CHILDREN'S COMMISSIONER

Children's mental health services 2023-24

May 2025

Contents

Content warning

This report is not intended to be read by children, but by professionals working to improve children's mental health and support services. This report makes reference to mental health conditions, including suicidal thoughts and self-harm. The Children's Commissioner's office acknowledges that this content may be difficult to read. However, it is important to understand the level of need among children, to ensure services are set up to support them.

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

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

NHS 111

Offers mental health support and advice, help to speak to a mental health professional, and can arrange an assessment to help decide on the best course of care.
www.nhs.uk/service-search/mental-health/find-an-urgentmental-health-helpline

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

Foreword from Dame Rachel de Souza

As Children's Commissioner, it is my job to make sure we never lose sight of the biggest challenges affecting children – mental health is one of the most significant. Each year, I publish this report to shine a spotlight on the state of children's mental health services in England.

This is the fourth report of its kind. I will continue to request NHS data on waiting times, investment in children's mental health services and ask the tough questions until there is a comprehensive plan to ensure that every child gets the support and help they need to thrive at the earliest opportunity.

There have been some welcome improvements in investment and access to services, but too often it remains a case of too little and too late, leaving children waiting far too long for help.

Black children and ethnic minority children are less likely overall to be accessing mental health services, and when they do come to the attention of services, they are often in crisis – well past the point of prevention, only treatment. We are talking about children who are in acute distress, and are at serious risk of harm, and even death.

I remain deeply concerned about the clear health inequalities that exist for children across the country highlighted in this report.

Every child has a right to a safe, healthy childhood – but this means not sitting on a list waiting for treatment. This report shows children who were yet to get support by the end of 2023-24 waited on average nearly six months for treatment to begin, with almost a third of these children waiting over a year. That's years of brief and precious childhoods wasted. Months of lost learning, of social development, of wellbeing that can come with a heavy cost in every aspect of a child's life.

Children are crying out for our help so they can get on with their lives, and we must listen.

When I ask children what is making them unhappy, their answers are clear and consistent: families struggling to afford food; feeling unsafe in their neighbourhoods or at home; being misunderstood at school; feeling isolated, unseen, disconnected.

Even the most skilled mental health and wellbeing practitioners cannot provide the antidote to these challenges alone: they are collective problems that require collective solutions with all the agencies in a child's life working together, across education, health and social care.

These issues need to be understood in the round, not just as personal challenges—they are societal ones. If we look at children's mental health in isolation, we risk placing the burden of change on children themselves.

We need a new vision for childhood—one that doesn't silo mental health away from education, care, or physical wellbeing. We need a system that works together to nurture, support, and empower every child from the start.

We need a cross-government approach to children and young people's mental health and wellbeing which addresses these wider determinants of happiness and health. If we are to break down barriers to opportunity, we must start here – because for hundreds of thousands of children, the barrier to opportunity is their mental health.

We need a world where children can access help without having to have a label, one where support is not dependent on a diagnosis.

And we need to provide needs-led support in schools so that mental health professionals can spend less of their time on lengthy diagnostic assessments, and more of their time actually supporting children.

So where do we go from here?

I believe we have a significant chance for change with the NHS 10 Year Plan.

It needs to set a clear, ambitious direction for a fairer share of investment in children and young people's mental health and wellbeing services – right across the spectrum of need.

I want to see national coverage of early support hubs and mental health support in school, so that the majority of children never need to come close to their thoughts, feelings and behaviours being diagnosable before they get help.

I want to see health working in partnership with the community-based services that are able to reach the children who currently seem to only be visible to statutory services once they reach crisis – and a national, cross-government strategy for children and young people's mental health and wellbeing that addresses the root causes of distress, not just its symptoms.

Above all, we need to stop asking children to prove they are unwell enough to deserve help. We must build a system that is not reliant on diagnosis for care, only responding to children who meet a threshold - but one which listens earlier, acts faster, and supports every child.

For the first time, I believe we have a genuine opportunity to rethink how we approach public health in this country, with prevention and early intervention at its heart.

I can think of no better public health approach than treasuring childhood, and giving young people the building blocks for long, happy, fulfilling adult lives.

I hope our leaders are ready to seize the moment, because our children can't wait.

Executive summary

This report describes children's access to mental health services in England during the 2023-24 financial year, based on new analysis of NHS England data using the same methodology as the Children's Commissioner's office's last annual report, covering 2022-23.[1]

Demand continues to grow for Children and Young People's Mental Health Services (CYPMHS, commonly known as CAMHS)[i], with the number of children with active referrals[ii] increasing by nearly 10,000 since last year to 958,200. Compared to last year,[2] there have been some areas of progress: fewer children's referrals are being closed before treatment, and investment in CYPMHS has increased in real terms and when adjusted for inflation. However, figures continue to highlight some concerning trends:

- Many children were still experiencing long waits to access mental health services, and the number of children with active referrals who were still waiting for treatment to begin at the end of the year has increased by almost 50,000 children from 270,300 in 2022-23 to 320,000 in 2023-24.
- Almost half of those referred for being 'in crisis' have their referrals closed or were still waiting for their second contact at the end of the year.
- There has been an uptick in children being referred for suspected and diagnosed neurodevelopmental conditions; these conditions are associated with some of the longest waits.

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

[ii] Throughout this report, 'active referrals' is used to refer to children who had any period of waiting in 2023-24. This includes: children who entered treatment during the year; children whose referral was closed during the year; and children who were still waiting to enter treatment at the end of the year. It does not include children who entered treatment before the start of the year, and who remained in treatment during the year.

- The accessibility of mental health services in England continues to vary widely from one ICB area to another, leading to a postcode lottery in children's access to suitable support for their mental health conditions.

The Children's Commissioner has been publishing research on waiting times and spending on children and young people's mental health services since she came into post in 2021. Since then, Clinical Commissioning Groups (CCGs) have been replaced with Integrated Care Boards (ICBs) – which have different geographical footprints. To include children waiting more than a year to receive help, the methodology for this annual briefing changed last year, from looking at data on children referred within the year, to now including all children with active referrals within the year. For these two reasons, **like-for-like comparisons can only be made with our previous report which covered the 2022-23 financial year.**

There are shortcomings in how NHS England reports how long children wait for treatment to begin. NHS England currently publishes waiting times based on how long children wait for a single contact with CYPMHS, which may include 'indirect activity' where the child is not present. NHS England advises providers that this activity can be recorded where it "directly benefits the patient", such as a mental health professional attending a multi-disciplinary meeting to discuss a child,[3] or talking to a parent or teacher. While these types of activity are important, it is the view of the Children's Commissioner's office that the most meaningful wait a child is subject to is the wait until mental health treatment (direct support) begins. To avoid underestimating how long children wait for support, the following data are presented in this report:

- Waiting time from referral to **second contact with CYPMHS (both direct and indirect activity)** – comparable with last year's report.[iii]
- Waiting time from referral to **second contact with CYPMHS (direct activity only)** – not comparable with last year's report.

[iii] Waiting time from referral to second contact is still a proxy for mental health treatment beginning, the limitations of which are acknowledged at the start of this report.

Unless otherwise stated, waiting times refer to both direct and indirect activity, for consistency with last year's report.

Key findings

Demand for mental health support has increased since last year

- Continuing a longer-term trend, the number of children with active referrals to Children and Young People's Mental Health Services (CYPMHS, sometimes referred to as 'CAMHS') increased from 949,200 in 2022-23 to 958,200 in 2023-24. This means that around 8% of the 12 million children in England had an active referral in 2023-24.

Investment in CYPMHS has increased, but not enough is being spent on children proportionately, and geographical inequalities persist

- **Overall, it is positive that investment in children's mental health services (excluding spending on mental health services for children with learning disabilities) has increased every year** from 2018-19 to 2023-24. Even after adjusting for inflation, spending on CYPMHS has grown between 2022-23 and 2023-24 – a 9% increase in cash terms (up from an 8% rise between 2021-22 and 2022-23) and a 2% increase in real terms (up from a 1% rise between 2021-22 and 2022-23). Last year the CCo reported that growth of investment in 2022-23 just about exceeded the pace of inflation.[4]

- **Despite this welcome increase, investment in CYPMHS continues to represent a very small proportion of total ICB spending**. ICBs spent £1.1 billion on CYPMHS in 2023-24, which is equal to 1.04% of their total spend – an increase of £87 million from £996 million (or 1.02%) in 2022-23.

- **Geographical disparities persist. ICB spend on CYPMHS in 2023-24 varied widely by area**:
    - Spend per child referred varied widely by ICB, from as much as £2,513 in North West London ICB to as low as £548 in Coventry and Warwickshire ICB.

- The three ICBs that spent the most per child referred were all in London: North West London ICB spent the most (£2,513 per child referred), followed by North Central London ICB (£2,403), and North East London ICB (£2,175).

The top referral reasons were anxiety, neurodevelopmental conditions, and being in crisis

- Of the known primary referral reasons, **anxiety was the most common** (16% - up slightly from 15% in 2022-23), **followed by neurodevelopmental conditions excluding autism** (11% - up from 9.2%), **suspected autism** (6.8% - up from 5.3%) **and 'in crisis'** (6.2% - up from 5.8%).

- **Since last year, the number of children being referred for neurodevelopmental conditions has increased by almost 30%** (increase from 147,600 in 2022-23 to 188,700 in 2023-24)**.** Neurodevelopmental conditions like autism and ADHD are not mental health conditions, however children's neurodevelopment is often assessed in CYPMHS, and neurodevelopmental and mental health conditions do frequently co-occur.[iv] [5]

More children began treatment, but more are still waiting for treatment to begin

Compared to last year, when using two contacts with CYPMHS (both indirect and direct) as a proxy for treatment beginning:

- **Fewer children had their referral closed before treatment** (31% in 2023-24 or 296,300 children, down from 39% in 2022-23).

- **More children began treatment** (36% in 2023-24 or 340,500 children, up from 32% in 2022-23). Comparing the 340,500 children who received two contacts with CYPMHS against the

[iv] Please see the Methodology section at the end of this report for more information on how children in CYPMHS are identified as primarily having a mental health need versus primarily having a non-mental health need relating to autism, a learning disability or another neurodevelopmental condition (the second group largely being excluded from this analysis). In October 2024, the CCo published separate analysis of waiting times for assessment and support for children with a primary need relating to autism, ADHD and other neurodevelopmental conditions.

approximate pool of 1.43 million children with a mental health need in 2023-24, the two-contact access rate is 24% (up from 22% in 2022-23).[v]

- **More children were still waiting for treatment** at the end of the year in March 2024 (33% in 2023-24 or 320,000 children, up from 28% or 270,300 in 2022-23).

Waiting times for children who began treatment in 2023-24 have held steady, but new analysis reveals waiting times are higher when considering direct contact only

- **Average waiting times for any type of second contact (both indirect and direct) have stayed roughly the same**, an achievement considering the increase in children referred. Children waited an average of over a month (a median of 35 days - unchanged from 2022-23) or a mean of close to four months (114 days - up from 108 days in 2022-23).
- **The vast majority of children (92%) who entered treatment (received two contacts), did so within the year.** Almost half (45%) received two contacts within a month (4 weeks) – largely unchanged from 2022-23.
- **A minority of children waited particularly long periods** before entering treatment:
    - 5.4% of children who entered treatment did so within 1 to 2 years (18,500);
    - 2.4% of children who entered treatment did so after a wait of over 2 years (8,300).
- **However, when looking only at direct activity with children, average waiting times are higher**.
    - Previously unpublished data, collected and analysed by the CCo for the first time, finds that children wait longer for 2 *direct* contacts – a median of over six weeks (45 days) or a

[v] While CCo adopts two contacts with CYPMHS as a proxy for mental health treatment beginning, the NHSE tends to report CYPMHS access and waiting times statistics with a one contact measure. When looking at the access rate with this one contact measure, the proportion of children accessing support appears higher than when using a 2-contact measure (with 55% of children accessing CYPMHS, compared to 22%).

mean of over four months (128 days). Published statistics include *indirect* contacts, such as a professional attending a multi-disciplinary meeting.

Some children were 'still waiting' for treatment after long periods of time, especially for some reasons and services

- For the 320,000 (33%) children still waiting at the end of the year for their second contact with CYPMHS, they had waited on average 179 days (median) or 384 days (mean).
- **Many children who were still waiting at the end of the year had been waiting for much longer periods of time than those who began treatment: almost a third of children (32%) who were still waiting for support had been waiting for over a year.**
    - 18% of children who were still waiting had been waiting for 6 months to 1 year (unchanged from 2022-23).
    - 18% of children who were still waiting had been waiting for 1 to 2 years (up from 15% in 2022-23).
    - 14% of children who were still waiting had been waiting for over 2 years (up from 12% in 2022-23).
- **The primary referral reasons** with the highest proportions of children still waiting for support at the end of the year in March 2024 were **gender discomfort issues** (75% of children referred for this reason were still waiting), **personality disorders** (65% of children referred for this reason were still waiting), and **suspected autism** (64% of children referred for this reason were still waiting).
- **The services** that children were most likely to still be waiting for were the **autism service** (78% of children referred to this service were still waiting) and the **neurodevelopment team** (73% of children referred to this service were still waiting).

Large geographical inequalities in waiting times remain

- **As in previous years, the average waiting time for children to receive two contacts with CYPMHS varies widely by geography.** In the NHS Leicester, Leicestershire and Rutland ICB area, children wait the shortest time, just 6 days on average (median) for their second contact with CYPMHS. Children in NHS Hampshire and Isle of Wight wait the longest on average: 103 days (median).

- **When looking at direct contacts only, average waiting times between referral and second contact were even longer in some areas.** In NHS South East London, average waiting times were 52 days longer when considering only 'direct contacts', the largest difference of any ICB. Despite this, the longest average waiting times were again in NHS Hampshire and Isle of Wight ICB when considering only 'direct contacts', at 118 days (median). The shortest waits were also again in NHS Leicester, Leicestershire and Rutland ICB, still at six days (median).

Demographics of children who accessed support

Age

- **Children aged 13 to 15 were by far the largest group accessing CYPMHS treatment** in 2023-24, making up 35% (down from 37% in 2022-23) of all entering treatment, despite making up only 18% of all children in England.

- **Children under 5 years old referred to CYPMHS were least likely to have accessed treatment of any age group –** with 21% receiving two contacts. This age group was also most likely to have their referral closed before treatment (40%).

Gender

- **More than half (56%) of all children who received two contacts with CYPMHS in 2023-24 were girls** – unchanged from 2022-23.

- **Non-binary children were both most likely to enter treatment (46%) and most likely to have their referrals closed before treatment (39%).**

Ethnicity

- **Children of white ethnic groups comprised 81% of those who accessed treatment** (excluding those of unknown ethnicity) – a notable overrepresentation compared to the Census 2021 figure of 73% of under 18s in England.

Waiting times by demographics

- **Average waiting times decrease as children get older**. For example, children aged under 5 wait a median of about three months (93 days), compared to about one month (29 days) for those aged 13 to 15, and just 16 days for those aged 16 to 17 - the shortest wait of any age group. However, almost two in five (38% - 56,650 children) of those aged 16 to 17 have their referrals closed, the second highest proportion behind children aged under 5 (40% - or 15,890 children had their referrals closed).

- **On average, boys wait longer than girls for their second contact with CYPMHS**, a median waiting time of 45 days compared to 29 days for girls, or over 50% longer. **Non-binary children wait the shortest length of time**, a median waiting time of 5 days before their second contact.

- **Asian and black children had notably shorter waiting times than any other ethnic group**. Compared to the national median wait of 35 days, on average Asian children waited 21 days, and black children 24 days. These children made up 5% and 4% of all children entering treatment, respectively.

Waiting times by referral reason

- **The referral reasons with the average shortest waiting times were 'in crisis'** (median five days – unchanged from 2022-23), **self-harming behaviours** (eight days – roughly the same as 2022-23), **suspected first episode psychosis** (13 days – unchanged from 2022-23) and **drug and alcohol difficulties** (16 days, up from nine days in 2022-23). While it is encouraging that children with such serious conditions are seen within three weeks, **five days is still a long time for those in crisis to wait.**

- **Of all the primary reasons for a referral (excluding unknown), the longest waiting times were for suspected autism, gambling disorder, and neurodevelopmental conditions (excluding autism),** with respective median waits of 223 days (up from 216 days in 2022-23), 195 days (up from 76 days) and 140 days (up from 111 days).

- **Looking at 'direct' contacts only, some of these average waits were even longer.** For example, the average wait for children referred with suspected autism was 103 days higher – meaning that children with suspected autism wait on average 326 days for their second direct contact with a CYPMHS professional. This is almost 46% longer than the reported figure of 216 days (which includes indirect contacts) in 2022-23.

New analysis shows that ethnic minority and especially black children, older children, girls, and non-binary children, are more likely to be referred for being in crisis

Last year, the Children's Commissioner's office published waiting times by demographics, and hypothesised that **shorter waits could be associated with more acute need at the point of referral.** To test this, for the first time the office requested data on the characteristics of children with different primary referral reasons. This new analysis suggests a relationship between the shorter waits experienced by particular groups of children and being referred for and accessing support due to being in crisis.

- **Older children are more likely to be referred for being in crisis, and access services for this reason.**

    - As children grow up, a bigger proportion of referrals relate to anxiety and children being in crisis. Among 16- and 17-year-olds, anxiety is the most common referral reason, followed by "in crisis" – respectively accounting for 22% and 17% of referrals for this age group.

    - Of the 16- and 17-year-olds referred, those in crisis made up almost a quarter (24%) of children who entered treatment. Another 23% entered treatment for anxiety.

- **Children from ethnic groups other than white are more likely to be referred for being in crisis, and access services for this reason.**
    - 'Crisis' is the most common referral reason for black children and children recorded as having an 'other' ethnicity, accounting for 29% and 24% of respective referrals. Crisis was among the top three most common primary referral reasons for all ethnic groups, besides the white ethnic group.
    - When it comes to children who entered treatment, those in crisis account for a large proportion of referrals for all ethnic groups besides white children (28% of referrals of Asian children, 34% of referrals of black children, 20% of children from mixed ethnic groups, and 32% of children recorded as an 'other' ethnicity who entered treatment – versus 13% of white children).
- **Girls are slightly more likely than boys to be referred in crisis, and to access services for crisis and self-harming behaviours.**
    - Compared to boys, girls are slightly more likely to be referred in crisis - making up 11% of primary referral reasons, compared to 9.0% of referrals for boys.
    - When it comes to those who enter treatment, after anxiety, 'in crisis' (16% of referrals) and self-harm behaviours (8.6%) were the two most common primary referral reasons for girls. For boys, after anxiety it is neurodevelopmental conditions excluding autism (16% of referrals) and crisis (14%).
- **Similarly, non-binary children were also more likely than boys to be referred for crisis, and to access services for crisis and self-harming behaviours.**
    - Non-binary children, children with an 'indeterminate' gender, and children with an 'other' gender were all more likely than boys to be referred for being in crisis, and at least as likely as girls. It was the second most common referral reason for each group (making up 11%, 12% and 20% of respective referrals – compared to 9.0% for boys and 11% for girls).
    - Crisis, as well as anxiety and self-harm behaviours, were the top three referral reasons for non-binary children and children with an 'indeterminate' gender who entered treatment.

For children with an 'other' gender entering treatment, the top three were 'in crisis', anxiety, and depression.

Waiting times vary by service type

- **Of all the services children are referred to, those with the longest waiting times saw waits get longer between 2022-23 and 2023-24.** These were waiting times for the autism service, the neurodevelopment team, and community mental health team for organic brain disorders, with respective median waits of 1 year 9 months (636 days, up from 481 days in 2022-23), over 9 months (286 days, up from 194 days) and over 8 months (247 days, up from 82 days).

- **When considering direct activity with children only, some of these average waits were even longer**. For example, the median wait for the community team for learning disabilities was higher by 96 days, which was the biggest discrepancy in waiting times between direct only and all contacts.

New analysis shows that waiting times vary by referral source

The Children's Commissioner's office was keen to understand children's journeys through CYPMHS, and whether particular referral pathways are associated with quicker access to mental health support. For the first time, we are able to share insights based on children's referral source.

- In 2023-24, the most **common referral sources were local authority services, primary healthcare (like GPs), and self-referral** making up 26%, 23% and 13% of those entering treatment within the year respectively, or 62% in total.

- Interestingly, referral sources vary by child demographics. **Girls were more likely to self-refer than boys, as were non-binary children**. Boys are more likely to have an 'internal' referral, where they initially present at a different NHS service. **White children and Asian children were more likely to self-refer** than black children and children from mixed ethnic and 'other' backgrounds.

- Outcomes of referrals varied considerably based on referral source:

    - **Children referred by the justice system were by far the most likely to have their referrals closed before treatment,** with 72% of referrals from this source closed before

treatment. Fewer than 1 in 5 children (19%) referred by the justice system began treatment (received two contacts).

- **Those referred from within the health system were generally less likely to have their referral closed, but many were still waiting for support**. The referral sources with the greatest proportion of children still waiting were '**Other Mental Health NHS Trust'** (56% of children still waiting), and '**Internal'** (51% of children still waiting).
- The referral sources which led to the greatest proportion of children entering treatment were '**Acute Secondary Care'** (53% entered treatment), **Improving Access to Psychological Therapies** (47% entered treatment), and **Drop-in services** (42% entered treatment).

Key recommendations

This report is being published at an important crossroads. In March 2025, it was announced that NHS England would be dissolved as a standalone organisation, with many of its functions to be brought within the Department for Health and Social Care. The government is also developing its 10 Year Plan for the National Health Service, due to be published imminently. The government is striving for this plan to enable three shifts: from sickness to prevention, from hospitals to the community, and from analogue to digital. Children and young people's mental health must be at the heart of this plan, as well as the forthcoming workforce strategy. As these recommendations set out, the right way forward for children's mental health and wellbeing will only reinforce these three shifts. The full set of recommendations appear at the end of this report.

Understanding prevalence of need

- **The Department for Health and Social Care should re-commission the prevalence survey of children and young people's mental health**, which until 2023 provided the most accurate estimate of mental health need in the child population, including among those children who are not known to CYPMHS.

Preventing children from developing poor mental health

- **The Department for Education and Department for Health and Social Care should develop a joint strategy for improving children and young people's mental health and wellbeing and joint outcomes framework,** with input from the other departments that sit on the Health and Opportunity Mission delivery boards. This strategy should have a strong focus on addressing many of the wider determinants of poor mental health and wellbeing – including poverty, inequality, insecurity, and harms (both online and offline) – aligning with other strategies in development such as the National Youth Strategy, Violence Against Women and Girls strategy, and Child Poverty Strategy. This is essential for moving away from a medical, diagnosis-led model of support – and towards a social model which is needs-led.

Enhanced support in schools and the community

With enough open access, early support, delivered where children are - in their schools and communities, we can prevent children's needs from becoming overly medicalised. Children should not need labels or diagnoses before they can get help for their health and wellbeing.

- **Mental Health Support Teams (MHSTs) must continue to be rolled out at pace.** Currently 44% of pupils have access to MHSTs.[6] The CCo welcomes the government's commitment to national roll-out, but this must happen sooner than 2030. Evaluations of this model should measure the extent to which interventions are inclusive of children with additional needs, including those who are disabled and/or neurodivergent. National roll-out must be informed by emerging evidence on which interventions are most effective at improving children's mental health and wellbeing, and alongside clear guidance for professionals on the circumstances where diagnostic assessments are appropriate.[vi]

[vi] MHSTs are intended to provide preventative support and needs-led early interventions to children whose health and wellbeing needs are below the threshold of a diagnosable mental health condition. If children's needs do present as more severe and complex – and likely requiring external specialist clinical support, updated guidance for MHSTs should be even clearer about the circumstances in which diagnostic assessments are appropriate. Most children presenting with emerging needs or mild-moderate mental health problems can be supported by MHSTs without requiring a diagnosis.

- The new **Young Futures Hubs** announced by the government should provide inclusive, open access, early support for children's mental health in every ICB area - working closely with family centres and the proposed neighbourhood health centres, as well the voluntary and community sector. It is welcome that these hubs now sit within the Department for Education, rather than the Home Office. They must be designed and delivered in partnership with the Department for Health and Social Care, building on the findings from the pilot of Early Support Hubs.

Tackling health inequalities

- This research highlights that certain groups of children are particularly at risk of being in crisis. To prevent children's needs from escalating to this point, **Integrated Care Boards (ICBs) should provide sufficient funding to community-based therapeutic services led by and for the communities they serve**, which are able to reach children from marginalised communities, many of whom are less likely to access statutory CYPMHS for lower-level mental health needs. **DHSC and ICBs should work with these organisations, as well as children themselves, to understand and remove barriers to accessing early help from NHS-provided CYPMHS.**

Increasing accountability for children's mental health

- It is welcome that the Care Quality Commission (CQC) has appointed its first Chief Inspector of Mental Health. Under the new Chief Inspector's leadership, **CQC should prioritise carrying out a thematic review of children's mental health services**. As well as identifying common gaps in thresholds between statutory provision, this review should investigate the practice driving some of the concerning trends presented in this report, particularly health inequalities and inequalities in access.

Reducing waiting times for CYPMHS

- **No child should be turned away from mental health and wellbeing support, or wait more than four weeks for an initial assessment of their mental health needs, and four weeks for treatment to begin** in Children and Young People Mental Health Services (CYPMHS). It is positive to see the number of referrals being closed before treatment has declined since last year, however waiting times remain stubbornly high – particularly for those children who were still waiting for support at the end of the year.

- **To make this goal achievable, the NHS 10 Year Plan must make provision for additional, annual ring-fenced funding to Integrated Care Boards to ensure that every local area is able to meet the mental health needs of the children in its area**. Data in this report on how much high performing ICBs are spending per child with an active referral should be used as a benchmark of the additional investment required, with funding appropriately weighted by child population, levels of deprivation and other key indicators of need. Even the ICB in 2023-24 with the highest proportion of investment only spends 1.72% of its budget on children and young people's mental health services, which demonstrates the importance of ring-fencing this additional funding so that it is not absorbed into spending on adult and other services.

