Review of CAMHS Data from 2013-2022

This report is a standalone document, however further reflections and analysis of the data is available from NICCYs February 2023 monitoring report on the progress of implementation on the recommendations from the 'Still Waiting' Review. All documents are available from https://www.niccy.org/mental-health-review-still-waiting/

> "Data and statistics need to be recognised as a valuable public asset."
>
> Office for Statistics Regulation- Review of Mental Health Data in NI 2021

Publication Date: 09 February 2023

NICCY published *'Still Waiting'*- A Rights Based Review of Mental Health Services and Support in NI in September 2018. This report contained three strands of work, these were

1. Children's and young people's experiences of accessing or trying to access support;
2. A mapping and analysis of budgetary information and
3. A mapping and analysis of CAMHS operational data.

Strand 3 reporting on CAMHS service activity data found limited publicly available official data, and the data that was available was not centrally held but fragmented across different parts of the system. The 'Still Waiting' review identified a range of gaps in basic data which it advised Government to fill, along with a recommendation to publish CAMHS data in the same way as other parts of the UK (Rec 47, p278).

An Inter-Departmental Group (IDG) Chaired by the Department of Health and involving representatives from the Departments of Education, Justice, and Communities, along with members of the Voluntary and Community Sector was established to publish an action plan and be responsible for the implementation of the recommendations which includes those related to CAMHS Data.[1] One of the outstanding recommendations is to publish a comprehensive CAMHS Dataset in line with other health statistical reporting.

Alongside the establishment of the IDG, NICCY has committed to monitoring the implementation of the Still Waiting Recommendations on an annual basis between 2020-2023,[2] and part of this monitoring process includes using mental health data to inform its assessment of progress. NICCY has compiled a wide range of mental health data during the period 2013/14 -2021/22, much of which is not in the public domain and was requested from data holders. The data used in this report largely originated from the HSCB (now SPPG)[3] along with RQIA, BSO and BHSCT. The source of data used in this report is referenced under each table or figure. The areas covered in this report include referrals received and accepted across CAMHS Teams, numbers waiting and length of time waiting for CAMHS and psychological therapies, demographic profile of those accessing CAMHS, referral sources and rates of non-attendance at appointments. It also includes data on in-patient activity, anti-depressant prescribing for under 18s, admission to adult wards and extra-contractual referrals.

[1] Further information available from Mental Health Review - Still Waiting (niccy.org)

[2] Ibid.

[3] Please note that the information provided by the HSCB is used for information management processes is not official statistics.

Table of Contents

1.0 Definitions

The table below provides a description for titles / acronyms used within statutory CAMHS and which are referred to within this report.

Child and Adolescent Mental Health Services (CAMHS) is the overarching service provided by HSCTs encompassing the teams detailed below:[4]

Primary Mental Health Teams (PMHT) (Step 2)- dedicated CAMHS service which involves early detection and provision of preventative support for children and families.

Step 3 / Core CAMHS- Specialist community / outpatient CAMHS Teams / Clinics.

Eating Disorder-specialist CAMHS team dedicated to the assessment and treatment of complex eating disorders.

Crisis Response Home Treatment (CRHT) or Crisis Assessment Intervention Team (CAIT) dedicated to emergency / next day assessment and short term intensive intervention.

Drug and Alcohol Mental Health Service (DAMHS)- specialist CAMHS Team dedicated to the assessment and treatment of substance misuse. Also referred to as Addiction Services.

An Active Client is a child that has been seen at least once by a CAMHS professional and is deemed to be currently in receipt of treatment at a given point in time.

Global CAMHS- Global referrals relate to all referrals received into CAMHS for Step 2, Step 3 / Core CAMHS, Eating Disorder Service, Crisis Response Home Treatment (CRHT) & Drug and Alcohol Mental Health Service (DAMHS).

Please note that individual values within tables and figures may not sum to column/ row totals due to suppression of some data in line with disclosure protocol. Moreover, service

[4] Further details on CAMHS services are available from CAMHS Pathway Document- HSCB 2018

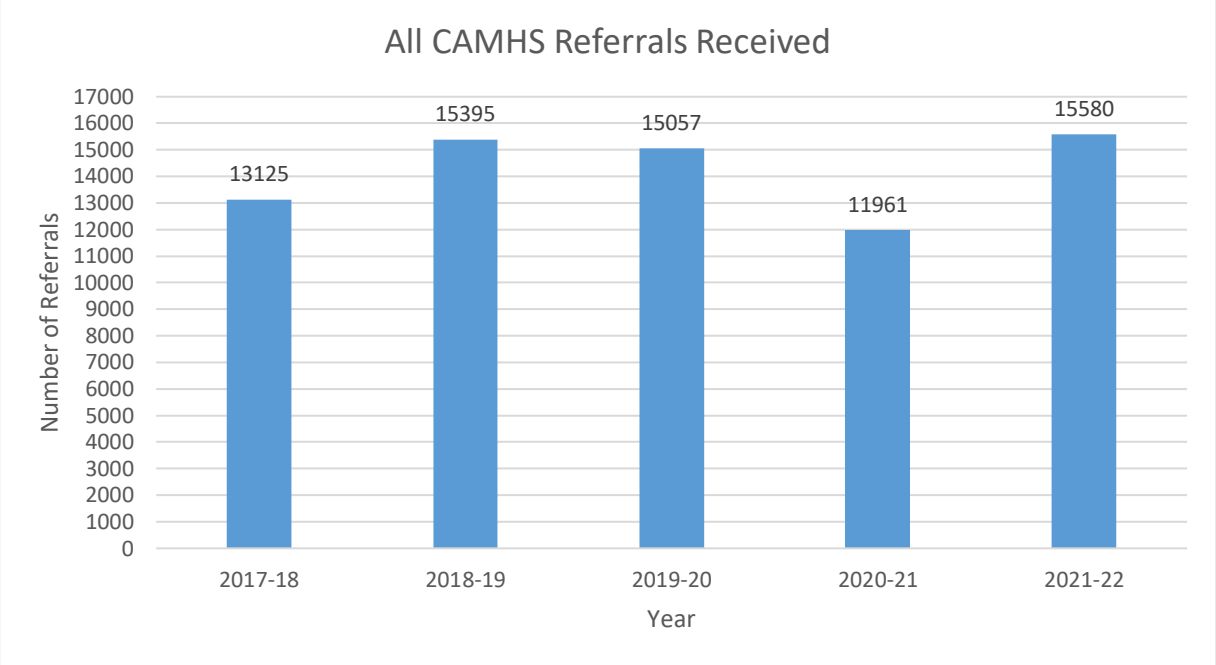
level data provided to us for Belfast and SEHST is amalgamated as Belfast Trust is the provider for CAMHS to the SEHST.

2.0 CAMHS Service Activity Data

Figure 1 below shows the number of referrals received from CAMHS between 2017-18 and 2021-22. It shows that between 2019/20 and 2020-21 referrals decreased quite considerably from 15057 to 11961. This may have been due to a 'pandemic effect', however referral figures for 2021 / 22 shows an increase to 15580 (3619 additional referrals received in 2021-22 compared to the previous year, 2020-21).

2.1 CAMHS Referrals Received and Accepted

Figure 1: All CAMHS Referrals Received 2017/18- 2021/22



Source: HSCB CAMHS Data Reports
Please note: Family Trauma Centre referrals are not included in this figure.

Table 1 below shows that the percentage of global referrals accepted and not accepted has not changed between 2017/18 and 2021/ 22 and sits around 70-75% and 25-30% respectively. Global referrals relate to all referrals received into CAMHS for Step 2, Step 3 / Core CAMHS, Eating Disorder Service, Crisis Response Home Treatment (CRHT) &

Drug and Alcohol Mental Health Service (DAMHS).

In 'Still Waiting', NICCY raised considerable concerns about the proportion of young people not accepted for Step 3 /Core CAMHS. We reported that regionally, the percentage of referrals not accepted increased from 33% in 2013/14 to 42% in 2015/16 (page 207-210), and the review included a specific recommendation to address the reasons for this, to include potential problems with the referral process (Rec 3, p274). Unfortunately, due to changes in how services are delivered, data on acceptance rates for Step 3 / Core CAMHS has not been available beyond 2015/16. However, the data for Global CAMHS shows that approximately 3 in 10 young people are referred to CAMHS for whom CAMHS is not deemed appropriate and therefore require other forms of support.

Table 1: Global referrals received and accepted from 2017/18-2021/22

Year	Referrals Accepted	% accepted	Referrals Not Accepted	% not accepted
2017/18	9852	75%	3273	25%
2018/19	11903	77%	3492	23%
2019/20	10744	71%	4313	29%
2020/ 21	8540	71%	3421	29%
2021/22	11282	72%	4298	28%

Source: HSCB CAMHS Data Reports

Nb. Figures include Step 2, Step 3 (core), Eating Disorders, Crisis and DAMHS services.

The Still Waiting Review also highlighted significant variation in acceptance rates for Step 3/ Core CAMHS across HSCTs during 2013/14 and 2015/16. Due to changes in how services are delivered, and how data is collated, it is no longer possible to review acceptance rates by HSCTs for Step 3 / Core CAMHS. However, a review of all (global) referral acceptance rates shows that in recent years (2020- 2022), there has been less variation in the % of referrals accepted across HSCTs compared to previous years (Table 2).

