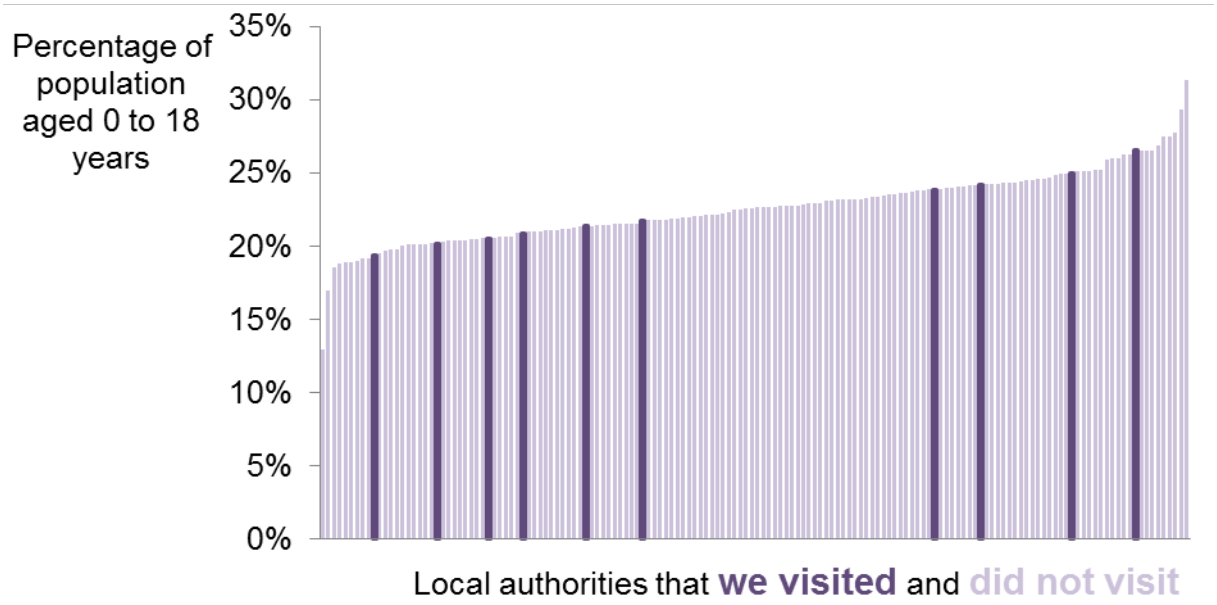
Children and young people population

Over one in five people in England in 2016 were aged 18 years or younger (22%). This varies by local authority, from 13% to 31% of people living in the local authority aged 18 years or younger (see figure 1). Within the areas we visited, the 0 to 18-year-old population ranged from 19% to 27%.

[a] We visited Bedford, Bristol, Dorset, Enfield, Hertfordshire, Liverpool, North Yorkshire, South Tyneside, Southwark and Walsall.

[b] The Children and Young People's Mental Health and Wellbeing Profiling Tool can be accessed at: http://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/

Figure 1. Variability in the percentage of the local population aged 0 to 18 years for local authorities in England we did (dark purple) and did not visit (lighter purple) during fieldwork (2016)

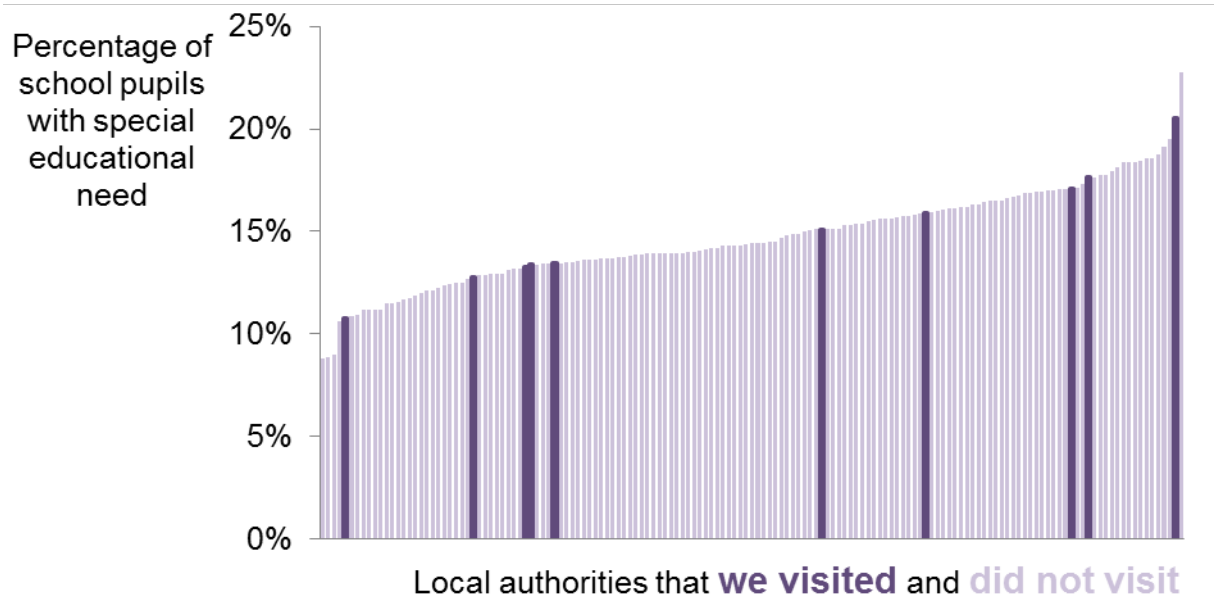


Source: Mid-year population estimates, Office for National Statistics

Children and young people with special educational needs

The number of school aged pupils with special educational needs has declined from 2014 to 2016. In 2016, 14% of school aged pupils had special educational needs compared to 18% in 2014. However, there is a lot of variation in the numbers of children with special educational needs across local authorities in England (see figure 2 for variance). Within the areas we visited, the percentage of children and young people with special educational needs in 2016 ranged from 11% to 21%.

Figure 2. Variability in the percentage of the local population of school aged children with special educational needs (2016)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Note: Data was not available for Isle of Scilly, City of London or Blackburn with Darwen for 2016.

Figure 3. Variability in the percentage of the local population of school aged children identified as having learning disabilities (2016)

Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Note: Data was not available for Isle of Scilly or City of London.

The number of school aged children identified as having learning disabilities (specific, moderate, severe, profound or multiple) increased from 3% to 5% from 2014 to 2015, but remained at 5% in 2016. In other words, 415,467 school aged children had diagnosed learning disabilities in 2016. However, there was national variance (see figure 3). Within the areas we visited, the percentage of school aged children with identified learning disabilities ranged from 4% to 6%.

The estimated prevalence of people with an autistic spectrum disorder[c] is around 1%.[7] However, this prevalence estimate is based on the ONS national survey data from 2004 by Green and colleagues of five to 16-year-olds. According to this survey, children and young people with autistic spectrum disorders are overwhelmingly male. The prevalence rate for boys was 1.4% and for girls was 0.3%. Eighty-two per cent of children and young people with autistic spectrum disorders were male. Similar rates were found in a cohort study of nine to 10-year-olds in South London, with 116 per 10,000 children having an autistic spectrum disorder.[8]

Children and young people with long-term illness, disability or medical condition

In terms of physical health, around a quarter (23%) of young people aged 11-15 reported they had a long-term medical illness or disability in the Behaviour in School-aged Children study (HBSC)[d] in England in 2014.[9] Around half of those children and young people (49%) reporting they had a long-term illness or disability had asthma. Six per cent reported having ADHD, 3% reported having a physical disability, 2% reported having diabetes and 2% had epilepsy. The remaining children and young people reported having another disability.

The same question was asked to 15-year-olds as part of the What About YOUth (WAY) survey.[10] However, these young people did not complete the survey under exam conditions and they may have had support from parents in completing it. The percentage of children and young people reporting long-term conditions was lower for this group of children. On average, 14% of respondents indicated they did have a long-term illness. The lower percentage of children and young people reporting long-term conditions could reflect the differences in age groups, differences in the methods to collect responses (exam conditions vs. not exam conditions) or could reflect other differences in samples that were not measured.

The percentage of 15-year-olds reporting they did have a long-term illness, disability or medical condition was reported by local authority and then weighted to reflect the general population. There was national variance (see figure 4). Within the areas we visited, the percentage of school aged children with identified learning disabilities ranged from 11% to 15%.

[c] The most recent diagnostic manual from the American Psychiatric Association in 2013 uses autistic spectrum disorder to bring together the various diagnoses of autism, autistic spectrum disorder and Asperger's. There is also a related diagnosis of social communication disorder. The defining characteristics of autistic spectrum disorders are impairments of social interaction, communication and imagination and often a reliance on repetitive, habitual activities and behaviours.

[d] The HBSC study involves 44 countries and regions and is in collaboration with the World Health Organisation. In England, 5335 young people aged 11, 13, and 15 years participated in the 2014 HBSC cycle. A random sample of all secondary schools in England was drawn (state and independent schools), stratified by region and type of school to ensure representative participation. Young people were asked to fill in the questionnaire under exam type conditions i.e. at individual desks and without discussion with other pupils.

Figure 4. Variability in the percentage of respondents to the What About YOUth (WAY) survey reporting they had a long-term illness, disability or medical condition (2014/15)

Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

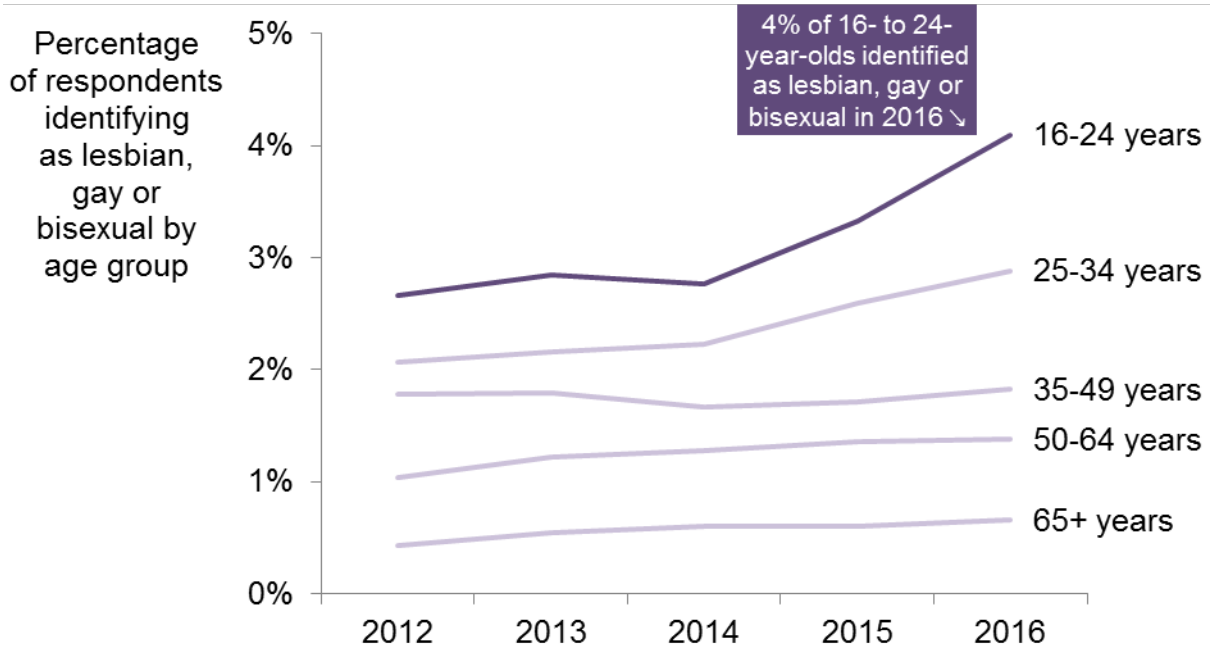
Lesbian, gay and bisexual children and young people

There is limited data available about the sexual orientation of children and young people in England. The Office for National Statistics calculates estimates of the numbers of people with different sexual identities for the UK from the Annual Population Survey. Sexual identity is one part of the umbrella concept of "sexual orientation" and does not necessarily reflect sexual attraction or sexual behaviour. Neither of these separate concepts are currently measured in the Annual Population Survey. Estimates can be broken down by age, but the youngest age group covers 16 to 24-year-olds and these estimates cover all of the UK. Therefore, the estimates are not restricted to children and young people (as defined in the scope of this review) and are not restricted to England. In addition, the sexual identity estimates are considered Experimental Official Statistics so caution should be exercised when considering this data.[e]

In 2016, 2% of people over 16 years old identified themselves as lesbian, gay or bisexual in the UK according to Annual Population Survey. Figure 5 shows that 16 to 24-year-olds were more likely to identify as lesbian, gay or bisexual, with the value increasing from 2.7% in 2012 to 4.1% in 2016. This value may be an underestimate of the true value as some 16 to 24-year-olds identified as "other" (1%) or "don't know" (5%). Similar rates of these two responses were seen across the other age groups.

[e] Experimental Official Statistics are those which are in the testing phase, are not yet fully developed and have not been submitted for assessment to the UK Statistics Authority. They are published to involve customers and stakeholders in their development, and as a means to build in quality at an early stage.

Figure 5. Percentage of respondents identifying as lesbian, gay or bisexual by age group and across data collection years (2012 to 2016)



Source: Sexual identity in the UK dataset, Office for National Statistics

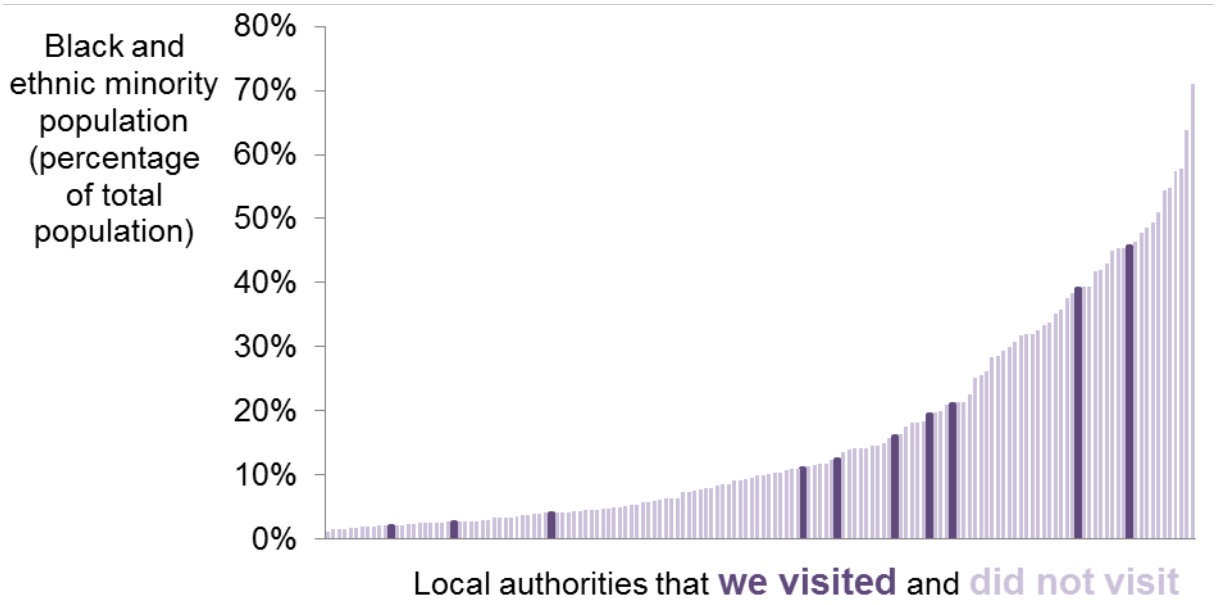
Transgender children and young people

Sexual identity and gender identity should be considered separately as they are distinct. Data on gender identity in the UK is limited, with no data on the number of children and young people who identify themselves as transgender.[11]

Black and minority ethnic population

Fifteen per cent of people in England in the 2011 census were BME. However, the percentage of people who are BME varies a lot by local authority, ranging from 1% to 71% (see figure 6). Within the areas we visited, the BME population ranged from 2% to 46%.

Figure 6. Variability in the percentage of the local population who are BME (2011)



Source: 2011 census data, Office for National Statistics

School students whose ethnic group is Gypsy or Roma

Of school age students in England, 0.3% had an ethnic group of Gypsy or Roma in 2015/16.[f] This value does not include pupils in special schools and is only based on the sample of pupils with classified ethnic group collected from the School Census by the Department for Education. This varies a little by government region office (see figure 7). However, it is worth noting that the figure covers a range of 1% as the percentage of Gypsy or Roma students is very small.

