

**The
Children's
Society**

Access Denied

**A teenager's pathway through the
mental health system**

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Foreword

Approximately 200,000 young people are referred to specialist mental health services each year.

Evidence suggests that the rising rates of young people presenting with serious mental health conditions are not being sufficiently met by help that is both timely and suitable. Every child who requires mental health support is vulnerable. But for some, this vulnerability is further heightened by the presence of safeguarding issues in their lives or difficult family circumstances. Those children and teenagers who are the most vulnerable are being let down the most because they face complex problems and needs.

When a child experiences abuse and neglect at home, or is targeted by criminals for sexual exploitation the first response of professionals is to keep that child safe, to deal with the dangers and risks and make sure that suffering stops.

This is a natural and important response. No child should ever be left without help in situations of risk. It is of equal importance though that the help doesn't

stop there. That alongside the safeguarding response the child gets all the help they need to recover from emotional trauma associated with experiences of abuse, neglect, violence or sexual exploitation.

In our direct work with vulnerable teenagers we see too many children who are turned away from vital mental health support services either because they do not meet the threshold, or because professionals believe that once the abuse has stopped they will recover without help.

We know that trauma experienced in childhood and adolescence can leave long-term emotional scars. With many mental health problems starting in adolescent years and clear evidence that they are more prevalent among young people who deal with a range of negative and traumatic experiences, the need to address access to mental health support for vulnerable children and adolescents is evident.

The timing is also right. The recently announced additional funding for mental health presents a real opportunity to improve access to mental health services for vulnerable groups of children which, as our report shows, is very patchy from one area to another.

We hope this report will help inform the development of new mental health plans and services and ensure that no vulnerable child is turned away from vital mental health support at the time when they need it most.



Matthew Reed
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Executive summary

The mental health needs of children and adolescents have recently come under the spotlight. Available data shows that increasing numbers of young people are turning to self-harm with hospital admissions over the last five years rising by almost 93% among girls and 45% among boys.¹ There are also more young people considering suicide² and an increasing number of young people are being treated for eating disorders.³

At the same time Child and Adolescent Mental Health Services (CAMHS) across the country have been struggling to manage increasing referrals to their services with limited budgets. As a result, many areas have either tightened or redefined their eligibility criteria and have raised thresholds in order to manage demand. The lack of up to date information about prevalence means there are uncertainties about the types and levels of local need resulting in limited strategic planning and commissioning of vital CAMHS services.⁴

For young people who experience other issues alongside their mental health needs, such as abuse, neglect or child sexual exploitation, and who don't have the support of loving families to help them navigate a complex system or ensure that they attend appointments, there is a risk that they can fall between services. Some may face additional barriers in accessing the mental health support they need because

safeguarding eclipse their need for access to mental health support. Yet the research is very clear that these vulnerable adolescents are more likely to develop mental health problems than their peers from supportive families and those who are not exposed to violence or abuse.

Our findings confirm that getting access to specialist mental health services is still very much a postcode lottery, with the average waiting time ranging anywhere from **13 days** to **140 days**. Although some areas have improved, increased waiting times were reported in nearly a third of areas.

Despite the recent welcome focus from national and local decision makers on the need to improve access to mental health services, access for vulnerable groups is an issue that is not well understood or prioritised, both in national guidance or in local practice. Our report shows that only one quarter of providers of specialist mental health services have clear policies to ensure that referrals of looked-after children – a group of children who have special status – are followed through adequately at all stages of the process, including when they transition to adult services. And less than half (47%) of trusts have clear pathways set up for referrals of children who have experienced sexual exploitation.

Our research identifies a number of factors which contribute to this, including the lack of clear national guidance, variations in what local data is available and different interpretations of what additional vulnerabilities need to be taken into account when a referral of a young person is assessed.

The recent and on-going focus on improving access to mental health support is welcome. The Government has made a commitment to invest £1.25bn into children's mental health needs over the next five years. The latest available data shows that only 6% of spending on mental health currently goes to children and young people's services,⁵ therefore this additional investment is very timely. Additional investment, alongside NHS England and CCG transformation plans, and the five-year action plan to achieving parity for mental health⁶ all present an opportunity to change how vulnerable children and adolescents access mental health services.

We hope this report will contribute to finding positive solutions and setting clear pathways for mental health support for vulnerable groups of young people in both national and local strategies. The report is based on the analysis of Freedom of Information responses from 36 mental health providers that we sent out in spring of this year and analysis of available research and policies on vulnerable groups.



Key findings

Increased prevalence of mental health problems amongst children from vulnerable groups.

Children and young people experiencing mental health problems can come from all walks of life. However, as our direct work with young people aged 10 to 18 indicates, teenagers who are also facing a range of difficult circumstances, such as poverty or experience safeguarding issues, such as abuse, neglect, witnessing violence or substance abuse at home or experiencing sexual exploitation, are particularly vulnerable to developing mental health problems.

Research confirms this. For example, 72% of children in residential care are experiencing some form of emotional and mental health problem.⁷ Evidence also suggests consistently increased levels of psychological ill-health among refugee children, trafficked children and children with experiences of sexual abuse, especially post-traumatic stress disorder, depression, and anxiety disorders. In addition, children in poverty are over three times more likely to experience mental health disorders as those in well-off families. Older teenagers are more likely to experience mental health disorders – 12% of children aged 11 to 15 have experienced a mental health disorder – increasing to 20% for 16 to 24 year olds.⁸

There is a severe lack of data on access to mental health services.

Overall, there is a lack of reliable and consistent data on the numbers of young people aged 10–17 referred to specialist mental health services and the responses they receive. For example, nine trusts told us that the data on referrals to their specialist mental health services is not available in an easily retrievable format. And out of 34 trusts who provided us data on referral rates only five trusts could supply some information on children from vulnerable groups, in most cases because there was a specialist service commissioned in the area.

Referral rates indicate high level of needs.

Based on the data we received from 34 providers we estimate that on average there are four referrals made to specialist mental health services for every 100 young people aged 10–17. Across England this equates to **nearly 200,000 referrals every year for young people aged 10 to 17.**

A third of referrals received are not accepted.

Based on the data we received from 14 providers we estimate that 7 in 10 referrals get accepted while **around 15% are not accepted without further action** and a similar number get signposted to other services. If these trends are indicative of nation wide trends it could mean that as many as **30,000** children are turned away from specialist mental health services without further support.

In addition, many children from vulnerable groups are not getting the help they need. Only five trusts out of 36 that responded could provide information on children from vulnerable groups. The data indicates that across those trusts nearly three quarters of children from vulnerable groups are accepted (**72%**), almost a third (**28%**) were not accepted and of these **15%** were not accepted without further action. Even though this finding is based on a limited number of responses, it is worrying that so many referrals of children from vulnerable groups are left without specialist mental health support. These rates may also be higher as this estimate is based only on 37% of cases where the outcomes were known.

Referral acceptance rates vary by the referral source.

Just over half (53%) of referrals to CAMHS Tier 3ⁱ services come from General Practitioners. 18% of these referrals were assessed and not accepted. Young people from vulnerable groups are more likely to be referred to specialist mental health services by practitioners in other statutory services. The data from 22 providers that responded shows that these referrals have high chances of not receiving the desired response. For example, 14% of referrals from social services are not accepted without further action. Although voluntary sector providers can find it challenging to refer a young person to specialist CAMHS, we found that 94% of their referrals were assessed and accepted.

Waiting times for CAMHS services vary a great deal by location.

Our findings suggest that providers who use a single point of entry system on average have a shorter waiting time compared to those who use a multiple point system. Based on the information we collected the national average waiting time for an initial Tier 3 assessment in the financial year 2013 to 2014 was **72 days**. This has reduced to **66 days** in the year 2014 to 2015. However there were substantial variations in

waiting times between providers with some offering an initial assessment within **13 days** and others a much longer period of up to **140 days**, a striking example of the postcode lottery that exists within CAMHS provision. Last year, 41% of providers reduced their average waiting time whilst a third of providers saw waiting times increase.

The majority of referrals that are not accepted are de-escalated.

Very high rates of referrals that are not accepted (87%) are referred to CAMHS Tier 2 early intervention and prevention services, indicating that they do not meet the threshold for intervention. Meanwhile, the Tier 2ⁱⁱ services they are referred on to report rising demand and face major cuts to their budgets.⁹

Inconsistent policies on access for vulnerable groups.

Overall, vulnerable groups of young people such as children in care and those who have experienced abuse and neglect are not being adequately supported in their journey through the CAMHS system. For example, we found that 64% of providers identify looked-after children as a vulnerable group in the initial stages of their referral, yet only 40% offer priority access and less than a third (28%) have

provisions in place to support them when they transition.

Cases of DNAs.

Over three quarters of recorded Did Not Attend cases (DNAs) are of those young people who were undergoing treatment from specialist CAMHS and only one in four instances were for initial appointments. This suggests that there may be issues in some areas in retaining engagement from service users that need to be further explored.

Young people are sometimes being discharged from services without a proper assessment.

Around one in every 10 cases (9%) involves children aged between 10 and 17 who fail to attend their appointment with a specialist mental health worker are discharged without a risk assessment.

ⁱ Please see appendix for an overview of the CAMHS system.

ⁱⁱ Ibid

Key recommendations

The analysis of data received in response to our Freedom of Information request indicates that access to mental health support for all adolescents and for those adolescents with vulnerabilities is currently patchy and inconsistent. The lack of clear policies and procedures in cases of young people from vulnerable groups may lead to many of them falling through the gaps when they may need help the most. The vulnerability factors that some young people face need to be better and more consistently recognised by those working with young people in relation to their mental health to enable better referral and treatment. Throughout this report we are making a range of recommendations addressed to national and local decision makers. The full list of recommendations is presented in the concluding chapter.

We believe that key changes at the national and local level should aim to improve access to services and improve the quality of response. In particular, we recommend that:

Waiting times

- NHS England should develop waiting time standards for all specialist mental health services that would at least match the six week standard currently expected for a diagnosis in physical health services.¹⁰ Local areas should ensure that the new funding is spent in part on improving access and reducing waiting times across all CAMHS services.

Access for vulnerable groups

- As part of taking forward the Future in Mind strategy, particularly around the vulnerable groups' agenda, the Government should focus on improving access to specialist mental health services for vulnerable groups of adolescents by putting policies and procedures in place to ensure timely and appropriate help, by collecting and publishing data on access and outcomes achieved, and by issuing a national guidance demonstrating how data on vulnerable groups should underpin the commissioning of local services.

- Local Safeguarding Children's boards, as part of the multi-agency safeguarding response to the most vulnerable children and young people, should review and monitor the referral rates and access to mental health services for children who are known to local services because of safeguarding concerns.
- Local Child Poverty strategies should address access to specialist mental health services for children living in poverty.
- The Department of Health and NHS England should strengthen the guidance on inclusion and exclusion criteria for CAMHS to end the postcode lottery that currently exists and to ensure that children and young people who have experienced trauma, including abuse, are always able to access mental health support.
- The guidance on Health and Well-being for Looked-after Children should be strengthened to recognise the needs of care leavers and require that they be given priority access to services when needed.
- Young people should be offered advocacy and support to enable them access to CAMHS services.

Working across agencies

- Local areas should invest in training for all professionals working with children who have mental health problems and for health practitioners about safeguarding risks relating to mental ill-health.
- Providers of CAMHS should ensure that voluntary sector organisations working with vulnerable young people can refer them to specialist mental health support when they need it. Mental health services and the voluntary sector should develop ways of working together to ensure that vulnerable young people have adequate support to engage in mental health treatment.
- A focus on Did Not Attend (DNA) rates is very important as in the case of the most extreme vulnerabilities, it is far too easy for young people to miss out on support all together. We believe that all mental health services should have DNA policies that clearly specify the need for risk assessments on both missed initial appointment and for those where the patient is on course for treatment. Specifically these policies should outline how service providers will liaise with other agencies in cases of young people from vulnerable groups. There is also a need for further research into why young people miss appointments.

Methodology

The findings in this report are based upon a Freedom of Information (FOI) request we sent out in April 2015 to 54 providers of specialist mental health services. We received responses from 36 providers who deliver CAMHS, a response rate of 67%. Respondents comprised of NHS mental health trusts and NHS children's hospital trusts. Of the four standalone NHS specialist children's hospitals in England, we sent and received CAMHS data from three.

We asked providers for information about the 10 to 17 year olds that they treated in the financial year 2014–2015, including those young people categorically identified as vulnerable.ⁱⁱⁱ In our FOI, we requested information about:

- The type of referral entry point system used in their area and average waiting times.
- Referral rates and processes including where referrals come from and where they go when they are not accepted by Tier 3 services.
- Provider policies on referral pathways for vulnerable groups, from identification through to transitions.
- Information about 'Did not attend' (DNA) cases and policies on follow-up.

- We also examined and reviewed guidance, including statutory guidance produced by the Government and service specifications produced by NHS England.