Table 2: % Global Referrals Accepted by HSCT for period 2017/18- 2021/22

	2017/18	2018/19	2019/20	2020/21	2021/22
Belfast & South Eastern	77	68	63	68	73

Northern	60	82	79	73	73
Southern	79	78	71	75	70
Western	87	92	83	75	72
Region	**75**	**77**	**71**	**71**	**72**

Source: HSCB CAMHS Data Reports
Nb. % is based on referrals to Step 2, Step 3 (core), Eating Disorders, Crisis and DAMHS services.

HSCTs do not track young people who are not accepted for their CAMHS service so are unable to provide data on whether young people access alternative support and what that support is. This was an issue raised in Still Waiting and a specific recommendation was made to track young people moving between services within the Stepped Care Model for CAMHS, to allow the system to monitor the length of time and the pathways taken by young people to access support, to include young people being redirected from Step 3 CAMHS (Rec 47, p.278). This recommendation was linked to the need to consider simplifying referrals processes and pathways to services.

2.2 Referral Types

CAMHS referrals are classified as routine, urgent and emergency. As Table 3 below shows routine referrals which are those which are assessed as requiring an appointment within 9 weeks, continue to make up the largest proportion of referrals to CAMHS. However, in 2021 /22, routine referrals have fallen below 90% for the first time since 2018/19, with emergency and urgent referrals accounting for a greater proportion of referrals made.

Table 3: Referral Types for the period 2014/15-2021/22

	Emergency (%)	Urgent (%)	Routine (%)
2014 /15	9.1	12.6	78.5
2015/16	9.5	11.6	78.9
2018/19	2.6	7	90.4
2019/20	1.9	4.9	93.2
2020/21	3.5	3.9	92.6
2021/22	5.2	8.4	86.4

Source: HSCB CAMHS Data Reports. Includes Step 2, Step 3 (core), Eating Disorders & DAMHS.
The CAMHS Crisis template does not ask for a breakdown of referrals accepted by priority.
* data not available for 2016/17 or 2017/18

2.3 Age and Gender of Accepted Referrals

Table 4 below provides a detailed age and gender breakdown of referrals for the period April 2021-2022. It shows that females accounted for 64% of accepted referrals and males

36% and reflects the pattern seen since 2018/19, although females are steadily increasing as a proportion of all referrals.

Table 4: Age and Gender breakdown of Accepted Referrals 2021/2022

Gender	Age Bands	Step 2	Step 3 (core)	Eating Disorder	DAMHS	Crisis	Total All CAMHS
Female	0-4	20	0	0	0	0	25
	5-11	629	233	15	0	51	928
	12-14	833	1192	101	0	464	2593
	15-17	608	1457	158	10	854	3087
	18+	0	8	0	0	10	23
Male	0-4	16	6	0	0	0	22
	5-11	689	375	0	0	59	1126
	12-14	394	607	16	7	143	1167
	15-17	288	735	12	31	348	1414
	18+	0	0	0	0	0	6
Total All Genders		3481	4622	308	51	1937	10399

Source: HSCB CAMHS Data Reports

NB: Please note individual values may not sum to column/ row totals due to suppression in line with disclosure protocol.

3.0 Active Clients in CAMHS Services

Table 5 below provides the number of active clients across any CAMHS services at 31 March for the years 2017-2022. The figures show that approximately 6000-6700 young people were being seen by a CAMHS Service at any given time.

Table 5: Active Clients in CAMHS Service at 31 March

	Number of active clients
2017	6692
2018	6218
2019	6645
2020	5979
2021	6648
2022	6664

Source: HSCB CAMHS Data Reports

Please note: This figure does not include KOI (Knowing Our Identity) and Family Trauma Centre; Duplication possible-YP may be active in more than one CAMHS service (e.g. ED & Step 3).

Table 6 below provides a breakdown of the number of young people accessing different CAMHS Services at March 2022 and shows the vast majority of clients (92%) were being

seen by Step 2 or 3 Services, with a much smaller number being supported by eating disorder, DAMHS or crisis support services. This reflects the general pattern in referral breakdown seen across the years that data has been provided.

Table 6: Active Clients in CAMHS Services by Trust and Service as at 31 March 2022

	Step 2	Step 3	Eating Disorder	Addictions	Crisis	Total
BHSCT & SE	937	1787	104	40	101	2969
Northern	552	844	67	0	0	1522
Southern	410	924	111	0	0	1445
Western	55	618	35	0		728
Region (n)	**1954**	**4173**	**317**	**73**	**147**	**6664**
Region (%)	**29.3**	**62.6**	**4.8**	**1.1**	**2.2**	**100.0**

Source: HSCB CAMHS Data Reports

NB: *SHSCT delivers Crisis, DAMHS and ID CAMHS within their Step 3 service and reports these four services as a single integrated service under the heading of Step 3. Therefore a breakdown of figures for DAMHS and Crisis are not available for this Trust.

4.0 Referral sources

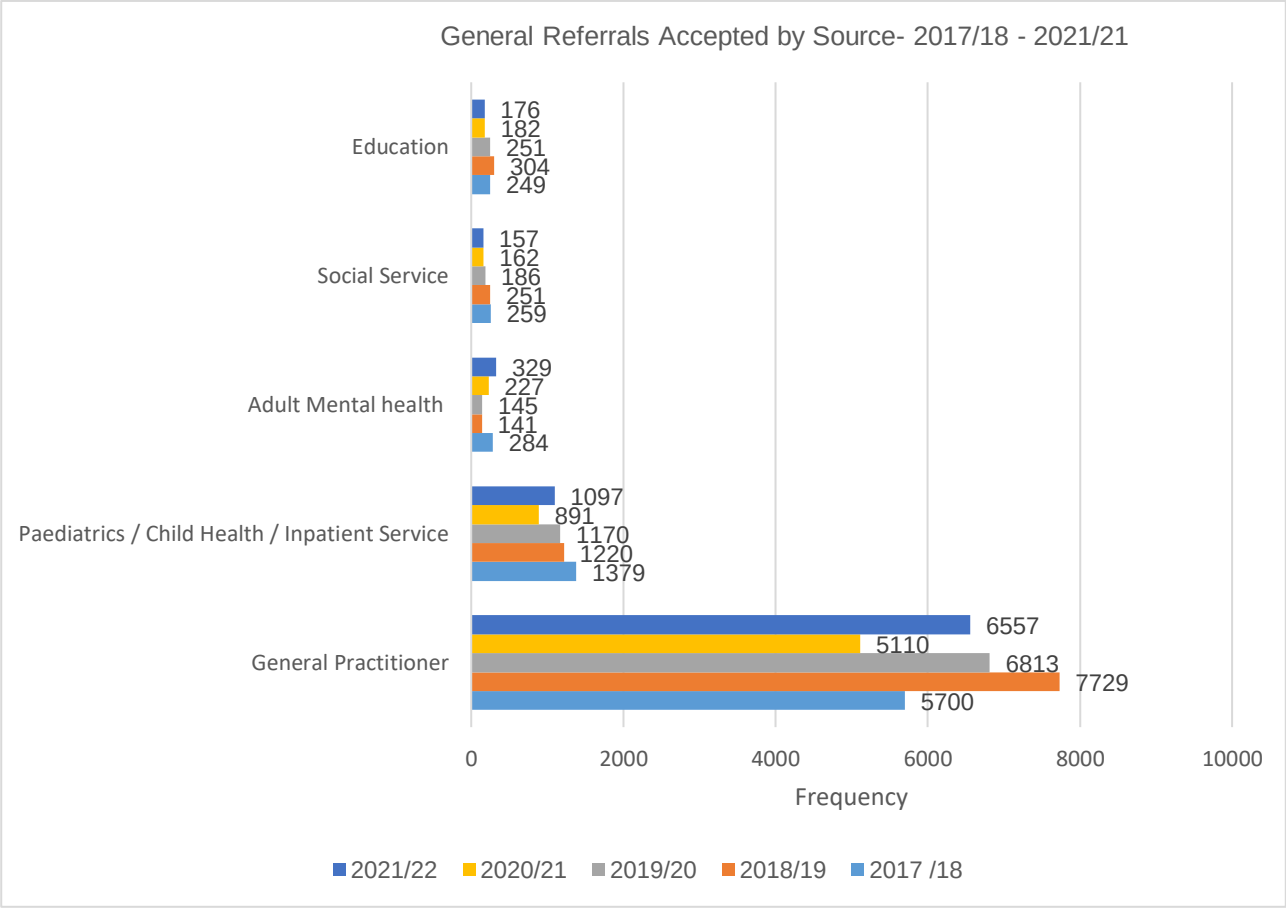
A referral source is the referring agent or team / service which has made a referral to CAMHS. The ongoing predominance of referrals from a small number of accepted sources was raised in Still Waiting, and the report recommended that serious consideration was given to opening up referrals pathways to enable professionals, other than GP, to refer young people to mental health services. The aim being to simplify patient pathways and speed up the referral process. It was also in recognition of the fact that GPs do not always know the young people as well as other professionals such as school counsellor or youth worker and that these alternative professionals may be better placed to provide relevant information to CAMHS (p243). NICCY also made a number of recommendations regarding pathways and referral processes (Rec 2-4, p274).