[f] Data was collected as part of the School Census by the Department for Education. All schools that were open on school census day, 19 January 2017, were required to submit a school census return via their local authorities. Ethnicity was recorded only for children of compulsory school age and above. Children must get an education between the school term after their 5th birthday and the last Friday in June in the school year they turn 16. More information available: https://www.gov.uk/know-when-you-can-leave-school

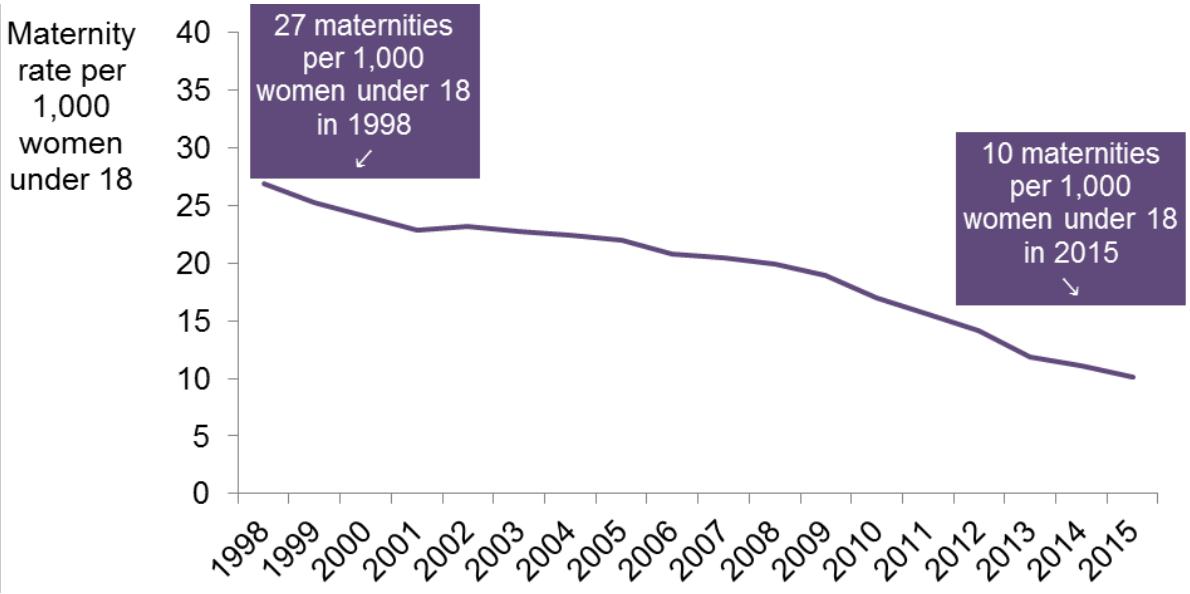
Figure 7. Variability in the percentage of the local student population who are Gypsy or Roma for government office regions in England (2015/16)

Source: Oral Health Profile, Public Health England

Pregnancy and maternity

The maternity rate for under 18 years old has reduced from 1998 to 2015 in England, declining from 27 to 10 per 1,000 women under 18 (see figure 8). A maternity reflects a pregnant woman giving birth at or after 24 weeks gestation (either live birth or stillbirth). Multiple births are counted as one maternity

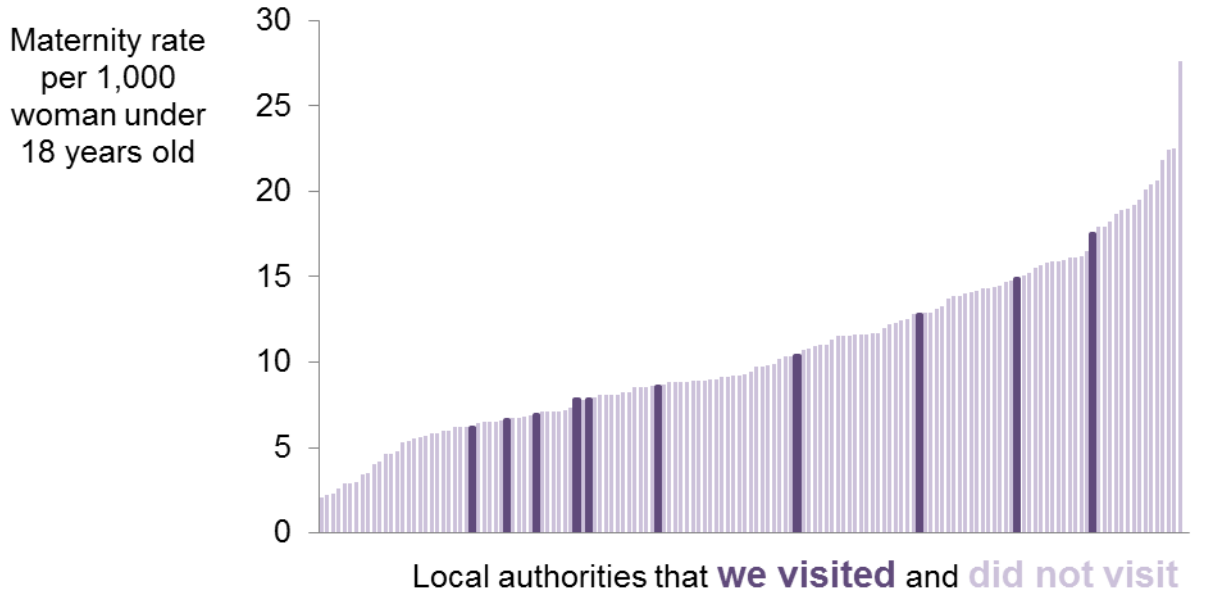
Figure 8. Reduction in the maternity rate for under 18s in England (1998-2015)



Source: Conception Statistics, England and Wales, Office for National Statistics

However, there was large national variance (see figure 9) in 2015. Within the areas we visited, the maternity rate for women under 18 ranged from six to 18 per 1,000 women under 18 in the local authority.

Figure 9. Variability in the maternity rate per 1,000 women under 18 (2015)



Source: Conception Statistics, England and Wales, Office for National Statistics

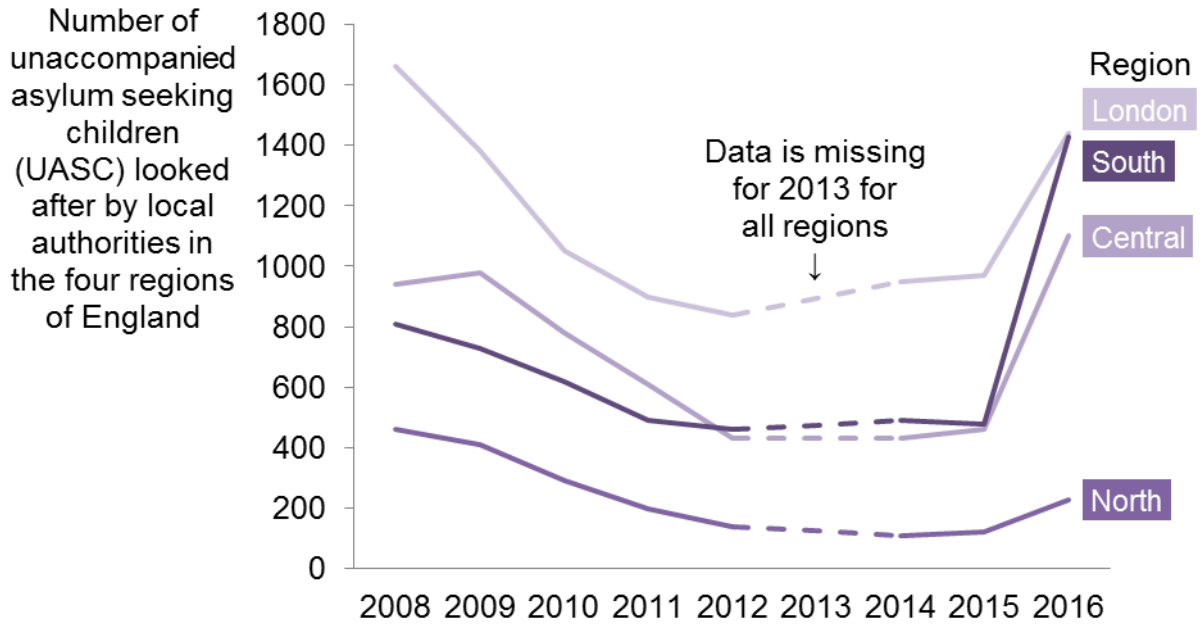
Note: A maternity reflects a pregnant woman giving birth at or after 24 weeks gestation (either live- or stillbirth). Multiple births are counted as one maternity. Values for Isles of Scilly/Cornwall and City of London/Hackney were combined. The value for Rutland was missing.

Unaccompanied asylum-seeking children (UASC)

An Unaccompanied Asylum-Seeking Child (UASC) is a person under 18, or who, in the absence of documentary evidence establishing age, appears to be under that age, is applying for asylum in his or her own right and has no relative or guardian in the UK. There were 3,175 asylum applications from UASC in 2016, a 2% decrease compared to 2015 (3,253). UASC applications remain below the peak of 4,060 in the year ending September 2008. Applications from UASC accounted for 10% of all main applications for asylum in 2016.[12]

Figure 10 shows the number of UASC looked after by local authorities within the four regions of England from 2008 to 2016 (although data was not available for 2013 hence the broken line at this point of the graph). All regions declined from the peak in 2008 to 2012. From 2014 numbers began to increase and numbers for the South and Central region increased the quickest and to above their 2008 value. London remained the highest across time, although the overall number was very similar to the South region in 2016. In 2016, 4,210 UASC were looked after by local authorities in England. We were not able to examine UASC looked after by individual local authorities as too many had data that was suppressed due to low numbers. Therefore, we had to focus on a wider geography – that is, the four government office regions.

Figure 10. Variability in the number of UASC looked after by local authorities in the four regions of England from 2008 to 2016



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

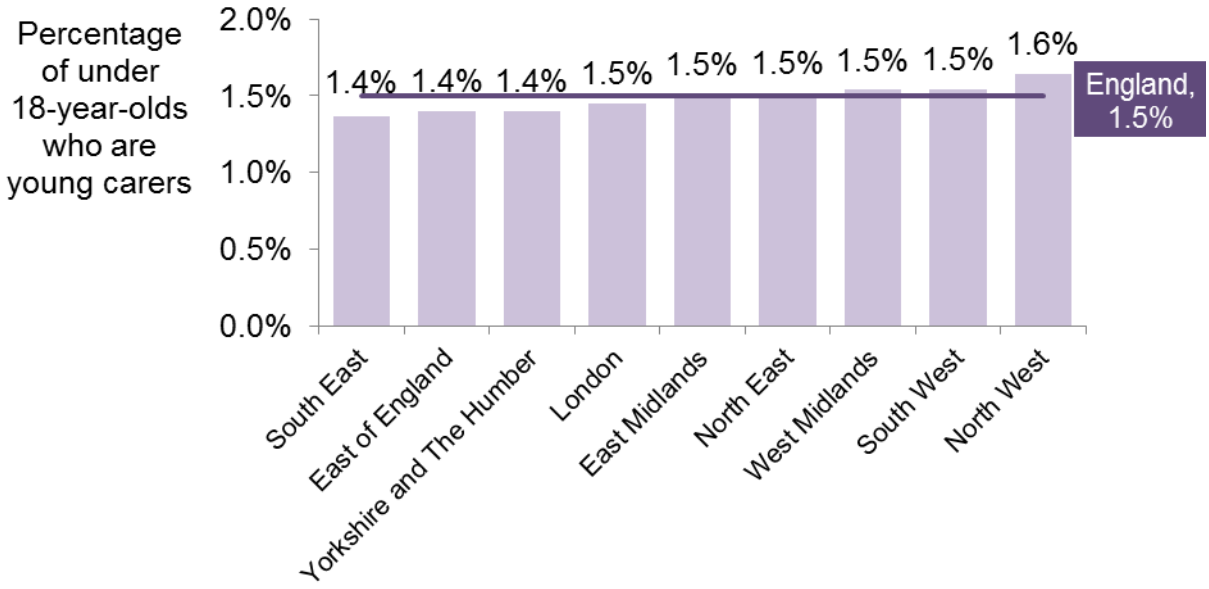
Young carers

The Memorandum of Understanding published by the Association of Directors of Children's Services and the Association of Directors of Adult Social Services defines young carers as children and young people under 18 who provide regular or ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances.[13] A young carer can become vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking impacting on his or her emotional or physical well-being or educational achievement and life chances.[14]

Two per cent of children and young people under the age of 18 in England in the 2011 census were helping to look after someone in their family who was ill, disabled or misusing drugs or alcohol. Across England, this meant 166,363 children and young people were young carers according to the 2011 census from the Office for National Statistics.[g] The census data can only be viewed for under 18-year-olds at a regional level (that is, the nine government office regions in England). Figure 11 shows there is not much variation between regions, with values ranging from 1.4% (South East) to 1.6% (North West). Data is only available for 0 to 24-year-olds at a local authority level. Therefore, we cannot be sure how much variation there is in the number of young carers by local authority.

[g] Numbers based on England values for the provision of unpaid care by general health by sex by age (regional) for children and young people under 18 years old (that is, up to and including 17-year-olds). Percentage was calculated by dividing those providing unpaid care and the sum of those providing and not providing unpaid care.

Figure 11. The percentage of children and young people under 18 years old who are providing unpaid care by government office region in England (2011)



Source: 2011 census data, Office for National Statistics

The 2011 census asked *Do you look after, or give any help or support to family members, friends, neighbours or others because of a long-term physical or mental ill-health or disability, or problems related to old age?* However, parents answered for their children and this question did not make it clear the possible range of conditions where caring may be needed, such as mental ill health, substance misuse or HIV. The Children's Society noted that their years of experience of working with young carers has highlighted that many young carers remain hidden from view. Therefore, census estimates likely under-reported the true numbers of children and young people under 18 that are carers.[15]

Other surveys that provide a clearer and broader definition of young carers have started to highlight the numbers of young carers in England and the UK. However, these are also potentially only show the tip of the iceberg in terms of the number of young carers.[16] Of the 15,427 13- and 14-year-olds in the original cohort of the Longitudinal Survey of Young People in England (LSYPE),[h] 5% (689) were young carers. Young carers were identified as replying yes to the question: *Some people your age may have to look after other people. This could be a brother or sister, a relative or someone else who is disabled or sick. Is there anyone like this who lives here with you that you have to look after on a regular basis?* Just over half were caring for a sibling, around a third were caring for a parent and one in eight were caring for their grandparents. Their caring responsibilities ranged from a couple of hours to over 100 hours a week in some extreme cases. Most young carers provided a few hours (62% up to five hours a week) but 30% did between five and 15 hours, 5% between 15 and 30 hours and 3% for 30 hours or more.[17]

[h] The LSYPE started in 2004, with over 15,427 young people aged 13 and 14 completing questionnaires. In 2010, 9000 young people from the original cohort were still completing questionnaires.

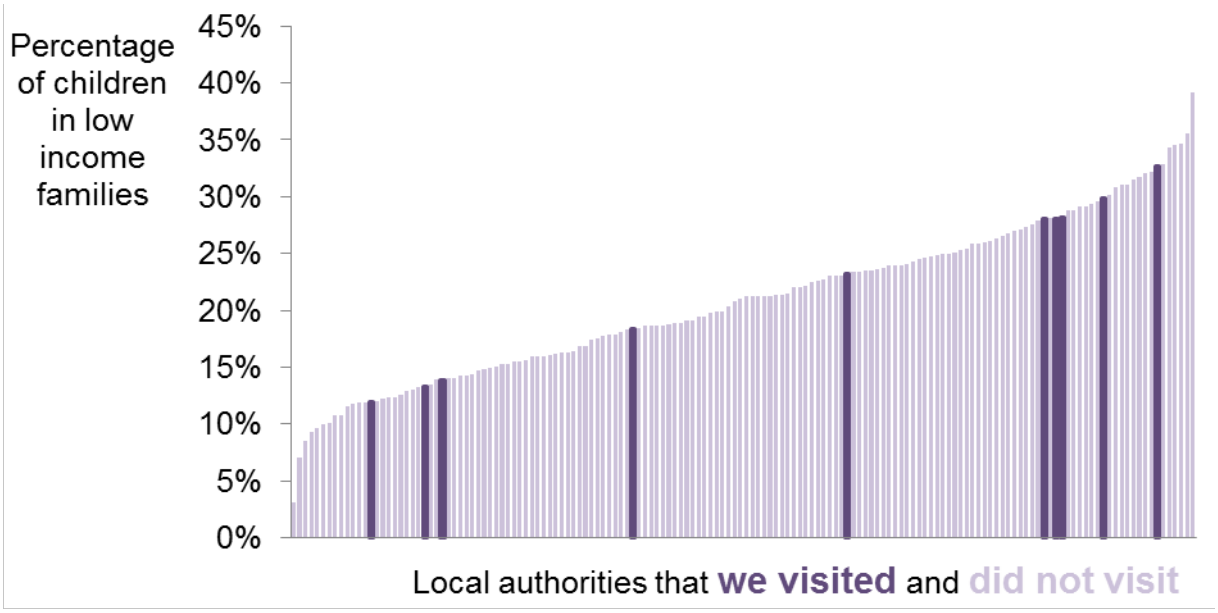
A BBC survey showed the number of young carers could be even higher. Over 4,000 pupils from 10 secondary schools in the UK responded to a BBC survey designed by academics at the University of Nottingham. The questions measured the level of responsibility and type of caring activities the young people had in their home. Eight per cent (337) had carried out "personal care"[i] for someone they lived with a lot or some of the time over the previous month. The levels of caring increase when considering emotional care,[j] 29% of school pupils reporting carrying out this type of care a lot or some of the time over the previous month. Although not all of these young people will necessarily be young carers, it is likely that many are providing support for family members with mental ill health or substance misuse.[18]

Children in low income families

The percentage of children under 16 living in low income families has been relatively stable from 2006 to 2014; ranging from around 19% (2012-2013) to 22% (2006-2009) in England. Low income was defined as children living in families in receipt of out of work benefits or tax credits where their reported income was less than 60% the median income.[k]

In 2014, 20% of children (just over two million) for whom child benefit was received were living in low income families in England. However, there was large national variance (see figure 12) in 2014. Within the areas we visited, the percentage of children under 16 living in low income families ranged from 12% to 33% for children whom child benefit was received in the local authority.