With this in mind, we asked whether CAMHS are sufficiently identifying factors of increased vulnerability and if so, what actions are being taken once that vulnerability is identified? Within our Freedom of Information questionnaire, we highlighted a number of examples of vulnerable groups we see through our services. We invited providers to inform us of other factors they identify as making a young person vulnerable. Whilst some listed a number of additional factors, the majority did not provide this.

The vulnerable groups we focus on in this report include:

- Children and young people living in poverty
- Children and young people with a vulnerability related to their age
- Children in care
- Children and young people known to local authorities
- Children and young people who may have experienced or witnessed violence, including domestic and sexual violence
- Young offenders

Throughout the report, we use the term 'mental health problems' to describe different conditions children and teenagers can experience. This includes mild, moderate to severe and ensuing conditions, ranging from anxiety to depression through to bipolar disorder, schizophrenia and eating disorders. We recognise a range of terms exist to describe these conditions and illnesses, but for consistency and clarity we are using 'mental health problems' throughout this report.

Abbreviations

- 1. CAMHS.**
Child and Adolescent Mental Health Services
- 2. CCGs.**
Clinical Commissioning Groups
- 3. CSE.**
Child Sex Exploitation
- 4. DNA.**
Did Not Attend

ⁱⁱⁱ See appendix for list of vulnerable groups system.

About The Children's Society

The Children's Society is a leading charity committed to improving the lives of thousands of children and young people every year. We work across the country with the most disadvantaged children through our specialist services and children's centres. Our direct work with vulnerable groups including disabled children, children in or leaving care, refugee, migrant and trafficked children, means that we can place the voices of children at the centre of our work.

We offer a range of counselling, befriending and emotional support services across the country. Some of these services are delivered alongside specialist support to children and young people who have experienced domestic violence, neglect and sexual abuse. Our practitioners tell us that there is a growing need for better mental health support for vulnerable children and young people. They are particularly worried about the lack of services available for older and neglected adolescents.

Our well-being research

We have been studying children's subjective well-being since 2005. Our Good Childhood Inquiry, launched in 2006, was the first independent national inquiry into childhood that sought to better understand modern childhood from the perspective of children themselves. The final report includes a set of recommendations for parents, teachers, the government and society more broadly. We have produced annual reports reviewing children's subjective well-being since 2012 and have analysed the impact of a range of factors affecting the way children feel about their lives.





Chapter 1: Setting the scene

Why we focus on the mental health needs of vulnerable adolescents

1.1 Focus on adolescents

Recently, children and young people's mental health has moved higher up on the agenda of both national and local government. The change has been influenced by a growing understanding of the importance of positive mental health on a child's life chances,¹¹ the consistent lower ranking on well-being indicators of children and young people in this country when compared to their peers in other Western countries,¹² and a greater recognition of the inadequacy of CAMHS' current resources and structures to meet the growing needs of children and young people in the last decade^{13,14} – as highlighted by recent worrying statistics on increases in self-harm episodes and attempted suicides.

At least one in every 10 children in Great Britain has mental health needs.¹⁵ Around the same proportion of children in England also have low levels of well-being as our well-being research programme has found.¹⁶ Around half of this group also have mental health problems,¹⁷ and others are at risk of developing these problems if they do not get the help they need. Yet many will struggle to get access to appropriate support to deal with their emotional and mental health needs. The Health

Select Committee's inquiry into children's mental health highlighted that:

'Providers have reported increased waiting times for CAMHS services and increased referral thresholds, coupled with, in some cases, challenges in maintaining service quality. In the view of many providers, this is the result of rising demand in the context of reductions in funding.'¹⁸

All children and young people with mental health needs are vulnerable, irrespective of their age or their family and life situation. However, as our direct work with young people aged 10 to 18 shows, adolescents who face a range of safeguarding issues, such as living with abuse or neglect, witnessing violence or substance abuse at home or experience sexual exploitation, alongside any pre-existing mental health needs, are particularly vulnerable. They find it difficult to access mental health support altogether or at the right time, if at all, leaving them open to even greater risks, including the risk

of developing more serious and long-term mental health problems. Young people living in poverty also faced a range of risk factors that can prevent them from accessing services, as their needs are too often not addressed in coordination by public services.¹⁹

Research has identified that adolescence is a peak age for the onset of serious mental illness, particularly mood disorders such as depression or bi-polar disorder, and psychotic disorders such as schizophrenia and self-harm. It is thought that about 75% of adult mental health problems have their roots in childhood.²⁰ The most common mental health problems for this age group are anxiety and depression, but other problems like eating disorders and psychosis can also emerge during this stage of development.

Evidence also suggests that from the age of 14 onwards mental health needs intensify.²¹ Our research into well-being also shows that there are clear declines in levels of well-being as children progress into adolescence – 2.4% of children aged 10 had low levels of life satisfaction, compared to 8.2% of children aged 16.²² At the same time adolescence – and particularly older adolescence – is

also a period when safeguarding concerns heighten. For example, previous research from The Children's Society has shown that young people aged 16–17 are more likely to be identified as 'children in need' than younger children in the majority of cases due to abuse and neglect.²³

Overall there is a lack of awareness about when to seek support with mental health and what support may be available. This message came out very strongly in our poll of 1004 young people aged 16 and 17 and their parents for our recent report *Seriously Awkward: How vulnerable 16 and 17 year olds are falling through the cracks*.²⁴

1.2 Access to mental health support for vulnerable groups of adolescents

The 2004 ONS prevalence survey estimated that only a quarter of children affected by mental health problems access any kind of specialist help.²⁵ The table below illustrates the rate at which parents sought support from mental health specialists over the last year by the four types of disorders covered in the study. Children who dealt with hyperkinetic conditions, such as Attention Deficit Hyperactivity Disorder (ADHD), were more than twice as likely to seek support from CAMHS than those with emotional problems such as depression. Over a quarter (28%) of families with children who presented with conduct disorders, including problems such as persistent aggressive and violent behaviour, sought support from mental health specialists.

This data shows that access to services is already low suggesting that it is likely to be even lower for vulnerable young people who may not have the usual support networks. Some of the conditions examined as part of the ONS study may be the result of the

intricate interaction of genes and experience.³⁰ Emotional and conduct problems in particular can be experienced alongside risks that result from environmental factors, such as those related to trauma. Research shows that among adolescents with severe emotional disorders involved in multiple service systems those who had Post Traumatic Stress Disorder (PTSD) were ‘more likely to have run away, engaged in self-injurious and delinquent behaviour, reported higher anxiety and depression, and functioned worse at school and home than those without PTSD.’³¹

The experiences of trauma during adolescent years are likely to have a long-term impact on young people. It is a critical point during which social stress and drug use are processed differently in the adolescent brain compared to other periods of life.³² In our experience, the mental health needs of a young person related to trauma or adverse life events they have experienced may become less of a priority when safeguarding concerns emerge.

Sometimes mental health and children’s practitioners may regard that a response to safeguarding concerns is sufficient on its own to improve the mental health of a young person. A Centre for Social Justice Study noted that,

‘existing resources in some areas are not being tailored to meet the particular mental health needs of some vulnerable children. They are instead expected to fit into what is available and offered.’³³

There is no single definition or list of what constitutes that additional vulnerability or which groups of children can be deemed vulnerable and prioritised in responses. Yet the research indicates that young people who live in poverty; young people known to children’s services as children in need (including young carers, children on child protection plans or children in families with substance abuse); 16–17 year olds, in particular those who are detached from their families; looked-after children and young people; and those who witnessed or experienced violence, including sexual violence and exploitation, have higher level of mental health needs as presented in boxes **A to F** below and their access to relevant mental health support is very much determined by how local services are commissioned.

Table 1: The use of mental health services by type of disorder

Type of condition	Rate in % at which parent of children sought support from mental health specialists
Emotional disorders	24% ²⁶
Conduct disorders	28% ²⁷
Hyperkinetic disorders	52% ²⁸
Autism spectrum disorders	43% ²⁹

Use of mental health services, 2004 ONS study by Green et al.

Research and national statistics show that access to mental health support for young people from vulnerable groups is even more difficult. According to a 2010 study, 63% of looked-after children were assessed as having a mental health problem but only one third (32%) were receiving support from CAMHS.³⁴

In another example, only half of depressed adolescents and young people have had contact with specialist services or a professional about their depression.³⁵ Studies have also found that for young people aged 16 and 17, service use declines precipitously, just when serious mental disorders are emerging.³⁶

And 33% of homeless young people using services run by Centrepoin are experiencing poor mental and emotional well-being but face barriers in accessing the help they need.³⁷ Despite the high prevalence of mental health symptoms, only 7% of these young people received a formal mental health diagnosis.³⁸

Box A: Children in poverty

- Over three times more likely to suffer from mental health disorders as those in well-off families³⁹ and nine times as likely to have psychotic disorders.⁴⁰
- Previous research we conducted found that economic factors have a significant link with children's subjective well-being as lower levels of household income, recent decreases in income and greater adult economic concerns about the future are all associated with children having lower average levels of subjective well-being.⁴¹
- Our Debt Trap report showed that around half of parents (47%) in arrears said that their financial situation caused their children emotional distress, with a quarter saying that it resulted in their children feeling stressed or anxious and 19% saying that it contributed to them having mood swings.⁴²
- Analysis we conducted as part of our Seriously Awkward report found that 16 and 17 year olds from the poorest backgrounds were nearly three times more likely than wealthy children to be happy with their life overall.⁴³

Box B: Vulnerable older adolescents

- Studies estimate that 12% of children aged 11 to 15 have a mental health disorder. This rate increases to 20% for 16 to 24 year olds.⁴⁴
- Self-harm and suicide attempts also emerge during adolescence and are particularly problematic with adolescent girls. One in five girls aged 15–17 have self-harmed and young women aged 15–19 are the most likely group to attempt suicide.⁴⁵
- Our latest report, *On Your Own Now*,⁴⁶ about the experiences of 16 and 17 year olds who can no longer live at home with their families, found that nine in ten providers expressed significant concerns about the risk poor mental health poses to the young people living in their accommodation. Poor mental health was seen as an exacerbating factor that often resulted in crises that could lead to an eviction from the accommodation or an unplanned move.

Box C: Children in Care

- 72% of children in residential care have some form of emotional and mental health problem.⁴⁷
- Looked-after children are five times more likely to develop a mental disorder than children living at home with their families, yet several studies indicate that only a small minority (32%) of those diagnosed access CAMHS.⁴⁸
- According to an ONS study on the mental health needs of looked-after children, among those aged 5–17 years, 45% were assessed as having a mental disorder: 37% had clinically significant conduct disorders; 12% were assessed as having emotional disorders (anxiety and depression) and 7% were rated as hyperactive.⁴⁹
- Looked-after children and care leavers are between four and five times more likely to self-harm in adulthood.⁵⁰
- As well as being at higher risk of developing mental health problems, children in care also at greater risks of facing challenges when they reach transition in-between and from CAMHS.⁵¹

Box D: Children known to children's services

- Learning from the Troubled Families programme revealed that 'having a child with a mental health problem was also associated with there being a child in need within the family – that is, children's services have identified a child as being likely to have impaired health and development without support; (25% had a child in need compared to 19% without a child with mental health problems).'⁵²
- Young people with substance misuse problems: smoking, drinking and drug use are more prevalent among 11–16 year olds with an emotional disorder.⁵³
- The prevalence rate of a diagnosable psychiatric disorder is 36% in children and adolescents with learning disabilities, compared with 8% of those who did not have a learning disability.⁵⁴
- These young people were also 33 times more likely to be on the autistic spectrum and were much more likely than others to have emotional and conduct disorders.⁵⁵
- The pressures of caring for parents and living their own lives frequently leads to anxiety, feelings of anger, frustration, guilt, resentment and stress.⁵⁶
- The 2011 Census data shows that there were 55,650 young carers aged 16–17 in England, with 6,690 of them caring for more than 20 hours each week and 4,525 caring for more than 50 hours per week – that is 8% of all carers in this age group. Young carers aged between 16 and 18 are twice as likely to not be in education, employment or training.⁵⁷

Box E: Children and young people who may who may have experienced or witnessed violence, including physical or sexual violence

- Children living in families where domestic abuse occurs may be the victims of abuse themselves or may need support in dealing with the psychological impact of witnessing abuse, building self-esteem and developing personal safety plans and support networks. A recent review of the Troubled Families programme found of those accessing its targeted services, having a child with a mental health problem is associated with the presence of domestic violence within the household; (36% had a domestic violence problem compared to 24% without a child with a mental health problem).⁵⁸
- The Office of the Children's Commissioner estimates that 16,500 young people are at high risk of sexual exploitation.⁵⁹ These young people are often extremely vulnerable and have multiple complex needs often around issues like drug and alcohol abuse, mental health, homelessness, gang affiliation or disabilities. The Children and Young People's Mental Health Taskforce acknowledged the difficulties young victims of sexual abuse face in accessing CAMHS to help them overcome their experiences of trauma.⁶⁰
- Falling victim to crime can have both a physical and emotional impact including fear, anxiety and sleep deprivation. Last year, a report published by Her Majesty's Inspectorate of Constabulary found that one in five crimes in England and Wales goes unreported.⁶¹ A later study further concluded that the majority of crimes against children and young people are not reported to the police.⁶² Child victims of crime often don't have the same level of access to counselling services. They often also don't meet the threshold for CAMHS intervention.
- Consistently increased levels of psychological morbidity among refugee children, especially post-traumatic stress disorder, depression and anxiety disorders.⁶³
- About one in eight trafficked children have tried to harm or kill themselves in the last month and a quarter have post-traumatic stress symptoms.⁶⁴

Box F: Young offenders

- 95% of imprisoned young offenders have a mental health disorder. Many of them are struggling with more than one disorder.⁶⁵
- Self-harm amongst young offenders increased by 21% in 2011–12.⁶⁶
- 31% of young offenders have mental health problems.⁶⁷
- An estimated 8% of young men and 5% of young women aged 11–16 in Great Britain have a conduct disorder.⁶⁸ This is the most common mental health disorder amongst adolescent boys. It is often, but not always, associated with violent behaviour.