"The government should put more money into supporting children who are under CAMHS. There should be more staff and funding because at the moment people are struggling more than ever with their mental health and lots of people are trying to get diagnosed with autism, ADHD etc. The waiting lists are too long and people are struggling as a consequence." – Girl, 16, The Big Ambition

Improving data on waiting times

- **The Department for Health and Social Care should continue to develop and roll out a single and comparable way of measuring the most meaningful wait a child is subject to**. Rather than number of contacts, this should focus on how long children wait from referral to assessment of their needs, and for support/treatment to begin. Currently NHS England publishes how long children wait for their first contact with CYPMHS, and this can include 'indirect' contacts (or 'activity'), which does not involve any direct contact with a child or their proxy[vii]. This may include a mental health professional attending a multi-disciplinary meeting to discuss a child, or speaking to a parent, teacher or other professional. The CCo does not believe this measure provides accurate insight into how long children are waiting to start receiving help for their mental health,

[vii] In cases where a child is unable to represent themselves (such as when they are too young or have mental/physical health conditions that mean they cannot do so), parents and carers will be considered proxies and activity related to them are considered direct contacts.

and welcomes the work already underway by DHSC and NHSE to improve this measure in the new community mental health (CMH) waiting times metric.[viii]

"*Early diagnosis and treatment can overall take pressure off of the NHS instead of giving psychiatric treatment to children which may not be necessary.*" – Girl, 18, The Big Ambition

"Better mental health support in schools, shorter waiting lists for support, equal opportunities for people with additional needs." – Girl, 17, The Big Ambition

Improving pathways for support

- **The Department for Health and Social Care should commission an independent, clinician-led review of diagnostic pathways and post-diagnosis support for children with suspected or diagnosable neurodevelopmental conditions**, both those with co-occurring mental health needs and those without. This review should focus in particular on:
    - **Why children and families are seeking a diagnosis, and whether a diagnosis is in a child's best interests.** The CCo report on *Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions* [7] shows that many children are seeking a diagnosis to unlock support that could be provided on a needs-led basis, such as adjustments in schools or access to certain therapies.
    - **How waiting times for assessment and support can be reduced.** This report and previous CCo research underline that autistic children and children with other neurodevelopmental conditions face some of the longest waits for the support they need in mental health and community health services.
    - **Inconsistency in diagnostic assessments.** CCo research highlights inconsistencies in thresholds for children being referred and diagnosed between local areas. A key aim of this

[viii] This moves away from only measuring the time taken for someone to have a first contact (the methodology currently used to measure access to CYPMH services). The 'clock starts' when a referral is received by a service and 'stops' when a contact, SNOMED intervention code and outcome/experience measure are recorded in the MHSDS.

review should be to assess the reliability of diagnoses across different services and improve consistency. Whether a child is referred for diagnostic assessment and whether they are diagnosed should not be subject to a lottery of where they live or which pathway they on.

- **The current cost of private diagnostic assessments to the NHS**, and what the impact would be on patient outcomes, costs to the NHS, and NHS capacity if neurodevelopmental disorder assessments **were regulated under the Health and Care Act 2008.**

Reforming the Mental Health Act 1983

- The new Mental Health Act (currently progressing through parliament) **should establish a test for assessing children under 16's competency** to make decisions and give consent.
- The new Mental Health Act must place new duties on relevant authorities to ensure **there is sufficient inpatient mental health service provision** for children and young people, and **strengthen procedural requirements to prevent children from being placed in inappropriate settings**, such as adult wards and out-of-area placements.
- **The Mental Health Act should be amended to place a duty on the NHS to provide health and therapeutic services to any child who meets the national criteria for admission**, but where it is agreed that inpatient provision would not be in their best interests.

"*I think you should improve mental health hospitals, especially ones for young people.*" – Girl, 13, The Big Ambition

Background

Figures from the NHS and other organisations have shown a large increase in the number of children suffering with mental health issues in recent years. The NHS estimated that in 2023 approximately 1 in 5 children in England aged 8 to 16 (20.3%) had a probable mental health condition, a stark increase from 1 in 8 (12.5%) in 2017.[8] More up-to-date national figures are not available, as this survey has since been discontinued.

"*Lots of children have mental health problems in my age range and find it difficult to make friends due to covid.*" – Girl, 14, The Big Ambition

Concerningly, some groups of children suffer from especially poor mental health. Rates for children and young people aged 17 to 19 are even higher, with 23.3% estimated to have a probable mental health condition (up from 10.1% in 2017).[9] This is particularly true for girls and young women: between the ages of 17 – 19 they were over twice as likely as boys and young men to suffer from probable mental health conditions (32% of girls aged 17 to 19 compared to 15% of boys in the same age group).[10]

Mental health services in this report refer to advice and support from a range of professionals, for problems like stress, low mood and depression, anxiety, self-harm, eating disorders or difficulty managing behaviours. NHS England refers to children's mental health services as 'CYPMHS', however many children, families and professionals still refer to 'CAMHS' (Child and Adolescent Mental Health Services). Sometimes CYPMHS is used as an umbrella term which includes CAMHS as well as other mental health services that may be available to children.

About this report

With new figures sourced from NHS England using the Children's Commissioner's statutory powers to request data, this report examines spending on children's mental health, the numbers of children referred to and accessing Children and Young People's Mental Health Services (CYPMHS), and waiting times between referral and treatment starting (defined as having two contacts with CYPMHS).

All quotes from children and young people in this report are drawn from the Children's Commissioner's office's (CCo) *The Big Ambition* survey, which ran from September 2023 to January 2024. The survey included one open text question which received 174,131 responses: *"What do you think the government should do to make children's lives better?"*

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

1. Mental health spend per child referred – calculated using NHS Mental Health Dashboard spending figures and referrals data provided in the data collection (where higher spend per child referred means a higher score).

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

3. Average waiting time for children who receive a second contact (both direct and indirect contacts) with services (where lower average waiting times means a higher score).

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

[ix] Last year the Children's Commissioner's office adjusted the metrics used to calculate overall area scores – changes which are maintained in this year's report. See *Children's mental health services 2022-23* for more details.

This year, the Children's Commissioner's office is able to provide further insights on:[x]

- The number and detailed waiting times for children who waited more than 12 weeks to access treatment as well as the number of children who were *still waiting* (having not received two contacts by the end of the year in March 2024) for mental health support and how they long they had been waiting for.[xi]
- Waiting times between referral and first contact, and between first and second contact, on top of the usual data on waiting times between referral and second contact.
- Children's primary referral reasons, and waiting times by referral reason.
- The services children are waiting for, and waiting times by service type.
- Breakdowns on waiting times by gender, age, ethnicity, and geography.

For the first time, CCo is also reporting:

- Waiting times for contacts with CYPMHS that directly involve children and their proxies, rather than direct and indirect contacts (such as a mental health professional attending a multi-disciplinary meeting to discuss a child's case, or speaking to a child's parent or teacher).
- Breakdowns on referral reasons by gender, age and ethnicity.
- Children's referral source, and waiting times by referral source.

[x] Data on spend and eating disorders is publicly available on the NHS Mental Health Dashboard and data provided to the CCo on referrals and waiting times has now been published on the NHS website (see the methodology section at the end of this report).

[xi] Previous CCo reports were based on data that only included children who were referred during the year. Children who were referred before the financial year were excluded so the analysis did not capture children waiting more than a year to enter treatment. This and last year's reports (for data covering the 2022-23 and 2023-24 financial years), includes children with any active referral within the respective financial year, allowing us to capture children waiting more than a year for support.

Aim of this report

Many frontline NHS practitioners work tirelessly to improve children's health outcomes, and many children are proud of the NHS, and all the people who make it possible. The purpose of this research is to keep a sustained focus on the issue of children's mental health and wellbeing, and highlight the need for sustainably resourced and geographically consistent services to support them.

"Start paying NHS staff a fair wage and funding the NHS so that waiting lists aren't so long, especially for mental health which isn't taken seriously enough." – Child, 17, The Big Ambition

Limitations of this report

The figures in this report do not provide insight into:

- **Exactly how long children wait for assessment and treatment to begin**

Pathways to support vary hugely from area to area. A first or second contact may mean very different things in terms of the support a child receives, depending on how the referral pathway is designed. Some children may continue to wait for long periods after their second contact for treatment to begin.

In this report, a child is counted as accessing treatment if they have two contacts with CYPMHS. In some cases, treatment may begin from the first contact, or a child may have more than two contacts before treatment begins. For this reason, we cannot confidently say that every child with two contacts has entered treatment. However, it is the view of the CCo that this remains the best proxy measure available.[xii]

[xii] The CCo welcomes work already underway by DHSC and NHSE to improve this measure. Since September 2024, NHS England has started publishing data on the new community mental health (CMH) waiting times metric. This will show the proportion of people starting to receive meaningful help within 4 weeks in CYP Community Mental Health services, in line with the Clinically-Led Review of Standards (CRS) consultation. The referral to help metric measures the time it takes for a child or young person to start receiving meaningful help. This moves away from only measuring the time taken for someone to have a first contact (the methodology currently used to measure access to CYPMH services). The 'clock starts' when a

- **How well supported children are during their wait**

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

- **What happens to referrals closed before treatment**

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

- **Children's experiences of mental health services, effectiveness of support, and outcomes**

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

referral is received by a service and 'stops' when a contact, SNOMED intervention code and outcome/experience measure are recorded in the MHSDS.

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

Overall rates of children with probable mental health conditions have increased substantially in recent years, from about 1 in 8 (12.5%) children in 2017 to 1 in 5 (20.3%) in 2023.[xiii] [11] There could be a range of reasons for this, with research suggesting that it could include the impact of the Covid-19 pandemic and increased levels of poverty due to the higher cost of living.[12]

Applying the NHS mental health prevalence estimate to Office for National Statistics (ONS) mid-2023 population estimate for those age 8 to 17 (the latest available figures) suggests that there is a pool of approximately 1.43 million children with a probable mental health condition in England, a slight increase from 1.41 million in 2022 and 1.38 million in 2021.

NHS England's Mental Health Dashboard (formerly called The Five Year Forward View for Mental Health dashboard), shows that 788,000 children had at least one contact with NHS funded CYPMHS in 2023-24,[xiv] up from 710,000 in 2022-23. This includes NHS funded community services and school or college based Mental Health Support Teams. From this we can estimate that 55% of children with a probable mental health condition in England had at least one contact with CYPMHS – an increase from the 50% access rate in 2022-23.

However, while one contact may be used as a proxy for initial access, it is unclear whether a child or young person's treatment for their mental health condition begins after one contact, so the CCo prefers

[xiii] More up-to-date national prevalence figures are not available, as NHS England has discontinued this survey.

[xiv] The figures from NHS England's Mental Health Dashboard count the number of children who received at least one contact during the year: this may be their first contact; or it may be their second or later contact, after a first contact in a previous year. The CCo's preferred 2-contact measure, used in most of this report, instead counts the number of children who received their second-ever contact during the year.

to retain the 2-contact measure as a proxy for treatment beginning.[xv] Measured in this way, NHS figures for England show that just over 340,000 children entered treatment within the 2023-24 financial year. Applying this number to the approximate pool of children with a probable mental health need in 2023-24, the two-contact access rate is 24% (up from 22% in 2022-23) - under half the one contact access rate.

[xv] Any research citing a lower number of children waiting for mental health support is likely an underestimate, due to being based on the NHS's 1-contact measure.

2. Investment in children's mental health services

Overall, it is positive that investment in children's mental health services[xvi] increased every year from 2018-19 to 2022-23 (see Table 1 below). Nationally, Integrated Care Boards (ICBs, which have replaced Clinical Commissioning Groups) spent £1.1 billion on CYPMHS in 2023-24, equal to 1.04% of their total budget allocation – an increase from £996 million and 1.02% in 2022-23.

Even when adjusted for inflation, spending on CYPMHS has grown – a 9% increase in cash terms (up from a rise of 8% between 2021-22 and 2022-23) and 2% increase in real terms (up from a rise of 1% between 2021-22 and 2022-23). This is positive, since last year the CCo reported that increased spending on CYPMHS had just about exceeded inflation.[13]

Bearing in mind the 958,200 children with an active referral in 2023-24, this £1.1 billion averages out to £1,130 per child with an active referral, an increase of 8% from £1,050 in 2022-23 (cash terms). Adjusted for inflation, this becomes £1,060 per child with an active referral – a £10 increase from 2022-23 in real terms.

Considering the pool of 1.4 million children with a probable mental health condition (see previous section), this figure becomes £760 per child in cash terms or £715 in real terms.[xvii]

[xvi] This excludes spending on mental health services for children with learning disabilities.

[xvii] As 2022-23 was used as the reference year for calculating inflation adjusted values, the 2022-23 value for real spend per child stays the same for both cash and real terms.

Table 1: Real and nominal spend on children's mental health services, 2018-19 to 2023-24

Year	Nominal spend (millions)	Nominal growth rate (%)	Real spend (millions)	Real growth rate (%)
2018-19	£724m		£832m	
2019-20	£799m	10%	£896m	8%
2020-21	£868m	9%	£925m	3%
2021-22	£922m	6%	£988m	7%
2022-23	£996m	8%	£996m	1%
2023-24	£1,082m	9%	£1,020m	2%

Note: Reference year of 2022-23, to account for recent inflationary pressures.

As with other indicators, spending on CYPMHS varies widely by area (see Table 2 below). Total spending on CYPMHS ranges from as much as £64 million in NHS North East and North Cumbria to £10 million in NHS Shropshire, Telford and Wrekin.

While this increase in investment is welcome, not enough is being spent on children proportionately, and geographical inequalities persist. As a proxy to gauge the prioritisation of children's mental health service amongst the ICB's other duties and departments, this report also looks into the proportion of each ICB's budget allocation spent on CYPMHS (see Table 2 below). ICBs spent £1.1 billion on CYPMHS in 2023-24, which is equal to just 1.04% of their total spend. As with other metrics, spending on CYPMHS as a percentage of ICB's total expenditure ranges from a maximum of 1.72% in NHS Norfolk and Waveney to 0.71% in NHS Mid and South Essex (see Table 2 below).

Examining total spend on CYPMHS only shows part of the picture, as the measure does not take into account the number of children referred to mental health services. Looking at spend per child with an active referral, NHS North East and North Cumbria only spends £1,038 per child despite having the highest total spend, and NHS Shropshire spends £1,248 per child referred - despite having the lowest total spend (see Table 2 below).

As with total spend, spend per child referred also varies widely by ICB, from as much as £2,513 in NHS North West London to in £548 in NHS Coventry and Warwickshire. Examining the ICBs which spent the

most per child, London ICBs occupy the top 3 spots - with NHS North West London closely followed by NHS North Central London (£2,403) and NHS North East London (£2,175).

In Chapter 10, this report draws on these insights, as well as data on average waiting times in ICB areas, to calculate overall scores for each Integrated Care Board.

Table 2: Spending on CYPMHS by ICB in 2023-24, ordered from highest to lowest spend per child referred

ICB name	Total spend on CYPMHS (£)	Spend per child referred (£)	% of budget spent on CYPMHS
NHS North West London ICB	£48m	£2,513	1.18%
NHS North Central London ICB	£45m	£2,403	1.58%
NHS North East London ICB	£44m	£2,175	1.19%
NHS Dorset ICB	£14m	£1,846	0.97%
NHS Birmingham and Solihull ICB	£34m	£1,775	1.32%
NHS Norfolk and Waveney ICB	£33m	£1,746	1.72%
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£17m	£1,610	1.10%
NHS South East London ICB	£40m	£1,577	1.13%
NHS Bristol, North Somerset and South Gloucestershire ICB	£15m	£1,542	0.87%
NHS Staffordshire and Stoke-on-Trent ICB	£27m	£1,524	1.31%
NHS Bedfordshire, Luton and Milton Keynes ICB	£20m	£1,515	1.23%
NHS Cornwall and the Isles of Scilly ICB	£13m	£1,470	1.20%
NHS Northamptonshire ICB	£12m	£1,392	0.92%
NHS Derby and Derbyshire ICB	£21m	£1,283	1.09%
NHS Gloucestershire ICB	£12m	£1,254	1.12%
NHS Shropshire, Telford and Wrekin ICB	£10m	£1,248	1.06%
NHS Black Country ICB	£28m	£1,242	1.23%
NHS Lincolnshire ICB	£11m	£1,227	0.77%
NHS Sussex ICB	£33m	£1,196	1.02%
NHS Mid and South Essex ICB	£15m	£1,195	0.71%

NHS Frimley ICB	£18m	£1,193	1.45%
NHS Lancashire and South Cumbria ICB	£31m	£1,134	0.87%
NHS Hertfordshire and West Essex ICB	£26m	£1,122	0.99%
NHS Greater Manchester ICB	£59m	£1,097	1.04%
NHS Devon ICB	£21m	£1,097	0.95%
NHS Surrey Heartlands ICB	£21m	£1,087	1.17%
NHS South West London ICB	£25m	£1,068	0.95%
NHS Suffolk and North East Essex ICB	£15m	£1,054	0.88%
NHS Hampshire and Isle of Wight ICB	£37m	£1,052	1.14%
NHS Somerset ICB	£10m	£1,049	0.97%
NHS North East and North Cumbria ICB	£64m	£1,038	1.06%
NHS South Yorkshire ICB	£22m	£979	0.82%
NHS Leicester, Leicestershire and Rutland ICB	£16m	£943	0.91%
NHS West Yorkshire ICB	£43m	£941	0.97%
NHS Cheshire and Merseyside ICB	£48m	£934	0.90%
NHS Herefordshire and Worcestershire ICB	£12m	£934	0.87%
NHS Humber and North Yorkshire ICB	£25m	£879	0.81%
NHS Cambridgeshire and Peterborough ICB	£14m	£759	0.92%
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£23m	£628	0.84%
NHS Nottingham and Nottinghamshire ICB	£16m	£623	0.77%
NHS Kent and Medway ICB	£28m	£580	0.84%
NHS Coventry and Warwickshire ICB	£16m	£548	0.96%

3. Referral outcomes and waiting times

"Actually help kids with mental health problems instead of leaving them on a waiting list most of their teenage years." – Girl, 13, The Big Ambition

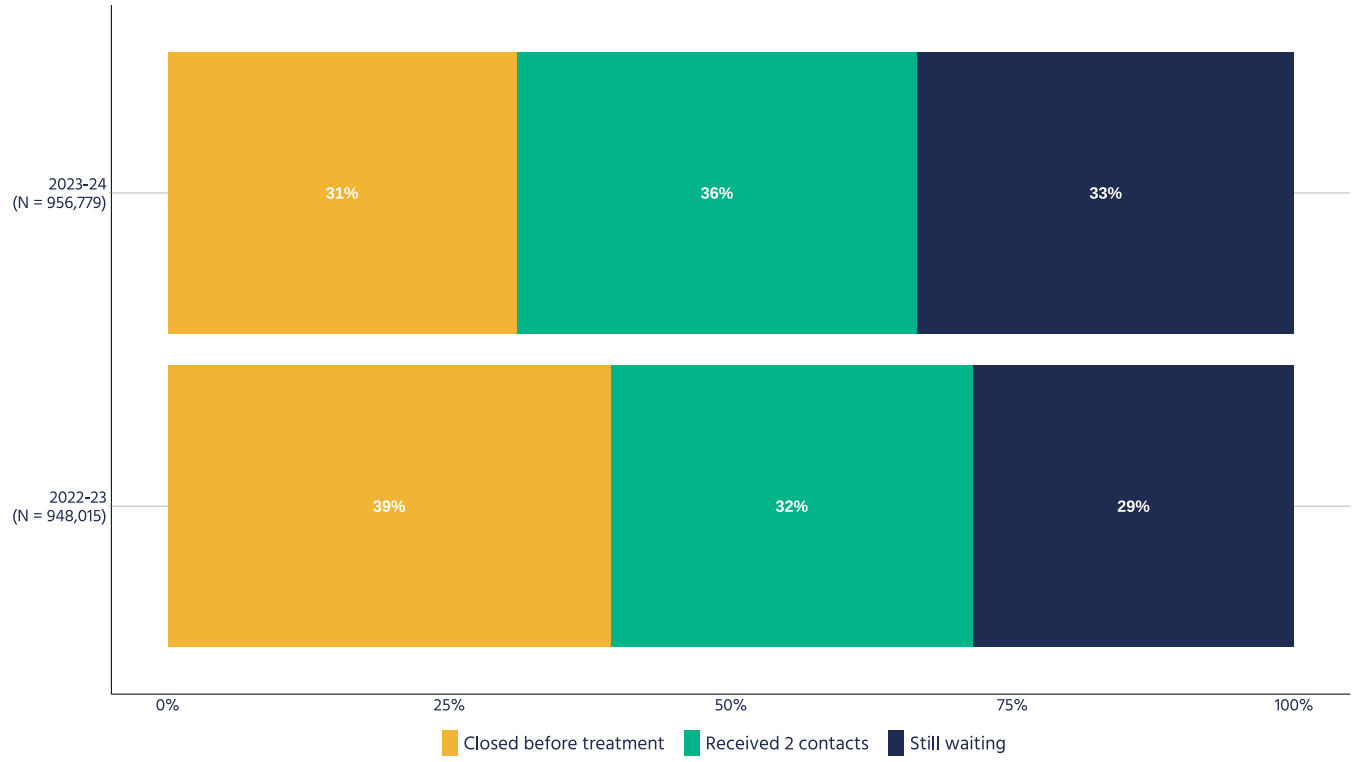
Broadly, it remains the case that by the end of the year around a third of children have been seen in CYPMHS (36%), around a third have had their referrals closed before accessing mental health services (31%), and around a third are still waiting (33%). However, compared to 2022-23, in 2023-24 more children began treatment, fewer children had their referrals closed and more were still waiting for treatment to begin.

Latest CCo analysis shows that there were 958,200 children who had active referrals to CYPMHS in the 2023-24 financial year – an increase from 949,200 in 2022-23.[xviii] Of these children:

- **296,300 (31%) children had their referrals closed before accessing CYPMHS** (referral closed before their second contact) – down from 373,000 (39%) in 2022-23. This is higher at 325,800 children (34%) when considering only direct contacts with the child.
- **Over 340,000 (36%) children had two contacts** – up from 305,000 (32%) in 2022-23. When only considering contacts that directly involve the child or their proxies in 2023-24, this was lower - 304,100 children (31%).
- **320,000 (33%) children were still waiting at the end of the year** (were yet to receive their second contact with CYPMHS by the end of March 2024) up from 270,300 (28%) in 2022-23. When considering only direct contacts, this is higher at 339,800 children (35% of those with active referrals).

[xviii] Figures from CCo mental health briefings published using data covering the 2021-22 financial year and earlier are not directly comparable to the figures in this and last year's reports due to a methodology change. To investigate children waiting longer than a year to enter treatment, all children with active referrals are now included in the data (some of whom may have been referred years before), not just those with referrals that started during the year.

Figure 1: Outcomes of children referred to CYPMHS in 2022-23 and 2023-24 – how many had their referrals closed, received two contacts or were still waiting by the end of the year.



**Note that some children marked as having contacts before referral, likely due to data collection and entry issues, have been omitted from this chart.*

Waiting times for children who accessed CYPMHS

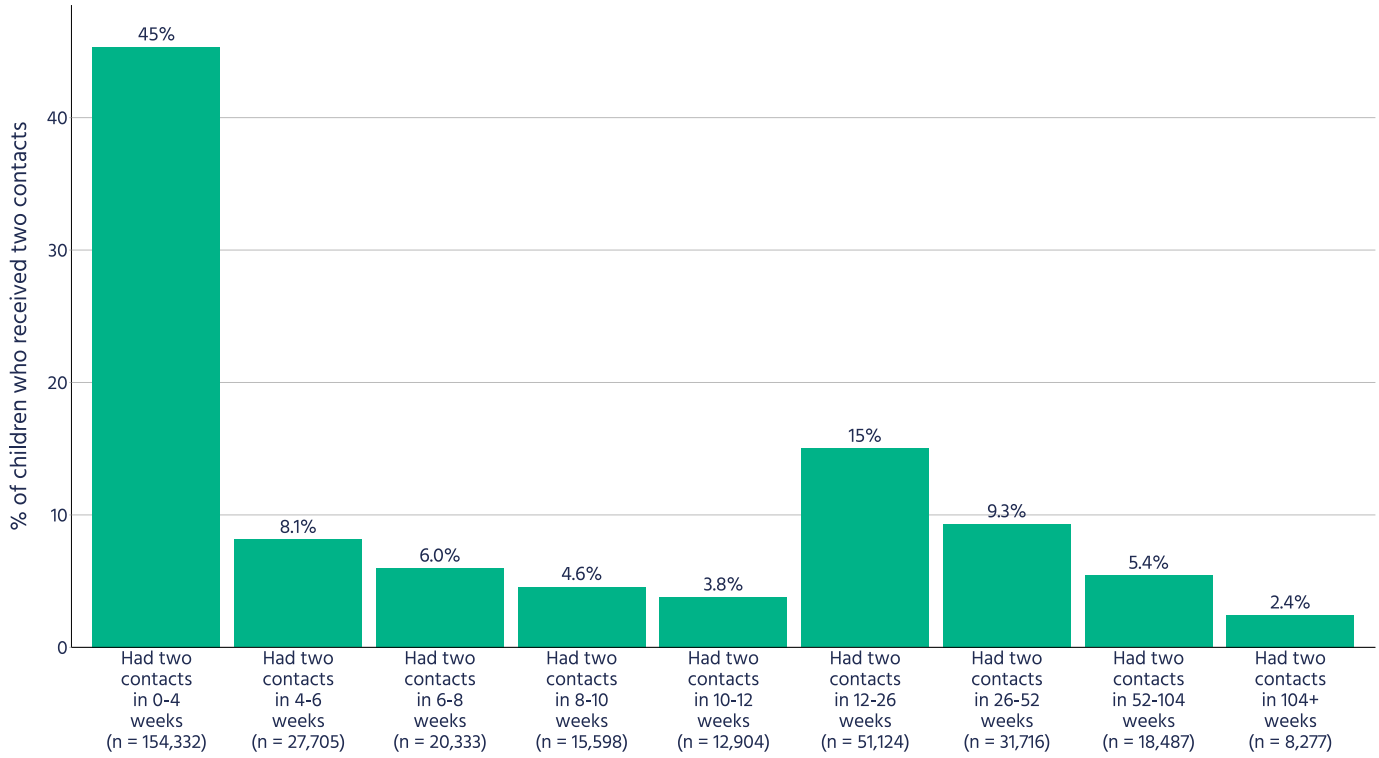
The 340,500 children who received at least two contacts with CYPMHS within the year waited an average of 35 days (median - unchanged from 2022-23) or 114 days (mean - up from 108 days in 2022-23).

As Figure 2 (below) shows, almost half (45% - 154,300 children) of these children received their first contact within a month (four weeks).

A growing minority of children waited particularly long periods before entering treatment. In 2023-24, there were 18,500 (5.4%) children who waited between 1 to 2 years to enter treatment, and there were 8,300 (2.4%) children who waited over 2 years (104 weeks) before entering treatment. For this group of children, average waiting times were 2 years 9 months (median, 1,007 days) or 3 years 5 months (mean,

1,247 days). This is an increase from 6,300 (2.1%) children waiting over 2 years to enter treatment in 2022-23, for whom the average wait was 3 years 1 month (median, 1,128 days) or 3 years 10 months (mean, 1,399 days).

Figure 2: How long it took for children referred in or before the 2023-24 financial year to receive two contacts with CYPMHS services in 2023-24.



When looking only at direct activity with children, meaning contacts that directly involve the child or their proxy, average waiting times are higher. New CCo analysis finds that children wait longer for their second direct contact – an average of over six weeks (a median of 45 days) or over four months (a mean of 128 days).