Figure 12. Variability in the percentage of children under 16 in low income families (2014)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

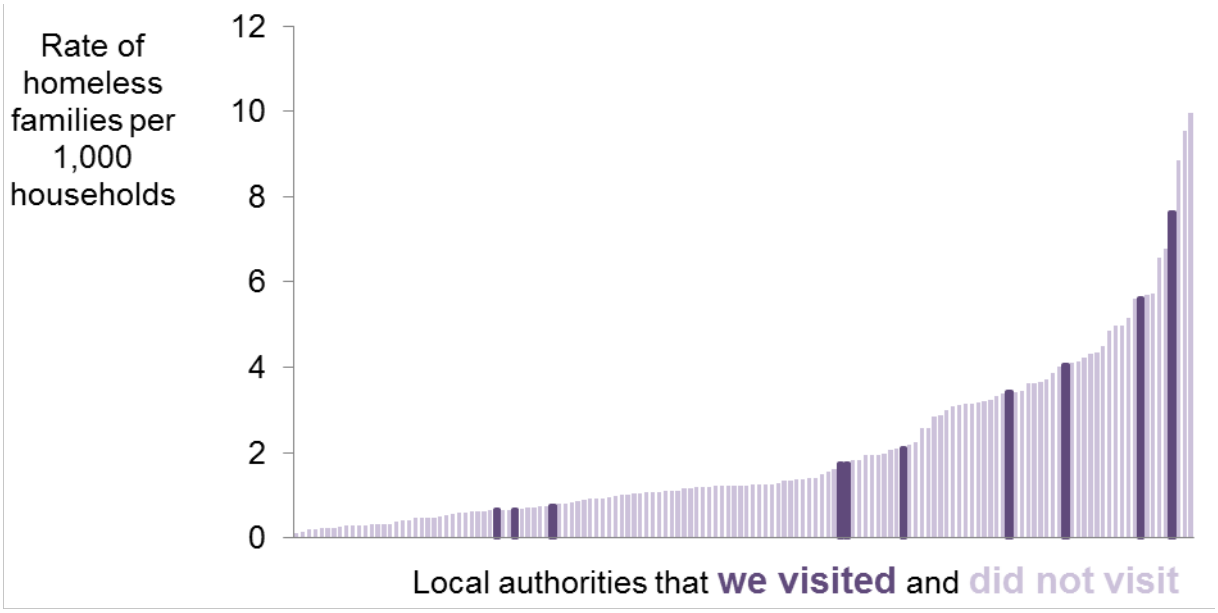
[i] Personal care includes activities such as helping someone dress, wash, bathe or shower.
[j] Emotional care includes activities such as sitting with the person they care for, reading to them, or taking them out for a walk.
[k] Definition for the indicator included in Public Health England's Children and Young People's Mental Health and Wellbeing Profiling Tool.

Homeless families

In 2015/16, two households per 1,000 in England had dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance. In other words, 43,044 households were considered homeless by the above definition. There was large national variance in the rates of homeless families by local authority (see figure 13). Within the areas we visited, the rate of homeless families ranged from one to 8 per 1,000 households.

This rate and number is likely an underestimate as this rate does not include those staying with friends or sleeping rough. For example, young people may be approaching providers directly or be signposted to these providers rather than going to their local authority for support.[19]

Figure 13. Variability in the rate of homeless families per 1,000 households (2015/16)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Note: Data is not included for Nottingham, Southend-on-Sea, Windsor and Maidenhead, Isles of Scilly, Salford, City of London, Kensington and Chelsea, and Kingston-upon-Thames due to suppression or data quality issues.

Children at risk of sexual exploitation

In the Department for Education's definitions and guidance,[20] child sexual abuse is defined as:

> Sexual abuse may involve physical contact, including assault by penetration (for example, rape or oral sex) or nonpenetrative acts such as masturbation, kissing, rubbing and touching outside clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet).

Child sexual exploitation is defined as:

> Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

The Department for Education's guidance highlights that there are many reasons why it is difficult to assess the prevalence of child sexual exploitation. Many children and young people who are sexually exploited are victims of many types of abuse. In addition, some methods of grooming mean that children and young people who are sexually abused do not always know or recognise that they are being abused and therefore detection rates are affected. Given sexual exploitation is often hidden it is difficult to get accurate prevalence estimates. Areas that have taken a proactive approach to looking for child sexual exploitation are uncovering the problem. Children aged 12-15 years old are most at risk, but children as young as 8 have been identified. Children over 16 can also experience child sexual exploitation but can be overlooked due to assumptions around capacity to consent. Females are more at risk but males are also at risk and less likely to disclose their experiences.[21]

The Association for Young People's Health report on key data again highlights that the low estimated numbers of children and young people who are trafficked or are victims of sexual exploitation are likely to reflect the low number of cases that become subject to official proceedings.[22] Recent high profile cases and reports suggest that the number is likely to be higher than estimated.

NSPCC documented data about the number of sexual offences, including rape, sexual assault, sexual activity with a minor and child grooming, committed against children and young people and that were reported to and recorded by the police. The NSPCC reported there were 37,778 recorded sexual offences against under 16 year olds in 2015/16 in England. The rate of sexual offences (36.3 per 10,000 children and young people under 16) increased by 23% from 2014/15. Responses to a freedom of information request to police forces in England showed there were 47,045 offences or 40.3 sexual offences per 10,000 children under 18 in 2015/16. However, police-recorded crime statistics suffer from under-reporting and therefore do not reflect the actual number of offences committed.[23]

Recorded sexual offences against children and young people under 16 were relatively static from 2004/05 to 2012/13. However, the number of offences has increased annually since 2012/13. The rate of offences per 10,000 under 16 year olds has more than doubled from 16.5 in 2005/06 to 36.3 offences in 2015/16. However, it is important to note that these changes may reflect increased public awareness and changes in policing rather than an increase in incidence. In addition, data reflects the year in which an offence was reported, not the year it was committed, so a proportion of offences will be historic.[24]

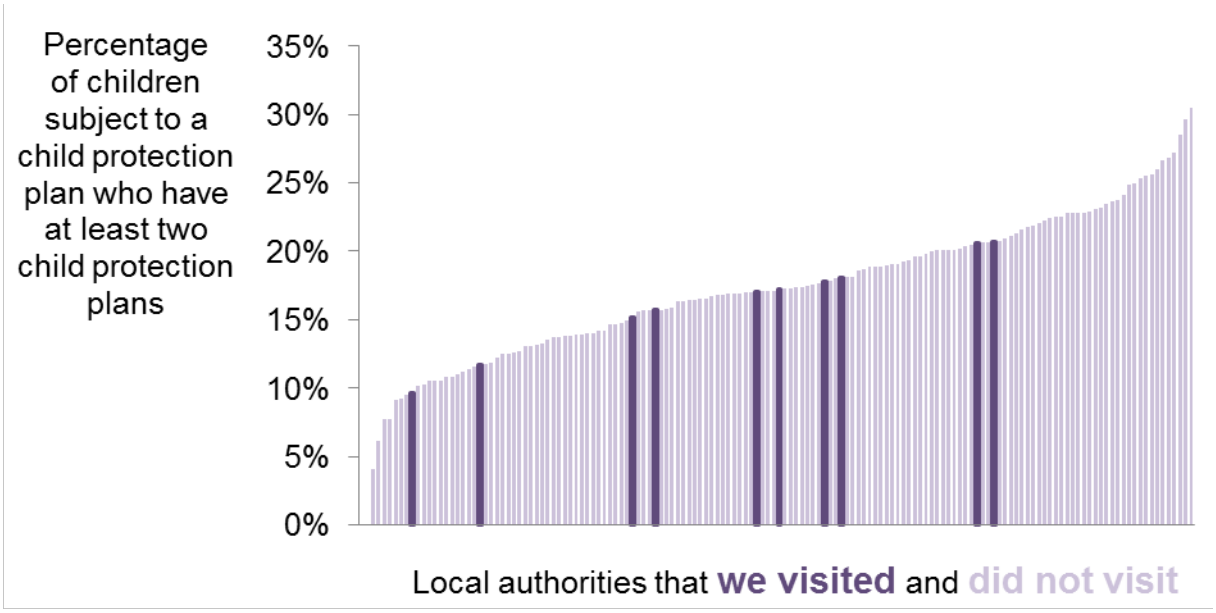
Repeat child protection cases

The number of children who were the subject of a child protection plan at 31st March increased 1.5% from 50,310 in 2016 to 51,080 in 2017.[25] This number has slowly been rising since 2010. On 31 March 2010, there were 39,100 children who were the subject of a child

protection plan.[26] Of these children, the number who were the subject of at least two protection plans within a year increased from 2014 (16%) to 2016 (18%). There were a total of 11,350 children subject to multiple protection plans in 2016. There was large national variance (see figure 14). Within the areas we visited, the rate of repeat child protection cases ranged from 10% to 21%.

Children who are the subject of a child protection plan have been identified as at risk of abuse and/or neglect.[27] However, it is important to remember when considering this data that not all children at risk of abuse and/or neglect will become the subject of a child protection plan. Furthermore, the values are only based on children that are subject to a child protection plan. Therefore, the area with the highest percentage of children with multiple child protection plans does not necessarily have the highest number or proportion of children with child protection plans in England.

Figure 14. Variability in the percentage of children with child protection plans in the local population who had at least two child protection plans in 2016

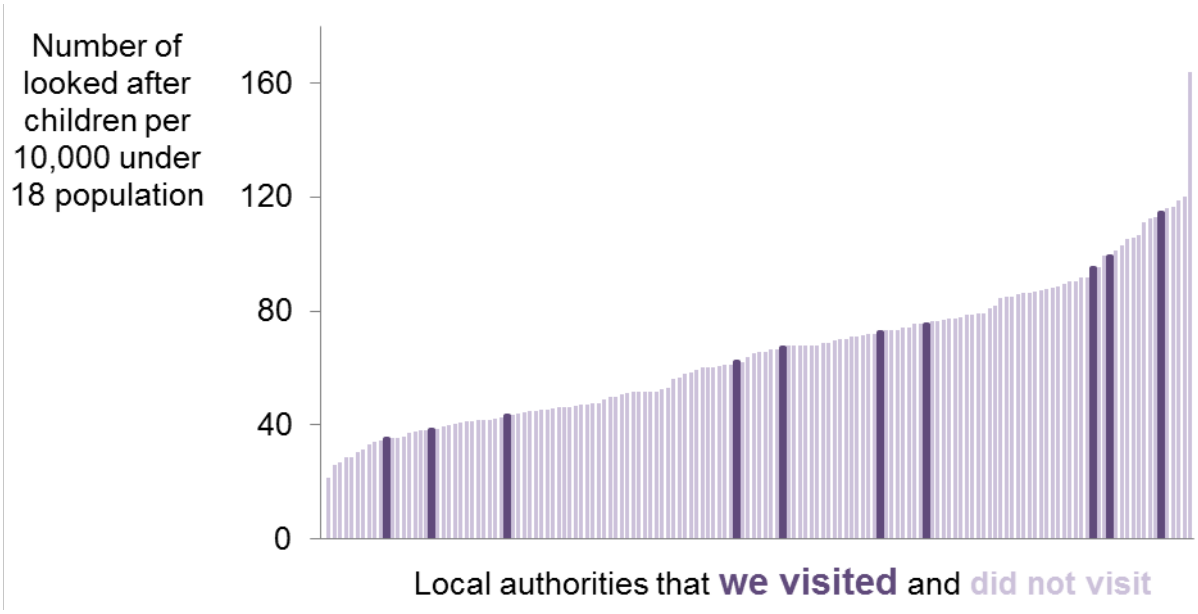


Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Looked after children

The number of looked after children has been fairly stable from 2012/13 to 2015/16, at around 60 children per 10,000 under 18 population. In other words, 70,440 children were looked after by local authorities in England during 2015/16. However, there was large national variance (see figure 15). Within the areas we visited, the rate of looked after children ranged from 35 to 115 per 10,000 population (under 18 years).

Figure 15. Variability in the rate of the local population of under 18 year olds who are looked after (2015/16)

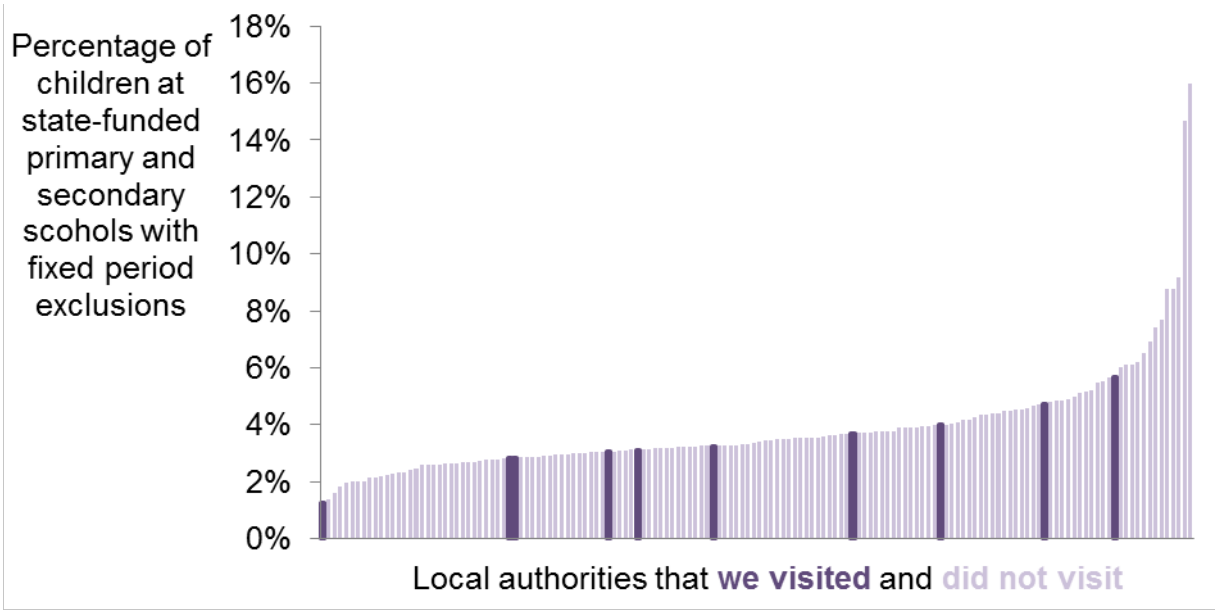


Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Children excluded from school

The number of school children with fixed period exclusions from state funded schools has been fairly stable from 2012/13 to 2014/15: 1% of children at primary school; 8% of children in secondary school; and 4% of children in all schools had fixed term exclusions in 2014/15. However, there was large national variance (see figure 16). Within the areas we visited, the percentage of children at state-funded schools with fixed period exclusions ranged from 1% to 6%.

Figure 16. Variability in the percentage of the local population at state-funded schools who have fixed period exclusions (2014/15)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Note: Data is not included for Isles of Scilly and City of London due to suppression.