Figure 2 below shows that across the reporting period, 2017-18 to 2021-22, 'General Practitioner' (GP) accounted for the largest proportion of referrals made to CAMHS, followed by 'paediatrics / child health / in-patient service' as the second most common referral agent group. Whilst there have been slight fluctuations in numbers of CAMHS referrals made by GP, overall, the numbers remain high with most referrals to CAMHS coming via GP. During 2021/ 22, 76% (n=6557) of all referrals came from a GP.

The ongoing predominance of referrals from a small number of accepted sources was

raised in Still Waiting, and the report recommended that serious consideration was given to opening up referrals pathways to enable professionals, other than GP, to refer young people to mental health services. The aim being to simplify patient pathways and speed up the referral process. It was also in recognition of the fact that GPs do not always know the young people as well as other professionals such as school counsellor or youth worker and that these alternative professionals may be better placed to provide relevant information to CAMHS (p243). NICCY also made a number of recommendations regarding pathways and referral processes (Rec 2-4, p274).

Figure 2: Referrals accepted by Source- 2017 /18- 2021/22



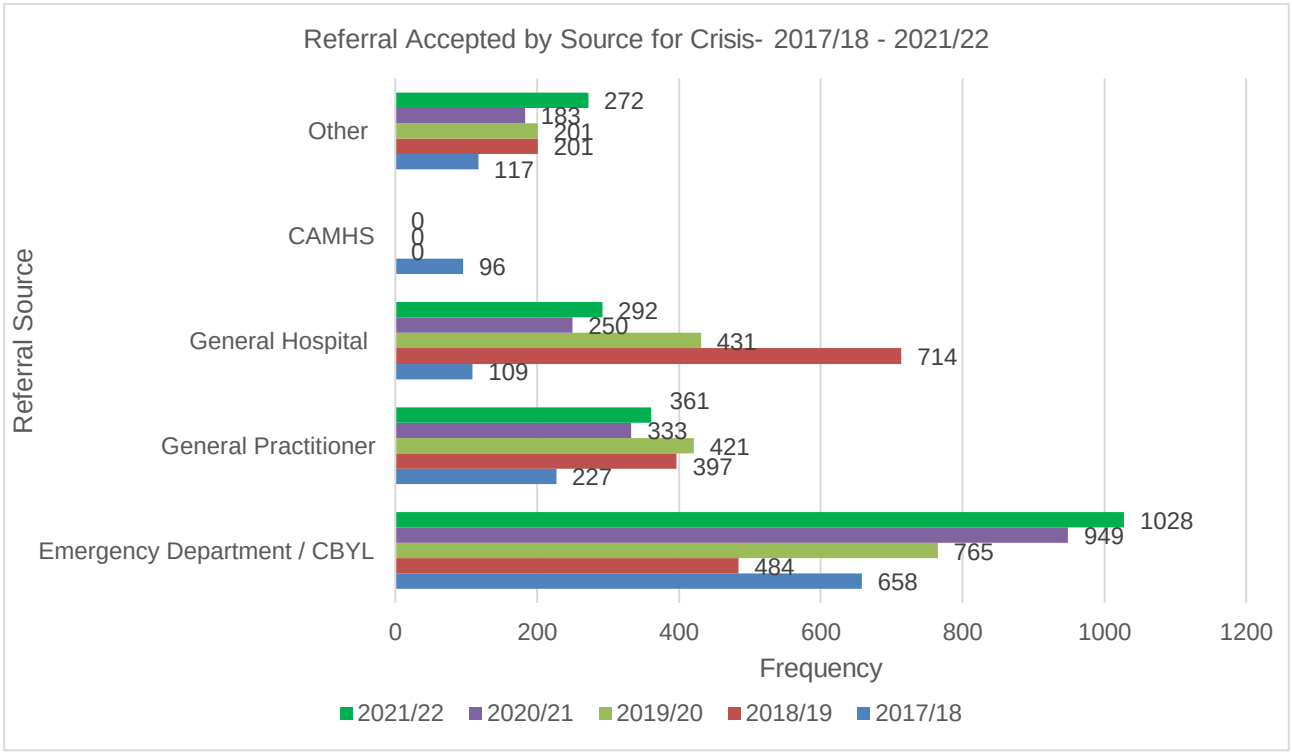
Source: HSCB CAMHS Data Reports
*Data includes Referral sources for Step 2, Step 3 (core), Eating Disorders and DAMHS.

4.1 Crisis Referrals

Figure 3 below shows that since 2018/19, referrals to crisis mental health services continue to predominately come from three sources i.e. Emergency Department, including Card Before You Leave, General Hospital and GP. The presentation of young people with mental health crisis continues to be particularly acute within ED departments, with annual referrals from Emergency Departments increasing year on year. Numbers referred from ED has more than doubled between 2018/19 (n=484) and 2021/22 (n=1028).

These statistics continue to highlight the pressure on emergency services and GPs to deal with mental health crisis; services which are generally not equipped to deal with these cases. In Still Waiting, NICCY made a number of pointed recommendations regarding the need to review crisis support for children and young people (Rec 21-25).

Figure 3: Referrals accepted by Source for crisis care- 2017 /18- 2021/22



Source: HSCB CAMHS Data Reports

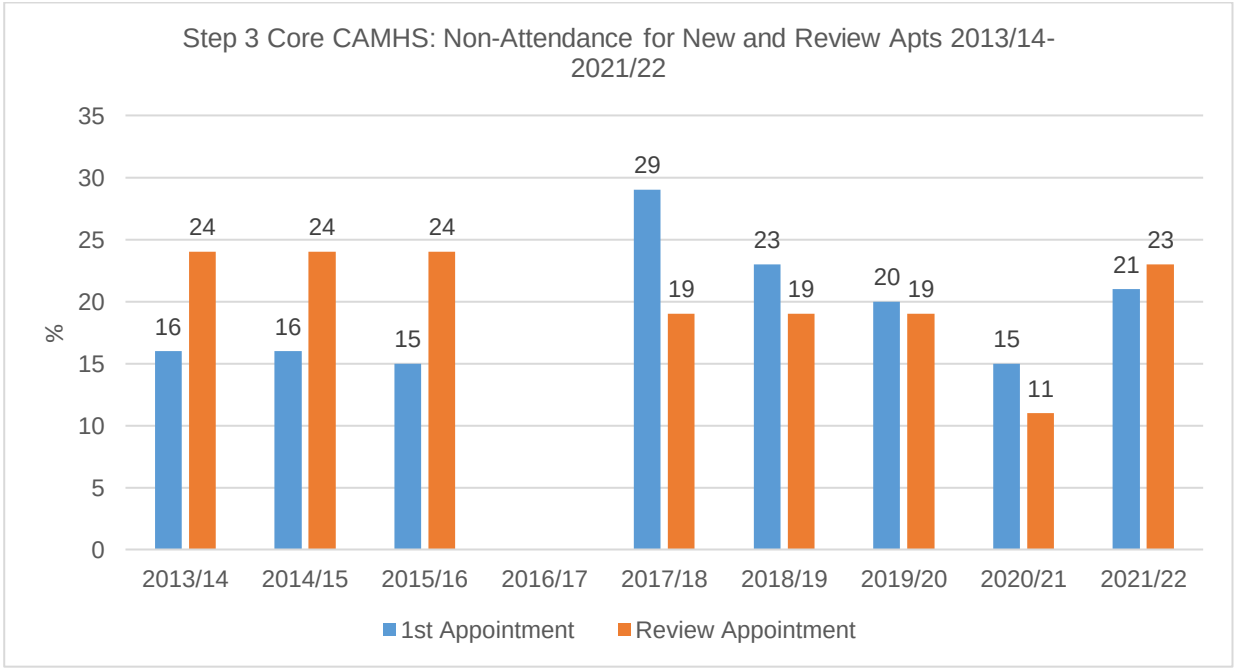
*Card Before You Leave (CBYL) scheme aims to ensure that any patient being discharged from A&E receive a card prior to discharge, giving details of contact numbers for support and details of their follow-up care

5.0 Non-Attendance at CAMHS Appointments

CAMHS record non-attendance at appointments in a number of ways, these are ‘DNA’- did not attend on the day and failed to give advanced notice to the hospital / clinic / professional; ‘CNA'- did not attend but gave advanced notice before the day of the scheduled appointment and ‘CND’- did not attend on the day but gave advanced notice on the day of the scheduled appointment.

Figure 4 below shows the changing pattern of non-attendance at appointments over time, and in general terms shows that it is an ongoing issue. Between 2019/20 and 2020/21 non-attendance has decreased from 20% to 15% for first appointments and from 19% to 11% for review appointments. The fall in non-attendance was also seen in global CAMHS referrals between 2019/20 and 2020 /21 (Figure 5 below). The introduction of more remote / technology-based service delivery was considered a potential factor in this decrease. However, non-attendance figures between 2021 /22 for core CAMHS has seen a substantial increase from 15% to 21% in first appointments and 11% to 23% for review appointments.