1.3 National policy context

The recent and on-going focus on improving access to mental health support is welcome. The Government has made a commitment to invest £1.25bn into children's mental health services over the next five years. With only 6% of spending on mental health known to be going to children and young people's services⁶⁹ this additional investment is very timely. Additional investment alongside NHS England and CCG transformation plans and the five-year action plan to achieve parity for mental health also present an opportunity to change how vulnerable adolescents access mental health services.

As part of the ministerial Children and Young People's Mental Health Taskforce, the Vulnerable Groups and Inequalities Task and Finish group acknowledged in their report an important distinction between young people who face a diagnosable and biological vulnerability to mental ill-health and those whose symptoms are triggered by contextual factors such as abuse and neglect. The group noted that particular attention is required for the latter group as:

'their life chances may be weighted down not by a single mental health difficulty, but by the accumulation of multiple

biological and contextual factors conferring vulnerability, which taken individually may not meet the eligibility for services designed for children and young people who meet a diagnostic threshold.'⁷⁰

The group made clear recommendations for CAMHS to better meet the needs of vulnerable groups. Proposals set out in their report include better and clearer routes of access to services and support, trauma-focused care, different delivery models including more accessible and engaging settings, increased participation, coordinated services and measures to tackle inequalities and promote equalities.⁷¹

In practice there is very little guidance on how the needs of vulnerable groups have to be met through commissioning and delivery of mental health services. This has resulted in variable and patchy local policies and services from area to area. As the Centre for Social Justice highlighted, 'CAMHS does not have its own statutory framework, and is shaped by government policy and *The National Service Framework* is practice guidance, and does not need to be followed if there are good reasons to depart from it.'⁷² The services that are commissioned locally are very

much determined by availability of regarding the needs of children from vulnerable groups and whether there are local champions ensuring that their voices and needs are represented adequately.

Changes introduced as part of the Health and Social Care Act 2012 transferred the responsibility of local Joint Strategic Needs Assessments (JSNAs) to Health and Wellbeing Boards through which local authorities and Clinical Commissioning Groups (CCGs) are expected to contribute to. These reports are used by local commissioners to inform their decisions about funding and the commissioning of services.

The Department of Health's Statutory Guidance requires JSNAs to include and assess current and future health and social care needs, including mental health needs, which should receive equal priority with physical health.⁷³ The guidance however does not provide enough detail about how inequalities within mental health services should be approached.

A review of JSNAs conducted by the Children and Young People's Mental Health Coalition found that two thirds of published documents did not include sections dedicated to addressing the mental health needs of children and young people and

one third did not contain an estimated or actual level of need for CAMHS in their area.⁷⁴ The report further noted that only one fifth of documents linked the risk factors faced by young people to their mental health.⁷⁵ JSNAs play an important role in shaping the priorities of local areas and without relevant and up to date information about the level of need in an area, many young people, particularly the most vulnerable, may miss out on receiving targeted support for their mental health difficulties.

Some vulnerable groups of children benefit from more detailed national guidance. For example, the joint health and education statutory guidance on promoting the health and well-being of looked-after children specifies that, 'CAMHS and other services provide targeted and dedicated support to looked-after children according to need... professionals need to work together with the child to assess and meet their mental health needs in a tailored way.'⁷⁶ However, most vulnerable groups do not receive this clarity in guidance.

1.4 Local policy context

Learning from FOI responses

With this report we set out to establish the referral pathways for adolescents from vulnerable groups to Tier 3 CAMHS services. Due to the fragmented nature of CAMHS commissioning, we decided to focus on referral pathways to specialist or Tier 3 services as a sharp increase in referral rates and changes to eligibility have been most reported in this tier.^{77,78} Our diagram in the appendix provides an overview of the CAMHS tier system.

Specialist CAMHS (Tier 3) services are often defined as multi-disciplinary teams providing a range of support services for young people with more severe, complex and persistent needs. These teams may include professionals ranging from therapists, psychotherapists, psychologists, social workers and Youth Offending Teams (YOTs). Some of the symptoms seen by these teams may include young people who experience a mental health diagnosis relating to drug and alcohol misuse. A full list of presenting conditions seen by Tier 3 practitioners is available in the appendix.

CAMHS Tier 3 services are normally commissioned by local Clinical Commissioning Groups (CCGs) and are often community-based with the purpose to facilitate access and reduce stigma. Professionals formally working with the young person, such as their GP, school or social services, can make referrals into these services.

Referral acceptance policies regarding voluntary sector organisations vary between providers of CAMHS and, whilst we acknowledge there are strong and positive relationships in some areas between community and statutory services, in others, voluntary sector services cannot even refer directly into CAMHS and are required to send children to their GP instead.⁷⁹

In their inquiry into CAMHS, the Health Select Committee gathered evidence from a range of CAMHS providers and service users. One of the key findings that emerged in their final report was the increase in waiting times and referral thresholds in CAMHS Tier 3 services; due to financial pressures and reduced resources – including a lack of specialist provision – some CAMHS thresholds have heightened, with services becoming more tightly targeted.⁸⁰

A mapping of CAMHS services conducted by the University of Durham found that referral rates to Tier 3 CAMHS increased by more than 40% between 2003 and 2009/10.⁸¹ This coincides with the growing number of children who have become known to children's services.

In addition, many of the cases seen by specialist CAMHS may involve safeguarding concerns relating to the young person's presenting need, for example, patients who are dealing with self-harm require safeguarding

responses in addition to mental health support.

Responses received from 36 providers showed that the availability, access and the level of response to adolescents overall, and to vulnerable adolescents in particular, varies considerably from one part of the country to another. While the detailed findings from FOI responses is discussed in the next chapters, it is important to note here some key findings related to data we received:

- Overall there is a lack of reliable and consistent data on the prevalence of how many young people 10–17 are referred and what the responses to them are. While of the 36 trusts who responded to our FOI, 34 could provide us with some or all data on referrals of adolescents they receive, only five could supply information on access to specialist mental health services by young people from vulnerable backgrounds.
- We asked providers for information about their service area, including the local authorities and Clinical Commissioning Groups (CCGs) they work with, to better understand both their reach and remit. There are big variations in the size, status and structures of providers. For example, one of the

larger mental health trusts in England works in partnership with 43 Local Authorities across England and their local CCGs, whereas another worked with one CCG and its partner local authority.

- There are also variations in policies within trusts. Our findings show a distinct lack of cohesion or unified policy decisions, not only nationally but also within trusts themselves. For example, some of the trusts that responded to our FOI request provide services in a number of areas where referral policies and processes can vary. This can be due to differences outlined in local priorities such as their Joint Strategic Needs Assessments (JSNAs). For example, one trust delivers services on behalf of three local authorities and health partners. Despite these three areas falling under the same trust and their locality, there are significant differences in the way they operate. For example, there are different referral entry point systems in place in these areas and the age to which services are offered also varies between 16 and 18 years of age.
- There is very little consistency about policies on vulnerable groups across local areas. In some areas there are specialist commissioned services for certain vulnerable groups, for instance, those

affected by drug and alcohol misuse or looked-after children or domestic abuse, who may have more detailed policies on assessment, being prioritised for quick access and re-engagement when they miss appointments. In others, additional vulnerabilities are addressed through general policies and procedures, or not addressed at all.

The overview of available research clearly highlights the need to pay greater attention to how children whose lives have been affected by a range of safeguarding issues get access to therapies, both to overcome their trauma and to prevent the development of more serious mental health problems as they move from adolescence into adulthood, and during the adolescent years, when their mental health needs intensify.

Unfortunately, the available national and local statistics show that the data needed to underpin development and commissioning of relevant support services is not gathered consistently. Very often the systems that are dealing with safeguarding concerns and with mental health needs are separate and do not effectively complement each other.

The lack of a robust national framework contributes to a situation where the availability of services becomes patchy and variable from one place to another and, in some cases, too difficult for young person to navigate.

What needs to change?

- The Department of Health should develop national guidance on mental health services for vulnerable groups, including guidance on how such services should be commissioned, how referrals should be assessed, including cases that need prioritising and policies to maintain engagement.
- The Health and Social Care Information Centre should collect and publish data access to special mental health services by children, including vulnerable children.
- The Department of Health and NHS England should ensure there are consistent approaches on the monitoring of outcomes for vulnerable groups accessing CAMHS.
- Clear guidance is needed about which groups should be considered consistently in the data analysis underpinning Joint Strategic Needs Assessments to ensure that an adequate level of services are commissioned locally.
- Health and Wellbeing Boards should ensure local Joint Strategic Needs Assessments explicitly include children and young people's mental health and the needs of different vulnerable groups at risk of developing mental health problems, to assess current and future need and inform commissioning strategies.



Chapter 2: What we found out

Access to specialist mental health services for adolescents

For children and young people who require help in overcoming mental health difficulties, a timely and appropriate referral to CAMHS is vital. A referral to the right service at the right time can ensure the needs of young people are identified and addressed early to prevent their problems from escalating.

However, a referral to a specialist mental health service does not always guarantee a

desired response. Very often the outcomes of the initial assessment depend on the local threshold to access services, and other local policies.

There may only be a short window of opportunity for professionals to intervene with teenagers from troubled backgrounds who, alongside having a mental health problem, often also experience chaotic home lives, distrust in professionals and (sadly, the older

they are) a lack of belief in the possibility of positive outcomes.

Our practitioners tell us that long waiting times and the complexity of referrals mean that this opportunity is often missed, unless local policies and procedures recognise these additional vulnerabilities and have built-in mechanisms for providing quick access when needed. However, often these mechanisms may be about how acute mental health needs are, rather than necessarily recognising the safeguarding and other factors of a child's life in context.

Whether a referral is undergoing initial assessment, or when a child does not turn up for assessment or appointment, the joint working between the mental health practitioners and professionals from children's services is a key to ensuring that a vulnerable child does not slip through the net of services and that risks are adequately assessed at each stage of decision making on the case.

With our Freedom of Information responses we set out to establish what happens with referrals of teenagers at each stage of decision making, from initial assessment to transitioning beyond CAMHS, and what information is available about the journeys of vulnerable teenagers as they progress through Tier 3 CAMHS.

Case study: Julia's story

Julia, a 12 year old female, was referred into The Children's Society's service supporting young people at risk of child sexual exploitation due to concerns that she was exposing her body to strangers. Julia had also been involved in web-based chats with a man where she had received indecent images and messages, which the police were investigating.

Prior to her referral into the project, she had been referred both to mental health services by another local service and to a community paediatrician's service regarding her diagnosis for ADHD by her GP. None of the referrals resulted in actions for more than a year.

Throughout her sessions with practitioners in The Children's Society's service, concerns arose around her behaviour that made her vulnerable to exploitation. A new referral was made into CAMHS copying in the relevant community paediatrician. The community paediatrician failed to respond. CAMHS rejected the referral due to the involvement of the community paediatrician, and their feeling that a referral to social care would be necessary. But social care services felt that they could not meet Julia's needs. This case is still on-going.

The name of the young person has been changed to preserve their anonymity.

2.1 Where do referrals come from?

Children, young people and their families who need emotional and mental health support often turn to universal services such as schools and GPs in the first instance as they cannot access advice without a prior referral.⁸² Some referrals for adolescents from vulnerable groups may come through universal services.

In other cases, particularly where children come from families with experience of abuse and neglect, or become known to police or other services as victims of crime, the referrals to specialist CAMHS services may come from specialist safeguarding agencies both in the statutory and the voluntary sector. Where a referral comes from can often shed light on the scale, nature and severity of the problem faced by a young person.