Children involved in the criminal justice system

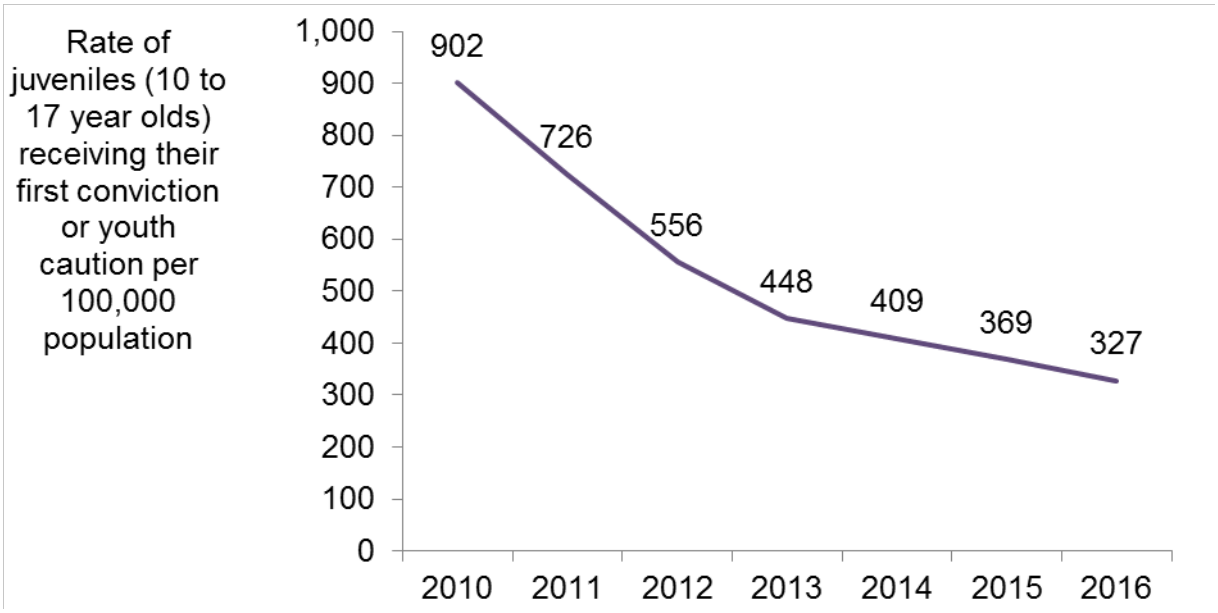
The number of children accommodated in secure children's homes was 203 in England and Wales on 31 March 2017, which has decreased from 210 during the previous year.[28] The number of 11 to 18-year-olds in youth custody in England and Wales rose in the early 2000s but has declined in recent years, with 909 young people in custody in April 2017.[29] This is a snapshot during one month. The average custodial sentence served by young people is less than a year so many more young people will pass through custody over the course of a year. Many children and young people in custody are very vulnerable. There were 16 deaths of young people aged 18 to 24 in prisons and youth offender institutions in 2016 in England and Wales. Twelve of these deaths were self-inflicted, one non-self-inflicted, one homicide and two were awaiting classification.[30] The report did not specify whether the 12 self-inflicted deaths were deliberate or accidental.

First time entrants to youth justice system

The number of first time entrants (juvenile and adult) peaked in 2007 and has fallen since then. The decline was much sharper for juveniles than for adults. The Ministry of Justice suggest that the decline has, in part, been driven by the decline in cautions. For juveniles and adults, simple and conditional cautions have shown a sharp decline in England and Wales (a 72% decline from 2007 to 2016) for all offences except robbery. In addition, police recorded crime (since 2003) and police stops and searches (since 2010/11) have declined in England and Wales.[31]

Figure 17 shows the reduction in the number of children age 10 to 17 years old receiving their first conviction or youth caution from 902 per 100,000 in 2010 to 327 per 100,000 in 2016 in England.

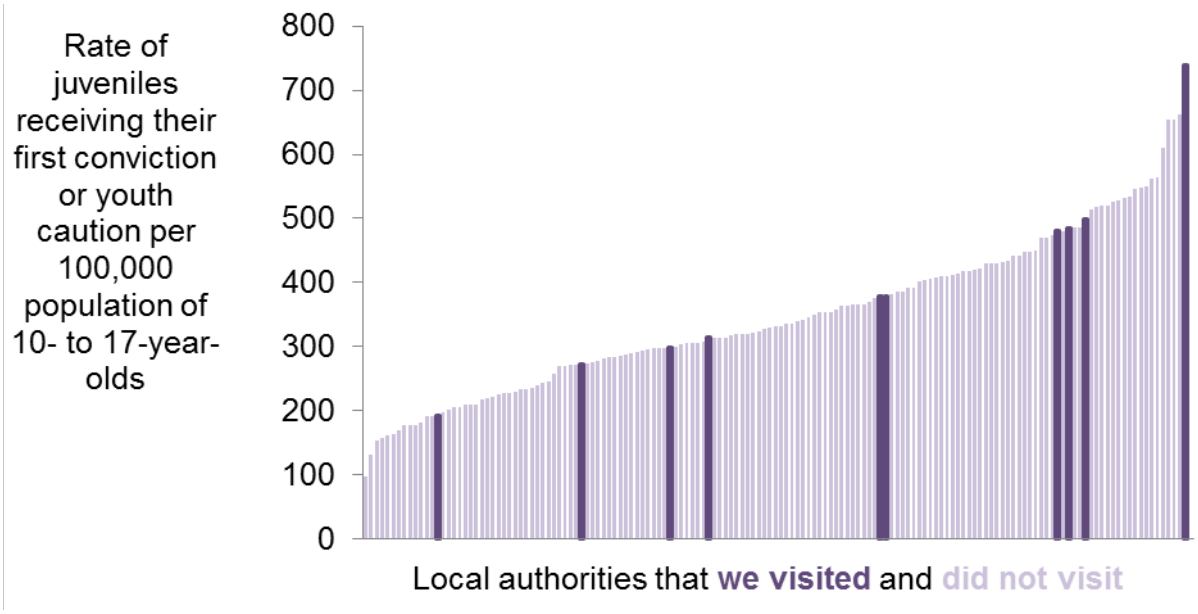
Figure 17. Reduction in the rate of juveniles receiving their first conviction or youth cautions from 2010 to 2016 in England



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

There was large national variance (see figure 18) in 2016. Within the areas we visited, the rate of juveniles receiving their first conviction or youth caution ranged from 193 to 740 per 100,000 population. Children entering the youth justice system are commonly from disadvantaged and deprived communities who have experienced abuse and neglect which can lead to emotional distress and mental health problems.[32] Therefore, national variation in the rate of juveniles receiving their first conviction or youth caution could reflect variation in other factors related to deprivation.

Figure 18. Variability in the rate of juveniles (10 to 17-year-olds) receiving their first conviction or youth caution per 100,000 population (2016)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Note: Data is not included for Isles of Scilly, City of London and Rutland due to suppression.

Variable prevalence of mental health needs for children and young people

Estimated prevalence

Figure 19 presents the percentage of children aged 5-16 estimated to have any mental health disorders by local authority based on the estimated prevalence from the mental health of children and young people in Great Britain survey from the Office for National Statistics in 2004. The values have been adjusted for age, sex and socio-economic classification to reflect estimated prevalence for 2015. In 2015, it was estimated 9% (or 701,006) five to 16-year-olds had mental health conditions.

Figure 19 shows the estimated prevalence of mental health conditions across local authorities in England. There is some national variation, with values ranging from 7% to 11% (and from 8% and 10% in the local authorities we visited). However, as the estimates are adjusted for age, sex and socio-economic classification variables, the map in figure 19 likely reflects variation in socio-economic factors rather than actual prevalence of mental health conditions. The map in figure 19 shows a very similar pattern to the map of the Index of Multiple Deprivation of local authorities in England (see appendix 1).

The map shows the local authorities with higher percentages of children and young people with mental health conditions (darker shading) seem to be in: a) the North of England; b) areas of London, such as, East and North East London; and c) around Birmingham. However, it is important to remember the difference between the local authorities with the lowest (7%) and the highest (11%) estimated prevalence is not particularly large. In addition, two local authorities may be placed in different quartiles but may have very similar values as the local authorities have been split into four equal groups. Therefore, the map should be considered in line with the benchmarking graph below the map to understand what the different quartiles reflect.

Caution should be exercised when using these estimated prevalence values. There are known data quality issues. The data is based on a baseline survey from 2004 and local prevalence is estimated each year based on the age, sex and socio-economic make-up of the local population at that time.[33] Furthermore, these values are based on grouping all mental health into one category. However, there is a move towards understanding mental ill-health as a number of different conditions with different severities and different needs for the children and young people (for example, the THRIVE model[34]). The results from the 2016 survey, due in 2018, will allow for an update of all of these prevalence rates.[35]

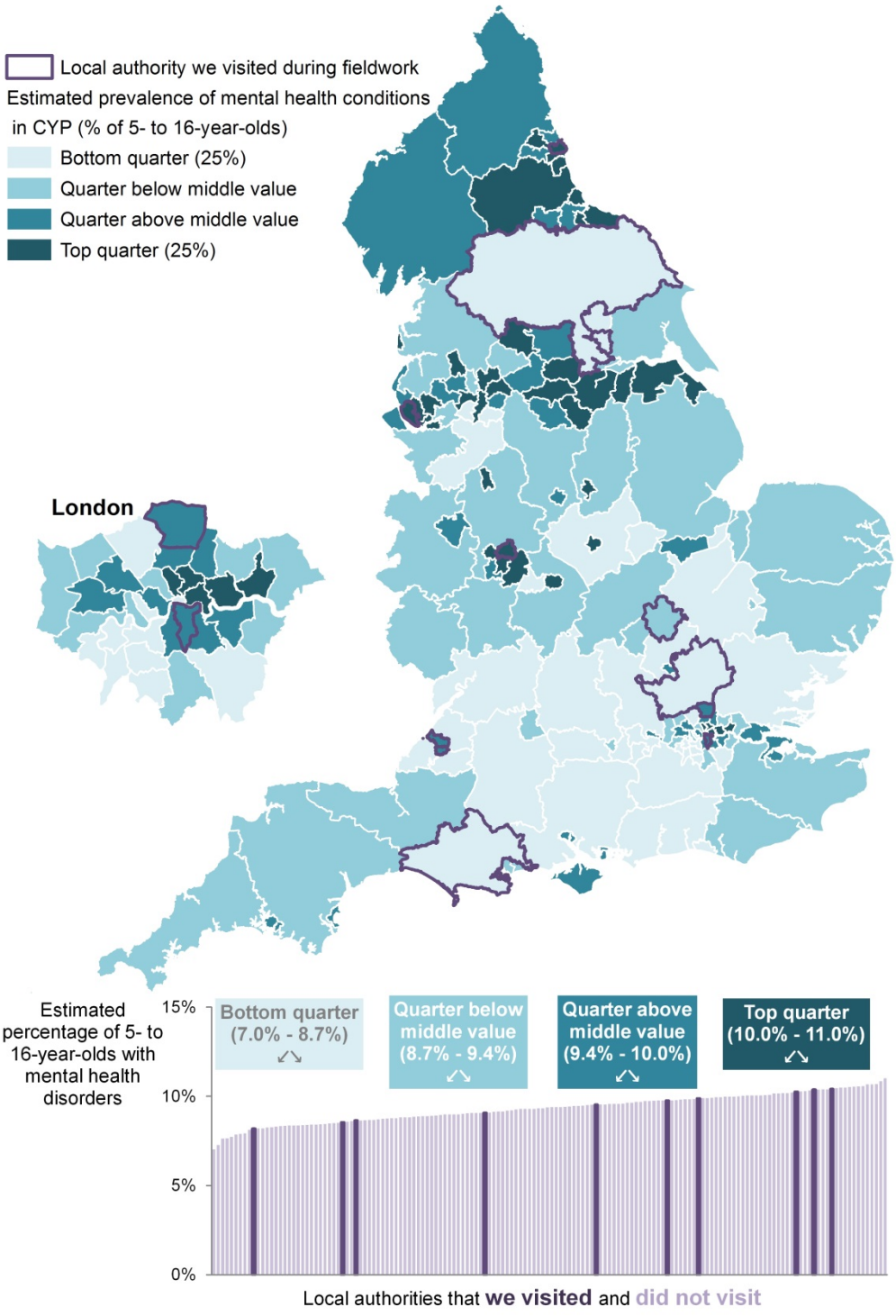
Social, emotional and mental health needs

Figure 20 presents the percentage of primary, secondary and special school pupils identified as having social, emotional and mental health needs[I] in 2015/16. There is some national variation in the percentage of pupils identified as having social, emotional and mental health needs, with values ranging from 1% to 5% (and from 1% and 3% in the local authorities we visited). In 2015/16, 184,276 (2%) pupils in England had identified social, emotional and mental health needs.

[I] School pupils where the primary need identified in their statement of special educational needs (SEN) is a social, emotional and mental health need.

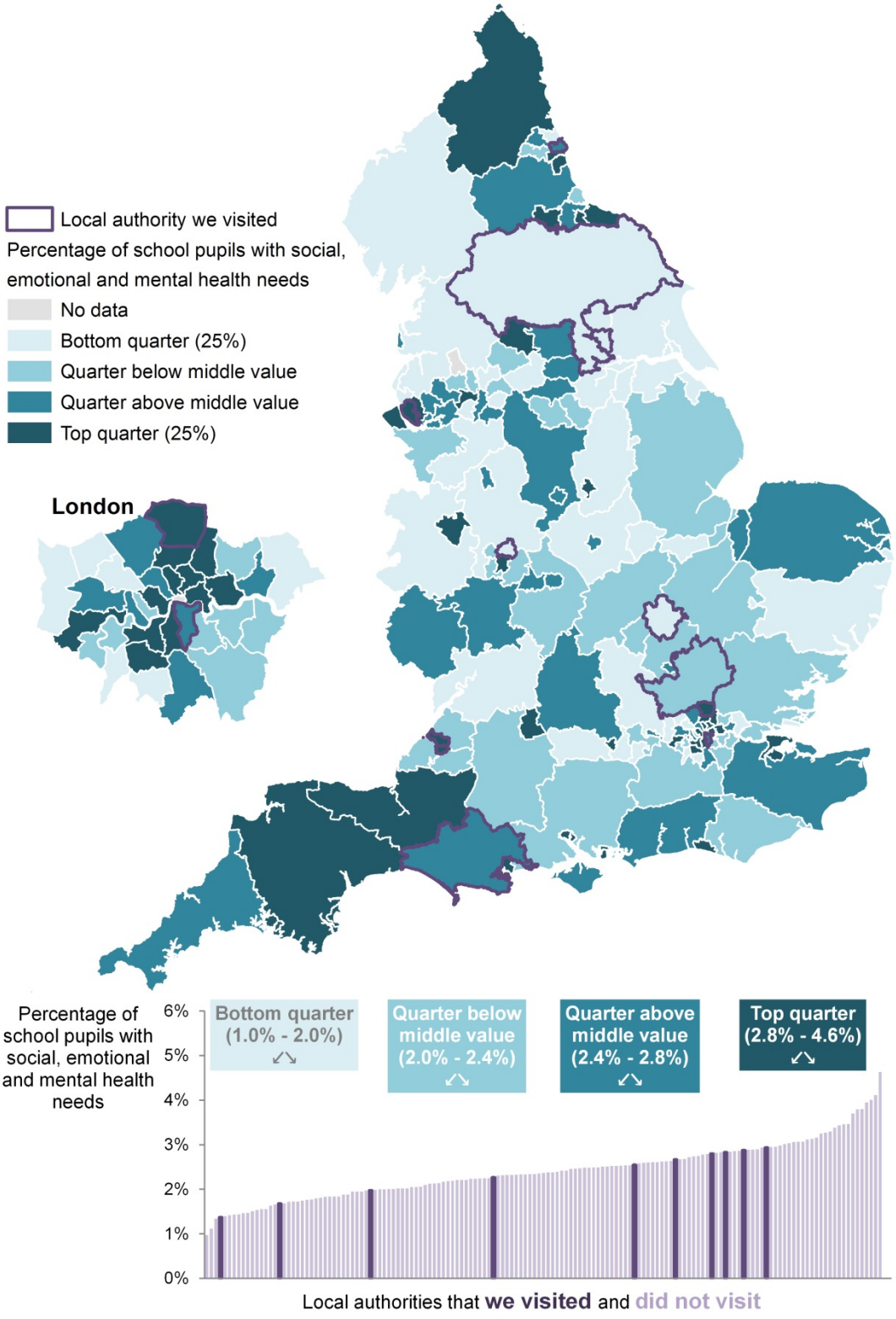
The national picture of the percentage of school pupils with social, emotional and mental health needs (see figure 20) is a little different from the estimated prevalence of mental health conditions (see figure 19). There are still areas in the north of England that are showing up with high social, emotional and mental health needs but there were also many local authorities in that region that were low. In addition, there are local authorities in the South West and London that seemed to have higher percentages of school pupils with social, emotional and mental health needs. The lowest and highest local authority ranged from 1% to 5%. The benchmarking graph below the map should be used to understand the different quartiles. For example, the middle 50% of local authorities only covers a range of 0.8% (from 2.0% to 2.8%), whereas the top 25% of local authorities covers a range of 1.8% (from 2.8% to 4.6%).

