Review of CAMHS Data from 2013-2020

This report is a standalone document, however further reflections and analysis of the data is available from NICCYs second monitoring report on the progress of implementation on the recommendations from the ‘Still Waiting’ Review. All documents are available from [Mental Health Review - Still Waiting (niccy.org)](https://www.niccy.org/StillWaiting)

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NICCY published ‘Still Waiting’- A Rights Based Review of Mental Health Services and Support in Northern Ireland 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 which covered CAMHS service activity data was a key aspect of the review and early scoping work in this area found limited publically available official information and what was collected was not centrally held but fragmented across different parts of the system. The ‘Still Waiting’ review further explored this area and 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.

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.[[1]](#footnote-1) One of the outstanding recommendations is to publish a comprehensive CAMHS Dataset in line with other health statistical reporting (Rec 47, p278).

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]](#footnote-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 -2019/2020, much of which is not in the public domain and had to be requested. Unless stated otherwise, the data used originated from CAMHS Update reports provided to NICCY from the HSCB between 2017-2020. In the absence of easily accessible, publicly available data, NICCY is publishing this report for those with an interest in this area. The areas covered in this paper include CAMHS service activity data such as referral received and accepted across CAMHS specialisms, waiting lists 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 18’s, admission to adult wards and extra-contractual referrals on mental health grounds.

Whilst this report is a standalone document, further reflections and analysis of the data contained in it is available from NICCYs second monitoring report on the progress of implementation on the recommendations from the ‘Still Waiting’ Review which is available from the [Still Waiting page of NICCYs website](https://www.niccy.org/StillWaiting).

Due to a lack of outcomes data collected by the system, the data contained in this report is mainly service activity data and therefore process focused. Furthermore, the effect of covid-19 on key service activity is not captured as the data doesn’t extend beyond March 2020, however, this will be included in any future CAMHS Data reporting and NICCY will also be publishing a covid specific report in 2021, which will consider the impact on children’s access to mental health services.

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1.0 Definitions

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

**Child and Adolescent Mental Health Services (CAMHS) is the overarching service provided by HSCTs encompassing the teams detailed below:[[3]](#footnote-3)**

**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.
* Service level data provided to us for Belfast and SEHST is amalgamated. 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 over the three-year period 2017-18 and 2019-20. It shows that referrals continue to increase with a significant increase between 2017/8 and 2018/19 from 13,125 to 15,395 with a levelling off between 2018/19 and 2019/20 from 15,395 referrals to 15,057.

The rise in demand for CAMHS between 2017/18 and 2018/19 has been put down to three main factors: ” 1) the reduction over time in community and voluntary sector provision which would have provided an appropriate alternative to CAMHS; 2) greater public awareness of children and young people’s mental health generally; 3) the mental health of children and young people would seem to be getting worse rather than improving.”[[4]](#footnote-4)

2.1 CAMHS Referrals Received and Accepted

Figure 1: All CAMHS Referrals Received 2017/18- 2019/20

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 addressing potential problems with the referral process (Rec 3, p274).

We are unable to provide an update on non-acceptance rates specifically for Step 3 /Core CAMHS for 2016/17 onwards in this report as this data is no longer available. The HSCB have informed us that due to a re-configuration of services and the introduction of a single point of referral mechanism, they are unable to differentiate number of referrals received between Step 2, Step 3 / Core, Eating Disorder, Crisis Response Home Treatment (CRHT) & Drug and Alcohol Mental Health Service (DAMHS).

We can report on the number of ‘global referrals’ received and accepted from 2017 onwards. 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). Table 1 shows that between 2017/18 and 2019/20 the % of referrals not-accepted ranged between 25-29%.

Table 1: Global referrals’ received and accepted from 2017/18-2019/20

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 |

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

The data shows that there are a significant number of young people referred to CAMHS for whom CAMHS is not deemed appropriate and therefore require other forms of support.