Table 2 below shows the whole picture of where referrals come from and how they are dealt. Key findings include:

- Just over half (53%) of referrals to CAMHS Tier 3 services come from General Practitioners. 18% of these referrals were known to have been assessed and not accepted without further action.
- The lowest numbers of referrals were received from Local Safeguarding Children's Boards.

- Referrals received by voluntary sector organisations make up only 0.3% of overall referrals and have the highest acceptance rates with 94% of cases being assessed and accepted.
- A high proportion (14%) of referrals made by social services were known to have been refused without further action.
- Around 12% of referrals come from multiple sources that we have categorised as 'other'. Most respondents did not provide further information about the source of these referrals but some have told us they included self-referrals or referrals made by a parent or carer.

The Freedom of Information responses revealed that as part of their referral guidelines, most providers of CAMHS specify who they accept referrals from. These typically include professionals ranging from GPs, social workers, schools, Youth Offending Teams and other CAMHS practitioners. For example, one area prescribed:

'If child is Looked After, referral must be received from an allocated Social Worker.'

Nearly all of the referral forms for specialist CAMHS we reviewed ask for details about what previous interventions have been tried by universal or targeted services and what the outcomes of these have been. For example, it is clearly stated in one provider's referral guidance:

'There is an expectation that a first level intervention must have been attempted prior to referral and information on the outcome of this is included in the referral.'

A recent review found evidence suggesting that voluntary sector providers are increasingly having their referrals turned away because they do not meet the threshold or have not sufficiently shown they have exhausted available interventions through other agencies such as schools.⁸³ However, in those areas where referrals from these services are welcome, Table 2 below shows they have a high acceptance rate.

Table 2: Source of CAMHS referral – referrals received over the period 2014 and 2015

Source of referral	Percentage of referrals received by CAMHS by source	Percentage of referrals assessed and accepted by source	Percentage of referrals assessed and not accepted without further action
GP	54%	53%	18%
Paediatric health service	6%	64%	13%
Other health service	12%	58%	10%
Educational psychologist	0.5%	38%	13%
School	7%	63%	15%
Further Education or other educational establishments	1.2%	77%	9%
Social services	6%	65%	14%
Local Safeguarding Children's Board	0.01%	56%	0%
Police	0.6%	82%	6%
Voluntary sector organisations	0.3%	94%	3%
Other	12%	72%	12%

n=22 providers

2.2 Referral rates and waiting times

According to data we collected, 34 trusts that provide specialist CAMHS received a total of 116,463 referrals relating to children aged 10–17 in the year 2014–2015. Based on this information, we estimate an average of four referrals to specialist CAMHS services are made per 100 children aged 10–17. We explore further in this chapter the rate at which they are accepted and what happens to children who have not been accepted.

Referrals into CAMHS can be accepted and managed through either single or multiple entry point systems. A single point of entry means that services use a 'single generic referral form which contains patient and referrer information plus a menu of available services.'⁸⁴ Multiple entry points into CAMHS involve individual teams within CAMHS having their own system for processing and managing referrals. Our analysis below finds that it is likely that more referrals came through a single entry point system, than multiple entry system.

There has been growing debate around which of the two systems is more effective in managing referrals and in ensuring quicker access. The recent Future in Mind report included examples of where single point of access was working well for targeted and specialist services through the development of a multi-agency 'triage' approach

involving statutory and voluntary services. The pathway allows patients to be triaged based on their level of need and directed to the most suitable service.⁸⁵ The taskforce has concluded that there is a 'pressing need to develop these approaches more widely.'⁸⁶

Our findings show that the majority of respondents (41%) use a single entry point system to manage their referrals into CAMHS where as 29% of providers use a multiple entry point system. Depending on the area they cover, 29% of providers employ both systems in a range of service areas. Two trusts informed us that they were in the process of transitioning from a multiple entry point system to a single entry point in the near future.

In Table 3, we have compared the waiting time for referrals received through both systems to establish whether there is any correlation between referral management system and waiting times.

Providers who told us they use a single point of entry system on average have a shorter waiting time, compared with those who use a multiple point system. CAMHS services using multiple entry point systems offered appointments within 84 days on average compared to 49 days for those using a single entry point. These findings remain consistent, though providers using either system report an average reduction in their waiting time between 2013 and 2015.

Table 3: Referral entry point systems and average waiting times 2013–15

Type of entry system	Average waiting time in 2013/14	Average waiting time in 2014/15
Single	8 weeks	7 weeks
Multiple	14 weeks	12 weeks

n=35 providers

Table 4: Referral entry point systems and rate of referrals received in 2014/15

Referral entry point system used	Proportion of referrals received out of local population aged 10–17
Single	9%
Multiple	6%

n=24 providers

We also found that services using a single entry point system to manage their referrals on average received more referrals to their Tier 3 services compared to those using a multiple system. These findings support conclusions reached by the Children and Young People’s Mental Health and Wellbeing Taskforce:

‘A single point of access can enable easier access to the system for children and young people, better management of referrals, advice or consultation for universal services and self-referral.’⁸⁷

Rates of young people currently receiving services and those on waiting lists:

Table 5: The numbers of young people placed on a waiting list for specialist CAMHS 2013/15

Number of young people 10–17 (inclusive) on waiting list	
2013/14	2014/15
11,447	10,257

n=21 providers

Table 6: The numbers of young people receiving help from specialist CAMHS 2013/15.

Number of young people 10–17 (inclusive) receiving help	
2013/14	2014/15
42,013	39,246

n=21 providers

Although the national picture shows that the numbers of young people on waiting lists and those who are currently receiving treatment has remained fairly steady, there were stark increases reported by some providers.

- Over half (52%) of respondents experienced an increase in the number of young people on their waiting list. One area reported an increase of 62% and had the longest waiting time.
- 42% of providers reported treating more young people in the last year compared to the previous.

It is also likely that young people referred to specialist mental health services had to wait for some time before they received access to services. Based on the information we collected through our FOI request, the national average waiting time for an initial Tier 3 assessment in the financial year 2013 to 2014 was **72 days**. This has reduced to **66 days** in the year 2014 to 2015. There were however substantial variations in waiting times between providers with some offering an initial assessment within **13 days** and others worryingly, in up to **140 days**. Variations in waiting times serve as a clear example of the postcode lottery that exists within CAMHS provision.

In addition, 44% of providers had decreased their waiting time between the year 2013–14 and 2014–15. Yet at the same time nearly one third (31%) of providers reported an increase in their waiting times for an initial Tier 3 appointment last year.

Longest reported waiting

time: The provider with longest waiting times reported an average wait of 123 days for an initial Tier 3 assessment in the year 2013–14. This rose to 140 days in the following year. The number of young people on the waiting list in this trust also rose by 62% which may explain the increase in waiting times. Despite the long waiting times, this trust reported assessing and accepting 93% of referrals made in the year 2015/15.

Shortest reported waiting

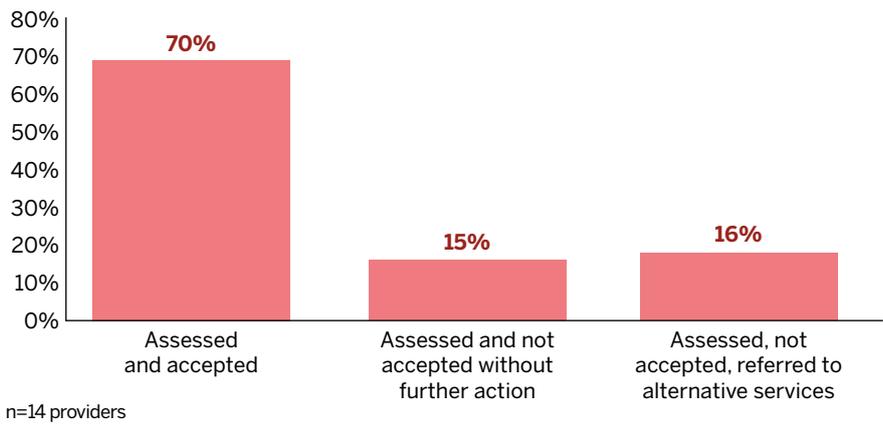
time: In the year 2013–14, the average wait for an initial assessment by a Tier 3 CAMHS service in one area was 13 days, increasing to 18 days in the year 2014/15. The acceptance rate for this provider was 88%.

2.3 What happens to referrals that are not accepted?

Our findings show that acceptance rates between providers varied from 99% to a disturbingly low 20% rate as reported by one trust. Additionally, the responses show a significant number of referrals awaiting a decision. In particular, eight trusts reported that a third of referrals made to their specialist services did not yet have a decision at the time of FOI response. This could be related to the length of time it takes to enable access to services. In these areas, the average waiting time for an initial assessment is 56 days suggesting that young people may be waiting up to eight weeks to be assessed.

Referral conversion rates within CAMHS can be useful in providing some indication about levels of need within an area. Based on cases from 14 providers where the outcomes were known at the time of our request, we found that 3 in 10 referrals were rejected with a near-equal split between ones where no further action was taken beyond rejection and others who provided referrals to alternative services.

Graph A: Referral rates in percentages for young people aged 10–17 for CAMHS Tier 3 services in the year 2014/5



Our findings

- Based on information gathered from 14 providers, over two thirds of referrals received were assessed and accepted.
- Good practice advice from NHS England states that where services are unable to meet the needs of a young person, they should proactively and explicitly signpost them to alternative services. We found that worryingly 15% of referrals received by these services were not accepted without further action.
- 16% of referrals that were not accepted were referred to alternative services. Nine of these providers told us where they sent these cases to (see Table 7 opposite).

The overwhelming majority (87%) of referrals not accepted by CAMHS are de-escalated or 'stepped down' to CAMHS Tier 2 early intervention and prevention services. Both the Health Committee and the Children and Young People's Mental Health taskforce noted the significant disinvestment and gaps in provision within Tier 2 early intervention and prevention services. Our practitioners tell us that due to recent reductions, they increasingly come into contact with young people facing serious and complex needs that require the intervention of specialist mental health practitioners. The Health Committee also found that many voluntary and community based services were supporting young people who failed to meet the threshold for Tier 3 and were being treated by services unable to address their needs.⁸⁸

Table 7: Where do referrals that are not accepted go?

Referrals not accepted and referred to alternative services by type of provider referred to	
CAMHS Tier 2 services	87%
CAMHS Tier 4 services	5%
Local Authority services	0.09%
Targeted school-based intervention	0.28%
Educational psychologist	0.18%
Other health services, such as GP	0.82%
Other, unspecified	7.09%

n=9 providers

2.4 Eligibility and exclusion criteria

Whether a referral is accepted or not may also be determined by local eligibility and exclusion criteria. As well as having a clearly defined and accessible acceptance criteria, guidance produced by NHS England on Tier 2 and 3 services stipulates that CAMHS should also have exclusion criteria so that referrers, young people and their families are clear about what does and does not qualify for CAMHS intervention.⁸⁹ These should include age limits for services, which presenting symptoms the service is not commissioned or suitable to address, or how they support young person involved in court proceedings. The acceptance criterion for CAMHS Tier 3 services outlined by NHS England is available in appendix. We believe that the guidance does not include sufficient information about how services should respond when some of these symptoms exist alongside safeguarding concerns.

Thresholds are high and how these criteria are defined locally act as levers in enabling or preventing access for young people. In addition, we recognise that in recent years due to reduction in services, the

boundaries between targeted and specialist services have become less defined. Indeed in the last year alone, the latest ChildLine Review reported a 124% increase in the number of young people who mentioned access to services, including CAMHS, in their counselling services.⁹⁰

Our findings reveal gross variations in what is and is not deemed appropriate for CAMHS intervention. For example, mental health problems arising from experiences of abuse and neglect do not qualify for support in some areas. One respondent told us they accept referrals relating to:

'Those with severe emotional difficulties' and severe functional impairment arising from child abuse and/or neglect.'

However, in stark contrast, another provider detailed in its CAMHS exclusion criteria that it would be inappropriate to refer cases where:

'Child neglect/abuse is the primary issue.'

Another provider of CAMHS that also took this approach explained in their policy that in relation to child protection concerns:

'It would not be appropriate to refer to CAMHS before those concerns have been addressed.'

Where mental health problems relate to abuse and neglect, some services refuse to treat the young person until their safeguarding issues are first addressed by social services. Variations in policies such as these support claims that services shift responsibilities amongst each other and fail to fulfil their duty to meet the mental health needs of young people and prevent them from harm.

2.5 Access and referrals

There has been a lot of concern raised about high thresholds in accessing mental health services in many areas as well as long waiting times, both for an initial assessment and appointments during the course of treatment. Data we received in response to our FOI requests validated these concerns and also highlighted the wide variation within different geographical areas leading to a postcode lottery in access to specialist mental health services.

This postcode lottery is evidenced in wide differences in waiting times and in the inconsistent application of eligibility and exclusion criteria between areas. In other words, a child victim of abuse may easily receive priority access in one area but be entirely ineligible for support in another area.