Figure 19. Variability in the estimated percentage of 5 to 16-year-olds with mental health conditions by local authorities in England (2015)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Figure 20. Variability in the percentage of primary, secondary and special school pupils identified as having social, emotional and mental health needs by local authorities in England (2015/16)



Source: Children and Young People's Mental Health and Wellbeing Profiling Tool, Public Health England

Variation in prevalence for children and young people in different circumstances

Particular groups of children and young people are particularly at risk. A child's gender, socioeconomic status, ethnicity, disability, sexual orientation and whether or not they are a looked after child or in the youth justice system all can have an impact on their development. In addition, adverse childhood events have a strong influence on the chances of developing mental health problems, including being the victim of: physical abuse; sexual abuse; domestic violence; emotional neglect; emotional abuse; living with an alcoholic or drug abuser; or having a parent in prison.[36] Below we highlight some reports focusing on these risk factors. These reflect reports that were recommended to us and cannot be considered a review of the literature. We have not analysed any nationally available data for this section. This section should be considered alongside the review of literature from phase one.

Gender

The Centre for Longitudinal Studies and the National Children's Bureau reviewed data on the prevalence of mental health problems among children taking part in the Millennium Cohort Study.[37] Data on mental health problems was collected using parent-report surveys when their child was three, five, seven and 14 years old and young people reported about their own depressive symptoms at 14 years.[m] A similar number of girls and boys suffered emotional problems from ages 3 to 11 years, according to their parents. Although the proportion of boys suffering from emotional problems remained similar from 11 to 14 years, the proportion of girls increased from 12% to 18%. When children reported on their own depressive symptoms at 14 years, 24% of girls and 9% of boys were suffering from high symptoms of depression. Across ages, parents of boys reported more conduct and disruptive behaviour problems than for girls.

Sexual identity

The School Report by Stonewall and the Centre for Family Research[n] found alarmingly high rates of poor mental health for lesbian, gay or bisexual young people.[38] For example, three in five (61%) lesbian, gay and bisexual pupils had self-harmed, which the report compared to the NHS estimates that around one in 10 young people had-self harmed. However, there were differences in rates of self-harm within the lesbian, gay and bisexual pupils. For example, young people who are bisexual or identify as another term such as pansexual or queer were more likely to self-harm (67% and 79%, respectively) compared to lesbian or gay young people (59%). Furthermore, disabled LGBT young people are more likely to self-harm than non-disabled LGBT young people (80% compared to 64%).

Lesbian, gay and bisexual pupils were more likely to consider taking their own life. Seven in 10 (70%) had thought about this, which the report compared to the Young Minds estimates that one in four young people have had these thoughts. One in five (22%) had attempted to take their own life, which the report compared to the NHS estimates of 13% of females and 5% of males aged 16-24 that had attempted to take their own life in the general population.

[m] The Millennium Cohort Study follows a representative sample of 19,517 children born across England, Scotland, Wales and Northern Ireland in 2000-01.

[n] The Centre for Family Research at the University of Cambridge conducted a survey for Stonewall about the experiences at school, online and at home of lesbian, gay, bi or trans (LGBT) young people. 3,713 young people aged 11 to 19 years old who were in secondary schools and colleges across Britain completed the survey online. Eighty-two per cent of the sample was from England. The sample varied by gender identity, sexual orientation, ethnicity, type of school they attended and whether they had a disability or received free school meals.

Again the school report found differences in the percentage of lesbian, gay and bisexual pupils who had considered taking their own life. Young people who used a different term to describe their sexual orientation (such as pansexual or queer) were more likely to consider taking their own life than lesbian, gay and bisexual young people (86% of young people identifying with a different term, 74% of bisexual young people and 71% of lesbian and gay young people). A higher percentage of disabled LGBT young people (87%) had considered taking their own life compared to nondisabled LGBT young people (73%). Furthermore, nearly half (48%) of disabled LGBT young people had attempted to take their own life. Higher rates of attempts to take their own life were also found for LGBT pupils who receive free school meals (40%) and LGBT pupils of faith (30%).

Gender identity

Stonewall found that while rates of poor mental health in LGBT young people was worryingly high, transgender young people seemed to be at particular risk.[39] More than four in five transgender young people (84%) had self-harmed at some point. Nine in 10 transgender young people (92%) had considered taking their own life and more than two in five transgender young people (45%) had attempted to take their own life at some point.

Concerns are also high for young people who identify as non-binary. More than four in five non-binary young people (84%) had self-harmed. Nine in 10 non-binary young people (89%) had thought about taking their own life and one in three (35%) had tried to take their own life.

Ethnicity

In the Millennium Cohort Study, children's reports of their own depressive symptoms varied by ethnicity. Girls from mixed and White ethnic backgrounds were the most likely and Black African girls the least likely to report high depressive symptoms. Boys from mixed and other[o] ethnic groups were the most likely and Bangladeshi and Indian boys the least likely to report high depressive symptoms.[40]

Family income

In the Millennium Cohort Study, family income was associated with reports of depressive symptoms, with children from higher income families less likely to report high depressive symptoms. Furthermore, the School Report highlighted that LGBT young people who were also receiving free school meals had higher rates of attempting to take their own life (40%) than LGBT young people who were not receiving free school meals (25%).

Young carers

Young carers are at increased risk of missing out on education and social opportunities, and may be carrying a significant emotional burden.[41] A Children's Society report found that young carers are 1.5 times more likely to have a disability, long-term illness or special educational need. This finding is in line with the census data showing that over 2,000 young carers had bad or very bad health problems.[42] Another found that almost a third (29%) had their own physical health problem and over a third of young carers (38%) reported having a mental health problem.[43] Young carers (aged five to 17 years old) that provided 50 or more hours a week of unpaid care were five times more likely to report their general health was 'not good' compared to those not providing unpaid care.[44]

[o] Ethnicity was broken down into the following ethnic backgrounds: White, Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, Mixed and Other.

Looked after children
Of those children who have identified special education needs (SEN), looked after children are more likely to have social, emotional and mental health problems than their peers who are not looked after but do have a SEN. Their peers are more likely to experience problems associated with autism and speech and language.[45]

Children and young people with long-term illness, disability or medical conditions
As noted above, disabled LGBT young people are more likely to self-harm (80% compared to 64%), consider taking their own life (87% compared to 73%) and attempt to take their own life (48% compared to 22%) compared to nondisabled LGBT young people.

Variable access to mental health care for children and young people

Referrals (by referral source) to mental health services for children and young people

The number of referrals of children and young people (aged 0-18) referred to mental health services across England (by referral source) was examined using Mental Health Services Dataset (MHSDS) data. The number represents referrals to mental health services (either children and young people or adult services) for children and young people aged 0-18 years.

Data from August 2016 to July 2017 was examined and was found not to fluctuate much in terms of the numbers and proportions of referral sources. The most recent set of data from July 2017 is presented in table 1. Most referrals of children and young people to mental health services were from primary health care (39%) followed by local authority services (13%). The lowest number of referrals were made by improving access to psychological therapies (IAPT) (0.1%).

Table 1: Referrals of 0-18 year olds to mental health services in England (July 2017)

Referral source	Number	Percentage
Primary health care	16,133	39%
Local authority services	5,370	13%
Other	4,814	12%
Acute secondary care	4,102	10%
Internal	2,503	6%
Child health	2,277	5%
Internal referrals from community mental health team (within own NHS trust)	2,236	5%
Self-referral	1,868	4%
Justice system	1,394	3%
Invalid[p]	197	0.5%
Transfer by graduation (within own NHS trust)	185	0.4%
Independent/voluntary sector	177	0.4%
Internal referrals from inpatient service (within own NHS trust)	155	0.4%
Other mental health NHS trust	126	0.3%
Employer	49	0.1%
Improving access to psychological therapies	42	0.1%
England total	41,628	100%

Source: MHSDS Monthly Statistics, NHS Digital

Note: This table excludes a total of 4,952 referrals that were categorised as 'missing'.

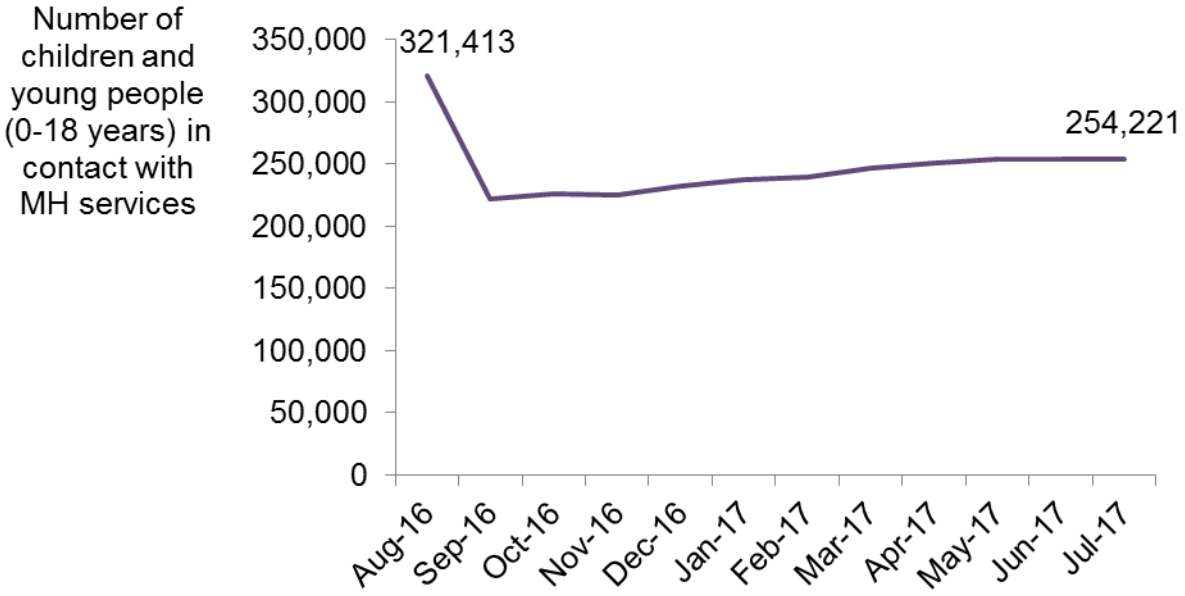
There are known data quality issues with MHSDS, including underreporting as some providers did not submit their data for processing in the national database. More details are provided below in the section on gaps and quality issues with data about access to mental health care.

[p] Invalid was coded for any entry that did not come under one of the other referral sources.

Contacts with mental health services for children and young people

Figure 21 shows the number of children and young people (aged 0-18) who had any contact with mental health services (children and young people *or* adult services) from August 2016 to July 2017. The number of children and young people in contact with mental health services decreased from August (321,413 children and young people) to September 2016 (221,840 children and young people), but this figure has been rising slightly from September 2016 to July 2017. However, there are known data quality issues with MHSDS, including underreporting as some providers did not submit their data for processing in the national database. Therefore, this drop could also reflect data quality issues rather than a real drop in the number of children and young people in contact with mental health services. More details are available in the section on gaps and quality issues with data about access to mental health care.

Figure 21. Number of children and young people (0-18 years) in contact with mental health (MH) services in England



Source: MHSDS Monthly Statistics, NHS Digital

Gaps and quality issues with data about access to mental health care

There are a number of gaps and quality issues with data around access to mental health care. Data around access to mental health care does not provide clear and reliable measures across the whole system of the number and source of referrals, number of children and young people meeting eligibility criteria following referral, and the number of contacts with services (see appendix 3 for data quality issues for indicators included in the data profile).

The JSNA toolkit for children and young people provides guidance to support joint strategic needs assessments for mental health care for children and young people.[46] The guidance highlights gaps in data, noting there is little data currently available at a national level that focuses on services for mental health care for children and young people. MHSDS, which includes children and young people's mental health from January 2016, is trying to fill this data gap. A monthly report from the MHSDS, published by NHS Digital, provides an overview

of access for some services for mental health care for children and young people (0 to 18 years). The dataset was expanded in January 2016 to include people in contact with mental health, learning disability and autism services for children and young people. The MHSDS monthly statistics is classed as experimental so should be treated with caution. It is likely to require significant time for the data quality of MHSDS to be assured and providers will be key in improving the data quality.

The consolidation of the CAMHS dataset into MHSDS has taken a long time, and the first data started to flow from January 2016. The coverage of the data is still being assessed, but it looks as though it could be improved: it is clear that not all providers who ought to be supplying data are doing so at present. CQC intends to do what it can to make sure that this data is collected and submitted. We also plan to make use of it to monitor the availability and the outcome of mental health and learning disability care provided to children and young people.

In addition, data around unmet needs is missing. For example, we do not have data that tracks vulnerable groups and indicates whether they are accessing services, for example, looked after children or children from Black and minority ethnic populations. We also do not have data about the number of children and young people in need of mental health services that are not able to access them, for example, because they are not able to get a referral to CAMHS or their referral is rejected. Some of this information is held locally. Therefore, studies that have made use of freedom of information requests can provide some insights (see section on access to care and thresholds below).

Data is also not available for transition between services and whether these transitions are monitored nationally. For example, we do not have data on the number of referrals from GPs and whether the GPs referred the children and young people to A&E or to specialised CAMHS services. In addition, we do not have data about transitions between paediatrics and specialised CAMHS care, or data about where schools recommended children and young people went for care.

Given the lack of nationally available data, some areas have focused on collecting local data on outcomes and feedback from children and young people, parents and carers. Some areas will have joint strategic needs assessments that provide more granular data on calculated local rates of incidence, prevalence, identified and treated children and young people. This should be considered in line with the summary of fieldwork evidence to understand what the areas we visited were doing to monitor local data. The Child Outcomes Research Consortium (CORC) provides support to registered members around collecting and improving data quality about children and young people mental health and wellbeing outcomes (according to the JSNA guidance).[47]

Review of others' findings

These reflect reports that were recommended to us and cannot be considered a review of the literature. We have not analysed any nationally available data for this section. This section should be considered alongside the review of literature from phase one.

Access to care and thresholds

Future in mind reported that the 2004 prevalence survey suggested that only 25% to 35% of children and young people needing support for their mental health were able to access services at the time of the survey.[48] Many children and young people do not meet the thresholds to access CAMHS. The Children's Society estimate that around 30,000 children

and young people are turned away from specialist CAMHS each year.[49] The Education Policy Institute sent a freedom of information request to 67 child and adolescent mental health service (CAMHS) providers in April 2017 for their report on access and waiting times.[50] Eighty-five per cent of providers responded in time to be part of the final sample. Just over a quarter (26%) of referrals to specialist CAMHS were rejected in 2016/17, which has increased from 21% in 2012/13. Not meeting the eligibility criteria was the most frequent cause for rejection.

The CAMHS benchmarking project (2016) reported on 100 submissions received from 77 individual participants across the UK.[51] The report highlights that half of referrals to CAMHS do not result in an offer of a CAMHS service following either a paper triage or face-to-face assessment.

Waiting times

For those children and young people who are accepted, there are often long waits. New data suggests children and young people are waiting, on average, 58 days for an assessment and a further 41 days to begin treatment.[52] The CAMHS benchmarking report (2016) found the average wait from referral to treatment is 17 weeks for community CAMHS services, with half of children and young people seen within 11 weeks. The average longest wait was 26 weeks. Inpatient CAMHS services show significant variation depending on sub-specialty bed type.[53]

According to the Education Policy Institute, waiting times have reduced a little from 2015/16 to 2016/17.[54] The average time to wait for an assessment was 33 days or 4.7 weeks (down from 39 days or 5.6 weeks) and for treatment was 56 days or 8 weeks (down from 67 days or 9.6 weeks). There has been no clear pattern in median waiting times over the last five years, but the most recent year is the lowest it has been across these five years. There is variation regionally. Children and young people in London had the longest waits to start treatment and children and young people in the Midlands and East of England had the shortest waits. There was a lot of difference in waiting times between providers too, with waits to treatments ranging from five to 112 days.[55]

Missed appointments

In their review of missed appointments, the Children's Society sent out freedom of information request to 50 NHS providers of specialist mental health services in England in April 2017, receiving responses from 39 providers. These responses indicated that approximately 157,000 appointments with specialist CAMHS were missed by children and young people aged 10 to 17 years old in 2016. This level of missed appointments is important given it means that children and young people are not receiving the help that they need and there is a substantial economic impact for specialist CAMHS. The Children's Society estimated this would be over £45 million a year based on the number of missed appointments. The Children's Society noted it is not surprising that children and young people give up on accessing CAMHS given the difficult thresholds and long waits.