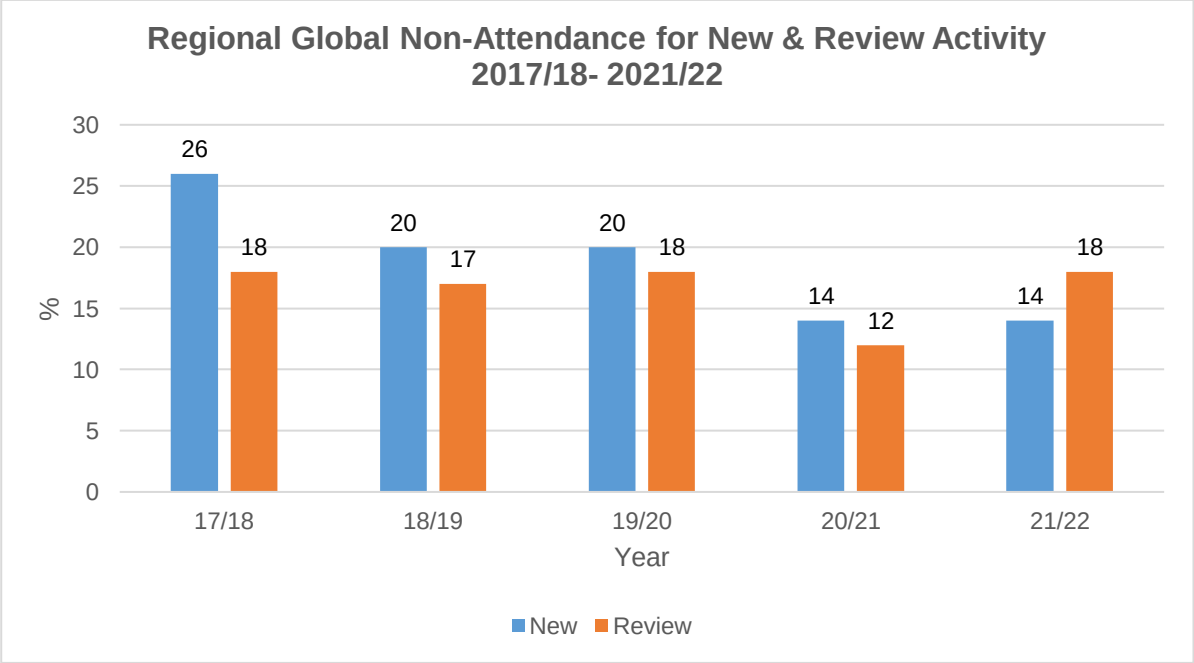
Figure 4: Step 3 Core CAMHS: Non-Attendance for New and Review Apts 2013/14-2021/22



Source: HSCB CAMHS Data Reports

*non-attendance is based on a combination of ‘DNA’, ‘CND’, ‘CNA’.

Figure 5: Regional Global Non-Attendance for New and Review Appointments 2017/18-2021/22



Source: HSCB CAMHS Data Reports
*non-attendance is based on a combination of 'DNA', 'CND' and 'CNA'.

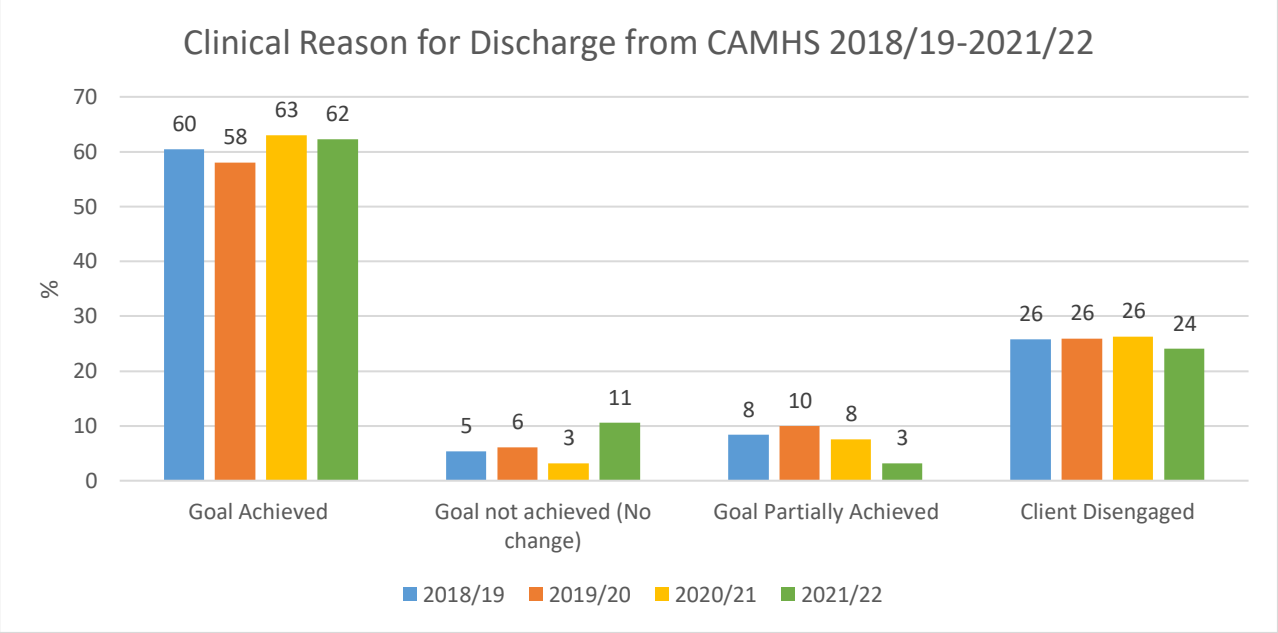
The Still Waiting report recommended that the CAMHS Dataset be augmented to record, monitor and urgently address reasons for non-attendance; record the numbers of young people discharged from CAMHS due to non-attendance, and monitor compliance with IEAP guidance (47 f-g).

6.0 Clinical Reason for Discharge

Data on the clinical reason for discharge has been collected as part of the CAMHS dataset since 2018/19,
Figure 6 below provides data for the period 2018/19 - 2021/22 and shows that broadly speaking the picture has not changed- 60% of the young people were discharged from CAMHS as 'goal was achieved'. The remaining 40% of young people were discharged without their goal being fully achieved and included a quarter that disengaged from the service.

For the year 2021/22, these percentages equate to 7517 young people discharged from a CAMH service, of these young people 4679 were discharged because the 'goal was achieved', however, 1806 (24%) of young people disengaged from the service before treatment or intervention was complete. In Still Waiting, NICCY highlighted the fact that a significant proportion of young people did not find the support they received helpful, although the intention is not to conflate these two measures, they both point to the need for further analysis of the effectiveness of treatment and service models and what changes might usefully be made.

Figure 6: Clinical Reason for Discharge from CAMHS 2018/19-2020/21



Source: HSCB CAMHS Data Reports
*suppression of data minimal for 2018/19 with no effect on % calculation

7.0 Waiting Time for Access to CAMHS

The 9 week waiting time target for a routine appointment at Step 3 / Core CAMHS is calculated from the date of acceptance of the referral to the time the patient is seen and assessed at their first appointment.[5] In Still Waiting, NICCY highlighted that the 9 week waiting time target to access a routine appointment for Step 3 CAMHS can represent a small part of the overall length of time young people are waiting for treatment or care. The

[5] HSCB (2018) Regional CAMHS Services Review Group (CAMHS Dataset), Definitions, Version 9, p10 (3.25-2.36)

report highlighted a number of other critical points along the care pathway where delays can occur, this includes between first appointment and review appointments, the waiting time between the referral being made to Step 3 CAMHS, and the decision being made about whether they are accepted (triage process). On this basis, NICCY made a number of specific recommendations regarding the collection and monitoring of additional waiting time data through the CAMHS Dataset (Rec 47 d).

Table 7 below provides an 9-year overview of the total number of young people waiting for an appointment at Step 3 / Core CAMHS at one time point (March). It also shows the number and percentage of young people waiting more than the statutory 9 weeks waiting time target to access the service. The data shows that the numbers of children being referred to CAMHS and the number waiting beyond 9 wks is increasing.