"The main thing the government can do to help children is to fix the NHS. Of course this would help everyone, but paediatric services are heavily underfunded as are all sectors of the NHS, especially the child psychiatric sectors. I have friends who have been on an NHS waitlist for mental health help for 2 years, and still not getting the help they need." – Girl, 17, The Big Ambition

"The waiting lists are currently far too long leaving struggling children and teens unsupported for long periods of time. This only worsens the difficulties they are facing, and early support is key when needing help with mental health." – Girl, 16, The Big Ambition

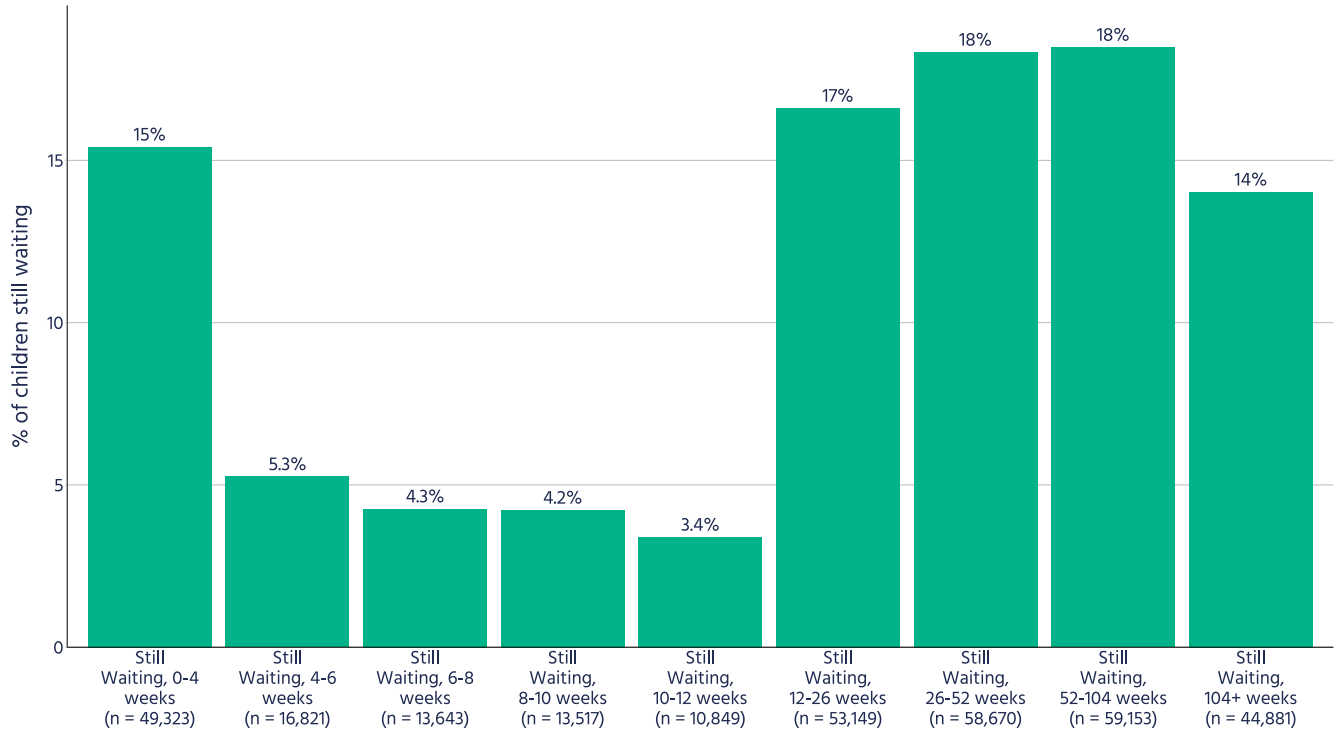
Waiting times for children who were still waiting to access CYPMHS

For the 320,000 (33%) children still waiting at the end of the year for their second contact with CYPMHS, they had waited on average 179 days (median) or 384 days (mean).

Many children who were still waiting at the end of the year had been waiting for much longer periods of time than those who began treatment: almost a third of children (32%) who were still waiting for support had been waiting for over a year (see Figure 3 below).

The longest waits among children still waiting have increased since last year. Of the 320,000 still waiting at the end of the year, 18% of children who were still waiting had been waiting for 1 to 2 years (up from 15% in 2022-23), and 14% of children who were still waiting had been waiting for over 2 years (up from 12% in 2022-23).

Figure 3: How long children still waiting to receive two contacts with CYPMHS services at the end of 2023-24 have been waiting.



4. Referral outcomes and waiting times by demographic and geography

Last year, the CCo published findings that showed waiting times from referral to second contact varied substantially depending on where the child lived, their age, their gender, and their ethnicity. This year the CCo is also able to provide new insights into how the outcome of children's referral varies by demographic, that is – whether children have their referral closed before treatment, are able to access treatment, or were still waiting for support.

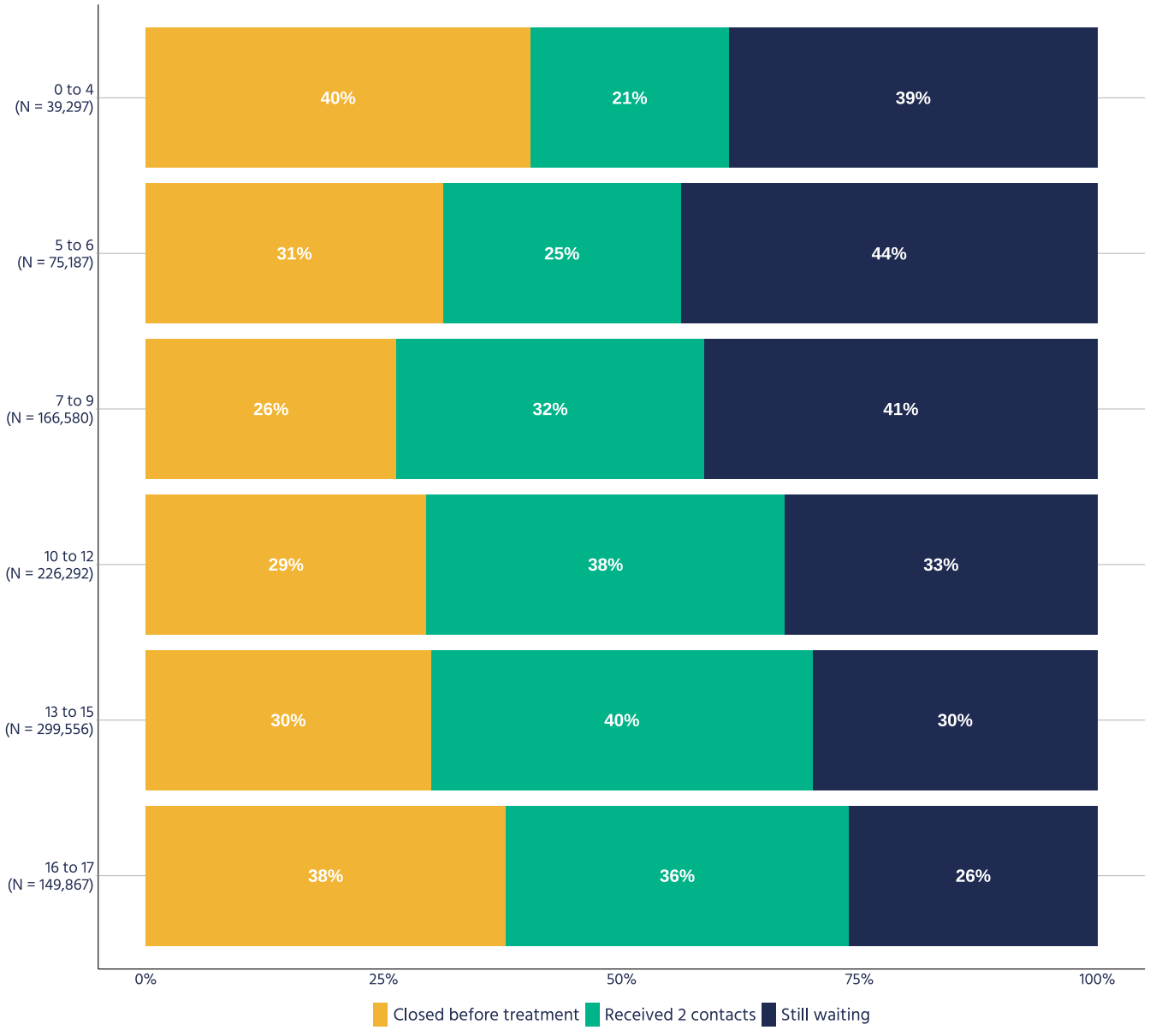
4.1 Referral outcomes and waiting times by children's age

Like last year, children aged 13 to 15 were by far the largest group of children accessing CYPMHS treatment in 2023-24, making up 35% (down from 37% in 2022-23) of all those entering treatment, despite making up only 18% of all children in England (see Figure 4 below). The large majority (76%) of all children entering treatment were aged 10 or above.

Referral outcomes by age – new analysis

CCo analysis shows that referral outcomes vary substantially by age group. Children under 5 years old referred to CYPMHS were least likely to have accessed treatment of any age group – with 21% receiving two contacts. This age group was also most likely to have their referral closed before treatment (40% of referrals). Those aged 5 to 6 were most likely to still be waiting for their second contact (almost half of those referred, 44%) and children aged 13 to 15 most likely to enter treatment (40% of all referred).

Figure 4: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by age group.



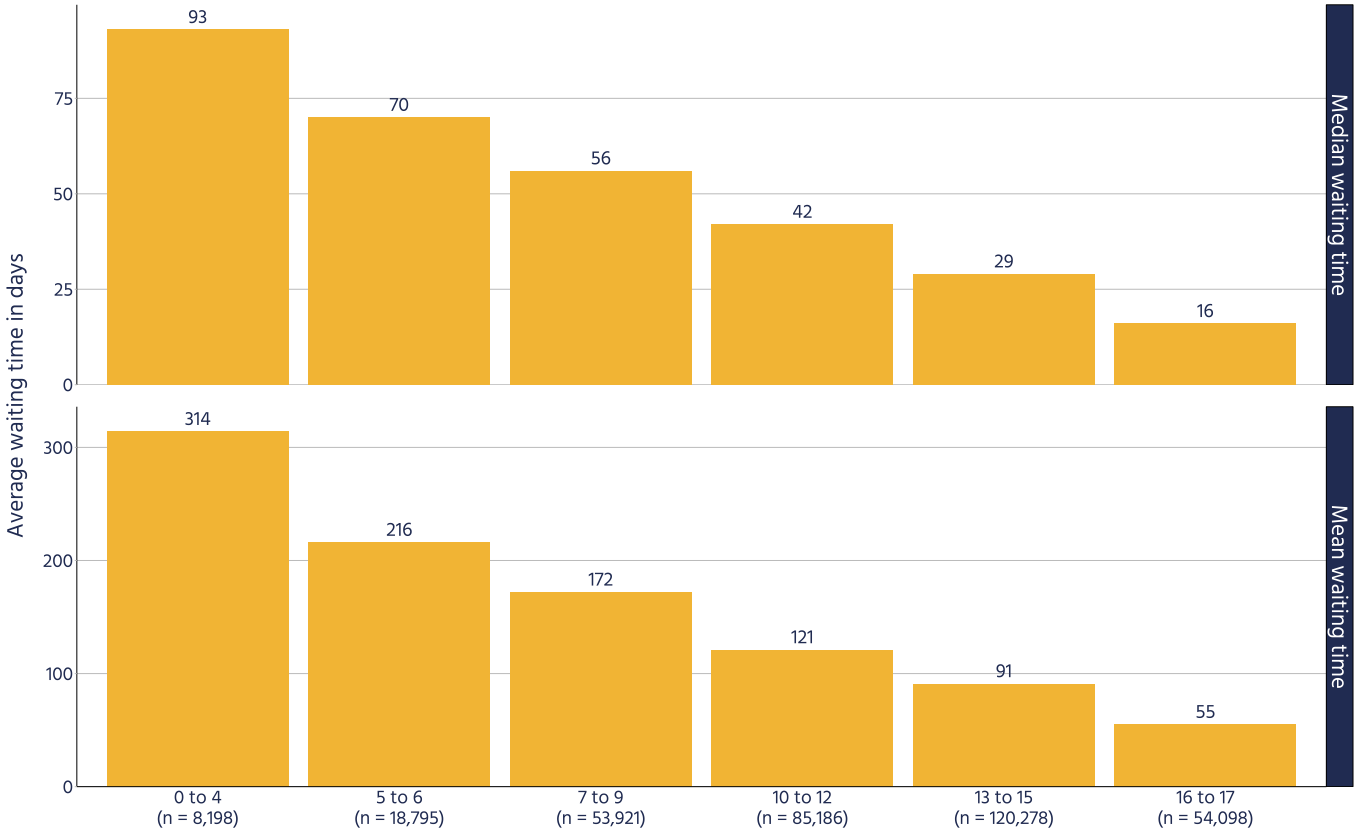
**Note that some children marked as having contacts before referral, likely due to data collection and entry issues, have been omitted from this chart.*

Waiting times by age

Waiting times are longest for the youngest children and shorten as they age, a continued trend from last year's report (see Figure 5 below). For example, children aged under 5 wait a median of 93 days, compared to 29 days for those aged 13 to 15, and 16 days for those aged 16 to 17 - the shortest wait of all age groups.

In last year's report, the CCo hypothesised that shorter waits were associated with more acute need at the point of referral. To explore this further, this year the CCo has for the first time requested data from NHS England on primary referral reasons by children's demographics, presented in Chapter 6. As is set out, older children are more likely to be referred for being in crisis. Of the 16- to 17-year-olds referred to CYPMHS, those in crisis made up almost a quarter (24%) of children who entered treatment. As Chapter 7 confirms, waits for crisis services are the shortest – which is expected given the nature of children's needs who are referred to these services.

Figure 5: Median and mean waiting times for children receiving two contacts with CYPMHS in the 2023-24 financial year, by age group.



As is highlighted throughout the report, when analysing 'direct' contacts only, these average waits can be even longer. For example, the average wait for children referred who are aged under 5 is 26 days longer (see Table 3 below). The age group with the smallest difference in waits is age 16 to 17, an increase of only 6 days. This suggests that children presenting with the highest need at the point of referral are more likely to receive direct contact with mental health professionals.

Table 3: Comparison of waiting times from referral to second contact between children waiting for all contacts (direct and indirect contacts) and direct contacts only in 2023-24, by age group.[xix]

Age group	Median wait in days - all contacts (direct and indirect)	Median wait in days - direct contacts only	Difference in days
0 to 4 years	93	119	26
5 to 6 years	70	91	21
7 to 9 years	56	72	16
10 to 12 years	42	53	11
13 to 15 years	29	39	10
16 to 17 years	16	22	6

4.2 Referral outcomes and waiting times by children's gender

More than half (56%) of all children receiving two contacts with CYPMHS in 2023-24 were girls – unchanged from 2022-23. To compare, 41% of this group were boys and 1% were non-binary.[xx] Gender was recorded as other, unknown or indeterminate for the remaining 2% of children.

[xix] For an explanation of what is considered a 'direct' and 'indirect' contact, please see the Executive Summary at the beginning of this report.

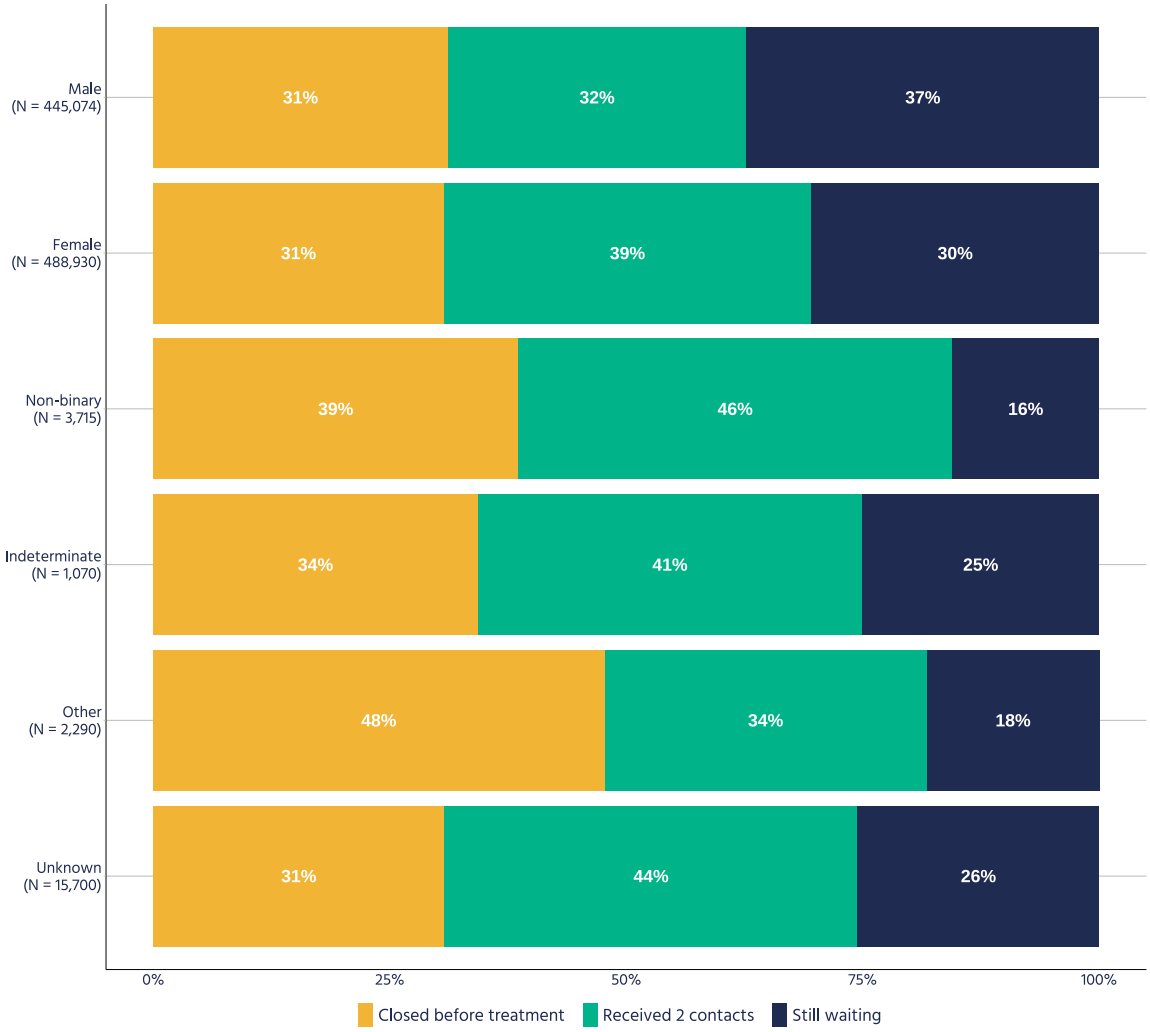
[xx] Note that gender identity information was only introduced as part of MHSDS version 5, which went live in October 2021. There are still a number of providers who do not submit data on non-binary children. As a result, the numbers quoted for non-binary are almost certainly an undercount.

This finding reflects wider research, which shows that teenage girls and LGBTQ+ children on average have higher rates of mental health conditions.[14] In the Children's Commissioner's 2021 *The Big Ask* survey, 1 in 5 children (20%) reported they were not happy with their mental health, rising to 2 in 5 (40%) among older teenage girls.[15]

Referral outcomes by gender - new analysis

Aside from non-binary and children whose gender is recorded as 'other', referral outcomes do not vary substantially by gender (where known). When looking at different gender categories less than half of children referred received two contacts and at least 3 in 10 had their referrals closed (see Figure 6 below). Non-binary children were both most likely to enter treatment (46%) but also second most likely to have their referrals closed before treatment (39%) after those recorded as 'other' (48%). Boys were most likely to still be waiting for a second contact (37% of those referred) followed by girls (30% of those referred).

Figure 6: Referral outcomes - percentage of children who had their referrals closed, received two contacts and were still waiting for a contact with CYPMHS in 2023-24, by gender.



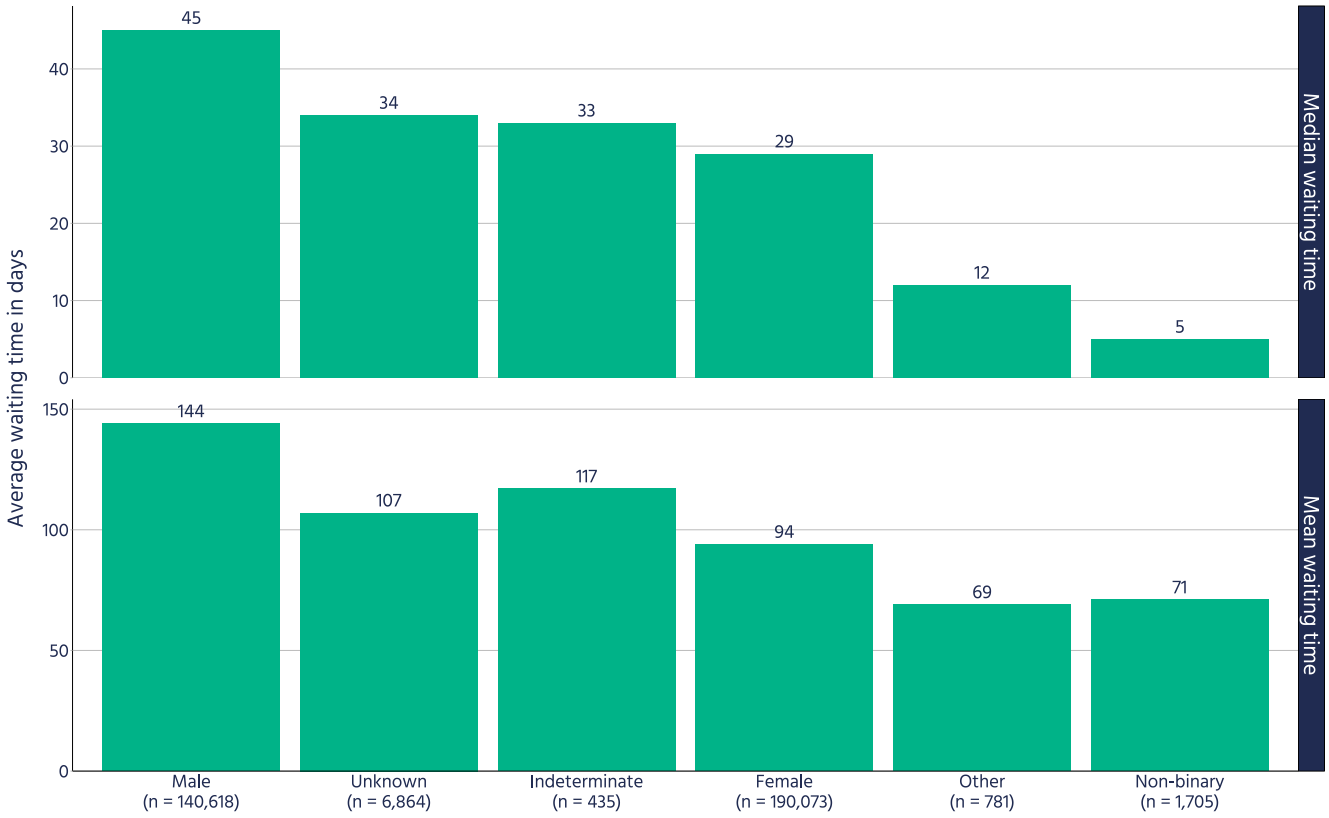
Waiting times by gender

On average, boys wait longer than girls for their second contact with CYPMHS, a median waiting time of 45 days (about the same as 46 days in 2022-23) compared to 29 days for girls (unchanged from last year), or over 50% longer. Waiting times for those who are non-binary were strikingly shorter than any other group, with a median wait of 5 days (down from 7 days in 2022-23) – see Figure 7 below.

This same trend was observed in last year's report.[16] To explore whether shorter times are associated with more acute need at the point of referral, this year the CCo has for the first time requested data from NHS England on primary referral reasons by children's demographics, presented in Chapter 6. The findings suggest that girls and non-binary children are slightly more likely to be referred in crisis, and boys are more likely to be referred for neurodevelopmental conditions (which Chapter 7 shows are associated with some of the longest waits in CYPMHS).

"More support for children whether it be mental health, abuse, sexual abuse etc, there's always a huge waiting list for them to be seen which is unfair, get them the help they need." – Girl, 12, The Big Ambition

Figure 7: Median and mean waiting times for children receiving two contacts with CYPMHS in the 2023-24 financial year, by gender.



When considering direct contacts only, waiting times increased for all children except non-binary children. The largest difference was for boys and for children whose gender is recorded as 'indeterminate', an increase of 14 and 29 days respectively.

Table 4: Comparison of waiting times from referral to second contact between children waiting for all contacts (direct and indirect contacts) and direct contacts only in 2023-24, by gender.[xxi]

Gender	Median wait in days - all contacts	Median wait in days - direct contacts only	Difference in days
Male	45	59	14
Female	29	38	9
Non-binary	5	5	0
Indeterminate	33	62	29
Other	12	14	2
Unknown	34	36	2

4.3 Referral outcomes and waiting times by children's ethnicity

Excluding those of unknown ethnicity, children of white ethnic groups comprise 81% of those accessing treatment – a notable overrepresentation compared to the 2021 Census benchmark (73% of under 18s in England). This is compared to the underrepresentation of those Asian children (5% accessing CYPMHS vs 12% of the child population) and black children (4% accessing CYPMHS vs 6% of the child population).[17] These proportions receiving two contacts are virtually unchanged from 2023-24.

Referral outcomes by ethnicity – new analysis

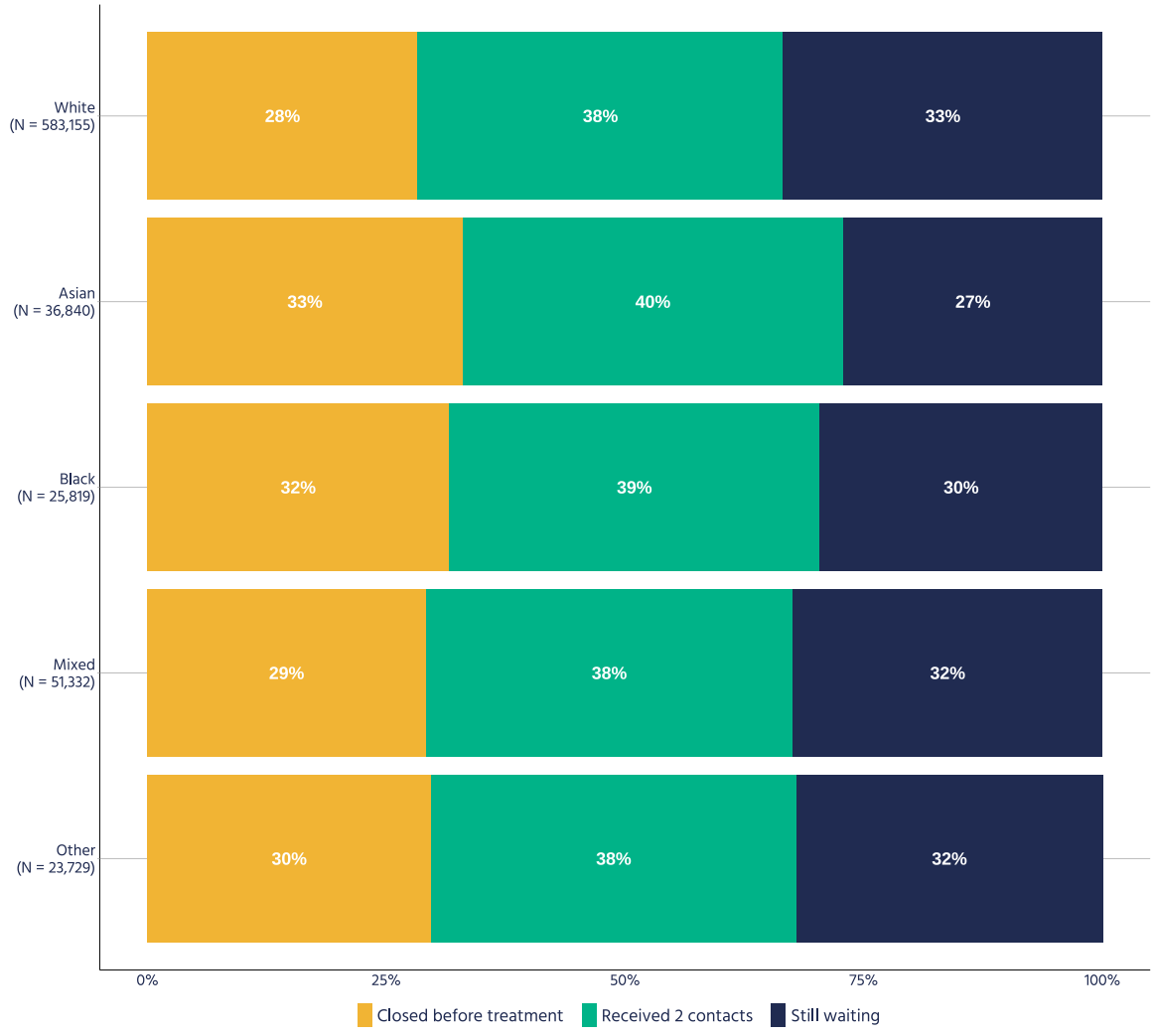
Children's referral outcomes do not vary much by broad ethnic group.[xxii] Children of all ethnic backgrounds have their referrals closed, enter treatment (received two contacts) and are still waiting at

[xxi] For an explanation of what is considered a 'direct' and 'indirect' contact, please see the Executive Summary at the beginning of this report.

