



Children's Mental Health briefing

A briefing by the Office of the Children's Commissioner for
England

NOVEMBER 2018

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Introduction from the Children’s Commissioner, Anne Longfield



Since I became Children’s Commissioner, children’s mental health has been the issue most frequently raised with me. I have been deeply moved by the stories I have heard from children and families about the difficulties they have encountered trying to access help and treatment. I have been shocked by the sheer number of children I have encountered, in a whole range of situations, who have been denied mental health treatment and have suffered profound consequences.

In response to the cases I was encountering across my work, last year I published a comprehensive briefing on the state of children’s mental health services. It detailed a system failing to meet children’s needs at every level; a system failing to give children’s mental health the resources, leadership or priority desperately required.

Since then, we have had further critical reports on children’s mental health from a range of reputable bodies, including the National Audit Office¹. We have also had a Green Paper from the Government, which has been widely criticised for its lack of ambition. A joint inquiry by the Health and Education Select Committees found that “Government’s proposal will provide no help to the majority of those children who desperately need it” and thus risk “failing a generation”².

Central to this is the issue of funding. Children make up 20% of the population, yet account for only 9%³ of overall mental health spending. On average, local NHS areas spend less than 1% of their budget on children’s mental health; this would need to treble to achieve parity of spending between adult and child mental health. In cash terms this means children’s mental health services require an additional £1.7 billion a year to achieve equivalent funding to that provided to adult mental health. This may sound like a tall order, but the Government has given the NHS a historic 10-year funding settlement, with the Chancellor pledging that *at least* £2 billion a year of extra funding for mental health services. If children are prioritised by the NHS, it is entirely possible to achieve spending parity.

To inform this, I undertook to update the briefing that I produced last year. This year’s briefing takes a close look at community Child and Adolescent Mental Health Services (CAMHS) provision. For each area in England, I analyse spending on CAMHS, numbers receiving treatment, waiting times and, crucially, the numbers of children not accepted into treatment. The data I have used is not my own – these are NHS figures – but I have used my unique statutory powers as Children’s Commissioner to get access to this data, and I am now sharing it with Parliament and the public. I am indebted to the analyst team at NHS Digital who have conducted much of the analysis which has enabled this briefing.

¹ <https://www.nao.org.uk/report/improving-children-and-young-peoples-mental-health-services/>

² <https://social.shorthand.com/CommonsHealth/3CYE7IOL7n/thousands-of-children-to-miss-out-on-mental-health-support>

³ NHS England 8.75% that of all mental health spending goes on children (figure provided directly to the CCO). This includes central NHS England spending. When we look just at spending by local NHS areas, the figure falls to 6.7%.

Overall, I find that CAMHS are improving in most areas of the country, which is welcome progress. I was also pleased to see an increase in workforce capacity and numbers of children seen in this year's NHS Benchmarking data⁴. Yet the rate of improvement is highly variable, and as the NHS Benchmarking results show, the increase in capacity is not keeping pace with increasing demand. There is still a vast gap between what is provided and what is needed to get help to all the children who require it. My main findings are (for the year 2017/18):

- Less than 3% of children in England accessed CAMHS last year, a small fraction of those who need help.
- Of more than 338,000 children referred to CAMHS last year, less than a third (only 31%) received treatment within the year. Another 37% were not accepted into treatment or discharged after an assessment, and a further 32% were still on waiting lists at the end of the year.
- Of those children who did enter treatment, around half did so within six weeks. This compares poorly to areas where the NHS has implemented waiting time targets: 90% of adults accessing the Increasing Access to Psychological Therapies (IAPT) mental health service are seen within six weeks; nearly 80% of children entering eating disorder treatment are seen within four weeks.
- I welcome the fact that most areas are increasing funding for CAMHS. Nevertheless, parity of esteem⁵ remains a distant prospect. On average, local areas spend £54 per child on mental health, compared to £800 on physical health.
- Currently 15 times as much is spent on adult mental health as child mental health.

The good news is that there are a minority of areas which are increasing investment in CAMHS at a much greater rate. These areas are already far exceeding the existing NHS target to be treating a third of children with significant need (based on 2004 levels of prevalence) by 2021. Yet for every area exceeding what NHS England expects of them, there is an area failing to deliver.

I want to see the Government and NHS England dramatically increase the level of ambition for children's mental health services. We have seen before that NHS England can drive service improvements. In the last two years, the NHS has delivered 70 new community eating disorder services for children, with a waiting time standard of one week for urgent referrals and four weeks for routine⁶. The adult IAPT service (which is for those with depression and anxiety) has gone from nothing in 2008 to a service that will treat 1.2 million people by 2021. Between 2016 and 2021, the IAPT service will expand by 600,000 places a year. For the same period, the ambition for CAMHS is an expansion of 70,000. While this expansion is welcome, the Government must be more ambitious about expanding access for children and young people.