Similar observations can be made about who can make referrals into specialist mental health services. It is worrying that the high proportion of referrals coming from GPs, social services and schools are not accepted by specialist mental health services. Referrals coming from social services are likely to be in relation to children with safeguarding concerns who display mental health needs serious enough for safeguarding practitioners to pick up on them and refer them for support. The high numbers of those who do not get accepted suggest that there is a lack of shared understanding of what constitutes mental health needs that warrant the intervention of

specialist mental health services or the lack of CAMHS services at level 2 that could support young people with a lower level of needs.

Another set of findings that need to be emphasised are the very low level of referrals from voluntary sector organisations at the same time that they have higher acceptance rates. Concerns about the interface between CAMHS and voluntary sector providers have been raised in numerous publications in recent years.^{91,92} In particular, in some areas voluntary and community sector providers who deliver extensive and sometimes long term support to vulnerable young people experiencing serious mental health problems face barriers in referring them because they may not be registered with a GP or have a functioning parent to support them.⁹³ Our experience in supporting Julia, our case study above, exemplifies some of these challenges.

This finding does not come as a surprise. From our direct practice we know that voluntary sector organisations like The Children's Society come into contact with a high number of vulnerable young people. Yet, in some areas our practitioners report having their hands tied when it comes to making referrals to CAMHS as only referrals from either GPs or Children's Services are accepted. We believe this creates a system where the most vulnerable face a double barrier in access to services and further delays. Those

areas that do accept referrals from voluntary sector report higher rates of acceptance compared to all other referral sources.

In order to help overcome some of these challenges, services should consider ways to increase involvement from young people in the development of services, taking into account their views on access and receiving help from multiple services.

What needs to change?

- There is a need for closer collaboration between CAMHS and the voluntary sector. More specifically, voluntary sector organisations supporting vulnerable young people should be able to make referrals into CAMHS.
- Training for practitioners delivering CAMHS should specifically include training on the vulnerabilities of young people who experience safeguarding issues.
- NHS England should develop waiting time standards for all specialist mental health services that would at least match the six week standard currently expected for a diagnosis in physical health services. Local areas should ensure that the new funding is spent in part on improving access and reducing waiting times across all CAMHS services.

Access Denied

A teenager's pathway through the mental health system

- Providers of CAMHS should review the effectiveness of their referral management system. Consideration should be given to how the system improves access and waiting times.
- Providers of CAMHS should have clear policies on providing support for those who are not accepted, including guidance on where to refer them as well as what risk assessments need to be undertaken.
- Young people should be offered advocacy and support to enable them access to CAMHS services.
- Providers of CAMHS should develop mechanisms to enable children and young people to participate in commissioning and designing mental health services, including access routes, to improve their responsiveness and ensure they meet the specific needs of vulnerable groups.





Chapter 3: Referral pathways for vulnerable groups

3.1 Overview of policies relating to vulnerable groups

There is no legal framework in place for the provision of CAMHS services,⁹⁴ however, obligations in relation to duty of care, safeguarding and multi-agency working are implied through some of the frameworks listed below.

The National Service Framework was developed by the Department of Health in 2004 as a 10 year strategy setting out quality standards for children, young people and maternity services. Standard 9 – The Mental Health and Psychological Well-Being of Children and Young People,⁹⁵ although now outdated, serves as good practice guidance for the delivery of effective CAMHS.

'Services ensure that an emphasis is placed on children and young people who are vulnerable to mental health problems and on providing focussed, structured, proactive programmes which target risk factors, using the common assessment framework as appropriate.'⁹⁶

The recent Future in Mind report has since been described as the blueprint for CAMHS and will form the basis of local CAMHS quality of service transformation plans over the next five years.⁹⁷

To remedy the lack of a nationally led approach on quality and standards of these services, NHS England has recently developed service specifications for CAMHS Tier 2 and 3 services and a model service specification for transitions from child to adult mental health services.

There are a number of nationally established safeguarding mechanisms in place for vulnerable young people who are accessing support from health services, including CAMHS. For example, Working Together to Safeguard Children guidance envisages the multi-agency approach to safeguarding children in each area involving health services. In the same way, the regulations and guidance on support for looked-after children, care leavers and children with Special Educational Needs (SEN) and disabilities, all envisage close collaboration between different services to ensure that the needs of these vulnerable groups are met.

The statutory guidance *Promoting Health and Well-Being of Looked-After Children* specifically states that:

'CCGs, local authorities and NHS England should ensure that CAMHS and other services provide targeted and dedicated support to looked-after children according to need. This could include a dedicated team or seconding a CAMHS professional into a looked-after children multi-agency team. Professionals need to work together with the child to assess and meet their mental health needs in a tailored way.'⁹⁸

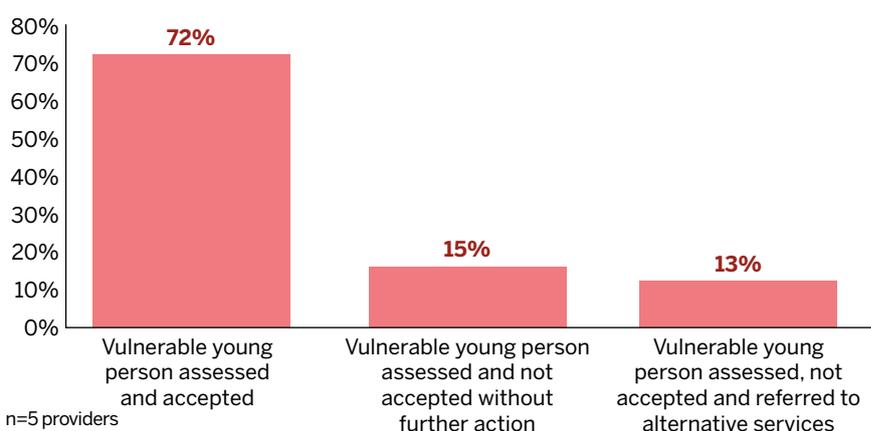
CAMHS staff members can be involved in a number of multi-agency forums including, but not limited to, Local Safeguarding Children's Board; Youth Offending Teams or the Troubled Families Programme. Yet the practice of how such involvements happen is very inconsistent from one area to another, depending on local variations in data collected, local policies and even local champions for different groups, as our data also confirms.

3.2 Referral rates for vulnerable young people aged 10–17

Only a small number of trusts (five) could provide information on the number of children from vulnerable groups they identify in their assessments, DNA cases and at other stages of their pathway through the mental health system. The overwhelming majority of providers (87%) were unable to ascertain the numbers of vulnerable young people they support through their services, with many citing they,

'do not record this level of information in patient information system and would only be outlined manually in case notes.'

Graph B: Referral rates in percentages for vulnerable young people aged 10–17 for the year 2014/15



Some of this information was retrieved through dedicated services for vulnerable young people such as looked-after children and young offenders, as well as young people accessing services for substance misuse. Later in this chapter we examine how vulnerable groups are identified and supported when they do receive help from specialist services.

Based on the information we did collect, Graph B shows that similar to rates for the general population, 28% of referrals received about vulnerable young people between the ages of 10 and 17 are not accepted by specialist CAMHS services. Whilst nearly three quarters of the referrals about these young people are accepted, we are concerned that 15% of these are not accepted without further action.

3.3 Recognising and responding to signs of vulnerability

The remainder of this report will examine the policies of 26 providers who responded to our information request about whether they identified vulnerable

groups in referral and initial assessment forms, offered priority access, recognised the needs of vulnerable groups in their DNA policies and supported them

during transitions. We asked for a broader range of vulnerability factors to ensure that we allowed the trusts to share with us as complete information as possible.

3.4 Identification of vulnerable groups in referrals and initial assessments

It is important that information concerning a vulnerable or at risk child is recorded in referral forms to ensure this information is taken into account when making decisions about providing treatment and also to help determine the type of intervention needed. Nearly three quarters (72%) of respondents identified one or more vulnerable groups in their referral or initial assessment forms.

Our analysis of these responses demonstrates a great discrepancy

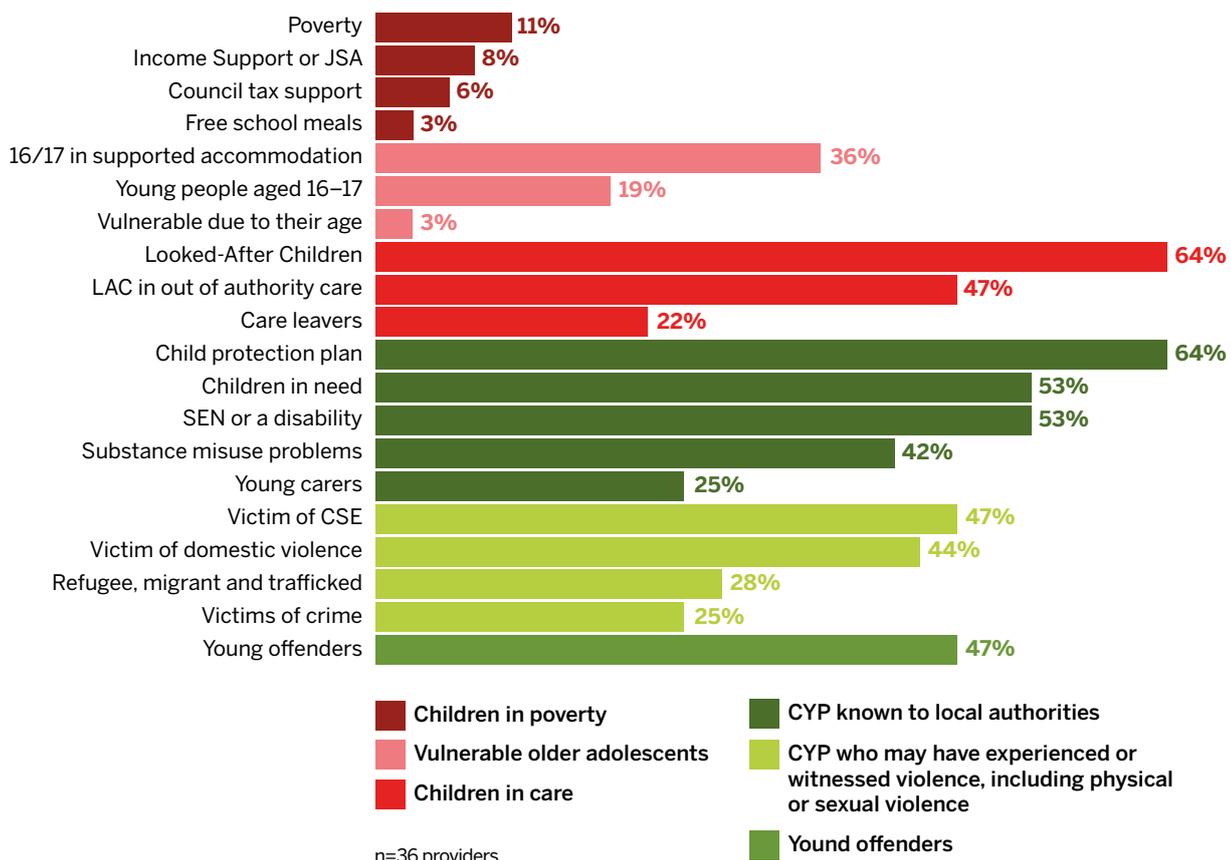
between both what constitutes an increased factor towards vulnerability and if the identifying of vulnerability resulted in any action taken. For example, only two providers identify poverty as an additional risk that may be detrimental to a child’s mental health, yet neither provides priority access.

For our analysis of graphs C, D, F and G we have grouped the data further under broader categories of vulnerability by colour (see graph below). These graphs are

based on responses from 26 providers.

- The least identified groups in referral forms were children living in poverty.
- Children in care and children and young people who are known to local authorities are the most identified vulnerable groups in CAMHS referral and initial assessment forms.

Graph C: Percentage of providers who identify vulnerable groups in referral and initial assessment forms



- Looked-after children and children on a child protection plan were most frequently (at 64% each) included as a vulnerable category within referral and assessment forms. For both groups, some CAMHS referral forms request additional information such as whether a Common Assessment Framework has been completed or outcomes of any Strength and Difficulties questionnaires completed.

As the examples of the responses below show, the reference to safeguarding assessments in the referrals to mental health services can be seen as a factor facilitating access to mental health services in some areas, while in others it delays the response, as some providers believe that safeguarding needs have to be addressed before mental health intervention are considered. It is a worrying discrepancy in policies. From our direct practice we know that the lack of mental health support for the most vulnerable teenagers at the time when problems in their lives escalate leads to further escalation of the situation and even crisis.

There are examples of good practice in some areas, for example, the referral guidance of one provider makes it clear that,

'Safeguarding is a more inclusive concept than child protection and emphasises not only the recognition and management of harm to children but also the importance of recognising children in distress, this may be as a result of mental health problems or mental illness and staff must intervene to prevent a range of adverse outcomes.'