[xxii] The CCo did not request data on more specific ethnic groups due to data quality issues. However, the office recognises that these may not be the terms that children and young people use themselves or identify with, and broad ethnicity categories can fail to recognise differences between the different cultures and communities within them.

similar rates (see Figure 8 below). Asian children were least likely to still be waiting for their second contact (27%) but also have the highest rates of referrals closed before treatment (33%).

Figure 8: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by ethnic group.



Waiting times by ethnicity

Children of white and mixed ethnicities waited the longest (both a median of 35 days – largely unchanged from 2022-23), followed by children of 'other'[xxiii] ethnic backgrounds (median 33 days). Asian and black children, despite only making up 5% and 4% of all children entering treatment (respectively), had notably shorter waiting times than any other ethnic group (see Table 5 below). Compared to the national median of 35 days from referral to second contact with CYPMHS, Asian children waited on average 21 days (up slightly from 19 days in 2022-23), and black children waited on average 24 days (about the same as 25 days in 2022-23).

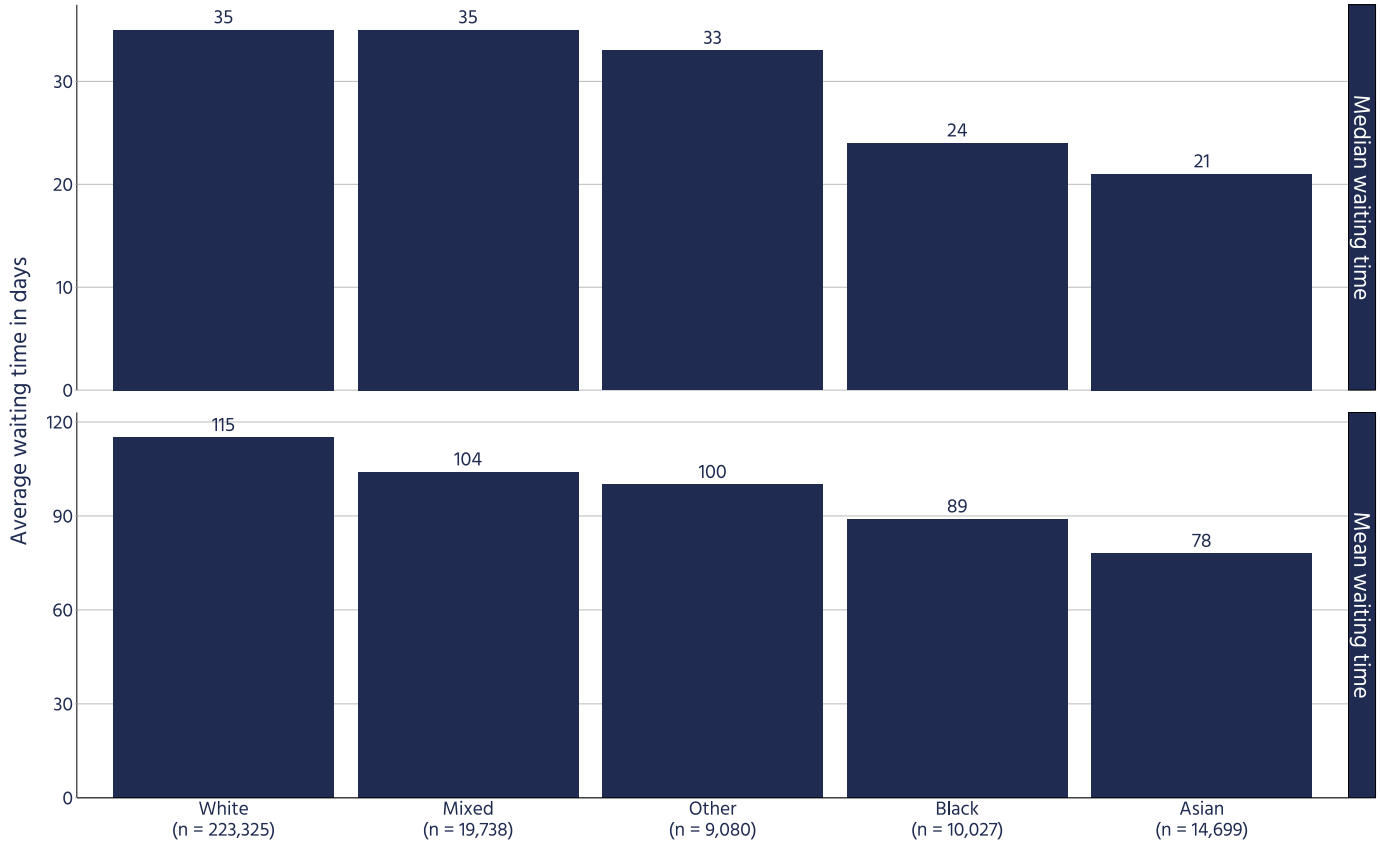
As with the variation in waiting times by age and gender, the variation in waits by ethnicity is similar to the trend observed in last year's report – with black and Asian children experiencing the shortest waits.[18] To explore whether shorter times are associated with more acute need at the point of referral, this year the CCo has for the first time requested data from NHS England on primary referral reasons by children's demographics, presented in Chapter 6. The findings show that 'in crisis' accounts for a bigger proportion of referrals for black and Asian children than other children – indeed, it is the most common referral reason for black children.

Table 5: Waiting times for children receiving two contacts with CYPMHS in the 2023-24 financial year, by ethnic group.

Ethnic group	Number of children referred	Median wait in days	Mean wait in days	Percentage of children receiving two contacts (%)
White	223,325	35	115	81%
Asian	14,699	21	78	5.3%
Black	10,027	24	89	3.6%
Mixed	19,738	35	104	7.1%
Other	9,080	33	100	3.3%

[xxiii] This may include some children from Latin American and Arabic backgrounds, among others.

Figure 9: Median and mean waiting times for children receiving two contacts with CYPMHS in the 2023-24 financial year, by ethnic group.



Waiting times for every ethnic group all increase when considering 'direct' contacts only, with the biggest difference seen for children of 'other' ethnic backgrounds, waiting 13 days longer. Asian children have the smallest difference in waits when comparing the 'direct only' measure to the 'any second contact' measure, a difference of only 7 days.

Table 6: Comparison of waiting times from referral to second contact between children waiting for all contacts (direct and indirect contacts) and direct contacts only in 2023-24, by ethnic group.[xxiv]

Ethnic group	Median wait in days - all contacts	Median wait in days - direct contacts	Difference in days
White	35	45	10
Asian	21	28	7
Black	24	36	12
Mixed	35	46	11
Other	33	46	13

4.4 Waiting times by geography (ICB area)

As with previous years, the average waiting time for children to enter treatment (receive two contacts with CYPMHS) varies widely by geography – analysed in this report by Integrated Care Board (ICB) footprint.[xxv] Children experience median waits from as quick as 6 days in NHS Leicester, Leicestershire and Rutland ICB to as slow as 103 days in NHS Hampshire and Isle of Wight ICB (see Table 7 below).

In 2022-23, NHS Mid and South Essex ICB had the shortest median waiting time at 5 days. The ICB has continued to perform well and has the second shortest median wait at 8 days in 2023-24. In contrast, NHS Hampshire and Isle of Wight ICB's waiting times have lengthened by almost a month despite also being the ICB with the longest waiting time in 2022-23 (median wait 79 days vs 103 days in 2023-24).

[xxiv] For an explanation of what is considered a 'direct' and 'indirect' contact, please see the Executive Summary at the beginning of this report.

[xxv] Integrated Care Boards (ICBs) replaced Clinical Commissioning Groups (CCGs) in the NHS in England from 1 July 2022. There are 42 Integrated Care Boards in England.

Table 7: CYPMHS average waiting times by Integrated Care Board (ICB)

Integrated Care Board name	Number of children referred	Median wait in days	Mean wait in days	Percentage receiving two contacts (%)
NHS Hampshire and Isle of Wight ICB	8,305	103	205	24%
NHS Devon ICB	4,660	75	202	24%
NHS Gloucestershire ICB	3,590	72	110	38%
NHS Sussex ICB	5,925	72	161	22%
NHS Black Country ICB	6,660	71	134	29%
NHS Nottingham and Nottinghamshire ICB	6,970	69	213	27%
NHS Norfolk and Waveney ICB	5,200	67	167	27%
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	7,590	64	178	20%
NHS Herefordshire and Worcestershire ICB	3,590	62	168	27%
NHS Frimley ICB	4,015	61	148	27%
NHS North Central London ICB	7,825	56	135	42%
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	4,170	55	117	40%
NHS Dorset ICB	3,110	54	91	41%
NHS Birmingham and Solihull ICB	4,240	52	120	22%
NHS Derby and Derbyshire ICB	6,960	51	122	42%
NHS Cambridgeshire and Peterborough ICB	5,345	50	111	29%
NHS Somerset ICB	3,110	46	146	32%
NHS Surrey Heartlands ICB	5,490	46	102	28%
NHS Kent and Medway ICB	15,105	43	145	31%
NHS Lincolnshire ICB	4,150	42	62	46%
NHS Coventry and Warwickshire ICB	4,615	41	180	16%
NHS North East and North Cumbria ICB	24,510	41	101	40%
NHS South East London ICB	7,840	37	134	31%
NHS Staffordshire and Stoke-on-Trent ICB	5,920	36	109	33%

NHS South West London ICB	9,485	36	80	40%
NHS Cheshire and Merseyside ICB	17,985	35	155	35%
NHS North West London ICB	8,750	34	73	46%
NHS West Yorkshire ICB	17,675	34	125	39%
NHS Northamptonshire ICB	5,470	31	60	63%
NHS Shropshire, Telford and Wrekin ICB	1,710	31	83	22%
NHS Hertfordshire and West Essex ICB	8,545	28	72	37%
NHS Humber and North Yorkshire ICB	9,885	27	115	35%
NHS North East London ICB	10,715	27	78	54%
NHS Suffolk and North East Essex ICB	6,685	25	93	45%
NHS Bristol, North Somerset and South Gloucestershire ICB	4,340	25	66	45%
NHS Lancashire and South Cumbria ICB	12,300	25	109	46%
NHS South Yorkshire ICB	8,490	22	94	39%
NHS Cornwall and the Isles of Scilly ICB	4,215	21	50	47%
NHS Greater Manchester ICB	25,805	14	71	48%
NHS Bedfordshire, Luton and Milton Keynes ICB	7,810	13	47	58%
NHS Mid and South Essex ICB	7,085	8	37	56%
NHS Leicester, Leicestershire and Rutland ICB	10,925	6	45	63%

When looking at direct contacts only, average waiting times in some areas can be even longer. For example, in NHS South East London ICB, average waiting times increase by 52 days when filtering to 'direct contacts' only (see Table 8 below).

Table 8: Comparison of waiting times from referral to second contact between children waiting for all contacts (direct and indirect) and direct contacts only in 2023-24, by ICB.[xxvi]

ICB name	Median wait - all contacts	Median wait - direct contacts	Difference in days
NHS South East London ICB	37	89	52
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	55	77	22
NHS Bedfordshire, Luton and Milton Keynes ICB	13	34	21
NHS Coventry and Warwickshire ICB	41	62	21
NHS North East London ICB	27	48	21
NHS Mid and South Essex ICB	8	28	20
NHS Sussex ICB	72	90	18
NHS Hampshire and Isle of Wight ICB	103	118	15
NHS Cheshire and Merseyside ICB	35	49	14
NHS Norfolk and Waveney ICB	67	80	13
NHS Greater Manchester ICB	14	26	12
NHS Cambridgeshire and Peterborough ICB	50	61	11
NHS North Central London ICB	56	67	11
NHS Nottingham and Nottinghamshire ICB	69	80	11
NHS West Yorkshire ICB	34	44	10
NHS Derby and Derbyshire ICB	51	60	9
NHS South Yorkshire ICB	22	31	9
NHS Hertfordshire and West Essex ICB	28	36	8

[xxvi] For an explanation of what is considered a 'direct' and 'indirect' contact, please see the Executive Summary at the beginning of this report.

NHS Humber and North Yorkshire ICB	27	35	8
NHS South West London ICB	36	44	8
NHS Suffolk and North East Essex ICB	25	33	8
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	64	71	7
NHS North East and North Cumbria ICB	41	48	7
NHS Staffordshire and Stoke-on-Trent ICB	36	43	7
NHS Frimley ICB	61	67	6
NHS Birmingham and Solihull ICB	52	57	5
NHS Cornwall and the Isles of Scilly ICB	21	26	5
NHS Lancashire and South Cumbria ICB	25	29	4
NHS North West London ICB	34	38	4
NHS Devon ICB	75	78	3
NHS Gloucestershire ICB	72	75	3
NHS Kent and Medway ICB	43	46	3
NHS Surrey Heartlands ICB	46	49	3
NHS Black Country ICB	71	73	2
NHS Bristol, North Somerset and South Gloucestershire ICB	25	27	2
NHS Dorset ICB	54	56	2
NHS Herefordshire and Worcestershire ICB	62	64	2
NHS Shropshire, Telford and Wrekin ICB	31	33	2
NHS Lincolnshire ICB	42	43	1
NHS Northamptonshire ICB	31	32	1
NHS Somerset ICB	46	47	1
NHS Leicester, Leicestershire and Rutland ICB	6	6	0

5. Referral outcomes and waiting times by primary referral reason

5.1 Referral outcomes by primary referral reason

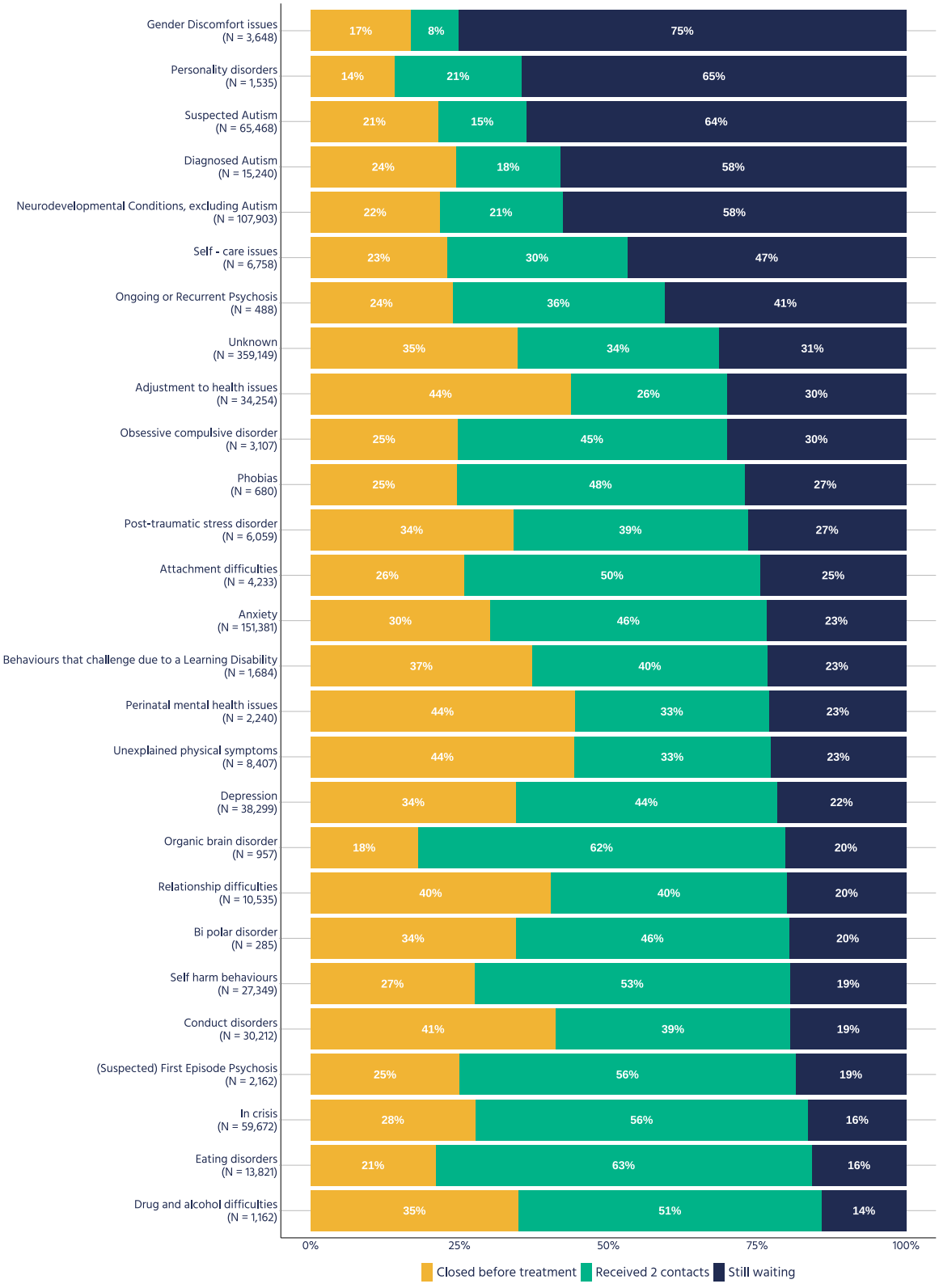
Children's access to mental health services not only varies by a child's characteristics, but also according to why there are referred to CYPMHS. Figure 10 below shows that the primary referral reasons with the highest proportions of children still waiting for support are gender discomfort issues (75% of children referred for this reason are still waiting), personality disorders (65% of children referred for this reason are still waiting), and suspected autism (64% of children referred for this reason are still waiting).

Children who were referred for adjusting to health issues,[xxvii] perinatal mental health issues, and unexplained physical symptoms were most likely to have their referrals closed before treatment - almost half (44%) of all children referred for these reasons.

The reasons with the highest proportions of children entering treatment and receiving two contacts were children with eating disorders (63%), organic brain disorders (62%), suspected first episode psychosis (56%), those "in crisis" (56%) and self-harming behaviours (53%).

[xxvii] This may include support services for children learning to adapt to life with a chronic or long-term condition, including following an injury or serious incident.

Figure 10: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by primary referral reason.



5.2 Waiting times by primary referral reason

"I think a lot of the time, anxiety can be blamed on hormones, or depression can be viewed as mood swings, when in reality these are life-limiting conditions that affect everyday living for a lot more of the population than the Government realises. I also think that if they made more of an effort in supporting children's mental health, it would positively affect that of adults in the future, as many cases of mental health issues in adults stem from childhood issues." – Girl, 16, The Big Ambition

There are many reasons why a child or young person is referred to mental health services. In 2023-24, due to shortcomings in NHS England data, the most common primary reason was 'unknown', making up 38% of those entering treatment within the year (down from 43% in 2022-23). NHS England told us reasons for this include that the data field is not mandatory, and the reason for a child or young person accessing support may not become apparent until their first appointment.

Of the known primary referral reasons (see Table 9 below), anxiety was the most common (16% - up slightly from 15% in 2022-23), followed by neurodevelopmental conditions excluding autism (11% - up from 9.2%), suspected autism (6.8% - up from 5.3%) and 'in crisis' (6.2% - up from 5.8%).

Suspected neurodevelopmental conditions account for a growing proportion of all referrals to CYPMHS. Neurodevelopmental conditions, such as autism and Attention Deficit Hyperactivity Disorder (ADHD), are not mental health conditions. "Neurodivergent" is a term used to describe individuals whose cognitive functioning differs from what is considered typical or "neurotypical". This may include people with neurodevelopmental conditions. The term "neurodiversity" was coined in the 1990s by autism activists and academic communities to highlight that differences in individual brain function and behavioural traits are a natural part of human diversity.[19]

However, many children with neurodevelopmental conditions also experience poor mental health, and experience their neurodivergence as disabling. This includes the challenges of living in a world predominantly designed by and for neurotypical people.[20] Identifying children's primary need, and whether mental health services are appropriate, is challenging due to shortcomings in the way data is

currently collected by NHS England. [xxviii] Recorded primary referral reasons as presented in MHSDS are often shorthand for a range of presenting symptoms and/or behaviours.

Last year, for the first time, CCo published analysis of waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions.[21] This research analysed waiting times in both CYPMHS and community health services, as neurodevelopmental assessments of children are carried out in both these types of services. This research highlighted that children are facing huge waits in both services, but waits are generally shorter in CYPMHS than in community health services. For example, the average wait time from referral to an autism diagnosis in community health services is 2 years 2 months, compared to 1 year 5 months in CYPMHS.[22]

What is clear from both this research and the separate research on waiting times for children with neurodevelopmental conditions is that there is a fast-growing need for assessment and support for children's neurodevelopmental conditions, both where a child has overlapping mental health needs and where they do not.

"I had to wait 3 years to get my ASD [Autism Spectrum Disorder] test and eventually went private, which was very expensive, and 5 years for CAMHS. I think this needs to improve." – Girl, 16, The Big Ambition

Table 9: Primary referral reasons to CYPMHS in the 2023-24 financial year.

Primary referral reason	Number of children referred in 2023-24	Percentage of children referred in 2023-24	Percentage point change from 2022-23 to 2023-24
Unknown	360,184	38%	-5.6%
Anxiety	151,479	16%	1.0%
Neurodevelopmental Conditions, excluding Autism	107,939	11%	2.1%
Suspected Autism	65,530	6.8%	1.5%
In crisis	59,720	6.2%	0.4%

[xxviii] Please see the Methodology section at the end of this report for more information on how children in CYPMHS are identified as primarily having a mental health need versus primarily having a need relating to autism, a learning disability or other type of neurodevelopmental condition.

Depression	38,319	4.0%	-0.5%
Adjustment to health issues	34,261	3.6%	0.3%
Conduct disorders	30,243	3.2%	0.2%
Self harm behaviours	27,362	2.9%	-0.1%
Diagnosed Autism	15,247	1.6%	0.5%
Eating disorders	13,827	1.4%	-0.1%
Relationship difficulties	10,547	1.1%	0.1%
Unexplained physical symptoms	8,409	0.9%	0.0%
Self - care issues	6,769	0.7%	0.0%
Post-traumatic stress disorder	6,066	0.6%	0.0%
Attachment difficulties	4,234	0.4%	0.0%
Gender discomfort issues	3,649	0.4%	0.1%
Obsessive compulsive disorder	3,109	0.3%	0.0%
Perinatal mental health issues	2,240	0.2%	0.1%
(Suspected) First episode psychosis	2,164	0.2%	0.0%
Behaviours that challenge due to a Learning Disability	1,685	0.2%	0.0%
Personality disorders	1,535	0.2%	0.1%
Drug and alcohol difficulties	1,166	0.1%	0.0%
Organic brain disorder	962	0.1%	0.0%
Phobias	680	0.1%	0.0%
Ongoing or recurrent psychosis	490	0.1%	0.0%
Bi polar disorder	285	0.0%	0.0%
Gambling disorder	73	0.0%	0.0%

*** Some referral reasons are not shown for reasons of statistical disclosure control (counts of 10 children or fewer)*

"Body image and eating disorders is a huge problem at school and with kids my age. I don't think anyone of my friends hasn't struggled with eating." – Girl, 15, The Big Ambition

"Many of my friends have self-harmed, had eating disorders or had suicidal thoughts. There is a mental health crisis. Typically, they never reached out for help. The CAMHS system and general school counselling system have a terrible reputation with many believing that going there 'only makes things worse'." – Child, 15, The Big Ambition

These top six referral reasons add up to the vast majority of all children entering treatment (82% - about the same as 81% in 2022-23).

Of all the primary reasons for referral (excluding unknown), the longest waiting times were for suspected autism, gambling disorder, and neurodevelopmental conditions (excluding autism), with medians of 223 days (up from 216 days in 2022-23), 195 days (up from 76 days) and 140 days (up from 111 days) respectively. This aligns with the findings from the CCo report *Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions.*[23] Children and families that the office spoke with described how mental health services are often not accessible to or inclusive of children with neurodevelopmental conditions. Evidence shows that when mental health interventions are not tailored to neurodivergence, they can be less effective for children with co-occurring neurodevelopmental and mental health conditions - and even harmful in some cases.[24]

Some referral reasons had relatively short waiting times (see Table 10 below). This year, the referral reasons with the shortest waiting times were "in crisis" (median 5 days – unchanged from 2022-23), self-harming behaviours (median 8 days – roughly the same as 7 days), suspected first episode psychosis (13 days – unchanged from 2022-23) and drug and alcohol difficulties (median 16 days, up from 9 days in 2022-23). While it is encouraging that children with such serious conditions are seen on average within 16 days, 5 days is still a long time for those in crisis to wait.

"[We need] better mental health services for children, faster access, waiting times are too high. My brother has an 18 week wait to get help for his mental health problems in the meantime mum is trying to keep him safe with no support or guidance, even though he threatens to end his life. 18 weeks is a very long time when you are in a really bad place mentally." – Boy, 18, The Big Ambition

Table 10: Primary referral reasons by waiting time in the 2023-24 financial year.

Primary referral reason	Number of children referred	Median wait in days	Mean wait in days
Suspected Autism	9,681	223	413
Gambling disorder	52	195	228
Neurodevelopmental conditions, excluding Autism	22,295	140	272
Diagnosed Autism	2,680	93	258
Personality disorders	328	90	203
Organic brain disorder	591	83	144
Obsessive compulsive disorder	1,405	78	143
Post-traumatic stress disorder	2,392	70	115
Phobias	328	64	112
Behaviours that challenge due to a Learning Disability	666	63	110
Attachment difficulties	2,105	58	106
Perinatal mental health issues	733	57	105
Gender Discomfort issues	291	56	189
Unexplained physical symptoms	2,772	47	124
Adjustment to health issues	8,980	45	97
Anxiety	70,259	42	87
Depression	16,782	40	85
Relationship difficulties	4,178	38	82
Conduct disorders	11,901	35	79
Bi polar disorder	131	34	60
Self - care issues	2,045	34	71
Eating disorders	8,734	17	49
Ongoing or recurrent psychosis	174	17	68
Drug and alcohol difficulties	592	16	33
(Suspected) first episode psychosis	1,220	13	38

Self harm behaviours	14,503	8	55
In crisis	33,371	5	34

As is highlighted throughout the report, when filtering for 'direct' contacts only, these average waits can be even longer, and seem to cluster around children referred for neurodevelopmental conditions and autism. For example, the median wait for children referred with suspected autism and neurodevelopmental conditions increases by 103 days and 46 days respectively. Fortunately, children referred for conditions requiring urgent attention, for example those in crisis, self-harming or experiencing psychosis and brain disorder, do not experience a large discrepancy between combined and direct only waiting times, suggesting that these referral reasons are more likely to lead to earlier direct contact with a CYPMHS professional.