Instead, we need to look to the areas of CAMHS where there have been significant improvements – such as eating disorders, in youth justice but also perinatal mental health which will have a real impact on children – and show the same level of ambition across the whole children's mental health system. While there have been improvements in CAMHS as a whole this has been patchy across the country and it is

⁴ <https://www.nhsbenchmarking.nhs.uk/news/2018-camhs-project-results-published>

⁵ Parity of esteem is the principle that mental health must receive equal priority to physical health. It is enshrined within the NHS Mandate, see https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/briefing46_NHSmandate.pdf

⁶ <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/mental-health-services-for-children-and-young-people/oral/92201.html>

not always possible to quantify this progress. This requires funding and leadership. As the Children's Commissioner I find the discrepancy in funding between adult and child mental health to be unacceptable. The NHS now has the opportunity to change this but additional funding must be matched with ambitious leadership. The 10-year plan needs to set out a vision for children's mental health and the roadmap to achieve that with clear targets and timetables. So I want to see:

- 1) A spending benchmark that brings parity between child and adult mental health. I believe this requires an increase in CAMHS spending of £1.7 billion. This should be achieved within five years.
- 2) A large expansion of specialist mental health treatment to ensure that access is provided to all children who need it. By 2023 the NHS should be in a position to ensure no child who needs help is turned away combined, with a clear four-week waiting times target.
- 3) A comprehensive plan for the NHS and local partners to provide lower-level children's mental health services, to ensure easy access before conditions deteriorate. This should include an NHS-funded counsellor in every school.

I believe the last of these points is very important. The children I speak to do not want a formal or medicalised CAMH service. They want a service that is open and accessible. Most want to be able to access support through their school. Others are keen on online support. The most vulnerable children need services to come to them. Support provided in such a way is not just more child friendly, it is also far cheaper. The adult IAPT service is designed specifically to meet these lower levels of need. We need an equivalent level of ambition for children; the Government, working with the NHS and other partners, must set out how it will provide this across the country.

The level of investment needed is significant. I do not deny this. But the potential return on this investment is enormous. A properly resourced children's mental health system would work with children and families from a young age; would respond to issues as they emerge; would support children to remain in school and stay away from risks such as gangs. For those children with more acute need, it would provide intensive support in the community and reduce the need for children to be admitted to unpleasant inpatient units. The benefits would be seen in childhood and last into adulthood. They would be reflected in educational, social and economic outcomes. This prize is worth pursuing, and can be achieved. The 10-year plan is the opportunity to do this. We must not let this chance pass.



Anne Longfield OBE
Children's Commissioner for England

Background: what's in this briefing

This briefing is based on data obtained from two NHS datasets for the financial year 2017/18. Each dataset enables us to examine the performance of each Clinical Commissioning Group (CCG) in England.

NHS Five-Year Forward View Dashboard

The dashboard brings together key data from across mental health services to measure the performance of the NHS in delivering the targets in the Five Year Forward View for Mental Health⁷. This includes an ambition to increase the number of children in treatment by 70,000 in the period 2016 to 2021 and to introduce a four-week waiting time target for children accessing eating disorder services. It also includes an ambition to expand adult IAPT service by 600,000, with a six-week waiting time target and the introduction of an overall mental health spending benchmark. We have combined the data within this dataset with other national statistics, including ONS population estimates and NHS England figures on CCG budgets to enable us to identify:

- Spending on CAMHS – per child, and as a proportion of total CCG budget.
- Number of children receiving treatment as a proportion of the population of children.
- Number of children accessing eating disorder treatment within four weeks (standard referral).

Most of this data was also produced for 2016/17, so it is also possible to identify year-on-year changes.

Mental Health Services Data Set

The Mental Health Services Data Set (MHSDS) contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services⁸. It is published monthly, and is primarily for administrative purposes. It is known to be incomplete due to underreporting by some providers. It is important to bear this in mind particularly when looking at comparisons between areas.

For the purpose of this briefing, the Commissioner used her unique statutory powers under Section 2(F) of the Children's Act 2004 to request a bespoke analysis of this dataset (conducted by NHS Digital) which isolated children's first entry into the system, and subsequent contacts. The analysis covered all children *referred* for treatment during 2017/18, enabling us to identify the following four things:

- 1) How many children, as a percentage of those referred during the year, entered treatment within six weeks
- 2) How many entered treatment, but waited more than six weeks
- 3) How many children were not accepted into specialist treatment or discharged after an assessment*
- 4) How many children were still awaiting treatment at the end of the year**

⁷ <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

⁸ <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/mental-health-services-monthly-statistics>

As far as we are aware, this analysis was last conducted at the behest of NHS England in 2016 and only looked at a four-month period⁹. Therefore it has not been possible to compare the data for 2017/18 with previous years.