Table 7: Regional Overview: Step 3 / Core CAMHS Waiting Times 2014-2022

Year	Total no. waiting	Total no. waiting > 9 wk	% waiting > 9 wk
28-Mar-14	934	114	12%
27-Mar-15	1022	99	10%
25-Mar-16	742	19	3%
31-Mar-17	746	77	10%
31-Mar-18	608	46	7.6%
31-Mar-19	967	179	18.5%
31-Mar-20	1205	552	46%
31-Mar-21	667	167	25%
31-Mar- 22	1151	545	47%

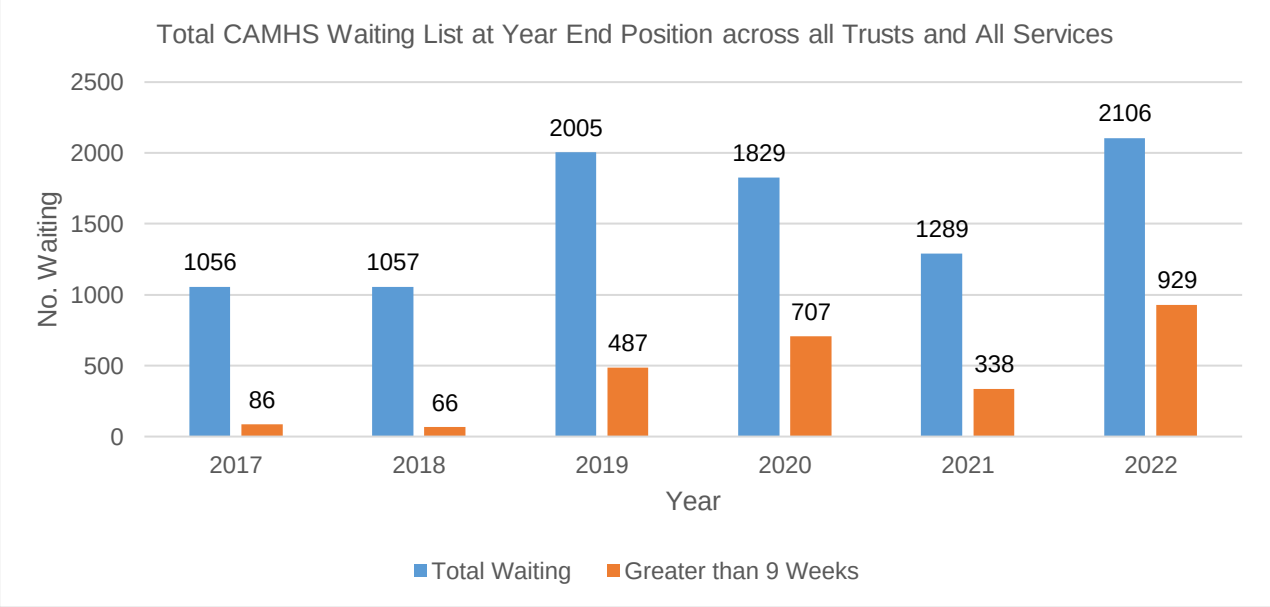
Source: HSCB CAMHS Data Reports

In general, across the period that NICCY has been collecting data, the majority of waiting times, including breaches of the 9-week waiting time target, have been for Step 2 and Step 3 (core) services. A relatively small number of young people, if any at all, have waited to access Eating Disorder Services, DAMHS, Crisis Service or Family Trauma Centre.

Figure 7 below shows the waiting times for children and young people to access any CAMHS service in NI at 31st March for the years 2017-2022. Between March 2021 and March 2022, the number of young people waiting for any CAMHS service increased from 1289 to 2106 (817 more young people waiting), the number waiting more than 9 weeks to access CAMHS also increased from 338 to 929 (equating to 591 more young people waiting more than 9 weeks). At March 2022, the overall number of children waiting for

CAMHS is the highest number it has been since NICCY started monitoring waiting times in 2017.

Figure 7: Total CAMHS Waiting List at Year End Position across all Trusts and All Services at March 2021



Source: HSCB CAMHS Data Reports

Table 8 below provides numbers waiting by service area and HSCT at March 2022. It shows that across all the HSCTs waits are predominately for Step 2 and 3 services. In comparison with March 2021 numbers waiting have increased substantially across all HSCTs apart from the SHSCT which has seen the smallest increase.

Table 8: Numbers waiting by service area and Trust at March 2022

CAMHS Service	BHSCT/ SET	Northern	Southern	Western	Total
Step 2	101	466	114	184	865
Step 3	489	200	159	303	1151
Eating Disorder Services	17	7	9	10	43
DAMHS	0	0	0	0	0
Crisis	0	0	0	0	0
Family Trauma Centre	43	0	0	0	43
Grand Total	**652**	**673**	**282**	**499**	**2106**

Source: HSCB CAMHS Data Reports

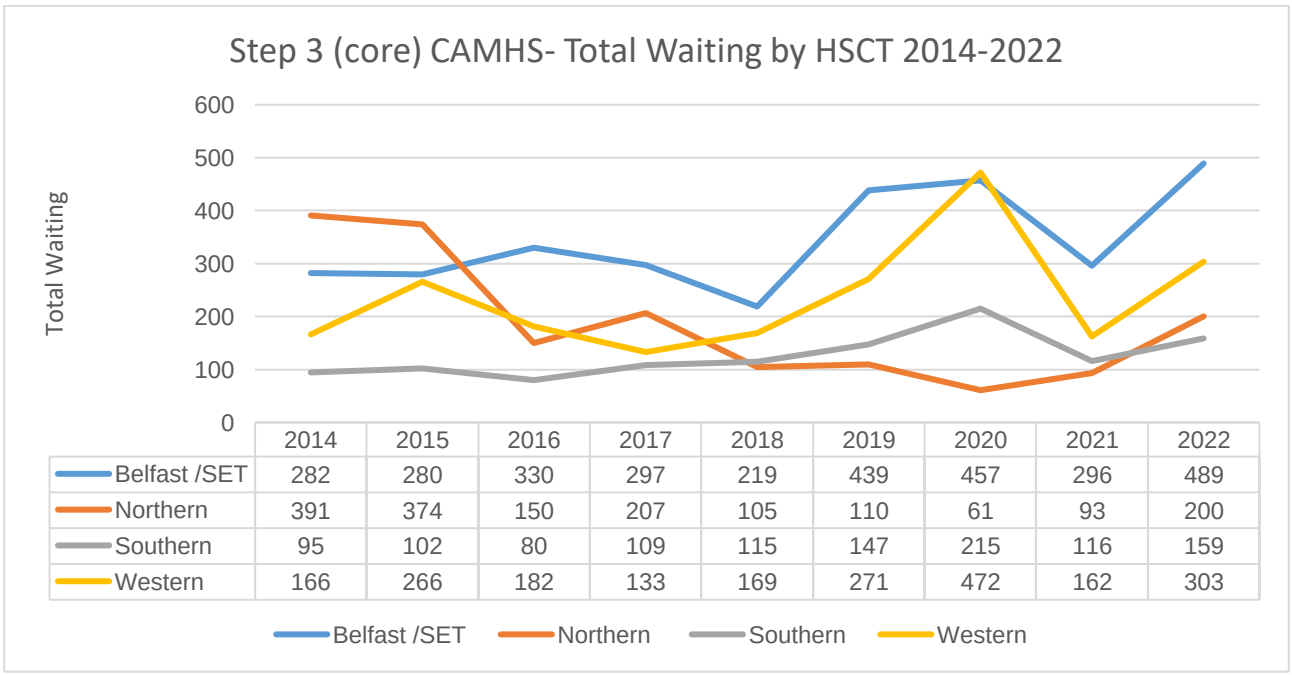
*Figures less than 10 are not disaggregated to maintain anonymity.

NB: Individual values may not sum to column/ row totals due to suppression in line with disclosure protocol.

After a decrease in total numbers waiting between 2020 and 2021, the numbers waiting at March 2022 represent a significant increase compared to the year before. There are differences in extent of changes seen between 2021- 2022 across HSCTs, the SHSCT had the smallest increase in lists and the WHSCT and BHSCT / SEHSCT the biggest increases.

Figure 8 below shows how waiting lists for Step 3 (Core) CAMHS have changed within each HSCT at 31st March between 2014-2022. After a decrease in total numbers waiting between 2020 and 2021, the numbers waiting at March 2022 represent a significant increase compared to the year before. There are differences in extent of changes seen between 2021- 2022 across HSCTs, the SHSCT had the smallest increase in lists and the WHSCT and BHSCT / SEHSCT the biggest increases.

Figure 8: Step 3 / Core CAMHS: Numbers Waiting by HSCT 2014-2022 (at 31 March)