Table 11: Comparison of waiting times from referral to second contact between children waiting for all contacts (direct and indirect) and direct contacts only in 2023-24, by primary referral reason.

Primary referral reason	Median wait - all contacts	Median wait - direct contacts	Difference in days
Suspected Autism	223	326	103
Neurodevelopmental Conditions, excluding Autism	140	186	46
Diagnosed Autism	93	129	36
Behaviours that challenge due to a Learning Disability	63	94	31
Gambling disorder	195	217	22
Post-traumatic stress disorder	70	92	22
Attachment difficulties	58	75	17
Obsessive compulsive disorder	78	95	17
Relationship difficulties	38	53	15
Unexplained physical symptoms	47	62	15
Perinatal mental health issues	57	70	13
Phobias	64	76	12
Conduct disorders	35	46	11
Depression	40	49	9

Self - care issues	34	43	9
Anxiety	42	50	8
Gender Discomfort issues	56	64	8
Personality disorders	90	98	8
Adjustment to health issues	45	52	7
Bi polar disorder	34	41	7
Drug and alcohol difficulties	16	23	7
Ongoing or Recurrent Psychosis	17	22	5
Self harm behaviours	8	13	5
(Suspected) First Episode Psychosis	13	16	3
Eating disorders	17	19	2
In crisis	5	6	1
Organic brain disorder	83	83	0

6. Primary referral reason by demographic

Last year, the CCo published waiting times by demographics, and hypothesised that shorter waits could be associated with more acute need at the point of referral. To explore this further, for the first time CCo has requested data on primary referral reason by children's demographics. While it is not possible from NHS England data to determine the severity or complexity of children's needs based on broad primary referral reason categories alone, a child being 'in crisis' or self-harming is a strong indicator that they have acute need for mental health support.

The figures presented in this chapter suggest that there is a relationship between the shorter waits experienced by particular groups of children, and presenting with the most acute need. There also appears to be a relationship between increased likelihood of being referred for neurodevelopmental conditions and experiencing the longest waits. Please note that referrals where the referral reason was unknown has been excluded from this analysis.

6.1 Primary referral reasons by children's age

Younger children (ages 0 to 6) were most likely to be referred for suspected autism and other neurodevelopmental conditions, accounting for approximately half of all referrals of children in this age bracket. Anxiety appears to be more common from the age of 10, and concerningly, 'in crisis' becomes more common from the age of 13. Being in crisis is the second most common referral reason for age groups 13 to 15 (12% of those referred) and 16 to 17 (17% of those referred).

Table 12: Top known primary referral reasons by age group in 2023-24.

Age group	Primary referral reason	Number of children referred	Percentage of children referred (%)
0 to 4 years	Suspected Autism	8,786	37%
	Neurodevelopmental conditions, excluding Autism	2,704	11%
	Anxiety	2,168	9.2%
5 to 6 years	Neurodevelopmental conditions, excluding Autism	15,413	32%
	Suspected Autism	9,558	20%
	Anxiety	7,853	16%
7 to 9 years	Neurodevelopmental conditions, excluding Autism	30,603	28%
	Anxiety	27,653	25%
	Suspected Autism	15,891	14%
10 to 12 years	Anxiety	43,651	32%
	Neurodevelopmental conditions, excluding Autism	25,302	18%
	Suspected Autism	14,410	10%
13 to 15 years	Anxiety	49,233	27%
	In crisis	22,185	12%
	Neurodevelopmental conditions, excluding Autism	22,134	12%
16 to 17 years	Anxiety	20,921	22%
	In crisis	16,134	17%
	Neurodevelopmental conditions, excluding Autism	11,783	12%

As has been highlighted in Chapter 3, not all of children's referrals lead to them accessing mental health support. Some children have their referrals closed, and others are still waiting. Table 13, below, shows the most common referral reasons that led to children accessing CYPMHS, and how long they waited to access support.

Table 13: Waiting times from referral to second contact by top known referral reasons and age group in 2023-24.

Age group	Primary referral reason	Number of children receiving two contacts	Percentage of children receiving two contacts (%)	Median wait in days	Mean wait in days
0 to 4 years	Suspected Autism	1,229	25%	431	713
	Anxiety	581	12%	41	94
	Neurodevelopmental conditions, excluding Autism	537	11%	175	347
5 to 6 years	Anxiety	3,124	26%	42	93
	Neurodevelopmental conditions, excluding Autism	2,675	22%	184	364
	Conduct disorders	1,404	12%	43	104
7 to 9 years	Anxiety	13,014	36%	42	87
	Neurodevelopmental conditions, excluding Autism	6,239	17%	176	341
	In crisis	3,391	9.5%	20	72
10 to 12 years	Anxiety	22,002	41%	40	86
	In crisis	6,270	12%	9	50
	Neurodevelopmental conditions, excluding Autism	5,790	11%	143	256
13 to 15 years	Anxiety	23,158	30%	47	92
	In crisis	13,279	17%	4	29
	Self harm behaviours	7,929	10%	9	57
16 to 17 years	In crisis	8,744	24%	2	15
	Anxiety	8,380	23%	40	70
	Depression	3,833	11%	36	67

Ahead of the 2024 general election, the Commissioner ran *The Big Ambition* survey from September 2023 to January 2024 – to hear from the children of England what their priorities were for the next government.[25] Children of all ages and parents responding on their behalf talked about the importance of children's mental health and wellbeing. Children were clear that there is no minimum age for poor emotional and mental health to set in, and support is needed for children at all different ages and stages of their development.

"More help with mental health in young children with feeling scared, worried, sad, angry, (dealing with emotions) caused by covid." – Girl, 7, The Big Ambition

"Don't say that kids are too young to have bad mental health. Because they aren't." – Girl, 10, The Big Ambition

6.2 Primary referral reasons by children's gender

Anxiety was the top known referral reason across for all children except boys – making up 30% of all girls and 25% of all non-binary children referred to CYPMHS. In contrast, **boys were most likely to be referred for neurodevelopmental conditions, with over a third (37%) referred for neurodevelopmental conditions and suspected autism.**

Girls and non-binary children are slightly more likely to be referred for being in crisis, making up 11% of primary referral reasons, compared to 9% of referrals for boys. Girls are also more likely to be referred for depression than boys, making up 7.6% of their referrals.

Table 14: Top known primary referral reasons by gender in 2023-24.

Gender	Primary referral reason	Number of children referred	Percentage of children referred (%)
Male	Neurodevelopmental conditions, excluding Autism	69,791	24%
	Anxiety	60,123	21%
	Suspected Autism	38,135	13%
	In crisis	25,973	9.0%

	Conduct disorders	19,725	6.8%
Female	Anxiety	89,003	30%
	Neurodevelopmental conditions, excluding Autism	37,695	13%
	In crisis	32,729	11%
	Suspected Autism	27,084	9.0%
	Depression	22,986	7.6%
Non-binary	Anxiety	189	25%
	In crisis	84	11%
	Gender discomfort issues	66	8.8%
	Suspected Autism	64	8.5%
	Neurodevelopmental conditions, excluding Autism	63	8.4%
Indeterminate	Anxiety	124	28%
	In crisis	55	12%
	Neurodevelopmental conditions, excluding Autism	47	11%
	Suspected Autism	38	8.6%
	Self harm behaviours	33	7.4%
Other	Anxiety	85	23%
	In crisis	71	20%
	Depression	29	8.0%
	Gender discomfort issues	27	7.4%
	Suspected Autism	26	7.1%

However, as acknowledged in the previous section, not all of children's referrals lead to them accessing mental health support. Some children have their referrals closed, and others are still waiting. For girls, non-binary children, and children recorded as having 'indeterminate' or 'other' gender, the top three most common primary referral reasons associated with accessing treatment are: anxiety, being in crisis, and self-harming behaviours. For boys, it is: anxiety, neurodevelopmental conditions excluding autism and being in crisis.

As mentioned, while it is not possible to determine the severity of children's needs based on broad primary referral reason categories alone, a child being 'in crisis' or self-harming is a strong indicator of acute need. This helps to explain why girls and non-binary children experience some of the shortest waits (see Chapter 4.2). Boys are disproportionately likely to be referred for and have contact with services because of suspected neurodevelopmental conditions, which are associated with some of the longest waits in CYPMHS (see Chapter 7).

Table 15: Waiting times from referral to second contact by top known referral reasons and gender in 2023-24.

Gender	Primary referral reason	Number of children receiving two contacts	Percentage of children receiving two contacts (%)	Median wait in days	Mean wait in days
Male	Anxiety	26,507	28%	42	89
	Neurodevelopmental conditions, excluding Autism	14,974	16%	153	291
	In crisis	13,188	14%	7	42
Female	Anxiety	42,146	35%	43	87
	In crisis	19,673	16%	4	28
	Self harm behaviours	10,393	8.6%	7	53
Non-binary	Anxiety	106	33%	47	106
	In crisis	61	19%	1	9
	Self harm behaviours	33	10%	8	62
Indeterminate	Anxiety	65	35%	98	141
	In crisis	37	20%	2	49
	Self harm behaviours	15	8%	4	48
Other	In crisis	50	30%	4	41
	Anxiety	43	26%	69	102
	Depression	17	10%	35	91

Many children who responded to *The Big Ambition* survey highlighted how experiences of gender-based discrimination, harassment and abuse negatively impacted on their mental health and wellbeing. Children want to receive support which is sensitive to these experiences.

"Promote equal opportunities and reduce inequalities amongst children and young people. Invest in gender-sensitive mental health and psychosocial support services for children and adolescents." – Girl, 17, The Big Ambition

"I think we should have more equality shown to people of the LGBTQ+ community. I have seen countless cases of harassment both online and in real life towards them. I also think children's and young people mental health should be taken more seriously." – Girl, 13, The Big Ambition

"Focus on children's mental health [...] encourage parents to develop their children in a safe environment and teach them to not be sexist, homophobic, and not allow them to access parts of the internet because I've seen it happen - my old friend has seen horrible things (at a young age) on the internet due to online access." – Girl, 13, The Big Ambition

6.3 Primary referral reasons by children's ethnicity

When looking at primary referral reasons by ethnicity, it is very concerning that being in crisis was among the top three most common primary referral reasons for all ethnic groups besides white. It is the most common reason black children were referred to CYPMHS – accounting for 29% of all referrals – as well as children recorded as having an 'other' ethnicity[xxix] – comprising 24% of all referrals.

[xxix] This may include some children from Latin American and Arabic backgrounds, among others.

Table 16: Top known primary referral reasons by ethnic group in 2023-24.

Ethnic group	Primary referral reason	Number of children referred	Percentage of children referred (%)
White	Anxiety	95,767	26%
	Neurodevelopmental conditions, excluding Autism	62,430	17%
	Suspected Autism	41,328	11%
Asian	Anxiety	4,779	21%
	In crisis	4,423	19%
	Neurodevelopmental conditions, excluding Autism	3,665	16%
Black	In crisis	4,858	29%
	Anxiety	2,643	16%
	Neurodevelopmental conditions, excluding Autism	2,504	15%
Mixed	Anxiety	8,495	24%
	Neurodevelopmental conditions, excluding Autism	6,108	17%
	In crisis	5,115	15%
Other	In crisis	4,243	24%
	Anxiety	3,301	19%
	Neurodevelopmental conditions, excluding Autism	2,677	15%

Last year, the CCo found that children of black and Asian backgrounds had much shorter waiting times from referral to second contact. The office speculated that this was due to the children's mental health conditions being more severe at the point of referral. As with older children, girls, and non-binary children, this new data shows that there is an association between shorter waits and these groups of children presenting with the most acute need.

Considering those who entered treatment (received two contacts), being in crisis was the common referral reason for Asian (28%), black (34%) and children of 'other' ethnicity (32%). The most common

referral reason for white and mixed children was anxiety, making up 34% and 30% of those entering treatment respectively.

Table 17: Waiting times from referral to second contact by top known referral reasons and ethnic group in 2023-24.

Ethnic group	Primary referral reason	Number of children receiving two contacts	Percentage of children referred (%)	Median wait in days	Mean wait in days
White	Anxiety	48,153	34%	44	89
	In crisis	18,898	13%	4	29
	Neurodevelopmental conditions, excluding Autism	13,827	9.7%	149	286
Asian	In crisis	2,543	28%	8	29
	Anxiety	2,230	24%	34	74
	Neurodevelopmental conditions, excluding Autism	825	9%	119	226
Black	In crisis	2,355	34%	11	56
	Anxiety	1,390	20%	31	67
	Neurodevelopmental conditions, excluding Autism	654	9.5%	105	188
Mixed	Anxiety	4,252	30%	43	80
	In crisis	2,786	20%	7	47
	Neurodevelopmental conditions, excluding Autism	1,265	9.1%	137	245
Other	In crisis	2,275	32%	14	48
	Anxiety	1,514	21%	43	80
	Neurodevelopmental conditions, excluding Autism	601	8.5%	127	234

Many ethnic minority children who responded to The Big Ambition survey spoke about their experiences of poor mental health. This was sometimes directly linked to their experiences of racist harassment and abuse. However, children also commonly spoke about wider challenges: including the barriers they faced to having their mental health needs identified and to accessing early mental health support. This is reflected in the CYPMHS access figures presented in Chapter 4.3. Excluding those of unknown ethnicity, children of white ethnic groups comprise 81% of those accessing treatment – a notable overrepresentation compared to the 2021 Census benchmark (73% of under 18s in England). This is compared to the underrepresentation of those Asian children (5% accessing CYPMHS vs 12% of the child population) and black children (4% accessing CYPMHS vs 6% of the child population).[26] It is possible this gap in early mental health support is leading to more ethnic minority children presenting in crisis.

"[The government] could prioritise early intervention, emotional intelligence education, accessible counselling services, focus more on mental health education, more supportive environments for struggling children and accessible resources, collectively working towards a resilient and thriving generation of and for children." – Boy, 17, Black, The Big Ambition

"Racism should end [...] I also think school should be more considerate about mental health and how young kids can be extremely upset, suicidal, depressed and other emotions and have to go to school every day covering these emotions and pretending their okay and not being able to focus in lessons which then leads to anger and misbehaviour which then gets punished even though all of it was triggered by emotions that no one bothered to listen to when going to pastoral support and saying I need talk to someone they assume that I am trying to skip lessons when all I'm looking for support." – Girl, 14, Asian, The Big Ambition

Ethnic minority children responding to *The Big Ambition* also highlighted the impact of poverty on their wellbeing. Children in England from certain ethnic minority backgrounds are disproportionately likely to grow up in poverty.[27] Asylum-seeking and refugee children are particularly at risk of destitution.

"Increase equality between middle class children and asylum-seeker children as well as other groups like refugees and children living in poverty. [...] Make sure that children struggling with mental health are not dismissed and feel safe enough to speak up." – Girl, 18, of 'other' ethnic group, The Big Ambition.

"Another thing that could help to make children's lives better would be to help struggling families with the cost of living crisis because a lot of kids will be worried about their parents not having enough money to pay for essentials. The government should invest more money into helping places that deal with mental health, especially after coming out of lockdown, which resulted in many children developing mental health conditions." – Child, 11, of mixed ethnic background, The Big Ambition

"Put funding into deprived areas in the country with ethnic minorities to help even out the playing field and tackle racism and discrimination within schools." – Girl, 18, of mixed ethnic background, The Big Ambition

"Government should help immigrant kids. My baby sister and I will be homeless in few weeks. I am sad because I will be changing school for the third time." – Boy, 8, Black, The Big Ambition

7. Referral outcomes and waiting times by service/team type

7.1 Referral outcomes by service and team type a child was referred to

"I believe therapy should be more accessible to those who need it, be it for identity issues or just general depression." – Child, 15, The Big Ambition

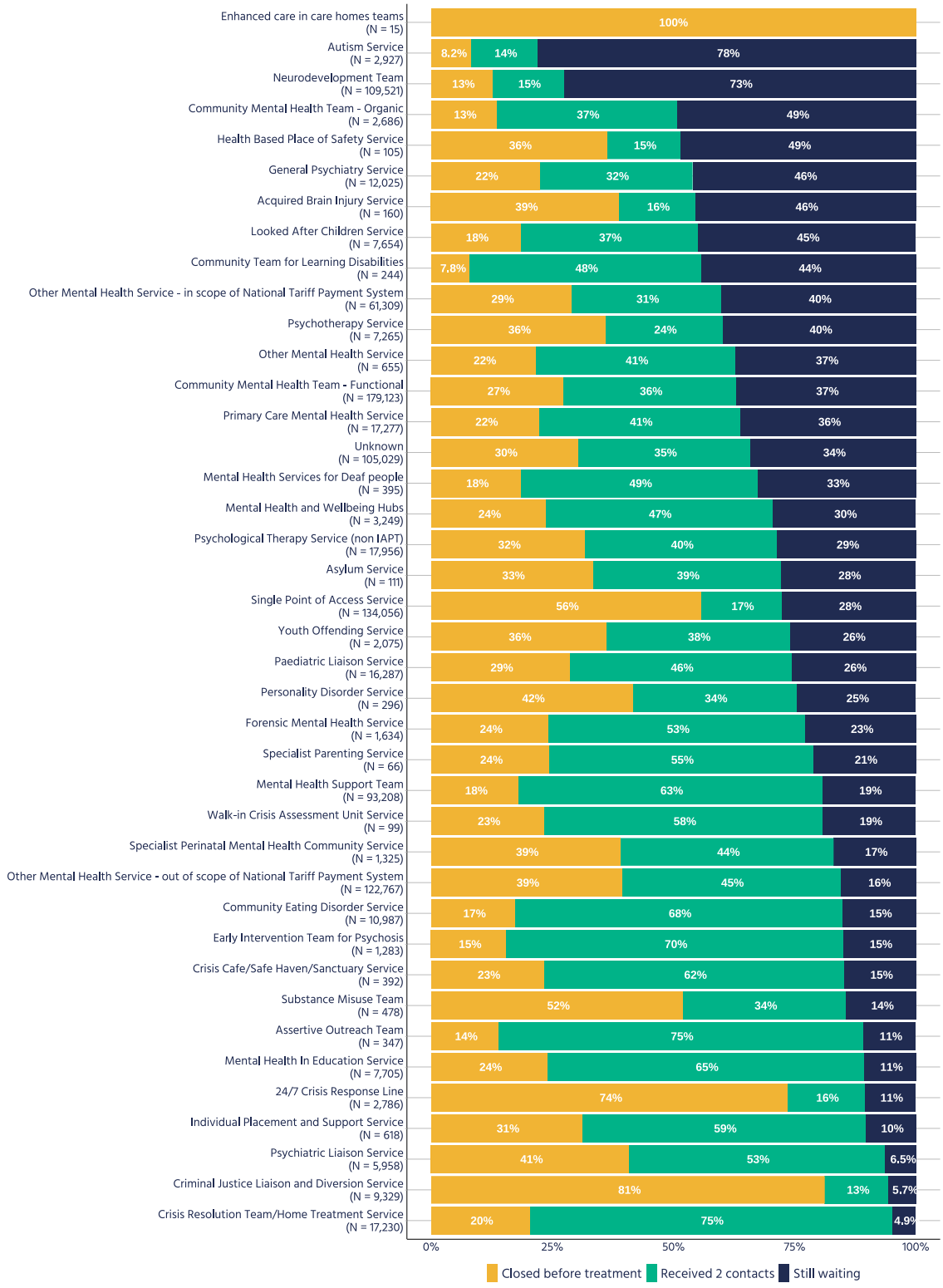
For the first time, CCo is able to provide insights into the outcomes of children's referrals to particular services in CYPMHS – that is, whether children had their referral closed, accessed treatment (two contacts), or were still waiting.

Figure 11 below shows that the majority of children referred to the Autism Service or to the Neurodevelopment Team were still waiting for their second contact: 78% of children referred to the Autism Service, and 73% by the Neurodevelopment Team, were still waiting. These were the only services where the majority of children were still waiting.

There were also four service types where the majority of children had their referral closed before their second contact: 81% of referrals by the criminal justice liaison and diversion service, 74% of referrals to the 24/7 crisis response line; 56% to the single point of access service; and 52% to the substance misuse team.

Every child referred to enhanced care in care home teams in 2023-24 had their referral closed before treatment. However, it should be noted that this only included 15 children.

Figure 11: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by service and team type the child was referred to.



7.2 Waiting times by service and team type

A key factor in how long children wait for mental health support is which service they are waiting for. Of all the services children are referred to, the longest waiting times were for the autism service, neurodevelopment team, and community mental health team for organic brain disorders, with respective average waits of 636 days (up from 481 days in 2022-23), 286 days (up from 194 days) and 247 days (up from 82 days) – see Table 18 below.

Table 18: Service and team types by waiting time to second contact, ordered by longest to shortest median wait in days

Service type	Number of children referred	Median wait in days	Mean wait in days	Percentage of children receiving two contacts (%)
Autism Service	405	636	691	0.1%
Neurodevelopment Team	16,002	286	407	4.7%
Community Mental Health Team - Organic[xxx]	1,002	247	411	0.3%
Acquired Brain Injury Service	25	217	244	0.0%
General Psychiatry Service	3,796	167	337	1.1%
Mental Health Services for Deaf people	193	151	254	0.1%
Asylum Service	43	146	162	0.0%
Primary Care Mental Health Service	7,165	114	163	2.1%
Psychotherapy Service	1,768	114	195	0.5%

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

Psychological Therapy Service (non IAPT)[xxxi]	7,116	76	134	2.1%
Community Mental Health Team - Functional	63,769	69	136	19%
Other Mental Health Service	270	62	88	0.1%
Individual Placement and Support Service	362	57	66	0.1%
Looked After Children Service	2,799	56	171	0.8%
Mental Health in Education Service	5,037	50	87	1.5%
Unknown	37,235	49	142	11%
Other Mental Health Service - in scope of National Tariff Payment System	19,005	42	126	5.6%
Specialist Parenting Service	36	40	82	0.0%
Mental Health and Wellbeing Hubs	1,522	38	84	0.4%
Substance Misuse Team	161	37	52	0.0%
Community Team for Learning Disabilities	117	35	198	0.0%
Specialist Perinatal Mental Health Community Service	583	35	57	0.2%
Mental Health Support Team	58,399	31	54	17%
Personality Disorder Service	100	28	47	0.0%
Single Point of Access Service	22,407	28	109	6.6%
Forensic Mental Health Service	867	26	43	0.3%
Youth Offending Service	786	22	64	0.2%
Community Eating Disorder Service	7,424	18	45	2.2%
Early Intervention Team for Psychosis	892	14	28	0.3%
Other Mental Health Service - out of scope of National Tariff Payment System	55,376	8	67	16%
Walk-in Crisis Assessment Unit Service	57	8	17	0.0%
Assertive Outreach Team	261	7	30	0.1%

[xxxi] Improving Access to Psychological Therapies.

Day Care Service	62	6	12	0.0%
Paediatric Liaison Service	7,472	6	77	2.2%
Crisis Caf/Safe Haven/Sanctuary Service	243	5	9	0.1%
Crisis Resolution Team/Home Treatment Service	12,885	2	6	3.8%
Criminal Justice Liaison and Diversion Service	1,224	1	13	0.4%
Health Based Place Of Safety Service	16	1	2	0.0%
24/7 Crisis Response Line	442	0	2	0.1%
Psychiatric Liaison Service	3,138	0	5	0.9%

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

As is highlighted throughout the report, when filtering for direct activity with children only, these average waits can be even longer – particularly for neurodevelopmental services, mental health and general psychiatry services. For example, the average wait for the community team for learning disabilities increases by 96 days.

Table 19: Comparison of waiting times from referral to second contact between children waiting for all contacts (includes professionals discussing a patient with each other) and direct contacts only (involves the child or their proxy) in 2023-24, by service type.