*These children not accepted into NHS CAMHS. They may have been subsequently referred to other services – one of the major limitations of the current data-capture is that it fails to give information about this.

**This analysis only captures children who were referred in 2017/18. There will be many children accessing treatment in 2017/18 but who were first referred to treatment in previous years. Similarly, there will be children who were referred in 2017/18 and who will have entered treatment in 2018/19. The latter children will be amongst those listed as “still awaiting treatment”. It is possible that some of these children may have been referred towards the end of 2017/18, in which case they may not necessarily have experienced a long waiting time.

We are aware of certain limitations in terms of the quality and completeness of data sourced from the MHSDS. There have been issues of under-reporting by some providers, although this has improved during 2017/18. To the extent that the underlying data that feeds into MHSDS is missing, that reduces the extent to which analysis based upon it can be taken as a perfectly reliable view of CAMHS referrals and waiting times. We cannot assess whether ‘data missingness’ could be biasing our findings in one direction or another. Nevertheless, we believe that the MHSDS data (and analysis resulting from it) still have significant research value by providing the best available information locally and nationally¹⁰, despite their limitations, and look forward to seeing further improvements in the collection and quality of the MHSDS in due course.

What’s not in this briefing

This briefing is focused on NHS-provided, specialist, community children’s mental health services. This means it does not include:

Information on low-level mental health provision

Low-level mental health provision can roughly be divided between:

- Universal services: these are services for all children, delivered by non-mental health professionals. An example is wellbeing sessions in schools.
- Targeted services: these are services provided to children with additional needs, but not necessarily a diagnosable mental health condition. An example could be support for a child who is struggling to control their emotions. This includes school-based counselling, delivered either one-to-one or in groups. For younger children, this might mean mental health-focused parenting classes.

⁹ [http://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/media/23329/CYP-Referral-to-second-contact-Q2/xls/CYP_Referral_to_second_contact_\(Q2\).xlsx](http://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/media/23329/CYP-Referral-to-second-contact-Q2/xls/CYP_Referral_to_second_contact_(Q2).xlsx)

¹⁰ We are also aware of the NHS CAMHS Benchmarking project, which found average waiting times of 13 weeks to the start of the first treatment. However this was not a national statutory data collection and cannot therefore provide a picture across all local areas.

A number of organisations play a role in delivering universal services, making it very hard to capture total levels of provision. NHS guidance is for local CCGs to commission a targeted CAMH service, to complement their specialist service¹¹, but there is no monitoring as to whether this is being done. Local authorities, schools and the voluntary sector will also play a crucial role in the provision of targeted services.

In 2014 the Health Select Committee called on the Government to conduct an audit of low-level mental health services for children¹². This never occurred. However, the Children's Commissioner is currently using her statutory powers to request information on the spending and provision of low-level children's mental health services. She has asked every CCG, Director of Public Health and Director of Children's Services in England how much they spend, and on what services. The results of this work should be published in Spring 2019.

Information on inpatient mental health provision

NHS England centrally commissions all inpatient care for children's mental health conditions, which is organised through regional teams. No one wants a child to go into inpatient mental health facilities unless absolutely necessary, but it is vital that if that level of care is necessary, it can be accessed quickly, as near to home as possible, and for no longer than necessary.

Last year 4,561 children¹³ were admitted to inpatient units. Their care is not covered in this briefing. But the Commissioner will be publishing a briefing looking at the inpatient units to which these children are admitted: where they are, what specialisms they cater for and the quality of these units. It will include a focused look at the children who are most vulnerable of all: those who need to be held in secure accommodation because of the harm they pose to themselves or others. We are still awaiting the final data for this publication from NHS England. This is due in late 2018 and we are hoping to publish this work in early 2019.

¹¹ <https://www.england.nhs.uk/wp-content/uploads/2018/04/mod-camhs-tier-2-3-spec.pdf>

¹² <https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/342.pdf> (p3)

¹³ Figures from the Dashboard, see above.