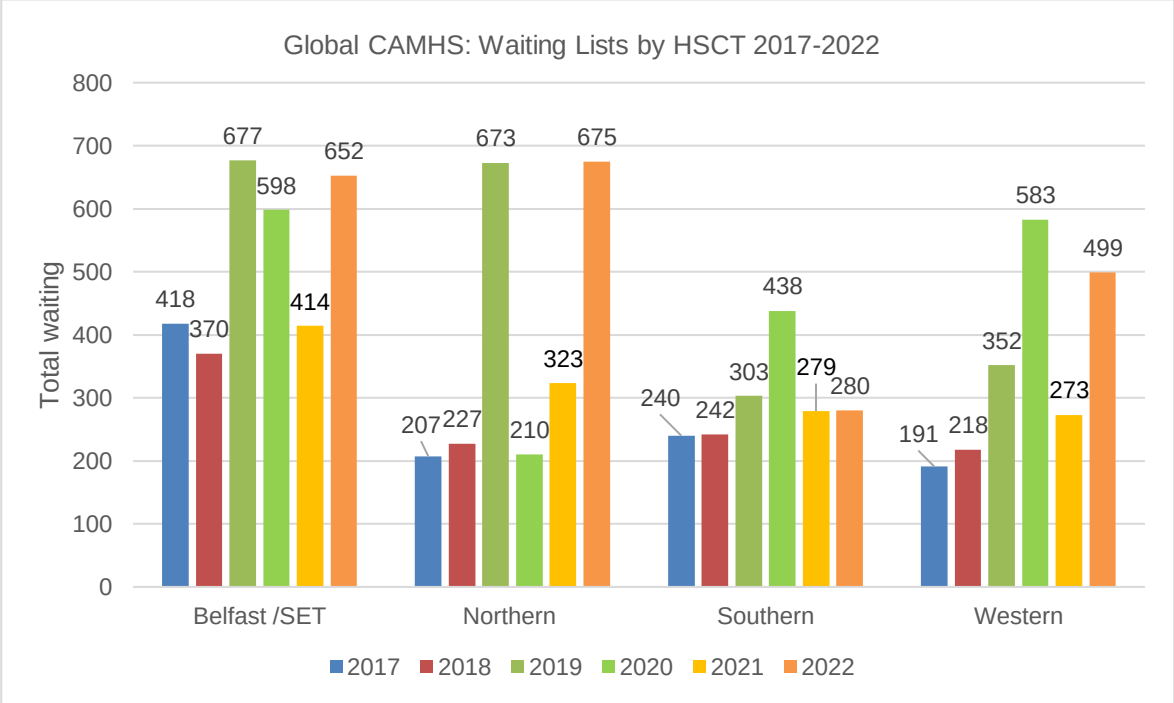


	2014	2015	2016	2017	2018	2019	2020	2021	2022
Belfast /SET	282	280	330	297	219	439	457	296	489
Northern	391	374	150	207	105	110	61	93	200
Southern	95	102	80	109	115	147	215	116	159
Western	166	266	182	133	169	271	472	162	303

Source: HSCB CAMHS Data Reports

Figure 9 below provides an overview of waiting lists across all CAMHS areas and shows a noticeable increase in numbers of young people waiting for services between 2021 and 2022 across all HSCTs other than SHSCT.

Figure 9: Global CAMHS: Waiting Lists by HSCT 2017-2022



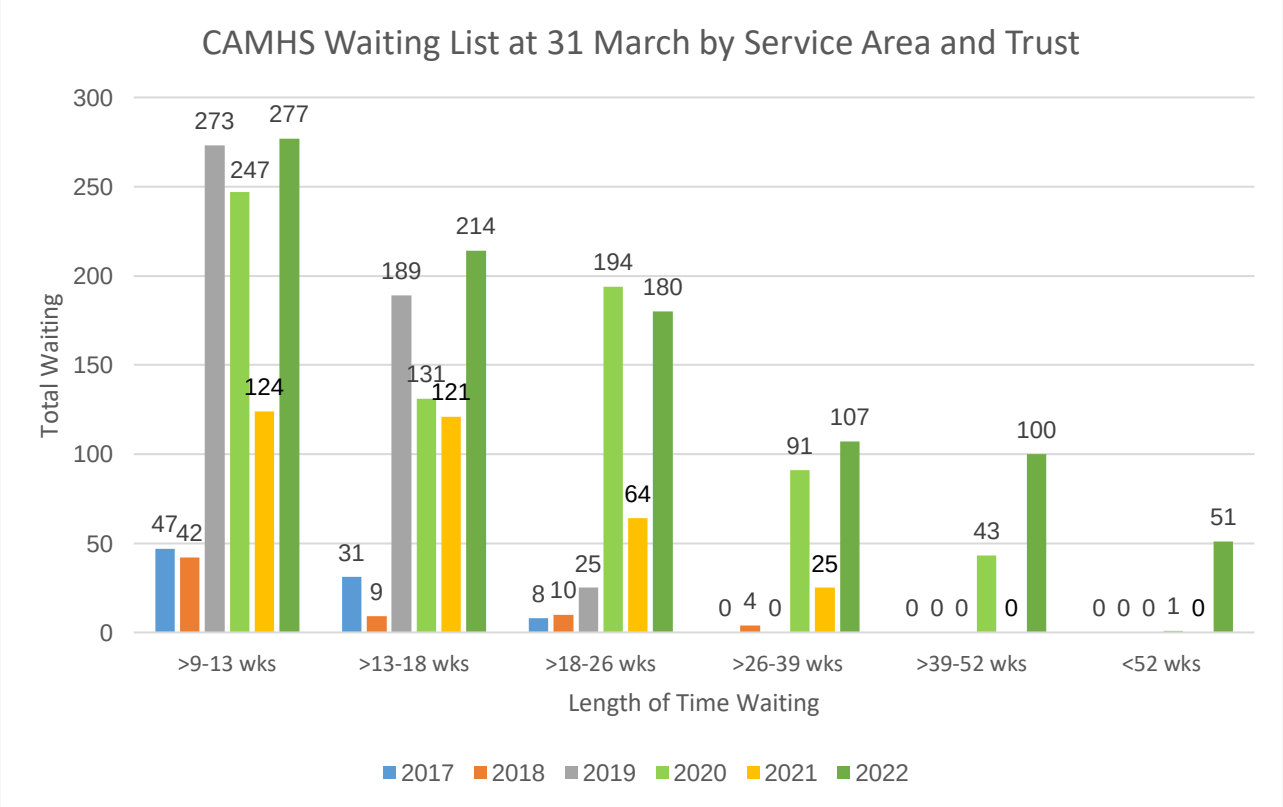
Source: HSCB CAMHS Data Reports

7.1 Length of Time Waiting for CAMHS

The 9-week waiting time target has been a ministerial target for many years and is included as part of the yearly Commissioning Plan Directive.

Figure 10 below provides a detailed breakdown of the length of time young people were waiting for a first appointment between 2017-2022 and shows more young people waiting longer lengths of time, with some young people waiting over 52 weeks for a first appointment.

Figure 10: Global CAMHS Waiting List (Greater than 9 wks) 2017-2022



Source: HSCB CAMHS Data Reports

8.0 Anti-depressant Prescriptions for under 18s

Table 9 below provides an overview of the number of children prescribed anti-depressants between 2018 and 2021, and the number of prescriptions dispensed across the same period**. The data shows that while the number of children in receipt of medication has remained steady overall, there has been a small decrease in the number of under 12s in receipt of these medications. Similarly, the number of anti-depressants prescriptions being administered every year in Northern Ireland has remained steady, while the number provided for children under 12 has decreased significantly.** In 2021, 17,430 prescriptions were dispensed to 2915 under 18s in Northern Ireland, this includes 573 prescriptions to 118 children under the age of 12.

In Still Waiting, NICCY highlighted that between 2014-2017, children in Northern Ireland were being prescribed anti-depressant medication that was not recommended by National Institute for Clinical Excellence (NICE), including drugs that had not been trialled with young people, and those that NICE recommends should not be used in the treatment of depression in children and young people (p258).

The data for 2018-2021 shows a list of at least 11 anti-depressant drugs being prescribed to under 18s. Whilst the majority of children are being prescribed one of the three drugs recommended by NICE i.e. Fluoxetine, Sertraline, and Citalopram. **Fluoxetine remains the only antidepressant for which clinical trial evidence shows that the benefits outweigh the risks.** Venlafaxine is also still being prescribed to children despite it not being recommended by NICE, although it is important to note that the number of prescriptions are falling.

Table 9: Anti-depressant prescribing data for under 18s for period 2018-2021

	No. of prescriptions to under 18s	No. of children under 18s in receipt of medication	No. of prescriptions to under 12's	No. of children under 12's in receipt of medication
2018	13,233	2789	585	130
2019	16,864	3070	802	141
2020	17,981	2950	822	140

2021	17,430	2915	573	118

BSO Data Requests

8.1 Waiting Time for Access to Psychological Therapies

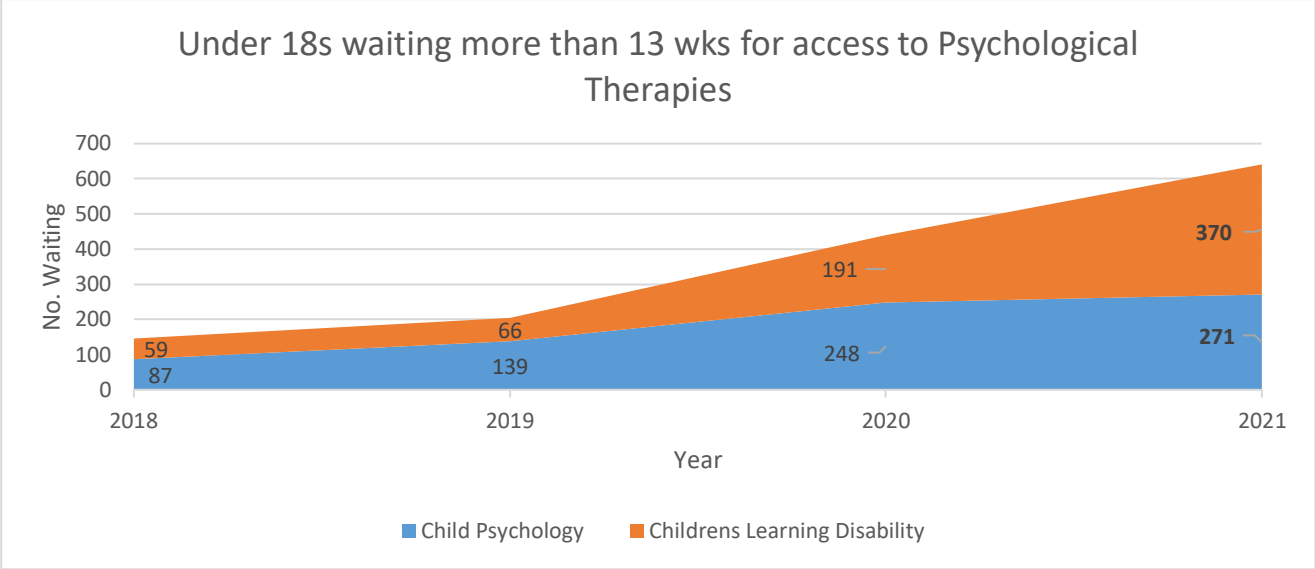
Waiting times for access to psychological therapies is an important indicator of how accessible and responsive mental health services are for young people. The Committee on the Rights of the Child and NICE guidelines are clear that prescribing anti-depressant medication to children should be a measure of last resort (Still Waiting Report-Rec 14, p275).