Service type	Median wait - all contacts	Median wait - direct contacts	Difference in days
Community Team for Learning Disabilities	35	131	96
General Psychiatry Service	167	206	39
Mental Health and Wellbeing Hubs	38	75	37
Neurodevelopment Team	286	316	30
Looked After Children Service	56	78	22
Other Mental Health Service - in scope of National Tariff Payment System	42	59	17
Forensic Mental Health Service	26	42	16
Psychological Therapy Service (non IAPT)	76	91	15
Community Mental Health Team - Organic	247	261	14
Specialist Parenting Service	40	54	14
Community Mental Health Team - Functional	69	82	13
Primary Care Mental Health Service	114	127	13
Specialist Perinatal Mental Health Community Service	35	46	11
Youth Offending Service	22	32	10
Mental Health In Education Service	50	57	7
Psychotherapy Service	114	121	7
Single Point of Access Service	28	35	7
Mental Health Support Team	31	37	6
Other Mental Health Service - out of scope of National Tariff Payment System	8	14	6
Autism Service	636	640	4

Criminal Justice Liaison and Diversion Service	1	4	3
Asylum Service	146	148	2
Early Intervention Team for Psychosis	14	16	2
Paediatric Liaison Service	6	8	2
Community Eating Disorder Service	18	19	1
Day Care Service	6	7	1
24/7 Crisis Response Line	0	0	0
Acquired Brain Injury Service	217	217	0
Assertive Outreach Team	7	7	0
Crisis Cafe/Safe Haven/Sanctuary Service	5	5	0
Crisis Resolution Team/Home Treatment Service	2	2	0
Health Based Place of Safety Service	1	1	0
Individual Placement and Support Service	57	57	0
Mental Health Services for Deaf people	151	151	0
Other Mental Health Service	62	62	0
Personality Disorder Service	28	28	0
Psychiatric Liaison Service	0	0	0
Substance Misuse Team	37	37	0
Walk-in Crisis Assessment Unit Service	8	8	0

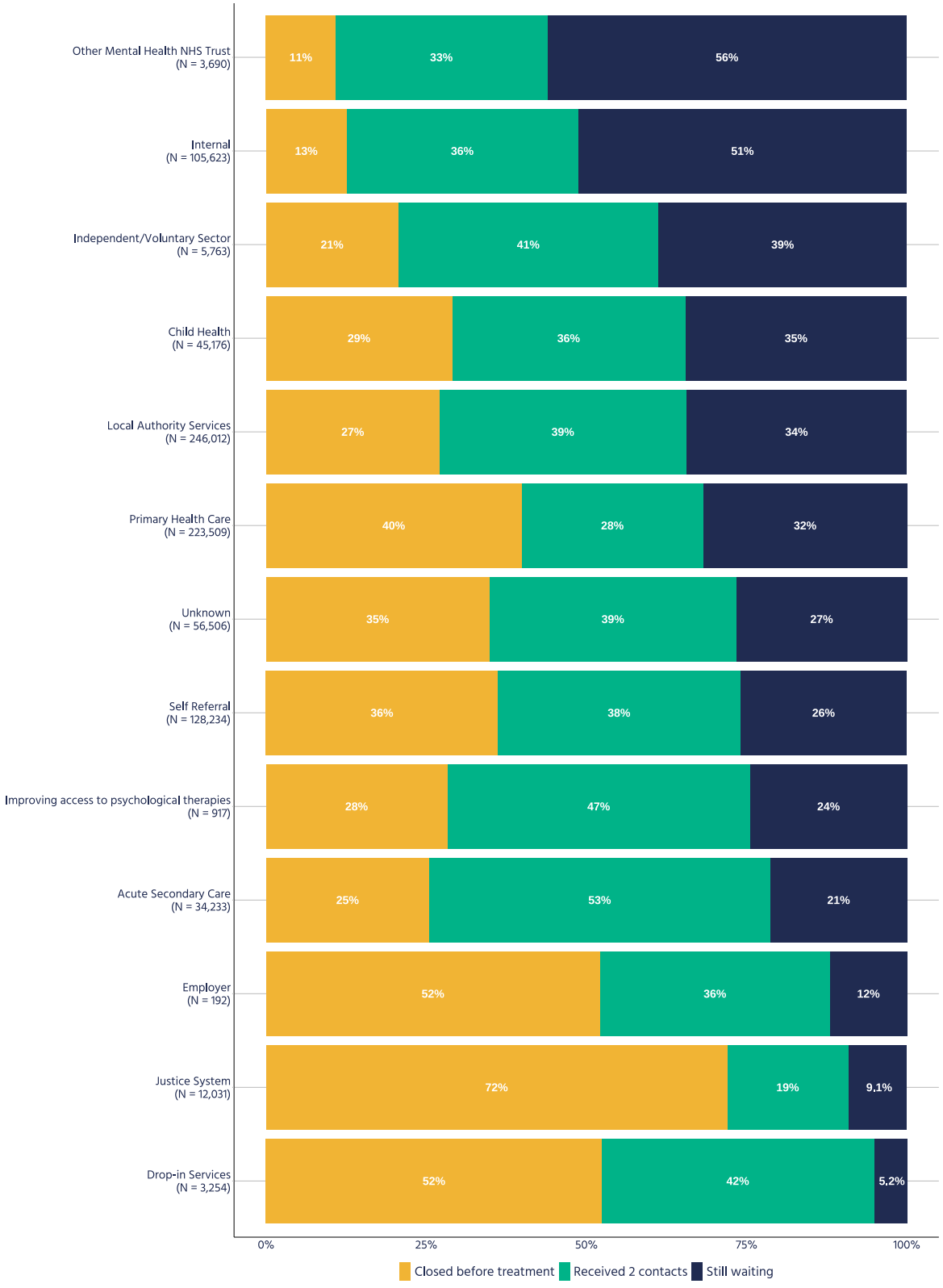
8. Referral outcomes and waiting times by referral source

8.1 Outcomes by referral source

Outcomes of referrals vary considerably based on referral source (see Figure 12 below). Children referred by the justice system were by far the most likely to have their referrals closed before treatment (making up 72% of referral outcomes). Fewer than 1 in 5 children (19%) referred by the justice system began treatment.

Those referred from within the health system were generally less likely to have their referral closed, but many are still waiting for support. The referral sources with the greatest proportion of children still waiting were 'Other Mental Health NHS Trust' (56% of children still waiting), and 'Internal' (51% of children still waiting). The referral sources which led to the greatest proportion of children entering treatment were 'Acute Secondary Care' (53% entered treatment), Improving Access to Psychological Therapies (47% entered treatment), and Drop-in services (42% entered treatment).

Figure 12: Referral outcomes - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by referral source.



8.2 Waiting times by referral source

This year the CCo is also able to provide insight on where children are being referred *from* to CYPMHS. Table 20 below highlights that the top referrers to CYPMHS are local authority services (accounting for 26% of children referred), primary health care (23%) and self-referrals (13%). There were very few referrals from non-health services, such as the justice system (accounting for just 1.3% of children referred), the independent/voluntary sector and employers (both accounting for less than 1% of those referred).

Table 20: Number and proportion of children referred by referral source in 2023-24

Primary referral reason	Number of children referred	Percentage of all children referred in 2023-24 (%)
Local Authority services	246,210	26%
Primary Health Care	223,586	23%
Self Referral	128,552	13%
Internal	105,665	11%
Other	91,677	9.6%
Unknown	57,136	6.0%
Child Health	45,250	4.7%
Acute Secondary Care	34,257	3.6%
Justice System	12,032	1.3%
Independent/Voluntary Sector	5,768	0.6%
Other Mental Health NHS Trust	3,694	0.4%
Drop-in Services	3,256	0.3%
Improving access to psychological therapies	917	0.1%
Employer	192	0.0%

Not all of these referrals result in children being able to access treatment, as Figure 12 in the previous section highlighted. However, when it comes to children who did have two contacts in 2023-24 – the most common three referral sources were the same: local authority services, primary health care and self-referral, making up 28%, 19% and 14% of those entering treatment within the year respectively. These top 6 sources add up to a majority (88%) of all children entering treatment. Of the 13 sources

(excluding unknown), the longest wait times were for 'other' referral sources (median 59 days), internal NHS referrals (median 55 days), primary health care (52 days) and child health services (46 days).

Table 21: Waiting times from referral to second contact by referral source in 2023-24.

Referral source	No. CYP referred	Median wait (in days)	Mean wait (in days)	Percentage of children receiving two contacts (%)
Local Authority Services	94,773	35	100	28%
Primary Health Care	63,483	52	139	19%
Self Referral	48,532	28	81	14%
Internal	38,207	55	154	11%
Other	31,256	59	133	9.20%
Unknown	21,803	18	107	6.40%
Acute Secondary Care	18,240	2	34	5.40%
Child Health	16,459	46	170	4.80%
Independent/Voluntary Sector	2,342	42	96	0.70%
Justice System	2,278	3	23	0.70%
Drop-in Services	1,381	1	47	0.40%
Other Mental Health NHS Trust	1,219	26	73	0.40%
Improving access to psychological therapies	434	41	66	0.10%
Employer	69	2	51	0.00%

When only considering direct contacts, some children wait much longer depending on their referral source. For example, those referred by the independent/voluntary sector face a difference in waits of 34 days (see Table 22 below).

Table 22: Comparison of waiting times from referral to second contact between children waiting for all contacts (includes professionals discussing a patient with each other) and direct contacts only (involves the child or their proxy) in 2023-24, by referral source.

Referral source	Median wait - all contacts	Median wait - direct contacts	Difference in days
Independent/Voluntary Sector	42	76	34
Primary Health Care	52	69	17
Child Health	46	61	15
Other Mental Health NHS Trust	26	40	14
Internal	55	66	11
Other	59	70	11
Self Referral	28	37	9
Local Authority Services	35	43	8
Justice System	3	10	7
Improving access to psychological therapies	41	42	1
Acute Secondary Care	2	2	0
Drop-in Services	1	1	0
Employer	2	2	0

9. Referral source by demographic

To explore whether the variation in waiting times for different groups of children is also associated with referral pathways, for the first time the CCo has also analysed referral source by children's demographics. While referrals by services do not vary considerably by children's age, gender and ethnicity, it is interesting that particular groups of children are more or less likely to self-refer.

The findings also indicate that self-referrals are generally associated with shorter waiting times (and possibly more acute need at the point of referral). The fact that not all children are self-referring at the same rate, and some local areas do not accept self-referrals from children, suggests that some children – particularly boys and children from black and 'other' ethnic groups, could be missing out on support from CYPMHS.

9.1 Referral source by children's age

Across all age groups, the most common referral sources were primary health care and local authority services, with the exception of children aged 16 to 17 – see Table 23 below. For those aged under 16, when combined, primary health care and local authority services had referred around half (or more) of all children. For those aged 16 to 17, while the top referral source was still primary health care, having referred 31% of children, the next most frequent sources were self referral (15% of children) and internal sources (14%). Self-referral appears to be a more common pathway as children grow older, and slightly dips for children aged 16 and 17.

Table 23: Top known referral sources by age group in 2023-24.

Age group	Top referral sources	Number of children referred	Percentage of children referred (%)
0 to 4	Primary Health Care	10,473	29%
	Local Authority services	6,699	19%
	Internal	5,232	15%
5 to 6	Local Authority services	25,716	37%
	Primary Health Care	16,716	24%
	Other	7,167	10%
7 to 9	Local Authority services	60,114	39%
	Primary Health Care	34,432	22%
	Self Referral	16,947	11%
10 to 12	Local Authority services	68,793	32%
	Primary Health Care	48,049	22%
	Self Referral	33,110	16%
13 to 15	Primary Health Care	69,165	24%
	Local Authority services	67,021	24%
	Self Referral	46,869	17%
16 to 17	Primary Health Care	44,751	31%
	Self Referral	21,508	15%
	Internal	19,586	14%

The most common referral sources do not appear to change much when considering only children who had two contacts with CYPMHS (Table 24 below). Across all age groups for children aged under 16 who received two contacts, on average those referred by local authority services had shorter waiting times than those referred by primary health care. For those aged 16 to 17 who received two contacts, of their top three referral sources, the shortest waiting times were on average for those who had self-referred.

Table 24: Waiting times from referral to second contact by top known referral sources and age group in 2023-24.

Age group	Top referral sources	Number of children referred	Percentage of children receiving two contacts (%)	Median wait in days	Mean wait in days
0 to 4	Primary Health Care	2,365	31%	111	301
	Local Authority services	1,402	18%	83	237
	Internal	1,178	15%	137	292
5 to 6	Local Authority services	6,736	40%	55	168
	Primary Health Care	3,231	19%	101	262
	Self Referral	2,015	12%	41	109
7 to 9	Local Authority services	21,340	43%	42	127
	Primary Health Care	8,318	17%	91	216
	Self Referral	5,792	12%	45	113
10 to 12	Local Authority services	29,429	37%	33	90
	Primary Health Care	14,242	18%	62	151
	Self Referral	12,979	16%	36	90
13 to 15	Local Authority services	28,636	25%	32	79
	Primary Health Care	23,190	20%	45	115
	Self Referral	18,721	16%	24	75
16 to 17	Primary Health Care	12,137	24%	31	71
	Self Referral	8,430	16%	13	49
	Internal	8,294	16%	26	67

9.2 Referral source by children's gender

When looking at how referral sources vary by children's gender, the differences in self-referrals are particularly interesting. Girls are more likely to self-refer than boys, as are non-binary children. Boys are more likely to have an 'internal' referral, suggesting they initially present at a different NHS service - see Table 25 below.

Table 25: Top known referral sources by gender in 2023-24.

Gender	Top referral sources	Number of children referred	Percentage of children referred (%)
Male	**Local Authority services**	120,174	29%
	Primary Health Care	103,389	25%
	Internal	52,603	13%
Female	**Local Authority services**	120,007	26%
	Primary Health Care	117,411	25%
	Self Referral	73,659	16%
Non-binary	**Self Referral**	1,458	41%
	Local Authority Services	1,153	32%
	Primary Health Care	267	7.4%
Indeterminate	**Local Authority services**	187	27%
	Primary Health Care	172	25%
	Other	111	16%
Other	**Self Referral**	685	42%
	Local Authority services	449	28%
	Other	134	8.2%

The most common referral sources do not appear to change much when considering only children who had two contacts with CYPMHS (Table 26). Of boys who received two contacts, among their top three referral sources, the shortest waiting time was for those referred by local authority services. For girls and non-binary children, this was instead the case for those who self-referred. This suggests that self-referrals are an important referral pathway for children presenting with the most acute need. It may also

be the case that allowing children to self-refer means mental health problems are picked up earlier than when having to rely on professionals to identify children's needs and make a referral.

Table 26: Waiting times from referral to second contact by top known referral sources and gender in 2023-24.

Gender	Top referral sources	Number of children receiving two contacts	Percentage of children receiving two contacts (%)	Median wait in days	Mean wait in days
Male	**Local Authority services**	40,587	31%	41	121
	Primary Health Care	26,711	20%	65	169
	Internal	17,088	13%	81	205
Female	**Local Authority services**	50,678	28%	34	85
	Primary Health Care	36,124	20%	44	117
	Self Referral	29,216	16%	25	76
Non-binary	**Self Referral**	680	41%	2	61
	Local Authority services	535	32%	4	66
	Other	109	6.6%	8	85
Indeterminate	**Local Authority services**	45	22%	37	192
	Other	35	18%	60	150
	Primary Health Care	31	16%	73	192
Other	**Self Referral**	242	35%	7	74
	Local Authority services	220	32%	3	51
	Other	61	8.9%	7	81

9.3 Referral source by children's ethnicity

For all ethnic groups except 'other', referrals from local authority services were most common, accounting for around 30% of all referred. For children of 'other' ethnic backgrounds, primary health care was the most common referral source, accounting for a third (33%) of these children. White, mixed and

Asian children were slightly more likely to self-refer than black children and children from 'other' backgrounds.

Table 27: Top known referral sources by ethnic group in 2023-24.

Ethnic group	Top referral sources	No. CYP referred	Percentage of children referred (%)
White	**Local Authority Services**	162,549	29%
	Primary Health Care	121,493	22%
	Self Referral	86,134	15%
	Internal	67,881	12%
	Other	55,233	9.9%
Asian	**Local Authority Services**	10,205	30%
	Primary Health Care	9,733	28%
	Self Referral	4,362	13%
	Other	3,153	9.2%
	Internal	3,073	8.9%
Black	**Local Authority Services**	7,401	30%
	Primary Health Care	5,432	22%
	Internal	3,870	16%
	Self Referral	2,657	11%
	Other	2,283	9.3%
Mixed	**Local Authority Services**	13,492	27%
	Primary Health Care	13,326	27%
	Internal	6,433	13%
	Self Referral	6,058	12%
	Other	4,544	9.2%
Other	**Primary Health Care**	7,463	33%
	Local Authority Services	6,002	26%
	Internal	2,764	12%
	Self Referral	2,249	9.8%
	Other	1,985	8.7%

For children of all ethnic groups, among their top five referral sources, the shortest waiting time between referral and second contact was for those who had self-referred, followed by those referred by local authority services.

Table 28: Waiting times from referral to second contact by top known referral sources and ethnic group in 2023-24.

Ethnic group	Top referral sources	No. CYP referred	Percentage of children receiving two contacts (%)	Median wait	Mean wait
White	**Local Authority Services**	65,359	31%	36	102
	Primary Health Care	37,655	18%	54	143
	Self Referral	35,263	17%	28	80
	Internal	25,883	12%	55	155
	Other	20,440	9.60%	59	133
Asian	**Local Authority Services**	4,520	34%	25	70
	Primary Health Care	3,049	23%	42	102
	Self Referral	1,700	13%	13	65
	Internal	1,247	9.50%	28	102
	Other	1,040	7.90%	43	102
Black	**Local Authority Services**	3,069	33%	28	80
	Primary Health Care	1,889	20%	48	113
	Internal	1,369	15%	35	115
	Self Referral	984	11%	11	61
	Other	810	8.70%	40	113
Mixed	**Local Authority Services**	5,576	30%	34	92
	Primary Health Care	4,237	23%	55	124
	Internal	2,436	13%	50	134
	Self Referral	2,418	13%	25	76
	Other	1,657	8.80%	66	135
Other	**Local Authority Services**	2,518	29%	32	88
	Primary Health Care	2,509	29%	54	120
	Internal	1,071	12%	47	123
	Self Referral	755	8.70%	16	67
	Other	730	8.40%	43	113

10. Overall Integrated Care Board (ICB) level scores

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

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

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

3. **Average waiting time (in days) for children** who receive a second contact (both direct and indirect contacts) with services (where lower average waiting times means a higher score).

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

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

[xxxii] This report defines a child as not receiving treatment if they were referred but had their referrals closed before they received at least two contacts with CYPMHS.

Some ICBs may have invested in lower-level wellbeing services which are not considered 'CYPMHS' – and therefore not necessarily be reflected in the number of children referred, average waiting times or percentage of referrals closed. This should, however, be captured in the two spending measures.

Unlike CCo mental health briefings based on data from before the 2022-23 financial year which looked at spend per child aged 0 to 17 in the ICB (previously CCG), this report uses spend per child referred. This aims to capture more directly the link between mental health spend and need, as most children in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated as the percentage of the child population receiving two contacts with CYPMHS, has been dropped from the list of metrics this year.

Given these changes, while scores for 2023-24 and 2022-23 can be compared, no comparisons can be made with scores published in CCo mental health briefings for the financial years 2021-22 and earlier. Furthermore, in 2021, 106 CCGs merged to form 42 combined ICBs. Many top performing CCGs in last year's report have been merged with CCGs that do not perform as well by CCo metrics (and vice versa when worse performing CCGs merged with better performing CCGs). As a result, the top and bottom performing areas this year are not the same as those in previous years.

According to these scoring criteria, provision of children's mental health services varies hugely by local area (see Figure 13 below). The best performing ICB in 2023-24 was NHS Bedfordshire, Luton and Milton Keynes, maintaining its position at the top of the table with a score of 19 out of a maximum of 20. The ICB is closely followed by NHS Cornwall and the Isles of Scilly, NHS North East London and NHS Norfolk and Waveney, with respective overall scores of 17, 17 and 16 (Table 29 below). It should be noted that no London CCGs appeared in the top 20 CCGs in 2021-22 when ranked by overall score. This year, 4 of the top 20 ICBs are in London.

The worst performing ICBs in 2023-24 were NHS Cambridgeshire and Peterborough and NHS Buckinghamshire, Oxfordshire and Berkshire West, both with scores of 6. Slightly higher with 7 points out of a maximum of 20 were NHS Kent and Medway, NHS Humber and North Yorkshire and NHS Nottingham and Nottinghamshire.

In 2022-23, NHS Devon was the lowest performing ICB with 6 points. The ICB has since improved and received 10 points in 2023-24. However, NHS Kent and Medway and NHS Nottingham and Nottinghamshire remain in the bottom 5 of the table, having both received 7 points in 2022-23 as well.

Figure 13: ICBs by overall score.

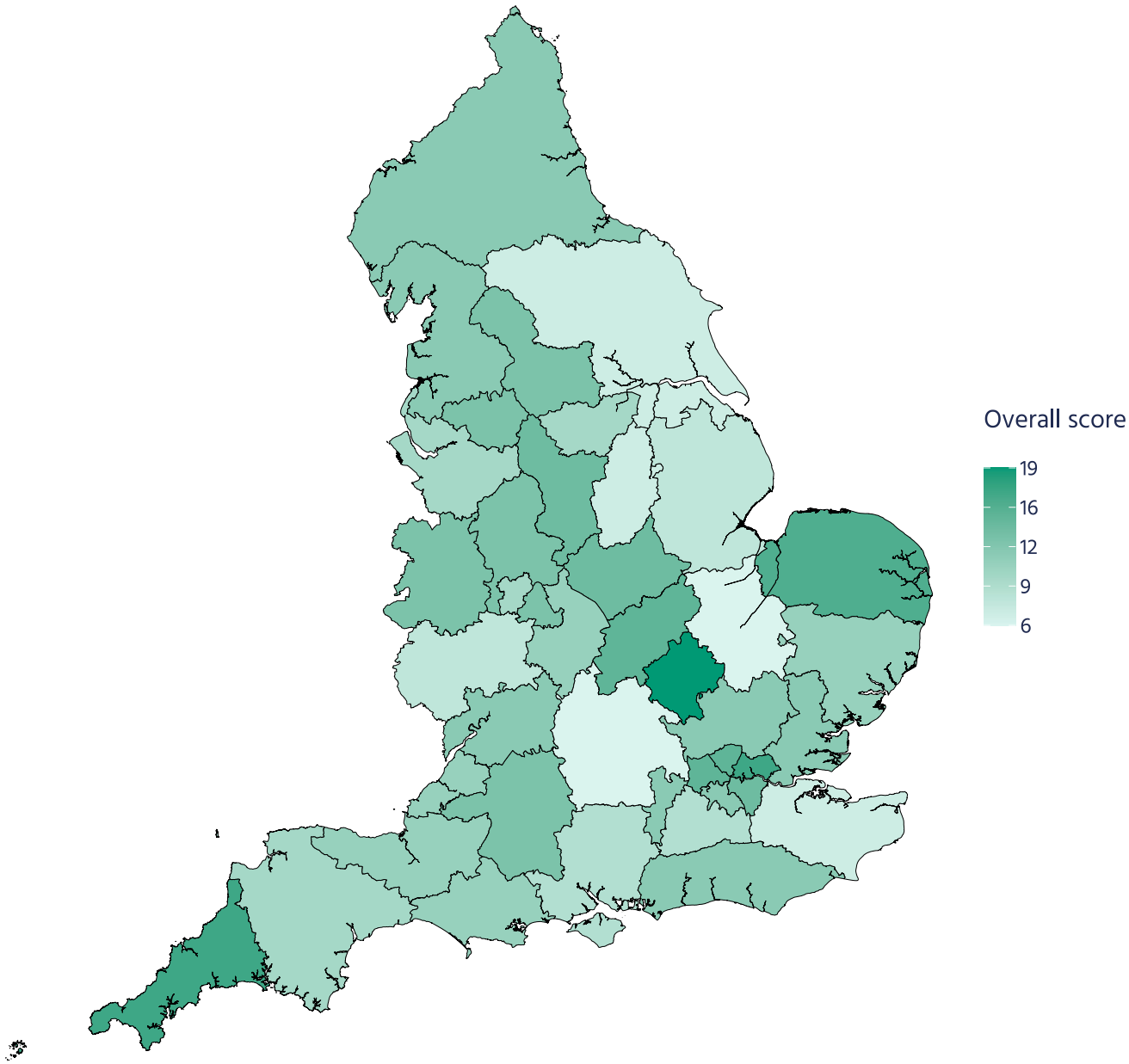


Table 29: ICB overall scores and how they have changed from 2022-23 to 2023-24.

ICB name	Overall score - higher is better		
	2022-23	2023-24	Change
NHS Bedfordshire, Luton and Milton Keynes ICB	19	19	0
NHS North East London ICB	17	17	0
NHS Cornwall and the Isles of Scilly ICB	15	17	2
NHS Norfolk and Waveney ICB	15	16	1
NHS North Central London ICB	16	15	-1
NHS North West London ICB	14	15	1
NHS Northamptonshire ICB	13	15	2
NHS Leicester, Leicestershire and Rutland ICB	14	14	0
NHS South East London ICB	14	14	0
NHS Derby and Derbyshire ICB	10	14	4
NHS Staffordshire and Stoke-on-Trent ICB	15	13	-2
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	14	13	-1
NHS Birmingham and Solihull ICB	14	13	-1
NHS Greater Manchester ICB	12	13	1
NHS Shropshire, Telford and Wrekin ICB	12	13	1
NHS West Yorkshire ICB	12	13	1
NHS Frimley ICB	14	12	-2
NHS Sussex ICB	14	12	-2
NHS North East and North Cumbria ICB	13	12	-1
NHS Mid and South Essex ICB	13	12	-1
NHS South West London ICB	13	12	-1
NHS Gloucestershire ICB	11	12	1
NHS Hertfordshire and West Essex ICB	11	12	1
NHS Lancashire and South Cumbria ICB	9	12	3
NHS Somerset ICB	14	11	-3
NHS Suffolk and North East Essex ICB	12	11	-1
NHS Bristol, North Somerset and South Gloucestershire ICB	11	11	0

NHS Coventry and Warwickshire ICB	11	11	0
NHS Dorset ICB	10	11	1
NHS Black Country ICB	12	10	-2
NHS Cheshire and Merseyside ICB	10	10	0
NHS South Yorkshire ICB	8	10	2
NHS Devon ICB	6	10	4
NHS Surrey Heartlands ICB	10	9	-1
NHS Hampshire and Isle of Wight ICB	9	9	0
NHS Herefordshire and Worcestershire ICB	9	8	-1
NHS Lincolnshire ICB	7	8	1
NHS Humber and North Yorkshire ICB	8	7	-1
NHS Kent and Medway ICB	7	7	0
NHS Nottingham and Nottinghamshire ICB	7	7	0
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	9	6	-3
NHS Cambridgeshire and Peterborough ICB	8	6	-2

Table 30: 2023-24 ICB performance by indicator, best overall score to worst overall score.

ICB name	Spend per child referred	% budget spent on CYPMHS	Median wait in days	% referrals closed before treatment	Overall score (higher is better)
NHS Bedfordshire, Luton and Milton Keynes ICB	£1,515	1.23	13	21	19
NHS Cornwall and the Isles of Scilly ICB	£1,470	1.2	21	29	17
NHS North East London ICB	£2,175	1.19	27	25	17
NHS Norfolk and Waveney ICB	£1,746	1.72	67	24	16
NHS North Central London ICB	£2,403	1.58	56	31	15
NHS Northamptonshire ICB	£1,392	0.92	31	19	15
NHS North West London ICB	£2,513	1.18	34	32	15
NHS Leicester, Leicestershire and Rutland ICB	£943	0.91	6	17	14
NHS Derby and Derbyshire ICB	£1,283	1.09	51	26	14
NHS South East London ICB	£1,577	1.13	37	32	14
NHS Staffordshire and Stoke-on-Trent ICB	£1,524	1.31	36	50	13
NHS Greater Manchester ICB	£1,097	1.04	14	32	13
NHS Birmingham and Solihull ICB	£1,775	1.32	52	43	13
NHS West Yorkshire ICB	£941	0.97	34	23	13
NHS Bath and North East Somerset, Swindon and Wiltshire ICB	£1,610	1.1	55	34	13
NHS Shropshire, Telford and Wrekin ICB	£1,248	1.06	31	34	13
NHS Gloucestershire ICB	£1,254	1.12	72	28	12
NHS Sussex ICB	£1,196	1.02	72	23	12
NHS Hertfordshire and West Essex ICB	£1,122	0.99	28	35	12
NHS Mid and South Essex ICB	£1,195	0.71	8	32	12
NHS Lancashire and South Cumbria ICB	£1,134	0.87	25	30	12
NHS North East and North Cumbria ICB	£1,038	1.06	41	27	12

NHS South West London ICB	£1,068	0.95	36	24	12
NHS Frimley ICB	£1,193	1.45	61	32	12
NHS Dorset ICB	£1,846	0.97	54	41	11
NHS Suffolk and North East Essex ICB	£1,054	0.88	25	30	11
NHS Bristol, North Somerset and South Gloucestershire ICB	£1,542	0.87	25	37	11
NHS Somerset ICB	£1,049	0.97	46	26	11
NHS Coventry and Warwickshire ICB	£548	0.96	41	16	11
NHS South Yorkshire ICB	£979	0.82	22	36	10
NHS Cheshire and Merseyside ICB	£934	0.9	35	28	10
NHS Devon ICB	£1,097	0.95	75	24	10
NHS Black Country ICB	£1,242	1.23	71	41	10
NHS Hampshire and Isle of Wight ICB	£1,052	1.14	103	35	9
NHS Surrey Heartlands ICB	£1,087	1.17	46	37	9
NHS Herefordshire and Worcestershire ICB	£934	0.87	62	26	8
NHS Lincolnshire ICB	£1,227	0.77	42	39	8
NHS Nottingham and Nottinghamshire ICB	£623	0.77	69	26	7
NHS Humber and North Yorkshire ICB	£879	0.81	27	38	7
NHS Kent and Medway ICB	£580	0.84	43	36	7
NHS Buckinghamshire, Oxfordshire and Berkshire West ICB	£628	0.84	64	29	6
NHS Cambridgeshire and Peterborough ICB	£759	0.92	50	52	6

11. Spotlight on children in crisis

11.1 Numbers of children referred for being in crisis.

This report underlines that far too many children are being referred 'in crisis'. In 2023-24, 59,700 children were referred for being in crisis - 6.2% of all referred to CYPMHS. This marks a 7.7% increase from 55,500 children (5.8% of all referred) in 2022-23.