The Still Waiting Review also highlighted significant variation in acceptance rates for Step 3/ Core CAMHS across HSCTs during 2013/14 and 2015/16. Although we can no longer extrapolate comparable data for future years for this specific service, a review of all (global) referral acceptance rates shows variation in the % of referrals accepted across HSCTs. For example, in 2019/20 the Belfast and South Eastern Trust had an acceptance rate of 63% compared to 83% acceptance in the Western Trust (regional average, 71% Table 2)

Table 2: % Global Referrals Accepted by HSCT for period 2017/18- 2019/20

|  |  |  |  |
| --- | --- | --- | --- |
|  | **2017/18** | **2018/19** | **2019/20** |
| Belfast & South Eastern | 77 | 68 | 63 |
| Northern | 60 | 82 | 79 |
| Southern | 79 | 78 | 71 |
| Western | 87 | 92 | 83 |
| **Region** | **75** | **77** | **71** |

Nb. % is based on referrals to Step 2, Step 3 (core), Eating Disorders, Crisis and DAMHS services.

Referrals not being accepted by CAMHS has implications for the demand for other services and support such as those provided in Step 2 and the Voluntary and Community Sector. None of the HSCTs track young people who are not accepted for their CAMHS service so is unable to provide statistics 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, which would allow the system to monitor the length of time and the pathways required for young people to access support, to include young people not accepted for referral to Step 3 CAMHS (Rec 47, p.278).

2.2 Referral Types

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 (Table 3). In 2014 /15, routine referrals accounted for 79% of all referrals and this increased to 93% in 2019/20. Figures regarding emergency and urgent referrals are showing a downward trajectory since 2014/15. The reason for this is unclear but may have something to do with the introduction of the CAIT / CRHT service.

Table 3: Referral Types for the period 2014/15-2019/20

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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 |
| \* data not available for 2016/17 or 2017/18 | | | |

\* Includes Step 2, Step 3 (core), Eating Disorders & DAMHS. The CAMHS Crisis template does not ask for a breakdown of referrals accepted by priority.

\*HSCB unable to validate all figures as referrals by priority were not provided in reports for 2014/15 and 2015/16

2.3 Age and Gender of Accepted Referrals

Table 4 provides a detailed age and gender breakdown of referrals for the period April 2019-2020. Its show that slightly more females (54%) than males (46%) were seen by CAMHS (accepted referrals). The data also shows gender differences in referrals to specialist services- females are more likely to be referred to eating disorder services and crisis support than males. Males are more likely to be referred to DAMHS and to be referred to CAMHS at a younger age.

Table 4: Age and Gender breakdown of Accepted Referrals 2019/20



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 2017-2020. 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 |

Table 6 provides a breakdown of the number of young people accessing different CAMHS Services at March 2020 and shows that 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.

Table 6: Active Clients in CAMHS Services by Trust and Service as at 31 March 2020

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Step 2** | **Step 3 (core)** | **Eating Disorder** | **DAMHS** | **Crisis** | **Total** |
| BHSCT & SET | 667 | | 1334 | 57 | 66 | 37 | 2161 |
| Northern | 349 | | 853 | 64 | 16 | 30 | 1312 |
| Southern | 369 | | 807 | 54 | - | - | 1230 |
| Western | 116 | | 991 | 64 | 28 | 77 | 1276 |
| **Region (n)** | **1501** | | **3985** | **239** | **110** | **144** | **5979** |
| **Region (%)** | **25.1** | | **66.6** | **4.0** | **1.8** | **2.4** | **100.0** |

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

The referral source is the referring agent or team / service which has made the referral to CAMHS. Information from 2017/18-2019/20 shows a list of 13 potential referral sources to CAMHS (Figure 2), it shows that the largest proportion of accepted referrals came from either GP (76%) or Paediatrics (12-13%). Over the reporting period ‘GP’ were by far the main source of referrals to CAMHS, with ‘paediatrics / child health / in-patient service’ being the second most common referral agent.

Figure 2: Referrals accepted by Source- 2017 /18- 2019/20

\*referral source for Step 2, Step 3 (core), Eating Disorders and DAMHS.