The state of CAMHS in 2017/18

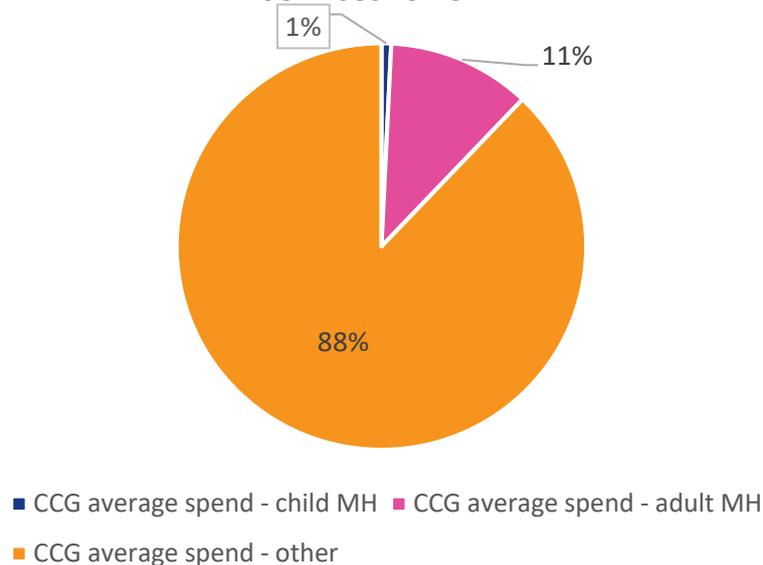
Spending

Last year Clinical Commissioning Groups (CCGs) spent a total of £641 million on CAMHS. In addition, £47 million a year was spent on eating disorder services for children. This does not include funding for inpatient care, which is provided by NHS England centrally. It also excludes spending by local authorities. This is out of an overall NHS budget of £108 billion, and a total CCG spend on mental health of £10.1 billion. CCGs in England spend an average of 14% of their overall budget on mental health, but just 0.9% of their overall budget on children's mental health. This means local adult mental health services receive 15 times the level of funding given to children's mental health, despite the fact that children make up 20% of the population.

Looked at another way, CCGs spend about £55 on CAMHS for every child. This compares to about £800 per child on physical health¹⁴.

The good news, however, is that spending on children's mental health is generally increasing. Out of 207 CCGs in England for which we have data, 134 increased their spending on CAMHS last year. Across England, CAMHS spending per head has risen from £49 in 2016/17 to £54 in 2017/18, a rise of approximately 10% (though this is likely to be an overestimate of the increase as last year's figure was reduced by some areas reporting implausibly low figures). Unfortunately, however, there were 72 CCGs in England which reported a reduction in CAMHS spending between 2016/17 and 2017/18.

Average proportion of CCG budget allocated to MH services for CYP



¹⁴ This figure is an estimate that excluded spending by GPs (on both physical and mental health) and an estimate of spending made by the IFS for the Children's Commissioner. It is based on 2015/16 spending, as it was not possible to make an estimate for more recent years. <https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/Public-Spending-on-Children-in-England-CCO-JUNE-2018.pdf>

Number of children accessing services

Last year 324,724 children accessed NHS CAMHS. This is equivalent to 2.85% of the total population of all children in England. There is strong evidence that this is a fraction of the total number of children needing help. We are awaiting the publication of the national study of the population prevalence of child mental health issues and disorders since 2004, due to be published this week. It is expected to show a rise in the number of children with mental health needs. Yet even if we use the 2004 prevalence data we find a significant gap between need and provision. The 2004 study found that 9.6% of children aged 5-16 had a clinically significant mental health condition. It did not contain an estimate for 0-5s, for whom mental and emotional health conditions do exist but manifest differently; nor did it include an estimate for 16-18. Yet if we use the 9.6% figure as a rough estimate, we can see the NHS is on track to treat about a third of children with significant needs by 2021, which is the target the NHS was set within the Five Year Forward View¹⁵. This target is arguably not ambitious enough, but we welcome the progress being made such that the NHS is on track to meet this target.

There are also children who do not necessarily have what would be considered a diagnosed mental health condition, but do have poor mental or emotional health. This includes teenagers with high levels of anxiety or depression (estimated to be an additional 14% of 14-year-olds) and younger children who may present with poor emotional control and challenging behaviour. At present we are unable to assess NHS provision for these groups.

Eating Disorder Service

The Eating Disorder Service is one area where NHS England have made welcome progress, backed up by clear waiting times standards. This has led to significant improvements in the provision of eating disorder services, with new services opening and shorter waiting times. In 2017/18, nearly 80% of children referred to eating disorder services were seen within 4 weeks. For those children given an 'urgent referral' nearly 80% are seen within one week. Moreover, NHS England has committed to getting both of these figures up to 95% by 2021¹⁶.

However, it should be noted that eating disorder services remain a relatively small element of community CAMHS provision, accounting for just £47 million in spending last year.