In other areas:

'We do not specifically identify children as vulnerable unless they are subject to a Child Protection Plan or Care Order.'

'Referral forms prompt for identified safeguarding risks. Additional information is often supplied with the referral such as completed CAF which also highlights additional needs. Through use of the screening tool further vulnerabilities are highlighted...'

It is also worth noting the differences in responses to children who have experience of the looked-after system. While overall, they are the most identified group; the lack of prioritisation for looked-after children placed out of area and care leavers is evident. These children are particularly vulnerable due to a lack of the usual social networks around them and their experiences of transition. For care leavers, a lack of response may also result in difficulties in accessing mental health support overall as they move to adult services.

The responses included some positive policies that may help in identifying vulnerable groups better. For example, in one area a *Choice and Partnership Approach* is used in referring young people, access for vulnerable groups is determined by information included in a separate 'risk chronology' document required as part of the referral. This provider also has an extensive section in its referral form designed to extract safeguarding information about a range of issues.

3.5 Prioritising help for young people from vulnerable groups

Some vulnerable young people with mental health needs that can rapidly escalate need urgent access to help. As appointments received by CAMHS are triaged as either routine, urgent or an emergency in our FOI requests, we asked mental health trusts what mechanisms they had in place to prioritise quick access into CAMHS for young people from vulnerable groups who may have safeguarding needs.

The majority of providers we received information from outline specific groups of young people as being priority patients needing

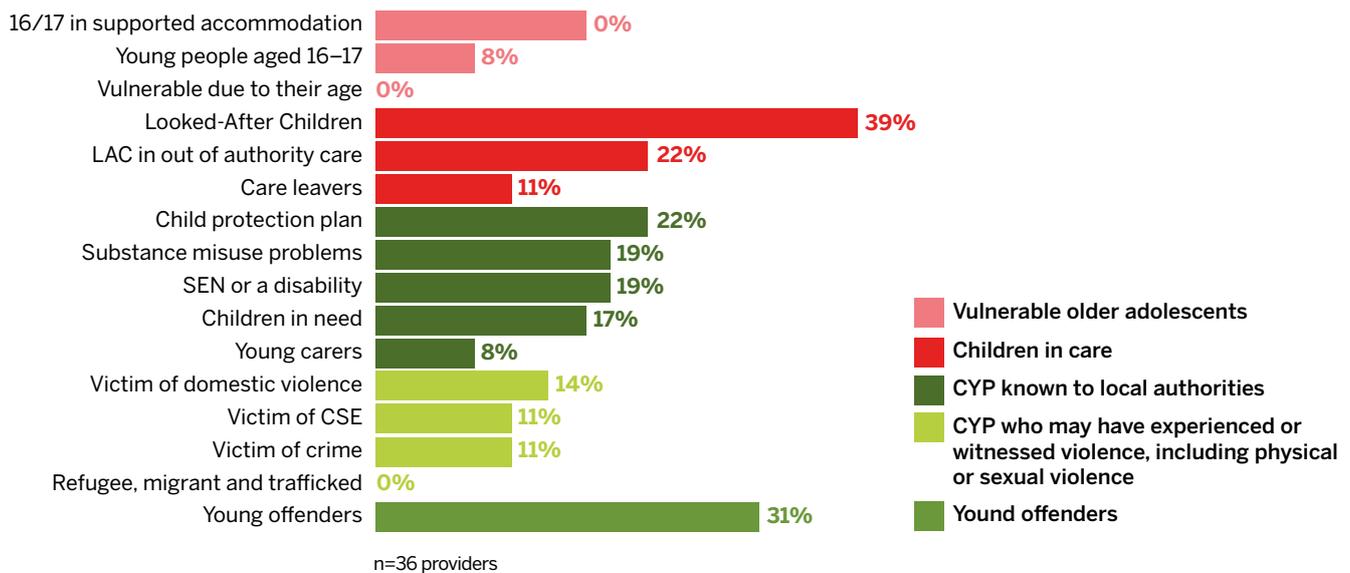
more targeted responses, such as looked-after children. For those seen as priority, access to treatment is fast-tracked using a number of approaches. 60% of respondents to our FOI said that they had some form of fast-tracking mechanism in place for vulnerable groups of young people.

Graph D shows the percentage of vulnerable groups who have priority quick access to CAMHS services. Looked-after children (39%) followed by young offenders (31%) who were the groups most recognised

as needing priority access to services.

Here again, similarly to the policies on referral and assessments, even though looked-after children as a group are identified more than any other group in fast-tracking policies, there is a notable difference between looked-after children, children in out-of-authority placement and care leavers. Such discrepancies highlight the need to better identify all groups within looked-after populations both in the fast-tracking policies and in commissioning of services overall.

Graph D: Percentage of providers who offer fast-track access to CAMHS by vulnerable group



Victims of child sexual exploitation (CSE) are identified as vulnerable by nearly half of providers who responded but they were only offered priority access in 14% of areas and children living in poverty were not identified in any area. Considering the focus across the country on dealing with child sexual exploitation, and greater understanding of the impact sexual abuse has on the mental health and well-being of a child, as well as the government commitment to ensure that all victims of child sexual exploitation are given support to recover from abuse they suffered, such a low level of prioritisation points at significant gaps in provision that needs to be addressed.

Fast-tracking mechanisms

In some areas, additional assessment tools such as outcomes of Strength and Difficulties Questionnaire or a Common Assessment Framework (CAF) support the referrals of young people regarded as vulnerable.

- **Strength and Difficulties Questionnaire**
Used in some areas as a screening tool to help identify emotional and behavioural problems. In CAMHS the assessment involves collecting responses from the child themselves but may also include information from parents or teachers.

'The SDQ is used by looked-after nurses to support referral to CAMHS.'

- **Common Assessment Framework**

A number of providers in their initial referral forms require a CAF to be undertaken where there are safeguarding concerns about a young person. CAFs are used to gather and share information about a child where there are concerns about their safety and well-being. Two providers said that all referrals being made by educational establishments require the completion of a Pre-CAF. One of the providers further explained that these were needed where there were conduct and behavioural concerns in particular.

'All educational referrals need a Pre-CAF. All referrals from Social Services need a CAF.'

- **Multi-agency working**

In other areas, information surrounding a vulnerable young person or their family is raised during multi-disciplinary meetings (as specified by three providers) or as part of Local Safeguarding Children's Board meetings. Where there are mental health concerns raised, groups within these multi-agency forums

are expected to develop a joint approach to support the young person.

Integrated teams. In some areas, children in care are seen first by a mental health specialist working with social services. This practitioner is expected to escalate to CAMHS when they cannot address the needs of the young person.

Example of integrated teams in one area:

'There is a CAMHS mental health practitioner placed in the local authority team that supports these groups of children and young people who would undertake a mental health assessment in the first instance and refer into local CAMHS for intervention as required.'

'There are CAMHS nurses in both of the local criminal justice teams who undertake mental health assessments in the first instance and refer into local CAMHS teams for intervention as required.'

Care Programme Approach. One provider said that they employ a Care Programme Approach to assess, plan and follow-up the care of young people it sees in its services. As part of this approach, young people are assigned a care coordinator who will collect and assess information regarding risk and vulnerability. A similar approach exists for young people in the youth justice system.

Risk assessments during initial stages of referral process

In four services, vulnerabilities are flagged during the referral process through the completion of a risk assessment. Below are some examples of this undertaken in practice based on responses received from providers.

'Risk and priority is assessed at point of 'Access' which is an in-house referral receiving and Triage CAMHs clinician on a rota basis. Fast-track is assessed/prioritised and sent to the relevant team to action based on the risk and vulnerability identified.'

'Risk assessments and the initial assessment are used to prioritise cases where treatment is indicated as being more urgent. There is no specific policy but this is part of the routine clinical assessment and treatment planning. Duty cases are often fast-tracked but based on assessment.'

'We do routinely risk screen referrals if there are concerns identified such as CSE. In such occurrences we would do a telephone risk screen with the family and young person, as appropriate, and we would also complete telephone liaison with the referrer to ensure that safeguarding concerns are being addressed. We are then able to offer "urgent" assessments if required on an individual basis.'

This provider also told us that referrals relating to young offenders, young people with substance misuse problems and looked-after children placed out of borough risk was screened via telephone by experienced clinicians.

3.6 Referrals for young people from vulnerable groups

The responses we received in relation to young people from vulnerable groups highlight both the lack of reliable and consistent information on these children and the lack of consistent policies and responses in different areas. Collectively, these factors are likely to result in a postcode lottery for young people accessing the help they need, and in turn, contribute to both poor short-term and long-term outcomes these young people.

Many of the examples of responses we received that were quoted in this chapter present the positive practice that needs to be learnt from, developed and replicated in other areas.

At the same time, responses showed that the lack of clear definition of what constitutes vulnerability, whether it is poverty, or experience of violence or abuse, or even in relation to looked-after status, can lead to confusion. For example, even though looked-after children, were one of the groups most prioritised for response, the response clearly shows that looked-after children in out of area placements or care leavers would not be seen as the same priority as children placed within the local authority boundaries. If such children are placed outside their local authority boundaries as well as outside of the boundaries of the mental health trust that works with their home local authority, they may experience real difficulties in accessing services. We see this situation in our direct work with

young people very often.

It is also an issue of great concern that victims of sexual abuse are prioritised in only in 14% of trusts for fast track access to services. From our direct work we know that without the adequate support to deal with trauma of such abuse, it is very difficult both to enable the child to move on with their lives and even to keep them safe from future abuse. And in some cases there may be only a short window of opportunity when they will be prepared to engage with services.

What needs to change

- The Department of Health should consult on and develop guidance on the provision of specialist mental health services for vulnerable groups.
- The Department of Health should facilitate the sharing of the good practice between those trusts that collect information and have clear policies in place on access and response to vulnerable groups of children and young people.
- The statutory guidance on Promoting the Health and Well-Being of Looked-After Children should be strengthened to ensure that children in out of area placements and care leavers have the same access to services as looked-after children overall. The guidance needs to recognise the difficulties care leavers in particular face in accessing services.
- The Government should strengthen the guidance on the role of local multi-agency forums in CAMHS. Where there are safeguarding concerns as well as mental health needs, the guidance needs to be particularly clear about responsibilities.
- Local Authorities through Local Safeguarding Children's Boards (LSCBs) should review and monitor access to mental health support for children who have experienced abuse and trauma and ensure that such services are commissioned locally and that there are policies in place for priority access to services for all children who need it.
- Providers of CAMHS should collect information on referrals from social services, police and other agencies with safeguarding responsibilities on the numbers referred, accepted, not accepted and referred somewhere else to inform commissioning of services to share with their LSCBs.
- Local CAMHS services should have mechanisms in place to identify vulnerable young people and prioritise access if they may be at risk. This is particularly important for care leavers and victims of trauma, as there is a lack of nationally-led approach for these groups.



Chapter 4: Maintaining levels of support and engagement DNAs and transitioning

4.1 Why DNA and transitioning are important: the link to safeguarding

In our Seriously Awkward report⁹⁹ we drew attention to the risk factors faced by vulnerable teenagers as they begin to experience significant changes in their life and become exposed to some of the realities of adulthood.

Our report identified the turbulent period many of these young people go through when they transition between services, as they do not consistently receive the same levels of support from services dedicated to children. Unfortunately this means that the problems faced by young people often become compounded and they may never access the help they are entitled to. Some of this may be due to their own disengagement from services, or crisis situations in their lives that prevent them from accepting help. Some could be due to the lack of clear transitioning policies when they move between levels of services or from childhood to adulthood.

In the case opposite, given the young person's vulnerable situation, it may have been more beneficial and productive to have had some flexibility. Both the delay in offering an appointment and the speed at which the young person was discharged did not prove helpful in this situation. Also in this situation an 'outreach' option may have been more beneficial in engaging this young person.

All services managed by the NHS are required to have protocols in place on DNAs as part of their child safeguarding policies.¹⁰⁰ These may be combined policies outlining approaches to DNAs among all child health services or, as developed by most CAMHS providers, a document on DNAs only within CAMHS.

In addition to safeguarding, there is also an economic case for preventing DNAs. Missed appointments cost the NHS almost £1bn a year.¹⁰¹ There is a strong economic argument for tackling the causes of DNAs and doing more to proactively engage those that may be hard to reach.