The 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 allow professionals, other than GP, to refer young people to mental health services. The aim was to simplify patient pathways and speed up the referral process. It was also in recognition of the fact that GPs do no 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)

4.1 Crisis Referrals

Data for the period 2017/18 to 2019/2020 shows that crisis referrals came from three of twelve potential sources- Emergency Department, including Card Before You Leave, General Hospital and GP (Figure 3). In 2018/19 and 2019/20, approximately 89% of all referrals to crisis services came from these sources. It again highlights pressure on universal services which are not equipped to deal with these cases and draws attention to a lack of involvement of key stakeholders that should be more active in crisis care such as specialist crisis response teams, the voluntary and community sector services and social services. In Still Waiting, NICCY made a number of pointed recommendations regarding crisis support for children and young people (Rec 21-25).

Figure 3: Referrals accepted by Source for crisis care- 2017 /18- 2018/19

\*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 records 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.

The Still Waiting Review reported on regional non-attendance rates for Step 3 / Core CAMHS over a 3-year period between 2013-2016 and highlighted that rates had persisted around 15-16% for first appointment (new) and 24% for review appointments (p215-216). In the report, NICCY raised concerns about the number of young people not attending appointments, including the fact that the reasons for non-attendance are not monitored by the Health and Social Care Board (HSCB) and that there were no plans to do so. NICCY was also concerned about compliance with IEAP guidance which stipulates the procedures that must be undertaken before discharging a patient due to non- attendance; there was no data available on the number of young people being discharged from the statutory CAMHS system due to non-attendance (p214-216) as non-attendance is not monitored by HSCB. Figures on regional non-attendance rates for Step 3 / Core CAMHS for the period 2017/18- 2019/20 show that overall rates have not decreased, however, the pattern appears to have flipped since 2017/ 2018 with greater non-attendance for first appointments rather than review appointments.

Figure 4: Step 3 Core CAMHS: Non-Attendance for New and Review Apts 2013/14-2019/20

More generally, between 2017/18-2019/20, figures relating to any CAMHS services (global) show a considerable proportion of non-attendance at appointments (Figure 5).

Figure 5: Regional Global Non-Attendance for New and Review Appointments 2017/18-2019/20

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

The Still Waiting report which reviewed data up to 2016, identified a significant proportion of non-attendance at first and review appointments, with regional variations, and without clear regional monitoring of reasons for non-attendance. It would appear that this issue identified in Still Waiting, continues to be a problem area for services. NICCY’s review recommended that the CAMHS Dataset be augmented to record, monitor and urgently address reasons for non-attendance; and 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

New data on the clinical reason for discharge has been collected as part of the CAMHS dataset since 2018/19, Figure 6 provides data for 2018/19 and 2019/20 and shows that 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 26% that disengaged from the service. 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 2018/19-2019/20

\*suppression of data minimal for 2018/19 with no effect on % calculation

7.0 Waiting Time for Access to CAMHS

Waiting times to access CAMHS is a key quality indicator used by the system to determine the capacity to meet demand and maximise use of resources, however, waiting lists alone should not be the sole measure of quality of care. 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]](#footnote-5) In Still Waiting, NICCY drew attention to the fact 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 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 provides a 7-year overview of the total number of young people waiting for an appointment at Step 3 / Core CAMHS. 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 figures show that breaches of the waiting time target increased to 46% (n=552) in March 2020 which is the highest waiting time figure recorded in the last 7 years and shows that almost three times more young people were waiting over 9 weeks for a first appointment compared to the same time the year before. The data doesn’t extend across the full period affected by the pandemic, however, the potential impact of the pandemic on waiting times will be captured in future reporting.

Table 7: Regional Overview: Step 3 / Core CAMHS Waiting Times 2014-2020

|  |  |  |  |
| --- | --- | --- | --- |
| **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% |

Figure 7 shows the waiting times for children and young people to access any CAMHS service in NI at 31st March for the years 2017-2020. Between March 2017 and March 2020, the number of young people waiting for any CAMHS service increased from 1056 to 1829. This equates to a 73% increase in young people waiting for a service across the period. In the same period, there was also an increase of 722% in the number of young people waiting more than 9 weeks to access any CAMHS service (from 86 to 707).