Children referred to CAMHS

For this year's briefing, NHS Digital conducted a bespoke analysis for the Children's Commissioner based on the MHSDS. This analysed what happened to the 338,633 children referred to CAMHS during 2017/18¹⁷.

Across England:

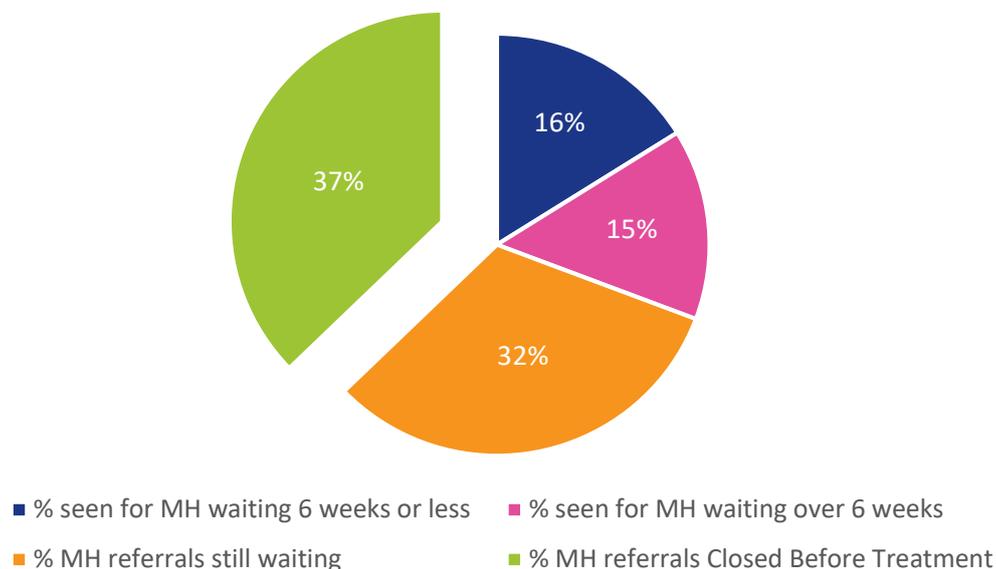
¹⁵ <https://www.england.nhs.uk/mental-health/taskforce/imp/>

¹⁶ See the testimony of Claire Murdoch to the Public Accounts Committee <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/mental-health-services-for-children-and-young-people/oral/92201.html>

¹⁷ Data obtained from the Dashboard and the MHSDS is not directly comparable. The Dashboard shows all children who received treatment during 17/18, including children who were referred during 16/17 yet started treatment in 17/18 and children who started treatment in 16/17 but whose treatment continued into 17/18. Data from the MHSDS only shows children referred during 17/18.

- 124,812 children (37%) had their referral closed before they entered treatment. In other words, they were not accepted into treatment or discharged after a first assessment appointment.
- 56,602 children (16%) entered treatment within six weeks.
- 49,257 children (15%) entered treatment but waited more than six weeks.
- 107,846 children (32%) were still on the waiting list at the end of the year¹⁸.

What happens to children referred to CAMHS?



Children ‘turned away’

In 2017/18 there were 125,277 children not accepted into specialist treatment or discharged after an assessment appointment. There are many reasons why this may happen. One of the most common reasons is that the child does not reach the threshold for accessing services. This may be because they do not have a level of need which justifies a clinical intervention, or because the local CAMH service does not have the capacity to treat all the children who need help. No area in England is treating as many children as we estimate need help. Previous research from the Children’s Commissioner in 2016 found that children were routinely discharged from treatment for reasons such as missed appointments, which in turn could be linked to their mental health condition. Children have told us about the stress of attending their first appointment.

The crucial limitation in the data is that we do not know what, if any, service can be accessed by children when they are not accepted into specialist CAMHS. Lots of children can be effectively supported in other ways, if there is an alternative service available. NHS Digital notes that “A proportion of those referred to CYP MH services will not require specialist mental health support. Following assessment some may require support of a different kind, such as social care, or may benefit from signposting to support provided elsewhere – such as voluntary sector organisations. In other cases a service may not have capacity to accept a referral. It is not possible from these data to ascertain the reason a referral is closed”¹⁹.

¹⁸ See explanation on page 6.