Addressing DNAs is also important in preventing harm and even death amongst children and young people. The 2008 Confidential Enquiry into Maternal and Child Health¹⁰² reviewed cases of children who had died. The enquiry repeatedly discovered instances where children who had failed to attend appointments on one or more occasions were not followed-up, with devastating consequences. The report was particularly critical of instances where the 'failure to follow-up' occurred in the context of a referral to CAMHS.¹⁰³ Recommendations from the report included improving systems in identifying children who miss appointments and more proactive follow-up responses.¹⁰⁵

According to recent guidance produced by NHS England on the provision of CAMHS Tiers 2 and 3 services,

'When a service user does not attend, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children/young people and parents/carers.'¹⁰⁵

The Vulnerable Groups and Inequalities Task and Finish Group also recommended that where there are instances of missed appointments,

'Missed appointments should be actively investigated to establish why the young person or parents did not attend, to ensure that the child or young person is safe and to offer services the young person or parents are willing to engage

with. Not attending appointments should not lead to the families or young people being rejected from services and should be considered as an indicator of need or risk in itself.¹⁰⁶

In relation to transitions, and as we noted earlier in our report, adolescence can be a critical point for young people with deteriorating emotional and mental health. Effective transition that considers the needs of the young person is vital in helping those in need to continue receiving treatment and even recover.

Problems surrounding transitions from CAMHS to adult mental health services (AMHS) has been repeatedly acknowledged in reviews, academic literature and by national bodies and decision-makers themselves.¹⁰⁷

'Problems at the interface between CAMHS and adult services are historical and rooted in the ideological, conceptual and practical differences in how these services are organised and delivered.'¹⁰⁸

Case study: Ruby's story

We have been helping 16 year old Ruby who has been directly affected by Child Sex Exploitation (CSE). Ruby came to The Children's Society because she had been sexually exploited, being gradually groomed and was given drugs in exchange for sexual favours. The grooming started at around the age of 14. This young person also has a history of her own child's bereavement. Her social

worker referred her to CAMHS with the intention of getting her emotional support for both the bereavement and CSE. CAMHS responded by offering an appointment after many weeks on a waiting list. However, as this young person is difficult to engage she did not attend at the given time. She was subsequently discharged for not attending.

In particular, there are concerns about poor planning, lack of coordination and participation from service users and their families. Indeed these same concerns have been reported almost since the formation of the four-tiered CAMHS system.

Last year, the Government committed to improving transitions for young people from CAMHS within the next five years as part of its mental health strategy.¹⁰⁹ The recent Future in Mind report has also raised the importance of smooth transitioning and recommended that it be based on need rather on a particular age.¹¹⁰

With growing pressure on national bodies to step in and advise on this issue, including pressure from CAMHS commissioners

themselves,¹¹¹ NHS England this year published the first service specification for transitions from CAMHS to support commissioners of CAMHS and other agencies they may work with. The service specification identifies a number of groups requiring a 'robust transition process', including looked-after children, care leavers, young offenders, children with Special Educational Needs, and young carers.¹¹²

The focus on DNAs and transitions is very important. They present the safeguarding opportunity for the most vulnerable children and young people. Where the correct policies are in place they ensure that a young person is not denied a chance to have support when they need it most.

4.2 How many young people Do Not Attend?

Across universal to specialist services (Tiers 1 to 3), the latest NHS Benchmarking report on CAMHS found that 'DNAs in Tier 1-3 CAMHS show a wide range from 2% to 25%, with an average for the sample of 11%, rates have fallen by 1% from the previous year.'¹¹³

In our FOI requests we asked how many Did Not Attend cases were recorded for initial assessments and those on course for treatment. Eight responses included the information we asked for. The responses showed

that across these trusts 6,520 DNA cases were recorded.

Responses from these eight providers show that DNAs occur on a much higher rate during the course of a service user's treatment. This suggests that there may be problems in maintaining engagement between the young person and the service they have been accepted into.

As noted earlier in this chapter, when a young person misses their appointment, there is an expectation for practitioners to

undertake a risk assessment to establish why the young person missed their appointment and what impact, if any; it has on their progress and treatment. We recognise that some cases of DNA may be the result of lateness, young people or their carer's being unwell that day or because they simply forgot about their appointment. In these circumstances, CAMHS may not undertake a risk assessment but may follow up to rearrange.

As Ruby's story above illustrates, there can be a number of reasons why a young person fails to attend their appointment that may relate to adversities in their life. Ruby was discharged for failing to engage and attend her appointment. Unfortunately, we hear of similar stories from other young people using our services.

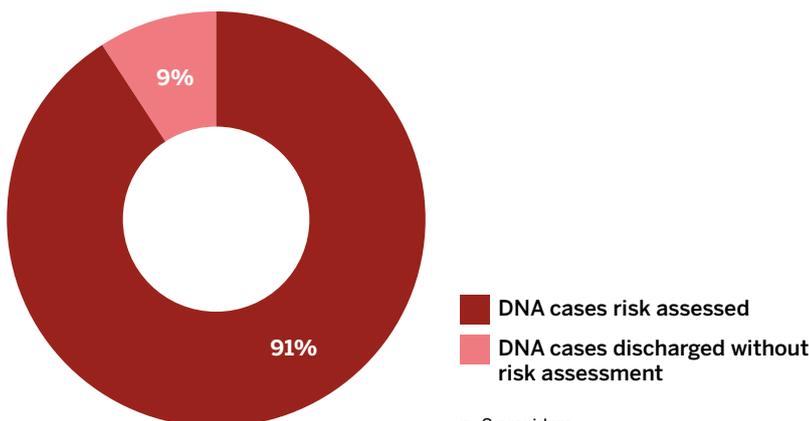
It is policy in some areas, if there are no risks, to discharge a patient from service for failure to engage. Providers of specialist CAMHS are required to communicate with the referrer before reaching a decision a decision.¹¹⁴ We found that 9% of DNA cases in the year 2014/15 resulted in young people being discharged from specialist services without a risk assessment.

Table 8: Total number of DNA rates for young people aged 10-17 during the financial year 2014/15

Total number of DNAs for both initial assessment and those on course (for 10-17)	Percentage of DNAs for initial assessment	Percentage of DNAs for patients on course for treatment
6,520	24%	76%

n=8 providers

Graph E: Percentage of DNAs risk assessed relating to young people aged 10-17 in the year 2014/15



n=8 providers

4.3 DNA policies

Providers of CAMHS are expected to have policies in place on assessing risks when children and young people do not attend and how they re-engage those young people who repeatedly miss appointments. With that in mind, we set out to find out how these policies identify the needs of vulnerable groups of young people.

What providers told us:

'The Trust does not have a policy on DNA re-engagement. This is because vulnerable children/children at risk referrals are flagged and the GP/referrer is notified if they do not attend the first appointment.'

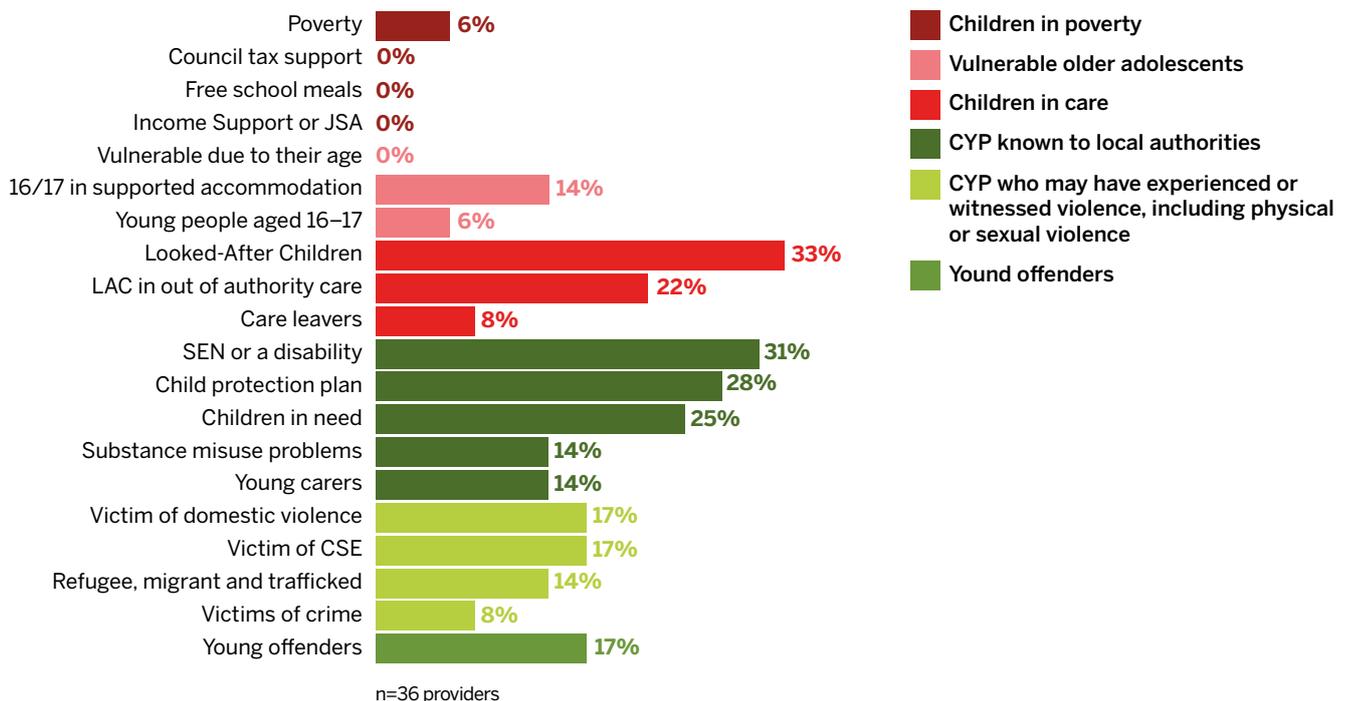
In some areas, DNA cases result in young people being discharged from services as our case study about Ruby demonstrates. In some cases it can also mean that young people are discharged and will only be seen following a re-referral process. This means that these young people may go untreated for even longer and some may give up on seeking support all together. One provider told us:

'Our Operational Policy states that after two DNAs a patient may be discharged, depending on level of risk, to be reviewed in MDT or by a clinical team manager.'

Overall, Graph F reveals that policies on DNA do not go far enough in highlighting the needs of particular vulnerable groups and the specific approaches that may be needed to follow-up, re-engage and risk assess.

The responses we received show that looked-after children and those on a child protection plan are most likely to be followed up after missing an appointment. Notably, care leavers and children in poverty are unlikely to be explicitly identified in a CAMHS DNA policy. These two groups may face disadvantages that affect their ability to routinely attend appointments such as high transport costs.

Graph F: Percentage of providers who identify vulnerable groups in their DNA policy



4.4 Review of policies on transitions

In our FOI, we requested policies on transitions from specialist CAMHS, we received policies on transition from 19 providers. Only one provider had separate policies on transition between its services and for transitioning to discharge to adult services. A number of policies were out of date (32%) and four were reaching their review date. We hope that the findings in this section can help those areas which need to amend their policies to include clear processes for vulnerable groups when they transition.

Some trusts recognise the need for flexibility in their policies, for instance, one provider has outlined that,

'Transition is usually at a young person's 18th birthday but there may be a requirement for flexible practice. For example a young person keen to be seen in adult services early, or conversely those over the age of 18 years old who may be about to transfer geographically. Such cases should be considered on their merits.'

Based on our review of 19 CAMHS policies on transition, there was emphasis on using the Care Programme Approach by most trusts to communicate with all parties involved in the transition and to plan, evaluate and risk assess the transfer of care.