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

Statistics also show that across all CAMHS services, the majority of the waiting time, including breaches of the 9 week waiting time target, is for Step 2 and Step 3 (core) services. A very small number of young people, if any at all, waited to access Eating Disorder Services, DAMHS or Family Trauma Centre, Crisis Service or Knowing Our Identity service (KOI). Table 8 has been provided as an illustration of this, however other years show a similar pattern.

Table 8: Waiting times by service area and Trust at March 2019



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

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

As Figure 8 and Figure 9 show each HSCT has a very different situation when it comes to the overall numbers of young people waiting to access CAMHS, and the time series data also show that waiting lists have fluctuated quite considerably within HSCTs from year to year.

Figure 8: Step 3 / Core CAMHS: Waiting Times by HSCT 2014-2020

Figure 9: Global CAMHS: Waiting Times by HSCT 2017-2020

A common explanation from HSCTs regarding spikes in waiting times are 'unplanned staff absences' and 'vacancies' alongside and increasing demand (HSCB Board Meeting Performance Report- April 2019, p16).

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. Table 7 and Figure 10 showed the proportion of young people waiting more than 9 weeks for CAMHS services. However, we know that some young people can wait far more than 9 weeks to receive a first appointment and official figures show this. Figure 10 provides a detailed breakdown of the length of time young people were waiting for a first appointment between 2017-2020 and shows that waiting times are getting longer, with some young people waiting over 39 + weeks for a first appointment. Furthermore, the full extent of the number of young people waiting to access support is not fully known because official figures only relate to those who are recorded by the system. As NICCY’s Still Waiting Review found, many young people struggle to get referred in the first place (p243-249).

Figure 10: Global CAMHS Waiting List (Greater than 9 wks) 2017-2020

8.0 Anti-depressant Prescriptions for under 18’s

Table 9 provides an overview of the number of children prescribed anti-depressants between 2014 and 2019, and the number of prescriptions dispensed across the same period. This data was requested from the Business Service Organisation (BSO). Whilst recognising technical issues regarding how prescriptions are counted which may be affecting year to year figures, the figures show that a substantial number of young people continue to be prescribed anti-depressants every year in Northern Ireland.

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)

Additional data on prescribing practice for the years 2018 and 2019 show that the number of young people being dispensed anti-depressant medication continues to rise and that

in general, the same range of drugs are listed as being prescribed to children, which includes those not recommended by NICE, namely Paroxetine and Venlafaxine. In 2019, 17,006 prescriptions were dispensed to 3480 under 18’s in Northern Ireland, these are the highest figures for number of prescriptions, and numbers of young people affected, across the reporting period.

Table 9: Anti-depressant prescribing data for under 18’s for period 2014-2019

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **No. of prescriptions to under 18's** | **No. of under 18’s in receipt of medication** | **No. of prescriptions to under 12's** | **No. of under 12's in receipt of medication** |
| **2014** | 11,077 | 2504 | 464 | 212 |
| **2015** | 12,250 | 2686 | 425 | 169 |
| **2016** | 12,793 | 2744 | 349 | 142 |
| **2017** | 12,765 | 2706 | 459 | 133 |
| **2018** | 13,296 | 3155 | 586 | 137 |
| **2019** | 17,006 | 3480 | 802 | 149 |

|  |
| --- |
| NB. Historically, between 10-20% of all prescription forms in any given month could not be scanned. Due to this issue all figures provided are estimates only and will be an undercount of the true number of prescriptions prescribed to patients aged under 18 in Northern Ireland. |
| Please also note that the overall proportion of prescriptions for antidepressant items where the patient information was not available was: 2017 [21%]; 2018 [25%]; 2019 [11%]. |
| There has been a significant improvement in the scanning rates towards the end of 2018 and during 2019 due to a refresh of the scanner’s in BSO. More patients can now be identified which means at least some of the increase in the volumes between years could be attributed to the increased scan rate. |

Antidepressant prescribing data must also be viewed in the context of other systemic issues affecting care and treatment options for children and young people, this includes waiting times for access to psychological therapies which is discussed below.