¹⁹ <http://digital.nhs.uk/mhldsreports>

This comment from NHS Digital is surprising in that it implies that children who do not reach the threshold for specialist CAMHS fall within the remit of other organisations; namely local authorities and the voluntary sector. Yet NHS England guidance to CCGs is clear that they are expected to commission a targeted service to complement the specialist provision. In line with this commissioning advice, the Children's Commissioner has consistently maintained that children who need mental health support, but do not necessarily need specialist CAMHS, should be able to access other forms of NHS treatment. Unfortunately, NHS England does not currently capture any data on the provision of such services (see above). This undermines our ability to assess how many children individual local areas are turning away. We can see the number of children turned away from specialist services, but we do not know what other services these children are subsequently referred to.

Given this, it is perhaps unsurprising that the numbers of children not accepted into CAMHS varies considerably across the country, from as few as 7% of referrals, to more than 80%. Generally, areas with higher CAMHS spend, tend to accept more children into treatment. However, we should be cautious in criticising areas with high numbers of children not accepted into specialist treatment. Some CCGs will have invested in targeted services, often provided by the voluntary sector, enabling them to refer children these services.

Conversely, the data shows some areas which are spending little on CAMHS and have fewer children accessing the service, yet still have a smaller proportion of children not accepted into treatment. It is possible that this reflects services which are hard for children to access, and therefore receive few referrals. It is also possible that these areas have good targeted provision which is not captured in the data.

Waiting times

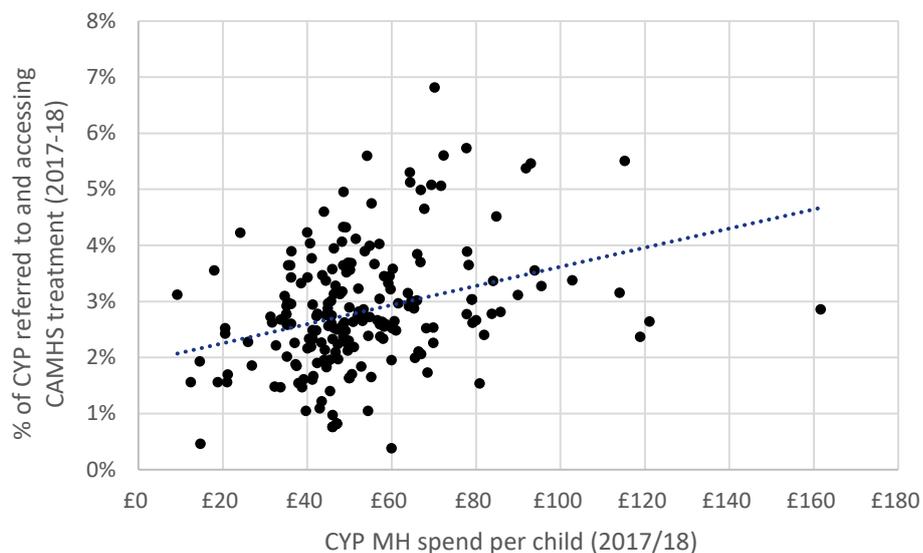
We only have waiting times data for children who were both *referred* and *treated* within 2017/18. This is only 105,859 children out of more than 338,633 who were referred. Yet for these children, just over half entered treatment within six weeks and 43% were seen within four weeks. There were 26,295 children who waited more than 12 weeks for treatment.

The average waiting time for those who did enter treatment was 57 days, or just under two months. Again, however, regional variation was considerable. Three areas had average waiting times of less than three weeks, while 18 areas had average waiting times of three months or more. Publicly available data from NHS CAMHS Benchmarking shows an average waiting time of 13 weeks²⁰.

²⁰ <https://www.nhsbenchmarking.nhs.uk/news/2018-camhs-project-results-published>

The relationships between indicators

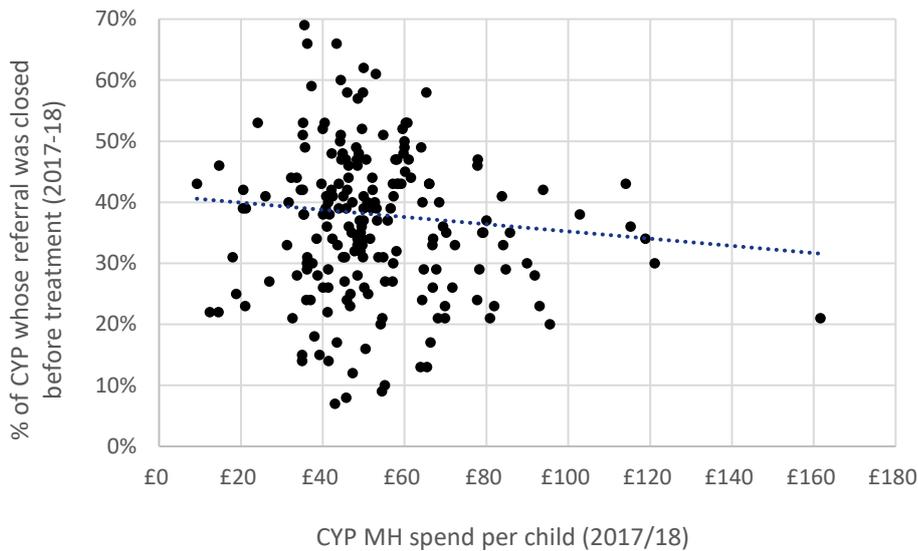
Generally, we would expect that areas which spend more on children's mental health would be able to see more children. Our analysis shows this is somewhat true, as shown in the graph below:



There is wide variation in this relationship: many areas with similar levels of funding have different rates of access, and vice versa. The relationship is therefore suggestive rather than concrete. It is also worth noting that there are a significant number of areas which are seeing fewer children than we would expect given the level of funding. There are two possible explanations for this:

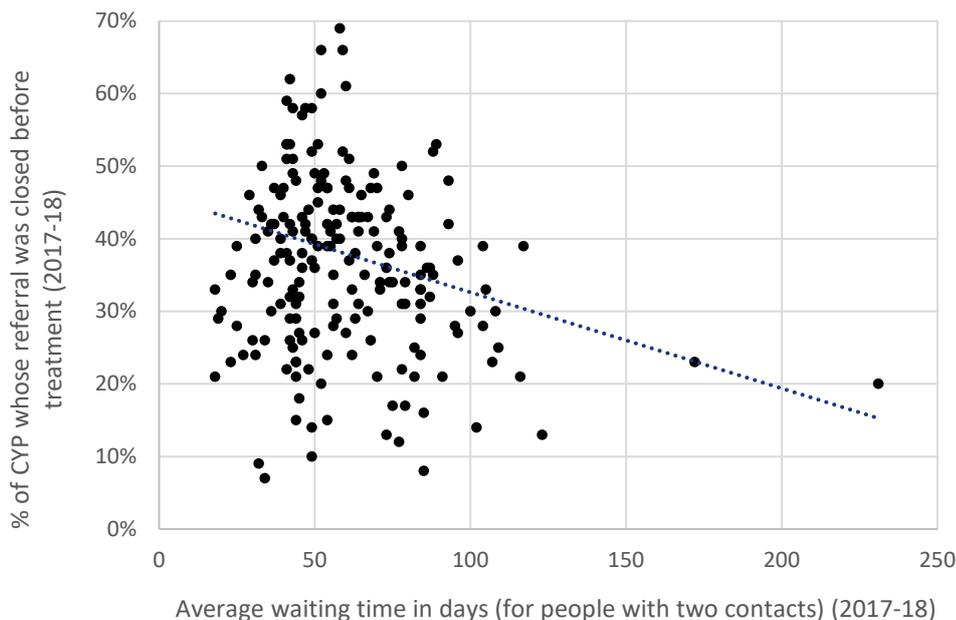
- (1) Local areas have put the investment into lower-level services, not included in the treatment data.
- (2) Local areas have only recently increased investment, and this is taking time to translate to higher treatment rates.

We have also examined, below, whether there is a relationship between spending and the numbers of children turned away. There is very wide variation in rates of children whose referral is closed before treatment – even among areas with similar spend per child – but overall, on average, areas with higher spending are more likely than not to have slightly lower rates of referrals closed before treatment, and vice versa. However the relationship is very weak, and needs to be seen in the context of a small number of outliers rather than a general trend.



If there is a negative relationship, then the most plausible explanation for it would be that areas which have invested in their CAMH service have also promoted and opened up their service, encouraging more referrals. But if referrals increase at a greater rate than capacity (due to the large level of unmet need amongst the population) this will lead to a greater number of children being turned away. Anecdotally, local areas have reported this phenomenon to the Children’s Commissioner.

There are other indicators between which we may expect an inverse relationship. For example, there is a danger that areas which have focused on lowering waiting times could achieve this by turning away more children. We have explored in the graph below whether this could be a possibility. There is very wide variation in rates of referrals closed before treatment even among CCGs with very similar waiting times, so the relationship is unclear. Again the pattern, to the extent that there is one, needs to be seen in the context of a small number of outliers rather than a general trend. This issue does, however, warrant further investigation beyond what has been shown here.



How much money does children’s mental health need?