Children who are in crisis are in acute distress, and are very often self-harming and/or suicidal. Children who responded to The Big Ambition felt that CYPMHS (often referred to as 'CAMHS') had become crisis-led, with many children not able to get any help until their needs escalated to this point.

"Mental health support is totally limited, you have to be "in" crisis before CAHMS can see you. Why is there not more?" – Adult on behalf of girl, 18, The Big Ambition

"Fund mental health support for young people before it reaches crisis point." – Boy, 14, The Big Ambition

"*No child should have to reach a devastating crisis point before being able to access the mental health care they need."* – Adult on behalf of child, 14, The Big Ambition

Even children who do tragically reach crisis can struggle to access timely support. The median wait for children referred for being in crisis is the same as last year (5 days). For many children, this is still too long to be waiting for support. Despite being referred for being in crisis, many children in 2023-24 did not receive two contacts and were still waiting at the end of the year. These children were left waiting on a median of 60 days – a length of time which could put their lives at risk.

"I have been waiting for months and months to have someone to talk to about my mental health. I am a young carer, and work part time alongside full-time college, and over the past 6 years have had to cope with two traumatic deaths within my immediate family. There is not enough provisions in place, and I am not surprised how high the suicide rate is of young people around my age, when you are waiting months - years for any kind of intervention or help. My own brother was suicidal and he was declined help by *CAMHS. We are lucky that my parents let go of paying bills to pay out for private therapy, as I don't know if we'd still have him today, if they hadn't."* – Girl, 17, The Big Ambition

"It is very apparent that I am autistic and physiatrists and other specialists in ASD [Autism Spectrum Disorder] have concluded that I do have autism 100%. However, since I have not yet had the proper assessment, I can't have a formal diagnosis so I can't get some of the accommodations I desperately need. I also really struggle with my mental health and I had to wait so long for therapy and medication that I couldn't cope with being alive any more so I attempted suicide three times. Tragically, so many other young people attempt suicide because of the failing mental health services and unfortunately a lot of those people who attempted were successful. Therefore, there needs to be better care available now or more youths will suffer and die." – Child, 14, The Big Ambition

In fact, close to half (44%) of those referred in 2023-24 for being 'in crisis' had their referrals closed or were still waiting for their second contact at the end of the year.

"I was severely depressed [CAMHS] told me to take a bath and drink a "nice hot cup of tea" I don't like tea and I was trying to commit [suicide] at those times so I don't know if they are trained at all to be fair." – Girl, 13, The Big Ambition

Some children's need is so severe that they need to be hospitalised. However, often there is not enough local inpatient provision, and children are admitted far away from their homes and local communities, and sometimes even into adult wards. Previous CCo research found that just over a fifth (21%) of children and young people were placed more than 50 miles from their home.[28] In 2024, CQC reported they received 196 notifications of children being admitted to adult wards.[29] There is no other residential setting where it is deemed appropriate for children and adults to reside in close proximity.

"In my volunteering in the paediatric ward of a hospital, I met several patients who had been waiting in the paediatric ward for 6 months following suicide attempts because there was no space in the mental health ward." – Girl, 17, The Big Ambition

Table 31: Number and percentage of children referred to CYPMHS for being in crisis in 2023-24, by referral outcome and waiting time (where applicable).

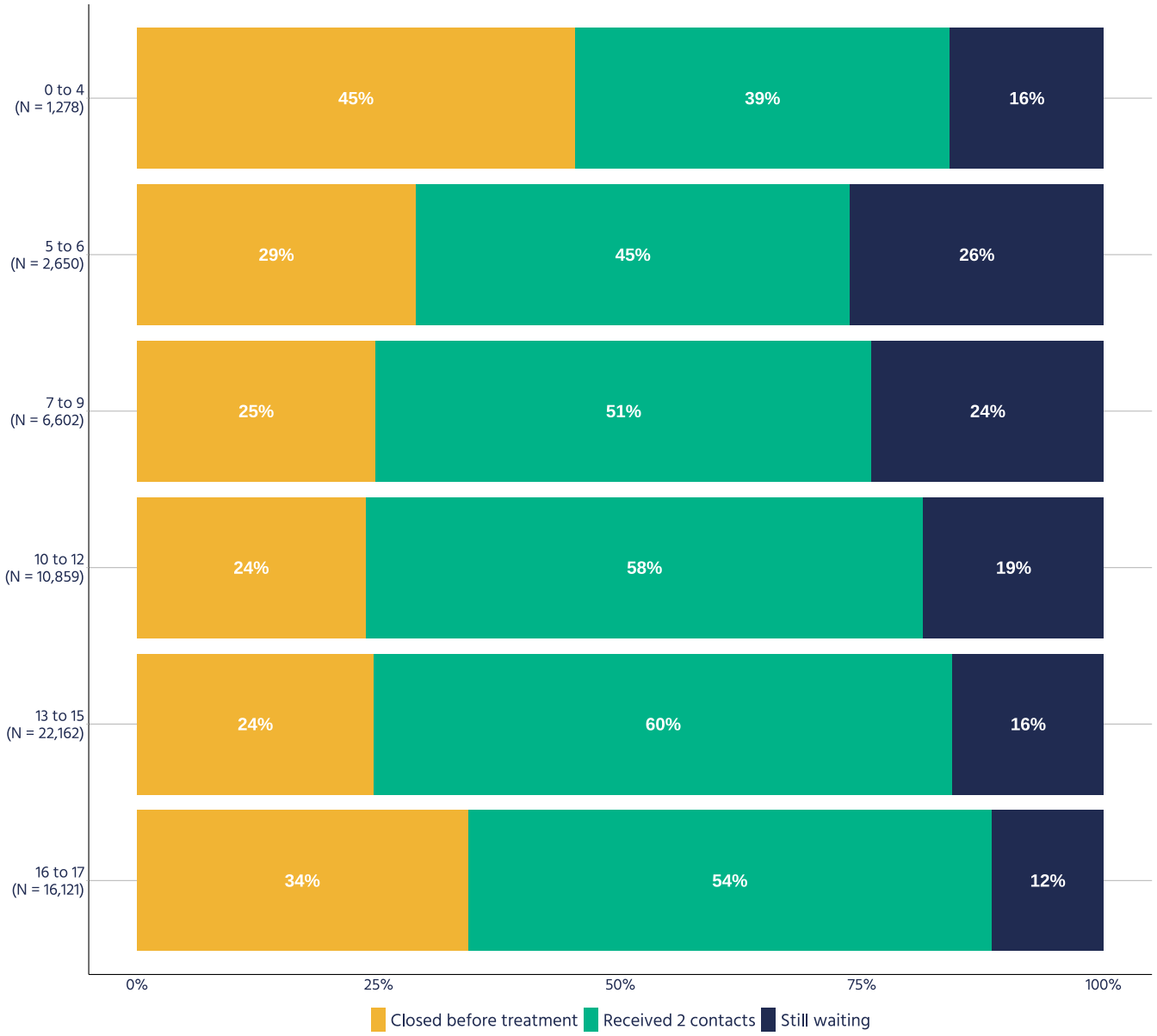
Outcomes	Number of children referred	Percentage of children referred	Median wait in days	Mean wait in days
Closed before treatment	16,477	28%		
Entering treatment	33,371	56%	5	34
Still waiting for treatment	9,824	16%	60	201
Totals	59,720	100%		

11.2 Children in crisis by demographic characteristics

11.2.1 Age group

When looking at the outcome of crisis referrals by age group, it is notable that the youngest children (those aged 0 to 4) were most likely to have their referrals closed. Nearly half of referrals (45%) for this age group were closed before treatment. Children aged 5 to 6 were most likely to still be waiting (26% of referrals).

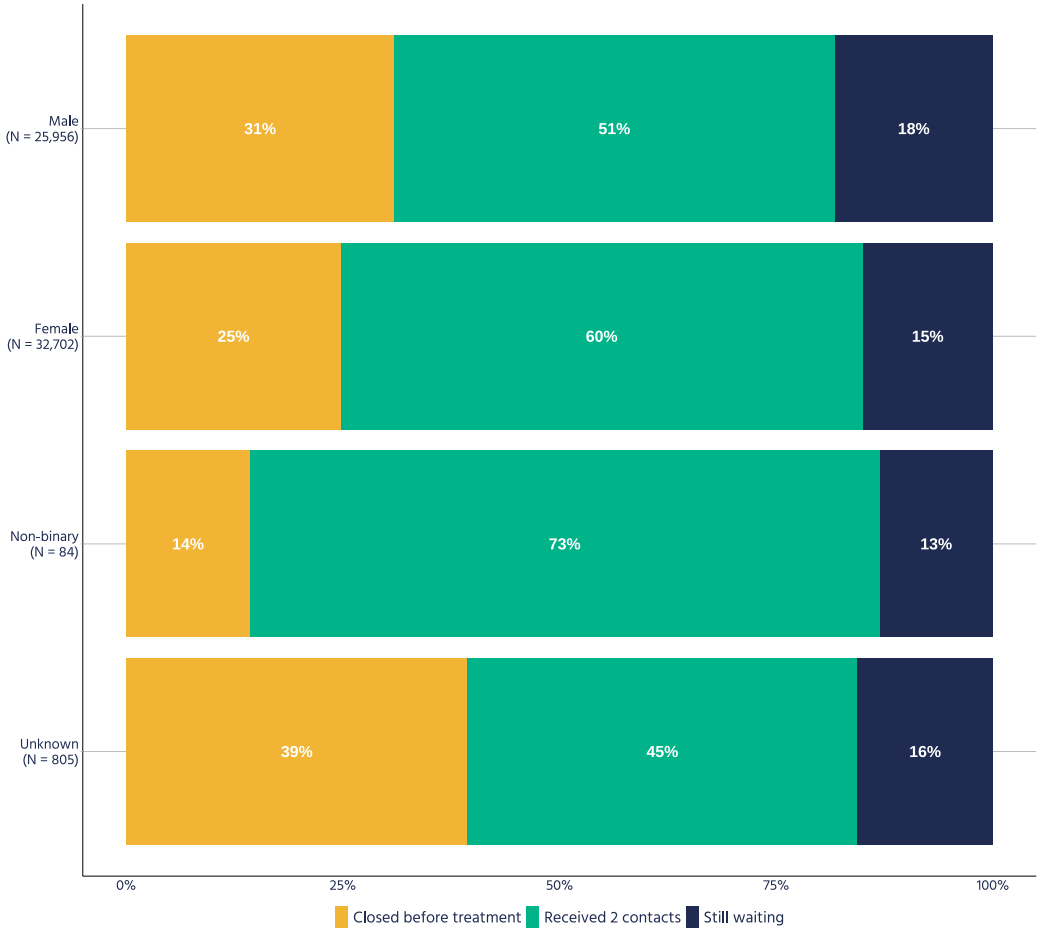
Figure 14: Outcomes of children referred for being "in crisis" - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by age group.



11.2.2 Gender

When looking at the outcome of crisis referrals by children's gender, a majority of both boys and girls received two contacts, although a greater percentage of girls had received two contacts: 60% of girls and 51% of boys. As a result, where gender is known, boys in crisis were the most likely to have their referral closed before contact (31%) and to still be waiting (18%). Conversely, across all children in crisis where their gender was known, non-binary children were the most likely to have received two contacts (73% of referrals).

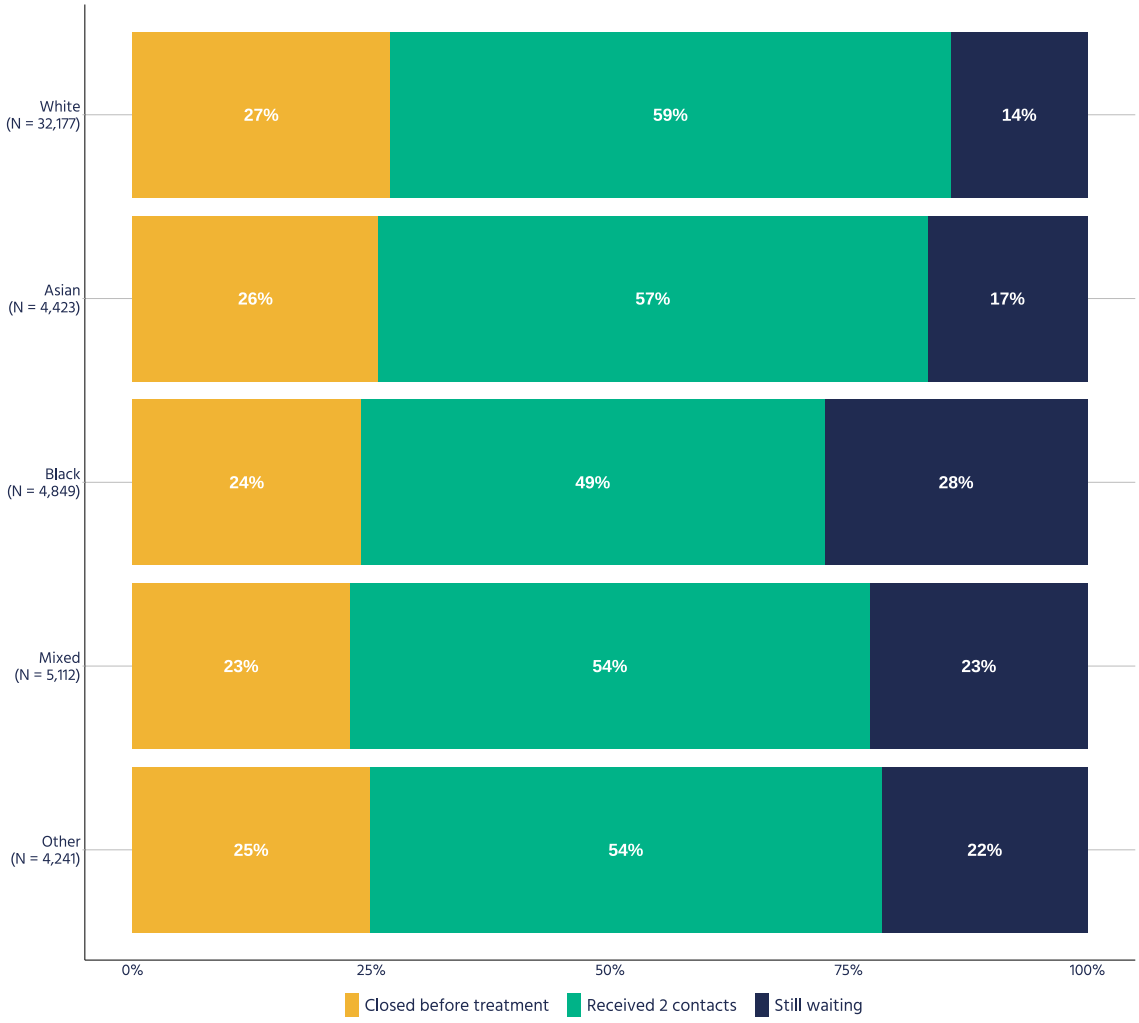
Figure 15: Outcomes of children referred for being 'in crisis' - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by gender.



11.2.3 Ethnic group

Across all ethnic groups, children in crisis were similarly likely to have had their referral closed before treatment, ranging from 23% for children of mixed ethnic backgrounds, to 27% for white children. However, there was a lot of variation in the percentages who had received two contacts: 59% of white children in crisis had received contacts, compared to only 49% of black children. As a result, 28% of black children referred for crisis were still waiting, compared to only 14% of white children.

Figure 16: Outcomes of children referred for being "in crisis" - percentage of children who had their referrals closed, received two contacts and still waiting for a contact with CYPMHS in 2023-24, by ethnic group.



12. The way forward

This report is being published at an important crossroads. In March 2025, the Secretary of State for Health and Social Care announced that NHS England would be dissolved as a standalone organisation, with many of its functions brought within the Department for Health and Social Care. The government is also developing its 10 Year Plan for the National Health Service, due to be published imminently. The government is striving for this plan to enable three shifts: from sickness to prevention, from hospitals to the community, and from analogue to digital. Children and young people's mental health must be at the heart of this plan, as well as the forthcoming workforce strategy. As these recommendations set out, the right way forward for children's mental health will only reinforce these three shifts.

Recommendation 1: Preventing children from developing poor mental health, and preventing children's mental health needs from escalating

1a: Preventing children from developing poor mental health

- **The Department for Education and the Department for Health and Social Care should develop a joint strategy for improving children and young people's mental health and wellbeing and joint outcomes framework**, with input from the other departments that sit on the Health and Opportunity Mission delivery boards. This strategy should have a strong focus on addressing many of the wider determinants of poor mental health and wellbeing – including poverty, inequality, insecurity, and harms (both online and offline)[30] – and align with other strategies in development such as the National Youth Strategy, Violence Against Women and Girls strategy, and Child Poverty Strategy. This is essential for moving away from a medical, diagnosis-led model of support – and towards a social model which is needs-led.
- **A Children's Health and Wellbeing Advisory Board should be established**, to advise and provide oversight of this strategy as well as the NHS 10 Year Plan design and delivery.

1b: Preventing children's mental health needs from escalating

Supporting children to self-refer

- **Children and young people's mental health services (CYPMHS) should accept self-referrals from children, with enough upfront information and guidance to help them understand which pathway is right for them.** This research highlights that self-referrals from children and young people are associated with some of the shortest waits for CYPMHS, which in turn are associated with children presenting with acute need. Local areas should design their referral pathways to accept self-referrals from children and young people, and **Integrated Care Boards should develop strategies for increasing self-referrals from under-represented groups, including boys and certain ethnic minority children.** As well as ensuring children's needs are identified and they get timely support, the below case study highlights how accepting self-referrals can improve the quality of referrals and help to streamline triaging.

Case Study: Leicester, Leicestershire and Rutland (LLR) ICB

This year, Leicester, Leicestershire and Rutland (LLR) ICB has the shortest waiting time for children's mental health services, with a median waiting time of just 6 days (as in 2022-23). In last year's report, CCo reported that LLR ICB had recently begun to accept self-referrals by children and young people. Despite being prepared for a potential uptick in referrals which could increase waiting times, LLR ICB reported that the result has been a significant increase in the quality of referrals and speed with which they can be processed - with fewer referrals being rejected on the basis that more detailed information is needed.

Preventing health inequalities

- This research highlights that certain groups of children are particularly at risk of being in crisis. Very concerningly, it is the most common reason black children and children recorded as having

an 'other' ethnicity[xxxiii] are referred to CYPMHS. To prevent children's needs from escalating to this point, **Integrated Care Boards (ICBs) should provide sufficient funding to community-based therapeutic services led by and for the communities they serve,** which are able to reach children from marginalised communities, who are less likely to access statutory CYPMHS for lower-level mental health needs. **DHSC and ICBs should work with these organisations, as well as children themselves, to understand and remove barriers to accessing early help from NHS-provided CYPMHS.**

Increasing accountability for children's mental health

- It is welcome that the Care Quality Commission (CQC) has appointed its first Chief Inspector of Mental Health. Under the new Chief Inspector's leadership, **CQC should prioritise carrying out a thematic review of children's mental health services**. As well as identifying common gaps in thresholds between statutory provision, this review should investigate the practice driving some of the concerning trends presented in this report, including the high rate of referrals from justice agencies which are closed before treatment. Children in contact with the justice system are often very vulnerable, and should not be refused support.[31] [32]

- **Integrated Care Board Children and Young People Leads should be publicly identifiable, and accountable for children's health outcomes at a local level.**

Reducing waiting times for Children and Young People Mental Health Services CYPMHS (also known as 'CAMHS'). No child should be turned away from mental health and wellbeing support, or wait more than four weeks for an initial assessment of their mental health needs, and four weeks for treatment to begin in CYPMHS. It is positive to see the number of referrals being closed before treatment has declined since last year, however waiting times remain stubbornly high.

"More mental health services because children and young people like me are on waiting lists for years only to be told that service can't help us and that we have to go on another list." – Girl, 16, The Big Ambition

[xxxiii] This may include some children from Latin American and Arabic backgrounds, among others.

- **To make this goal achievable, the NHS 10 Year Plan must made provision for additional, annual ring-fenced funding to Integrated Care Boards** to ensure that every local area is able to meet the mental health needs of the children in its area, and prevent future pressure on adult mental health services. Data in this report on how much high performing ICBs are spending per child with an active referral should be used as a benchmark of the additional investment required, with funding appropriately weighted by child population, levels of deprivation and other key indicators of need. Even the ICB in 2023-24 with the highest proportion of investment only spends 1.72% of its budget on children and young people's mental health services, which demonstrates the importance of ring-fencing this additional funding so that it is not absorbed into spending on adult and other services.

"The government should put more money into supporting children who are under CAMHS. There should be more staff and funding because at the moment people are struggling more than ever with their mental health and lots of people are trying to get diagnosed with autism, adhd etc. The waiting lists are too long and people are struggling as a consequence." – Girl, 16, The Big Ambition

Improving pathways for support

- **The Department for Health and Social Care should commission an independent, clinician-led review of diagnostic pathways and post-diagnosis support for children with suspected or diagnosable neurodevelopmental conditions**, both those with co-occurring mental health needs and those without. This review should focus in particular on:
    - **Why children and families are seeking a diagnosis, and whether a diagnosis is in a child's best interests.** The CCo report on *Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions* [33] shows that many children are seeking a diagnosis to unlock support that could be provided on a needs-led basis, such as adjustments in schools or access to certain therapies.
    - **How waiting times for assessment and support can be reduced.** This report and previous CCo research underline that autistic children and children with other neurodevelopmental conditions face some of the longest waits for the support they need in mental health and community health services.

- **Inconsistency in diagnostic assessments.** CCo research highlights inconsistencies in thresholds for children being referred and diagnosed between local areas. A key aim of this review should be to assess the reliability of diagnoses across different services and improve consistency. Whether a child is referred for diagnostic assessment and whether they are diagnosed should not be subject to a lottery of where they live or which pathway they on.
- **The current cost of private diagnostic assessments to the NHS**, and what the impact would be on patient outcomes, costs to the NHS, and NHS capacity if neurodevelopmental disorder assessments **were regulated under the Health and Care Act 2008.**

- **The Department for Health and Social Care should issue guidance for commissioning mental health services which are inclusive of neurodivergent children.** Currently many therapies offered within CYPMHS are designed by and for neurotypical people experiencing poor mental health, which neurodivergent children experience as inaccessible, ineffective – and even harmful in some cases.[34]
- **The Department for Health and Social Care should be clear in guidance to ICBs that triaging of referrals and assessments of children should never be commissioned out to organisations without clinical expertise.**

"Early diagnosis and treatment can overall take pressure off of the NHS instead of giving psychiatric treatment to children which may not be necessary" – Girl, 18, The Big Ambition

Recommendation 2: Delivering more mental health support in the community, rather than in hospital and inappropriate settings

With enough open access, early support, delivered where children are - in their schools and communities, we can prevent children's needs from becoming overly medicalised. Children should not need labels or diagnoses before they can get help for their health and wellbeing.

2a: Delivering more mental health support in the community

Support in the community

- The new **Young Futures Hubs** announced by the government should provide inclusive, open access, early support for children's mental health in every ICB area - working closely with family centres and the proposed neighbourhood health centres, as well as the voluntary and community sector. It is welcome that these hubs now sit within the Department for Education, rather than the Home Office. They must be designed and delivered in partnership with the Department for Health and Social Care, building on the findings from the pilot of Early Support Hubs.

"Better mental health support in schools, shorter waiting lists for support, equal opportunities for people with additional needs" – Girl, 17, The Big Ambition

Support at school

- **There should be a school nurse in every school,** who would be expertly placed to provide early support to children to maintain good emotional health and wellbeing. Research by the CCo highlights that children wait on average 2.5 years to see a school nurse - one of the longest community health service waits in the country.[35] Since 2009, the number of school nurses has declined by a third.[36]

- **Mental Health Support Teams (MHSTs) must continue to be rolled out at pace.** Currently 44% of pupils have access to MHSTs.[37] The CCo welcomes the government's commitment to national roll-out, but this must happen sooner than 2030. Evaluations of this model should measure the extent to which interventions are inclusive of children with additional needs, including those who are disabled and/or neurodivergent. National roll-out must be informed by emerging evidence on which interventions are most effective at improving children's mental health and wellbeing, and alongside clear guidance for professionals on the circumstances where diagnostic assessments are appropriate

[xxxiv] MHSTs are intended to provide preventative support and needs-led early interventions to children whose health and wellbeing needs are below the threshold of a diagnosable mental health condition. If children's needs do present as more

"I also think that teachers are unequipped to deal with conditions such as social anxiety, generalised anxiety and panic disorders. Teachers are also unaware of how their students are actually feeling, and only check up when things get severe (ie. self harm etc). Teachers should be made aware that not all students express their feelings on their faces, or in their attitudes, some bottle them up and are unable to help due to feeling scared of them or are intimidated by a lot of teacher's attitudes." – Child, 16, The Big Ambition

- **Fewer children should miss school for mental health-related reasons.** Where a child is on a CYPMHS waiting list or in receipt of CYPMHS support and is starting to disengage from school, these **children should be automatically referred to multi-agency attendance forums and assigned a key worker** – who can work together to address any underlying issues which may be causing the child's poor mental health.

2b: Avoiding hospitalisation and deprivations of liberty

"I think you should improve mental health hospitals, especially ones for young people." – Girl, 13, The Big Ambition

Reforming the Mental Health Act 1983

The Children's Commissioner strongly welcomes the government's prioritisation of modernising the Mental Health Act, with the Mental Health Bill currently progressing through parliament. Children in mental health hospitals are especially vulnerable, lacking many of the protections and rights afforded to adults. Rather than getting better, children's experiences of being hospitalised can be traumatic – negatively impacting on their mental health and wellbeing, and increasing the risk they will return to hospital.