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. It is also a reminder that waiting times for a first appointment to CAMHS is the first stage in their pathway to accessing treatment / support and that young people may face a range of additional ‘internal waits’. As stated above, availability of psychological therapies is very significant in the context of how much medication is prescribed to children and young people. NICCY’s Still Waiting Report recommended that the CAMHS Dataset should include data on waiting times for psychological therapies and types of therapies used with under 18’s (p 258-261). It also recommended that prescribing data was monitored to ensure compliance with NICE guideline and that where medication is prescribed to a young person with a history of alcohol and/or drug problems this should be risk assessed and appropriately supervised (Rec 14, p275).

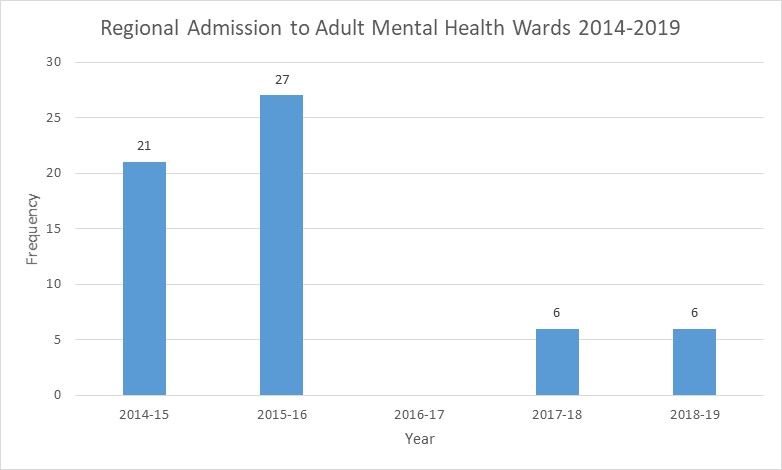
Figure 11 was extracted from data provided at HSCB Board meetings and shows the number of under 18’s waiting more than 13 weeks for access to psychological therapies for child psychology and children’s learning disability are growing at a considerable rate. We understand that psychological therapies sit within a different work area and the figures are not included as part of the CAMHS dataset. NICCY is of the view that this work should link clearly to the CAMHS dataset and the figures should be included as these therapies are being provided to children and young people. The Health and Social Care Board meet with all the Trusts in respect of breaches and the development of service improvement plans to prevent further escalation and to reduce the number of breaches as much as possible. The accepted view by the HSCB and HSCTs is that the current problems will not be addressed in a sustainable way without additional recurrent investment.[[6]](#footnote-6)

Figure 11: Number of under 18’s waiting more than 13 wks for access to psychological therapies

9.0 Under 18 admissions to adult ward

Data on under 18 admissions to adult wards was requested from the Regulation and Quality Improvement Authority (RQIA). The number of under 18’s admitted to adult wards has remained at 6 per year since 2017 /18 (Figure 12). Furthermore, there has been no repeat admissions recorded since 2016/17, the average length of stay has increased across the reporting period but the maximum length of stay has reduced significantly from 100 to 48 days. (Table 10)

Figure 12: Regional Admission to Adult Mental health Wards



\*under 5

Table 10: Under 18's 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 | | \* | |
| **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 | |
| *\*less than 5 repeat admissions in 14-15* |  |  | |  | |
| *^ one young person remained in an adult ward for 48 days which raised the average to 23 in 2018/19* | | | | | | |

10.0 Beechcroft

Figure 13 shows the annual admission and discharges from Beechcroft between 2013 and 2019. The figures show that annual admissions have increased across the period whilst annual rates of discharge have fallen. Table 11 provides an overview of activity in the unit at 31 March, for the years 2017-2020 and shows that numbers of young people being cared for in the unit has fallen from 29 on 2017 to 19 in 2020.