Many missed appointments are never followed up and thousands of children and young people are discharged from services having missed repeated appointments. This discharge from services will mean the mental health needs of many children and young people are likely to get worse and potentially reach crisis point. There are Serious Case Reviews where children and young people have died and repeat missed appointments were identified as an important weakness in the safeguarding of the children and young people.[56]

Inpatient provision

In December 2015, there were 1,440 CAMHS inpatient beds in the NHS in England (a 71% increase since 1999).[57] Almost half (around 47%) of inpatient beds are run by independent providers, compared to only a quarter in 1999. Having sufficient beds is not just about overall capacity but where the beds are regionally and by speciality. There are 2.5 beds per 100,000 total population, on average, in England. The North East has the greatest level of provision (three beds/100,000) and the South West the lowest (one bed/100,000). The Royal College of Psychiatrists has proposed that between two and four beds per 100,000 population is appropriate. The average ratio for England is at the low end of this scale and Yorkshire and Humber and the South West are below this ratio. On three occasions in the last financial year there were no beds available in at least one region of England.

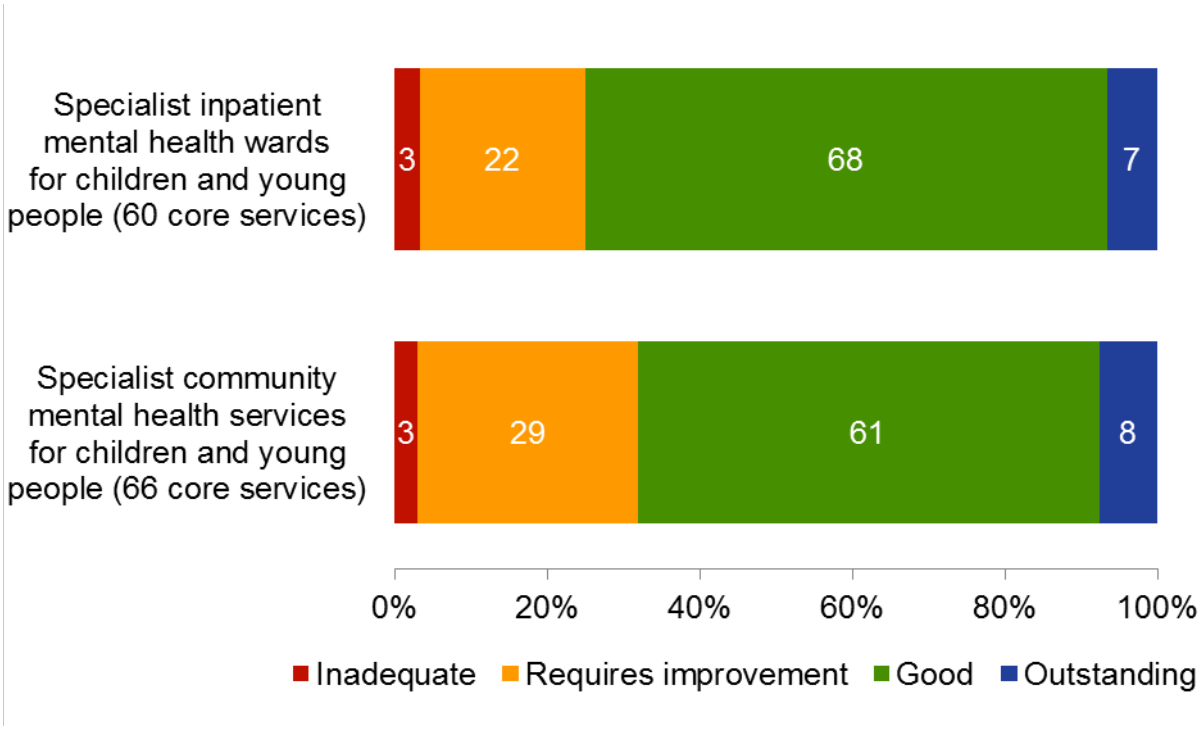
The CAMHS benchmarking report (2016) found that children and young people were staying as inpatients longer than previous years. The report also found low bed occupancy in Tier 4 CAMHS remains an issue as does the high level of incidents reported.[58]

Variable experiences of mental health care and outcomes for children and young people

Current CQC ratings for specialist child and adolescent mental health core services

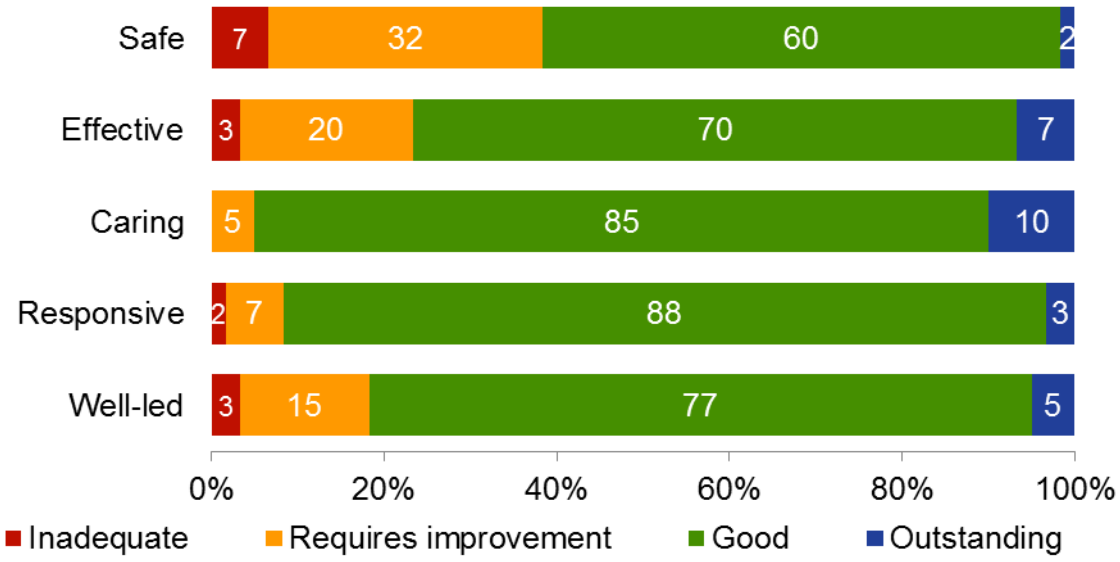
The current CQC ratings for specialist child and adolescent mental health services (CAMHS), as at 16 October 2017, are provided in figures 22 to 24. Figure 22 shows that the majority of specialist community and specialist inpatients services were rated good or outstanding. There are still, however, a number of services that are rated requires improvement or inadequate.

Figure 22. CQC Overall ratings of specialist CAMHS services (2017)



Source: CQC ratings, as at 16 October 2017

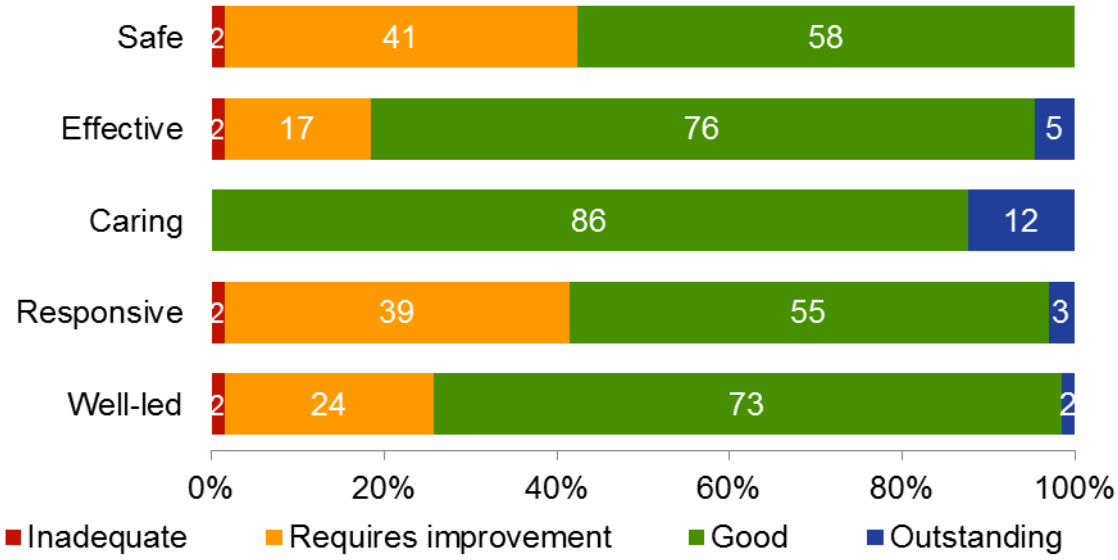
Figure 23. CQC ratings of specialist inpatient wards by key question (2017)



Source: CQC ratings, as at 16 October 2017

Figure 23 illustrates that the majority of specialist inpatient wards were rated good or outstanding across the five key questions that CQC inspects services against. The safe and responsive domains were the areas that were rated the lowest across the five domains. Figure 24 illustrates that the majority of specialist community mental health services were rated good or outstanding across the five key questions that CQC inspects services against. The safe and effective domains were the areas that were rated the lowest across the five domains.

Figure 24. CQC ratings of specialist community mental health services by key question (2017)



Source: CQC ratings, as at 16 October 2017

Changes over time in CQC ratings for specialised CAMHS core services

This section provides an overview of change in CQC ratings data. The change in ratings data examined the first rating given to CAMHS services, under CQC's latest inspection framework (2014) and their current ratings. Not all services have been inspected more than once and, therefore, the number of services considered here is a subset of the full sample of services that have current ratings. Change in ratings for specialist inpatient wards and specialist community mental health services are provided in a series of tables for overall, safe and responsive key questions. Colour coding in the table signifies change, with green font showing an improvement, red showing a worsening and black showing no change in rating.

The numbers should be considered with caution. Only 23 inpatient wards and 18 community services have been re-inspected and therefore the re-inspection of one or two services could have an effect on the findings. For specialist inpatient wards, the overall ratings of 11 services improved, five services worsened and seven services stayed the same. For specialist community mental health services, 10 services improved their overall ratings, two services worsened and six services stayed the same (see table 2).

Table 2. Change in CQC overall ratings of specialist inpatient wards and specialist community mental health services (2017)

Service	First rating	Current rating	Change	Number
Inpatient wards	Inadequate	Requires improvement	Improve	1
	Inadequate	Good	Improve	1
	Requires improvement	Inadequate	Worsen	1
	Requires improvement	Requires improvement	No change	1
	Requires improvement	Good	Improve	7
	Good	Inadequate	Worsen	1
	Good	Requires improvement	Worsen	3
	Good	Good	No change	6
	Good	Outstanding	Improve	2
Community services	Inadequate	Requires improvement	Improve	1
	Requires improvement	Inadequate	Worsen	1
	Requires improvement	Requires improvement	No change	3
	Requires improvement	Good	Improve	9
	Good	Requires improvement	Worsen	1
	Good	Good	No change	2
	Outstanding	Outstanding	No change	1

Source: CQC ratings, as at 16 October 2017

Table 3. Change in CQC Safe ratings of specialist inpatient wards and specialist community mental health services (2017)

Service	First rating	Current rating	Change	Number
Inpatient wards	Inadequate	Requires improvement	Improve	1
	Requires improvement	Good	Improve	5
	Good	Inadequate	Worsen	1
	Good	Requires improvement	Worsen	2
	Good	Good	No change	12
	Good	Outstanding	Improve	1
Community services	Inadequate	Requires improvement	Improve	1
	Requires improvement	Inadequate	Worsen	1
	Requires improvement	Requires improvement	No change	5
	Requires improvement	Good	Improve	6
	Good	Requires improvement	Worsen	1
	Good	Good	No change	4

Source: CQC ratings, as at 16 October 2017

For specialist inpatient wards, the safe ratings of 15 services improved, three services worsened and five services stayed the same. For specialist community mental health services, the safe ratings of 10 services improved, one service worsened and seven services stayed the same (see table 3).

For specialist inpatient wards, the responsive ratings of seven services improved, three services worsened and 12 services stayed the same. For specialist community mental health services, the responsive ratings of seven services improved, two services worsened and nine services stayed the same (see table 4).

Table 4. Change in CQC Responsive ratings of specialist inpatient wards and specialist community mental health services (2017)

Service	First rating	Current rating	Change	Number
Inpatient wards	Inadequate	Requires improvement	Improve	1
	Requires improvement	Good	Improve	4
	Good	Inadequate	Worsen	1
	Good	Requires improvement	Worsen	2
	Good	Good	No change	13
	Good	Outstanding	Improve	1
Community services	Inadequate	Requires improvement	Improve	1
	Requires improvement	Inadequate	Worsen	1
	Requires improvement	Requires improvement	No change	5
	Requires improvement	Good	Improve	6
	Good	Requires improvement	Worsen	1
	Good	Good	No change	4

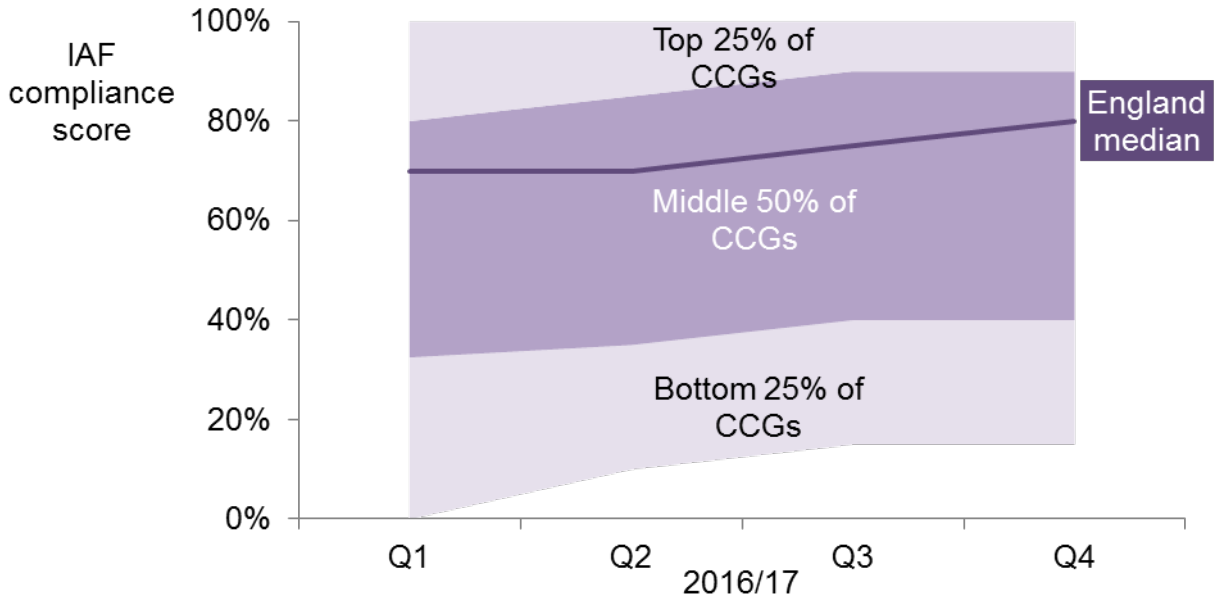
Source: CQC ratings, as at 16 October 2017

Clinical Commissioning Group Improvement and Assessment Framework CAMHS transformation milestones score

NHS England reported that improving the mental health and wellbeing support offered to children and young people is a key priority in the *Five Year Forward View for Mental Health* and *Future in Mind*. As part of this, the ambition for clinical commissioning groups (CCGs) and their partners is to build effective, evidence-based outcome-focused CAMHS, working in collaboration with children, young people and families. The children and young people mental health transformation programme has been designed to address a range of issues including, for example, supporting commissioners to develop integrated services with clear care pathways from early intervention to crisis and inpatient care, supporting the introduction of new community eating disorder teams for children and young people and working with Health Education England and other partners to support workforce planning.[59]

As part of the Improvement and Assessment Framework (IAF) CAMHS transformation plan, NHS England developed an indicator to focus on the extent to which the CCGs, working with partners, have complied with updating and publishing an assured local transformation plan that includes baseline data to deliver system wide transformation in children and young people's mental health outcomes that has set agreed local trajectories for improvement towards 2020. CCGs IAF CAMHS transformation milestones scores are calculated as a percentage based on level of compliance with a list of service expectations.[q]

Figure 25. CCG IAF CAMHS transformation Milestones scores (2016/17)



Source: CCG IAF Mental Health Transformation Milestones score from the Mental Health Five Year Forward View dashboard, NHS England.