Reforming this legislation is an opportunity to address this inequality, and ensure children are safe and supported to get well. The Commissioner welcomes many aspects of the bill, including removing police

severe and complex – and likely requiring external specialist clinical support, updated guidance for MHSTs should be even clearer about the circumstances in which diagnostic assessments are appropriate. Most children presenting with emerging needs or mild-moderate mental health problems can be supported by MHSTs without requiring a diagnosis.

stations and prisons as 'places of safety' and measures to reduce the number of autistic children and children with learning disabilities who are detained and the length of their detention. However, there are still key omissions and areas of the bill that can be strengthened for children and young people. In particular, the Commissioner would like to see:

- **A test for assessing children under 16's competency.** Many of the provisions in the Mental Health Act hinge on a patient's capacity or competence to make a particular decision – including consent to admission, treatment, advance decisions and appointing a Nominated Person. The Mental Capacity Act 2005 sets out a presumption that any person over the age of 16 has capacity to make decisions for themselves. Where a person's capacity is in question, the legislation establishes a test for assessing their mental capacity. While children under the age of 16 are presumed not to have capacity, the Mental Capacity Act Code of Practice advises against relying on parental consent to admit or treat children under 16 who are deemed to be 'Gillick competent'.[xxxv] Despite this, in the absence of an equivalent test for assessing whether a child is 'Gillick competent', there is currently no consistent criteria to test a child's decision-making ability. **The new Mental Health Act should establish a test for assessing children under 16's competency to make decisions and give consent.**

- **Better protections and safeguards for children in hospital.** The Commissioner remains deeply concerned that many children continue to be accommodated in inappropriate settings. In 2020, CCo research found that just over a fifth (21%) of children and young people were placed more than 50 miles from their home.[38] In 2024, CQC reported they received 196 notifications of children being admitted to adult wards.[39] There is no other residential setting where it is deemed appropriate for children and adults to reside in close proximity. Children who are admitted to hospital must be accommodated in safe and appropriate environments. The Commissioner would like to see robust action towards children being placed on adult wards or out of-area as 'never events'. **The new Mental Health Act must place new duties on relevant authorities to ensure there is sufficient inpatient mental health service provision for children and young people**,

[xxxv] The House of Lords decision in Gillick v West Norfolk (1989) held that a child aged under 16 can consent to medical treatment if they are deemed by professionals to have the maturity and intelligence to understand what is involved. Link.

and strengthen procedural requirements to prevent children from being placed in inappropriate settings. The Joint Committee on the Draft Bill recommended that these kinds of placements must be 'demonstrably in the child's best interests'.[40] The government should accept Professor Sir Simon Wessely's recommendation in his independent review of the Mental Health Act that **CQC be informed within 24 hours of a child being placed on an adult ward or placed out of area.**[41] CQC should also be compelled to centrally collect and publish all notifications it receives.

- **Enhanced community-based support to tackle inequalities and prevent hospitalisation.** Children can be prevented from being admitted to hospital with the right support in the community. Many of the inequalities presented in this report are mirrored in the over-representation of certain children detained under the Mental Health Act, such as girls and ethnic minority children.[42] **The Mental Health Act should be amended to place a duty on the NHS to provide health and therapeutic services to any child who meets the national criteria for admission**, but where it is agreed that inpatient provision would not be in their best interests.

"Increasing the funding to the NHS, everyone would have access to a higher quality of health care. Waiting lists for conditions such as: autism, ADHD, gender dysphoria and others would have less waiting time, allowing people to get the treatment they need to live a more comfortable life." – Boy, 17, The Big Ambition

Improving support for children who are at risk of / on a Deprivation of Liberty order

Last year, the CCo was commissioned to carry out research with children by NHS England and the Department for Education's Task and Finish Group: 'Improving cross-sector support for children with multiple needs in complex situations'.

The final report, Children with complex needs who are deprived of liberty, showed just how complex and varied the needs of children on Deprivation of Liberty orders (DoL) are.43 In addition, the office found that of 775 children living in unregistered placements on 1st September 2024, 31% were subject to a court-ordered DoL.[44]

Ensuring children are accommodated appropriately

- Clause 10 in the Children's Wellbeing and Schools Bill would amend Section 25 of the Children Act 1989 to provide for the courts to be able to authorise the deprivation of a child's liberty in accommodation other than a secure children's home (referred to as "relevant accommodation"). **The office greatly welcomes this reform, but is urging parliamentarians to seek further clarification on the type of accommodation this change would apply to.** The office has outstanding questions about what types of settings constitute 'relevant accommodation'. Specifically, about whether it would include any registered children's home that meets the standard of being able to deprive a child of their liberty, or whether it only apply to a specific type of new provision intended for this purpose.

Therapeutic placements for children with complex needs

- **Alongside the reforms to the Mental Health Act, the Department for Education and the Department for Health and Social Care should continue to prioritise developing a solution to the gap in support for children who fall between health and social care services** – including those who have mental health needs, neurodevelopmental conditions, and trauma. **A joint commissioning model** between children's social care and health (and justice where appropriate) should be developed to ensure there are enough therapeutic secure children's homes for those children who need them, and alternative therapeutic settings which can cater to children with complex needs who are at risk of being hospitalised or deprived of their liberty. These therapeutic homes should have pathways to support children to move back into their family home where possible. **This should be funded through an expanded Better Care Fund for children and young people.**

- **The Department for Health and Social Care should support every Integrated Care Board to develop a strategy to ensure it can meet the mental health needs of children with complex needs and trauma**, who are at risk of being deprived of liberty. Representatives from children's social care services should be present at relevant Integrated Care Board and Integrated Care Partnership decision-making forums to enable data sharing, alignment of resources, planning, and provision of a range of accessible, joined-up mental health services.

Recommendation 3: Making the most of technology, data, and insights

Understanding prevalence of need

- **The Department for Health and Social Care should re-commission the prevalence survey of children and young people's mental health**, which until 2023 provided the most accurate estimate of mental health need in the population, including among those children who are not known to CYPMHS.

- **The national picture of need should be also informed by Integrated Care Board's (ICBs) and Joint Strategic Needs Assessments (JSNAs).** This will allow for detailed insight into the distinct needs of children by geography and demographic, and a central government funding formula which more adequately and sustainably meets demand for children's mental health services.

- **Further research into the national picture of children and young people's experiences of accessing assessment and support services for mental health conditions should be carried out using child-level data.** A key limitation of this research has been the inability to explore how children's various characteristics and circumstances may interact to impact on their ability to access health services in a timely way, for example a child's gender and ethnicity. This research also did not have information about children's socioeconomic background, which is an important factor associated with children's health outcomes.

Accurately measuring waiting times and referral outcomes

- **The Department for Health and Social Care should continue to develop and roll out a single and comparable way of measuring the most meaningful wait a child is subject to.** Rather than number of contacts, this should focus on how long children wait from referral to assessment of their needs, and for support/treatment to begin. Currently NHS England publishes how long children wait for their first contact with CYPMHS, and this can include 'indirect' contacts (or 'activity'), which does not involve any direct contact with a child or their proxy. This may include a mental health professional attending a multi-disciplinary meeting to discuss a child, or speaking to a parent, teacher or other professional. The CCo does not believe this measure provides accurate insight into how long children are waiting to start receiving help for their mental health,

and welcomes the work already underway by DHSC and NHSE to improve this measure in the new community mental health (CMH) waiting times metric. This moves away from only measuring the time taken for someone to have a first contact (the methodology currently used to measure access to CYPMH services). The 'clock starts' when a referral is received by a service and 'stops' when a contact, SNOMED intervention code and outcome/experience measure are recorded in the MHSDS.

- **The Department for Health and Social Care should better align the Mental Health Services Dataset (MHSDS) and Community Services Dataset (CSDS),** so that both collect data on the number of children referred with suspected neurodevelopmental conditions in the same way- broken down by the different types of condition. There should also be a standalone code for neurodevelopmental disorder assessment pathways as service types. Currently it is not clear when children are being referred to CYPMHS for neurodevelopmental assessments alone, and when their referral relates to an overlap in mental health need and neurodivergence.

- **Where a referral is closed before treatment, more detailed data should be collected by the Department for Health and Social Care on why the referral was closed,** and whether and what service children were referred to, to support their mental health and wellbeing, and whether there was a separate waiting list for this service. Local areas should be incentivised and supported to pioneer linked data systems between the NHS and voluntary, community and social enterprises (VCSE), so that children's outcomes in other wellbeing services can be measured.

Joining up data and improving information-sharing

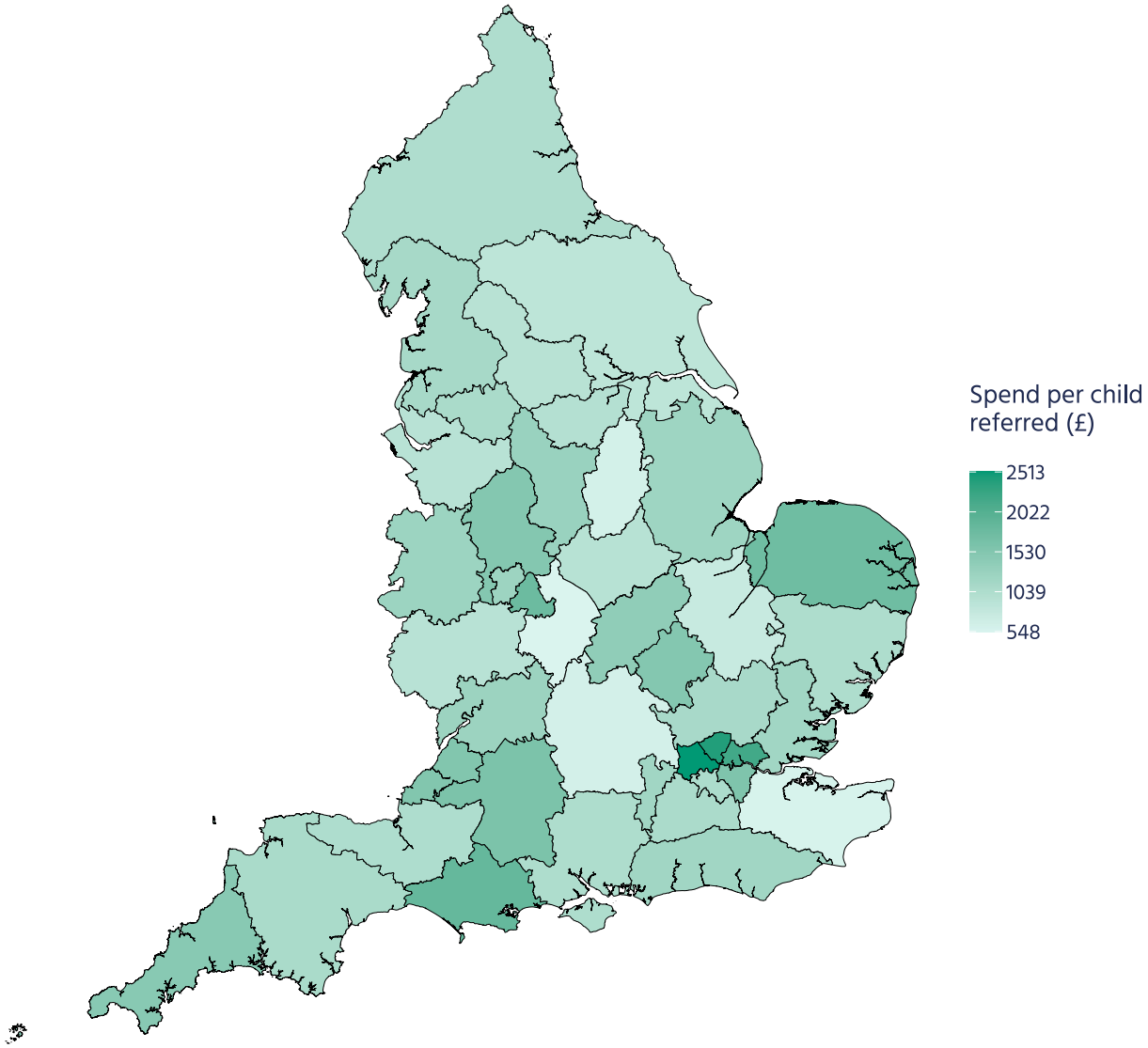
- **Overcoming the barriers created by many health services still not using a single Electronic Patient Record (EPR).** The use of paper-based records can hinder effective information-sharing within the health services. While there has been progress since the pandemic to move to EPRs, there is still some way to go.

- **A universal and unique child identifier is developed and implemented without delay, so that no child falls through the gap.** It is very welcome that the government have made provision in the Children's Wellbeing and Schools Bill to make this possible. This will enable health professionals and other agencies to better track children who move around the system. Having

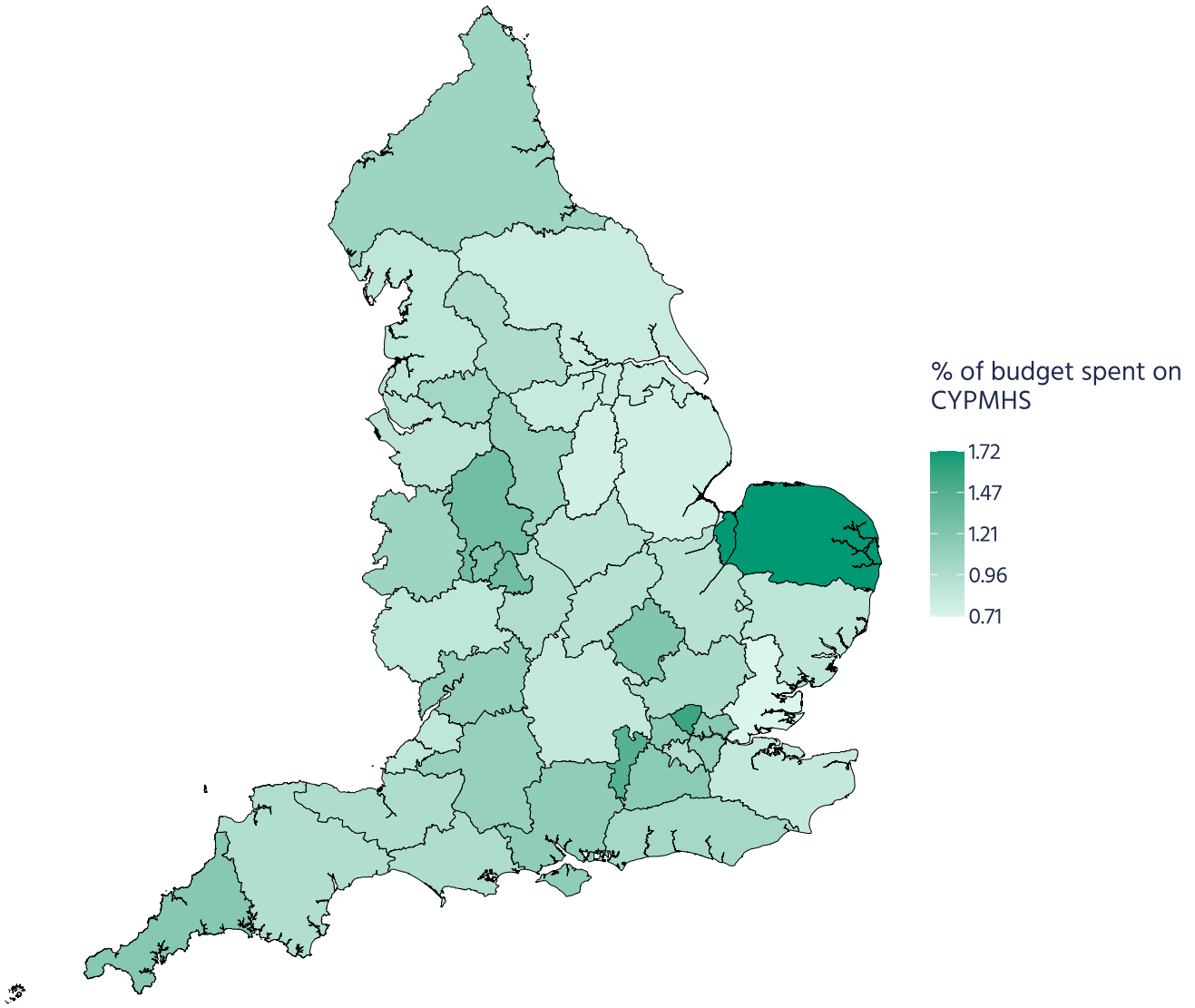
a single unique identifier will help CYPMHS and other statutory services to better identify children at risk of poor mental health, and put in place early support.

Annex

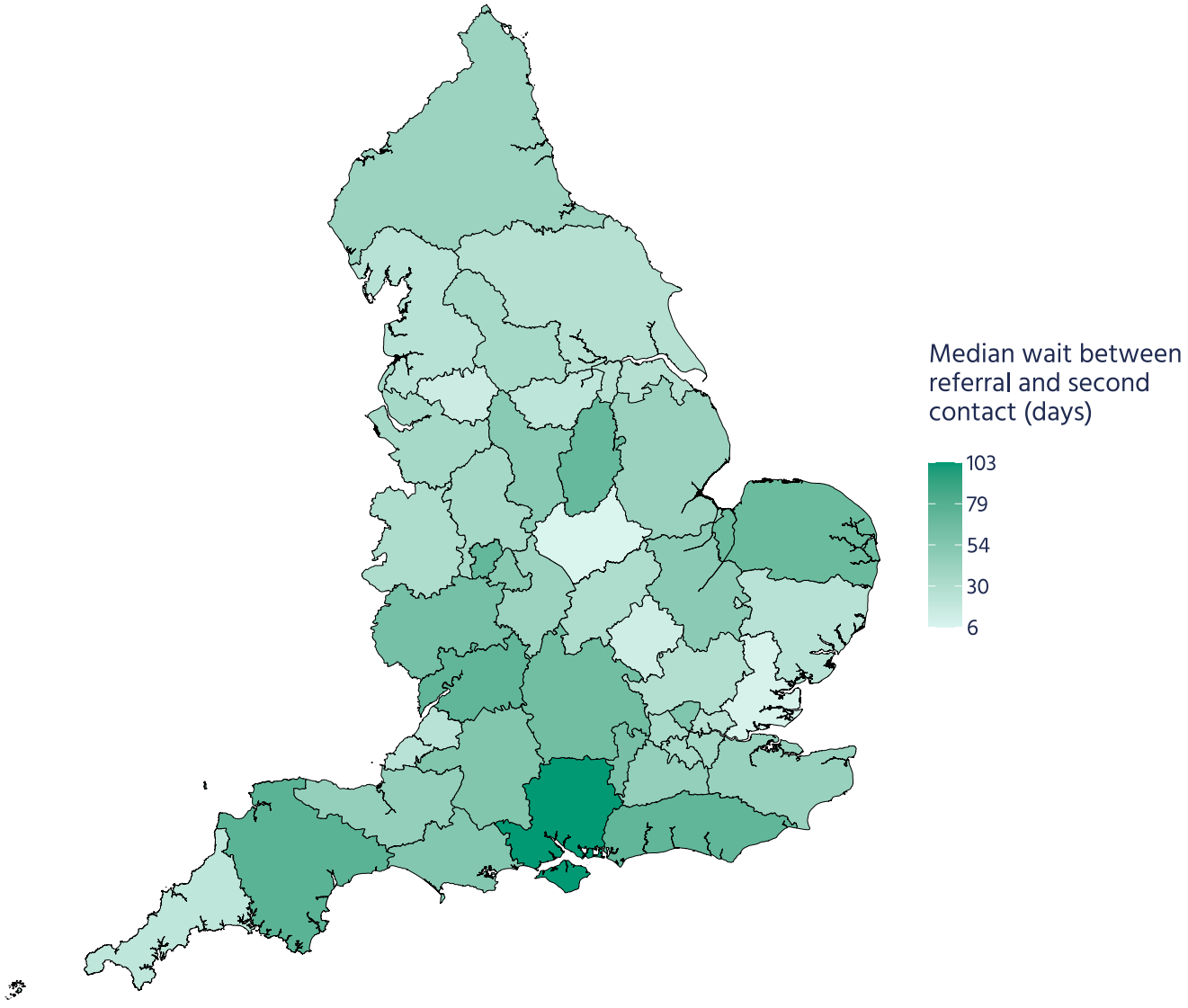
Annex A1: Map showing ICBs by the spend per child with an active referral, the first component of their overall score



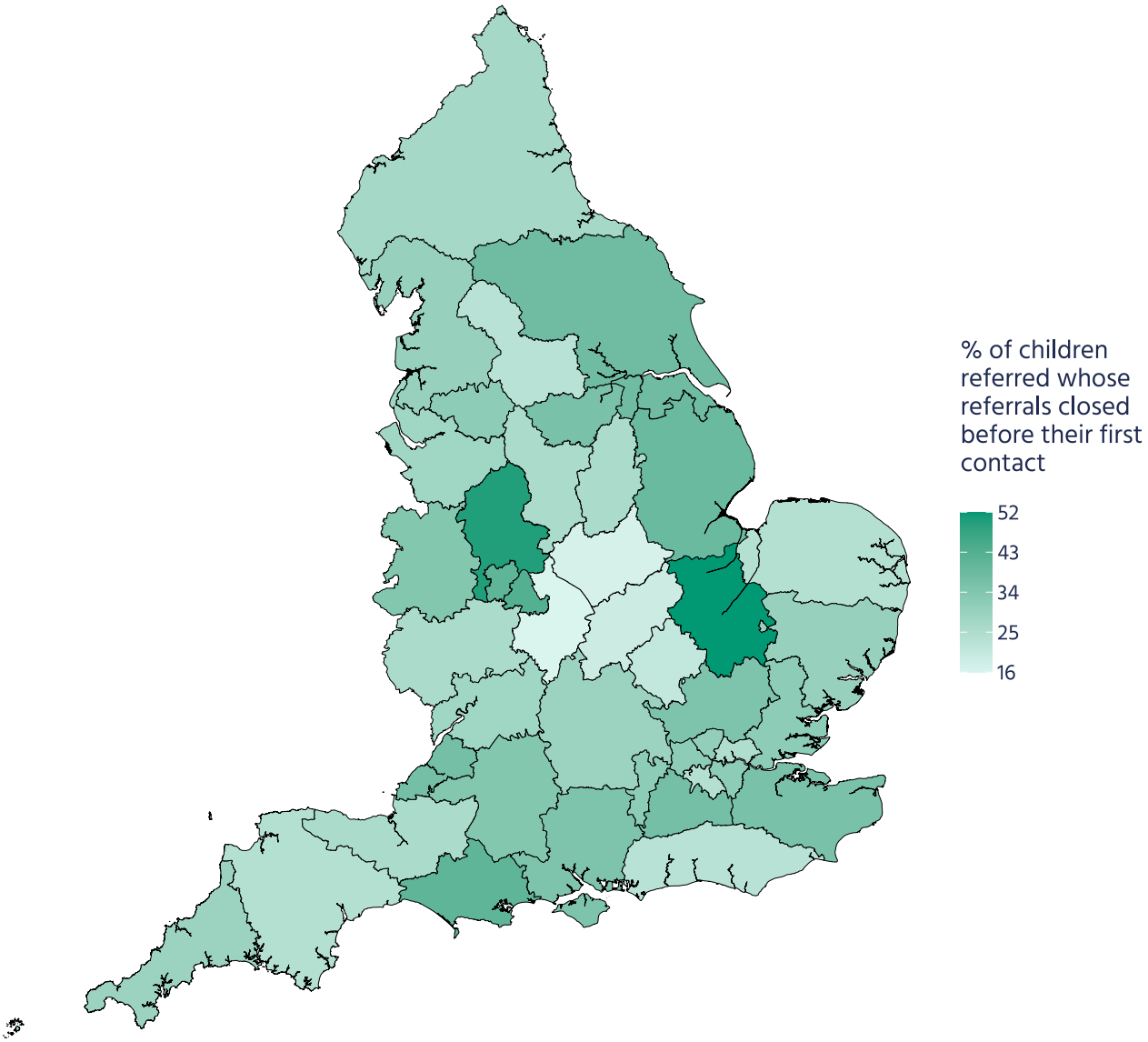
Annex A2: Map showing ICBs by the percentage of total expenditure spent on CYPMHS, the second component of their overall score



Annex A3: Map showing ICBs by the median wait of a child entering treatment, the third component of their overall score



Annex A4: ICBs by the percentage of active referrals closed before treatment, the fourth component of their overall score



Methodology

This report is based on analysis of NHS England data for 2023-24 and comments written by children and young people in response to the Children's Commissioner's *The Big Ambition* survey, which ran from September 2023 to January 2024.

All quantitative data used in this analysis, except where specified, was sourced from the two datasets described below. Both are extracts provided to the Children's Commissioner's office (CCo) by NHS England. Data on spend is publicly available on the NHS Mental Health Dashboard (see below) while the data provided to the CCo on referrals and waiting times has now been published on the NHS website.[45]

All quotes from children and young people in this report are drawn from *The Big Ambition* survey, which ran from September 2023 to January 2024.[46] The survey included one open text question which received 174,131 responses: *"What do you think the government should do to make children's lives better?"*

NHS Mental Health Dashboard

The NHS Mental Health Dashboard, formerly known as the Five Year Forward View for mental health (FYFVMH) dashboard, aggregates key data across mental health services to monitor performance against targets set in their five-year plan. In 2023-24, the underlying data aggregated in the dashboard was collected via the NHS Mental Health Services Dataset (MHSDS). The dashboard data provides information on:

- The percentage of children accessing mental health services during the year estimated as a percentage of children and young people with a diagnosable mental health condition.
- Levels of spending on children and young people's mental health services and how this compares to overall ICB budgets.
- The percentage of children and young people able to access eating disorder treatment within a 1 week or 4 week time frame.
- Total number of bed days and admissions for children and young people under 18 in Children and Young people's Mental Health Inpatient wards.

NHS Mental Health Services Data Set

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

The dataset provided to the CCo contained information on all children with active referrals to CYPMHS for treatment during 2023-24 including:

- Average waiting time between referral and second contact.
- The number and percentage of children who had referrals that were closed before receiving treatment.
- The number and percentage of children still awaiting their second contact at the end of the year.
- The number and detailed waiting times for children who waited more than 12 weeks to access treatment as well as the number of children who were still waiting (having not received two contacts by the end of the year) for mental health support and how they long they had been waiting for.
- Waiting times between referral and first contact, and between first and second contact, on top of the usual data on waiting times between referral and second contact.
- Children's primary referral reasons, and waiting times by referral reason.
- The services children are waiting for, and waiting times by service type.
- Breakdowns on waiting times by gender, age, ethnicity, disability and geography
- Waiting times and referral data that only includes contacts that directly involve children and their proxies (e.g. family where the child is unable to represent themselves.
- Breakdowns on referral reasons by gender, age and ethnicity.
- Children's referral source and waiting times be referral source.

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

Limitations of data and analysis

1. Comparability of this report with CCo mental health briefings that covers data from before the 2022-23 financial year is limited. This is because from July 2022, multiple smaller CCGs merged to form new combined ICBs. This gives the impression that performance in some areas has worsened over the past year when this may not be the case (and vice versa when worse performing CCGs are merged with better performing CCGs).

2. The metrics used to calculate overall area scores have changed since 2024. Instead of spend per child in the ICB (previously CCG), this (and last year's) report uses spend per child with an active referral (using totals previously provided by NHS Digital and now provided by NHS England) to CYPMHS. This aims to capture more directly the link between mental health spend and need, as most children in a local area, especially young children, do not have diagnosable mental health conditions. This is also why access rates, calculated by the percentage of the child population receiving two contacts with CYPMHS, has been dropped from the list of metrics this year. Given these changes, the scores are not comparable with the those calculated using data from 2021-22 and earlier.

3. Previous iterations of the referrals and waiting times data (pre-2022-23 financial year) looked only at referrals which started within the financial year. To examine children waiting over a year, the CCo requested data that included any referrals which were active within the financial year. This

means that the referrals have potential to have been open much longer and, as a result, the CCo is able to look at children waiting over 2 years before entering treatment.

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

5. A child is counted as accessing treatment if they have two contacts with CYPMHS. In some cases, a child may have more than one contact before treatment begins, while others may be referred or not need further support from CYPMHS after one contact. Therefore, we cannot confidently state in all cases that a child with fewer than two contacts did not have their needs met or that every child with two contacts has entered treatment. However, this remains the best proxy measure available due to a lack of other reliable data sources estimating the number of children receiving treatment at a single contact. It is also in line with the measures used to monitor progress in the Five Year Forward View for mental health.

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

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