Figure 13: Beechcroft Admissions and Discharges 2013/14-2019/20

Table 11: In-patient numbers, delayed discharges and length of stay 2017-2019

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **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 | 276 | 5 | 24 | 150 | 77 | 25 |
| 2020 | 19 | 0 | 0 | 12 | 0 | 0 |

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

Table 11: In-patient numbers, delayed discharges and length of stay 2017-2019

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | **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 |

11.0 Iveagh Centre

As of 28 August 2019, 3 young people were on a waiting list to be admitted to Iveagh from two HSCT areas. Please note that this figure is likely to be a significant under-representation of the real situation as referral agents are not likely to make a referral if it is known that no beds are available.[[7]](#footnote-7)

It is also the case that on occasion young people more suitable for Iveagh are being placed in Beechcroft due to a lack of capacity at Iveagh although a small number of young people appear to be affected by this i.e. 1-2 per year[[8]](#footnote-8), it is concerning that this is happening and that there is no statutory obligation for a HSCT to inform RQIA when a young person is assessed as requiring admission to the Iveagh Centre but is admitted to Beechcroft. However, we have been informed that co-working arrangements are in place to ensure that any young person admitted to Beechcroft, who receives community Intellectual Disability services, is cared for jointly by the Consultant Psychiatrist covering Iveagh and Consultant Psychiatrist covering Beechcroft.

At 27 August 2019, there were 7 young people being treated in Iveagh, and four of the young people were experiencing extreme delayed discharge, the average delayed discharge was 378 days (over a year) and ranged between 280 days to 546 days (1 ½ yrs). 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.

Table 1.0 outlines the minimum, maximum and average length of stay between 2017 and 2019 and shows that the minimum length of stay was 7 days, maximum stay 870 days (well over 2 years) and the average length of stay was 1 year (351 days).

It is important to note that the Iveagh Centre is a hospital therefore stays of 1 -2 years are completely out of line with its service specification.

Table 12

|  |  |  |  |
| --- | --- | --- | --- |
| Length of Stay at Iveagh (in days) between 2017-2019 | | | |
|  | Minimum | Maximum | Average |
| Days | 7 | 870 | 351 |

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 2019/20.[[9]](#footnote-9) 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 2014-2020. 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 new cases and ongoing children and young people subject to an ECR across a 6-year period, between 2014/15 and 2019/20. It shows that the number of children that have been transferred to an in-patient facility outside of NI has ranged between 20 and 14, and 2019/20 recorded the lowest number of placements at 14. The table also shows that annually, since 2014/ 15, there have been 1-9 in-year admissions to a facility outside of NI under ECR. The total cost of ECRs across the 6 years was £26 million, ranging between £2.5 million and 7 million.

Table 12: Non Acute Family and Child Care ECRs included for 2014/15-2019-20

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **No. of ECR Placements** | **No. of In Year Admissions** | **Total Cost** |
| 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 | 14 | >10 | £5,306,187 |
| **TOTALS:** | **102** | >10 | **£26,096,457** |

**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.[[10]](#footnote-10)

Between 2014/15 and 2019/20 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 dual diagnosis / co-occurring mental health and substance use problems.

Table 13: Primary condition of young people referred under an ECR between 2014/15 and 2019/20

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

12.2 ECR- Age Range & Length of Admission

The majority of children transferred under an ECR were in their teens, however, a number were pre-teen, a further breakdown is not possible due to the potential of identifying individuals. 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 N. Ireland at the earliest opportunity. Table 14 shows that there is a significant range with respect to the minimum, maximum and average length of time young people are treated out of jurisdiction. The minimum length of time was 4 days and the maximum 1826 days (5 years), with an average stay of 244 days.

Table 14: Length of admissions i.e. (average, maximum and minimum) 2014/15-2019/20

|  |  |  |
| --- | --- | --- |
| Number of days | | |
| Average: 244 | Minimum : 4 | Maximum: 1826 |

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 which is not as yet being collected across HSCTs. 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:

1. Waiting times for services beyond Generic Step 3 CAMHS, to include key services across Steps 2 – 5 and waiting times for urgent and emergency appointments to Step 3 CAMHS;
2. Waiting times between referral being made and referral being accepted or not accepted;
3. 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.[[11]](#footnote-11)

14.0 Conclusion

Progress is being made in the amount and quality of standardised regional data being collected across the system, however, there continues to be significant gaps in what is collected, and what data is available in the public domain. In the absence of a publically available comprehensive CAMHS Dataset, NICCY has published this report which is a compilation of mental health data it has been reviewing and collecting between 2017-2020.