Providing an exact answer to this question would demand a level of knowledge of children’s need, and the costs of different types of treatment, which is not in the public domain. However, we have considered what it would cost to raise children’s mental health spending to the level of adult mental health spending. This is not to say that adult mental health services are perfect. That is almost certainly not the case. But they have been the recipient of a far higher funding level than children’s mental health services. This has enabled, for example, the creation of the IAPT programme, to provide access to support for 1.2 million adults by 2021 who have anxiety or depression but not at a level of need that would qualify for acute services. There is no equivalent NHS programme for children²¹.

Children are roughly 20% of the population. Current estimates of mental health prevalence are slightly higher for adults than children²², but are hard to directly compare as adult prevalence data is from 2014, and children’s from 2004, meaning there are both time and methodological differences. We do know, however, that mental health conditions are most common amongst adolescents and young adults.

A good proxy for parity of spending would be to aim for 20% of all mental health spending to go on children. We are currently nowhere near this. At present, children’s mental health accounts for only 6.7% of community mental health spending²³. Adult mental health spending is roughly 15 times as spending on children’s mental health. If we look at this within the context of CCG budgets; 13.7% of current CCG spending goes on overall mental health spending. Broken down, adults gets about 12.8% of CCG overall spending, and children get about 0.9% of overall spending. In very broad terms, raising children’s mental health spending to about 3% of CCG spending – thereby trebling it as a proportion of CCG spending – would bring about parity. We believe this is doable within the new financial settlement. Below, we have modelled how much it would cost to raise up children’s mental health spending to 20% of overall mental health spending (based on 2017/18 spending levels). Nationally, this would have required an extra £1.72 billion extra spending on CYP MH in 2017/18. This equates to an average increase in CAMHS funding of £8.3 million per CCG area. Not all of this additional money needs to come from additional central funding. We would expect areas which are currently committing very low-level of funding to CAMHS to increase their existing spend levels.

Additional funding required in 2017/18	£1,720,000,000
Average required per CCG	£8,300,000
Minimum required in a CCG	£1,640,000
Maximum required in a CCG	£29,500,000

²¹ There is a child IAPT programme, but this programme aims to increase the use of psychological therapies within specialist CAMH services. It does not seek to create new services, expand services (though it is part of the general expansion of CAMHS by 70,000) or service the needs of children below the threshold for CAMH services.

²²

https://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/catalogue/PUB21748/amps-2014-full-rpt.pdf

²³ NHS England cite a figure of 8.75% of all mental health spending going towards children. This includes specialised commissioning (largely inpatient units) which is done by NHS England centrally. 6.7% is the percentage of local-area mental health spending directed towards children.

Under this hypothetical scenario, total CCG spending on all mental health (adult and children's) in 2017/18 would have been £11.8 billion. Total spending on children's mental health would have been £2.36 billion – a 268% increase on the £641 million that was actually spent in 2017/18.

Performance by area

We have compared CCG performance across five indicators to give an overall score for each CCG. The five indicators we used for this are:

- 2017/18 children's mental health spend per child
- Children's mental health spend as a percentage of the CCG budget
- Total number of children treated (as a percentage of the population)
- Average waiting time for those children who do get seen
- The percentage of children referred who are not accepted into treatment

The overall score is given out of 25, and is based on the quintile score for each CCG on each of these measures. This means the overall score is a relative one. It is based purely on how each CCG compares to other CCGs. We have included two spending measures as we are aware that there will some areas which have invested in lower-level mental health services which may not be picked up within the other indicators we have included. While not perfect, the best way to mitigate against this is to include a greater weighting for spending.

On this basis we find Ealing to be the lowest performing CCG area in the country, with a total score of 6 out of a maximum possible 25. It is closely followed by four other West London CCGs: Hounslow, Hammersmith and Fulham, Harrow and Hillingdon. In Ealing, over half of children referred to CAMHS are not accepted into treatment and those who do get treatment wait, on average, nearly three months. Unsurprisingly, Ealing spends considerably less than average on CAMHS, and last year had a third fewer children accessing CAMHS than the national average.

There are 55 CCGs to whom we have awarded a score of less than 13. Of these, 11 CCGs are in Greater London. Other big cities to have very poorly performing CCGs include Leeds, Sheffield, Nottingham, Bristol, Bradford and Leicester.

At the other end of the spectrum, there is only one CCG in England, South Tees CCG, to get the maximum possible score of 25. This is closely followed by three other CCGs in the North East: Hartlepool and Stockton-on-Tees CCG; Durham Dales, Easington and Sedgefield CCG; and Darlington CCG – in addition to one in Kent, Thanet CCG. All these CCGs perform consistently well across our five key measures. All three of these areas have high CAMHS spend which enables a much higher percentage of the child population to access CAMHS, with shorter waiting times, while turning away much fewer children. These areas set a standard the rest of the country could and should obtain.



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