Data from Figure 11 below was extracted from information provided as part of HSCB Board meetings and shows the number of under 18s waiting more than 13 weeks for access to psychological therapies for child psychology and children's learning disability. [6] Unfortunately, with the dissolution of the HSCB, access to more up to date waiting time figures for psychological therapies is no longer available.

Figures for 2018-2021 were showing that the number of children waiting for these services had increased and that there has been a significant increase in waiting times for children's learning disability services. It must also be noted that whilst the data available from HSCB Board meeting minutes are useful, they have only ever provided a partial picture, as it does not include the full range of child psychological therapy services that children are waiting for.

Figure 11: Number of under 18s waiting more than 13 wks for access to Child Health and Child Learning Disability Psychological Therapies

[6] HSCB Board Meetings 2021 - HSCB (hscni.net)

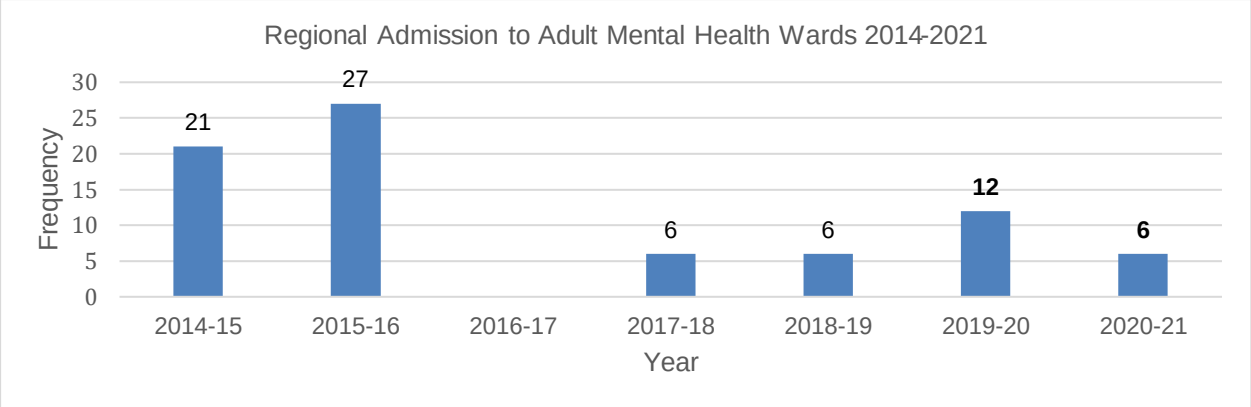


*Source: HSCB Board Minutes- Performance Reports * All dates are for March, apart from 2021 which is April. Please note some of those receiving services may be over 18th if therapy started before 18th birthday.

9.0 Under 18 admissions to adult wards

Figure 12 below, shows the number of under 18s admitted to adult wards increased to 12 in 2019/20 from 6 the year before. However, the reported number of admissions to adult mental health wards has decreased to 6 again in 2020 /21.

Figure 12: Regional Admission to Adult Mental health Wards



Source: RQIA * Data not available for 2016/17 or 2021/22

Table 10 below outlines the length of stay and number of repeat admissions of under 18s to adult mental health wards between 2014/15 and 2020 / 21. It shows that the average length of stay has fallen from 11 days in 2018-19 to 8 days in 2020-21, the minimum and maximum length of stay has also decreased across this period. Whilst there were no repeat admissions in 2020-21, there was 5 readmissions in 2019-20 relating to 2 young people.

Table 10: Under 18s in adult mental health wards: length of stay & repeat admissions (regional figs)

Year	Average length of stay (Days)	Minimum/ Maximum Stay	No. of repeat admissions
2014-15	17	1- 100 days	<5
2015-16	7	2- 26 days	6
2016-17	12.5	4-21 days	0
2017-18	12	2-25 days	0
2018-19	23	8-48 days	0
2019-20	11	2- 35 days	5
2020-21	8	3-27 days	0

Source: RQIA. Data not available for 2021/22

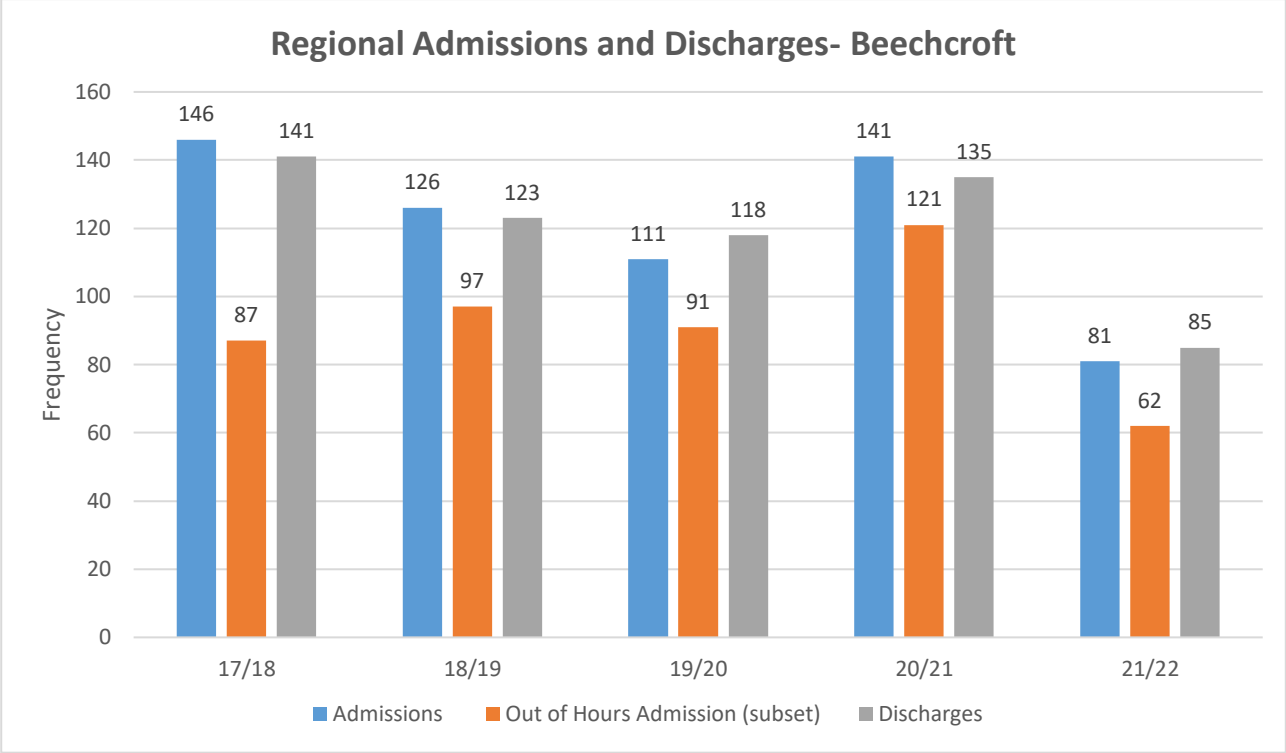
^ one young person remained in an adult ward for 48 days which raised the average to 23 in 2018/19

The data in relation to under 18s being admitted to adult mental health wards was not available for 2021-22, as RQIA have undertaken a review of Article 118 data and found significant inaccuracies in the data received from the HSCTs. RQIA have therefore agreed a quality improvement approach to ensure future HSCT returns are accurate and provide a clear picture of admissions that fall within the definition of Article 118.

10.0 Beechcroft

Beechcroft is the regional child and adolescent mental health inpatient facility in Northern Ireland. Figure 13 below shows the annual admission and discharges from Beechcroft between 2017 / 2018 and 2021 / 2022. The number of admissions (to include out of hours admissions) and discharges have seen a noticeable decrease between 2020/21 and 2021/22.

Figure 13: Beechcroft Admissions and Discharges 2017/18-2021/22



Source: HSCB CAMHS Data Reports
Please note: out of hour admission figures shown are a subset of Admissions.

Table 11 below provides an overview of activity in Beechcroft at 31 March for the years 2017-2022.

Table 11: In-patient numbers, delayed discharges and length of stay 2017-2022

			Length of Stay			
At 31st March	Inpatient Numbers	Delayed Discharges	0-7 days	8-90 days	91-365 days	>365 days
2017	29	1	6	14	6	3
2018	29	1	5	13	9	2
2019	29	5	2	20	5	2
2020	19	0	0	12	0	0
2021	24	0	0	16	0	0
2022	20	0	0	9	10	0

Source: HSCB CAMHS Data Reports. NB: Please note individual values may not sum to column/ row totals due to suppression in line with disclosure protocol.