Overall, the data in this report represents a very concerning picture of the mental health system in Northern Ireland. The waiting time statistics for CAMHS and for psychological therapies are some of the starkest illustrations of a system at breaking point, and unable to provide an accessible service. These increasing waiting lists are against a backdrop of rising demand in the face of covid pandemic; and the situation will not improve without a significant annual uplift in the proportion of the block grant that goes to children’s mental health services and support.

The continuing increase in the number of prescriptions given to under 18’s and under 12’s is significant, and is particularly concerning when one considers the extent of the waiting lists for referral and access to psychological therapies.

The referral source data illustrates the continuing pressure on a small number of universal services, specifically GP and A&E (for crisis), for making referrals to CAMHS. Regrettably the data does not indicate an extension in the types ‘referral agent’ being used, to simply referral pathways and ensure that those professionals that know young people best are positioned to refer to CAMHS, and which was part of a number of recommendations made in NICCY’s ‘Still Waiting’ Review. It is also vital that crisis support is in place so that young people that do not need to go to A&E have other more appropriate sources of support.

Rates of non-attendance at appointment for first and review appointments are not decreasing. It is very concerning that young people who require professional mental health support are not attending appointments. The reasons for non-attendance must be monitored and measures put in place to bring these figures down.

The ongoing issue of delayed discharge from the Iveagh Centre is one of the most egregious breaches of children’s rights evident in Northern Ireland. The need to address the lack of long term planning for the needs of these children, needs which are often evident from birth, must be addressed by the NI Government with the utmost urgency.

These concluding points touch upon just some of the key issues highlighted by the data in this report, however, we recommend that this mental health data report is reviewed alongside NICCY’s monitoring report which incorporates and reflects on more of the key data contained in this report, as part of its assessment of progress against the Inter-Departmental Still Waiting Action Plan (SWAP). The SWAP is the response to the recommendations set out in NICCYs review of mental health services and support for children and young people in Northern Ireland.

1. Further information available from [Mental Health Review - Still Waiting (niccy.org)](https://www.niccy.org/about-us/our-current-work/mental-health-review-still-waiting/) [↑](#footnote-ref-1)
2. Ibid. [↑](#footnote-ref-2)
3. Further details on CAMHS services are available from CAMHS Pathway Document- HSCB 2018 [↑](#footnote-ref-3)
4. [HSCB Board minutes- Sept 2019](http://www.hscboard.hscni.net/download/PUBLIC-MEETINGS/HSC%20BOARD/board_meetings_2019/september_2019/Item-08-02-DSF-Overview-Report-March-2019.pdf), p16 [↑](#footnote-ref-4)
5. HSCB (2018) Regional CAMHS Services Review Group (CAMHS Dataset), Definitions, Version 9, p10 (3.25-2.36) [↑](#footnote-ref-5)
6. [HSCB Board Meeting Minutes Sept 2019](http://www.hscboard.hscni.net/download/PUBLIC-MEETINGS/HSC%20BOARD/board_meetings_2019/september_2019/Item-08-02-DSF-Overview-Report-March-2019.pdf), p. 17 [↑](#footnote-ref-6)
7. Meeting with Iveagh Staff-03.05.2019 [↑](#footnote-ref-7)
8. Information shared with NICCY Legal Team, June 2018; Letters from HSCB to NICCY dated July 2020 [↑](#footnote-ref-8)
9. ECR Data Report provided to NICCY by HSCB- 22.10.20 [↑](#footnote-ref-9)
10. ibid [↑](#footnote-ref-10)
11. NICCY requested data from the Department for Health pertaining to this issue. 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).* However, in July 2020, the DoH responded to an Assembly Written Question detailing the number of people presenting to (i) Altnagelvin Hospital; and (ii) Causeway Hospital, in relation to mental ill-health, broken down by age category for the period Jun 2019-May 2020 using data provided by the WHSCT (AQW 5324/17-22) [↑](#footnote-ref-11)