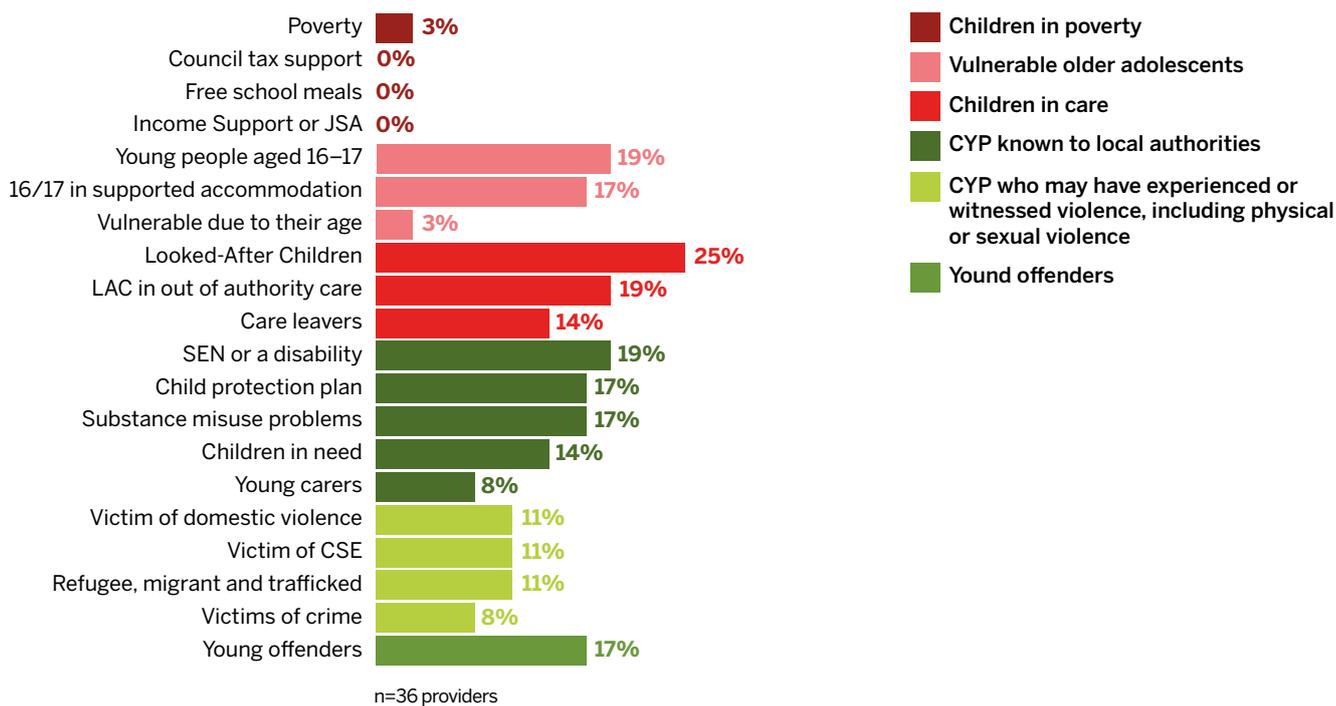
However in the policies of other areas, we found little evidence of how CAMHS work closely with other agencies in ensuring an effective and jointly produced transition plan is in place. While most policies identify the need for planning for transfer of care to adult or other services, policies do not go far enough in explaining the role of different agencies who may be involved in this process. In one area for example, the policy simply states 'Any joint working needed'. The service specification states that for vulnerable young people who may be receiving support from other agencies, plans for transition '...are coordinated during transition and address their individual needs, providing a holistic approach'.¹¹⁵

We also asked providers if they identified vulnerable groups in their transition policies. We received responses from 26 providers, our analysis of these responses is presented in Graph G opposite.

Children in care and care leavers were the most identified group in transition policies but still their needs are not recognised by more than two thirds of providers. Actions for vulnerable 16 and 17 year olds, particularly those living independently, were highlighted in the policies of nearly a quarter of providers. We know from previous research that these groups of young people are most at risk of disengaging from services because they often live unsettled lives and unlike most young people do not have the support of their families.

It is notable in that there are low levels of transition planning for children who have been victims of violence – including domestic violence and CSE. Many of this group already face particularly difficult transitions in other areas of their lives – the lack of support during transitions in mental health service is an additional concern.

Graph G: Percentage of providers who identify vulnerable groups in their transitions policy



4.5 Maintaining levels of support and engagement: DNAs and transitioning

In our direct work with vulnerable young people we often come across the situations where teenagers disengage from services as crisis situations in their life escalate or as approach adulthood and services that they require step away due to their age. The data analysed in this section provides a good insight into why this may be happening.

The high rates of DNA for patients on course for treatment indicate that providers are not always able to engage young people after they have been accepted into services. This is the situation we see in our direct work with vulnerable young people who often disengage from services as crisis situations in their life escalate. It is also worrying that a small yet significant proportion of DNA cases are not risk assessed leading to young people falling through the gaps of services.

The lack of transition policies for both between different mental health services and between child and adult services also places vulnerable children and young people at risk of not getting the support they need at crucial times in their lives.

What needs to change?

- There is a need to strengthen the national guidance on Did Not Attend cases and what follow up needs to be undertaken, particularly in cases involving vulnerable young people such as those with safeguarding needs.
- Providers of CAMHS should have policies in place on DNAs that specify the need to follow up when a young person misses their appointment including the undertaking of risk assessments. Services should specify how they are going to liaise with other agencies in cases of young people from vulnerable groups.
- Commissioners of mental health services should consider ways to decrease DNA rates, for example by offering flexible booking of appointments and giving young people, particularly older adolescents, the option to choose a suitable appointment time and location.
- All mental health services should have policies in place on transitions for young people from vulnerable groups between the levels of CAMHS services and to transition to adult services to ensure that children do not fall through the cracks of services and that they have continuous access to mental health support. Policies on transitions should outline how CAMHS will work with other agencies in planning transition.

Conclusion

The recent political and public focus on children and young people's mental health is a welcome step forward. It is vital that all young people who seek help from mental health services are receiving the support they need.

Our findings provide a glimpse into the experiences of vulnerable young people accessing CAMHS but we know that many of the most vulnerable and hard to reach young people in our society may never be identified or supported by these services. We believe there is scope to strengthen processes in CAMHS to improve access and the referral pathway of vulnerable children and young people.

Getting it right the first time is important in helping young people recover and move on from their problems and to also prevent serious mental health problems from worsening. Our report shows that there are opportunities throughout the journey to care in CAMHS to recognise and provide more intensive and timely support to those most in need.

The evidence demonstrates that in many areas young people who are in vulnerable circumstances are being identified in the initial stages but there is a real lack of follow through during their pathway that can result in young people being left in limbo.

As providers of CAMHS across England begin transforming their quality and standards of delivery, we hope that the messages in this report can help to shape these plans to enable access to services to all who need them and tailor support for those with complex needs.

Recommendations

As well as ensuring that mental health services receive parity to physical services, within mental health services themselves - there is a need to ensure that there is also prioritisation of services for particularly vulnerable groups such as victims of trauma and care leavers to ensure robust access and standards for the services they receive.

National recommendations

- The Department of Health should develop national guidance on mental health services for vulnerable groups, including guidance on how such services should be commissioned, how referrals should be assessed, including cases that need prioritising and policies to maintain engagement.
- The Health and Social Care Information Centre should collect and publish data access to special mental health services by children, including vulnerable children.
- The Department of Health and NHS England should ensure there are consistent approaches on the monitoring of outcomes for vulnerable groups accessing CAMHS.
- Clear guidance is needed about which groups should be considered consistently in the data analysis underpinning Joint Strategic Needs Assessments to

ensure that an adequate level of services are commissioned locally.

- NHS England should develop waiting time standards for all specialist mental health services that would at least match the six week standard currently expected for a diagnosis in physical health services.¹¹⁶ Local areas should ensure that the new funding is spent in part on improving access and reducing waiting times across all CAMHS services.
- The Department of Health should consult on and develop guidance on the provision of specialist mental health services for vulnerable groups.
- The Department of Health should facilitate the sharing of the good practice between those trusts that collect information and have clear policies in place on access and response to vulnerable groups of children and young people.
- The statutory guidance on Promoting the Health and Well-Being of Looked-After Children should be strengthened to ensure that children in out of area placements and care leavers have the same access to services as looked-after children overall. The guidance needs to recognise the difficulties care leavers in

particular face in accessing services.

- The Government should strengthen the guidance on the role of local multi-agency forums in CAMHS. Where there are safeguarding concerns as well as mental health needs, the guidance needs to be particularly clear about responsibilities.
- There is a need to strengthen the national guidance on Did Not Attend cases and what follow up needs to be undertaken, particularly in cases involving vulnerable young people such as those with safeguarding needs.

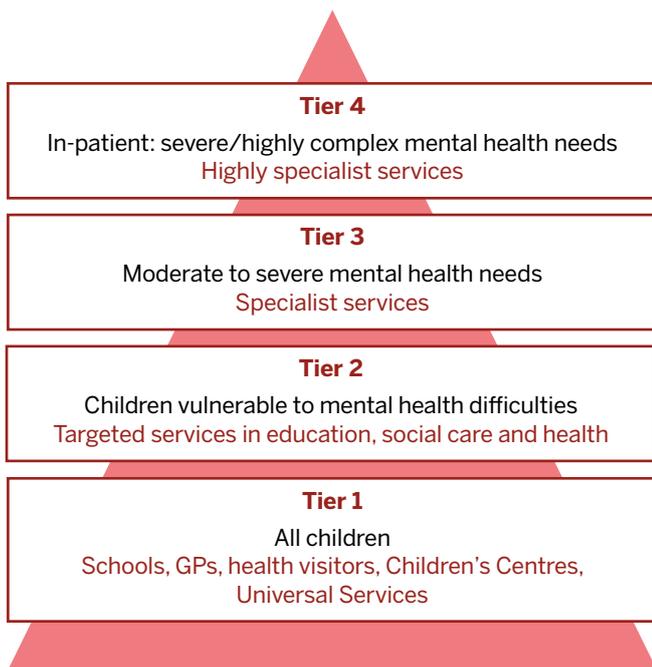
Local recommendations

- Health and Well-Being Boards should ensure local Joint Strategic Needs Assessments explicitly include children and young people's mental health and the needs of different vulnerable groups at risk of developing mental health problems, to assess current and future need and inform commissioning strategies.
- There is a need for closer collaboration between CAMHS and the voluntary sector. More specifically, voluntary sector organisations supporting vulnerable young people should be able to make referrals into CAMHS.

- Training for practitioners delivering CAMHS should specifically include training on the vulnerabilities of young people who experience safeguarding issues.
- Providers of CAMHS should review the effectiveness of their referral management system. Consideration should be given to how the system improves access and waiting times.
- Providers of CAMHS should have clear policies on providing support for those who are not accepted, including guidance on where to refer them as well as what risk assessments need to be undertaken.
- Young people should be offered advocacy and support to enable them access to CAMHS services.
- Providers of CAMHS should develop mechanisms to enable children and young people to participate in commissioning and designing mental health services, including access routes, to improve their responsiveness and ensure they meet the specific needs of vulnerable groups.
- Local Authorities through Local Safeguarding Children's Boards (LSCBs) should review and monitor access to mental health support for children who have experienced abuse and trauma and ensure that such services are commissioned locally and that there are policies in place for priority access to services for all children who need it.
- Providers of CAMHS should collect information on referrals from social services, police and other agencies with safeguarding responsibilities on the numbers referred, accepted, not accepted and referred somewhere else to inform commissioning of services to share with their LSCBs.
- Local CAMHS services should have mechanisms in place to identify vulnerable young people and prioritise access if they may be at risk. This is particularly important for care leavers and victims of trauma as there is a lack of nationally-led approach for these groups.
- Providers of CAMHS should have policies in place on DNAs that specify the need to follow up when a young people misses their appointment including the undertaking of risk assessments. Services should specify how they are going to liaise with other agencies in cases of young people from vulnerable groups.
- Commissioners of mental health services should consider ways to decrease DNA rates, for example by offering flexible booking of appointments and giving young people, particularly older adolescents, the option to choose a suitable appointment time and location.
- All mental health services should have policies in place on transitions for young people from vulnerable groups between the levels of CAMHS services and to transition to adult services to ensure that children do not fall through the cracks of services and that they have continuous access to mental health support. Policies on transitions should outline how CAMHS will work with other agencies in planning transition.

Appendix

1. CAMHS system¹¹⁷



2. Vulnerable groups

We wanted to understand the referral pathways for the below vulnerable groups specifically but gave individual providers space to include any additional vulnerable young people their services support.

Children and young people living in poverty

Children affected by poverty and deprivation identified by post-code or area

Children from families in receipt of council tax support

Children on free school meals

Children of parents in receipt of Income Support of Job Seekers Allowance

Vulnerability related to age

Children vulnerable due to their age

Young people aged 16 and 17

Young people aged 16–17 who reside in supported accommodation, hostels and B&Bs

Children in care

Looked-After Children

Looked-After Children in out-of-authority placements

Care leavers

Children and young people known to local authorities

Children on child protection plan

Children in need

Young people with substance misuse problems

Young carers

Children and young people with SEN needs or a disability

Children and young people who may have experienced or witnessed violence, including physical or sexual violence

Child victims of domestic violence

Child Victims of Child Sexual Exploitation

Child victims of crime

Refugee, migrant and trafficked children

Young offenders

3. Specialist/Tier 3 CAMHS¹¹⁸

Most young people will present with moderate and severe mental health problems that are causing significant impairments in their day-to-day lives. These may be acute presentations. There should be a pathway for challenging behaviour of mild to moderate severity in place.

Commissioners should consider how they will commission a range of services for children and young people who will typically present with one or more of the following:

- Emotional and behavioural disorders (moderate to severe)
- Conduct disorder and oppositional defiant disorder
- Hyperkinetic disorders

- Psychosis
- Obsessive-compulsive disorder
- Eating disorders
- Self-harm
- Suicidal ideation
- Dual diagnosis – including comorbid drug and alcohol use
- Neuropsychiatric conditions
- Attachment disorders
- Post-traumatic stress disorders
- Development disorders
- Significant mental health problems where there is comorbidity with mild/moderate learning disabilities or comorbid physical and mental health problems
- Mood disorders
- Somatising disorders
NB: Presentations that could be described as emerging personality disorder will probably be accepted under mood disorder, suicidal ideation and self-harm.

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Names used in this report have been changed to maintain anonymity. All photographs posed by models.

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