11.0 Iveagh Centre

The Iveagh Centre is a six bed, acute (Step 4 – 5), short term, multidisciplinary inpatient assessment and treatment service for children and young people up to the age of 18, who have a learning disability, additional mental health difficulties, and who may display associated complex patterns of behaviour. The service is commissioned to cover all HSCT areas.

Table 12 below shows the number of inpatients and length of stay and discharges between 2019-2022. It shows that the number of children being treated in Iveagh in 2022 returned to a similar level as in 2019-20. Table 12 shows that it was working at full capacity at March 2022 and that, unlike previous years, the length of stay for half of inpatients was less than 90 days. This is a welcome change.

Table 12: Inpatient numbers, length of stay and discharges

At 31st March	Inpatient Numbers	0-7 days	8-90 days	91-365 days	>365 days	Number of repeat admissions
2019	7	0	0	4	3	0
2020	6	0	0	1	5	2
2021	4	0	0	1	3	0
2022	6	1	2	1	2	0

Source: BHSCT

Table 13 below outlines the number and length of delayed discharge at Iveagh Centre. Overall, it reports delayed discharge and inpatient stays which extend into years. The average stay had previously reached an extraordinary 924 days in 2021, although this related to one young person. It is important to note that the Iveagh Centre is a hospital therefore stays of 1-2 years is completely out of line with its service specification. In all cases the reason for delayed discharge was due to a domiciliary care package in community not being in place and / or a lack of community intensive support. While the maximum delay in 2022 was 583 days, the average had dropped to 197 days, considerably lower than the previous two years.

Table 13: Number and Length of delayed discharge at Iveagh (in days)

At 31st March	Number of Delayed Discharges	Minimum	Maximum	Average
2019	4	131	397	228
2020	3	559	763	627
2021	1	924	924	924
2022	3	2	583	197

Source: BHSCT

12.0 Extra Contractual Referrals (ECRs)

An Extra Contractual Referral (ECR) occurs when a child or young person is transferred to an inpatient facility outside of Northern Ireland for specialist clinical treatment or therapeutic care/ interventions which are not available in Northern Ireland. Under an ECR, young people are usually provided with healthcare as an inpatient in Britain or the Republic of Ireland. The data below was provided by the HSCB and refers to all ECR applications received by them between 2014/15 and 2021/22.[7] Overall, the number of ECRs year to year can vary and are usually in single figures. Given the small numbers involved and the potential for identification of individual children, the data below is an aggregation of key information from 2014-2022. Please note: NICCY's original request asked for a breakdown of young people transferred from in-patient, community settings and between HSCTs. However, the HSCB stated that they do not record this level of information centrally.

Table 12 below shows the number of 'ECR placements' and 'in year admissions' between 2014/15 and 2021/22. It shows that the number of children transferred to an in-patient facility outside of NI has ranged between 14 and 20. The number of ECR placements had been reducing, with 2020/21 recording the lowest number of placements at 14. However, 2021 /22 figures have shown an increase to 20. The table also shows that since 2014/ 15, annually there have been between 1-9 'in-year admissions' to a facility outside of NI under ECR. The total annual cost of ECRs have ranged between £2.5 million and 7 million and for the most recent year 2021-22, the annual cost was £6,848,934.

Table 12: Non Acute Family and Child Care ECRs included for 2014/15-2021-22

Year	No. of ECR Placements	No. of In Year Admissions	Total Cost

[7] Annual updated ECR Data Report provided to NICCY by HSCB- 22.11.22

2014/15	18	<10	£3,696,110
2015/16	20	<10	£3,390,734
2016/17	15	<10	£2,387,103
2017/18	17	11	£4,364,790
2018/19	18	<10	£6,951,533
2019/20	15	<10	£5,441,996
2020/21	14	<10	£5,384,574
2021/22	20	<10	£6,848,934

Source: HSCB

12.1 ECR- Clinical Reason for Referral

When a HSCT makes an ECR referral request one of the main conditions is that it is deemed the best clinical option for a child or young person. ECRs are recorded in terms of primary presenting condition, however children and young people transferred under an ECR can often have a significant number of needs including social complexity, emotional and mental health and various disabilities, therefore any support is premised on the specific needs of the child rather than being condition led.[8]

Between 2014/15 and 2021/22 the primary presenting conditions of the young people referred under an ECR are listed in Table 13. They include a range of developmental and learning disabilities, along with eating disorder and co-occurring mental health and substance use problems.

Table 13: Primary condition of young people referred under an ECR between 2014/15 and 2021/22

1. Acquired Brain Injury	6. Challenging Behaviour
2. Autism Spectrum Disorder	7. Complex Behaviour
3. Attachment Disorder / Complex Trauma	8. Eating Disorder
4. CAMHS	9. Learning Disability
5. CAMHS/Opiate Abuse	

Source: HSCB

12.2 ECR- Age Range & Length of Admission

Due to concerns about identifying individual children the HSCB cannot provide a detailed age breakdown for children subject to ECRs, however, they have confirmed that the

[8] ibid

majority of children transferred under an ECR are in their teens, this includes the most recent year 2021/22.

The purpose of an ECR is for children to be provided with specialist assessment and treatment for their primary health condition within a time limited period. The process is not intended to fund long term placements. The Board expects children to be repatriated by HSC Trust to NI at the earliest opportunity. Table 14 below shows that there is a significant range in the minimum, maximum and average length of time young people are treated out of jurisdiction. Since 2014 the average length of stay for ECRs is 248 days, the minimum was 4 days and the maximum was 1,826 days (5 years).

Table 14: Length of admissions i.e. (average, maximum and minimum) 2014/15-2021/22

Number of days		
Average: 248	Minimum: 4	Maximum: 1826 (5 years)

Source: HSCB

13.0 Gaps in CAMHS Dataset

There continues to be a range of data that HSCB and HSCT agree should be part of the CAMHS Dataset, but which data is not yet available for. This includes information on child reported and family reported outcomes, number of young people transitioning to Adult Mental Health Services (AMHS), number of young people transitioning to AMHS who have a transition plan in place, presenting need, core care interventions received, and re-referrals within 4 weeks of discharge. These all represent critically important key performance indicators which need to be collected on a regional basis.

Still Waiting also recommended that the CAMHS Dataset should be augmented to include the following data, to date no data is available on these areas which are listed below.

47 (b) The specific reasons for referrals not being accepted to Step 3 CAMHS.

47 (d) Collection and monitoring of additional waiting time statistics:

i. Waiting times between referral being made and referral being accepted or not accepted;
ii. Waiting times for second appointment to Step 3 CAMHS.

47 (d) iv. Waiting times for access to psychological therapies;

47 (e) Data on the types of psychological therapies and alternative therapies used as part of young people's treatment plan.

47 (f) The reasons for DNAs/CNAs should be recorded and monitored. Specific attention must be given urgently to addressing the reasons for non-attendance.

47 (g) Record the numbers of young people who are discharged from CAMHS due to DNA/CNA and monitor compliance with IEAP guidance.

47 (j) A greater range of demographic information for specific groups of young people should be collected e.g. those with a physical, learning, sensory disability, looked after children; LGBT children; Newcomer and Separated Children.

47 (i) Discharge destinations of young people admitted to adult mental health wards should be recorded and monitored. (available from RQIA but should be incorporated into CAMHS Dataset)

48. A greater depth of information regarding patient experiences and outcomes should be collected and monitored, including outcomes defined by, and important to' young people e.g. improvements in relationships with friends and family - in addition to psychometric scores of mental health.

50. When a young person is admitted to a general paediatric bed for mental health treatment or care, the DoH should request that RQIA are notified, and provided with information on what care and treatment is being provided.

Attendances of under 18 year olds at each Emergency Care Department in Northern Ireland, in which mental-ill health was a presenting issue.[9]

14.0 Conclusion

The amount and quality of standardised regional child and adolescent mental health data being collected across the system has been maintained, and this is welcomed. However, there continues to be significant gaps in what is available in the public domain**. The recommendation from the Still Waiting Review to publish standardised regional**

[9] NICCY requested data from the Department for Health pertaining to this issue in 2020. We have no reason to believe administrative systems have changed, therefore we have not reissued a request for information for this 2022 report. In 2020, we were informed that *'It is not currently possible for HSC Trusts to provide the reason for attendance to the Department, as the administrative systems in use do not hold diagnostic information in a standardised format.' (emailed dated 17.09.2020).*

CAMHS data remains outstanding and has been repeated by the Office for Statistics Regulation (OSR) in its review of mental health data in Northern Ireland published in 2021. The OSR highlighted the need for improvements in the type, quality and accessibility of data. **The OSR report concluded that statistics and data should be equally available to all and published at a sufficient level of detail that is practicable for meeting user needs.[10] It is important that mental health statistics are released in line with other health statistical reporting and we urge the Department of Health to progress this.**

[10] Review of mental health statistics in Northern Ireland – Office for Statistics Regulation (statisticsauthority.gov.uk)