Figure 25 displays the IAF compliance scores for the top 25%, bottom 25%, and middle 50% of CCGs for all four quarters of 2016/17. Based on the median compliance scores of CCGs in England, compliance levels rose from Q2 to Q4. However, there was a lot of variation in

[q] The six questions are:

1) Has the CCG working with partners updated and re published the assured local transformation plan (LTP) from 2015/16 which includes baseline data?
2) Is the dedicated community eating disorder service commissioned by the CCG providing a service in line with the model recommended in the access and waiting time and commissioning guidance?
3) Is the Children and Young People's Eating Disorder Team commissioned by the CCG part of a quality assurance network?
4) Does the CCG have collaborative commissioning plans in place with NHS England for tier 3 and tier 4 CAMHS
5) Has the CCG published joint agency workforce plans detailing how they will build capacity and capability including implementation of Children and Young People's Improving Access to Psychological Therapies programmes (children and young people IAPT) transformation objectives?
6) Is the CCG forecast to have increased its spend on Mental Health Services for Children and Young People by at least their allocation of baseline funding for 2016/17 compared to 2015/16, including appropriate use of the resources allocated from the Autumn Statement 2014 and Spring Budget 2015? (sourced from CCG financial submission to NHS England)

compliance in every quarter. For example, in Q1 some CCGs had 0% compliance whereas others had 100% compliance. Not all CCGs had data for one of the questions (question 6) due to data quality issues. The first five questions were self-assessed by the CCGs. These caveats should both be remembered when viewing the data.

Use of the Mental Health Act 1983 for under-18s

There are a number of different ways in which a child or young person can be detained under the Mental Health Act 1983.

Section 136 detentions

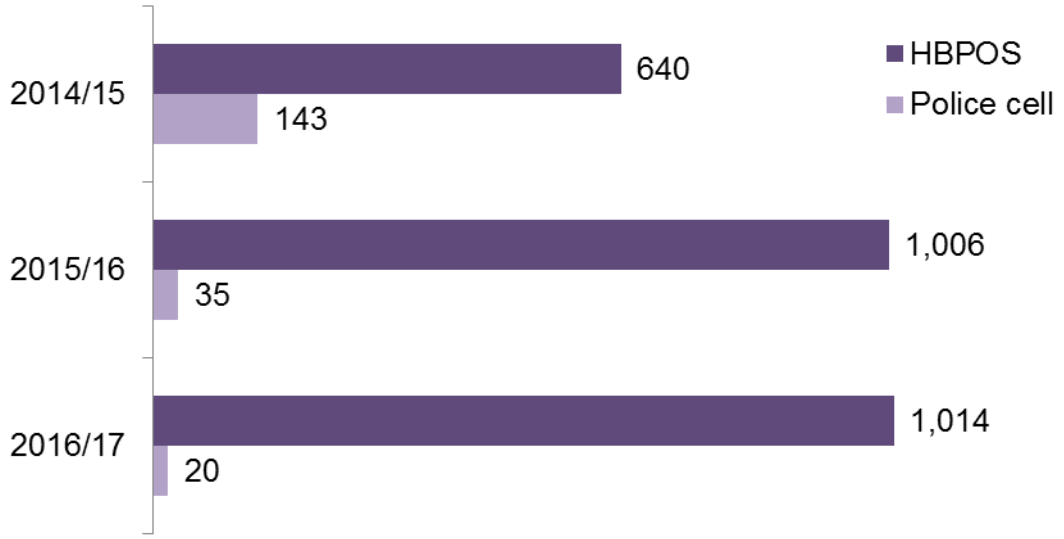
A section 136 detention gives police emergency power to take a child or young person to a place of safety if a police officer considers that the individual is suffering from mental illness and in need of immediate care. It is the type of detention that is often discussed in the context of sectioning and can be a challenging experience for a child or young person who has gone through the process. In 2015, *Future in Mind* set out the aspiration that no young person under the age of 18 should be detained in a police cell as a place of safety.[60] Therefore, it is important to review where children and young people are taken following a section 136 detention and whether this has changed over time. CQC has a map of health-based places of safety in England on our website.

The number of section 136 detentions[r] increased by 33% from 783 detentions in 2014/15 to 1,041 detentions in 2015/16. Figure 26 shows the number of children and young people detained under section 136 who were taken to a health based place of safety (HBPOS) or a police cell. More children and young people were taken to a HBPOS than a police cell every year. The number of children and young people taken to a police cell has decreased substantially since 2014/15. However, the aspiration was that no young person should be detained in a police cell. Therefore, the 20 detentions taken to a police cell means this aspiration has not yet been met.

For 2014/15 and 2015/16, section 136 detentions data was collected by the National Police Chiefs Council (NPCC). For 2016/17 this data was collected by the Home Office. The NPCC provided data explicitly for the number of detentions taken to police cells and the number of detentions taken to a HBPOS for individuals aged under 18. However, the Home Office data only provided the number of under 18-year-olds that were taken to police cells and the total number of detentions. Therefore, the number of detentions taken to a HBPOS was calculated by subtracting the number of detentions in police cells from the total number of detentions. Therefore, the value presented for HBPOS for 2016/17 includes a combination of HBPOS, accident and emergency used as place of safety, private home, and other or not known.

[r] Sum of section 136 detentions taken to a health based place of safety and to a police cell.

Figure 26. Number of section 136 detentions taken to a health based place of safety (HBPOS) or a police cell for children and young people under 18 years



Source 2014/15-2015/16 data: Use of Section 136 of the Mental Health Act 1983 in England and Wales, National Police Chiefs Council (NPCC)

Source 2016/17 data: Police powers and procedures England and Wales ending 31 March 2017, Home Office

All detentions under the Mental Health Act 1983

NHS Digital has recently published the annual figures for the Mental Health Act Statistics. This data showed that the rate of detentions across England for individuals aged 17 and under was nine per 100,000.[61] However, NHS Digital notes that this figure is likely to be underreported as the data is derived from the Mental Health Services Dataset (MHSDS), which is incomplete as some providers did not submit their data or submitted incomplete data.[62] The Mental Health Act Statistics dataset is new and currently considered 'experimental statistics'.

Community treatment orders (CTOs)

A CTO is part 17A of the Mental Health Act. If a child or young person has been sectioned and treated in hospital under certain sections, their responsible clinician can apply for them to be put on a CTO. This means that the individual can be discharged from the section and leave hospital, but might have to meet certain conditions such as living in a certain place or going somewhere for medical treatment. The Mental Health Act Statistics showed the rate of CTOs in England for individuals aged 17 and under was 0.3 per 100,000.[63] However, this figure is likely to be lower than actual levels due to the issues raised about the Mental Health Act Statistics dataset described above.

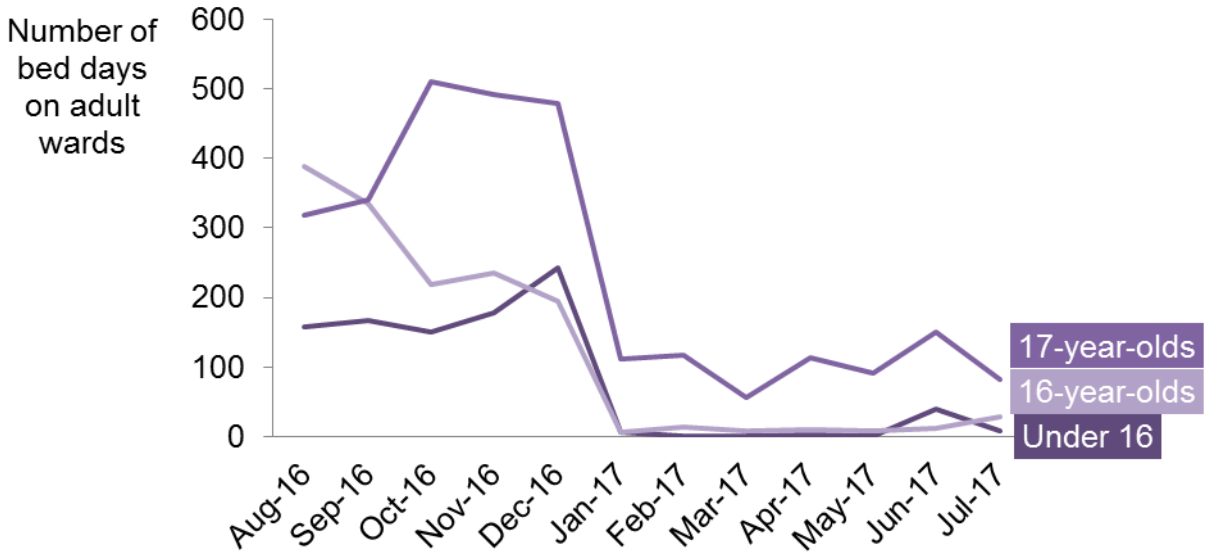
Bed days spent on adult wards

Although providers of CAMHS have a duty to prevent children and young people staying on adult wards under the Mental Health Act 2007, when there are pressures on CAMHS inpatient beds, children and young people are sometimes admitted to adult mental health

wards. The Education Policy Institute[s] reported that 83 under 18-year-olds were treated on adult wards for a total of 2,700 days in Q3 2016/17 (October to December).[64]

Monthly MHSDS statistics from August 2016 to July 2017 provide insight into how many bed days children and young people spent on adult wards as the data is broken down into three age groups: 17-year-olds, 16-year-olds and under 16-year-olds. Figure 27 illustrates that the number of bed days spent on adult wards has reduced considerably from August 2016 to July 2017 for all three age groups. Out of the three groups, 17-year-olds spent the highest number of bed days on adult wards across time (except for August 2016).

Figure 27. Number of bed days spent on adult wards by age group



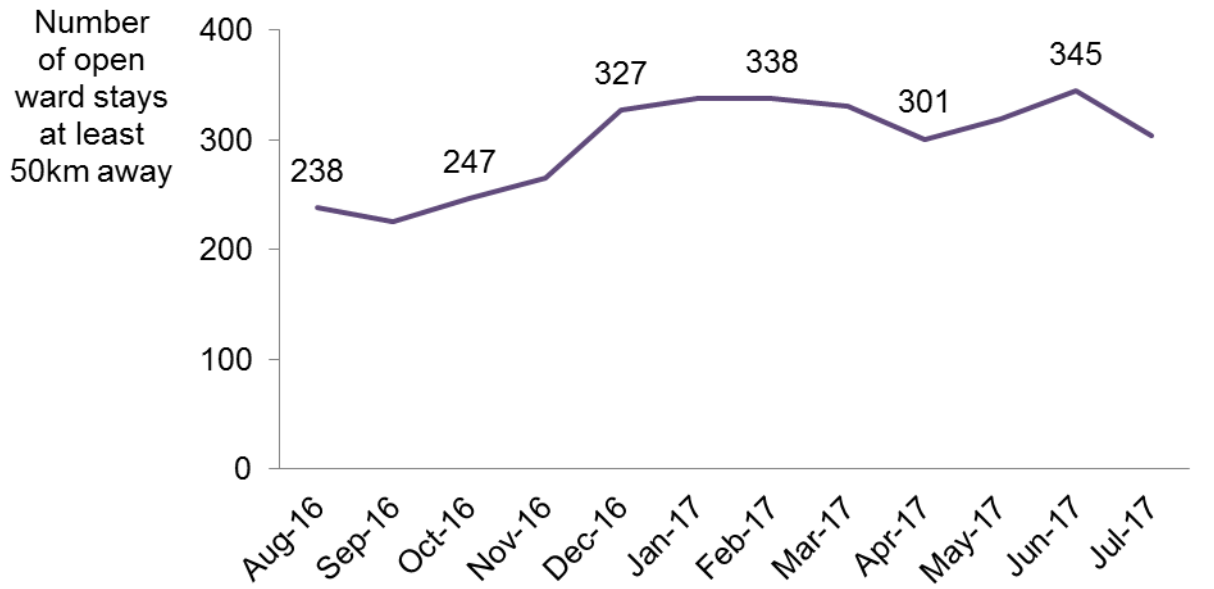
Source: MHSDS Monthly Statistics, NHS Digital

Ward stays at least 50km away

Figure 28 shows monthly MHSDS statistics for August 2016 to July 2017 for the number of inpatient ward stays children and young people (aged 0-18) had that were at least 50km away from their homes. The number of ward stays has generally risen from August 2016 to July 2017, with the highest count taking place in June 2017 (345 open ward stays). There was a 28% increase in the number of ward stays children and young people had at least 50km away from home when comparing August 2016 figures (238 open ward stays) with the most recent figures in July 2017 (304 open ward stays).

[s] The Education Policy Institutes review of inpatient provision focused on existing literature and data. The purpose of the paper was to establish what is currently known about inpatient mental health services for children and young people. The review covered data from MHSDS, the NHS England Five Year Forward View for Mental Health Dashboard, and data provided by NHS England on request.

Figure 28: Total number of ward stays at least 50km away from home for children and young people aged 0-18 across England



Source: MHSDS Monthly Statistics, NHS Digital

Experiences of children and young people with mental health conditions accessing care for their physical health needs (the Children and young people's Survey)

The 2016 Children and young people's inpatient and day case survey considered patients admitted to an acute hospital as an inpatient or day case and aged between 15 days and 15 years when discharged between the 1 October and 31 December 2016. CQC received 34,708 completed questionnaires (response rate of 26%) from respondents. Participants responded in relation to care received from a total of 132 acute (specialist and non-specialist) trusts (see appendix 4 for further details). It is important to note, the survey focuses on children and young people's care in acute hospitals and excludes psychiatry patients, including those receiving care from CAMHS services. Therefore, the findings below focus on the experiences of children and young people with mental health conditions receiving care in acute hospitals for physical health needs.

Questionnaires covered a range of questions grouped into themes that children and young people aged 8-15, as well as parents of children and young people aged 0-15, answered. Three questionnaires were used as each one was appropriate for a different age group: 0-7, 8-11, 12-15. Questionnaires sent to those aged 8-11 and 12-15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete. Where a child was aged 0-7, the questionnaire was completed entirely by their parent or carer.

Table 5 includes the themes and questions which children and young people, and their parents, provided responses. Statistical tests were used to highlight significant differences[t] between the means of different groups of children and young people from the overall mean of the whole sample. Table 5 also shows differences in responses between children and young people, and their parents, with and without mental health conditions.

Children and young people with mental health conditions reported poorer experiences around information and communication, including feeling like staff were not talking to them or answering their questions. These children were less likely to report they understood what they were being told when they were admitted to acute hospitals. Children and young people also reported poorer experiences of transition and continuity, which included not knowing what was going to happen or receiving advice about how to look after themselves when they left the hospital. These children and young people were also less likely to feel involved in care and treatment decisions or feel that they were given privacy when receiving their care.

Similarly, parents of children and young people with mental health conditions were less likely to report that those looking after their children knew how to show respect for their child's individual needs and preferences. This included how to care for their child's individual or special needs, or that there was special equipment or adaptions on the ward for their child's needs. Parents of children and young people with mental health conditions reported less involvement in their child's care, including involvement in care planning, decisions about care and being able to ask questions about their child's care. Parents of children and young people with mental health conditions were also less likely to report that different members of staff were aware of their child's medical history. Finally, parents reported poorer overall experiences of care when their child had a mental health condition.

Although the children and young people's survey focuses on children and young people's experiences of receiving care in an acute hospital, the findings highlight that children and young people with mental health conditions have poorer experiences of receiving care for their physical health needs than their peers without mental health conditions. Therefore, reports of poorer involvement, understanding of their individual needs and histories, and understanding what is happening during their hospital stay and once they are discharged are not restricted to their experiences of receiving mental health care. Furthermore, their parents also report poorer involvement and responding to their children's needs when their child is receiving care for their physical health needs.

[t] Significance criteria: Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the composite score are treated as being significant, provided that the confidence interval does not overlap the mean line.

Table 5: Statistical comparisons between children and young people with and without a mental health condition (2017)

Theme	Questions	Note of differences
Children and young people aged 8-15		
Information and communication	Did hospital staff talk with you about how they were going to care for you? When the hospital staff spoke with you, did you understand what they said? Did the hospital staff answer your questions?	Those with a mental health condition scored significantly lower than those without
Transition and continuity	When you left hospital, did you know what was going to happen next with your care? Did a member of staff give you advice on how to look after yourself after you went home?	Those with a mental health condition scored significantly lower than those without
Respect for patient centred values, preferences and expressed needs	Were you involved in decisions about your care and treatment? Were you given enough privacy when you were receiving care and treatment?	Those with a mental health condition scored significantly lower than those without
Individual questions	Did you like the hospital food? Were there enough things for you to do in the hospital? If you had any worries, did a member of staff talk with you about them? Overall, how well do you think you were looked after in hospital?	No difference in any questions
Parents (of children and young people) aged 0-15		
Welcoming the involvement of family and friends	Did a member of staff agree a plan for your child's care with you? Did staff involve you in decisions about your child's care and treatment? Were you able to ask staff any questions you had about your child's care?	Parents of those with a mental health condition scored significantly lower than those without
Respect for their child's individual needs and preferences	Did you feel that staff looking after you and your child knew how to care for their individual or special needs? Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?	Parents of those with a mental health condition scored significantly lower than those without
Individual questions	Were the different members of staff caring for and treating your child aware of their medical history? Overall experience	Parents of those with a mental health condition scored significantly lower than those without

Theme	Questions	Note of differences
	Did you have confidence and trust in the members of staff treating your child? Were members of staff available when your child needed attention? Do you feel that you (the parent/carer) were well looked after by hospital staff?	No difference in these questions

Source: The Children and young people's Survey, CQC

Review of others' findings

These reflect reports that were recommended to us and cannot be considered a review of the literature. We have not analysed any nationally available data for this section. This section should be considered alongside the review of literature from phase one.

Delayed discharges

The Education Policy Institute review of inpatient services noted that delayed discharges occur when the child or young person is able to leave but cannot be discharged for some reason. Between October 2015 and February 2017, there were nearly 9,000 wasted days in NHS children's mental health hospitals. Delayed discharges of children and young people from mental health hospitals appear to be increasing with the numbers up 42% in December 2016 to February 2017 compared to the same period the year before.[65]

Quality of care received

The Education Policy Institute review of inpatient services discussed the quality of care received. Quality standards are grouped into Type 1, 2 and 3. Failure to meet Type 1 standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law. An accredited unit would be expected to meet Type 2 standards and an excellent unit should meet Type 3 standards. Type 3 standards may also be those standards that are not the direct responsibility of the front line staff in the service. Ninety-three per cent of Type 1 standards were met in members of the Quality Network for Inpatient CAMHS. Ninety-six CAMHS units had a peer or accreditation review visit between September 2015 and May 2016. The units are a mix of NHS, Independent, Private and international units. In addition, six teams were included as they were at the second year self-review phase. A self-review involves teams measuring their compliance against the standards without receiving a peer review.[66] The Education Policy Institute noted that this meant 7% of inpatient CAMHS failed to meet these standards and suggests substantial room for improvement.[67]

Workforce

Inpatient services have a particular problem with workforce shortages according to the Education Policy Institute review of inpatient services. Twelve per cent of members of the Quality Network for Inpatient CAMHS did not reach the minimum standard for staff to patient ratios for high dependency/high acuity[u] or medium dependency[v] cases. Only 2% of members of the Quality Network for Inpatient CAMHS did not reach the minimum standard for staff to

[u] Minimum standard for high dependency/high acuity cases (e.g. high levels of observation, use of seclusion, increased risk of violence or self-harm) is 1:1 ward staff to patient ratio (3:1 for the most acute cases).

[v] Minimum standard for medium dependency (e.g. 10-minute checks, intensive support at meal times) is 1:2 ward staff to patient ratio.

patient ratios for general observation wards[w] or night-time in a 12 bedded ward with general observations.[x] About a quarter did not meet the standard that: "the unit is staffed by permanent staff, and unfamiliar bank and agency staff are used only in exceptional circumstances".[68] These standards were used by the Quality Network for Inpatient CAMHS to evaluate care through reviews against shared standards. These standards may not match CQC's position on staff to patient ratios.

[w] Minimum standard for general observations is 1:3 ward staff to patient ratio.
[x] At night-time in a 12 bedded unit with general observations there is a minimum of two staff on duty, including one registered member of staff and access to additional support as appropriate.

Summary of data gaps and data quality issues

The following data gaps and data quality issues were identified in the process of compiling the information to support fieldwork, and through conversations and feedback from our national professional advisors and analysts supporting CQC inspections of mental health services for children and young people. In addition, issues with the quality of data about the mental health of children and young people were highlighted in reports, including *Future in Mind*.[69]

Data gaps and quality issues for indicators about access and waiting times are discussed in the section on gaps and quality issues with data about access to mental health care above. Below we focus on additional data gaps and quality issues.

Prevalence data
There are known data quality issues with prevalence data. The data is based on national prevalence rates from the 2004 Survey of Mental Health of Children and Young People in Great Britain. Local prevalence is estimated based on the age, sex and socio-economic make-up of the local population. The results from the 2016 survey, due in 2018, will allow for an update of all of these prevalence rates.[70]

Currently prevalence rates are based on grouping mental health as one homogeneous group. However, there is a move towards understanding that there are a number of "conditions" that come under children and young people's mental ill-health. These are set out in the THRIVE model as part of the CAMHS Currencies work that was used to inform the THRIVE needs-based grouping. The THRIVE model emphasises using a common language when talking about the needs of children and young people rather than focusing on service structure. Furthermore, the THRIVE model uses a wider view on mental health services and focusing on how you can support children and young people where ever they are in the wider system. THRIVE is the conceptual framework that measures need under five categories: thriving; getting advice; getting help; getting more help; and getting risk support.[71]

Data about the whole system and not just NHS services
A major concern around available data is its focus on NHS-commissioned services. Therefore, we know very little about provision of mental health care for children and young people in other parts of the system.

Experiences of care
We are also lacking data about children and young people's experience of care, for example, through patient surveys. Data is available from the Children and young people's survey about the experiences of children and young people with mental health diagnoses when accessing care for physical health needs. However, we do not have a national survey about children and young people's, or their parent's or carer's, experiences of receiving care for their mental health needs.

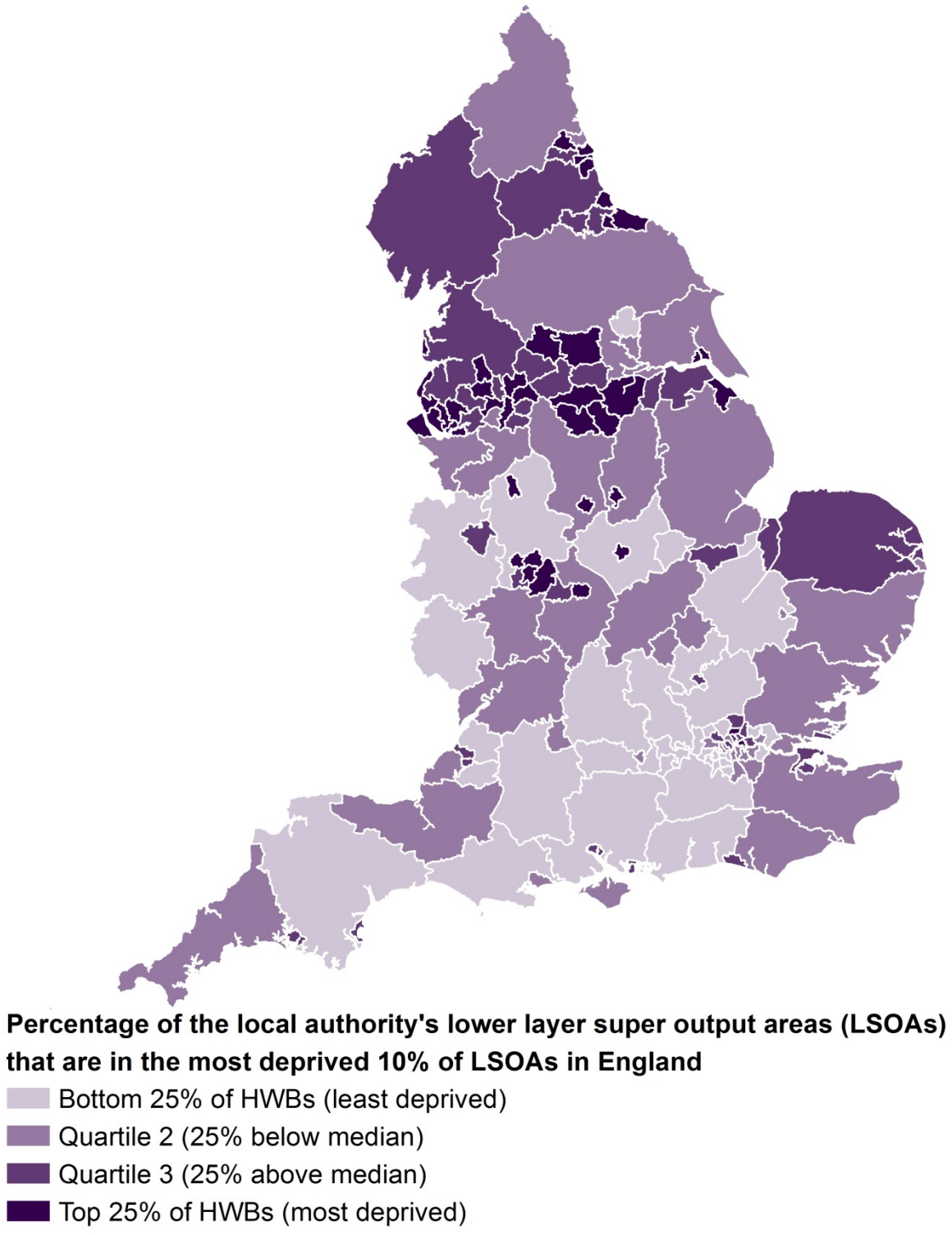
High levels of suppressions
Some of the other indicators (for example, bed days in adult wards or open stays that are at least 50 km away from the children and young people's home) have high levels of suppression. Data is suppressed to prevent deductive disclosure. That is, we are not able to report, or sometimes access, data that has between one and five individuals due to concerns that an individual could be identified from this data. We have focused on national levels rather than examining national variation for these indicators. Where national levels are

provided in the report, they are based on the England value provided in the raw data and not calculated by summing non-suppressed areas. Therefore, the national value will not be affected by the high levels of suppression in some indicators.

List of figures

Appendices

Appendix 1: Index of Multiple Deprivation by local authorities in England (2015)



Source: English indices of deprivation, Department of Communities and Local Government

Appendix 2: National levels of children and young people with different characteristics and in different circumstances (hyperlinks in the first column take you to details about variation across England in the main document)

		Time period	Number	Percentage
Children and young people (18 years and under)		2014	12,247,454	23% of total population
		2015	12,338,887	23% of total population
		2016	12,434,195	22% of total population
Children and young people with special educational needs	Pupils with Special educational needs	2014	1,492,950	18% of all school pupils
		2015	1,301,445	15% of all school pupils
		2016	1,133,622	14% of all school pupils
	Pupils with a learning disability	2014	239,015	3% of all school pupils
		2015	419,630	5% of all school pupils
		2016	415,467	5% of all school pupils
	Prevalence of autism spectrum disorders	2004	Not reported	~1% of 5 to 16-year-olds[y]
Children and young people with long-term illness, disability or medical condition	Behaviour in School-aged Children study (HBSC) of 11 to 15-year-olds	2014	Not recorded	23% of respondents reported having a long-term illness, disability or medical condition diagnosed by a doctor
	What About YOUth (WAY) survey of 15-year-olds	2014/15	Not recorded	14% of respondents reported having a long-term illness, disability or medical condition diagnosed by a doctor
Lesbian, gay, and bisexual young people (aged 16-24 years)		2014	~202,000	3% of 16 to 24-year-olds
		2015	~242,000	3% of 16 to 24-year-olds
		2016	~295,000	4% of 16 to 24-year-olds
Transgender children and young people				No data available[72]
Black and minority ethnic (BME)	White	2011	45,281,142	85% of total population
	Asian	2011	4,143,403	8% of total population
	Black	2011	1,846,614	4% of total population

[y] Throughout the summary, ~ represents the value is an estimate.

		Time period	Number	Percentage
population	Mixed	2011	1,192,879	2% of total population
	Other	2011	548,418	1% of total population
School students whose ethnic group is Gypsy or Roma[z]		2013/14	16,200	0.2% of pupils with classified ethnic group
		2014/15	18,470	0.3% of pupils with classified ethnic group
		2015/16	19,926	0.3% of pupils with classified ethnic group
Pregnancy and maternity	Maternity rate for women under 18 years old	2013	Not included	12 per 1,000 women under 18
		2014	Not included	11 per 1,000 women under 18
		2015	Not included	10 per 1,000 women under 18
Unaccompanied asylum-seeking children (UASC)	UASC applications	2015	3,253	N/A, number reflects number of applications for UASC
		2016	3,175	
	UASC looked after by a local authority	2014	1,970	N/A, number reflects number of UASC looked after by a local authority
		2015	2,030	
		2016	4,210	
Young carers (according to census)		2011	166,363	2% of under 18s
Children in low income families[aa]		2012	1,912,310	19% of under 16s[bb]
		2013	1,854,005	19% of under 16s
		2014	2,003,060	20% of under 16s
Homeless families[cc]		2013/14	38,080	2 per 1,000 households
		2014/15	40,410	2 per 1,000 households
		2015/16	43,044	2 per 1,000 households

[z] Special schools were not included as the numbers were very low.
[aa] Children under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income
[bb] For whom child benefit was received.
[cc] Households with dependent children or pregnant woman accepted as unintentionally homeless and eligible for assistance.

		Time period	Number	Percentage
Children at risk of sexual exploitation	Number of recorded sexual offences against children[dd]	2015/16	47,045	40.3 recorded sexual offences per 10,000 under 18
Repeat child protection cases		2014	9,450	16% of children with a child protection plan
		2015	10,310	17% of children with a child protection plan
		2016	11,350	18% of children with a child protection plan
Looked after children		2013/14	68,840	60 per 10,000 under 18s
		2014/15	69,540	60 per 10,000 under 18s
		2015/16	70,440	60 per 10,000 under 18s
Children with fixed term exclusions from state-funded school	Primary schools	2012/13	37,870	1 fixed term exclusion per 100 pupils at state-funded primary school
		2013/14	45,010	1 fixed term exclusion per 100 pupils at state-funded primary school
		2014/15	49,650	1 fixed term exclusion per 100 pupils at state-funded primary school
	Secondary schools	2012/13	215,560	7 fixed term exclusion per 100 pupils at state-funded secondary school
		2013/14	210,580	7 fixed term exclusion per 100 pupils at state-funded secondary school
		2014/15	239,240	8 fixed term exclusion per 100 pupils at state-funded secondary school
	All school aged pupils	2012/13	253,430	3 fixed term exclusion per 100 pupils at state-funded school
		2013/14	255,590	3 fixed term exclusion per 100 pupils at state-funded school
		2014/15	288,890	4 fixed term exclusion

[dd] Based on a freedom of information request to police forces in England by NSPCC reported in: "How safe are our children? The most comprehensive overview of child protection in the UK"

	Time period	Number	Percentage
			per 100 pupils at state-funded school
First time entrants to youth justice system for juveniles (10 to 17 year olds)	2014	20,062	0.4% of 10 to 17-year-olds
	2015	18,021	0.4% of 10 to 17-year-olds
	2016	15,980	0.3% of 10 to 17-year-olds

Appendix 3: Data quality issues identified in data profiles used in fieldwork

Indicator	Problem with data quality
Variable prevalence of mental health needs for children and young people	
Estimated prevalence: estimated percentage of population aged 5-16 with mental health disorders (fingertips data)	Prevalence is estimated from a 2004 survey so has data quality concerns (fingertips itself notes "there are some concerns regarding the quality of this data")
Variable access to mental health care for children and young people	
Number of referrals: Number of referrals to CAMHS per month (Mental Health Services Data Set (MHSDS) Monthly Reports)	MHSDS is an experimental statistic. Data is incomplete as not all providers currently submit data and therefore numbers of referrals are likely underreported.
Variable experiences of mental health care and outcomes for children and young people	
Bed days on adult wards: Number of CAMHS bed days in adult wards (NHS England Five Year Forward View Dashboard)	Very high levels of suppressed data. We will only be able to provide an overall national value.
Ward stays at least 50km away: Number of ward stays where the person has travelled 50km or more from their home to the ward (MHSDS Monthly Reports)	Very high levels of suppressed data. We will only be able to provide an overall national value.

Appendix 4: Methodology of the Children and young people's Survey

The sample

The following exclusions criteria were applied to potential participants:

- patients who were not admitted to hospital (for example, those who attended a ward or who attended an outpatient appointment, but were not admitted).
- patients who had died
- patients aged 16 years or older at the time of their discharge
- babies aged between 0 and 14 days at the time of their discharge
- newborn babies whose mother was the primary patient (well babies, treatment function code 424)
- patients who were only admitted to a neonatal intensive care unit (NICU) or a special care baby unit (SCBU) (treatment function code 422)
- obstetrics/maternity patients, including spontaneous miscarriages
- patients admitted for planned termination of pregnancy
- psychiatry patients, including those receiving care from CAMHS
- private patients (non-NHS)
- NHS patients treated at private hospitals
- any patients who were known to be current inpatients
- patients without a UK postal address
- any patient, parents or carers who had requested that their details were not used for any purpose other than their clinical care.

Analysis

Mean composite scores were calculated for each theme by grouping together the scores for each question into one composite. Statistical tests were used to highlight significant differences[ee] between the means of different groups of children and young people from the overall mean of the whole sample. Groups were based on demographic characteristics variables of the children and young people including, for example, age, gender, ethnicity, long-term conditions. Of particular interest in relation to the review of children and young people's mental health services was the 'long term conditions' variable which considers whether or not a child or young person has *a mental health condition* or has *no mental health condition*.

[ee] Significance criteria: Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the composite score are treated as being significant, provided that the confidence interval does not overlap the mean line.

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